EMORY
HEALTHCARE

From Cohort to Consent

Choosing the Right Epic Recruitment Path

A practical framework for IRB review of MyChart invitations, silent alerts, and study team-driven outreach

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A decision-focused conversation

What IRB staff should be able to distinguish by the end

01 **Why recruitment stalls**

02 **How Epic can intervene**

03 **Three recruitment mechanisms**

04 **How we choose the right path**

05 **Metrics, safeguards, and the future**

The recruitment problem is not one problem

Discovery, trust, eligibility, timing, and capacity fail at different points

Patients

- May never learn that a study exists
- May distrust unfamiliar outreach

Study teams

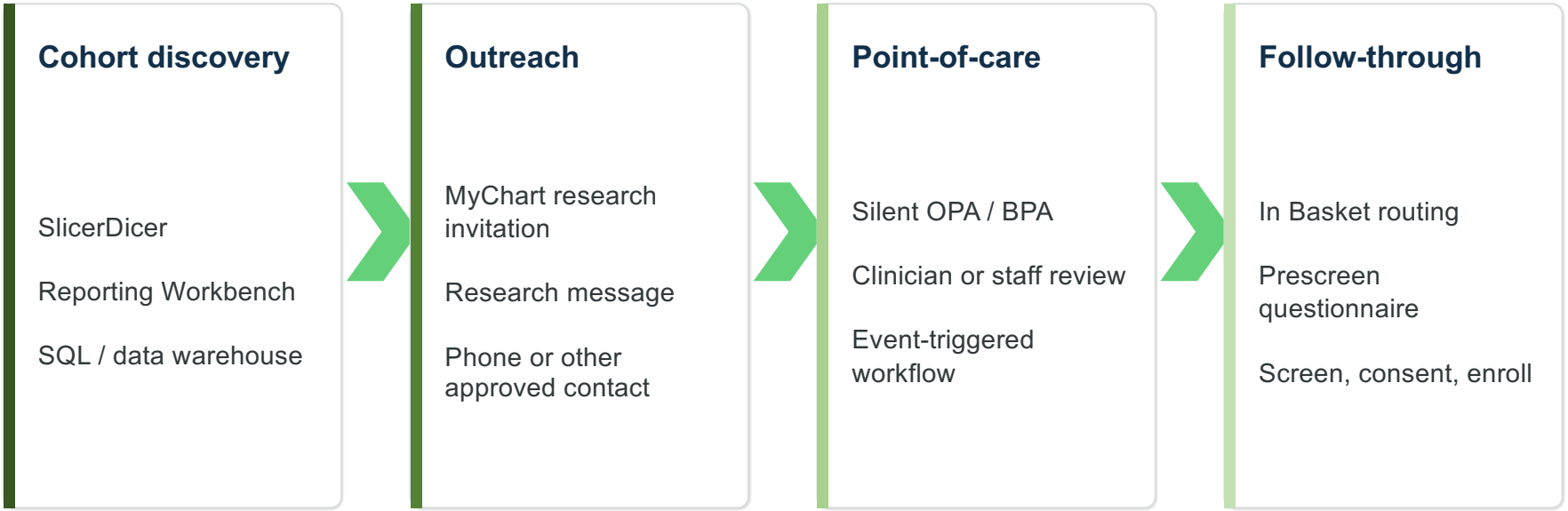
- Cannot efficiently find the right cohort
- May lack rapid follow-up capacity
- Screening outcomes may be inconsistently tracked

Health system

- Balance reach, privacy, burden, and fairness
- Needs repeatable governance and auditable workflows

Epic recruitment is an ecosystem, not a single tool

Mechanisms differ by trigger, outreach channel, and who initiates the next step



IRB protocol should name the pathway, source cohort, message content

Three Epic-enabled recruitment paths

Each mechanism fits a different combination of scale, urgency, and computability

Bulk MyChart invitations

Best for
Large computable cohorts; recurring outreach; patient-controlled response

Watch for
MyChart access, invitation fatigue, follow-up capacity

Silent OPA / BPA

Best for
Event-triggered or visit-linked opportunities requiring clinician/staff review

Watch for
Alert burden, missed triggers, workflow ownership

Study team-driven analytics

Best for
Exploration, targeted lists, lower-volume recruitment, iterative criteria

Watch for
Manual review, access controls, inconsistent outreach execution

MyChart: controlled, patient-facing recruitment

A research invitation is a defined workflow, not an ad hoc portal message



Why it works

Secure channel tied to an authenticated patient account

What makes it “research recruitment”

Study-specific invitation with clear rationale, responsible party, concise study description, and explicit response choices

Operational handoff

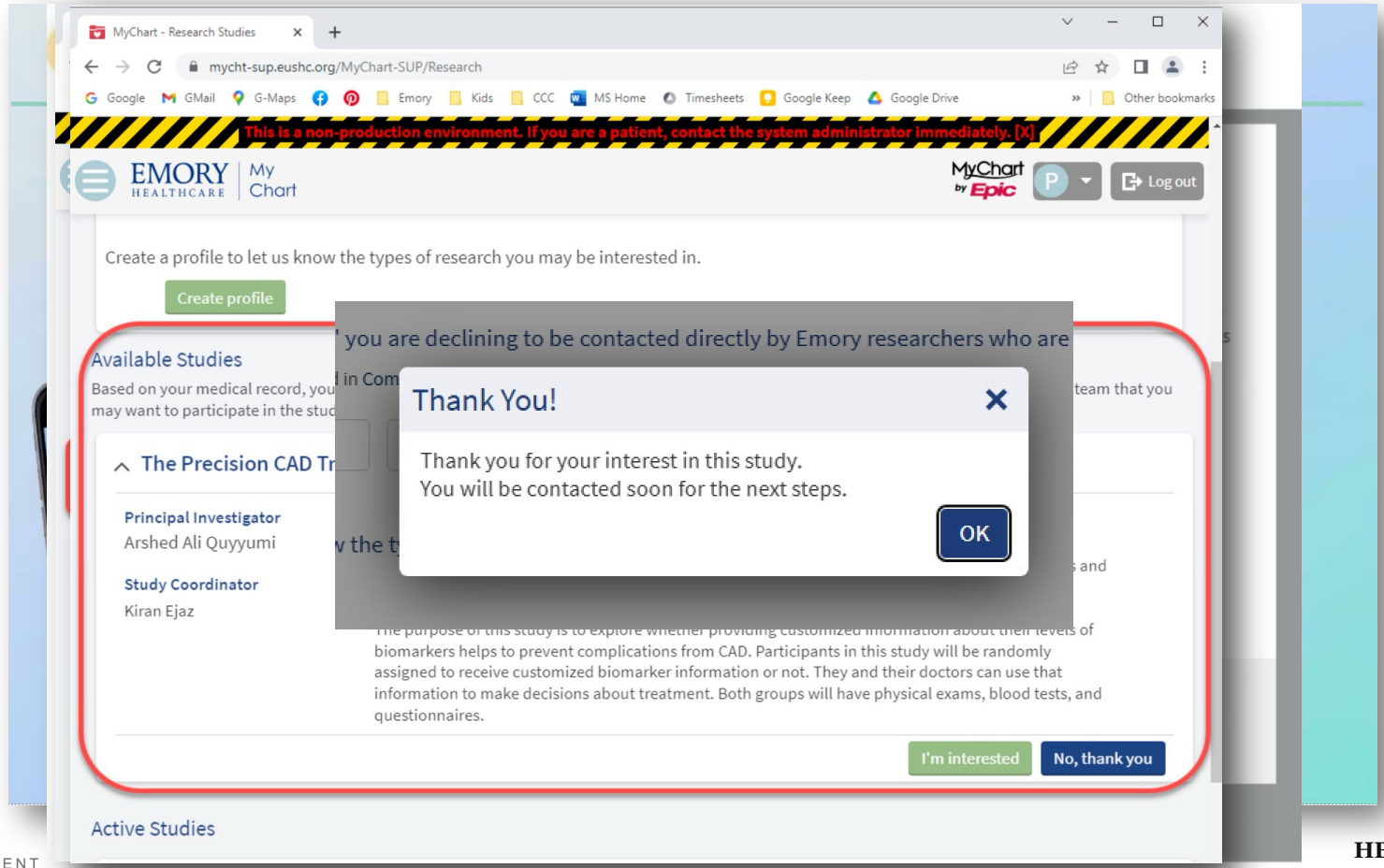
Interested responses route to the study team for screening, consent, and enrollment

MyChart: controlled, patient-facing recruitment

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Email/SMS MyChart notification

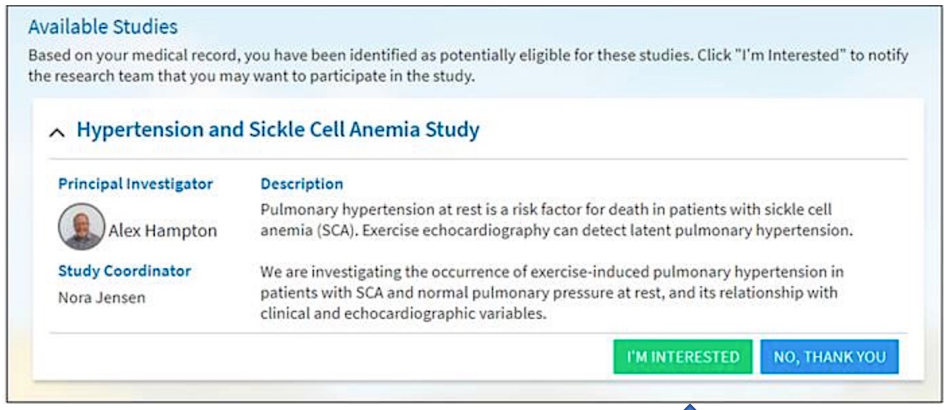
Open MyChart



Anatomy of the Invitation

Why am I being contacted

What issue/disease is being studied 1-2 sentences max. Purpose is for participants to recognize a disease/issue they are familiar with to draw their attention the purpose and motivation to study it.



Who is responsible

Call to action

What does the study entail broadly speaking.

Based on experience from other institutions:

Johns Hopkins Institute for Clinical & Translational Research

Yale School of Medicine

UCSF Participant Recruitment Clinical & Translational Science Institute

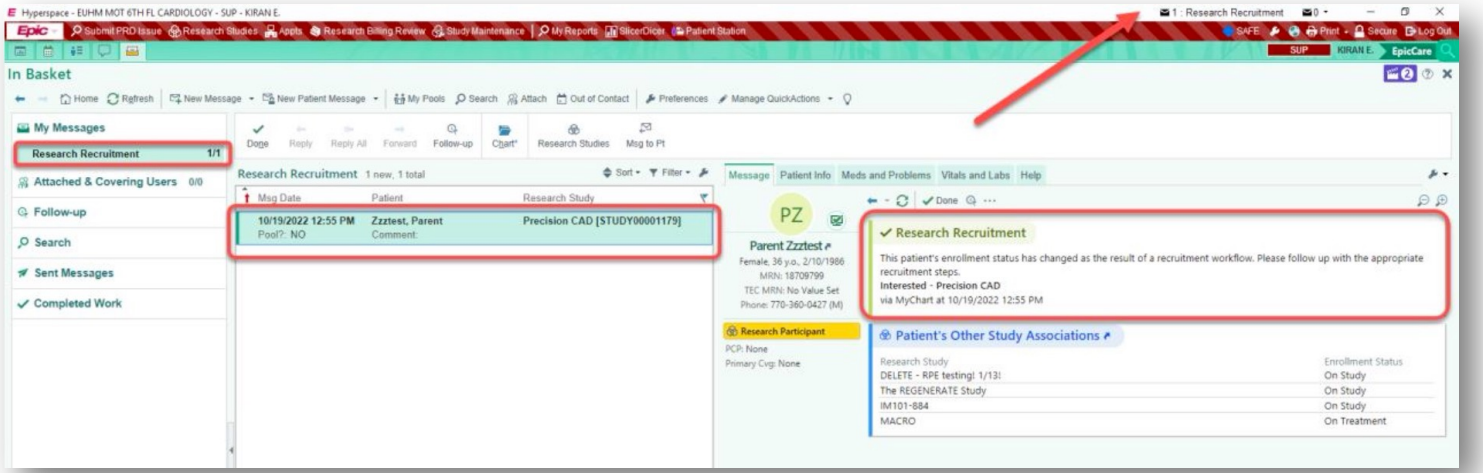
MUSC Health Medical University of South Carolina

University of Rochester Medical Center

Allows for rich formatting, images, tables, hyperlinks, barcodes, QR codes, and different alignments

Study Team Perspective

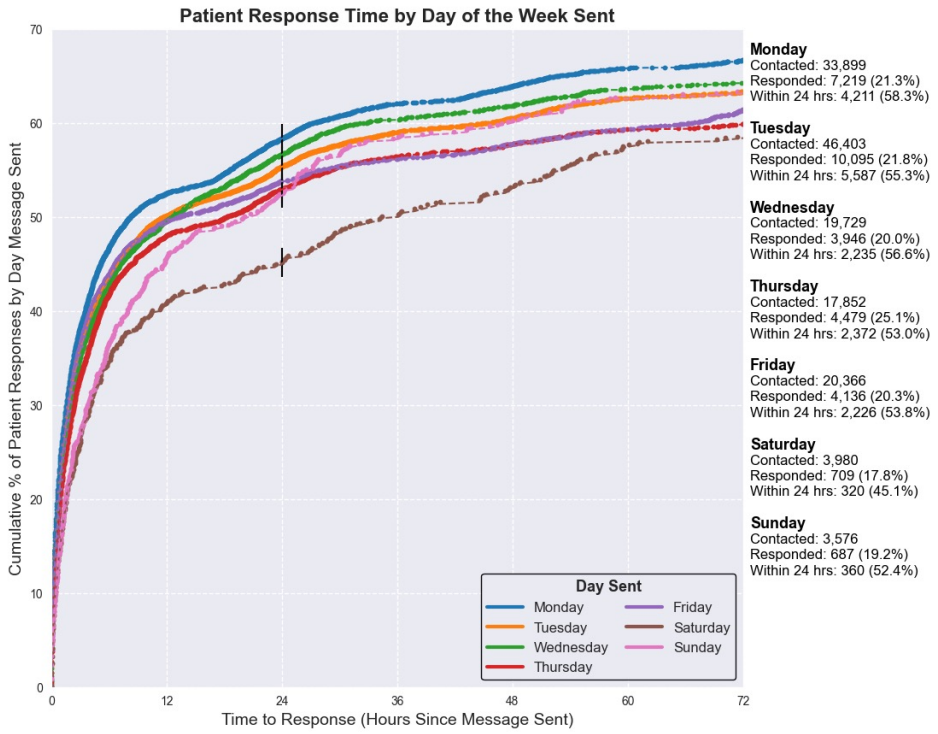
Study Team gets In Basket Message after patient responds



Coordinator contacts patient and further screens, consents, enrolls

Experience So far

- Patients respond quickly
  - Most often within 24
  - Study teams need capacity to respond
    - How many patients can be screened per day after an “interested” response?
    - Do we prioritize more frequent, smaller batches of invitations instead of infrequent large batches?
    - Does the study team have adequate screening log procedures?



Research invitation ≠ ad hoc MyChart message

The distinction matters for transparency, tracking, and patient choice

Dimension	Research invitation	Ad hoc MyChart messaging
Purpose	Structured invitation to a specific IRB-approved study	General communication that may not use research recruitment workflow
Patient choice	“I’m interested” or “No, thank you”	Reply behavior depends on message type
Routing	Research-specific In Basket notification	May route to a general pool or sender
Measurement	Invited, interested, declined, screened, enrolled	Often difficult to connect outreach to recruitment funnel
Governance	Defined cohort, cadence, message, and study linkage	Higher risk of inconsistent content and contact practices

IRB takeaway: approve the intended mechanism, not just the words in the message.

Measure the funnel, not only enrollment



Interested and declined responses are immediate signals. Enrollment depends on downstream screening, consent, documentation, and study-team workflow.

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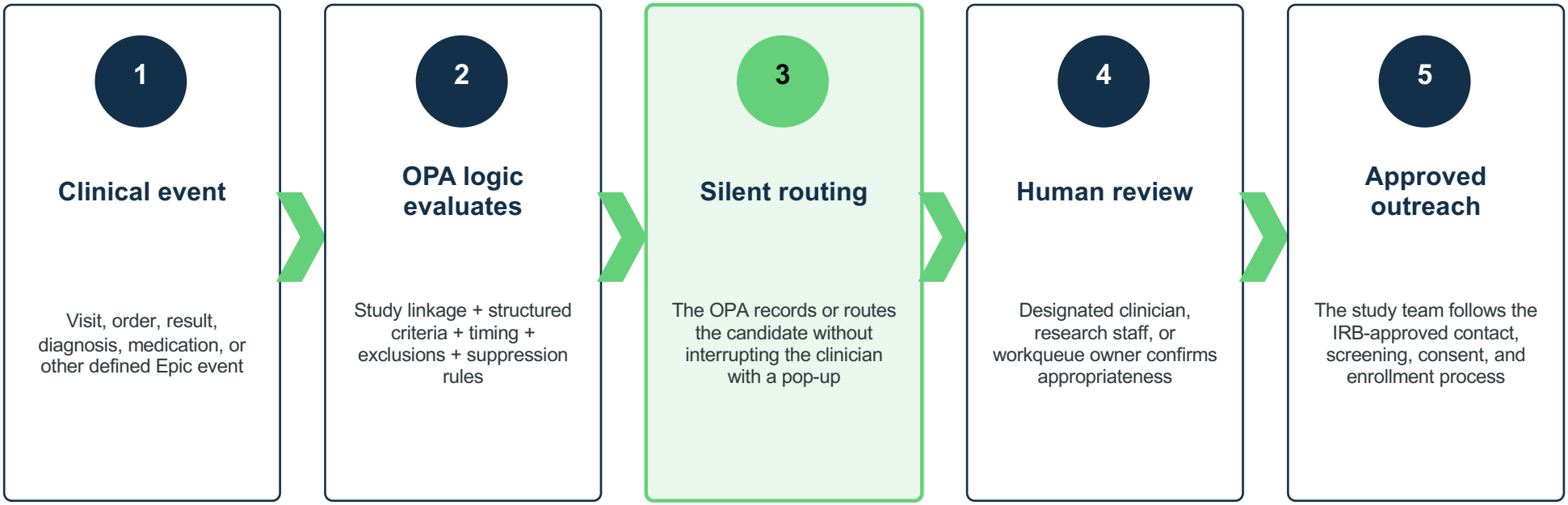
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How a silent OPA recruitment workflow works

The alert identifies an opportunity and routes it for review; it does not automatically determine final eligibility or authorize contact



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When is a silent OPA the best option?

Choose it when eligibility becomes meaningful inside a clinical workflow, not simply because a patient exists in a cohort

Time-sensitive trigger

A visit, order, diagnosis, result, treatment decision, or discharge creates a short recruitment window.

Clinical context matters

A clinician or designated staff member must confirm appropriateness before the study team approaches the patient.

Criteria are triggerable

The key signal can be represented reliably in Epic with structured data and precise timing logic.

Manageable volume

The expected number of firings is low enough for the receiving workflow to review and act consistently.

OPA sweet spot — **Event-linked + clinically contextual + computable + actionable now**

Not ideal for broad awareness campaigns or very large cohorts

Build decisions for an OPA

Approval should describe the operational mechanism, not only the eligibility criteria

Decision	What should be specified
Trigger	Exact encounter, order, result, diagnosis, or other event that causes evaluation
Candidate logic	Inclusions, exclusions, lookback windows, study linkage, and data elements used
Recipient	Who reviews the candidate, what the reviewer sees
Suppression	Repeat-fire interval, prior decline, prior screening, enrollment, study closure, and expiration
Contact boundary	Whether clinician permission is required before study-team outreach and how that approval is documented
Monitoring	Firings, unique candidates, reviewed, contacted, screened, eligible, consented, enrolled
Fallback	What happens when routing fails, ownership changes, or the study team cannot act within the recruitment window

Good OPA design

High precision
Low unnecessary firing
Clear owner
Auditable disposition
Time-limited build

Common failure modes

Alert without action
No suppression logic
Overly broad phenotype
No monitoring plan

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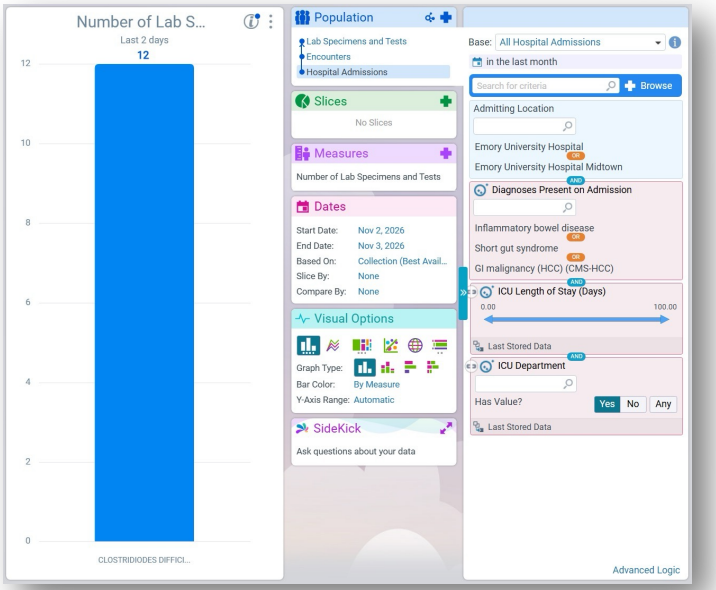
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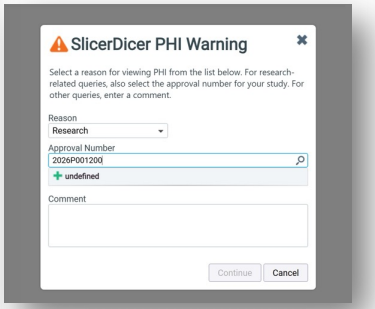
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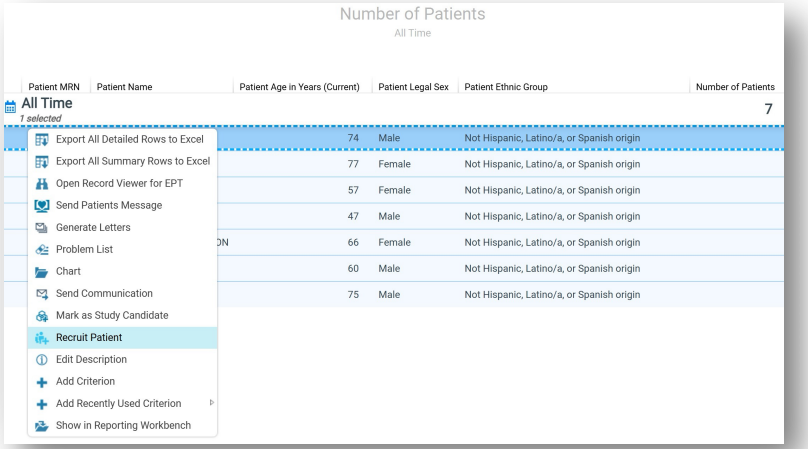
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Study Team Driven – Option 1

Slicer Dicer → **Epic Study Linkage** → **Review Chart** → **Recruit to Study**

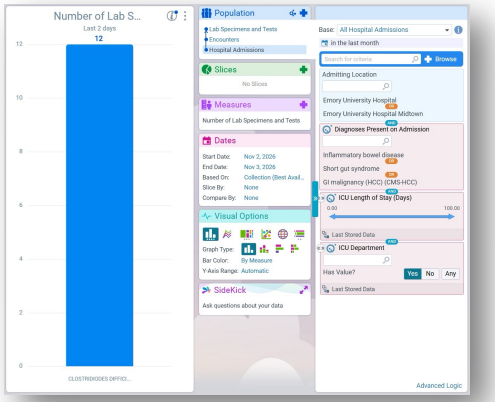


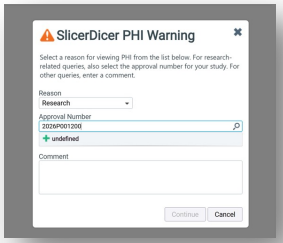


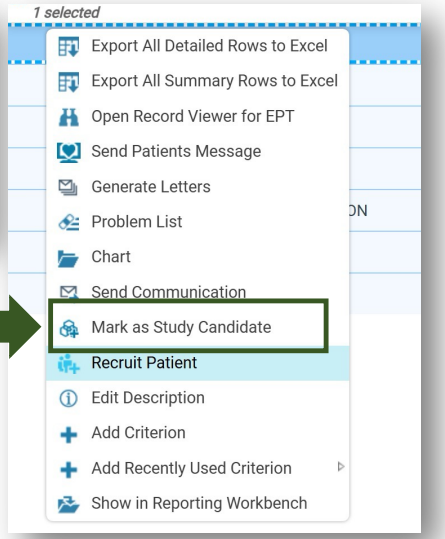


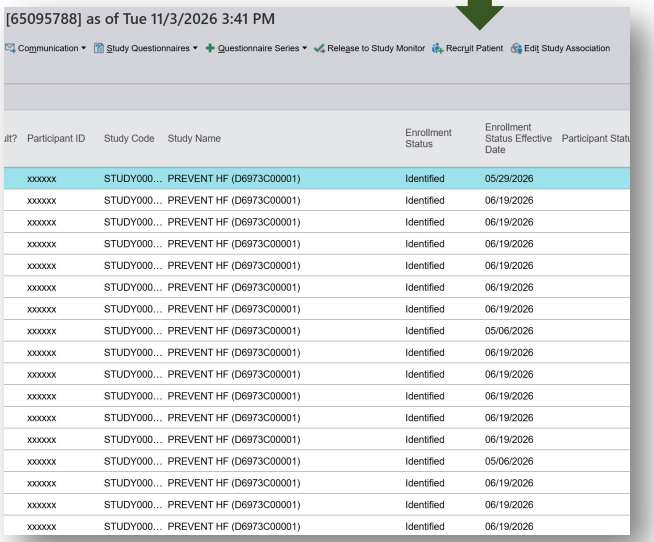
Study Team Driven – Option 2

Slicer Dicer → **Mark as Study Candidate** → **Run Report of Candidates** → **Recruit to Study**









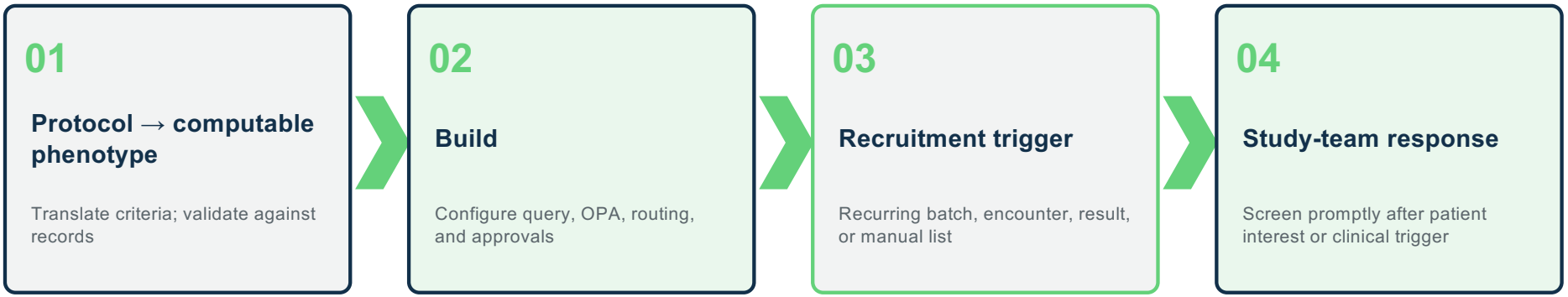
What is the right path?

Use a small set of factors to make the mechanism explicit and defensible

Factor	Bulk MyChart	Silent OPA/BPA	Analytics-driven
Enrollment target	High	Low to moderate	Low to moderate
Timeline	Recurring / planned	Immediate event-based	Flexible / iterative
Potential pool	Large	Event linked	Known or discoverable
Criteria	Mostly structured	Triggerable in workflow	May require manual refinement
Build effort	Moderate to high	Moderate to high	Low to moderate
Team capacity	Must handle response bursts	Must fit clinical workflow	Must review and contact lists
Best control	Batch size + cadence	Trigger + suppression	Access + outreach SOP

Timing can determine the mechanism

Separate “time to build” from “time to identify and contact”



If eligibility depends on an event that must be acted on immediately, a scheduled cohort pull may be too slow.

If recruitment ends soon, a new build may not mature in time.

Study team feedback is encouraging

The strongest signal is improved reach, but success still depends on workflow discipline

Cdiff Study (C4771002)

2–3 / month

before MyChart

5–9 / month

after MyChart

Study team feedback

“Game-changing” and easier to target than broad advertising

Operational reality

Patients often respond within 24–48 hours, so teams need timely screening and adequate capacity

Interpret cautiously

A before-and-after example is useful operational evidence, but it is not a controlled effectiveness comparison. Track invitations, eligibility, consent, and enrollment over time.

IRB review

Population definition

Source system, inclusion logic, exclusions, validation plan

Contact plan

Channel, wording, sender, frequency, batch size, repeat-contact interval

Patient choice

Clear opt-out or decline pathway; respect contact preferences

Human factors

Alert burden, clinician discretion, accessibility, language, non-MyChart patients

Data handling

Minimum necessary access, export controls, list retention, role-based permissions

Accountability

Named owner for responses, screening logs, deviations, and outcome reporting

Future: AI-assisted eligibility

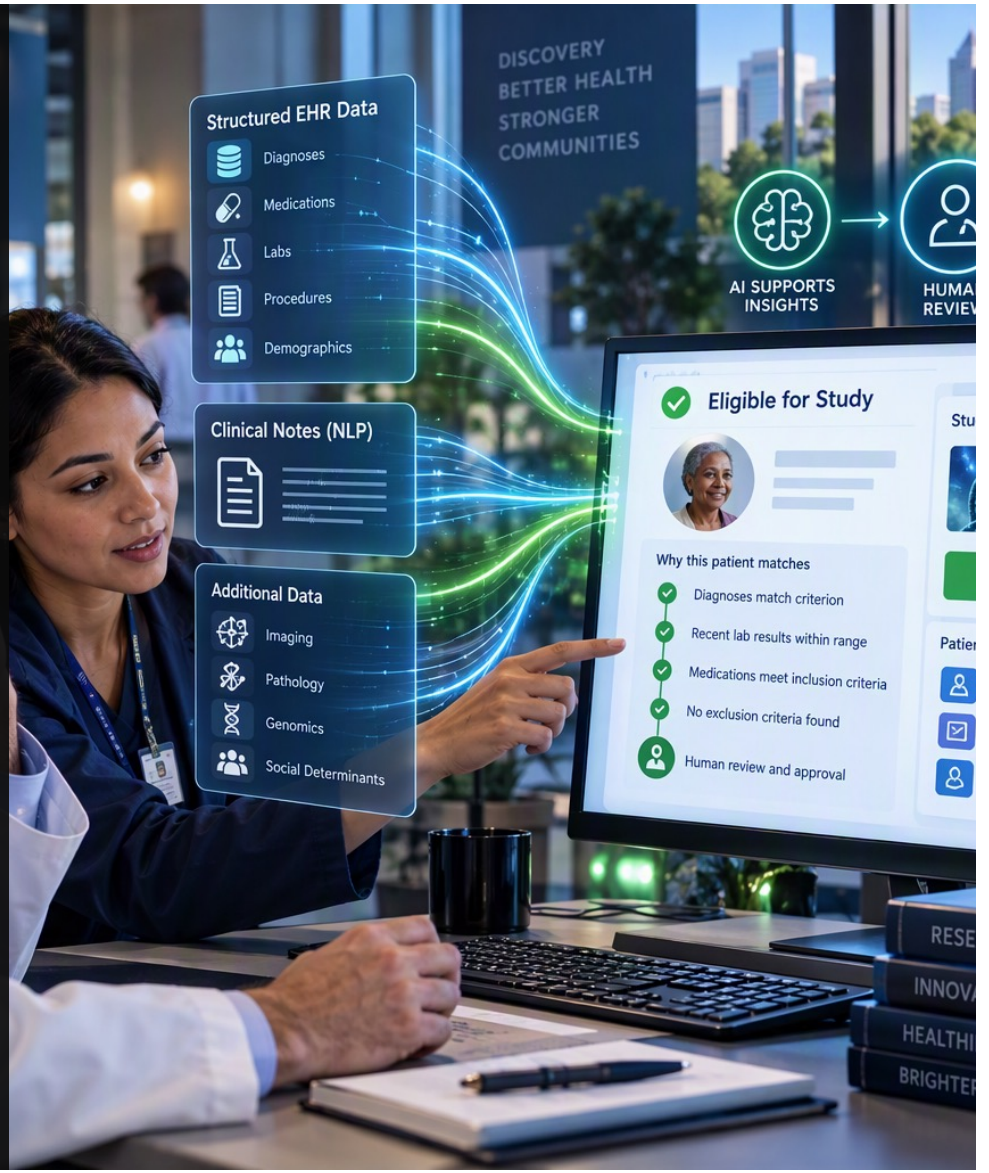
Potential value

- Extract candidate criteria from notes and reports
- Rank charts for human review
- Reduce manual prescreening time
- Identify data-quality gaps

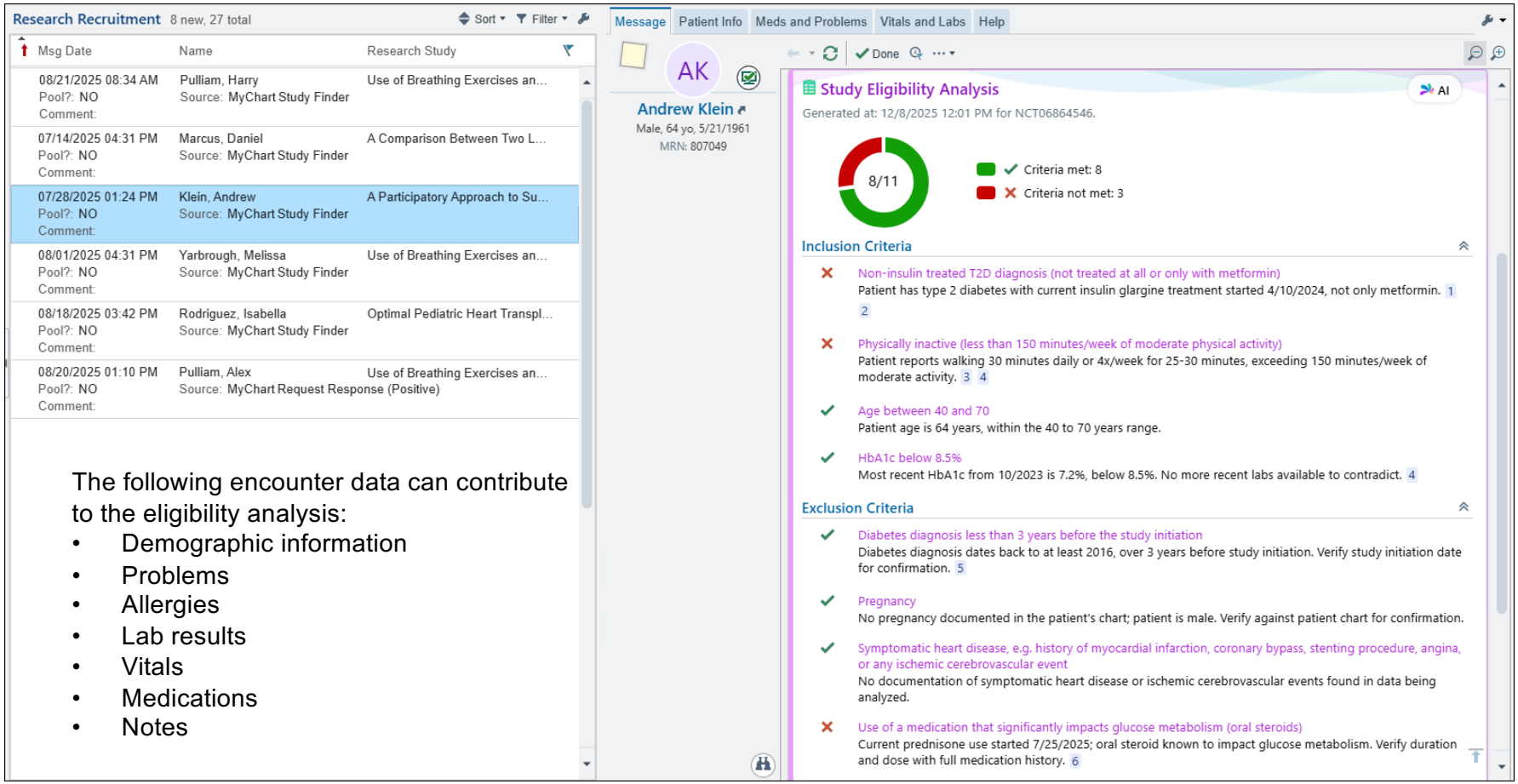
IRB and governance requirements

- Explainability and validation
- Bias and subgroup performance
- Human confirmation before contact
- Versioning, monitoring, and auditability

AI can prioritize review. It should not silently redefine eligibility or authorize patient contact.



How it works



In Basket recruitment message → Eligibility Analysis

A practical approval question

Does the pathway fit the study and protect the patient?

1. Who is being identified, and from which data?
2. Why is this mechanism better than alternatives?
3. When and how often will patients be contacted?
4. Who receives and acts on responses?
5. How will reach, interest, decline, screening, and enrollment be measured?

Questions & discussion