Opioid Prescribing: Chart Review Procedure (SOP #3) **Purpose**:

This procedure describes how staff (Chart Reviewers) in primary care practices review charts of patients who are prescribed opioids and answer REDCap[1] survey questions about their treatment . This procedure includes the equipment needed and a list of documents used in training and to collect data.

Setting up for Chart Review: Needed items checklist

- A room or desk space in an office.
- One or two desktop or laptop computers. The computers must be able to access the patient electronic record system of the practice and the Internet for REDCap at the same time, and, for the training session, Zoom.
  Recommended: A large monitor screen, 2 monitor screens, or two computers to view and use two systems simultaneously.

Documents needed

- The invitation and link to access the Chart Review survey instrument in REDCap. You should have received this link by email. Keep and save this link address because you will use it every time you are working with patients charts and entering data in the survey.

- The list of patients (Study List) you will be looking up in the electronic health record as supplied by the Study Leaders and the lookup list by patient nameand birth year from the Practice Manager (Lookup List). These lists are needed for everychart review session.

- Your Practice's responses to the Practice Specific Survey. This document was filled out by your practice manager. It includes information about measures typically used such as pain level and risk assessment tools.

- A copy of the REDCap Chart Review Survey instrument in print or PDF. It's recommended to keep a print copy handy for reference. Depending on the patient record, questions may vary depending on patient circumstances.

Procedure Steps

1. Identify the next patient to review on the Study List and match to the name and year of birth on the Lookup List.
2. Open the Electronic Health Record with your credentials.

[1] REDCap is an electronic data capture system

[2]

3. Open REDCap. In the email invitation to the project you received, there is a link. Click on the link and connect to the Redcap data collection instrument called “Chart review”.

[Note: If you are interrupted or must leave the survey at any point, click Save and Return Later.. See additional directions about how to Save and Return Later at the end of this procedure.]

4. In the EHR, find the next patient to review on the Study List.
5. In the REDCap instrument, answer the questions beginning with chart reviewer initials and practice name.
6. Enter the patient ID from the list, starting with the first letter of your practice name followed by a hyphen and the patient ID number, for example: H-0001.
7. Enter date of most recent visit for a pain problem in 2022 or earlier. Date must not be later than 12/31/2022.
8. Answer all subsequent questions in the survey instrument based on the information in the patient’s chart in the EHR and follow any notes and directions in the survey instrument.
   [REDCap tip] The reviewer can delete and redo answers by using the delete key or reset button.
9. Required fields. Nearly all fields require an answer, and the survey will prompt you to answer any unanswered questions.
10. The survey may vary questions you see depending on the answer to a previous question such as “Yes” versus “No”.
11. Instructions for Sections.

    Section: *Pain Score in index visit – Tool and score*

    If there is a PEG score, include the three sub-scores, one each for Pain, Enjoyment, and General Activity, as well as the Summary score.

    Section: *Functional status in index visit – note or tool*

    If the function status is reported as a text note or provider comment in the EHR, choose the “Note or structured question” answer. There is no option to write the text of the note or comment.

    Section: *Pain score in prior visit*

    If there was no pain score found in the index visit, you will see a question for a pain score in a previous visit . If you find one, enter the score and date found. The date must be earlier than the index visit date.

    Section: *Functional Status in prior visit*

    If there was no functional status score found in the index visit, you will see a question for a functional status score in a previous visit . If you find one, enter the score and date found. The date must be earlier than the index visit date.

Section: *Chart dates for most recent occurrences of procedure in the last 2 years.*

A response to these visit procedure questions is required. Choose: "None found" if you could not find any occurrence. For Informed Consent the fully completed form with signature must be present for a "Yes" response.

Section: *Risk Assessment*

This section asks for any Risk Assessment Tools used in the last two years prior to the index visit. Check all that apply including "other" if tool used is not on the list. If no tool used, check "None Found."

Section: *Depression Screening*

This section asks the reviewer to look back two years. It may be easier to go back 2 years from index visit and come forward. The multiple-choice format of the screening tool question allows for more than 1 choice of tool. Record the score for each tool checked.

Section: *Non-medical therapies consideration referral or implementation*

Consider the non-medical therapies broadly based on provider notes. For example, consider gardening or walking as exercise.

12. When you have completed the Chart Review survey for a patient, submit the completed chart review by clicking the SUBMIT button.

OR

13. If you were interrupted, and must leave the survey, or wish to come back to it, click Save and Return Later button located at the bottom of the survey. A box with a code will pop up. Write down the code and close the box. In the next box that comes up, enter your email address and click. You will receive an email from the REDCap Administrator with the link to return to the incomplete survey. The email from the REDCap administrator <u>will not</u> supply the code. Go to the link and enter the code that you had saved or written down elsewhere and continue the survey to completion.

14. When the survey is completed and submitted, line through the patient ID for the chart review just completed on your Study List.

Repeat the procedure for each patient on your Study List.

End SOP #3