Process Owner:
Date Issued:
Reviewed by:

Opioid List Manager Workflow

The opioid list manager is a staff person who monitors and updates patient data. This person could be a care coordinator, refill processor, nurse, MA, IT staff member, or another position as is appropriate at your organization. This workflow supports the tracking and monitoring of patients on long-term opioid therapy and is meant to be adapted based on the needs of the organization and the position of the person serving as opioid list manager. To help adapt this workflow, we included the purposes of tracking and monitoring patients on long-term opioid therapy on the next page.

Weekly

- Add any patients to the list who signed their first Patient Agreement (MAs/Nurses will regularly inform opioid list manager of all newly signed Patient Agreements).
- Look at list of patients on long-term opioid therapy for:
- Patients without a scheduled follow-up pain appointment and make a note for the front desk to schedule appointments.
- Look for all patients with pain appointment the following week. For those patients, identify any overdue care processes (urine drug test, state prescription monitoring program database check, patient agreement) and make a note in the chart for the MA.*

Monthly

Run reports to share with clinicians and Chronic Pain Management Team or Quality Improvement Committee. Reports should include identified quality measures (e.g., proportion of patients on long-term opioid therapy with an MED ≥ 90). Highlight any high-risk patients for discussion.**

*Use whatever communication process is in operation at your clinic. For example, putting this information in the "reason for visit" on the schedule.

**High risk, as defined by your organization. For example:

- Taking more than 90 mg morphine equivalent dose per day
- Taking methadone
- Age 25 years or younger
- High score (≥8) on the Opioid Risk Tool
- Overdue for care processes
- History of a past overdose
- Sleep apnea
- Substance Use Disorders
- Severe depression or anxiety

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Purposes of Tracking and Monitoring

This document tells you about four different reasons you might want to track and monitor.

Planning for Visits and Refills

- Ahead of visits or processing refills, identify patient care gaps
- Communicate patient care gaps with staff to trigger action
- Ensure data on current patient status is available to the care team (e.g., MED, last PEG score, etc.)

Monitoring the Patient Population to Improve Care Quality

- Regularly review patient data to check for care gaps and high risk patients
- Create a plan to close care gaps and attend to high risk patients

Looking for Clinical Variation

- Regularly review patient data to check for clinical variation
- Identify if a clinician has a high risk practice or is practicing outside of the clinic's policies (e.g., many patients with high MEDs) and provide one-on-one consultation with the clinician to offer assistance
- Review reports at regular medical staff meetings to facilitate conversations about how to handle complex patients
- Inform clinicians of their prescribing patterns to create peer pressure as a motivator to adhere to agreed-upon practices

Monitor Overall Success

- Determine what data are feasible to monitor. Prioritize which of these feasible data you want to use to monitor success.
- Make a plan for regularly monitoring and adjusting based on these data (e.g., query your EHR to produce a report of patient MED values by provider once per quarter).
- Understand your baseline metrics.
- Regularly share monitoring reports with clinicians and staff to help identify areas for improvement and to create buy-in.

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