1. If d/c to Rehab or SNF: do we record the prescription sent to rehab?	Record any prescriptions that that are given to the patient at the point of discharge for pain related to the surgical procedure.
2. Is Sickle Cell considered for chronic pain?	If on chronic opioids
3. Should Lido patch be considered as "multimodal pain management?	Yes. Will add to database.
4. If so, Variable 6: Type of multimodal pain management, if you choose "other" you cannot text in any names. Should this be changed?	Will add to database
5. Patient on Buprenorphine preop, transitioned to methadone for 3 days ahead of surgery, transitioned back after. I wasn't sure whether to record the chronic Buprenorphine for preop rx or the short term methadone?	Record the chronic medication not the short-term.
6. Multimodal pain management administered in preop? (gaba, Acetaminophen) For OPs this may be the extent that we find.	Okay to use. Note: MMPM is considered during the perioperative period (preop. Periop, & postop). May assign is pt. receives only one dose of a modality. Ignore if the medication is ordered as "PRN".
7. Is the first post op refill to be considered only if it is ≤ 30 days?	Yes. All refills are to be added within 30 days postop.
8. When Ketamine is administered intraop only should it be recorded as multimodal pain management?	If it is given as the primary anesthetic, do not use as multimodal pain management. If it is given as an adjunct to the primary anesthesia it can be recorded as multimodal pain management.
9. Hydromorphone is frequently being administered during anesthesia. It is not on the drop down list. Should we add this?	Yes
10. Omnicare – Pharmacy for LTC – should we record these from PDMP?	Yes. Record any prescription that is in the PDMP and follows the criteria of the variable.
11. If spinal anesthesia is used only, should it be also recorded as intraop block in POSSE?	Yes even if it is used as the primary anesthetic.

12. Round up or down for MME/D? NSQIP accepts only integers without decimals. I have been rounding down.	>/= 0.5 = Round Up </= 0.4 = Round Down
13. Max MME is 200, chronic opioid users often > 200. I have just been recording 200. Should we up the limit?	Yes. The steering committee will work with ACS to amend the registry. In the meantime, if you have a situation with MMEs =/> 200 enter 200 until this is amended.
14. Pre-op prescription should be defined as the last one filled unless you are wanting us to count up all of the MME's for all of the prescriptions filled within 180 days of surgery.	Count all prescriptions. The steering committee will work with ACS to amend the registry. In the meantime, if you have a situation with MMEs =/> 200 enter 200 until this is amended.
15. Endocet should be added to the list.	Will add to the operations manual.
16. Why can't you use the anesthesia info that we already have to provide for NSQIP?	The intent is to collect information regarding nuances beyond what NSQIP already has built.
17. What is the need to differentiate the type of blocks beyond what NSQIP recognizes as a block?	To understand the practices & variations among the hospitals.
18. Why do we have to select the modalities for multimodal?	To understand the practices & variations among the hospitals.
19. When the patient has received more than one opioid prescription at discharge, like Oxy & Tramadol, are we supposed to add up the MME's, mgs, & # of pills? Also you can only choose one drug from the list.	Total all the prescription MMEs. Will change the field to accept multiple choices.
20. Pt. takes Tramadol 50 mg BID preop. Going back 180 days that's 360 tabs. **In the POSSE database, the # of opioid pills prescribed pre-op can only be between 1-99 tablets. My guy is up to 360 tablets pre-op in 180 days.**	Strength & # of pills is optional. Only record the total MME's for the past 6 months.

21. Pt. had Tramadol 50 mg from one doc and Oxy 5 mg from us post op that would equal 40 MMEs together. You can only add one prescription to the database. If I included both scripts for the total MMEs and we are audited this would like a math error for one prescription.	Only record prescription given to patient by the hospital at discharge.
22. MD writes at discharge to continue preop pain regimen, refill later may be by physician other than surgeon – just an observation. How will we know if the refill is for surgery pain or chronic preop pain?	Record if a prescription was given to the patient at discharge. If a prescription was not given to the patient at discharge then no "Postop Opioid Prescription at Discharge" is recorded. Record opioid refill that was indicated for surgical procedure to the best of your ability.
23. Variable #5. <u>Intra-op Block Administered</u> Question: Clarify "Do not assign if local anesthetic is injected only at the initiation or end of the procedure." Tap blocks are performed prior to or at the end of the procedure, it appears the tap block would not count?	Local anesthetic is infiltrated in the skin and subcutaneous tissue. A TAP block is a nerve block that anesthetizes the nerves of the abdominal wall. Both are different types of anesthetics regardless of when it was given. TAP block will be clearly documented in the record.
24. Variable #6. <u>Type of Multi - Modal Pain Management</u> Question: Scenarios to clarify (Do not assign variable). PRN orders for these medications would not qualify if the patient did not receive the medication. Does it count if the patient receives the medication once? i.e. Patient on Ketamine and received Gabapentin once.	Can record if modality is used only once. Must not be a PRN medication.
25. Variable #7. <u>Postop Opioid Prescription at Discharge</u> Question: Definition: This question refers to <u>new medication</u> prescribed to the patient at the point of discharge. Please clarify "new".	If a prescription was given to the patient at discharge for postoperative pain regardless if they took it preop or in the hospital. Will remove "new" to avoid confusion.

-If the patient is taking Codeine in the hospital and prescribed Codeine for home does this count as yes or no? - If the patient is taking Codeine at home preop and now receives a prescription to go home with Codeine does this count as yes or no?	Yes Yes
26. Are additional / concurrent procedures and length of surgery going to be considered when the data are analyzed? I think this is a big impact – particularly for spine procedures.	Yes. Looking at all CPT codes that are recorded and all information recorded in the registry will be considered.
27. May we enter data on other cases? If I want to track some cases locally – outside the POSSE CPTs – will the data be available to me, much like when we use custom fields?	Not recommended by the steering committee as it may potentially skew the data.
28. What is the purpose of knowing which Intra-op opioid was used? Will the other Risk adjusting factors that are entered into the NSQIP case form somehow be used in a correlation between the "name" of the intra-op opioid.	Looking for how often and which opioids are used intraop and any patterns by the different hospitals.
29. What is the purpose of the pre-op opioid prescription within 180 days vs. pre-op opioid prescription filled? If they didn't have the prescription filled, I wouldn't know if they had a prescription.	To differential opioid naïve patients or not.