



July 26, 2016

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Centers for Medicaid & Medicare

Re: eMeasure: Safe Use of Opioids – Concurrent Prescribing Measure (Identifier 506)

Henry Ford Health System (HFHS) appreciates the opportunity to provide comments on the concept of an electronic clinical quality measure (eCQM) for the safe use of opioids – concurrent prescribing in inpatient and outpatient hospital settings.

HFHS is an integrated delivery system serving metropolitan Detroit and the Jackson, Michigan area. The system has six acute care hospitals and one hospital specializing in inpatient psychiatric care. HFHS provides outpatient behavioral health services, including addiction treatment and chronic pain management, at locations across the region. HFHS is a recipient of the 2011 Malcolm Baldrige National Quality Award and strives to provide high-quality care across the system to every patient.

Henry Ford Health System's (HFHS) comments focus on the five areas in which feedback was requested.

1. The usefulness of the measure to assess and improve the quality of care for patients

As stated by CMS, the intent of the proposed measure is to calculate the proportion of patients ages 18 and older with active, concurrent prescriptions for opioids at discharge or with active concurrent prescriptions for an opioid and benzodiazepine at discharge. HFHS believes the proposed measure is a useful measure to track at this point in time. Although currently there is some baseline data available, this measure may help clarify, among prescribers and other health care providers, what needs to be worked on and by which prescriber/health care provider, to help reduce the number of concurrent opioid prescriptions.

2. The appropriateness of the measure to assess hospital performance (including inpatient, outpatient, and emergency department settings) and any unintended consequences of implementing the measure

HFHS has the following concerns about unintended consequences:



- A measure designed to favor reduced use is going to conflict in some ways with other measures about patient satisfaction and about effective pain control. There has to be a balance in the measure portfolio as there is in the decision-making for individual patient. HFHS wants satisfied patients who are as pain-free as possible, but also not addicted to opioids. The measures used in pay-for-performance programs have to be chosen and balanced in such a way as to not distort the relationships among those goals.
- There is a great fear - within the community of patients with pain - that the focus on reduction of opiates will result in more pain going untreated.
- It appears that improvement will be measured by a “decreased rate of concurrent prescriptions” in the identified population. This may be problematic, in the long-term, because there is a point at which the rate cannot be decreased further without getting to an inappropriately low use rate. That rate will need to be determined before linking the rate to quality of care and/or pay-for-performance.
- If a prescriber/health care provider has a low rate and then has a slight (non-significant) increase the next year, there needs to be a method to ensure that the insignificant increase is not considered a failure.

3. Whether data elements related to the measure are available in structured, extractable fields in hospital electronic health record (EHR) systems

HFHS believes the data elements are currently available in our EHR system.

4. Whether there are any additional denominator exclusions that should be included in the measure

HFHS recommends that patients on treatment with buprenorphine and naloxone (suboxone) and/or methadone should be excluded. We want to promote treatment, and these are clearly treatments for an opioid use disorder and not problematic.

5. Whether the prescriber should be held accountable if a patient has concurrent, active prescriptions for opioids or opioids and benzodiazepines before intake and then maintains that previous regimen after discharge

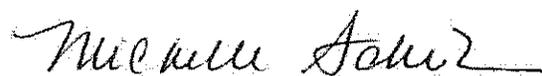
HFHS believes the prescriber should be held accountable. This is not the same, though, as saying that the hospital should be held accountable. A physician, not a hospital, is the prescriber of medications. Our belief is that a prescriber is responsible for all medications started unless the prescriber gives clear instructions that they should be stopped. As an example: An Emergency Department (ED) physician sees a patient with severe acute injury that requires 23 days of opiates, but gives a 30 day supply with no instructions to stop. The patient then goes to his/her primary care physician and has it refilled. In this instance, HFHS believes that both the ED physician and the primary care physician are accountable. On the other hand, if the ED physician prescribes a 3 day supply of opiates with instructions to change to NSAID, and another prescriber decides to continue the opiate, then the second prescriber should be held accountable.

The same would be true if a patient is admitted to a physician's service and is on an inappropriate opiate regimen. Once this physician writes to continue the opiates, then that prescriber should be held accountable.

One concern is whether physicians/prescribers are equipped to deal with possible detox/withdrawal as a result of stopping these regimens.

Thank you again for the opportunity to provide comments on this potential quality measure at an early stage of development.

Sincerely,

A handwritten signature in black ink that reads "Michelle Schreiber". The signature is written in a cursive style with a long, sweeping underline.

Michelle Schreiber
Senior Vice President, Chief Quality Officer
Henry Ford Health System