Inpatient Quality Reporting (IQR) Program

Support Contractor

The HCAHPS Survey, Pain Management, and Opioid Misuse. The CMS Perspective: *Clarifying Facts, Myths, and Approaches*

Presentation Transcript

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Matt McDonough: And good afternoon, everyone, and welcome to our webinar today. My name is Matt McDonough. I'm going to be your virtual host this afternoon. And before we begin today's event, I would like to cover some brief housekeeping items with you so that you understand how today's event is going to work and you understand how you can submit your questions to our panelists at any time throughout today's event. As you can see here on this slide, we are streaming audio over the Internet. And, if you're hearing my voice coming through your speakers right now, you know that. And that means that no telephone line is required for you to listen in today. However, you do have to keep those speakers connected and active to hear our streaming audio feed. Now, we do have a limited number of dial-in lines that are available. If you do need those numbers at

any time, please send us a chat message and one of our hosts on the line, our subject matter experts, will get that number out to you. Also, we need to let you know that today's event is being recorded to be archived and played back at a future date.

Now, for those of you who are listening over your computer speakers, you may possibly encounter a few audio issues, such as your audio breaking or suddenly stopping from your computer speakers. Now, before you dial in to today's event, there are a couple of things that you can do to try to remedy that problem. One would be to click the F5 key on your keyboard. On a PC that will cause your browser to refresh, and you'll be reconnected to the event and refresh your audio feed as well. Also, you could click the refresh button on your browser and, as illustrated here for Internet explorer, if you click that refresh button, the same thing will happen, your browser will refresh and reconnect you to our audio feed. Also, if you find that your audio is lagging behind, meaning the slide being displayed doesn't sync with what's being spoken about by our presenters, you can do this as well to refresh your audio feed and catch up so to speak.

Now, if you're hearing my voice right now, and it sounds like there are a multiple versions of me talking to you, that echo is caused by having multiple connections to an event. If you're connected more than once, you're hearing more than one audio feed. This, fortunately, is an easy problem to remedy. Simply close all but one of your browsers or tabs and that will reduce the number of audio feeds you're hearing down to one. That should clear up your echo. Again, if you find that either of these two last slides don't remedy your problem, please feel free to submit a chat question and request one of those dial-in lines, so that we can get that out to you as soon as possible.

And, although we're in a listen-only mode today on today's webinar, you do have the ability to submit questions or comments to our presenters at any time using that chat feature we spoke about. In the bottom left – excuse me – the bottom left corner of your screen, as illustrated here by this yellow arrow, there is a chat with presenter box. Simply type your question into that box and click the send button. Your question will be

visible by all presenters and as time and as resources and, most importantly as the availability of answers allows, we will answer as many questions as we can on today's event. However, please do keep in mind that all questions are being archived to be addressed in a future Q&A document.

That's going to it for my introduction. So, without further ado, I'm going to hand things over to our first speaker.

Candace Jackson: Thank you. Hello and welcome to the IQR webinar entitled *The HCAHPS Survey, Pain Management, and Opioid Misuse. The CMS Perspective: Clarifying Facts, Myths and Approaches*. My name is Candace Jackson, and I am your host for today's webinar. Today's webinar is being recorded and the transcript and the audio portion of the program will be posted on our website as well as the slides and the transcript of the questions and answers, which will be posted at a later day. Slides were already posted before the event to the Quality Reporting Center website, which is www.qualityreportingcenter.com. And now, I would like to introduce our guest speakers for today. They are Dr. Lemeneh Tefera and Dr. William Lehrman. Dr. Tefera served as the Medical Officer, resubmission and policy advisor for the Centers for Medicare & Medicaid Services Hospital Value-Based Purchasing Program, in addition to the lead opioid quality advisor for the Center for Clinical Standards Quality. Dr. William G. Lehrman is the government task leader for the HCAHPS survey at CMS. Since joining CMS in 2003, he has participated in the development, management, public reporting, oversight and analysis of HCAHPS. He is also involved in the development and implementation of the Hospital Value-Based Purchasing and the comprehensive care for joint replacement program and the coordination of patient experience survey at CMS. Prior to joining CMS, Dr. Lehrman taught and conducted research on organizations at universities in the U.S., Australia, and Japan. And now, Dr. Tefera will begin our webinar. Dr. Tefera, the floor is yours.

Lemeneh Tefera: Thank you, Candace, and thank you to all the participants who joined today, especially in the northeast where we're dealing with a lot of snow.

I'd just like to review our objectives and overview to start. I'm going to give a background of the history of the prescription opioid epidemic. We'll be describing the methodology of the Hospital Consumer Assessment of Healthcare Providers and System Survey or the HCAHPS Survey. We'll also be discussing the rationale for pain management in HCAHPS, the contribution of the pain – of pain management to the HCAHPS score in Hospital Value-Based Purchasing, and also HHS and CMS policy initiatives that address the prescription opioid epidemic. At the end of our presentation, we'll have an opportunity for questions and answers from our participants.

A good place to start is looking at the rates of prescription opioids sales, deaths, and substance abuse treatment admissions since 1999. This first graph from the treatment episode dataset out of DEA shows that sales have been steadily increasing since 1999 of prescription opioids. Along with increasing sales, the numbers of deaths have been increasing and the treatment admissions for opioid abuse have also been increasing in tandem.

Looking at the age-adjusted rates for drug overdose deaths and drug overdose deaths related to opioids, we see that this analysis from 2000 to 2014 shows a very clear pattern of increasing deaths overall for overdose and certainly for overdose linked to opioids, again starting in the late 1990s/2000.

When we look into more detail about what types of medications were involved in these deaths from 2000 to 2014, we can separate again overall drug overdose deaths, which is the solid blue line, natural and semi-synthetic opioids, synthetic opioids (excluding methadone and heroin). What I'd like to call out is: approaching 2011 there's a spike in heroin-related deaths and recently, after 2012, there's also a spike in synthetic opioid (excluding methadone, which is primarily fentanyl).

I'd now like to review some of the data we have regarding admissions for opiates and synthetic opioids per 1,000 – or 100,000 population for age 12

and over since 1999. The next several graphs will show a dramatic change in the number of admissions across the United States. Here is 1999.

Moving on to 2000, you see the red expanding into the southern region and further west.

In 2003, the Midwest and central areas are being impacted by these hospitalizations and you see, again, much more involvement in the northeast and the south.

In 2005, again, a coalescing of dark red in the south and more red in the middle of the country.

2007: there are a few states that do not appear dramatically affected by increased rates of admissions for opioids and synthetics nationally.

2009, we see a complete change from where we started in 1999. I think it's important to understand that this epidemic has been slowly moving and has been ongoing for the better part of 15 to 20 years.

Looking at prescription opioids dispensed since the early 1990s, again, looking at the total number of opioid dispensed, you'll see a consistent rise from year to year peaking in the early 2010s with the volume of prescription opioids. This rise was linked to several changes in practice nationally, including the marketing of opioids directly both to patients and detailing of medical providers and an expanded interest in trying to provide appropriate pain control for patients who previously felt that their pain was not adequately managed. And, in an effort to control the pain of a certain population of patients, there was a much broader marketing opioid medications to patients that traditionally were not receiving opioids.

Looking at one particular medication, oxycodone, you'll see that from 1980 to 2013 a dramatic rise in the number of milligrams per capita dispensed nationally. This medication remains amongst one of the highest prescribed opioids in the United States.

Turning back again to the death rates overall and the death rates related to opioids, we see that as a result of increased prescribing patterns, as I just reviewed in the last several slides, there has tracked a consistent trend in increasing deaths related to overdose, and in particular, opioid overdose.

Looking at who is impacted by overdoses from heroin and prescription opioid pain relievers, we see that it is not necessarily the young – the younger portion of the population that's impacted. And in fact, older patients are dramatically impacted by death related to over-the-counter – I'm sorry – opioid pain relievers and we see that there is a disparate impact by race and ethnicity, where there is a much higher impact in white and non-Hispanic patients by overdose and abuse of opioid pain relievers.

Again, historically, this started in the late 1990s and this trend is continuing to the current day.

Turning to the topic at hand of the Hospital Consumer Assessment of Healthcare Providers and Systems, the HCAHPS Survey, I'd like to review the timeline of HCAHPS. The HCAHPS Survey was launched in 2006 with voluntary reporting. The following year, mandatory reporting started. And in 2008, the first set of information from – reporting from HCAHPS was publicly reported on the *Hospital Compare* website. In 2012, the Patient Experience domain incorporated HCAHPS reporting data into the Hospital Value-Based Purchasing Program.

When we look at the previous trends in, for example, prescription opioids dispensed from 1991 to 2013, I'd like to point out that the milestones for the HCAHPS Survey did not occur until well into the development of the epidemic. So, you'll see at the first red arrow in the top left indicates that 2006 was the first year of voluntary data collection; 2007 was the first year of mandatory collection; 2008, the bottom upward pointing red arrow, was first year of public reporting on *Hospital Compare*; and 2012, the final red arrow on the top right, was the first year of the Patient Experience entering the Hospital Value-Based Purchasing Program. Again, this survey initiated well after there was clear evidence that there was already an ongoing epidemic.

Looking back to the same slides we reviewed earlier about overall overdose deaths and overdose deaths related to opioids, we see again that the highest or steepest part of the slope of the overdose curves and opioid curves really occurred in the early 2000s prior to the initiation of the HCAHPS program and the three red arrows again indicate that the initial data collection, public reporting and *Hospital Compare* and the Patient Experience domain and training of the Hospital Value-Based Purchasing Program.

Again, looking at prescription sales and deaths and comparing them to the milestones in the the HCAHPS program, there is not a correlation to the increasing number of deaths and sales of prescription opioids and the initiation of this new program at CMS.

I'll now turn it over to Dr. Lehrman, who will be reviewing details of the methodology of the HCAHPS survey.

William Lehrman: Thank you, Dr. Tefera. In this section of the presentation, I'd like to talk a little bit about the HCAHPS Survey, assuming not everybody is completely familiar with the survey; speak a little bit about how HCAHPS is a part of the Value-Based Purchasing Program for hospitals; review of crucial issues and that is the level of analysis of the HCAHPS, what it measures, and how it is applied or misapplied; and, a bit about the HCAHPS survey and opioids or other analgesics. I'd like to begin on this slide talking a bit about the method of the HCAHPS Survey. This is it very simply. We ask the patients about their experience of care in the hospital, that is we survey them. We collect this data in a standardized and consistent manner across all participating hospitals in the USA. We analyze the data here at CMS, and we adjust the certain patient mix factors to make sure we can make credible and fair comparisons across hospitals. We publically report HCAHPS scores on the *Hospital Compare* website, and we do all this with the intention that hospitals will use this information to improve their quality of care and consumers will use information in choosing hospitals. Once again, HCAHPS was developed and implemented back in 2006 because CMS believes that patient experience of care in hospital is a vital aspect of hospital quality; that it's separate and

different from clinical and outcome measures of hospital quality. Next slide please.

HCAHPS 101 is a quick overview of the HCAHPS Survey. Which hospitals participate? Well, generally speaking, short-term acute care hospitals participate in the HCAHPS Survey. Some people call these general hospitals. From the CMS point of view, these are hospitals paid under the IPPS system, or Inpatient Perspective Payment System, and also Critical Access Hospitals. Let me note that IPPS hospitals must participate in HCAHPS, or they face reduction in their annual payment update; whereas, Critical Access Hospitals voluntarily – may voluntarily participate in HCAHPS. Who do we survey? Inpatients, that is adult inpatients aged 18 or older at admission, and fee service lines, the medical, surgical or maternity care service lines, who had an overnight stay or longer in a hospital and/or alive at discharge. Now, that may seem obviously that patient must be alive at discharge to participant survey, but it underlines the fact that only the patient himself or herself may answer the questions on the survey. That is we're interested in the patient's own experience in the hospital, not his wife, not her husband, not the parent, not some other proxy who might answer the survey. The survey is of the patient himself or herself. We estimate that there are approximately 80 to 85 percent of all inpatients that are eligible for the HCAHPS survey, and it's important to point out that outpatients do not participate in HCAHPS. It is an inpatient survey. Next slide please.

A few words about the methodology of HCAHPS or, more specifically, some of the special features of the HCAHPS survey. It is a post-discharge survey. It is administered at least 48 hours after discharge and could be initiated up to 42 days after discharge. So, it's important to note the survey is given after the patient has left the hospital and has had time to reestablish himself or herself in a post-hospital setting. HCAHPS is administered to a random sample of patients. Hospitals at their option can survey every single eligible patient, but it's intended to be a random sample of eligible patients who were chosen for the survey. There are four modes of survey administration with mail and telephone being the most

popular, and we have standardized the survey – data collection from the survey, data submission, data analysis and public reporting on *Hospital Compare*. So, it's a national standardized survey. Next slide please.

Just to point out the – how pervasive HCAHPS has become, in this current – actually December 2015 public reporting – with mild correction here – in the December public – 2015 public reporting on *Hospital Compare*, the HCAHPS scores are based upon more than 3.1 million completed surveys from patients at nearly 4,200 hospitals. Looked at differently, everyday on average, more than 8,600 patients complete the HCAHPS Surveys. HCAHPS is ongoing. Data collection is conducted throughout the entire year at participating hospitals. Unlike other surveys, we have a very broad net of patients who are eligible for the survey and we also require multiple attempts to reach the patient, so we don't only catch the patients who respond early or respond on the first attempt. And, as mentioned earlier, there are no proxy respondents allowed for the HCAHPS Survey. Next slide please.

OK. Here, we get to some of the important points for this presentation. HCAHPS was designed and intended for inter-hospital comparisons. That is comparing one hospital to another. It was not designed or intended for making comparisons within the hospital. That is comparing a particular ward or floor or staff member to others. So, HCAHPS is designed for inter-hospital or hospital-hospital – hospital-to-hospital comparisons. It's important to note that CMS does not review, endorse, or recommend the use of HCAHPS scores for intra-hospital comparisons. That is comparing a floor, a ward, or staff member to others. These tests or comparisons are unreliable, unless a large number or large sample size is collected for each unit that's being compared, that being a ward, a floor or individual doctor or nurse. In addition to having enough data to make valid comparisons, it's important that appropriate patient mix adjusted – adjustments would be applied at that level of analysis. We do apply patient mix adjustment at the hospital level. We do not apply them for intra-hospital comparisons. In addition, as you'll soon see, the HCAHPS items or questions are not tailored for individual physicians, nurses, or the staff. They speak about

categories of hospital staff, such as all nurses or all doctors. Next slide please.

Turning to the role that HCAHPS plays in the Hospital Value-Based Purchasing Program run by CMS. HCAHPS has been part of VBP, since they were initiated in 2012. HCAHPS scores, based on the HCAHPS Survey, are the basis for this domain in VBP. Currently, the domain is called Patient and Caregiver Centered Experience of Care/Care Coordination Domain. And, this domain is one of four domains in Hospital VBP. Next slide.

And, this shows you the four domains in Hospital VBP in FY 2016, the period we're currently in. So, the patient experience of care domain has the weight of 25 percent in the composition of the total performance score, the TPS. And hospitals that participate in VBP, that is IPPS hospitals, get a score based upon their total performance across the four domains in VBP. In addition to patient experience of care, there's a clinical process of care domain, an outcome domain, and an efficiency domain. At the bottom of the slide, you can see that in FY 2016, the current period, the total performance score affects 1.75 percent of IPPS hospitals' Base Operating DRG, so that is the amount in total that the VBP Program affects hospital payment, that is IPPS hospital payment. So, HCAHPS is one of four dimensions. And altogether, the four dimensions affect 1.75 percent of Base Operating DRG. In 2017, that will go up to 2.0 percent and it's scheduled to stay there from 2017 and forward. Next slide.

OK. What about – what from HCAHPS is in the VBP program? Well, there are eight equally rated dimensions of HCAHPS in Hospital VBP, so eight dimensions from the survey are included in the patient experience domain in the Value-Based Purchasing Program. Important to note that they are equally weighted. Pain management, number four, is one of them. It has the same impact on VBP as a discharge information or communication about medicines or how clean and quiet the hospital environment was. So, pain management is one of eight equally weighted dimensions in the HCAHPS domain on – in VBP. Next slide.

So, you might be wondering about, well, what are these HCAHPS items that are attracting so much attention? We call this the pain management composite. There are three items on the HCAHPS Survey that ask patients about pain. The first one is, "during this hospital stay, did you need medicine for pain?" If the patient answers yes, the patient is directed to the next two items: "during this hospital stay, how often was your pain well controlled?" (with answer options ranging from never to always); and then, the last pain management item, "during this hospital stay, how often did the hospital staff do everything they could to help you with your pain?" (again, never to always). So, these are the actual survey items from the HCAHPS Survey. Next slide.

Why does VBP include pain management? CMS believes that pain control is an appropriate part of routine patient care that hospitals should provide. We found through the survey that 73 percent of patients report needing medicines for pain during the hospital stay. So, pain is something that the majority of hospital inpatients experienced. Proper pain control is expected by patient's families, and of course, by patients themselves. Being treated properly for pain is a major concern of patients. We discovered this when we designed and developed the HCAHPS Survey through conversations with patients, patient advocates, hospitals, and others. Patient pain management is an important part and important aspect of the hospital stay. The pain management includes not just prescribing drugs but things such as: communicating with patients about pain-related issues; setting patient's expectations about pain and pain treatment; shared decision making between hospital staff and the patient about pain treatment or pain therapy; and, of course, proper prescription practices. So again, pain management is a crucial concern of patients. It's something CMS believes hospitals should strive to do well on. It's something hospital – patients use when discussing and comparing hospital experiences. And for these reasons, it is included as one of the eight dimensions – one of the eight equally weighted dimensions in VBP. Next slide.

So, what is the impact of pain management on the VBP score? We hear a lot of anecdotes and stories about how important pain management is in terms of hospital payment. So, we'd just like to clarify the exact role that pain management, and in fact, all HCAHPS dimensions have on hospital payment. So, as noted earlier, pain management is 1/8 of the HCAHPS domain in Hospital VBP. It's one of eight equally weighted dimensions. And, as we noted earlier, the HCAHPS domain is 25 percent of the Hospital VBP total performance score for 2016 and going forward. And, Hospital VBP itself affects 1.75 percent of hospital base operating DRG in FY 2016. So, we can do a simple calculation, 1/8 times 25 percent equals 3.125 percent of Hospital VBP is accounted for by the pain management item or the pain management dimension. We multiply that by the 1.75 percent of base DRG that is affected by the hospital VBP program in its entirety, and we see that the pain management item – pain management dimension of HCAHPS affects 0.055 percent of base DRG payment or less than 1/19 of one percent. The calculation of the Hospital VBP score is a bit complicated, and we have a document on our HCAHPS online website that will walk you through every step of the way of how we get from HCAHPS scores to the dimension – to the domain – the patient experience of pain score in VBP. And we can give you that – we will give you that website address later, but it's hcahpsonline.org. Next slide.

OK. Again, HCAHPS is designed for hospital-to-hospital comparison. The survey is designed to evaluate the entire hospital experience, not just one dimension or aspect of it. Survey items reference the whole hospital experience, not interactions with particular physicians and nurses. As you might recall from that pain management item, it asks about hospital staff. It didn't ask about particular doctors or nurses or the hospital staff. It asked about pain management during the entire hospital visits and care from all hospital staff, not particular individuals. CMS in fact calculates and reports only hospital-level HCAHPS scores. We don't break HCAHPS down by ward or floor or even service line. We don't calculate scores for individual nurses or doctors. We calculate the hospital level score and that is what is publicly reported. We do that because, when we develop the HCAHPS survey, we realized that patients typically interact

with multiple nurses and doctors and other hospital staff. It's often difficult for them to recall experiences of any particular one or even all the ones – all the doctors and nurses they saw during their visit. So, the HCAHPS Survey was designed to ask the patient about the entire hospital stay, not about particular people or places in it, but the entire stay. Next slide.

HCAHPS is not designed for comparing hospital staff members. As mentioned, the survey does not identify individual hospital staff. The survey is not validated for comparison of individual hospital staff. We didn't design it that way. We don't claim it's valid for comparing Dr. A to Dr. B or nurse X to nurse Y. Analyses that link scores to particular staff may not accurately reflect the intent of patient responses. That is, a patient is asked about all communications with all doctors or all communications about medicines, not particular ones. When a hospital – when a patient responds never or always to an item, the patient should have in mind the entire hospital experience, not one particular encounter. The amount – the number of survey responses for particular staff may well be insufficient for reliable measurement or comparisons. That is, in order to reliably compare different staff members or even different wards or floors, hospitals would have to collect a very large number of patient responses. For VBP, we require that hospitals have at least 100 completed surveys over a four quarter or 12-month period to participate in the program. Ideally, we strongly encourage hospitals to get at least 300 complete surveys for that four quarter period. Similarly, if a hospital were comparing wards or floors or individuals, they would need a large number of completes in order to attain a minimal level of statistical reliability. And again, the hospital – the survey was not designed for comparing individual doctors and nurses but the hospital as a whole. Next slide.

So, how is it that hospitals use the survey, apparently, to identify and compare individual staff members? Well, we don't know for sure, but we surmise that hospitals could disaggregate their set of responses, join them with other internal data, and link to individual physicians and nurses. That is, they could use their HCAHPS Survey data. They could link it to other

data that they have selected and make – attempt to make comparisons and evaluations. So, for instance, a hospital might properly have, from its records, whether a patient was given the pain medication and, internally using its own data, it could identify patient and connect that patient to the survey responses. I should note here that all the patient information, all the patient survey responses submitted to CMS are patient de-identified, that is, we do not know who the patient was. We could not identify the patient. They're de-identified in the data that is submitted to us. But, the hospital owns its own data and often works with the survey vendor. In addition, hospitals may add supplemental items to the survey. We allow hospitals to do this because, when HCAHPS was launched, there was a strong desire amongst hospitals to be able to add additional questions to the survey. I don't think I mentioned, but the HCAHPS survey is only 32 items long, so a relatively short survey. Hospitals often like to add their own items. They are committed to add a reasonable number of supplemental items. But, those supplemental items are not part of the official HCAHPS survey, are not vetted or pre-approved or reviewed by CMS, and are not submitted to CMS. CMS on its part strongly discourages disaggregation for intra-hospital comparison and evaluation, but does not oversee how hospitals use their internal data. That is to say, hospitals collect the data. They have the data before they send them to CMS. We encourage them not to disaggregate and use that data for individual comparison and evaluation of staff members, but we cannot – we do not oversee that and we cannot prevent that. We can only discourage its use because the survey is not valid or reliable for that type of use of the survey data. And in fact, if a hospital or survey vendor produces reports based upon its own internal analysis of its data, it should report – it should disclaim in that report that these are not official HCAHPS scores, but were based upon the hospitals own internal data. Next slide.

OK. Just to summarize, correcting a few myths about HCAHPS. The survey itself does not ask about method of pain management. The survey does not recommend or encourage either pharmaceutical or non-pharmaceutical analgesia. And, the survey does not mention opioid

analgesia. So, there are a number of claims we've seen over the last year or two or three that the survey – the HCAHPS survey encourages use of analgesics, of opioids, et cetera. It does not. We do not. The survey does not specify or present one method of pain management over any other. It simply asks whether pain was managed well. Next slide.

CMS, in fact, strongly opposes the use of the HCAHPS Survey to identify individual providers, that is doctors, nurses or other hospital staff, because HCAHPS is designed and validated only for inter-hospital comparisons; that is, hospital-to-hospital comparisons, as can be done on *Hospital Compare*. It is not designed for comparison of individuals – individual staff members, wards, floors, et cetera. But, because the HCAHPS survey is in the public domain, it's a government product after all, hospitals and private entities use it outside its designed and valid purpose. CMS, for its part, can only discourage inappropriate uses of the survey, but we cannot prevent it. And with that, I'll turn the presentation back to Dr. Tefera.

Lemeneh Tefera: Thank you Dr. Lehrman. In recognizing the myths and misperceptions that were just reviewed, I think it's important to note that there's an ongoing national prescription opioid epidemic, and it is concern about this epidemic that is driving stakeholders and the public to ask if there are any unintended consequences from our existing programs. We certainly believe that the HCAHPS Program does not promote opioid inappropriate prescribing, but we also like to point out the work we're doing in the agency to address the public's concern, to address our concern about the ongoing epidemic. Specifically, there are multiple initiatives within Health and Human Services and action plan to address the opioid epidemic. The Secretary has outlined clear objectives for the agency to follow. They are to decrease opioid overdoses and overdose-related mortality and decrease the prevalence of opioid dependence. The plan to reach these goals is, number one, thoughtfully impact opioid prescribing practices so that we reduce opioid use disorders and overdose. We help providers in their clinical decision making to reduce inappropriate prescribing. We enhance the monitoring of electronic systems, so we can support provider decision making in prescribing opioids. And, we also

support data sharing so that providers make informed decisions when selecting medications for their patients. Regarding heroin and prescription opioids for those who suffer from an overdose, the agency is strongly promoting the dissemination of use of naloxone to fight overdose and to decrease overdose deaths, and there is work to accelerate the implementation of naloxone formulations. The FDA recently approved the intranasal naloxone for example and also disseminating naloxone throughout the nation's counties and cities to first responders, so it's available and that first responders are aware of how to utilize this medication. Thirdly, besides decreasing the supply of inappropriate prescription opioids that could be used for illicit purposes that could lead to dependence and abuse and addiction (for those who are currently addicted and have a substance disorder), it's important to treat those with – with the substance abuse conditions and promoting the effective use of medication assisted treatment. It's important to manage patients who are fighting dependence and fighting addiction, and there is work to increase the diffusion of medication assisted therapy nationally and increase the number of clinics and providers who are able to provide this treatment, so patients can start the path to rehabilitation and again become productive citizens.

At CMS, we have multiple policies to help fight the opioid epidemic. The Overutilization Monitoring System helps Part D sponsors. Part D being the prescription Medicaid – Medicare coverage for beneficiaries. It helps Part D sponsors identify beneficiaries who are identified as high opioid utilizers and making sure that sponsors of Part D Medication Programs audit and examine the utilization of these high – high opioid utilizers and make sure that their utilization is appropriate and not for illicit purposes or not related to dependence and abuse. Besides the Overutilization Monitoring System, the agency has also start – expanded the Medicare Advantage Prescription System. This system for Medicare Advantage Programs, again, helps identify beneficiaries who are known to be high opioid utilizers and when they – if they change from one Medicare Advantage Program to another, that information will move with the beneficiary so that the new Part D plan sponsor is aware that they have

been identified as beneficiary with potential and appropriate utilization and they will audit their utilization appropriately.

CMS just recently also expanded the requirements for participation in the Part D Program, so as of June 2015, for providers to have their prescriptions filled in Part D, they'll need to be enrolled in the Medicare Program. This is important because this empowers Medicare to revoke provider privileges in the Medicare Program, if their prescribing practices are identified as abusive and inappropriate. This gives us – our agency another lever to make sure that, while we maintain the appropriate pain control for our beneficiaries, if there are providers who are inappropriately prescribing opioids in the Part D Program, we can identify them and have a means to take corrective action. In the fall of 2015, the agency had grand rounds focused on the prescription opioid epidemic where we, not only reviewed the history of the epidemic as we did today on this webinar, but also rolled out a new web tool that shows Part D opioid claims rate nationally. This web tool with the website posted here [http://go.cms.gov/opioidheatmap] allows beneficiaries, the public, providers to identify their state, their county and even down to their Zip code and see the opioid claim rates for Part D beneficiaries in their neighborhoods. The policy principle here is that we hope to help the public and beneficiaries see that this prescription opioid epidemic impacts all of our communities, and if we happen to live in a community that is impacted, we can be empowered to engage our local public health officials to address the issue.

Regarding local actions outside of federal policy, I'd also like to point out the work of states to address the prescription opioid epidemic. This slide highlights work at the state level with the utilization of prescription drug monitoring programs and other regulations about the types of clinics where pain medications can be prescribed that had dramatic effect on overall opioid prescribing and also dramatic effect on patient's utilization of the health system in seeking prescriptions. So, for example in New York, after 2012, when New York initiated its prescription drug monitoring program and required its prescribers to use the prescription

drug monitoring program, within a year, there was a 75-percent drop in patients who were seeing multiple prescribers to obtain prescription opioids. And, there are also significant drops, a ten percent drop for example, in the volume of oxycodone prescriptions. Similar results in Tennessee, with a decrease in number of patients who were seeing multiple prescribers. And, Florida also demonstrated decrease in overdose deaths after its action in 2010 to regulate pain clinics and closely – more closely regulate the dispensing of opioid prescription medications. So again, the point here is that in addition to leading at the federal level, states have a strong role and an important role here to fight the prescription opioid epidemic.

In summary, as we discussed, pain control is an important concern for patients and an appropriate part of routine patient surgical and medical care that hospitals should provide. The HCAHPS Survey assesses patient experience. It does not identify individual providers, and it's designed to measure patient experience at the overall hospital level, not the individual level.

The survey is not validated for individual comparisons. CMS strongly opposes use of HCAHPS to identify or evaluate individual physicians and nurses and other health team members. The agency can discourage inappropriate use of the survey, but cannot prevent it, however. We'd also like to point out that HCAHPS does not mention opioid analgesia. In regards to the financial impact of the HCAHPS Survey and the Hospital Value-Based Purchasing Program, we point out that it has a very small impact, less than 0.055 percent on the base DRG rate for the Hospital Value-Based Purchasing Program. We believe it's clear that there's no incentive in the Hospital Value-Based Purchasing Program to prescribe opioids.

There are multiple references listed here that review the Hospital Value-Based Purchasing Program, the Secretary's Opioid Initiative, and also the policy levers I mentioned regarding the Overutilization Monitoring System and the Part D Opioid Heat Map.

Debra Price: Well thank you Dr. Tefera. This is Debra Price and I am the education coordinator for the team. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. If, however, we carry this webinar passed the one hour, we have – we are going to provide additional credit.

We now have an online CE certificate process. If you receive the certificate normally, then your – after the webinar, a survey will pop up and that's how you're going to receive your certificate. However, if you're sitting in a room with other people, we will be – we will be sending out another survey within 48 hours and you can pass that survey to other people in the room. After completion of the survey, you're going to click done at the bottom of the survey screen, and then another page will open up that asks you to register on our HSAG Learning Management Center. Keep in mind that this is a separate registration from the one that you used to listen to the webinar. Please use your personal e-mail with this registration because hospitals tend to have firewalls up that block our links.

If you're having problems, you'll know immediately because you will not be able to see the response that comes in to your e-mail. If you don't see the response, please go back to the new user link and register again with your personal e-mail.

This is what the bottom of the survey will look like that you'll see in a few minutes. When you're done, you click on that gray button in the very lower right-hand corner that says done.

And, up pops a page that has two links in the middle of that page. The first screen link is the new user link. This is, if you've never registered or if you've never received a certificate from us. We are asking that you register using a personal e-mail like Yahoo or Gmail or ATT. If, however, you already got received a certificate from us, excuse me, please use the existing user link.

This is what your new user link will look like. Put your first name, your last name and your personal e-mail address and the phone number for us to put in to the database.

This is what the existing user link takes you to. Your username is your complete e-mail address, including everything that's after the @ sign and then of course use your password.

And now, I will pass the webinar back to our host, Candace Jackson who will go over Q&As from today's event. Candace, the floor is yours.

Candace Jackson: Thank you Deb. We do have several questions that were submitted through the chat that we will ask on today's webinar. The first question that I have is: are the overdoses outpatient or inpatient?

Lemeneh Tefera: Hi, this is Dr. Tefera. The data is from CDC and the MMWR is Morbidity Mortality Weekly Reports and they are inclusive of both outpatient and inpatient deaths.

Candace Jackson: Thank you. The next question says that kg are per 100,000, what is kg referring to?

Lemeneh Tefera: In that particular slide that you're referring to, that was kilograms of opioid pain relievers.

Candace Jackson: And the next question that we have, I think you did touch on, but you may want to reiterate. The question is: I think many hospitals do use HCAHPS for unit to unit comparison, why isn't it recommended?

William Lehrman: Hi. This is Bill Lehrman. As I tried to make clear in the presentation, the survey is not valid for that purpose of unit to unit comparisons. The questions aren't designed to ask about care from a particular unit, in a particular unit or from a particular nurse or doctor. And, it's unlikely – it's also unlikely the hospital has enough completed surveys to make reliable comparisons, and even if it did, it'd probably have to do some kind of patient adjustment of those answers at the unit or individual doctor or nurse level. So, in a nutshell, it just was not designed for that purpose.

Candace Jackson: Thank you Bill. The next question: is there a way to demonstrate the financial value to an organization by improving HCAHPS scores or individual question scores? And, please let me know if you need the question repeated.

William Lehrman: Hello. This is Bill Lehrman again. Yes, there – as I mentioned, the method of scoring VBP in general and the patient experience domain in particular is rather complicated. Hospitals receive a report of their score. There are ways to calculate the financial impact of improving a domain – one of the domains in VBP. I suggest the questionnaire go to the link on the last slide about the Hospital VBP materials for more information.

Candace Jackson: Thank you. Next question: what about CG-CAHPS, will its data be used to compare one provider staff member to another?

William Lehrman: Hello. CG-CAHPS is the acronym for Clinician and Group Practices CAHPS Survey. I do not work in that survey myself. I think it's a clinician group based survey, and I really cannot speak directly to that question. I believe there is a website about CG-CAHPS on the CMS – within the CMS webpage domain. Then, we can maybe get back to that person with a bit more information.

Candace Jackson: Thank you. Maybe when we submit the published Q&As, we can provide additional information. The next question: is there a number of surveys that need to be returned in order to publish?

William Lehrman: Actually, we have a very low minimum to publish scores on *Hospital Compare*; however, when the number of survey – completed surveys on which the scores are based is, I believe, below 100 completes or below 50 completes, we put them – we put a footnote on the website indicating that caution should be taken when assessing the scores because they were based upon a small or very small number of completed surveys.

Candace Jackson: Thank you. Our next question: what does CMS recommend after identifying high-utilizers? We do not have anywhere to send addicts, so if we cut them off from opioid they can just turn to heroin.

Lemeneh Tefera: Hi, this is Dr. Tefera. You know, I think what the question is getting at is the challenge of managing patients who have an ongoing substance use disorder. As the secretary's initiatives clearly recommend, besides decreasing the supply of inappropriate prescription opioids and decreasing the number of new patients who are susceptible to substance abuse, we need to provide treatment. The treatment in the secretary's initiatives is medication assisted therapy and the reasonable access to medication assisted therapy. As the questioner likely knows, one of the biggest challenges is that there are not enough providers who have license to prescribed buprenorphine/naloxone for example, and there is a chronic shortage of outpatient mental health facilities to help patients work through and access help for their conditions. So it – the participant's question strikes at one of the biggest challenges of this epidemic is that the resources for dealing with substance abuse are very regionally and vary within the state, within counties and are an ongoing challenge for clinicians who are trying to provide reasonable care.

Candace Jackson: Thank you. The next question: in working with hospital quality departments, I am finding a lack of narcotics over sedation monitoring protocols or policy, can you share a resource for this?

Lemeneh Tefera: Hi, this is Dr. Tefera. I do not have a resource to share with you, but I can reach out to folks within our center and see if that exists for over sedation monitoring protocols, but nothing I can share with you at this time.

Candace Jackson: Thank you. And the next question: I believe we have addressed, but I will ask again. Why such a focus on no individual comparison, any logical person would use this data for individual comparison knowing the limitation, are there lawsuits pending from the ANA or AMA?

Lemeneh Tefera: This is Dr. Tefera. To my knowledge, I'm not aware of any lawsuits on this issue and the two organizations that you mentioned, we're actively engaged with on multiple policy issues, including stakeholder concerns about HCAHPS and inappropriate prescribing. So, the answer is no, there are no pending lawsuits that we are aware of. I think Candace there was a prior question that I wanted to address, and I can…

Candace Jackson: OK.

Lemeneh Tefera: I can just read it for simplicity. The participant asks: there is a disconnect between the presenter saying that because HCAHPS don't ask about opioids, it therefore doesn't promote opioid prescribing. However, when patients are asking for opioids and physicians know the patient's satisfaction scores will be made public and determine reimbursement, they may be more likely to prescribe an opioid to satisfy the patient when it is not necessarily in the patient's best interest.

This question from the participant, I think strikes really at the core issue of this webinar, and touches upon some of the misperceptions about the survey. The first comment I'll make regarding this question is that the expectation in managing a pain syndrome from patients is that their pain is managed, and it is not an expectation for that pain management – pain control to be managed with opioid medications. It is also unusual to be dictating the type of pain management to the physician or other professional managing and consulting the patient. I think it's reasonable to provide the best options for that patient in their particular situation. That best option may be non-pharmaceutical, it may be pharmaceutical but non-opioid, and it may be an opioid; but, we think that providers should make the most appropriate decision based on their history, their exam based on risk assessment of that patient for different types of potential analgesia. Regarding the second component of the question about physicians and other professionals being aware that patient satisfaction will impact their reimbursement, as Dr. Lehrman described in the talk, in fact when you look at the survey, and how it's organized, and how it contributes to the Hospital Value-Based Purchasing Program, the pain management dimension has a negligible impact on overall payment to the hospital. It is simply not true that the pain management questions will drive reimbursement for that particular hospital. We also like to emphasize again that the questions themselves are asking about overall experience and not the experience with an individual provider, so when making decisions about prescribing for patients, we think it would be unfair if

there is individual level information being surveyed, which is why we did not do that.

Candace Jackson: Thank you, Dr. Tefera. Our next question: do hospital providers have to register as Part B prescriber?

Lemeneh Tefera: So, with the new policy that was instituted by the Center for Program Integrity in June of 2015, to be a prescriber in Part B, providers will have to be registered in the Medicare Program. So, if a provider is not registered in the Medicare Program, does not see Medicare patients, they will not – their prescriptions will not be filled by Part B plans.

Candace Jackson: Thank you. Our next question: are the HCAHPS answered choices being changed to a ten point scale, if yes when will this take effect?

William Lehrman: Hello. This is Lehrman. No, they're not being changed. There is one item on the HCAHPS survey about overall rating of the hospital that has a zero to ten scale, but that's the only item in the survey that has that kind of a scale. We do not intend to change the response categories for the HCAHPS items, which in the most part are: never, sometimes, usually, and always.

Candace Jackson: Thank you. Our next question: I am not concerned with the HCAHPS pain management scoring, as these patients are admitted for an acute reason and are treated appropriately based on this finding; however, the huge concern is in the treatment of chronic pain patients – narcotics tapers in the emergency department – those patients that are discharged from the ED. Is CMS planning to address this important issue in the development of the EDCAHPS? As you stated – as you said they have implemented programs and interventions to address the opioid epidemic. If we appropriately treat the patient, the patient will not be satisfied in these situations and we believe that these types of patients should be excluded from the emergency department survey process.

William Lehrman: Hello. This is Lehrman. I'll try to field that. As the questioner may be aware, CMS is in the process of developing its survey for Emergency Department patients, we're in the process of testing that now. We are in

fact looking at the wording in the pain items in that survey. And, in response to criticism and other reactions, we are testing alternative wording for the pain items in that survey. With regard to screening patients, who get the survey, that is not part of our protocol. We haven't – the ED survey has not been finalized or implemented. Those are open questions, but typically HCAHPS, or other CAHPS surveys are available to the class of patients who attend a certain type of provider, such as a hospital or home health agency or hospice.

Candace Jackson: Thank you. Our next question: given the relatively poor safety profile of opioids and their high potential for misuse and abuse, what role do cannabinoids have, if any, as an alternative or adjunctive therapy, in the treatment of acute and persistent pain; specifically, neuropathic pain, do they have any place in a broader risk reduction strategy to reduce opioid overdose?

Lemeneh Tefera: Hi, this is Dr. Tefera again. Without comment on the role of cannabinoids for the treatment of neuropathic pain or risk reduction, I think what's important to emphasize, again, is that the patient experience of their pain control does not specify what type of analgesia is offered. It asks only about if analgesia was offered and its effectiveness. So, there are many options again. Non-pharmaceutical, pharmaceutical including non-opioids and, as this participant is suggesting, that there are new types of pain management options, in this particular case, those options vary from state to state. But, the important thing is really addressing the pain concerns of our beneficiaries.

Candace Jackson: Thank you. Our next question: the slides indicated that the opioid epidemic was in effect prior to adopting HCAHPS, what do you attribute is the cause of the epidemic?

Lemeneh Tefera: So, I think the epidemic has a multi-factorial cause. Several of the slides that I showed, documented the increase in opioid pain reliever prescriptions from 1999 onward. There is a clear link between opioid sales and opioid marketing by the pharmaceutical industry that was selling a brand and generic opioid medications. There was also extensive

detailing of providers in regards to how beneficial and safe opioids were. There was a clear misinformation about the addiction and risk of addiction regarding opioids and detailing our providers and the many providers have falsely believed that opioids were safe and effective for chronic pain. This type of false advertising has certainly contributed to it and the rise in the opioid dispensement in the 2000s was clearly linked to the strong – the strong marketing of opioids as a reasonable and safe alternative for pain management, when in fact there was plenty of evidence suggesting that that was not the case.

Candace Jackson: Thank you, and I believe we have time for just a few more questions. The next question: the survey is supposed to be completed by the patient; however, many families complete it, will there ever be an adjustment or consideration for these survey?

William Lehrman: Thank you. We did not have an adjustment for proxy completion of HCAHPS survey. We do not offer that on the survey. We plan to look into the effect, if any, of proxy completion of the survey. But, right now we – the survey indicates – survey says that the patient himself or herself should be the only person to complete it, with the exception of patients who need, let's say, has difficulty hearing or seeing, of course somebody could repeat the questions or relay the questions to that patient. But, we – HCAHPS does not allow for proxy respondents.

Candace Jackson: OK. And then, our last question: I thought you said if there were not 100 completed surveys, the hospital would not be included in the VBP HCAHPS domain, is this true?

William Lehrman: Yes, that's true. In order for a hospital to participate in the Value-Based Purchasing HCAHPS domain, it must have at least 100 completed surveys in the four quarter or 12-month period.

Candace Jackson: Thank you. And, we would like to thank everyone for joining in today, and we would want to wish you a wonderful afternoon. Dr. Tefera, do you have any additional comments before we close the call?

Lemeneh Tefera: Thank you, Candace. One comment that I'd like to make is in response to a participant's question about disclosures of both the speakers. We do not have any conflicts of interest with, or financial relationships, with any other related organization or private organizations. We're both federal employees and don't have any conflicts to report. We will certainly make that clear in the future webinars with a slide, but I thank you for asking us to do that and I hope that satisfies your question.

In closing, on this important issue of how to respond to the ongoing prescription of opioid epidemic, I'd like to note that CMS is aware of the concern that the HCAHPS survey and its contributions to the Hospital Value-Based Purchasing Program is believed to be possibly contributing to increased opioid use. We hope that the presentation today and the data, much of which is from the CDC over the last 20 years, has clearly shown that in fact the prescription of opioid epidemic started long before the HCAHPS survey and the way the HCAHPS survey is designed and implemented in the Hospital Value-Based Purchasing Program, the financial incentive simply is not there for the questions in the pain dimension to impact payment. We hope this has addressed some of the questions and concerns regarding HCAHPS and we look forward to further questions and believe that the references and web links provided can be of excellent resource regarding with these issues.

Thank you very much.

Candace Jackson: OK, thank you. And again, the questions and answers will be posted at a later date on the Quality Reporting Center website and on *QualityNet*. Thank you again and have a great day.

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