Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Questions and Answers Transcript

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Question 1: **Are the overdoses outpatient or inpatient?**

The data are from the Centers for Disease Control and Prevention (CDC) Morbidity Mortality Weekly Report (MMWR) and they include both outpatient and inpatient deaths.

Question 2: **Sales (kg per 100,000 - what is kg referring to?**

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

Question 3: **I think many hospitals do use HCAHPS for unit to unit comparison. Why isn't it recommended?**

As stated in the presentation, the survey is not valid for the purposes 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. It is also unlikely that the hospital would have enough completed surveys to make reliable comparisons. Even if it did, it would probably have to do some kind of patient adjustment of those answers at the unit or individual doctor or nurse level to make valid comparisons. Again, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey was not designed for that purpose.

Question 4: **Is there a way to demonstrate the financial value to an organization by improving HCAHPS scores or individual question scores?**

Yes. The method of scoring Value-Based Purchasing (VBP) in general and the patient experience domain in particular are rather complicated. Hospitals receive a report of their score and then there are ways to calculate the financial impact of improving one of the domains in VBP. I suggest the questioner go to the links on the last slide about the Hospital VBP materials for more information, these are:

- https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237147
- http://go.cms.gov/valuebasedprogams.

Question 5: **What about CG-CAHPS? Will its data be used to compare one provider/staff member to another?**

CG-CAHPS, or the Clinician and Group Practices CAHPS Survey, is beyond our scope here. It is designed to compare physician groups. The CMS website, https://www.cms.gov/, provides CAHPS information.

Question 6: **Is there [a specific number] of surveys that need to be returned in order to publish?**

The Hospital Compare *website has a low minimum for published scores. If the number of completed surveys is below 100, and also below 50 a footnote indicates that caution should be taken when assessing those scores because they were based upon a small number of completed surveys.*

Question 7: **What does CMS recommend after identifying high utilizers? We don't have anywhere to send addicts, so if we cut them off from opioids, they can just turn to heroin.**

The question strikes at one of the biggest challenges of this epidemic. The resources for dealing with substance abuse vary regionally, within states, and even within counties. The difficulty of accessing resources is an ongoing challenge for clinicians who are trying to provide reasonable care for dependence and abuse.

As the Secretary's opioid initiative describes, 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 for those who are currently dependent. The Secretary's initiatives promote both medication assisted therapy and the reasonable access to medication-assisted therapy. One of the biggest challenges is that there are not enough providers who are licensed to prescribe buprenorphine/naloxone,

for example, and there is a chronic shortage of outpatient mental health facilities to help patients.

Question 8: **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 form the ANA or AMA?**

To my knowledge, I'm not aware of any lawsuits on this issue. Regarding the American Nurses Association (ANA) and American Medical Association (AMA), we are actively engaged with them on multiple policy issues, including stakeholder concerns about HCAHPS and inappropriate prescribing. So, the answer is no, we are not aware of any pending lawsuits.

Question 9: **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 patients' satisfaction scores will be made public & 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. It would be nice to address how HCAHPS may provide an incentive to overprescribe opioids.**

This question strikes 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 controlled. It is not a patient's expectation that their pain control be necessarily managed with opioid medications.

It is also unusual for patients to dictate the type of pain management to the physician or other professional managing and consulting for the patient. It is reasonable and expected that the provider prescribe the best options for that patient in their particular situation. That best option may be non-

pharmaceutical, it maybe pharmaceutical but a non-opioid, and the option could also be an opioid. We think that providers should make the most appropriate decision based on their history, their exam, and the risk assessment of that patient for different types of potential analgesia.

The second component of the question is about physicians and other professionals being aware that patient satisfaction will impact their reimbursement. As described in the presentation, the way that the HCAHPS survey is organized and contributes to the Hospital Value-Base Purchasing Program makes the pain management dimension negligible as far as its impact on the overall payment to the hospital. Therefore, it is simply not true that the pain management questions will drive reimbursement for any hospital.

Again, remember that the survey questions themselves are asking about overall hospital experience and not the experience with an individual provider. HCAHPS has never obtained or reported scores for individual hospital staff.

Question 10: Do Hospital providers have to register as a part D prescriber?

The new policy instituted by the Center for Program Integrity in June of 2015 requires that, to be a prescriber in Part D, providers will have to be registered in the Medicare Program. So, if a provider is not registered in the Medicare Program and does not see Medicare patients, their prescriptions will not be filled by Part D plans.

Question 11: Are the HCAHPS answer choices being changed to a 10 point scale? If yes, when will this take effect?

No, they're not being changed. There is only one item on the HCAHPS Survey, 'overall rating of the hospital', that uses a zero to ten scale. We do

not intend to change the response categories for the HCAHPS items, which for the most part are comprised of a choice among "never," "sometimes," "usually," or "always."

Question 12: **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 these findings. However, the HUGE concern is in the treatment of chronic pain patients/narcotic seekers 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 ED CAHPS? As you said, states 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.**

CMS is in the process of developing its survey for Emergency Department patients, we're in the process of testing that now. In response to criticism and other reactions, we are carefully looking at the wording of the pain items in that survey. With regard to screening patients who get the survey, the ED survey has not been finalized or implemented. So, 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 hospital or home health agency or hospice.

Question 13: **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?**

Reference:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3295721/#__abstractid930521title

CMS does not interpose itself between doctor and patient regarding the role of cannabinoids (or other substances) for the treatment of neuropathic pain or their risk versus opioids. It is important to emphasize again that the patient's experience of pain control question does not specify what type of analgesia is offered. It only asks about whether analgesia was offered.

There are many options: non-pharmaceutical; pharmaceutical, including non-opioids; and, as suggested by the question, there are new types of pain management options like cannabinoids. In this particular case, the availability of the option varies from state to state; However, the important principle being addressed is appropriate pain control for our beneficiaries.

Question 14: **Slides indicated that the opioid epidemic was in effect prior to adopting HCAHPS. What do you attribute as the cause of the epidemic?**

The epidemic has a multi-factorial cause. Several of the slides documented the increase in opioid pain reliever prescriptions from 1999 onward. There is a clear link between opioid sales, along with opioid marketing by the pharmaceutical industry, and the rise of opioid prescriptions, abuse, dependence, and deaths.

There was also extensive pharmaceutical detailing of providers (meaning pharmaceutical reps visiting doctors' offices to promote their product) in regards to how beneficial and safe opioids were. This detailing misled providers about the risk of addiction regarding opioids. Many providers believed this misinformation, stating that opioids were safe and effective for chronic pain. This type of false advertising certainly contributed to the prescription opioid epidemic and the rise in the dispensing of opioids in the 2000s. The epidemic is clearly linked to the false marketing of opioids as if they were a reasonable and safe alternative for pain management, when

there was plenty of evidence suggesting that it was not the case.

Reference: http://nyti.ms/1Oxa60G

Question 15: **The survey is supposed to be completed by the patient; however, many families complete it. Will there ever be any adjustment or consideration for these surveys?**

CMS does not make an adjustment for proxy completion of HCAHPS surveys, nor does it obtain any information on it. However, we do not believe that this is a large-scale phenomenon. The HCAHPS Survey clearly states that the patient himself or herself should answer the survey. Exceptions are permitted for patients with special needs, such as patients having hearing or sight impairments who would need someone to relate the questions to them. However, the answers are still expected to come from the patient.

Question 16: **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?**

Yes, that is true. In order for a hospital to participate in the Value-Based Purchasing HCAHPS domain, it must have achieved at least 100 completed surveys in a 12 month period.

Question 17: Ca**n you tell us what made the Georgia data unavailable?**

For the states on the legend marked as having "incomplete data," the Substance Abuse and Mental Health Services Administration did not receive those states' admissions information for that given year.

Question 18: **Is the score at DRG level calculated and available?**

No. CMS does not receive the patient's Diagnosis Related Group (DRG) and does not calculate HCAHPS scores at the DRG level. Rather, CMS recommends that hospitals use the DRG to assign patients to one of three service lines: Medical, Surgical or Maternity care. While these service lines are used as part of the patient-mix adjustment of the survey, CMS does not calculate or report HCAHPS scores by service line. The patient-mix adjustment coefficients for the three service lines, as well as a description of the patient-mix adjustment process, can be found on the HCAHPS On-Line *website at* http://www.hcahpsonline.org/modeadjustment.aspx .

Question 19: **Could you please have all presenters identify or disclose any conflicts of interest or any other form of financial relationships or honorarium with any healthcare related organization over the past 5 years? That is normally routine procedure in a nationally broadcast policy webinar. Thank you.**

Thank you for the question. We agree that it is customary to inform participants of any conflicts and will revise our future slide decks to include this information. Neither Lemeneh Tefera nor William Lehrman have any conflicts of interest to report.

Question 20: **After hearing this presentation, I believe that CMS is completely ignoring their part in creating this opioid epidemic. As an emergency physician for over 40 years, it seems apparent to me that this epidemic was started by the passage of Senate bill 402, the "Pain Patient's Bill of Rights," followed by the 1999 "Pain--5th Vital Sign," which was CMS created and demanded of providers. This was followed by HCAHPS and the demand that patients be satisfied. CMS is right at the epicenter of this problem yet your presentation today is trying to state otherwise. You are trying to cover your tracks in this disaster by implying that HCAHPS has nothing to do with this problem. This problem will never**

end until physicians are allowed to correctly treat patients without the overhanging risk of receiving a bad patient satisfaction score. It will never end until CMS engages themselves in the "TWELVE STEP PROGRAM" for addiction and announce that they are a major problem here and will change with respect to HCAHPS.

CMS recognizes that there is a misperception that the HCAHPS Survey causes or is related to opioid abuse. CMS shares the concern about the damage and harm caused by misuse and overuse of prescription pain medications, including opioids. This presentation intended to counter that belief by presenting facts about the survey and its role in Hospital Value-Based Purchasing. We have also presented material data on the trend of opioid use and mortality over time and across states, as well as information on opioid prescription practices. The ascending prescription and addiction rates predate CMS efforts through HCAHPS to assess quality of care.

To clarify, the concept of "Pain as the 5th Vital Sign" was introduced in 1996 by the American Pain Society, not CMS. And, the opioid crisis began years before the HCAHPS Survey was authorized by Congress and launched in 2006.

Patient experience is a valuable component of care and has contributed to improving hospital quality nationally. To this end, HCAHPS is designed to measure patient experience of care, not satisfaction; and scores are reported at the hospital level, not the physician or staff level. HCAHPS is not designed for individual comparisons, and the provider level criticism that the question refers to is undertaken by hospitals that use the survey outside of its intended purpose. Also, of particular concern to the questioner, the HCAHPS Survey was not designed, intended, or authorized by CMS for use in the emergency room.

CMS strongly discourages the use of the HCAHPS Survey beyond its stated purpose and setting. CMS is not aware of empirical evidence that

physicians' decisions to prescribe opioids to inpatients is intended to obtain better scores on the pain management items, or that patients who receive opioids rate their hospital experience more positively than those who don't.

Question 21: **Could you compare HCAHPS by race within a hospital if you had the sample size for each group?**

If there were a sufficient number of completed surveys, ideally 300 or more per group, it would be fine to compare patient-mix adjusted scores by race/ethnicity within a hospital.

Question 22: **Is it possible to compare physicians if enough surveys are returned per physician?**

For several reasons, it is not appropriate to compare individual physicians, or other hospital staff, using HCAHPS. As noted during this presentation, HCAHPS Survey items were intended and designed to reference the entire hospital experience rather than experiences with particular physicians. Further, it would be conjectural to assume that a patient's responses to physician-related items were influenced by a single physician. It is also unlikely that a hospital would have sufficient survey responses for individual physicians to make statistically reliable comparisons. More importantly, if such comparisons were made without appropriate patient-mix adjustments of the scores, then additional biases would be present. While it may be technically feasible for hospitals to associate their internal HCAHPS data with particular hospital staff, or to add supplemental items about particular staff, for the reasons noted in this presentation, CMS strongly cautions against such practices.

Question 23: **Not sure how we as a hospital can target to improve our HCAHPS scores and in turn VBP, if we can't see the scores by ward or unit.**

WL: While it is inappropriate to use HCAHPS data to compare individual hospital staff, it may be possible to compare hospital units or wards, if each of three conditions are met: (1) patients spend their entire hospital stay in a single ward, (2) the sample size for each of the wards is large enough (we recommend 300 or more completed surveys per ward), and (3) patient-mix adjustment is applied to the data.

LT: The overall scores from HCAHPS would apply to all medical, maternity and surgical admissions and the feedback could be applied throughout the hospital- not just to one ward.

Question 24: **The speaker's assertion about comparison of providers may not be valid with CG-CAHPs. That is the point I was making. Providers will be compared on Pain management variables in CG-CAHPS and this may empower patients who are denied inappropriate narcotics by enabling them to "punish" those who refuse to prescribe opioids.**

CMS uses a version of the CG-CAHPS survey in the Physician Quality Reporting System (PQRS) program that does not include the pain management questions found on the HCAHPS Survey. You can learn more about the appropriate use of CG-CAHPS at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/pqrs.html. *Concerns about CG-CAHPS should be directed to this survey.*

Question 25: **Regarding an ED-CAHPS (for emergency room patients), is CMS concerned that pain control survey questions may adversely affect opiate prescribing for ER patients?**

There is no ED-CAHPS survey at this time. CMS is in the process of developing a patient experience of care survey for emergency room patients. We are testing the number, content and wording of the pain management items to assess patients' experience of pain in the most appropriate and

useful manner. The pain management items from the HCAHPS Survey are not on the current version of the emergency room survey. Should CMS adopt an emergency room patient survey, it will do so through the normal process, which includes public notification and comment.

Question 26: Are you seeing with the increase in opioid use an increase in patients that may respond to the survey negatively?

No, hospital scores on the pain management composite have increased over time. In the first public reporting of HCAHPS results in March 2008, 67% of patients reported that their pain was "Always" well controlled. This has risen to 71% in the December 2015 public reporting. The other HCAHPS measures have seen improvement over this time period as well.

Question 27: Is there a more accurate way to use the HCAHPS scores for smaller hospitals who do not receive many returned surveys?

Unfortunately, the accuracy of all survey results, including those from HCAHPS, are lower at small sample sizes. There are some steps a small hospital could take to increase its sample size, such as survey all eligible discharges, not just a portion of them. In addition, to increase response rate, a hospital might consider using the Mixed Mode (a mail survey followed by a telephone survey), which usually results in higher response rates than the Telephone Only, Mail Only, and IVR modes. Also, using the official translations of the HCAHPS Survey (Spanish, Chinese, Russian, Vietnamese and Portuguese) as needed can help increase survey response among patients who prefer those languages. Finally, for internal quality improvement purposes, a small hospital could pool its data over a longer time period than one year, using a longer "rolling" or "moving" average to calculate its HCAHPS scores.

Question 28: **FYI--At our hospital We utilize a sedation scale that must be done on each patient prior to each dose of opioids as well as other sedative type medications and this has greatly decreased the adverse reaction of over sedation/respiratory depression.**

We encourage efforts to promote patient safety and are pleased that you are decreasing adverse effects at your hospital.

Question 29: **Does the reduction on "base operating DRG" only affect Medicare patients?**

Yes, Hospital Value-Based Purchasing (HVBP) is for Medicare Part A payments.

Question 30: **What is to be done to address patients with legitimate chronic pain? Not all patients with chronic pain are drug seekers or substance abusers.**

We advise physicians to follow the recommended practices for treating patients who experience pain. Pain management is an important aspect of the hospital experience for patients, which is why the HCAHPS Survey asks about the patient's experience, publicly reports HCAHPS scores, and includes pain management as one dimension in Hospital Value-Based Purchasing for IPPS hospitals.

Managing chronic pain is a clinical challenge. What is clear, however, is that opioids have been used excessively for chronic pain. There are non-opioid alternatives to be considered. The CDC will soon release an extensive review of chronic pain management, and we encourage the participants to review this new guideline.

Reference: http://1.usa.gov/1jTLLej

Question 31: **For EDs are you seeing 1 time dispensing of naloxone for those patients that come in seeking narcotics (known pts with addiction/ frequent flyers)?**

We understand that some providers may provide a naloxone prescription for patients that they feel are at high risk for overdose. We do not have any data on the prophylactic prescribing of naloxone but it is an effective and often life-saving antidote for opioid overdose

Question 32: **With the HCAHPS Star rating calculation, are you thinking about change from TOP BOX to Linear Measurement?**

CMS publicly reports the HCAHPS measures on Hospital Compare as the percentage of patients who chose the top-box, middle-box or bottom-box response option (or most positive, middling, or least positive response). We do so in order to present the entire range of survey responses. CMS has no plans to change this approach. For the HCAHPS Star Ratings, we calculate linear mean scores (LMS) for each HCAHPS measure because they summarize all survey responses in a single statistic, which is then converted into a star rating. For more information about the LMS, please see the HCAHPS Star Rating Technical Notes at http://www.hcahpsonline.org/StarRatings.aspx

Question 33: **Pain management may have a small part in the survey but patients DO NOT separate out which piece of the experience they were unhappy with. They were in pain, the hospital didn't give them Oxy, and therefore the hospital didn't take good care of them. It does affect the whole HCAHPS survey.**

Keep in mind that any single dimension contributes one eighth of the

HCAHPS score to HVBP.

CMS believes that effective communication with patients about pain and treatment, including options other than prescription medicine when appropriate, is the preferred way to improve patient experience of care. In the process of developing the HCAHPS Survey, we did not find that experience with pain dominated patients' overall assessment of the hospital experience. In addition, several published studies have found that requests for pain medicines were not associated, or was negatively associated, with patients' hospital experience:

Maher DP, Wong W, Woo P, Padilla C. et al. *Perioperative factors associated with HCAHPS responses of 2,758 surgical patients.* Pain Medicine. 2015;16:791-801

Nota SPFT, Spit SA, Voskuyl T, Bot AGJ, et al. *Opioid use, satisfaction, and pain intensity after orthopedic surgery.* Psychosomatics. 2015 Sep-Oct;56(5):479-85.

Bot AGJ, Bekkers S, Arnstein PM, Smith RM, Ring D. *Opioid use after fracture surgery correlates with pain intensity and satisfaction with pain relief.* Clin Orthop Relat Res. 2014;472:2542-2549.

Schwartz TM, Tai M, Babu KM, Merchant RC. *Lack of association between Press Ganey emergency department patient satisfaction scores and emergency department administration of analgesic medication.* Ann Emerg Med. 2014 Nov;64(5):469-81.

Question 34: Are the questions on the survey that are rated "very poor" to "very good" HCAHPS questions?

No, "very poor" and "very good" are not among the response options used on the HCAHPS Survey. It is possible that a hospital adds supplemental items to its HCAHPS surveys that use these response options. Supplemental items added by hospitals are not reviewed, endorsed or submitted to CMS. The official HCAHPS Survey is available on the HCAHPS On-Line website,

http://www.hcahpsonline.org/surveyinstrument.aspx.

Question 35: **Can Dr. Lehrman expand on the testing of wording of pain questions on ED-CAHPS? What will happen to the pain questions if a patient gets an ED-admit version? Is he saying there will be different wording on pain items for ED-CAHPS (all versions) vs. HCAHPS?**

There is no ED-CAHPS survey at this time. The emergency department patient experience of care survey under development at CMS asks patients about their care in that setting, including whether the patient had pain, physicians and nurses helped reduce pain, patient received medicine for pain, and side effects of pain medicine were explained. The emergency department survey does not employ the same wording as the pain management items in the HCAHPS Survey.

Over the next several months CMS will conduct cognitive testing of the emergency department survey's pain management items and consider whether alternative wording may be suitable for the HCAHPS Survey.

Question 36: **Is there a future plan for the use of this data to actually help improve the patient experience? We are told we cannot use the language in the survey question, ex"control" to see if we are doing a good job with our patients. Why can't we tie our treatment plan to the question we are asking about patient experience?**

HCAHPS has been vigorously validated at the hospital level. There is not sufficient validation or reliability, including sample size, to use the survey at the individual level.

CMS encourages hospitals to regularly review their HCAHPS data to identify areas for improvement. Quality Improvement Organizations (QIOs), the Agency for Healthcare Research and Quality (AHRQ), and many others

have developed and share methods for improving specific aspects of patients' experience of care. There is evidence that hospitals are improving on all of the HCAHPS measures.

Question 37: What role, if any, do you think the concept that pain is the 6th vital sign or pain is what the pain says it is, has to do with the epidemic?

The pharmaceutical industry had a very methodical approach to the marketing of opioids, including supporting medical societies that developed guidelines or concepts for pain control. The American Pain Society, which was funded by industry, developed the "Pain as the 5th Vital Sign" concept and this was taught to a generation of doctors who were not simultaneously presented the risks of opioid dependence, abuse, and overdose. This marketing contributed to the development of the prescription opioid epidemic. Reference: http://on.wsj.com/1McwPUR

Question 38: Have correlations between Q13 and Q14 question individually and other composites been evaluated?

Yes, we have evaluated the correlations of the individual survey items. Questions 13 and 14, which comprise the Pain Management composite measure, are correlated. The correlation of the Pain Management composite with other HCAHPS measures can be found in the "HCAHPS Patient-Level Correlations Table" on the HCAHPS On-Line website at http://www.hcahpsonline.org/SummaryAnalyses.aspx. *These correlations range from .25 (with Discharge Information) to 0.56 (with Communication with Nurses). At this time CMS is conducting further research on the Pain Management measure and its constituent items.*