May 2, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Adverse consequences of removing pain-related questions from HCAHPS survey

Dear Administrator Slavitt,

On April 13, 2016, a Citizen Petition was sent to CMS requesting that the following questions be removed from the HCAHPS survey:

1. During this hospital stay, did you need medicine for pain?
2. During this hospital stay, how often was your pain well-controlled?
3. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

This petition was widely distributed to the public and was featured in a press release. While we share in the concern that rising rates of opioid addiction, diversion and overdose, including overdose deaths, must unequivocally be addressed, we are concerned by the blunt approach advocated in the Citizens Petition. Therefore, the undersigned organizations are writing to express strong concern that multiple damaging consequences could result were these questions to be removed and the incentives for optimizing inpatient pain control thereby weakened or abandoned. Further, we are writing to offer our assistance to CMS in seeking to improve upon the questions rather than simply jettisoning them until such time as a suitable alternative can be prepared and agreed upon by all stakeholders.

The petitioners state: “Aggressive management of pain should not be equated with quality healthcare as it can result in unhelpful and unsafe treatment, the end point of which is often the inappropriate provision of opioids.” However, the three HCAHPS questions do not mention opioids, and two of the three do not mention medications. The petition itself, and directly related Congressional bills\(^1\) and inquiries\(^2\) suggest that assessing and controlling pain in hospitalized inpatients is responsible for initiating or perpetuating opioid addiction in the population at large. No evidence is provided to establish such a causal effect. In the letter a single reference, to an article in a popular general

\(^1\) Promoting Responsible Opioid Prescribing of 2016; H.R. 4499, 114\(^{th}\) Congress, (2016).
magazine citing speculation by an unidentified emergency room doctor, is provided. In contrast, an enormous and growing evidence base points to numerous benefits of aggressive pain control in hospitalized patients, including whenever possible interventions to pre-empt pain (e.g., in advance of a scheduled operation). Therefore, a more accurate statement would be “Safe and effective pain treatment (or prevention when feasible) is an essential foundation of the care of many hospitalized patients.”

The damage that could result if the three pain-related questions were eliminated from HCAHPS is evident if one considers the progress made in the past 25 years in controlling inpatients’ pain. This progress has been informed by the science of quality improvement, principal tenets of which are to measure the outcome to be improved, and to assign responsibility and accountability to specific healthcare providers to achieve the desired outcomes.

The first U.S. federal clinical practice guideline, published in 1992, addressed the management of acute pain after operative or medical procedures or trauma. This topic was selected because of overwhelming evidence that undertreatment of pain in this context was widely prevalent and resulted in the following negative outcomes:

- A huge burden was exacted upon patients and families;
- Physiologic recovery was slowed; and
- Individual suffering was increased while quality of life including function was diminished.

This guideline acknowledged the value of nonpharmacological modalities for acute pain control, and the benefit of employing nonopioid medications, including regional anesthesia, to reduce opioid requirements. In the 25 years since that guideline panel was convened, acute pain control has emerged as a field in its own right. Safe and effective pain control has become woven into the fabric of clinical care, for example, as an indispensable component of short-stay surgery. Incalculable needless suffering has been avoided, and recovery from surgical or medical conditions accelerated and enhanced through

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4 Zoëga, Sigridur, MS, RN, CNS, Sigridur Gunnarsdottir, PhD, RN,, Margaret E. Wilson, PhD, RN, and Debra B. Gordon, DNP, RN, ACS-BC, FAAN. "Quality Pain Management in Adult Hospitalized Patients: A Concept Evaluation." Nursing Forum 2014.
the multimodal approaches that have now been integrated into everyday care. These opioid minimizing techniques are now emphasized in current practice because they allow effective pain control while diminishing adverse effects incurred with sole reliance upon opioids, e.g., nausea or respiratory depression. The extensive literature strongly supporting the value of employing multimodal, opioid-sparing techniques has most recently been summarized in a comprehensive 2016 evidence review.10

In the absence of focused attention paid to pain control, roughly half of postsurgical patients will have moderate to severe pain.11 Poorly controlled acute pain has numerous adverse effects. Poorly controlled acute pain is a clear and major risk factor for the development of chronic postsurgical pain after hospital discharge.12 Delayed rehabilitation due to lack of mobility, increased risk of dangerous blood clots, and demoralization are among many examples of the persistent negative impact of poorly managed acute pain. Additionally, certain types of acute pain such as from nerve injury strongly predict chronic pain.13 If these conditions are left unassessed, such patients may not be referred to early care to avoid poor long-term outcomes. Those practicing in the field recognize that there is room for improvement in traditional methods of assessing acute pain, such as with a 0-10 intensity scale. As summarized by leaders of the Acute Pain Shared Interest Group of the American Academy of Pain Medicine, numerous efforts are now underway to improve such measures.14 Removal of the pain-related HCAHPS questions at the present time, however, without replacing them with suitable alternatives, will remove an important driver of progress to develop improved means of acute pain assessment. Because such improvements often take years to refine and validate, removal of the pain-related HCAHPS questions now will leave a multi-year void in assessing this extremely important dimension of the patient experience.

Maturation of the field of acute pain has led to a significant decrease in unimodal opioid regimens and expansion of multimodal analgesia whereby two or more analgesic medications are used that work

through different mechanisms, thereby reducing the dose and side effects of each. As an example, McEvoy et al. showed that colorectal enhanced recovery pathways focused on acute pain and opioid minimization resulted in a decreased length of stay of 3 days and a 17% decrease in hospital costs.\textsuperscript{15} Similar findings have been found in other surgical populations such as total knee arthroplasty and complex spine surgery in which focused regimens to minimize acute pain resulted in improved outcomes in acute and subacute settings.\textsuperscript{16, 17} Such recent findings underscore the importance of vigilant acute pain surveillance in order to enhance recovery and minimize the reliance on opioid medications for acute pain.

The migration away from unimodal opioid therapy for acute pain is already well under way. Alarmingly, across-the-board removal of pain assessments from both the acute-care setting and post-discharge surveys would eliminate the very data that clinicians and researchers now rely upon to offer meaningful, non-opioid alternatives for patients complaining of pain and/or poor pain management.

According to the logic of the PROP proposal, hospital-based incentives for pain management stemming from HCAHPS questions pertaining to pain management lead to the “aggressive” overprescribing of opioids. There are no data to support this association. To the contrary, evidence suggests that hospitals performing well on HCAHPS measures associated with pain management instead have a decreased incidence of adverse safety events (decubitus ulcer, respiratory failure, deep venous thrombosis, pulmonary embolus) as measured by CMS patient safety indicators.\textsuperscript{18} This newer data is consistent with earlier evidence that robust pain management, implemented well, is associated with a decrease in postoperative complications.\textsuperscript{19, 20, 21, 22}

The need for uninterrupted data collection on pain management in the acute care setting is not limited to epidemiologic data. Historically, total knee replacement surgery required a week-long postoperative hospitalization for intensive, opioid-based pain management. With the advent of acute pain medicine teams and advanced continuous regional anesthetic techniques, leading joint-replacement programs across the U.S. have transformed this experience into one generally requiring only overnight hospitalization that is nearly devoid of any opioid administration. This progress has been accomplished through aggressive use of multimodal analgesic techniques that often include regional anesthetic infusions for several days after surgery. 23 24 Similar examples may be given for many different operations.

CMS has aggressively pursued implementation of value-based purchasing (VBP) programs. 25 In 2016, VBP domains are weighted as follows: Clinical Process of Care (10%), Patient Experience of Care (25%), Patient Outcome (40%), and Efficiency (25%). The Citizen Petition suggests that hospitals have a financial incentive to overprescribe opioids in order to improve HCAHPS scores. However, the VBP domain weights defined by CMS in actuality create a counter-incentive to avoid complications and improve patient outcomes in a manner that greatly exceeds any hypothetical incentive for overprescribing opioids to improve HCAHPS scores. Removal of patient experience (or patient safety) domains in VBP agreements could herald a national return to an earlier era in which pain was grossly undertreated. Removal of the HCAHPS questions would affect a very broad range of inpatients, ranging from those with sickle cell crisis or pancreatitis, to cancer or cancer-related surgery, to mothers giving birth.

Although we oppose the abrupt elimination of the HCAHPS pain questions, we fully acknowledge that clinicians have criticized these and other forms of outcomes assessment. Some physicians – particularly those in emergency medicine or primary care – report that the introduction of patient satisfaction surveys into routine care has decreased their own job satisfaction. 26 Therefore, we concur that there is a need to refine methods to assess quality assessment including patient satisfaction, while reiterating that the clinical community has long been doing so. 27 To cast aside the current HCAHPS pain questions in the absence of ready replacements would be a huge step backwards in patient-centered care, and send

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the wrong message to clinicians and patients – particularly those who are sick enough to warrant an inpatient stay.

The Citizen Petition dictates an ill-considered, dramatic course of action that could harm our most vulnerable patients. This Petition’s call that pain not be assessed in the acute care setting would eliminate quality- and reimbursement-related penalties for NOT asking patients suffering a heart attack about the intensity of their chest pain; NOT asking sickle-cell patients about the intensity of their chest or hip pain during a sickle-crisis; NOT asking a cancer patient about the pain from their pathologic hip fracture from a new metastasis; and NOT asking mothers in labor about how well their epidural is working.

Most alarmingly, the Citizen Petition proposal offers no solutions to offset the inevitable compromises to care that its proposal entails. Among other leaders, those in the Shared Interest Group on Acute Pain, of the American Academy of Pain Medicine, have identified limitations of current approaches to assessing pain intensity in the acute setting. More troubling, these leaders have demonstrated significant heterogeneity in patient experience with pain management during hospitalization, suggesting geographical disparities in how acute pain is managed in hospitals across the US. These shortcomings suggest that wholesale elimination of acute pain assessments would be inappropriate until, and unless, there are suitable, validated replacement questions that better capture the concepts probed in the current questions.

In conclusion, we suggest some potential solutions to address the concerns raised by the Citizen Petition in a manner that is less disruptive and risky for patient care, and that is deliberately integrated within the broader, coordinated agenda of the recently released National Pain Strategy:

1. Increased use of pain assessments oriented towards patient status and functional outcomes;
2. Promotion of accountable care models that incorporate addiction medicine and other mental-health related issues in post-discharge care, as needed;
3. Community-specific interventions for incentivizing longitudinal follow-up following severe acute pain experience;
4. Exploring community and hospital characteristics that influence HCAHPS scores associated with pain management;
5. Examining linkages between current and future HCAHPS pain-related and aggregate scores associated with functional outcomes following hospitalization;
6. Developing new pain-related HCAHPS metrics that combine qualitative patient experience and quantitative functional outcome.

We thank you in advance for your deliberate consideration of the above, and weighing of theoretical, unsubstantiated concerns expressed in the Citizen Petition against the reality of daily practice in which

advances in acute pain control of the past 25 years are one of the proudest achievements of an interprofessional public-private partnership. Working together, we can better determine what to measure, how to measure it, and how best to use this information to improve patient care and experience – while reducing unintended consequences of the valuable process of measurement.

Respectfully,

American Academy of Hospice and Palliative Medicine
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Chronic Pain Association
American College of Osteopathic Family Physicians
American Pain Society
Chronic Pain Research Alliance
The Pain Action Alliance to Implement a National Strategy
The TMJ Association
U.S. Pain Foundation