American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 28, 2016

The Honorable Sylvia Mathews Burwell
Secretary, Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary:

Prescription drug abuse has reached epidemic proportions with devastating effects on families across America. In many states, it has also fostered a heroin crisis, overwhelming our communities and families with often tragic consequences. Recently, the Centers for Disease Control and Prevention (CDC) announced that deaths from opioid pain relievers as a result of misuse and abuse have soared over the last fifteen years.[1] Moreover, the CDC reports that healthcare providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.[2] It is alarming that Americans consume opioids at a greater rate than any other nation, including twice as many opioids per capita as Canada.[3] The seemingly unending supply of prescription opioids is subject to misuse and diversion, which has become one of the foremost public health challenges facing our nation.

Of the over 136 million patient visits annually to the nation's emergency departments, 42% of these visits are related to painful conditions. While emergency physicians write a considerable number of prescriptions for opioids, we account for less than 5% of all opioid prescriptions in the US. In addition, **most are immediate release, the quantity in each prescription is generally quite low, and refills are rare.**

We also act as a bridge in the primary care system on nights, weekends, holidays, and other times when a primary care provider is not available. We are often the only access that patients have. Pain treatment centers regularly refer patients to the emergency department if the patient has not followed the agreed upon treatment plan and, as emergency physicians we must, by the EMTALA law, evaluate every patient who presents to our departments.

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[1] CDC Newsroom Archives. "Drug overdose deaths hit record numbers in 2014," December 18, 2015. Accessed from http://www.cdc.gov/media/releases/2015/p1218-drug-overdose.html.
[2] "Opioid Painkiller Prescribing." *CDC Vital Signs.* Accessed from http://www.cdc.gov/vitalsigns/opioid-prescribing/.
[3] Paulozzi, Leondard. "Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012," *Morbidity and Mortality Weekly Report* 2012. Accessed from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm.

In spite of the multiple efforts the Federal government (CDC's revised guidelines, FDA's Risk Evaluation and Mitigation Strategy, ONDCP educational sessions, CMS, etc.) has undertaken to tackle this crisis, we must point to a glaring issue that has worked at cross purposes not only for hospitals but soon for emergency physicians. Patient experience/satisfaction surveys are important, particularly regarding issues of treating patients with dignity and respect, but questions about pain have resulted in unintended consequences and the pursuit of high patient-satisfaction scores may actually lead health professionals and institutions to practice bad medicine by honoring patient requests for unnecessary and even harmful treatments.

On the hospital side, CMS operates the Hospital Value-Based Purchasing Program which includes a survey (HCAHPS) where discharged patients respond to questions including, "During this hospital stay, how often was your pain well-controlled?" and "During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?" Less than satisfactory patient perception scores will contribute to CMS reducing hospital DRG payments starting in 2016.

Similar questions are included in third draft version of the CMS' Emergency Department Patient Experience of Care. (EDPEC Survey 3.0) which the pilot test administered between 2-42 days after patients were treated and released. After ACEP submitted written comments to the first two versions, providing CMS with specific wording to change the pain questions, the third version now asks "during this ED visit did you have any pain, did the doctors and nurses try to help reduce your pain, and did you get medicine for pain?"

Any questions which provide an opportunity for patients to express dissatisfaction because they didn't get the drugs they sought, provide disincentives for physicians to prescribe non-opioid analgesics which will negatively affect their scores. This has been an issue for years with private surveys such as Press Ganey[4]. And, it is certainly not addressing important aspects of the opioid crisis that the government is expending tremendous resources to combat.

As DHHS continues to refine measures to reward quality care in the Medicare program, it is critical to correctly measure the quality being rewarded. Currently, there is no objective diagnostic method that can validate or quantify pain. Development of such a measure would surely be a worthwhile endeavor. In the meantime, we are concerned that the current evaluation system may inappropriately penalize hospitals and physicians who, in the exercise of medical judgment, opt to limit opioid pain relievers to certain patients and instead reward those who prescribe opioids more frequently.

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[4] Gunderman, Richard. "When Physicians' Careers Suffer Because They Refuse to Prescribe Narcotics," The Atlantic 2014, http://www.theatlantic.com/health/archive/2013/10/when-physicians-careers-suffer-because-they-refuse-to-prescribe-narcotics/280995/

We urge the Department to undertake a robust examination of whether there is a connection between these measurements and potentially inappropriate prescribing patterns, and, until that is completed, we urge you to remove pain questions from the various CAHPS surveys. We appreciate your prompt consideration of this request, and will work with you at any time to address these serious public health challenges.

Sincerely,

Jay A. Kaplan, MD, FACEP
President