Are Pain Management Questions in Patient Satisfaction Surveys Driving the Opioid Epidemic?

The United States is in the midst of a national opioid epidemic, with devastating consequences. We've seen an explosion of deaths and emergency room visits because of drug overdoses,[1] increasing morbidity and mortality from hepatitis C,[2] and recently in Indiana, the largest outbreak of HIV related to injection drug use in US history.[3]

We know that up to 80% of heroin users started by diverting prescription drugs,[4] and that the US Surgeon General has identified physician overprescribing as a causal link in this chain of addiction. Prescribing of opioid pain relievers has quadrupled since 1999, and the United States now consumes more than 90% of the world's opioids.[3] An underappreciated factor behind these statistics is the measurement of patient satisfaction related to pain.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, used since 2006 by the Centers for Medicare and Medicaid Services (CMS), is one of the many patient satisfaction surveys that includes questions about pain management. The survey, which is administered after discharge, is designed to measure patient perceptions of hospital experience as one surrogate for hospital quality.

Much attention has focused on Question 14 in the HCAHPS survey, "How often did the hospital or provider do everything in their power to control your pain?" This question is inextricably linked to the "pain as the fifth vital sign" culture promoted by the Joint Commission and Agency for Healthcare Research and Quality—a culture responsible for the misperception that patients should experience no pain.

CMS says Question 14 is intended to evaluate patients' experience of their pain management, not to judge prescribing behavior or compare hospital staff members.[5] Scores are reported for an entire facility, not for individual physicians, nurses, or other staff. Yet pain management is the only clinical measurement among eight components of Hospital Value-Based Purchasing, and many physicians see their patient satisfaction scores in patient surveys drop as a result of changes in their prescribing practices. These scores affect compensation and promotion.

The link between patient satisfaction scores and pain management plays out daily in physician offices and emergency departments as physicians who recommend physical therapy and nonopioid pain management encounter resistance from patients who simply want a quicker "solution" with pain pills. This leaves well-meaning professionals with the unsavory choice of prescribing opioids or facing dissatisfaction from disappointed patients on patient surveys.

As we've seen across the country, the consequences are tragic. Nationally, drug overdoses claimed more lives than traffic crashes in 2013; since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids.[6] Drug overdoses are everywhere—they do not discriminate by age, income, or location. In rural Scott County, Indiana, the 2015 HIV outbreak was traced to people who shared needles while injecting the powerful opioid Opana. Many who contracted HIV said their opioid addiction started with a legitimate opioid prescription.

The US Department of Health and Human Services (HHS) is reviewing how pain management is evaluated by patient satisfaction surveys, how those may connect to opioid prescribing, and how best to educate health professionals about prescribing guidelines. More than 40 professional organizations have committed to training 540 000 health care professionals across the United States in safe opioid prescribing in the next two years.[7] The Centers for Disease Control and Prevention recently released new guidelines for prescribing opioids for chronic pain and is working to improve public understanding of the risks and benefits of opioid use.

States are responding forcefully as well. In Indiana, a task force assembled by Governor Mike Pence to address the opioid epidemic has directed health officials to develop new guidelines for prescribing medication to treat acute pain. The Arkansas Medical Board is sending educational alert letters to prescribers who exceed the controlled substance prescribing norm for their discipline. Florida, which had an abundance of pill mills masquerading as pain clinics, implemented an aggressive plan through coordinated action by the Governor, the Attorney General, law enforcement, and the Department of Health in 2011. As a result of law enforcement investigations, the regulation of pain clinics, use of a voluntary prescription drug

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monitoring program, and health professional licensure suspensions, Florida has seen the number of deaths from prescription narcotics drop by more than 50%.

There is no single solution to the opioid abuse epidemic. We must educate the public and prescribers about the dangers of opioids, teach prescribers about opioid alternatives for pain management, optimize prescription drug monitoring programs, and increase the availability of substance-use disorder management.

We will not succeed unless CMS, HHS, pharmaceutical companies, prescribers, and communities take steps to counteract the driving incentives to overprescribe. Prescribers should not be scapegoats in a system that links patient perception of pain control to penalties in the setting of high consumer demand promoted by notions of "no pain is the norm."

It is time to acknowledge and eliminate the perverse incentives for overprescribing narcotics. We suggest four steps to effect real change: (1) The HCAHPS survey questions should be modified to reflect more appropriate pain management outcomes, such as return to function, multimodal pain management, and tolerable versus zero pain scores; (2) hospitals and systems should use standard acute and chronic opioid prescribing guidelines to assist health care professionals in doing right by patients with pain, without the fear of penalties for doing so; (3) states should encourage regional meetings of hospitals, health care professionals, and local health coalitions to standardize prescribing practices as a system; and (4) states should address the availability and outcomes of drug addiction treatment programs. By influencing the first step, CMS can partner with prescribers to be part of the solution, rather than part of the problem. AJPH

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