A Special Contribution from the Centers for Medicare and Medicaid Services: Valuing Patient Experience While Addressing the Prescription Opioid Epidemic

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Today, our country and health system face an extraordinary challenge regarding to the epidemic abuse of opioids. The system is burdened with persons seeking treatment for one of the largest substance use disorders of our time. We at the Centers for Medicare & Medicaid Services (CMS) are working closely with all our programs, other federal agencies, stakeholders, states, and the private sector to make sure we support efforts to educate physicians on the appropriate management of acute and chronic pain.1

As we respond to this crisis, we are also evaluating our policies toward pain management to ensure they don’t have the unintended consequence of encouraging the overprescription of opioid pain medications.2

Since 2008, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) has empowered patients with meaningful information to allow valid comparisons to be made across hospitals locally, regionally, and nationally.2 The HCAHPS survey is the first national, standardized, publicly reported survey of patients’ experience of hospital care. Data were first collected in 2006, with hospital scores publicly reported in 2008. In 2012, the HCAHPS survey became one component of the newly created Hospital Value-Based Purchasing (HVBP) program, which ties a portion of hospital payment to performance on quality and cost measures.

The HCAHPS survey contains 32 questions and is administered to a random sample of adult inpatients between 48 hours and 6 weeks after discharge from short-term, acute care hospitals. Patients admitted in the medical, surgical, and maternity care service lines are eligible for the survey.2 The HCAHPS survey, its methodology, and the scores it produces are in the public domain. Most of the more than 4,100 participating hospitals engage a CMS-approved survey vendor to administer HCAHPS, and although hospitals are permitted to add supplemental questions to the HCAHPS survey, these supplemental questions are neither reviewed nor submitted to CMS.

One of the 11 composite measures reported on the Hospital Compare Web site looks at patient experience in regard to pain management.3 Some health care providers have voiced concern that patient survey questions about pain management encourage the prescribing of opioids.4 Although there currently is not any empirical evidence of this, we understand the concerns and are making good on the commitment President Obama made in October to review the HCAHPS pain questions.5 Our goal is to ensure that they do not exert any unintended negative influence over clinicians’ prescribing practices.

In a rule published on July 6, 2016,6 CMS proposed temporarily removing the HCAHPS pain questions from the HVBP score. This approach is an attempt to address the tension occurring at the nexus of 2 national challenges: adequate pain management strategies and opioid overprescribing.7 Given the complexity of the issues involved and the need for additional research, CMS will continue to survey patients about adequate pain control, but these pain dimension results will not be part of the HVBP reimbursement calculation. The issues and science at this nexus are complex, and CMS will continue to invest in necessary research to understand the link between quality measurement approaches that directly incorporate patient feedback on their experience of care and clinical prescribing behavior.

HCAHPS was designed and validated for hospital-to-hospital comparisons and was never intended to be administered to emergency department (ED) discharges, nor to compare or evaluate individual physicians or...
nurses. CMS does not and cannot produce or report scores for individual staff or clinicians. HCAHPS surveys submitted to CMS have been deidentified; thus, CMS cannot trace surveys to particular patients or to other aspects of their treatment, such as which physicians, nurses, or other hospital staff they encountered. The HCAHPS scores that CMS calculates and publicly reports reflect hospital-level patient experience during a 12-month period. The survey is designed to provide patients and consumers with meaningful information to inform choice of hospital and to help drive quality improvement at the hospital level, not the individual staff or unit level. Despite its design and intent, however, hospitals and private survey vendors often add supplemental questions to the HCAHPS survey that are neither sanctioned by nor reported to CMS.

While internal manipulations such as these may be possible, they are ill advised. HCAHPS questions are designed to reference the entire hospital experience; they do not differentiate among the many physicians, nurses, and staff whom a patient encounters. More important, HCAHPS questions lack validity when used to compare particular staff members. It is unlikely that a hospital could collect enough completed HCAHPS surveys for individual staff to make statistically reliable comparisons, not to mention adjusting for patient characteristics that affect responses, such as service type, age, and education. Simply put, it may be that HCAHPS is being improperly used to produce dubious metrics of individual staff for comparisons and evaluations within hospitals, and even in EDs. Such practices generate mistrust among clinicians who express frustration that the specter of HCAHPS is used to influence clinical decisions, especially with respect to pain control medications.

Having reviewed the context, we now turn to the question of whether HCAHPS could be implicated in the increasing wave of opioid addiction and mortality. A review of historical prescribing rates reveals that a sharp increase in prescription opioids coincided with a concerted pharmaceutical industry campaign that started in the mid-1990s to prioritize pain management and increase opioid prescribing. Data from the Centers for Disease Control and Prevention show that, since the late 1990s, there has been a steady increase in opioid prescriptions, opioid-related hospitalizations, and opioid-related overdose deaths. There is no noticeable acceleration in the opioids prescribing trend in 2006, when HCAHPS was implemented, or in 2008, when public reporting of hospital scores commenced.

The Department of Health and Human Services performed a thorough review of the patient experience literature and found very few well-designed studies of the topic. The review identified 3 peer-reviewed publications that have adequate samples and designs to examine the relationship between opioid prescribing or use and HCAHPS scores. One additional study examined the relationship between opioid prescribing and Press Ganey patient satisfaction scores in the ED. What is consistent across all of these studies is that opioid prescribing was not associated with higher patient experience or satisfaction scores. In some cases, receipt of opioid analgesics in the inpatient setting was associated with a higher likelihood of reporting a poor care experience. Another consistent finding is that nursing and clinician courtesy and communication are most strongly associated with higher patient experience scores.

In addition to clarifying the proper use of the HCAHPS survey, the Department of Health and Human Services and CMS have taken a number of steps in direct response to concerns about an association between the survey and opioid overprescribing. These include testing alternative pain questions for the HCAHPS survey (including patients, clinicians, and administrators), examining the association between HCAHPS scores and its pain management questions, investigating the relationship between HCAHPS scores and opioid prescription at hospital discharge, creating and testing a survey specifically designed for ED patients, and the recent proposal to remove pain management from the HVBP score.

Regardless of what these projects demonstrate, CMS knows that it must maintain the trust and goodwill of physicians and other clinicians as it endeavors to increase transparency and provide incentive for quality improvement in health care. In all of our work, our primary focus is on improving the quality of health care for patients and providing individuals with information and data to help them make the best choices for their health. To reiterate, the opioid epidemic is a public health crisis that we are committed to addressing and will require a holistic approach. We must balance these efforts with those that ensure that patients in pain receive the care they need when they need it. We will continue to work with physicians and other clinicians, hospitals, patients and consumers, and the private sector to ensure that our programs are practical and equitable, and, most important, that they help improve patient care.

We look forward to continuing to evolve HCAHPS and HVBP to continue to improve and achieve those goals. Our policy interest is driving hospital-level improvement, taking seriously patients’ perspective of care, and ultimately improving overall patient care.
REFERENCES

2. Centers for Medicare & Medicaid Services. Hospital Consumer Assessment and Plan Performance (Lehrman, Goldstein), and Center for Program Integrity (Agrawal), Centers for Medicare & Medicaid Services, Baltimore, MD.

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