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Far Too Easy: Opioid Diversion During the Transition from Hospital to Nursing Home

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To the Editor,

The communication between hospitals and nursing homes is fragmented.¹⁻³ The vast majority of nursing homes do not share electronic medical records with hospitals.¹⁻³ When patients are discharged from the hospital to a nursing home, patient care-plans and prescriptions frequently travel with the patient in a paper-based discharge packet.^{1,4} Since many of these patients have conditions which impair their ability to self-advocate, patients rely on this system to accurately convey their information.

Nursing home nurses commonly report that opioid prescriptions are missing from the discharge packets they receive.¹ Legally, nursing home nurses cannot dispense controlled (i.e., Schedule II) substances without a signed, hard-copy prescription; so if the prescription is missing, delays in pain control can result.¹ In one study, nursing home nurses attributed missing opioid prescriptions to routine hospital error.¹ Since hospital providers often were unreachable by the time nursing home admission orders were processed, the nurses contacted outpatient providers to provide missing orders. With no way to know if the hospital sent the prescription, outpatient providers would typically re-order the opioid to ensure the patient received adequate pain control.

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To improve hospital-to-nursing home communication, we are piloting a hospital-based transitional care intervention. Before hospital discharge, the transitional care nurses work with hospital inpatient teams to confirm the presence of signed, hard-copy opioid prescriptions in patient discharge packets. As is routine in many hospitals throughout the US, the discharge packet is given to whoever is transporting the patient to the nursing home. As part of our intervention, the transitional care nurses call the nursing home nurse once the patient arrives on-site, and performs a series of protocolized tasks including a comprehensive medication reconciliation.

One early case in this program has raised alarm. The transitional care nurse worked with the inpatient team to confirm that a signed opioid prescription was included in a discharge packet. The packet was handed to the driver of a transport service, and the patient was transported to the nursing home. However, when the transitional care nurse contacted the nursing home staff, she was told that although the discharge packet had arrived, no opioid prescription was present. An internal investigation by the hospital confirmed the script was in the discharge packet when it was handed to the driver. The matter was reported to the local authorities.

Prescription drug overdose, particularly from opioids, is a leading cause of unintentional injury deaths.⁵ Although policies are in place to curb opioid diversion,⁵ none adequately address the issues encountered in this case. It would be simple to divert prescription opioids by being hired by or obtaining contacts within a patient transport service. All pertinent information needed to pose as the patient's caregiver is present in the discharge packet; nab the paper opioid prescription from the packet, bring it to the local pharmacy and fill the opioid prescription. Anyone who touches the packet has the same opportunity (Figure 1). Statewide Prescription Drug Monitoring Programs are operational in most states but typically do not include information on nursing home patients or on who picks up prescriptions.⁵ Hospitals would not typically identify a problem because most do not follow nursing home patients after discharge.^{2,3} Finally, and perhaps most importantly, care communications are so routinely poor that nursing home nurses would not think to report the prescription missing.¹ They would just assume the hospital had, yet again, omitted important information. Given the fact that drug dealers and abusers must be opportunistic in finding their drugs, it would be surprising if this diversion pathway was not being actively harnessed now.

A change is clearly needed. The presence of an universal electronic medical record spanning all care sites would help^{2,3} but is unlikely anytime soon given financial barriers. Prescription Drug Monitoring Programs should be inter-connected nation-wide⁵ and include the names of persons picking up controlled prescriptions. Electronic processes for opioid prescribing that eliminate paper prescriptions should be widespread. However, these initiatives will require infrastructure and policy changes which take time.⁵ Immediately, hospitals can institute tamper-proof packaging with opioid prescription-tracking for all discharge packet communications. This would not be fool-proof, but would be low-cost, and require minimal process disruptions. The hospital in the case above was able to implement tamper-proof packaging and opioid prescription-tracking quickly and easily.

The care fragmentation and poor communication that exist between hospitals and nursing homes make opioid diversion during transitions far too easy. This creates a situation in which care fragmentation could negatively impact society at large. Increased policy support and funding to promote nation-wide care coordination efforts, like transitional care programs, are needed.

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Figure 1. Chain of Possession of Opioid Prescriptions within Discharge Packets for Patients Transitioning from Hospitals to Nursing Home