Opioid Stewardship in PALTC Settings: Raising the Bar

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tewardship is defined as the “the careful and responsible management of something entrusted to one’s care” (Merriam-Webster). Providers in post-acute and long-term care have thoughtfully embraced the concept of stewardship, providing direction, guidance, and oversight for a variety of clinical, social, and regulatory initiatives. The residents and patients entrusted to our care are offered an opportunity to live under the umbrella of stewardship, which affords greater protection, supervision, and attention to detail where critically necessary. A recent, widely adopted example would be antimicrobial stewardship programs, led by data-driven analyses and evidence-based revelations. This initiative has been embraced out of medical necessity, with the prodding of regulatory partners and with oversight by the Department of Health and Human Services, the Centers for Disease Control and Prevention, and the Centers for Medicare & Medicaid Services. Opioids are another area where our stewardship matters. According to the CDC, more than 100,000 died from overdoses during the year ending April 2021, an increase of 56,064 deaths from the previous year (“Drug Overdose Deaths in the U.S. Top 100,000 Annually,” Nov. 17, 2021; https://bit.ly/3JtY4NY). Included are increases in deaths from synthetic opioids (primarily fentanyl), psychostimulants (e.g., methamphetamine), cocaine, and natural and semisynthetic opioids (e.g., prescription pain medication). The patients and residents we provide care to are among those who may not have been counted in those statistics — we must recognize this issue and help prevent these deaths from happening.

Recalling Recent History

Opioid use was encouraged by the “revelation” of the infamous extended release formulation, marketed as “non-addicting” forms of existing opioids. As prescriptions and use increased — all in the name of improved patient care for those suffering with chronic cancer pain, palliative, or end-of-life pain — regulators and medical professionals alike were slow to understand the ramifications. Expanded use of opioids for all types of pain, both acute and long-term (>3 months), as well as expanded coverage by insurance plans and later the Medicare Part D program, greatly influenced the case with which opioids became pervasive. The demand for prescription opioids also fueled the manufacturing and importing of illicit street substitutes, which only increased addiction, use disorder, and death.

Unintended Consequences of Opioid Prescribing

Opioids are highly addictive, even at low doses prescribed for a short duration. First-time exposure by prescription remains a leading driver of the cascade to dependence and substance use disorder. Researchers have found that half of overdose deaths had an active prescription of opioids at the time of death (Pain Med. 2016;17:85–98).

Adverse drug events (ADEs) are considered a leading cause of hospital admissions. In 2014, hospitals had more than 280,000 admissions for ADEs, including prescription opioid overdoses (Office of Disease Prevention and Health Promotion, National Action Plan for Adverse Drug Event Prevention, U.S. Department of Health and Human Services, 2014; https://bit.ly/3ulLQJ0).

Although opioid overdoses are often associated with young and middle-aged individuals, the crisis also affects our residents in PALTC settings. A recent study of community-based occurrences of opioid-related ADEs after a medical hospitalization indicated a 7% risk for an opioid-related ADE for patients 65 and older who were discharged with an opioid prescription, excluding hospice patients and those transferred to or from a facility (J Am Geriatr Soc. 2022;70:228–234).

Strategies to Incorporate Opioid Stewardship

How are we in PALTC addressing the opioid crisis and epidemic? The statistics provided on a regular basis should give us pause and prompt us to focus on some of the larger issues at hand:

• Assessing thoughtfully our approach to opioid prescribing.
• Using nonpharmacological treatment options.
• Creating care plans with actionable goals.
• Recognizing the medical necessity of care for those with substance use disorders, especially for those being denied access to our long-term living facilities.
• Collaborating with the members of our management teams at the individual and corporate levels.

As medical directors, advanced practice providers, consultant pharmacists, nurses, and pharmacy providers, we must collaborate to provide both appropriate structure and oversight to the use of opioids and recognize their ramifications.

Quality Measures and Opioid Prescribing

Quality measures are used by CMS to benchmark the quality of Medicare Advantage Plans and Medicare Part D plans. Part D plan sponsors must incorporate these quality measures into their workflow, report on interventions, and be rated by CMS annually. The Pharmacy Quality Alliance (PQA), a national quality organization dedicated to improving medication safety, adherence, and appropriate use of medications across all health care settings, has opioid measures as well (https://www.pqaalliance.org/opioid-measures). These, together with the CMS quality measures, play an important role in how prescription opioids are dispensed in our communities.

Although residents of PALTC facilities and those receiving palliative care, end-of-life care, and cancer pain therapy are exempt, all these Part D measures are in play for residents of assisted living and independent living facilities. Providers should become familiar with both sets of measures.

More Than Reducing Prescribing: Systems Approach

Ordering fewer opioids for residents and patients is a one-dimensional approach to countering the crisis. A more collaborative approach — including educational techniques and communication with other members of the clinical and administrative team — is essential to achieving stewardship goals.

Screening tools are available that can be integrated into admission or discharges assessments. These can identify the residents and patients who are at risk for substance use disorders and those who are ideal candidates for opioid avoidance or tapering treatment plans. For more information, see the Substance Abuse and Mental Health Services Administration (SAMHSA) program “Screening, Brief Intervention, and Referral to Treatment” (SBIRT) (https://www.samhsa.gov/sbirt).

Connecting with community resources and partner health care organizations for resident referral and follow-up care can also help identify and reduce the potential for transitioning residents’ health needs. Education for all facility staff on all areas of the provision of pharmacy services. Consultants, in conjunction with the medical director and the quality improvement team, can take the lead in facility stewardship activities.

Communication about opioids with the medical provider during monthly review activities usually includes:

• Reviewing pain scale documentation, which assesses the response to scheduled or as-needed (PRN) pain regimens.
• Questioning the need for PRN orders for opioids prescribed for acute pain after a transition from hospital to facility.
• Monitoring for evidence of ADEs, such as sedation and constipation.
• Reviewing drug combinations that

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increase the risk for sedation, orthostatic hypotension, and falls.

- Recommending efforts to taper or discontinue opioids before a scheduled post-acute discharge to home or when regimens are ineffective or unnecessary.
- Advising prescribers on patterns of dispensing to reduce the quantity of opioids on hand as a mitigation strategy for diversion.

Pharmacy providers to PALTC, assisted living, and residential facilities are ideally positioned to provide real-time support for opioid stewardship efforts with the use of their specialized dispensing software alert systems for dosing, interactions, and contraindications. These systems are in addition to the prescribing alerts generated by electronic medical records as providers enter medication orders.

Best practices encourage a three-way communication system: facility nursing staff, prescriber, and pharmacy sharing information on opioid prescribing, clarifications, side effects, stop orders, morphine milligram equivalent (MME) edits and concerns, and other pertinent matters.

**Preparation for CMS Surveys**

Best practices include preparation for CMS surveys. The “State Operations Manual Appendix PP: Guidance to Surveyors for Long Term Care Facilities” (https://www.hhs.gov/guidance/document/guidance-surveyors-long-term-care-facilities) is a document that PALTC pharmacists are most familiar with. The areas of concern, relative to the prescribing of opioids, include the following sections and F-tags:

483.12 Freedom from Abuse, Neglect, and Exploitation
F 608: Reporting of Reasonable Suspicion of a Crime; Concerns: patient not receiving care; diversion of personal prescription drugs

483.25 Quality of Care
F 697: Pain Management; Concern: inadequate or sub-standard pain relief

483.45 Pharmacy Services
F 757: Drug Regimen is Free from Unnecessary Drugs; Concern: assessing for response to medications

**Additional Resources:**