Opioid Misuse Risk

Implementing screening protocols in an ambulatory oncology clinic

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With morbidity and mortality related to opioid use continuing to increase, clinicians need to better understand the risk for opioid misuse in patient populations. Screening for opioid misuse risk has not been routinely adopted as a standard practice in clinical settings. A pilot study was performed to determine the feasibility of screening for future opioid misuse risk using the Opioid Risk Tool (ORT) in an ambulatory oncology clinic. Twelve patients in this sample scored in the moderate- to high-risk range for aberrant behavior, and 8 patients reported a personal history of substance abuse, indicating a need for opioid misuse risk screening in populations of patients with cancer. Because it is easy and quick to use, the ORT may be a feasible tool to incorporate into standard practice.

AT A GLANCE

- Screening for opioid misuse risk may help clinicians to identify individuals at a greater risk for future aberrant behavior related to opioid use.
- By screening for opioid misuse risk, clinicians can provide appropriate pain management for patients with cancer.
- As part of their oncology clinic workflow, RNs can implement and administer the ORT to patients who are prescribed medication for cancer-related pain.

KEYWORDS
opioid; pain management; risk assessment; substance abuse; cancer-related pain

DIGITAL OBJECT IDENTIFIER
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The treatment plan for a 53-year-old Caucasian woman named P.M. diagnosed with P16-negative squamous cell carcinoma of the right hypopharynx and at the base of the tongue, with right neck node metastases (cT2 N1 M0), was seven weeks of daily radiation and weekly cisplatin with curative intent. P.M. is a single mother of two adult children who lives alone and works as a director for a behavioral health partner network. Prior to starting treatment, an RN administered the Opioid Risk Tool (ORT) to P.M. as part of the feasibility study. P.M. scored in the high-risk category on the ORT and reported a family history of alcohol abuse, as well as a personal history of depression and alcohol, prescription drug, and illicit drug use. The oncology nurse practitioner reviewed P.M.'s score and referred her to palliative care for complex pain management. At her appointment with the palliative care nurse practitioner, P.M. expressed relief that the ORT was administered because she had concerns about discussing her history of substance abuse and being stigmatized. P.M. reported that she had been in recovery for substance abuse for 10 years and expressed a fear of taking opioids because of the risk for relapse. P.M. said the following about her experience with the risk assessment:

> I was grateful we did the assessment. . . . The last thing I needed to do was get one condition treated, [focusing] on my cancer, and not talk about my recovery and end up being addicted to opioids. . . . I was grateful we made a plan and communicated. . . . Everyone knew that I was safe, that my recovery was not in jeopardy, that we were treating me as having two conditions, one treatment together . . . not focusing on cancer and ignoring that fact that I have addiction issues and I am in recovery.

The palliative care and oncology teams collaborated to ensure that P.M.'s cancer-related pain was safely and adequately managed.

Background

Oncology clinicians have expressed concerns about the opioid crisis, which was declared a public health emergency in the United States in 2017 (U.S. Department of Health and Human Services, 2017). Since then, clinicians have focused on improving patient opioid risk assessment, management of patients with a history of opioid use or abuse, and best practices for the prescription of opioids. Based on their meta-analysis of 122 articles on pain and pain severity, van den Beuken-van Everdingen, Hochstenbach, Joosten, Tjan-Heijnen, and Janssen (2016) reported that pain prevalence rates in patients requiring opioid therapy were 40% in those receiving curative treatment, 55% in those receiving active antineoplastic therapy, and 66% in those diagnosed with advanced, metastatic, or terminal disease. Opioid use is also prevalent in cancer survivors who have no evidence of disease, but their use of opioids may be a result of factors other than a previous cancer diagnosis (Barbera et