



# Opioid Harm Reduction within OHSU Internal Medicine



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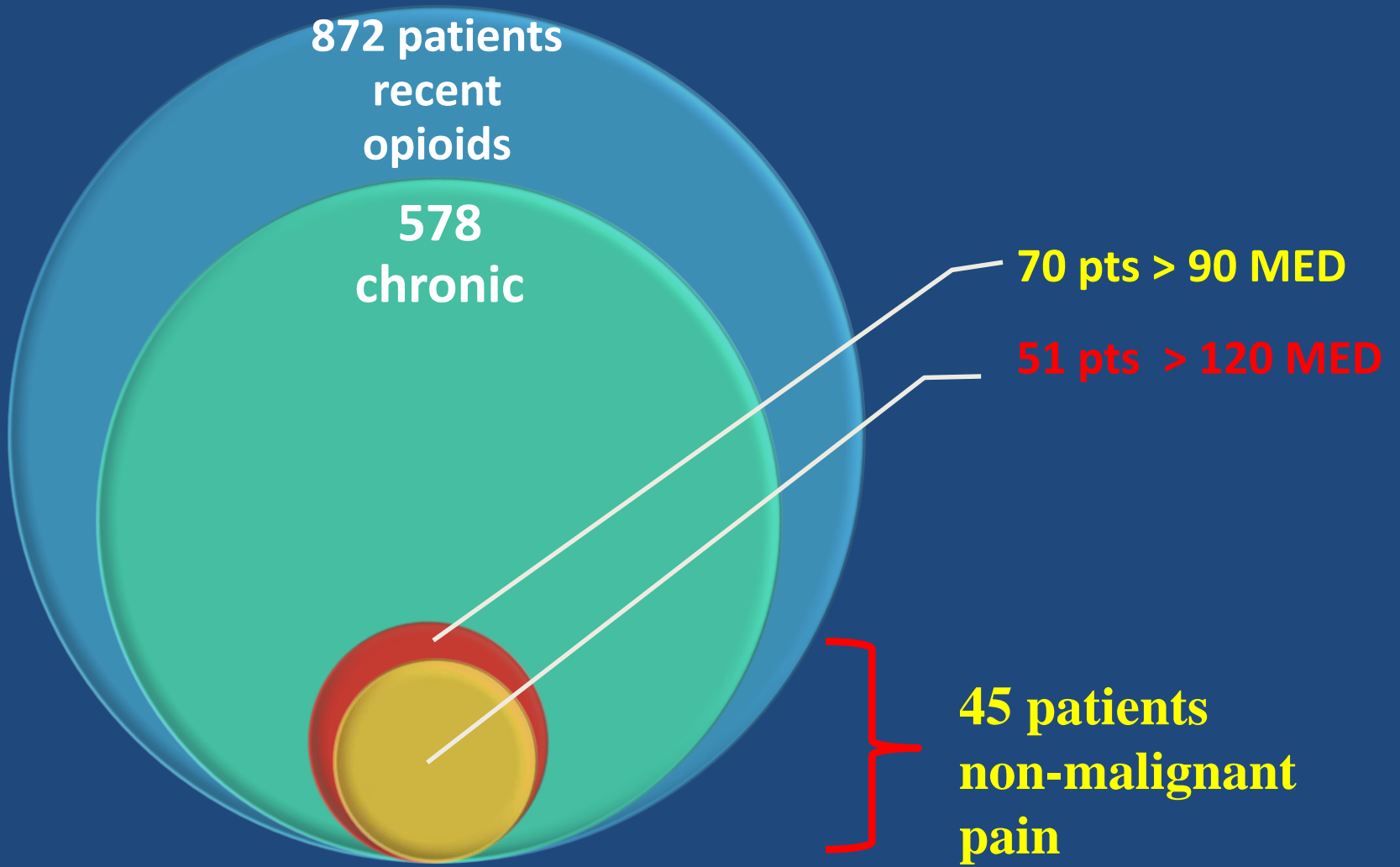
DATE: September 22, 2017, Mid-Willamette Valley Pain Summit  
PRESENTED BY: Jonathan L. Robbins MD, Assistant Prof. of Medicine,  
General Internal Medicine



# Learning Objectives

1. Understand the rationale for secondary review of high-risk opioid prescribing
2. Describe how a high-dose patient can be transitioned to buprenorphine within primary care

**From September to November 2016,  
faculty and residents reviewed patient  
charts with a recent opioid prescription.**



**Our opioid review board meets monthly to discuss patients who are “out of [CDC] guideline.”**

**May 30, 2017**

**Laura: 60 year-old woman with Sjogren's,  
fibromyalgia, depression, PTSD**

**Meds: fentanyl 100 mcg/hr, clonazepam  
0.5 mg BID (MED = 240)**

**Med harms: frequent falls, ED visit for  
manual disimpaction**

**August 30, 2017**

**Laura evaluated in PROPEL clinic.**

**DSM-5 for mild opioid use disorder.**

**Discussed buprenorphine (Suboxone).**

**Rx naloxone.**

**Established treatment expectations.**

**Communicated with psychiatrist.**

**September 4, 2017**

**Begin home buprenorphine induction.**

**Laura transfers to my primary care  
panel.**

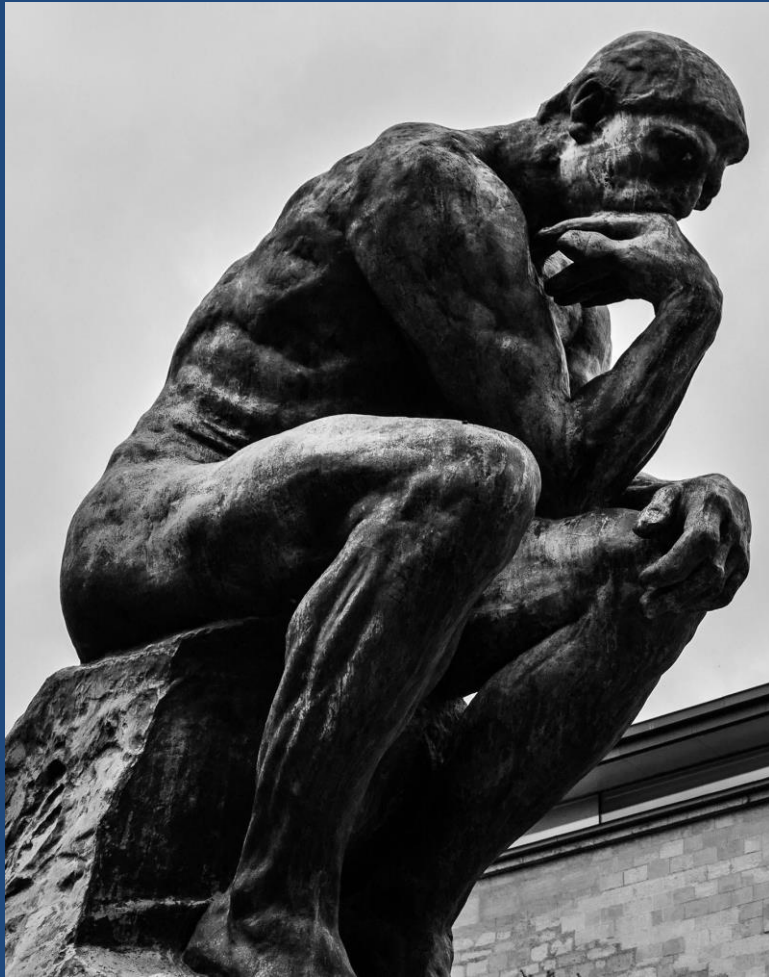


**September 12, 2017**

**Office visit. Stable on bup 4 mg – 2 mg – 4 mg. Sleeping better.**

**Psychiatrist reduced clonazepam to 0.125 mg QHS, started trazodone.**

**Rheumatologist looking into connective tissue disease.**



**What questions,  
comments are  
there before I  
conclude?**

# CONCLUSIONS

1. Secondary review by an opioid review board is helpful to both patients and providers.
2. Opioid harm-reduction and transition to medication assisted treatment can be accomplished within primary care.
3. The process increases patient and provider satisfaction.

**Contact me anytime!**

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