Supplemental materials for

Robbins JL, Byler J, Vinti A, et al. The Implementation of a Clinic-based opioid review board to address high-risk opioid prescribing in primary care. *Ann Fam Med*. 2021;19(6):563.

Jonathan L. Robbins, MD, MS[1]

Julie Byler, DO[2]

Angela Vinti, PharmD[3]

Scott Watson, MSW[4]

Afaf Sharen Azar, MD[1]

P. Todd Korthuis, MD, MPH[5]

Mary Pickett, MD[1]

[1]Division of General Internal Medicine, Oregon Health & Science University, Portland, Oregon

[2]Oregon Health & Science University, Portland, Oregon

[3]Internal Medicine Clinic, Oregon Health & Science University, Portland, Oregon

[4]Licensed Clinical Social Worker, Internal Medicine Clinic, Oregon Health & Science University, Portland, Oregon

[5]Addiction Medicine Program, Division of General Internal Medicine, Oregon Health & Science University, Portland, Oregon

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References

1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *JAMA*. 2016;315(15):1624-1645.

2. Parchman ML, Von Korff M, Baldwin LM, et al. Primary care clinic re-design for prescription opioid management. *J Am Board Fam Med*. 2017;30(1):44-51.

3. Chou R, Ballantyne J, Lembke A. Rethinking Opioid Dose Tapering, Prescription Opioid Dependence, and Indications for Buprenorphine. *Ann Intern Med*. 2019;171(6):427-429.

Supplemental Appendix: Controlled Medications Task Force Documentation of Secondary Case Review

Internal Medicine Clinic
Controlled Medications Task Force (IMC Opioid Review Board)
Documentation of Secondary Case Review

Case Conference Date: [redacted]
PCP: [redacted]
Patient: [redacted]

[redacted] is a 61 y.o. man whose care plan was reviewed by our committee due to the safety concern of DUII, possible alcohol use disorder, OSA and morphine equivalent dose above 90 mg/day.

Our recommendations are based on chart review by two committee members and discussion with consideration of risk vs benefit, in committee review.

Indication for chronic opioid: gout, RA, spinal osteomyelitis

Current morphine equivalent dose: MED 105 mg per day

Comments on case review:
[redacted] has had a DUI while boating and has a history of worsening pain (and depression) while on opioids. He also has a history of running out of medication early due to a gout flare. He has struggled to remain completely sober from alcohol while in his DUI diversion program.

Committee recommendations:

1. We recommend that the care plan for [redacted] include a medication taper, to align with our clinic's general practice of prescribing less than 90mg MED per day of an opioid.
2. [redacted] should be screened for an alcohol use disorder. He is likely a candidate for Suboxone therapy given his h/o DUI, OSA, and his worsening depression and function while on opioids.
3. Recommend referral to MAT clinic.
4. Recommend naloxone prescription for the patient.
5. In order to continue receiving opioids from the clinic, the patient should be abstinent from alcohol. At next office visit, please check an ethyl glucuronide urine level. If this is positive, pt is still using alcohol and risks may outweigh the benefits of further full agonist opioid prescription.

Review board will plan to follow up this care plan in: 12 months.

Supplemental Table 1. Overall Change In COT and SL Buprenorphine-Naloxone Prescribing During Quality Improvement Period

	February 2017	July 2020	Percent change
Total practice size	12841	14289	+11.2%
Total number of patients on chronic opioids	664	458	- 31.0%
Total number of patients 50-89 MEDD	213	114	- 46.5%
Total number of patients > 90 MEDD	128	41	- 68.0%
Total number of patients on opioids and benzos	73	41	−43.8
Total SL buprenorphine-naloxone	34	117	+ 344.1%
SL buprenorphine-naloxone (previously on COT)	19	64	+336.8%

Supplemental Figure 1.