

Background: Opioid Prescribing Improvement Program

In 2015, Governor Dayton worked with the Legislature to create the Opioid Prescribing Improvement Program (OPIP). The law tasked a group of experts with developing recommendations on opioid prescribing and use. The resulting Opioid Prescribing Work Group (OPWG) includes health care providers, mental health experts, pharmacists, law enforcement professionals, health plan representatives, consumers and representatives of the state. Minnesota officials are encouraging all providers statewide to adopt the new guidelines. Providers whose prescribing is excessive and who participate in Medical Assistance and MinnesotaCare will be required to participate in a quality improvement program to help them meet the new standards.

Overview: New Opioid Prescribing Guidelines

The new opioid prescribing guidelines developed by the OPWG reflect three broad values:

- 1. Prescribe the lowest effective dose and duration of opioids when used for acute pain.** Clinicians should also reduce variation in opioid prescribing for acute pain.
 - *Avoid prescribing more than a three-day supply (or 20 pills) of low-dose, short-acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (MME).*
 - *Prescribe no more opioids than will be needed for initial tissue recovery following more extensive surgical procedures and traumatic injury.*
 - *Limit the initial acute prescription to no more than seven days (or up to 200 MME), unless circumstance clearly warrant additional opioid therapy. Limit the entire prescription to 200 MME (not 200 MME/day).*
- 2. Monitor the patient closely during the post-acute pain period.** The post-acute pain period is a critical time to prevent chronic opioid use.
 - *Assess and document risk factors for chronic opioid use during the post-acute pain phase, including depression, anxiety, substance abuse, and fear avoidance.*
 - *Prescribe opioids in multiples of seven days, with no more than 200 MME per seven-day period, and no more dispensed than the number of doses needed. Prescribing should be consistent with expected tissue healing and recommended tapering.*
 - *Avoid prescribing in excess of 700 MME (cumulatively) in order to reduce the risk of chronic opioid use and other opioid-related harms.*
 - *Develop a referral network for mental health, substance use disorder, pain education, and pain medicine.*
- 3. Avoid initiating chronic opioid therapy and carefully manage any patient who remains on opioid medication.** The evidence to support long-term opioid therapy for chronic pain is insufficient at this time, but the evidence of harm is clear.
 - *Prescribe opioids at the lowest dose, with no more than 50 MME/day. Avoid increasing daily dosage to 90 MME/day or above.*
 - *Actively work to lower risks when prescribing long-term opioids and throughout the therapy. Strategies and frequency should be commensurate with risk factors.*
 - *Face-to-face visits with the prescribing provider should occur at least every three months. Prescribers should offer to taper use to a reduced dose or to discontinuation at least every three months.*
 - *Offer or arrange evidence-based treatment for patients with opioid use disorder.*

A complete set of the final guidelines is available [on the DHS website](#).