STEP ACT, Limiting Exposure to Opioids

AN ACT RELATIVE TO SUBSTANCE USE TREATMENT, EDUCATION AND PREVENTION (STEP ACT)

H.3817

Opioid Prescribing Facts

- Americans constitute 4.6% of the world's population but consume 80% of the global opioid supply and 99% of the global hydrocodone supply.[1]
- In 2012, health care providers in the United States wrote 259 million prescriptions for opioid pain relievers – enough for every American adult to have a bottle of pills.[2]
- In 2014, health care providers in Massachusetts wrote 4.4 million prescriptions for a schedule II or schedule III drug, which resulted in 240 million pills being dispensed. With 6.7 million people living in Massachusetts, enough pills were prescribed for every man, woman, child, and infant in the Commonwealth to have a 30 day prescription.
- In 2014, in the United States, an estimated 489,000 adolescents (age 12 to 17), 574,000 young adults (18 to 25), and 362,000 adults (26 or older) initiated nonmedical use of pain relievers. In other words, each day approximately 1,300 adolescents, 1,600 young adults, and 1,000 adults initiated nonmedical use of pain relievers.[3]
- Most people who misuse prescription opioids get them for free from a friend or relative.[4]
- Individuals who misuse or depend on alcohol are TWO times, marijuana are THREE times, cocaine are FIFTEEN times, and prescription opioid pain killers are **FORTY** times more likely to have a heroin addiction.[5]
- In 2014, approximately 1,256 people died in the Commonwealth from an opioid overdose.[6] More than 3 people each day.

---

[1] Manchikanti L, Singh A. Therapeutic opioids: a ten-year perspective on the complexities and complications of the escalating use, abuse, and nonmedical use of opioids. *Pain Physician.* 2008(a);11(2 Suppl):S63-88. Retrieved from: http://www.painphysicianjournal.com/current/pdf?article=OTgz&journal=42

[2] New CDC opioid prescribing guidelines, improving the way opioids are prescribed for safer chronic pain treatment. (2015). Retrieved from CDC website: http://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

[3] Lipari, R., Kroutil, L., & Pemberton, M. R. (2015). Risk and protective factors and initiation of substance use: results from the 2014 national survey on drug use and health. Retrieved from SAMHSA website: http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR4-2014rev/NSDUH-DR-FRR4-2014.pdf

[4] Jones CM, Paulozzi LJ, Mack KA. Sources of Prescription Opioid Pain Relievers by Frequency of Past-Year Nonmedical Use: United States, 2008-2011. *JAMA Intern Med.* 2014;174(5):802-803. doi:10.1001/jamainternmed.2013.12809. Retrieved from: http://archinte.jamanetwork.com/article.aspx?articleid=1840031

[5] Jones CM, Logan J, Gladden M, Bohm M, Demographic and substance use trends among heroin users, US, 2002-2013. MMWR, 2015. Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w

How does the bill limit exposure to opioids?

Under the STEP Act, the **first** time a patient obtains a prescription for an opioid, the patient will be limited to receiving a 72-hour supply. Additionally, the first time a patient obtains a prescription for an opioid from a new doctor, even if the patient has previously taken opioids, the patient will be limited to receiving a 72-hour supply. The bill provides an exception for emergency situations and permits the department of public health through regulations to identify additional exceptions to the 72-hour limit.

Why should the Commonwealth limit initial exposure to opioids?

Both genetic and environmental variables contribute to the initiation of use of addictive agents and to the transition from use to addiction.[7] While the Commonwealth cannot change an individual's genetics, the Commonwealth can reduce exposure to opioids and ensure that initial use is closely monitored by a medical professional. The Commonwealth has long recognized the importance of limiting exposure to addictive agents (e.g. tobacco, alcohol, gambling).

Will the STEP Act reduce doctor shopping?

Doctor shopping will likely be reduced if a person can only receive a 72-hour supply each time they visit a new provider.

How will the exceptions to the 72-hour limit be implemented?

The administration is committed to working with members of the medical community to identify appropriate exceptions to the 72-hour limit. As drafted, the bill ensures that prescribers have the flexibility to prescribe more than a 72-hour supply of an opioid in an emergency situation. Additionally, the Department of Public Health is tasked with identifying other appropriate exceptions to the 72-hour limit. At a minimum, the exceptions will ensure access to opioid pain medication for individuals being treated for chronic pain or who are receiving palliative or hospice care.

Why limit the first prescription to 72 hours?

Opioids are a narcotic medication with high potential for misuse. Given the risks associated with taking opioids, they should only be taken under the careful supervision of a medical professional and, with limited exceptions, should only be prescribed by a medical professional who has a relationship with the patient. The continued dialogue between a medical professional and a patient taking opioids can help to uncover additional risk factors, warning signs, and complications that may hinder the patient's recovery or put the patient at risk for addiction or death.

In guidelines recently adopted by the Massachusetts Hospital Association (MHA) for emergency departments, the MHA acknowledged that opioid therapy should

---

[6] DPH Data Brief (2015). Retrieved from: http://www.mass.gov/eohhs/gov/departments/dph/stop-addiction/current-statistics.html

[7] Bevilacqua L, Goldman D. Genes and Addictions. *Clinical pharmacology and therapeutics.* 2009;85(4):359-361. doi:10.1038/clpt.2009.6.

be managed through a primary care provider.[8] The guidelines specifically provide that emergency department providers should prescribe no more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than five days. The guidelines also provide that for acute exacerbations of chronic pain, the emergency department provider should notify the patient's primary opioid prescriber or primary care provider of the visit and the medication prescribed. However, if the primary opioid provider cannot be reached, the maximum prescription should not exceed a five-day supply of opioids.

Limiting a patient's first opioid prescription from a new provider to 72 hours will help to ensure that patients have a relationship with the medical professional who is prescribing the opioid. While, limiting a patient's first exposure to an opioid to 72-hours will allow providers an opportunity to evaluate a patient's progress and evaluate whether continued opioid therapy is an appropriate pain management strategy or whether alternatives should be considered.

Is there any evidence that medical professionals are too casual about prescribing opioids?

Over the past five years, several studies have questioned the efficacy of the use of opioids to treat acute pain and have overwhelmingly acknowledged the risks associated with the use of opioids.[9] In 2015, a survey conducted by the Boston Globe and Harvard T.H. Chan School of Public Health found that Massachusetts doctors are less likely to discuss the risks of prescription painkiller addiction with patients than their colleagues in other states.[10] Moreover, a 2011 survey of medical schools concluded that medical students receive limited, variable, and often fragmentary education about the treatment of pain.[11] The study further concluded that the twin dangers of pain under-treatment and the abuse of pain-active medications are among our society's deepest public health concerns; pain medicine does not receive the attention that it deserves in medical education.

These facts combined with the alarming quantity of opioids that are prescribed in the Commonwealth suggest that the medical community has historically failed to perceive the risk associated with prescribing an opioid.

---

[8] Retrieved from: http://www.mhalink.org/AM/Template.cfm?Template=/CM/ContentDisplay.cfm&ContentID=50511&FusePreview=True&WebsiteKey=a3f1fffe-a9f6-4b95-a06a-a551e90c7801

[9] Teater, M.D., D. (2014). Evidence for the efficacy of pain medications. Retrieved from National Safety Council website: http://www.nsc.org/RxDrugOverdoseDocuments/Evidence-Efficacy-Pain-Medications.pdf; Katz MH. Mitigating the Dangers of Opioids. *JAMA Intern Med*. 2015;175(4):616. doi:10.1001/jamainternmed.2014.8096. Retrieved from: http://archinte.jamanetwork.com/article.aspx?articleid=2110991; Miller M, Barber CW, Leatherman S, et al. Prescription Opioid Duration of Action and the Risk of Unintentional Overdose Among Patients Receiving Opioid Therapy. *JAMA Intern Med.* 2015; 175(4):608-615. doi:10.1001/jamainternmed.2014.8071. Retrieved from: http://archinte.jamanetwork.com/article.aspx?articleid=2110997

[10] Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States. Retrieved from: https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2015/05/Prescription-Painkiller-Poll-Report.pdf

[11] Mezei L1, Murinson BB; Johns Hopkins Pain Curriculum Development Team. Pain education in North American medical schools. *J Pain.* 2011 Dec;12(12):1199-208. doi: 10.1016/j.jpain.2011.06.006. Epub 2011 Sep 25.