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July 9, 2021

Regina M. LaBelle
Acting Director, Office of National Drug Control Policy
Executive Office of the President
1800 G Street, NW
Washington, DC 20006

Subject: 2022 National Drug Control Strategy

Dear Acting Director LaBelle:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I write to provide comments on the Biden Administration's 2022 National Drug Control Strategy (*Strategy*). Overall, the AMA believes that the Administration already has created an excellent foundation for the *Strategy* through its Statement of Drug Policy Priorities for Year One.[1] Specifically, the AMA strongly supports the cross-collaboration that the Administration emphasized to reduce drug-related harms and save lives across multiple domains. As the AMA has stressed through the work of our AMA Opioid Task Force, ending the nation's drug-related overdose and death epidemic and improving patient outcomes requires every stakeholder to work together. We greatly appreciate the Administration's recognition of this central fact.

In the comments below, we highlight four key areas where we urge the Administration to turn its 2021 priorities into strategic action items. First, the AMA urges the Administration to expand access to evidence-based treatment through additional steps to reduce barriers to medications to treat substance use disorders (SUDs), including medications to treat opioid use disorder (MOUD), and support for efforts to broaden access to a wide range of harm reduction services, including naloxone, sterile needle and syringe exchange services, and drug checking supplies. Second, the AMA calls on the Administration to require all health insurance programs, including Medicare and Medicare Advantage, Medicaid, the plans offered on the federal and state health exchanges, and health benefit programs serving veterans, military members and families, federal employees, Native Americans, and others to remove arbitrary restrictions for patients who benefit from opioid therapy. Third, the AMA urges that the *Strategy* make use of best practices that already exist—i.e., critically review programs and initiatives that have been federally funded to identify those that have reduced drug-related harms and improved patient outcomes. Finally, we strongly urge the Administration to take steps to develop and support a national, standardized reporting system for key metrics related to drug use, including fatal and non-fatal overdose. Taken together, these elements will help move the nation from a crisis framework to a more resilient public health framework, help reduce overdose and death, and improve patient outcomes.

In addition to the above, we urge that every element undertaken in the *Strategy* directly address health care inequities and social determinants of health. The data makes clear that the nation's drug overdose epidemic disproportionately affects marginalized and minoritized communities. The disparate effects

[1] The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Executive Office of the President, Office of National Drug Control Policy. April 1, 2021. Available at https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

include access to SUD, pain care, and harm reduction. The nation's drug-related overdose and death epidemic will not end without directly confronting and working to fix these pervasive inequities.

Remove Barriers to MOUD and Harm Reduction or the Epidemic Will Continue to Worsen

Among the most pervasive and unnecessary barriers to MOUD is prior authorization. When an individual is ready for treatment, and that treatment is delayed or denied, the results can be tragic.[2] When prior authorization for MOUD is removed, however, OUD treatment access increases and costs decrease.[3] The Commonwealth of Virginia has demonstrated that removing prior authorization for MOUD is an evidence-based best practice that saves lives for its Medicaid beneficiaries.[4] Yet, fewer than half the states have been able to overcome health insurance company intransigence. The research makes clear "that prior authorization exacerbates the challenge of sustaining patient willingness for OUD treatment."[5] Therefore, **we urge the Administration to take action to remove prior authorization in all health insurance programs,** including Medicare and Medicare Advantage, Medicaid, the plans offered on the federal and state health exchanges, and health benefit programs serving veterans, military members and families, federal employees, Native Americans, and others. We further urge the Administration to include in its *Strategy* a commitment to remove prior authorization for MOUD in ERISA plans.

A second area to remove barriers to MOUD concerns the provision of methadone in opioid treatment programs (OTPs) compared to buprenorphine in-office. The AMA continues to support federal flexibilities under the COVID-19 public health emergency to allow increased use of take-home dosing and patient check-ins via telemedicine for existing patients receiving methadone. We also support the federal flexibility to initiate buprenorphine using audio-only telemedicine. These flexibilities were embraced by physicians and patients[6] and likely have saved thousands of lives. However, while we are grateful that the nation is making progress on reducing COVID-19 infections and death, it is clear that the nation's drug-related overdose and death epidemic shows no signs of slowing down. Therefore, **the AMA recommends that the Administration continue the federal telemedicine flexibilities for at least the duration of the opioid public health emergency.**

Another important area to remove barriers to MOUD and treatment for SUDs is in the nation's jails and prisons. There is no legal, medical, or policy reason to deny access to MOUD for justice-involved persons. MOUD is the evidence-based standard of care whether a person is in a jail, prison, or in the

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[2] President's Message: A Tragic Ending. Bruce A. Scott, MD. Kentucky Medical Association. April 25, 2019. Available at https://kyma.org/2019/04/25/presidents-message-a-tragic-ending/.

[3] Mark TL, Parish WJ, Zarkin GA. Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries. *JAMA Netw Open.* 2020;3(4):e203132. doi:10.1001/jamanetworkopen.2020.3132. Available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764598.

[4] Medicaid Bulletin: Evidence-Based Practices and Medication Assisted Treatment for OUD. Virginia Department of Medical Assistance Services. February 11, 2019. https://www.dmas.virginia.gov/media/1330/evidence-based-practices-and-medication-assisted-treatment-for-opioid-use-disorder.pdf.

[5] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Examination of the Integration of Opioid and Infectious Disease Prevention Efforts in Select Programs. Opportunities to Improve Opioid Use Disorder and Infectious Disease Services: Integrating Responses to a Dual Epidemic. Washington (DC): National Academies Press (US); 2020 Jan 23. 3, Barriers to Integration. Available from: https://www.ncbi.nlm.nih.gov/books/NBK555819/.

[6] First glance: COVID-19 Buprenorphine Provider Survey Report. October 15, 2020. Available at https://www.aaap.org/wp-content/uploads/2020/10/COVID-29-Survey-Results-First-Glance_EW-10.15.pdf; AATOD Board of Directors OTP Operations Pulse Check. November 19, 2020. On file with author.

community. A recent AMA-Manatt Health presentation[7] detailed that as many as one-third of individuals who are incarcerated in a jail or prison have an OUD, and the risks[8] of post-incarceration overdose are even more severe for women who are pregnant and post-partum. Thankfully, multiple courts have held that an individual with an OUD has a right to MOUD while incarcerated.[9] In part, these rulings were buttressed by the fact that MOUD for those in justice-involved settings lowers costs, reduces recidivism and saves lives.[10] Therefore, **we urge that the Administration commit to providing MOUD to any individual who is incarcerated, on probation or parole, or in any other justice-involved setting within the Administration's jurisdiction.**

The AMA further supports efforts to "[e]xplore, identify barriers, and establish policy to help pregnant women with substance use disorder obtain prenatal care and addiction treatment without fear of child removal."[11] The AMA is actively working with states to ensure that individuals who are pregnant are not punished as a result of seeking or receiving care for an SUD, including taking MOUD. Some states have outdated reporting requirements under the Child Abuse Prevention and Treatment Act (CAPTA)/ Comprehensive Addiction and Recovery Act (CARA) for women who are in treatment or under the supervision of a physician, who are inappropriately reported for investigation by a state child and family welfare agency often resulting in trauma, massive stigmatization, and separation of the newborn from the mother, including when the child has neonatal abstinence syndrome.[12] We strongly oppose policies and practices employed against women who are pregnant in a carceral setting, and they are discontinued from MOUD either during pregnancy or immediately following return to jail or prison. The forced discontinuation leads to painful withdrawal and, given the disproportionate rates of incarceration for women of color, this is yet another area of structural racism that we believe must be confronted and ended. **We urge the Administration to take immediate steps to protect families by focusing on increasing access to evidence-based care rather than using punishment and the threat of family separation for women who are pregnant, postpartum and parenting.**

In addition to removing barriers to MOUD, we urge the Administration to strongly enforce the Mental Health Parity and Addiction Equity Act (MHPAEA). We are pleased that the U.S. Department of Labor (DOL) has taken initial steps in this regard.[13] But we remain concerned that enforcement may not be as robust as necessary given the repeated violations by health insurers.[14] We urge the Administration to

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[7] Improving Access to Substance Use Disorder Treatment in Justice-Involved Setting. April 4, 2021. Available at https://www.manatt.com/insights/webinars/improving-access-to-sud-treatment-in-justice-invol.

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7349469/.

[9] See *Pesce v. Coppinger*, https://www.aclum.org/en/cases/pesce-v-coppinger; *Smith v. Aroostook County*, https://www.aclumaine.org/en/cases/smith-v-aroostook-county; and *DiPierro v. Hurwitz*, https://www.aclum.org/en/news/federal-prison-provide-medication-addiction-treatment-massachusetts-woman

[10] https://www.lac.org/assets/files/OpioidAbatementFactSheet-Chapter4-v1.pdf.

[11] The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Executive Office of the President, Office of National Drug Control Policy. April 1, 2021. Available at https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

[12] The AMA provided a much more detailed discussion of these issues in testimony to the U.S. House of Representatives Committee on Oversight and Reform on May 6, 2021. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-5-6-Statement-of-the-Record_House-Oversight-Hearing_Maternal-Mortality.pdf.

[13] FAQS About Mental Health And Substance Use Disorder Parity Implementation And The Consolidated Appropriations Act, 2021 PART 45. U.S. Department of Labor. April 2, 2021. Available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[14] State Parity Regulatory Enforcement Actions. State Parity Track. Fall 2020. Available at https://www.paritytrack.org/resources/state-parity-enforcement-actions/.

provide DOL with the necessary resources and make clear that strong oversight and enforcement must be of the highest priority. This is particularly important given that DOL now can require health insurance carriers to submit a comparative analysis that their mental health and SUD benefits are in parity as compared to the plan's medical/surgical benefits.[15] Accordingly, **we urge the Administration to increase efforts to review plans on a regular basis to ensure they are in compliance with MHPAEA and hold them accountable if not.**

Without naloxone, it is likely that tens of thousands of additional Americans would be dead from an opioid-related overdose. As the Administration has made clear, illicitly manufactured fentanyl and fentanyl analogs are fueling the nation's drug overdose and death epidemic.[16] This illicitly manufactured drug is present in many other illicit drugs as well, including heroin, cocaine and methamphetamine.[17] This is one reason the AMA supported the newly approved formulation of a higher dose of naloxone.[18] **The next step, however, is to make naloxone in all of its forms available over-the-counter to reduce stigma and increase availability.**

Increased access to naloxone is not the only harm reduction strategy. The AMA also strongly supports access to sterile needle and syringe exchange services and programs. These programs not only reduce the spread of infectious disease, but they also have demonstrated success in connecting individuals to treatment and distributing naloxone to people who use drugs. A positive step was taken earlier this year when the federal government announced[19] that federal grants issued to states could be spent on fentanyl test strips. This positive step, however, comes against a backdrop where only a few states[20] do not consider fentanyl test strips drug paraphernalia and possession may subject individuals to civil and/or criminal penalties depending on the state. The AMA is also deeply concerned by a new law in West Virginia that may lead all sterile needle and syringe exchange services to cease operations. Accordingly, **the AMA urges that the *Strategy* not only codify the new ability of state grantees to use federal dollars to purchase, use and distribute drug checking supplies, but also ensure that state grantees**

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[15] See Question 1: "Plans and issuers that offer both medical/surgical benefits and MH/SUD benefits and impose NQTLs must make their comparative analyses of the design and application of NQTLs available to the Departments or applicable State authorities upon request, beginning 45 days after the date of enactment of the Appropriations Act. Because the Appropriations Act was enacted on December 27, 2020, the requirement applies beginning February 10, 2021. Accordingly, plans and issuers should now be prepared to make their comparative analyses available upon request." Available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[16] U.S. Drug Enforcement Administration 2020 National Drug Threat Assessment. Available at https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf.

[17] NIDA. Rising Stimulant Deaths Show that We Face More than Just an Opioid Crisis. National Institute on Drug Abuse website. https://www.drugabuse.gov/about-nida/noras-blog/2020/11/rising-stimulant-deaths-show-we-face-more-than-just-opioid-crisis. November 12, 2020.

[18] *See*, Statement from AMA Immediate Past President, Patrice A. Harris, MD, MA. https://www.ama-assn.org/press-center/ama-statements/ama-statement-fda-decision-naloxone-nasal.

[19] Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips. April 7, 2021. https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html.

[20] Colorado, the District of Columbia, and Rhode Island are among the states that have taken positive steps to change their drug paraphernalia laws to clearly permit the use or distribution of drug checking equipment. Colorado, for example, specifically excludes "Testing equipment used, intended for use, or designed for use in identifying or in analyzing the strength, effectiveness, or purity of controlled substances," from its definition for drug paraphernalia. Arizona also recently removed fentanyl test strips from its state drug paraphernalia law.

have authority to use federal funds for the purchase, use, distribution and possession of sterile needle and syringe supplies.

Finally, we remain deeply concerned that data continue to point to less availability of buprenorphine for Black patients.[21] This is important given that—even with some additional flexibility for OTPs—it is far easier to get a 30-day prescription for buprenorphine than to go to an OTP on a daily or weekly basis, which is what most patients must do. We also are deeply concerned that racial disparities exist for mental health care.[22] Access to naloxone similarly may be affected by racial bias.[23] There is no magic action the Administration can take to end these deep-seated structural inequities. However, the Administration can and should continue to follow its 2021 priority to make equity a predominant focus in all of its efforts to increase access to evidence-based treatment. The AMA is pleased to offer our partnership and strong support.

Support Patients with Pain by Emphasizing Individualized Patient Care Decisions

As the AMA has written to the U.S. Centers for Disease Control and Prevention (CDC), the nation is now facing an unprecedented, multi-factorial and much more dangerous overdose and drug epidemic driven by heroin and illicitly manufactured fentanyl, fentanyl analogs, and stimulants.[24] We can no longer afford to view increasing drug-related mortality through a prescription opioid-myopic lens. This is why the AMA continues its aggressive advocacy efforts in support of patients with pain and those with a SUD as well as broad support for harm reduction policies and practices that address the wide range of factors affecting patients. The nation's opioid epidemic has never been just about prescription opioids, but CDC, state legislatures, health insurance companies, pharmacy chains and pharmacy benefit management companies all have acted to severely restrict access to opioid therapy while doing very little to increase access to non-opioid alternatives.

As a starting point, the AMA points to the well-received recommendation from the U.S. Health and Human Services Pain Management Best Practices Interagency Task Force[25] that patients experiencing pain need to be treated as individuals, not according to one-size-fits-all algorithms and policies that do not take individual patient's needs into account. The recommendations of the Interagency Task Force remain as relevant as ever, and **we urge the Administration to advance them throughout the Centers for**

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[21] Goedel WC, Shapiro A, Cerdá M, Tsai JW, Hadland SE, Marshall BDL. Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States. *JAMA Network. Open.* 2020;3(4):e203711. doi:10.1001/jamanetworkopen.2020.3711. Available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663.

[22] Diversity & Health Equity Education. American Psychiatric Association. Accessed July 1, 2021. Available at https://www.psychiatry.org/psychiatrists/cultural-competency/education/african-american-patients.

[23] Madden EF, Qeadan F. Racial inequities in U.S. naloxone prescriptions. Subst Abus. 2020;41(2):232-244. doi: 10.1080/08897077.2019.1686721. Epub 2019 Nov 13. PMID: 31718487. Available at https://pubmed.ncbi.nlm.nih.gov/31718487/.

[24] AMA letter to Deborah Dowell, MD, MPH, Chief Medical Officer, National Center for Injury Prevention and Control. U.S. Centers for Disease Control and Prevention. June 16, 2020. https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-6-16-Letter-to-Dowell-re-Opioid-Rx-Guideline.pdf.

[25] "The Task Force emphasizes the importance of individualized patient-centered care in the diagnosis and treatment of acute and chronic pain." U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: https://www.hhs.gov/ash/advisorycommittees/pain/reports/index.html.

Medicare and Medicaid Services (CMS), the Department of Veterans Affairs (VA), and other federal agencies.

The AMA has three specific recommendations for improving care for patients with pain. First, as the CDC undertakes a review and potential revision of its 2016 Guideline, it must incorporate some fundamental revisions that acknowledge that many patients experience pain that is not well controlled, substantially impairs their quality of life and/or functional status, stigmatizes them, and could be managed with more compassionate patient care. This includes specific language calling for state legislatures, health insurance companies, pharmacy chains, and pharmacy benefit managers to rescind any policy based on a hard threshold. In addition, **the AMA urges that any health insurance company contracted to provide services for federal employees be prohibited from using a hard threshold for the prescribing of opioid analgesics.**

Second, patients with pain would be well-served by the Administration using a revised CDC Guideline as part of a coordinated federal strategy to help ensure patients with pain receive comprehensive care delivered in a patient-centric approach. This includes reviewing CMS, VA, and other federal agency policies to ensure that non-opioid pain care alternatives are available and affordable in all health insurance programs, including Medicare and Medicare Advantage, Medicaid, the plans offered on the federal and state health exchanges, and health benefit programs serving veterans, military members and families, federal employees, Native Americans, and others. Currently, there is a financial disincentive for physicians and other health care professionals to use non-opioid alternatives following surgery, for example, because the bundling of these treatments prevents payments from adequately covering their costs. For example, the AMA is supporting federal legislation[26] to remove the financial incentive to prescribe opioids by raising the payment for non-opioid pain treatments. Removing this barrier to providing alternatives to opioids for managing postoperative pain would positively impact patient safety, patient quality, and the drug overdose epidemic. **We support additional efforts by the Administration to employ similar strategies for patients covered by Medicare, Medicare Advantage, Medicaid, TRICARE, the VA, and any other federal health benefit program.**

Finally, we once again point out that there are troubling disparities and inequities in pain care.[27] This includes research demonstrating implicit bias and pervasive myths, including the false belief that Black individuals experience less pain than those who are white.[28] This affects Black patients in the emergency department, surgical settings, chronic care, and other conditions in many different insurance-related situations. Recognition that physicians can and should do more is essential,[29] as is a concerted effort led by the Administration to support efforts to remove these inequities. As part of its federal *Strategy*, the AMA encourages a focus on supporting treatment options for patients with pain that are accessible to the patient based on their health condition, social determinants of health (e.g., transportation, employment,

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[26] *See*, AMA letter to U.S. Representatives David McKinley and Terri Sewell re: AMA support for H.R. 5172, the "Non-Opioids Prevent Addiction in the Nation Act," also known as the "NO PAIN Act." November 24, 2020. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-11-24-Letter-to-Sewell_McKinley-re-HR-5172-NO-PAIN-Act.pdf.

[27] *See*, for example, National Institutes of Neurological Disorders and Stroke. National Institutes of Health. NIH Pain Consortium. Available at https://www.ninds.nih.gov/sites/default/files/DisparitiesPainCare.pdf

[28] How we fail black patients in pain. Janice A. Sabin, PhD, MSW. January 6, 2020. Available at https://www.aamc.org/news-insights/how-we-fail-black-patients-pain.

[29] "Racism in Pain Medicine: We Can and Should Do More." Natalie H. Strand, MD, *et al.* Mayo Clinic Proceedings. Volume 96, Issue 6. June 1, 2021. Available at https://www.mayoclinicproceedings.org/article/S0025-6196(21)00322-0/fulltext.

childcare responsibilities, race, gender, age) and insurance coverage. In addition, we further encourage the Administration to focus on patients with pain in its work to "advance efforts to identify data gaps related to drug policy to target unmet needs in diverse communities, in collaboration with the Equitable Data Working Group established by Executive Order 13985; [and] identify culturally competent and evidence-based practices for BIPOC across the continuum of care."[30] While we appreciate that ONDCP's focus understandably includes reducing the illicit supply of drugs, the need for specifically including patients with pain as a key stakeholder and focal point is essential for an effective national *Strategy* to improve patient outcomes for patients with SUDs and for patients with pain who have suffered as a result of misguided policies and their unintended consequences. And this includes understanding and dismantling the inequities that marginalized and minoritized patients face.

Evaluate Programs That Have Been Funded and Build off Those That are Working

In December 2020, the AMA released a national policy roadmap with Manatt Health to specifically provide best practices and tangible recommendations to help reduce drug-related mortality and improve patient outcomes.[31] The roadmap provides best practices from more than two dozen states. These range from establishing community-based treatment for OUD starting in the emergency department, policy actions to support increased access to non-opioid pain care alternatives, creative ways in which harm reduction efforts brought life-saving services to people who use drugs during the COVID-19 pandemic and more. Many of these programs were started with federal grant money, which demonstrates the importance of federal support for life-saving actions. We have little doubt that the $4 billion appropriated for behavioral health services in the American Rescue Plan will help many patients.

However, we also remain deeply concerned that there is a lack of standardized data collection and surveillance efforts to evaluate policies and outcomes to identify effective policies and clinical interventions. The federal government already has spent billions to help state efforts to save lives from drug-related overdose, but there is very little in the way of knowing which efforts have been more effective than others—and which efforts have not worked at all.[32] The AMA-Manatt Health 2020 national roadmap identified some efforts that we found to be working, but we also are aware that we likely only scratched the surface.

The AMA agrees with the Bipartisan Policy Center that "publicly available evidence-based evaluations of each of the streams of federal opioid funding must be conducted. These evaluations should include information on whether the grant is meeting the needs of at-risk populations as well as health equity goals."[33] Therefore, **the AMA encourages the Administration to require states to report—in a standardized fashion—the effects of programs funded to increase overdose prevention, support increased access to treatment, enhance evidence-based pain care, further access to harm reduction, or remove health inequities.**

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[30] The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Executive Office of the President, Office of National Drug Control Policy. April 1, 2021. Available at https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

[31] National Roadmap on State-Level Efforts to End the Nation's Drug Overdose Epidemic. American Medical Association and Manatt Health. December 2020. Available at https://www.ama-assn.org/system/files/2020-12/ama-manatt-health-2020-national-roadmap.pdf.

[32] *See*, for example, the FY 2020 State Opioid Response Awards. Available at https://www.samhsa.gov/sites/default/files/sor-tor-fy2020-awards.pdf.

[33] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2020/09/BPC-Opioids-Report_RV6-1.pdf.

Build a Data Infrastructure That Supports Prevention and Strategic Intervention

Improving the collection and use of data is critical to evolving the nation's efforts to combat the epidemic. The AMA recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats and recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data. The nation has been operating in a reactive, crisis framework when a sustainable and resilient infrastructure to monitor, prevent and treat overdose is necessary. Modernizing, standardizing, and adapting data collection will allow the development of more effective solutions tailored to the needs of individuals and their community.

The current reactive framework has created too many one-size-fits-all strategies and increased stigma for patients with SUD and those who have pain. Evidence-based solutions must rely on evidence and science—and better evidence is needed. Currently, national health surveillance efforts include fatal overdose data, but timely and consistent nationally representative data related to nonfatal overdoses do not exist. Early warning systems that further evidence-based prevention efforts and interventions, and rapid access to treatment are strongly encouraged. Relying on fatality data alone can result in an incomplete picture of the ongoing and evolving drug overdose epidemic and hinder advancements in targeted drug-related prevention, treatment, recovery, policy making, and harm reduction strategies.

Additionally, policies, programs, and data collection practices are not consistent across the United States. This is reflected in the difficulties in fully understanding the scope of the multiple factors of this epidemic. For example, data makes clear that drug-related mortality differs by region.[34] And reviewing state-level data show mortality differences within states.[35] These data, however, are highly limited views, including a lack of understanding of how drug-related overdose and death have impacted historically marginalized and minoritized communities as well as differences in age and gender. The AMA encourages the development of standardized data case definitions and terminology for drug use, SUDs, overdose, and outcomes so consistency in data collection and reporting across jurisdictions is obtained.

Effectively implementing optimal policies, prevention strategies, and interventions, will require coordination of stakeholders and accurate, timely, and actionable information. The AMA urges federal coordination and funding to support the modernization and standardization of public health surveillance systems for data collection by the CDC and state and local health departments and supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.

Put simply, the data need to be used to help identify the areas of greatest need for overdose prevention, SUD treatment, and harm reduction. And, that data need to be standardized so that policymakers and public health officials can better work together to target evidence-based interventions to the areas of greatest need. This includes standardized, accurate, and real-time tracking of key metrics associated with

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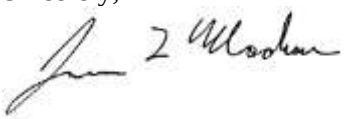
[34] Regional Differences in the Drugs Most Frequently Involved in Drug Overdose Deaths: United States, 2017. Holly Hedegaard, MD, MSPH. National Vital Statistics System. National Center for Health Statistics. Centers for Disease Control and Prevention. October 25, 2019. Available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_12-508.pdf.

[35] *See*, for example, the "Opioid Data Dashboard" for the Commonwealth of Pennsylvania. Available at https://data.pa.gov/stories/s/9q45-nckt/.

opioids and other substances related to drug use. Specifically, greater effort must be made to include comprehensive, disaggregated, racial and ethnic data collection related to testing, hospitalization, and drug-related mortality. Our nation cannot build effective or equitable public health interventions to combat the drug-related overdose and death epidemic without a complete picture of current inequities. As part of its federal *Strategy*, **the AMA encourages ONDCP to develop and implement systems to collect timely, adequate, standardized data for use to identify at-risk populations, fully understand polysubstance drug use, and implement public health interventions.** We would be pleased to offer our partnership and strong support of initiatives to accelerate the development and coalescence of the data modernization and standardization.

Thank you for your consideration. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at Margaret.Garikes@ama-assn.org or 202-789-7409.

Sincerely,



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