AMA
AMERICAN MEDICAL ASSOCIATION

OVERDOSE EPIDEMIC REPORT 2024

Physicians' actions to help end the nation's drug-related overdose and death epidemic—and what still needs to be done.

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Introduction

The American Medical Association and the AMA Substance Use and Pain Care Task Force continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose and death epidemic. In recent years we have witnessed positive actions from physicians, growth in harm reduction services and policy advancements. Some states have seen a slight decrease in drug-related mortality in the past year—a trend the AMA hopes will continue—but overdose deaths related to illicitly manufactured fentanyl, fentanyl analogs, methamphetamine and cocaine remain at historic highs.[1] The National Institutes of Health (NIH) report that illicit drug use among young people has decreased, but deaths among young people have increased,[2] and racial and ethnic inequities in overdose remain.[3] There have been some increased efforts to increase access to medications for opioid use disorder (MOUD) for individuals who are pregnant or who are in jail or prison, but stigma and health insurance companies continue to impede access to MOUD. The collateral trauma on the nation's communities and families has few, if any equals. This includes vast economic damage, psychological trauma, moral injury and new data showing that more than 320,000 children have lost a parent due to overdose.[4]

At the same time, prescriptions for opioid analgesics have decreased by more than half over the past decade, and key groups such as the U.S. Centers for Disease Control and Prevention (CDC) and the Federation of State Medical Boards (FSMB) have made clear that one-size-fits-all opioid prescribing guidelines are detrimental to patients' health. Yet, most states and national pharmacy chains continue to hold on to outdated, arbitrary dose and quantity restrictions that have led to harms for patients with chronic pain, sickle cell disease, cancer and for those in hospice or with palliative care needs.

One promising area where policy and practice have come together is the increasing availability of naloxone to prevent opioid-related overdose. In addition to physicians and other health care professionals increasing prescribing of naloxone, the life-saving medication is increasingly available in educational settings and public areas. Unfortunately, data still indicates that fatal overdoses often occur even when bystanders are present–underscoring the importance of making naloxone accessible and ensuring that Good Samaritan laws fully protect anyone who may be in a position to help during an overdose.

> **"This epidemic has caused harm across multiple generations. We need to employ every measure to increase access to care for individuals with a substance use disorder or pain—and do everything we can from a harm reduction standpoint to keep people alive and reduce their risks."**
>
> –Bruce A. Scott, MD, AMA president

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The epidemic has grown more complex in recent years, but several key features remain:

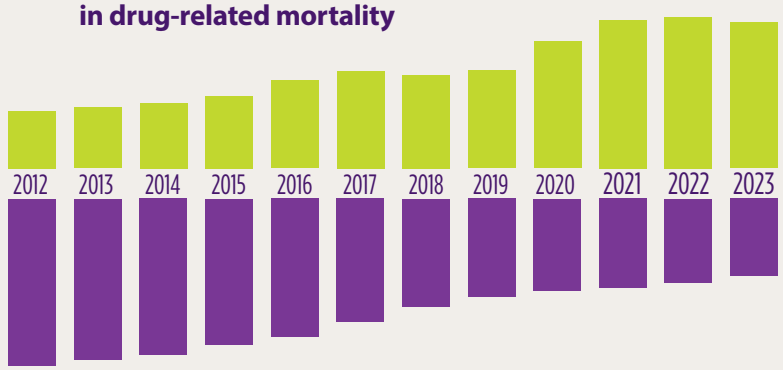
- Health insurance companies and other payers continue to fail and otherwise refuse to comply with state and federal laws requiring parity in coverage for mental illness and substance use disorders.
- Policymakers have not held health insurance companies and other payers accountable for these failures.
- Patients with pain continue to be stigmatized when they benefit from opioid therapy; and health insurers continue to make non-opioid alternatives cost-prohibitive, subject to administrative barriers and otherwise inaccessible.
- Pharmacies and pharmacy benefit managers continue to restrict access to medications for opioid use disorder and pain.
- Harm reduction measures—such as access to naloxone and other overdose reversal medications—have saved hundreds of thousands of lives. Additional, evidence-based harm reduction efforts need similar support, including overdose prevention centers, syringe services programs and comprehensive Good Samaritan protections for people at the scene of an overdose.
- Black, Latinx, Indigenous communities, pregnant individuals, LGBTQIA+ and young people are disproportionately dying at increasing rates compared to other population groups.
- Individuals with an opioid use disorder or other substance use disorder continue to face barriers accessing buprenorphine and methadone, including inadequate insurance networks, stigma, zoning restrictions for opioid treatment programs, and "treatment" or "rehab" facilities that prohibit MOUD.

> **We all have work to do to end this epidemic. We know that the status quo isn't working. Our hope is that this report helps propel public health and patient focused actions. The AMA is ready to work with everyone to save lives and improve outcomes.**
>
> –Bruce A. Scott, MD, AMA president

Reductions in opioid prescribing have not led to significant reductions in drug-related mortality

2023 overdose deaths:
107,543*

2023 opioid prescriptions:
125,920,878
(51.7% decrease since 2012)[33]



*Provisional data from 12-month period Jan. 2023–Dec. 2023
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

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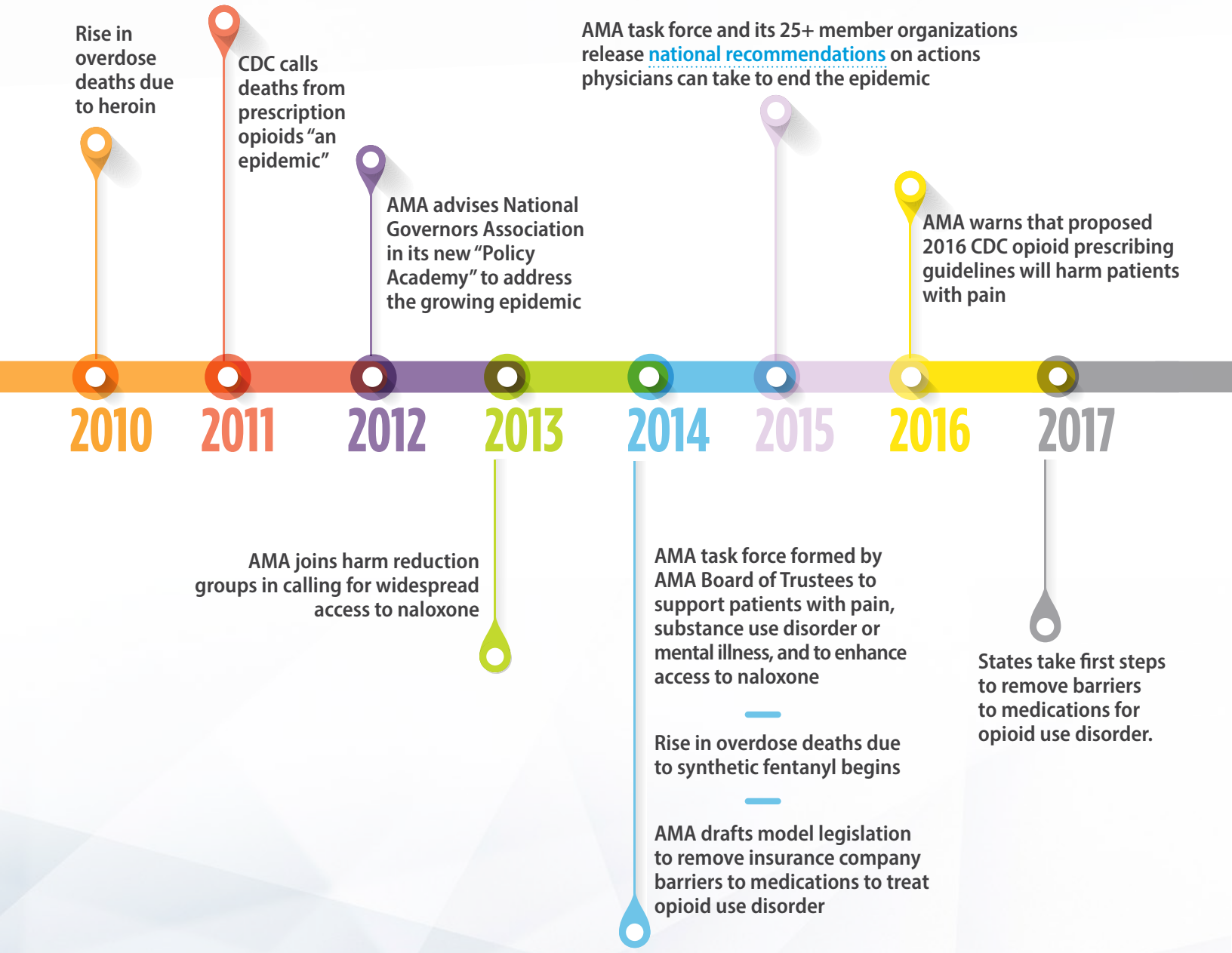
Timeline

The nation's overdose and death epidemic continues to change and require physicians to advocate for individuals to have access to evidence-based care and harm reduction services.



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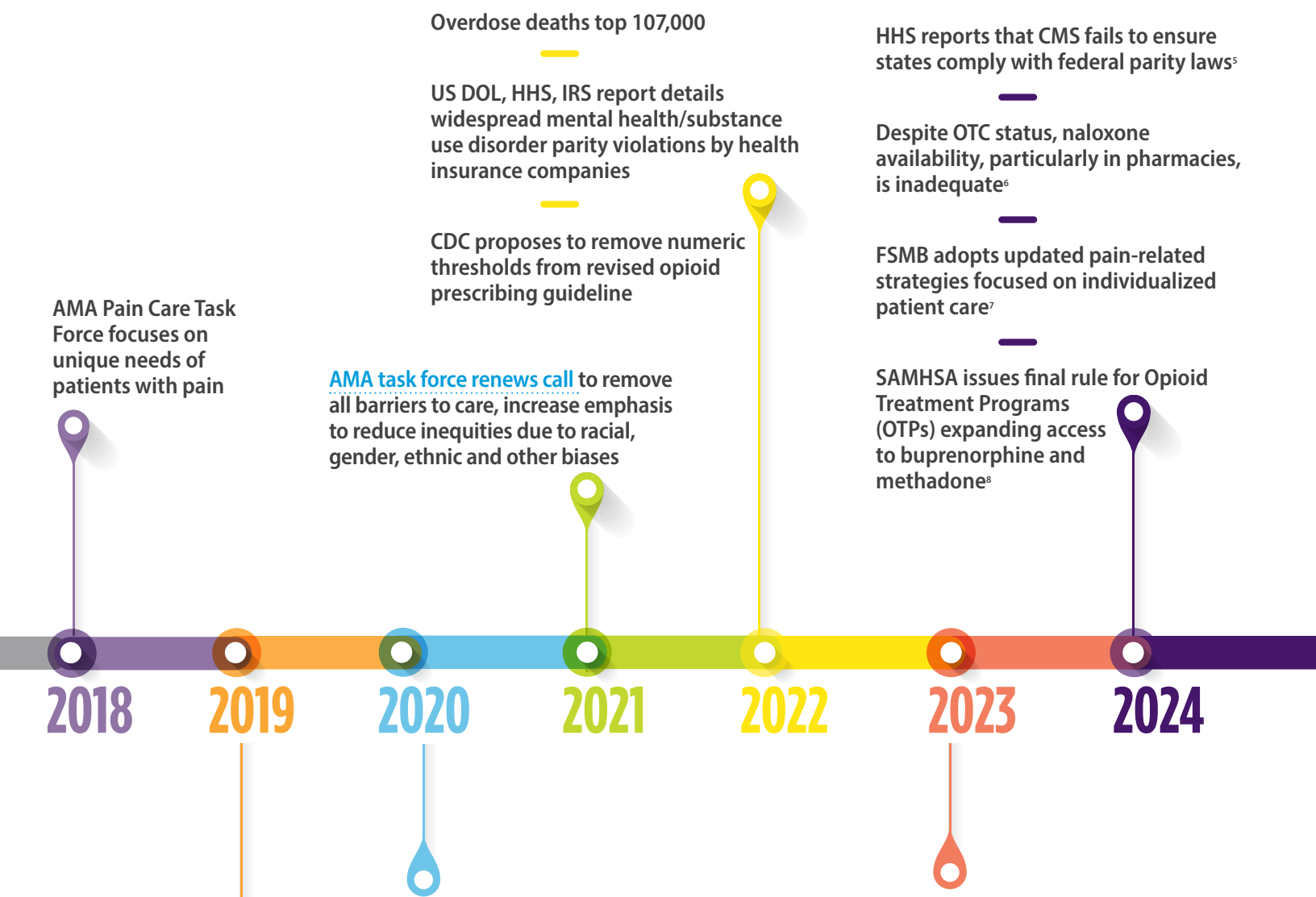

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National coverage on the drug overdose epidemic

The fourth wave of opioids swamps Montana with meth-fentanyl cocktail
–Daily Montanan

Treatment for teens is inaccessible, costly as U.S. opioid deaths rise
–USA Today

Amid opioid epidemic, Minnesotans of color have died of overdoses at disproportionately high rates
–The Minnesota Star Tribune

How Our Overdose Crisis Response Is Delayed At The Pharmacy.
–Health Affairs

Most Nebraskans know Narcan is a life-saving drug, but don't know how to get it
–Nebraska Public Media

Health district reminds public: Free fentanyl test strips, naloxone are available
–Nevada Current

Chronic Pain Patients Suffer From Opioid Epidemic Overcorrection
–WTTW News

Education Department wants more schools to have fentanyl overdose medication
–The Arizona Republic

Fighting discrimination in healthcare is crucial to ending the overdose crisis
–NC Newsline

New Federal Rules Cannot Improve Methadone Delivery Without State Actions
–The Pew Charitable Trusts

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Read about reports in all 50 states: AMA issue brief
National snapshot of overdose epidemic

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2023–24 federal updates

New federal parity rule follows AMA recommendations[9]

New rules strengthen the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and provide increased patient protections from health insurance company actions that unfairly and too-often discriminatorily restrict access to mental health and substance use disorder care. With direct advocacy and detailed recommendations, **AMA strongly supports multiple provisions that will help increase transparency, oversight and enforcement of MHPAEA in areas such as prior authorization and network adequacy.** Health plans have violated MHPAEA for more than 15 years, and this final rule is a step in the right direction to protect patients and hold health plans accountable for those failures.

New NIH buprenorphine study supports AMA buprenorphine policy[10]

The AMA urged policymakers to take notice of new study findings from the NIH that higher doses of buprenorphine may improve treatment outcomes for individuals with opioid use disorder (OUD). The findings support **AMA policy calling for flexibility in buprenorphine dosing, allowing patients to receive doses exceeding U.S. Food and Drug Administration (FDA)-approved limits when clinically recommended by their prescriber.**

HHS publishes final rule removing barriers to care in opioid treatment programs[11]

The final rule by the Department of Health and Human Services (HHS) allows buprenorphine to be prescribed to patients in opioid treatment programs (OTPs) with OUD based on telehealth visits on a permanent basis. The final rule also allows increased access to methadone treatment for patients in OTPs. **The AMA strongly supports efforts to increase access to care through OTPs.**

FSMB adopts updated pain-related strategies focused on individualized care[7]

The FSMB recently adopted revisions to its recommendations relating to opioids and pain care that focus on individualized patient-centered care. The AMA has long advocated against a one-size-fits-all approach to evaluating, treating and managing care for patients with pain. **The AMA strongly supports medical boards using the 2024 Strategies to replace policies or guidelines based on the FSMB's 2017 policy.**

X-waiver requirement eliminated for buprenorphine prescribing[12]

The Consolidated Appropriations Act of 2023 eliminated the requirement for physicians to obtain a waiver from the Drug Enforcement Administration (DEA) to prescribe buprenorphine for OUD treatment. The AMA has long viewed the X-waiver requirement as a major barrier between the number of patients who need OUD treatment and the number who obtain it. **The AMA urges state and federal officials to ensure health plans have adequate networks of physicians who are accepting new patients to start buprenorphine for OUD.**

FDA makes naloxone available over-the-counter [13]

The FDA approved two naloxone products for over-the-counter (OTC) sale and distribution without a prescription in 2023. **The AMA urges all manufacturers of overdose reversal agents to submit OTC applications and price their products responsibly. Payers must also cover naloxone at low or no cost.**

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State policies

State policies to support individuals with a substance use disorder and patients with pain

For more than a decade, state policymakers have struggled to find the right mix of policies to have a meaningful impact on reducing drug-related mortality and improving outcomes for individuals with a substance use disorder, patients with pain and people who use drugs. States are encouraged to review their laws and other policies to ensure that they have taken the following actions:

- **Remove treatment barriers for MOUD**

  Prohibit prior authorization for (MOUD), including for buprenorphine prescriptions greater than 24mg.[14]

  Ensure that all individuals entering a jail or prison have access to MOUD; can continue treatment throughout their sentence; and are linked to community-based treatment upon release.[15]

  Protect families and individuals who are pregnant or breastfeeding by removing penalties that automatically report a positive toxicology test to child welfare authorities.[16] States, hospitals and health systems all can make these changes.

- **Support individualized pain care**

  At least 39 states have opioid prescribing restriction policies[17] that interfere with patients being able to receive individualized pain care treatment options. While opioid prescribing has decreased by more than 51.7% since 2012, many patients who rely on or benefit from opioid therapy have been harmed by these state laws and related policies from health insurers, pharmacy chains and pharmacy benefit managers.

  Adopt updated recommendations from the FSMB that emphasize individualized pain care decisions for patients rather than one-size-fits-all formulas based on pre-determined prescribing thresholds.[18]

  Rescind prescribing policies based on the 2016 U.S. Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain to protect patients from nonconsensual reductions in therapy and physicians from inappropriate enforcement and oversight. States also are encouraged to review a new Minnesota law[19] supported by the AMA[20] that emphasizes physician discretion rather than strict adherence to pre-determined dose or quantity limits.

51.7%↓

decrease in opioid prescriptions
from 260.5M in 2012 to 125.9M in 2023

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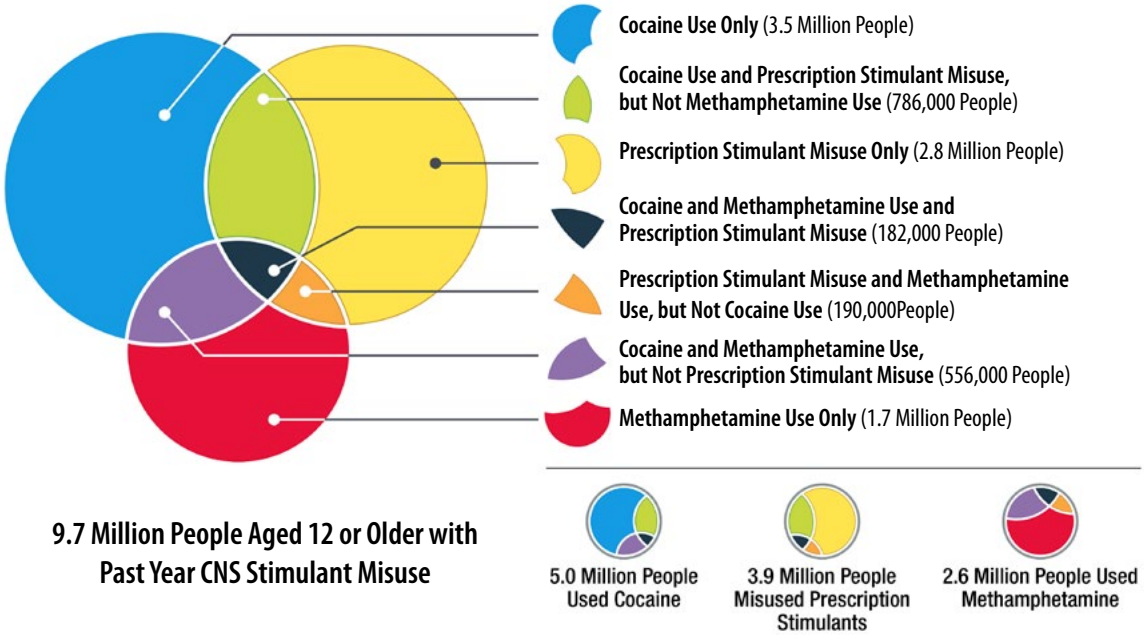
Treatment for stimulant use disorder (StuD)

Figure: Stimulant misuse for people 12 years or older in 2023[19]



In 2023 approximately 5 million people used cocaine, 3.9 million people misused prescription stimulants, and 2.6 million people used methamphetamine.[21] Overdoses involving stimulants (e.g., methamphetamine, cocaine) are rapidly increasing. Approximately 40% of fatal overdoses involving illicitly manufactured fentanyl also involved stimulants (e.g., cocaine, methamphetamine).[22] Stimulant-involved deaths are highest in rural counties, and have increased for all racial and ethnic groups, with methamphetamine-involved overdoses highest in American Indian and Alaska Native populations and cocaine-involved overdoses highest in Black populations.[23, 24]

Contingency management (CM)

There are no FDA-approved medications for stimulant use disorder (StUD) and federal laws pose barriers to implementing the most effective treatment—contingency management (CM).

- CM is a behavioral intervention that reinforces or rewards positive behavioral change related to substance use. Fewer than 10% of substance use disorder treatment programs in the U.S. routinely use CM despite CM demonstrating[25] the best effectiveness for treating StUD.
- Funding is a significant barrier to implementing CM. This includes concerns about federal or state anti-kickback statutes and Beneficiary Inducement Civil Monetary Penalty rule (i.e., the $75 per year cap on patient incentives), that must be analyzed for compliance on a case-by-case basis.[26] Other concerns regard program financing costs, including planning and training practitioners. Many state and private insurers do not cover CM services.
- CM is twice as effective as alternative treatments for StUD such as counseling and motivational interviewing.[27] Outcomes of CM include decreased substance use and medication non-adherence and increased treatment retention.[28]

CM is permitted under several HHS grant programs (SOR/TOR and HRSA). Three states (CA, WA, MO) have implemented CM through the submission and approval of a Medicaid 1115 demonstration waiver.

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Treatment for opioid use disorder (OUD)

Approximately 35% of substance use treatment facilities do not offer MOUD.[29] FDA-approved MOUD include buprenorphine, methadone and naltrexone.

There are vast racial, ethnic and geographical disparities in access to evidence-based MOUD treatment. Black, American Indian/Alaska Native, Asian and Hawaiian/Pacific Islander people have significantly lower odds of receiving buprenorphine than White people[30], partially because there are less prescribers in racially and ethnically diverse areas.[31]

1. Buprenorphine

Increasing access to buprenorphine is critical for reducing harm and improving patient outcomes. While it is not clear why the number of buprenorphine prescriptions appears to have plateaued, there remain multiple barriers that must be removed.

Insurers and states require prior authorization and dosage limits for buprenorphine.[32] Too many pharmacies do not stock buprenorphine. Additionally, distributors may be restricting access to buprenorphine based on concerns about suspicious order reporting requirements from the DEA. These restrictions often lead to delays in care, which can increase the risk of overdose and death. The AMA continues to urge all stakeholders to remove all barriers to buprenorphine to treat OUD.

Buprenorphine prescriptions dispensed from retail pharmacies[33]

2017	13,239,902
2018	14,538,270
2019	15,543,446
2020	16,042,629
2021	16,111,215
2022	16,040,432
2023	15,660,738

After several years of advocacy from addiction medicine physicians, the Medical Society of the District of Columbia and the AMA, the D.C. Department of Health Care Finance recently issued a bulletin removing prior authorization of buprenorphine-containing products for doses up to 32mg.

The Illinois State Medical Society helped champion a new law to remove dosage limits on buprenorphine for OUD.[34]

2. Mobile units and low threshold models

Telehealth, mobile medical units and other low threshold treatment options can help increase access to flexible, prompt and equitable care. Low threshold models are important options to help increase treatment initiation, retention and positive outcomes.[35]

Opioid overdoses disproportionately impact historically underserved neighborhoods. To address this crisis, mobile medical units are building partnerships with medical centers, community-based harm reduction organizations and OTPs to increase access to harm reduction services and MOUD treatment.

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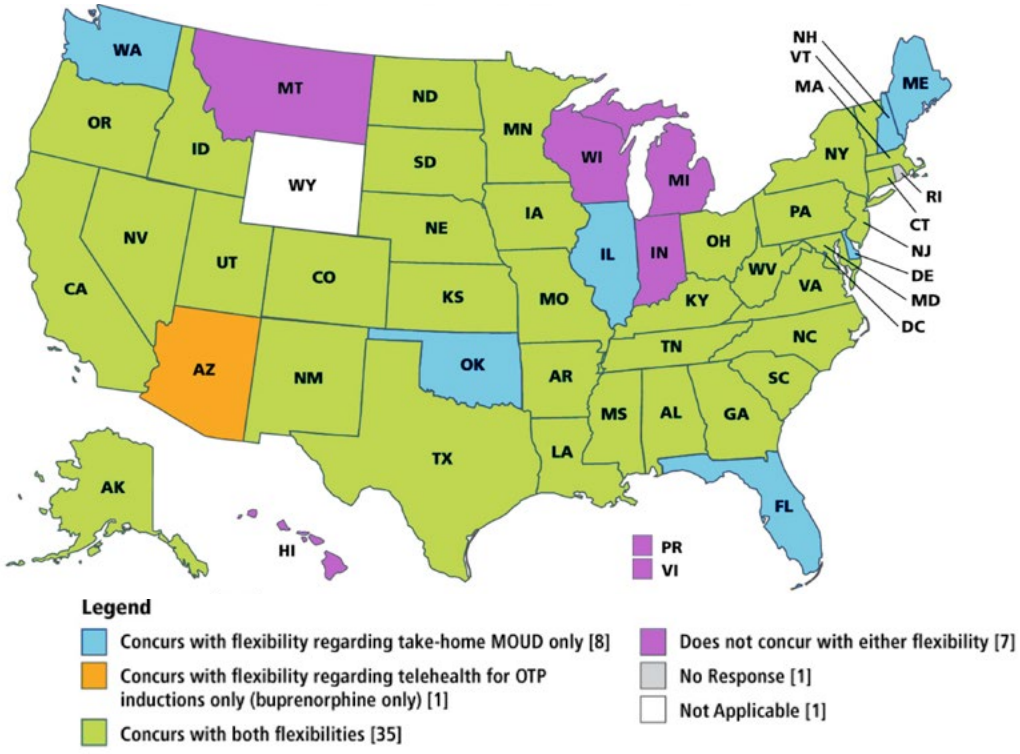
3. Methadone

Methadone is an FDA-approved MOUD and is only available through OTPS, which are not located in 80% of counties.[36] Existing barriers include restrictions on new OTPs, zoning restrictions and limited hours of operation. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently updated federal guidance to decrease barriers to access, however, states must act to update their state regulations.

The AMA strongly supports S. 644/H.R. 1359—the Modernizing Opioid Treatment Access Act (the "M-OTAA"). This bipartisan, bicameral legislation would responsibly expand access to methadone treatment OUD in medical settings and areas where it is not available now.[37]

The AMA also encourages all OTPs to take full advantage of federal flexibilities to provide take-home doses for patients. Given the challenges with child care, transportation and employment, the federal flexibilities can reduce barriers and increase retention in care. The AMA encourages all states to review and update regulations to make changes that align with the evidence-standards in the SAMHSA regulations on OTPs.

SAMHSA Certified Treatment Programs
Post COVID Flexibilities State Concurrence[38]



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Recommendations:

- Remove barriers to evidence-based care for patients with a substance use disorder (SUD). This includes removing prior authorization, step therapy and dosage caps for MOUD, continuing federal flexibilities for take-home medication for opioid treatment programs and continuing audio-visual and audio-only telehealth options for patients to begin MOUD.
- Remove barriers to MOUD and treatment for SUDs and co-occurring mental illness in the nation's jails and prisons or under judicial supervision. This includes ensuring pregnant people with OUD can receive MOUD and continue MOUD post-partum. There is no legal, medical or policy reason to deny access to MOUD or mental health care for individuals in jail or prison, or who are in a judicially-supervised diversion program or on probation or parole.
- Expand access to evidence-based strategies including pharmacotherapy and contingency management.
- Decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of OUD.
- Confront health care disparities. Increased efforts should be focused on removing barriers to care disproportionately experienced by Black and Brown patients.[39] This includes ensuring that MOUD is accessible in all communities. The data is clear that when patients are provided with "access to high-quality MOUD treatment, they demonstrate positive OUD outcomes."[40]

> **"The AMA, our Substance Use and Pain Care Task Force, and the nation's physicians continue to urge policymakers, health insurance companies and other payers to once and for all remove barriers to evidence-based treatment for substance use disorders, pain care and harm reduction initiatives. Delays or denials of this care only results in increased suffering and death. Ending the epidemic is possible, but much more work must be done."**
>
> –Bobby Mukkamala, MD
> Chair, AMA Substance Use and Pain Care Task Force

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Naloxone

291.5%[33]
Increase in naloxone dispensed 2018–2023

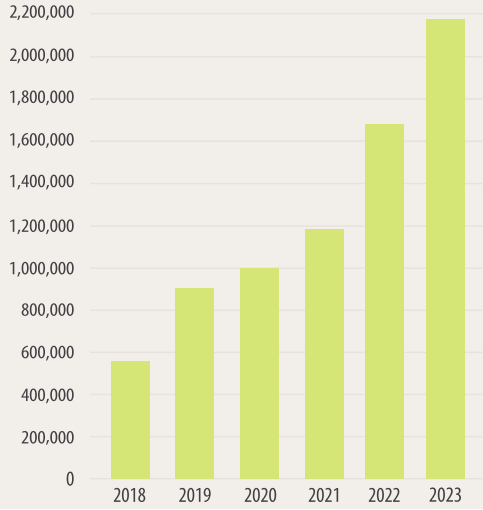
Naloxone's main purpose is to save lives from an opioid-related overdose—and it does this very, very well.[41] Harm reduction and other community-based organizations distributed more than 3.7 million doses of naloxone between 2017–2020.[42] From August 2021 to July 2023, national harm reduction organization, Remedy Alliance For The People, sent 1,639,542 doses of generic injectable naloxone to 196 harm reduction projects in 44 U.S. states, DC and Puerto Rico, of which 206,371 doses were provided at no-cost to 138 under-resourced harm reduction projects.[33] If it was not for naloxone, it is likely that hundreds of thousands additional Americans would be dead today.

How to increase access to opioid-overdose reversal medications

1. **Physicians are encouraged to prescribe naloxone or other opioid-overdose reversal agents to anyone at risk of an opioid-related overdose, including to youth and adolescents.** More than 2,200 adolescents (ages 10–19) died of a drug-related overdose between July 2019–December 2021, with nearly 84% of these deaths involving illicitly manufactured fentanyl; according to the CDC.[43] Naloxone was administered only 30% of the time.[44] Unintentional drug overdose deaths among young people (ages 15–19) continued to remain high in 2022, according to the National Institute on Drug Abuse (NIDA).[45] Two-thirds of those who died did not have any history of prior opioid use.[46]
2. **Schools, educational settings and public businesses are encouraged to have naloxone on the premises.** Multiple school districts and universities already provide naloxone and overdose prevention and education opportunities. "Our friends do not know that those pills are more than likely to be fake [or] have enough fentanyl in it to kill you. I carry Narcan in my school bag. If I am going to a party, I will put it in my purse. It is just a layer of protection. You wear your seatbelt not because you are going get in a car accident. It is to keep yourself safe."[47]
3. **Ensure OTC naloxone is available and update standing orders for pharmacies to include naloxone and all other FDA-approved opioid-overdose reversal medications.** Increasing access to naloxone was one of the first recommendations of the AMA Substance Use and Pain Care Task Force.[48] However, when pharmacies do not make OTC naloxone readily available to laypersons, they cannot use it to save lives.

Naloxone prescriptions dispensed from retail pharmacies[33]

United States 2018–2023



A note of caution
Naloxone and other opioid-overdose reversal agents do not reverse an overdose related to methamphetamine, cocaine or other substances. They also do not work to counteract overdose related to alcohol, benzodiazepines or xylazine, which may increase the sedative effects of opioids, making the antagonist effects of naloxone appear not as rapid or sustaining.[49] Polysubstance use, moreover, may be intentional or unintentional as illicit substances may contain multiple adulterants, including illicitly manufactured fentanyl.[50] The CDC, SAMHSA, NIDA and many other leading health organizations, including the AMA, continue to counsel that in addition to immediately calling 911, it is still advised to administer naloxone or another FDA-approved overdose reversal agent if an overdose is suspected because it is likely an opioid is present, and naloxone will not harm an individual. When in doubt, the AMA advises to administer the overdose reversal agent and give rescue breaths to help reduce respiratory depression.

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Pain care

Support individualized pain care

As the nation continues to face a deadly overdose and death epidemic fueled by illicitly manufactured fentanyl, patients with pain continue to face one-size-fits-all state laws. Pharmacy chain, payer and pharmacy benefit management companies continue to mistakenly hold on to the false belief that restrictions in opioid prescribing will result in improved pain care and reduced mortality. Since 2012, opioid prescribing has decreased by 51.7%, but restrictive laws and other policies stigmatize and harm patients with pain who require opioid therapy for surgery, sickle cell disease, chronic pain, hospice and palliative care, cancer and other medical conditions. State laws and payers have taken few actions to meaningfully increase access to non-opioid alternatives for patients.

Two key actions that every state can take to help patients with pain:

1. **State medical boards can adopt the April 2024 Federation of State Medical Boards "Strategies for Prescribing Opioids for the Management of Pain."**[51]

   The FSMB strategies:

   - Provide clear guidance to boards and physicians about the need for individualized patient care decisions.
   - Highlight the importance of patient-physician shared decision-making when considering whether to initiate opioid medication, taper medication, or take measures to discontinue medication.
   - Emphasize that evaluating the "success" of a treatment plan is multifaceted and could include functional improvement, improvement in quality of life, as well as reductions in a patient's pain.

2. **State legislatures, Medicaid agencies, health insurance companies, pharmacy chains and pharmacy benefit managers should rescind all numeric thresholds in laws/policies/protocols based on the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain—as recommended by the updated 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain.**[52]

   The 2022 CDC guideline specifically advises that it is not:

   - Intended to be applied as inflexible standards of care across patients, and/or patient populations by healthcare professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or abrupt discontinuation of opioids for patients.
   - A law, regulation and/or policy that dictates clinical practice or a substitute for FDA-approved labeling.
   - Applicable to the management of pain related to sickle cell disease, management of cancer-related pain, palliative care or end-of-life care.

> **Support coverage for, access to, and payment of comprehensive, multi-disciplinary, multi-modal evidence-based treatment for patients with pain, a substance use disorder or mental illness. Additionally, coverage, access and payment should directly address racial, gender, sexual orientation, ethnic and economic inequities as well as social determinants of health. Particular emphasis must be placed on individualized patient care decisions, protecting patients with pain, a substance use disorder or mental illness from continued stigma and addressing a lack of access to evidence-based care or accepted best practices.**
>
> –AMA Substance Use and Pain Care Task Force

States also are encouraged to review new Minnesota law supported by the AMA[19] that emphasizes physician discretion rather than strict adherence to pre-determined dose or quantity limits.

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Mental health and substance use disorder parity

Fifteen years after passage of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), access to mental health and substance use-related health care remains out of reach for many Americans. Insufficient coverage, high out-of-pocket costs and inadequate networks of mental health and substance use disorder (MH/SUD) physicians prevent many with health insurance from receiving timely, affordable care. In addition to health plans' continued and often flagrant non-compliance with state and federal MH/SUD parity laws, uneven state oversight and enforcement also has led to patients not being able to access timely, affordable care. Delayed and denied care are contributing factors to the ongoing mental health and overdose epidemic that continues to kill more than 100,000 Americans every year.

The common denominator to parity enforcement is that health insurers routinely fail to comply with MHPAEA or state laws.[53] When regulators evaluate parity compliance, they inevitably discover widespread parity violations in a wide range of areas:

- Lack of access to in-network mental health and substance use disorder care
- Treatment exclusions, such as for autism spectrum disorder, eating disorders and substance use disorders
- Excessive prior authorization and concurrent care review compared to medical/surgical services
- Reduced reimbursement rates and unduly restrictive contracting processes for addiction medicine physicians, psychiatrists and addiction psychiatrists
- Failure to have adequate networks for mental illness or substance use disorders
- Inappropriate use of non-medical medical necessity criteria, including failure to use—as required by state law–patient placement criteria from the American Society of Addiction Medicine[54]

What can be done about it? The AMA urges:

- **State medical societies to support model legislation** based on California Senate Bill 855, which requires all health insurers and behavioral health management organizations to rely on evidence-based treatment guidelines developed by physicians and health care professionals—and not financial considerations. Illinois[55] and Colorado[56] also have excellent state laws.

States also can adopt provisions in a new federal parity rule[9] strongly supported by the AMA, that include:

- **Plans must provide specific information to regulators.** Health plans must perform, document and provide their comparative analyses to show that the processes, strategies, evidentiary standards and other factors used to restrict care are no more stringent than for medical/surgical care.
- **Plans must provide data on prior authorization.** On request, health plans would be required to provide data for prior authorization and other restriction-based policies that could include rates of approvals and denials of prior authorization requests, rates of denials of post-service claims, and turnaround times for prior authorization requests.
- **Policies that violate parity can be stopped.** If a health plan is found to be using an utilization management policy that is more restrictive than a medical/surgical service, the health plan can be prohibited from using that non-quantitative treatment limitation until the violation is rectified.

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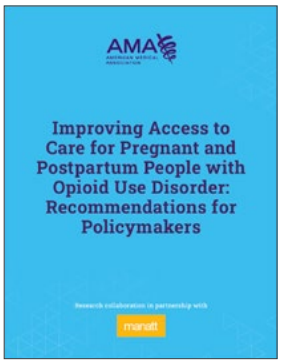
Maternal health

Substance use disorder



Among pregnant and postpartum persons, drug overdose mortality increased approximately 81% from 2017 to 2020, mirroring trends observed among persons of reproductive age overall.[57] Pre-adolescents and adults who died from a drug overdose during pregnancy, compared to those who died from obstetric causes, were more likely to be aged 10 to 34, non-college graduates, unmarried and die in "non-home, non-healthcare settings."[58] From 2018 to 2021, the mortality ratio more than tripled among pregnant and postpartum people aged 35 to 44 years.[59]

Despite U.S. Department of Justice (DOJ) guidance that denial of MOUD in jails and prisons violates the Americans with Disabilities Act, and federal court decisions protecting the right to receive MOUD in carceral settings, jails and prisons still provide far less access to MOUD than do community providers, including to individuals who are pregnant.[60] It is contrary to all medical evidence to force individuals to undergo discontinuation or abrupt cessation of MOUD, leading to withdrawal, which is associated with both physical and psychological harm. The AMA encourages policymakers to ensure that pregnant people in jails and prisons have access to their rights under the law, including access to MOUD during pregnancy and postpartum periods.[61]

Protecting pregnant patients with pain

The AMA also recommends the implementation of the HHS Interagency Pain Management Best Practices Task Force, which highlights individuals who are pregnant as a special population.[62] The HHS Task Force report recommends more research and innovation to address peripartum pain management, and ensure people of reproductive age are counseled on the risks of opioids and non-opioid medications in pregnancy, including balancing the risks and benefits to the pregnant person, fetus and newborn.

Pregnancy is not a reason to avoid evidence-based treatment for pain. To help guide policymakers, the AMA relies on guidance from professional medical associations, including the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Pain Medicine and American Society of Addiction Medicine. At their core, each of these societies highlight the need for individualized patient care decisions made between the physician and patient—a guiding principle the AMA strongly supports.

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Harm reduction

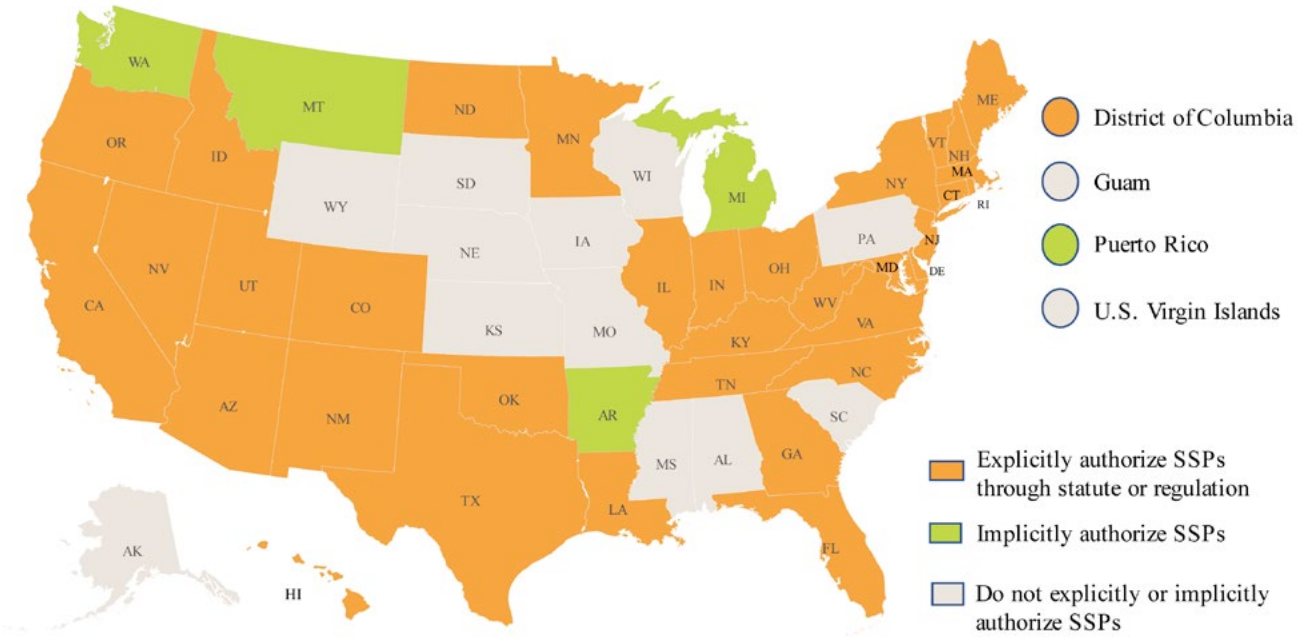
Syringe Service Programs (SSPs)

Harm-reduction services are not universally supported at the federal, state and local levels, including funding and support for syringe service programs. Only 38 states, DC and Puerto Rico authorize SSPs.[63] Six states require SSPs to use the outdated 1:1 exchange model, which is "associated with increased syringe sharing and increased risk of infections."[64]

SSPs are effective community-based prevention programs that provide comprehensive services to decrease drug-related harms, including access to and disposal of sterile syringes and other injection equipment, access to naloxone and MOUD, vaccinations, testing and linkage to infectious disease care and substance use treatment.[65]

- SSPs reduce Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV). SSPs are associated with an estimated 50% reduction in HIV and HCV incidence. When combined with MOUD, HIV and HCV transmission is reduced by more than two-thirds.[66,67]
- SSPs are more than just syringe exchanges. In addition to providing sterile syringes, injection equipment and safer-sex supplies to help reduce blood borne infections and STIs, SSPs distributed more than 700,000 doses of naloxone, including refills, during a 12-month study period that captured the responses of 263 SSPs nationwide.[68]
- SSPs are a safe and trusted resource. People who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection compared to those who have never used an SSP.[69]

States that Explicitly or Implicitly Authorize SSPs[70]



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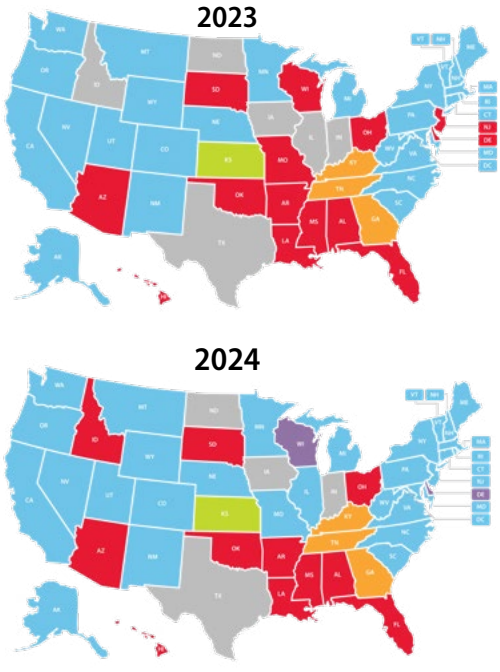
Test strips and other drug checking supplies

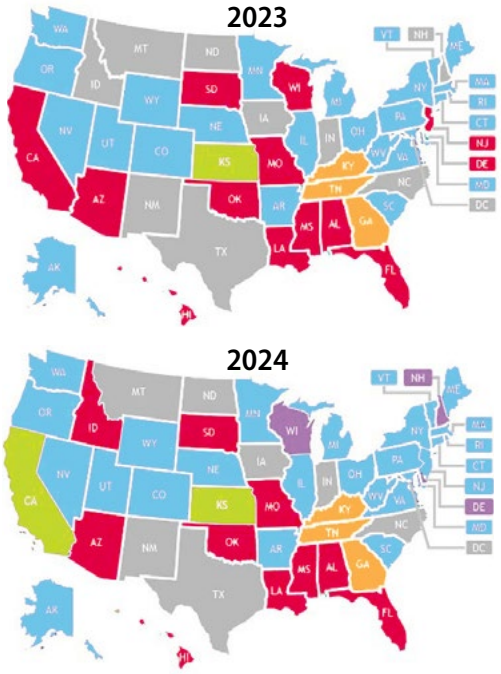
Drug checking equipment (DCE) helps detect fentanyl and other toxic adulterants. Preliminary research shows that drug checking services have a positive impact on individuals' intended drug use behaviors, including making changes to their drug use practices such as keeping naloxone nearby to prevent fatal overdose. Empowering individuals who use drugs with knowledge about the presence of adulterants and other substances in the drug supply can reduce harms associated with drug use.[71]

Understanding the drug supply is critical for public health support and harm reduction. Public health experts and harm reduction organizations view drug checking technology as an integral surveillance tool.

States with laws permitting possession of DCE, by year[72]



States with laws permitting free distribution of DCE, by year



All DCE | Fentanyl | Synthetic opioids | Fentanyl and Xylazine | Other

Almost half of states have decriminalized the use of fentanyl test strips, but additional state advocacy is needed to decriminalize test strips and other drug checking supplies for emerging adulterants, including xylazine. State laws should provide criminal protections for people using drug checking technologies (i.e., immunoassay testing strips, spectrometry devices, reagents), not just those used to detect synthetic opioids (i.e., fentanyl test strips). This includes protections against charges for "residual amounts" of illicit substances used as part of a test.

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Overdose prevention sites

Research demonstrates that overdose prevention sites OPS reduce overdose deaths. However, due to the fear of federal intervention under the "crack-house statute," political opposition and lack of funding, only two New York City OPSs currently operate in the U.S. Rhode Island continues to work toward opening a legally-authorized OPS (called a "harm reduction center" in Rhode Island).[73]

At this point in the nation's epidemic, the AMA urges states and communities to consider all evidence-based approaches, including OPSs, to prevent overdose death and provide access to resources, including naloxone, wound care, referrals for public and community services and treatment options if requested.

The data shows that OPSs help reduce drug related harms, overdose and death while improving public safety and access to health care.[74,75,76,77,78]OPSs increase referrals and access to treatment and decrease syringe sharing associated with injection drug use, the spread of infectious diseases and overdose deaths in the neighborhood of the facility.[79,80,81,82,83]

- OPSs save lives: Whether in Canada, Europe or the sites in New York City, thousands of overdose reversals have taken place while there have been no reported fatalities at the sites.
- OPSs increase access to health services: 52.5% of OPS participants received supportive services including naloxone distribution, counseling, hepatitis C testing, medical care and holistic services.
- OPSs reduce public drug use: 75.9% of OPS participants used the OPS instead of a public or semipublic location.[84]

AMA supports the decriminalization of harm reduction supplies, efforts to establish pilot overdose prevention sites, increased access to fentanyl test strips and other drug checking supplies for harm reduction practices, and encourages the establishment and funding of syringe service programs.

Data gaps limit ability to pursue evidence-based, public health outcomes

- **Data is old.** State, national and federal stakeholders are all working hard to improve surveillance efforts, but even the best efforts often lag several months—or years— behind current data trends.
- **Data is inconsistent.** Current available data is often incomplete, non-standardized for comparison and years behind and fails to provide a comprehensive picture. While metrics for drug-related overdoses are generally accessible, information on drug specificity, non-fatal overdoses, rates of infectious diseases and other crucial indicators is not consistently collected or standardized across states and communities.
- **Data is limited.** Furthermore, due to restrictive laws, there is limited research and significant data gaps. Improving the comprehensiveness, standardization, quality and timeliness of data collection and analyses will help advance local prevention, treatment and harm reduction efforts as well as broader public policy initiatives to improve outcomes and reduce overdose and death.

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Infectious disease

The nation's drug-related overdose and death epidemic has led to a rise in infectious diseases such as HIV, hepatitis A, B and C viruses, as well as bacterial, fungal and other infections (transmitted either via injection drug use or risky sexual behaviors).[85]

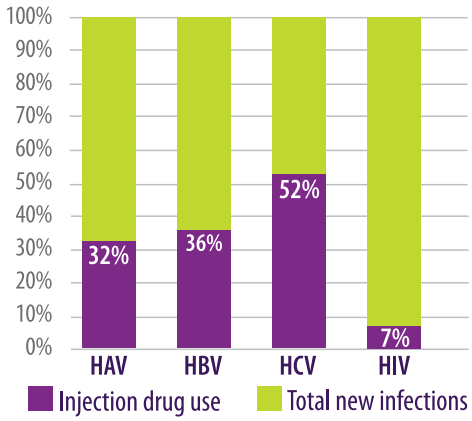
Hepatitis A: Among the 947 (41%) reported cases that included risk information for injection drug use, 299 (32%) reported injection drug use. 58% of Hep. A cases occurred among non-Hispanic white persons.[86]

Hepatitis B: Among the 976 (46%) reported cases that included risk information for injection drug use, 239 (24%) reported injection drug use. The rate of acute Hep. B is highest among non-Hispanic Black persons (1.0 cases per 100,000 population), with the rate of newly reported chronic cases highest among non-Hispanic/Asian/Pacific Islander persons (20.1 cases per 100,000 population). Urban areas have double the rate of chronic cases when compared to rural populations.[87]

Hepatitis C: Among the 1,595 (33%) reported acute cases that included risk information for injection drug use, 834 (52%) reported injection drug use. The rate of reported cases of acute Hep. C was highest among non-Hispanic American Indian/Alaska Native (AI/AN) persons (2.9 cases per 100,000 population). After over a decade of consecutive annual increases in acute Hep. C, the number of acute Hep. C cases declined for the first time in 2022.[87]

HIV: HIV diagnosis increased 5% (36,096 to 37,981) from 2021 to 2022. In 2022 injection drug use accounted for 7% (2,651) of all new HIV diagnoses in the United States. Men are heavily affected and account for 79% of diagnoses, with gay and bisexual men accounting for the majority (67%). Black people make up 38% of diagnoses. Young people (13–34) encompass over half (56%) of diagnoses. Geographically, the South continues to account for more than half (52%) of all diagnoses.

New reported cases of HIV and viral hepatitis in injection drug users[87,88]



*Note: data is from 2022

The AMA encourages physicians, hospitals, health plans, pharmacies and others to incorporate harm-reduction strategies wherever possible. Visit the Centers for Disease Control and Prevention National Harm Reduction Technical Assistance Center for comprehensive resources, education and strategies: https://harmreductionhelp.cdc.gov/s/

Resource: AMA's HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit for Community Health Centers and Emergency Departments

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Stakeholder collaboration

Ending the nation's drug-related overdose and death epidemic—as well as improving care for patients with pain, mental illness or substance use disorder (SUD), and increasing access to harm reduction services—requires partnership, collaboration and commitment.

The AMA continues to urge:

- State insurance departments to meaningfully enforce mental health and SUD parity laws
- Opioid treatment programs to expand their reach to underserved communities by using their existing license to operate "mobile treatment programs"
- Policymakers to support legislative and other actions to remove administrative and other barriers—such as prior authorization, step therapy and dosage caps for medications to treat opioid use disorder (MOUD), including dosage caps on buprenorphine
- The U.S. Drug Enforcement Administration (DEA) and other government agencies to issue clear guidance that DEA's suspicious order reporting requirements will not be enforced against buprenorphine approved by the FDA for the treatment of opioid use disorder until further notice.[89]
- State departments of corrections and private jails and prisons to ensure that all individuals with an OUD or mental illness are screened upon entry, receive MOUD while incarcerated, and linked to care upon release (These elements are among those protected by the U.S. Constitution and federal law.)[90,91]
- Faith and community leaders to help destigmatize SUDs and harm reduction by educating members about the benefits of MOUD, naloxone and fentanyl test strips, as well as holding overdose awareness and prevention events
- Medical and other health care professional licensing boards to help patients with pain by reviewing and rescinding arbitrary restrictions on opioid therapy—as now recommended by the CDC
- Employers to review their health insurance and benefits plans to ensure employees and their families have access to pain specialists and affordable access to comprehensive, multimodal pain care; physicians who provide MOUD; and psychiatrists who are in the employer's network
- Public health officials, colleges, universities and other educational settings to adopt best practices to reduce harms and help control infectious disease spread through supporting comprehensive needle and syringe exchange services, and supporting widespread, community-level distribution of naloxone and fentanyl test strips

Stakeholders should also address racial disparities and health inequities as well as underlying social needs that amplify overdose deaths such as housing and transportation. All stakeholders have a role to play in removing barriers for individuals with a substance use disorder, patients with pain, and to increase access to comprehensive harm reduction efforts.

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AMA advocacy

"The AMA strongly urges all health plans and policymakers to support removing all prior authorization, step therapy, dosage caps, and other harmful utilization management for medications to treat opioid use disorder (MOUD) altogether."

"The AMA urges that the Centers for Medicaid & Medicare Services (CMS) prohibit plans and issuers from continuing the use of non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder services if the plan or issuer cannot provide the documentation and other information to demonstrate that the NQTL is compliant with MHPAEA. The AMA further recommends that the plan or issuer be barred from re-instituting the NQTL until it has put a corrective action plan into place. In addition, the AMA also recommends that CMS levy monetary penalties upon the plan or issuer for the duration of time between a finding of insufficiency or non-compliance and the time it takes for the corrective action plan to be put into effect."

The AMA "support[s] H.R. 7050, the Substance Use Disorder Workforce Act, which would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine."

"The AMA strongly supports increasing access to fentanyl test strips and naloxone from pharmacies and other retailers. In addition, the AMA strongly supports the provisions in [Nebraska] LB 1325 providing authority to local public health department facilities to provide fentanyl test strips without a fee. These are common sense strategies to help prevent more people from dying."

"[Colorado] HB 24-1003 is another key step to helping ensure that life-saving medication is available in a greater number of school-based settings, including buses and school-sponsored events ... Naloxone and other opioid-overdose reversal agents can only save lives when it is readily available for use—and it gets used—during an overdose event. HB 24-1003 will help keep youth and adolescents alive."

AMA advocacy helped support a final rule from SAMHSA's that removes barriers to care, including for Medications for Opioid Use Disorder (MOUD) in OTPs while ensuring physicians' clinical discretion to ensure patient safety. The rule also provides increased flexibility for OTPs to provide take-home methadone and for physicians to begin OTP patients on buprenorphine for OUD via telehealth. The rule also removes barriers for patients to begin treatment in an OTP, including removing the one-year requirement of having an "addiction."

The Substance Use Disorder Workforce Act of 2024 is "thoughtful, bipartisan legislation would provide Medicare support for an additional 1,000 new graduate medical education positions over five years in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine and their prerequisite programs."

"As long as buprenorphine products approved by the FDA for OUD remain prevalent in Suspicious Order Reporting requirements and the opioid litigation settlement agreements, access to these buprenorphine products will remain a struggle across the country."

"The AMA strongly agrees that when pharmacists have questions about a prescription for buprenorphine for the treatment of OUD, it is essential for the pharmacist and physician to discuss the situation—and not automatically deny the patient access to the life-saving medication."

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Educational resources

Substance use disorders and addiction education to meet DEA requirements

On Dec. 29, 2022, the Consolidated Appropriations Act of 2023 enacted a new one-time requirement which went into effect on June 27, 2023, for any DEA-registered practitioner (except for veterinarians) to complete eight hours of training "on the treatment and management of patients with opioid or other substance use disorders."

A number of CME courses offered on the AMA Ed Hub™ related to substance use disorders and addiction qualify as meeting the requirement including:

- Basics of Safe Opioid Prescribing and Management
- Basics of Addiction Treatment
- Management of Addiction in Special Populations
- Opioids and Fatalities: Prevention and Management
- Addiction beyond Opioids

These courses can be taken in any combination to meet the requirement.

Many U.S. states already require physicians and other medical professionals to complete CME hours on topics related to opioid prescribing, pain management or similar areas. This new requirement asks physicians to have additional education on the treatment and management of patients with opioid or other substance use disorders.

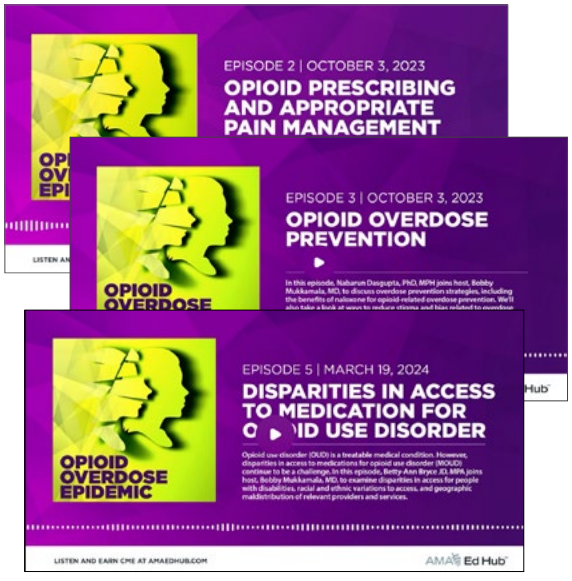
If you have not met this specific eight-hour training requirement yet, the deadline to do so is the date of a practitioner's next scheduled DEA registration submission.

Opioid overdose epidemic podcast series

This AMA podcast series shares expert discussions and insights to help physicians and other health professionals address the epidemic of opioid overdoses.

Recent episodes include:

- Opioid utilization in hospice and palliative care
- Opioid use disorder and pregnancy
- Opioid use: A prevention approach
- Disparities in access to medication for opioid use disorder
- Opioid overdose prevention
- Opioid prescribing and appropriate pain management
- Opioid use disorder treatment



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Overdose data dashboard

The AMA is releasing an updated interactive overdose data dashboard, which compiles state-level data for several indicators, including overdose mortality, non-fatal overdoses, and opioid prescriptions. One of the goals of this work is to continue to promote consistency in overdose-related outcome data and increased availability of state-level data.

Resources:

- Issue brief: Mental health and substance use disorder parity enforcement
- Issue brief: Dispelling myths of bystander overdose
- Issue brief: State snapshot of overdose epidemic
- Issue brief: National snapshot of overdose epidemic
- Report: Improving access to care for pregnant and postpartum people with opioid use disorder: Recommendations for policymakers
- Issue brief: State Strategies to Improve Mental Health and Substance Use Disorder Parity

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