From:	Halstead, Mary (CDC/NCIPC/OD)
To:	OMB-Comments (CDC); NCIPC OMB (CDC)
Subject:	RE: Request for revised 2026 Overdose Response Strategy instruments and logic model — OMB 0920-1461 / CDC-2026-1420
Date:	Monday, August 24, 2026 9:20:52 AM
Attachments:	Attachment D ORS Annual Survey Update_08.05.2026.docx Attachment I_ORS Quarterly Reporting Template_Dec 2025_submitted revision request_clean.docx Logic Model August 2026.pptx image001.png

Good morning, Jeff,

I hope you had a relaxing weekend! My apologies for not including these documents with the initial submission. Attached you'll find the updated Annual Survey and Logic Model. I've also included the Quarterly Reporting template, which hasn't been revised for this this revision.

Please let me know if you need anything else.

Peggy

From: OMB-Comments (CDC) <omb@cdc.gov>
Sent: Monday, August 24, 2026 8:52 AM
To: NCIPC OMB (CDC) <ncipcomb@cdc.gov>; Halstead, Mary (CDC/NCIPC/OD) <ygg9@cdc.gov>
Subject: FW: Request for revised 2026 Overdose Response Strategy instruments and logic model — OMB 0920-1461 / CDC-2026-1420

Good morning, Peggy/NCIPC. Hope all is well. ICRO received the following comment from the public related to the 60d FRN published for 0920-1461 - Overdose Response Strategy. The commenter would like to see the data collection instruments and logic model that were mentioned in the 60d FRN (I have the Annual Report and Quarterly Report, but do not have the Public Health/Public Safety Partner Survey [this may actually be part of the Annual Report]). Please send me these documents when you have a chance so I can get them back to the commenter.

Thanks,
Jeff

JEFFREY M. ZIRGER, Ph.D.
Health Scientist
Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services (HHS)
Phone: (470) 217-8909 (Mobile)

From: seth morrow <smorrow852@gmail.com>
Sent: Friday, August 21, 2026 10:36 PM
To: OMB-Comments (CDC) <omb@cdc.gov>
Subject: Request for revised 2026 Overdose Response Strategy instruments and logic model — OMB 0920-1461 / CDC-2026-1420

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hello,

I'm reviewing the August 20, 2026 Federal Register notice for the Overdose Response Strategy (ORS) Data Collection, Docket CDC-2026-1420 / OMB No. 0920-1461, and would like to review the exact revised instruments before submitting any public comment.

Could you please send the current proposed versions of:

- the revised annual ORS survey(s);
- the revised quarterly reporting template;
- the public health/public safety partner survey, if separate; and
- the updated ORS logic model referenced in the notice?

I'm specifically trying to verify how the revised collection distinguishes:

1. an activity being completed from a partner actually implementing or using the resulting information/intervention;
2. an observed outcome from a success story or perceived contribution;
3. no measurable effect from not evaluated / not enough data / unknown;
4. completed, failed, discontinued, delayed, and still-pending interventions or referrals; and
5. attribution to ORS from contribution alongside other programs or external factors.

Because the notice says these data support annual public reporting, Congressional reporting, and program improvement, I want any comment to be based on the current proposed fields rather than older approved versions.

Thank you,
Seth Morrow

From: OMB-Comments (CDC)
To: Halstead, Mary (CDC/NCIPC/OD); NCIPC OMB (CDC)
Subject: FW: Follow-up on ORS quarterly template — terminal project status vs. required "Outcomes in Progress"
Date: Monday, August 24, 2026 3:24:10 PM
Attachments: image001.png

Hi Peggy. Thanks for sending the most recent attachments as a response for 0920-1461. I just received a follow-up comment from the same commenter (below). I don't think I have the understanding to answer this question. Can you please send this to the Project Officers/Investigators, so they can provide a more thorough response than what I can offer? I already informed the commenter (Seth Morrow) that his additional comment would need to be forwarded to actual Project Officers/Investigators for a response. They are free to respond directly to the commenter (email highlighted below).

Thanks,
Jeff

JEFFREY M. ZIRGER, Ph.D.
Health Scientist
Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services (HHS)
Phone: (470) 217-8909 (Mobile)

From: seth morrow <smorrow852@gmail.com>
Sent: Monday, August 24, 2026 1:17 PM
To: OMB-Comments (CDC) <omb@cdc.gov>
Subject: Follow-up on ORS quarterly template — terminal project status vs. required "Outcomes in Progress"

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hello,

Thank you again for sending the current ORS materials. I found one reporting-logic point I want to verify before deciding whether to submit a formal comment through Regulations.gov.

In the revised quarterly reporting template:

- Project Status includes In Progress, Complete, On Hold, and Discontinued.
- "Complete" is defined as project activities being complete.
- "Discontinued" is defined as project activities no longer being pursued.
- The Outcomes section states that if no completed outcome is reported, the "Outcomes in Progress" section requires completion.

- “Outcomes in Progress” is described as a description of outcomes in progress not captured in the completed outcome table.

Taken literally, that appears to create a mismatch for a project that is Complete or Discontinued but has no completed outcome to report: the reporter could be required to describe an outcome as “in progress” even though the project itself is terminal.

Could you clarify whether the actual reporting system has conditional logic that suppresses or changes the “Outcomes in Progress” requirement for Complete/Discontinued projects with no completed outcome?

If that case is already handled in implementation, that resolves the concern. If it is not, I may submit a narrowly scoped recommendation through the formal docket to add a terminal/no-completed-outcome state (or otherwise condition the requirement on project status) so the collection does not force a false lifecycle description.

No formal comment is intended by this email; I am only verifying the current implementation before commenting.

Thank you,

Seth Morrow

Mechanic vs Machine | Independent public-interest review

From: NCIPC OMB (CDC)
To: smorrow852@gmail.com
Subject: Follow-up on ORS quarterly template — terminal project status vs. required "Outcomes in Progress"
Date: Tuesday, August 25, 2026 9:49:31 AM

Hello Seth,

Thank you for sharing your feedback and expressing interest in CDC's Overdose Response Strategy proposed information collection. We appreciate your questions regarding the relationship between project status and the outcome fields and would like to clarify how these elements work within the ORSTRS reporting process.

Project Status and the outcome fields capture different aspects of a project. ORSTRS reporting is retrospective; reporters are documenting project activities and outcomes that occurred during the previous 90-days.

A project may be marked **Complete** or **Discontinued** at the time of the quarterly reporting deadline while still having a completed outcome or an outcome that was in progress during the 90-day reporting period. Both can be true: the project has since reached a terminal status but there were new completed, or in-progress outcomes associated with the project during the preceding 90-days.

Once a project is marked **Complete** or **Discontinued**, it does not carry forward into subsequent quarterly reporting periods. As a result, reporters are not able or expected to add additional completed or in-progress outcomes for that project in future quarters.
The **Outcomes in Progress** requirement is intended to ensure that, when a project does not have a completed outcome to report for the quarter, relevant progress toward an outcome during that reporting period is still captured. It is not intended to indicate that a project marked Complete or Discontinued will continue into the next reporting period.

We appreciate your input and will take your comment into consideration. Please do not hesitate to contact us if we can be of further assistance.

Best regards,

OMB/PRA Office
Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Department of Health and Human Services

PUBLIC SUBMISSION

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Docket: CDC-2026-1420
Overdose Response Strategy

Comment On: CDC-2026-1420-0001
Overdose Response Strategy 2026-17037

Document: CDC-2026-1420-0002
Comment from austin, jordan

Submitter Information

Name: jordan austin
Address:
clarence center, NY, 14032
Email: jeallen2@buffalo.edu

General Comment

Given the rapidly changing chemical composition of the illicit drug supply, shortening the survey may reduce the administrative burden but could also limit the depth and utility of the information collected. Delays between the emergence of a dangerous drug supply and the CDC's receipt of survey data may further reduce the ability of public health agencies to identify emerging trends and implement timely interventions. Annual reporting may also reduce the relevance of the information by the time it is disseminated. The United Nations Office on Drugs and Crime (2026) reported that the increasing availability and diversification of synthetic opioids have created new opportunities for trackers to adapt their methods and evade drug-control efforts. Given the rapidly evolving nature of the illicit drug market, quarterly or biannual reporting may provide more timely information and improve the ability of public health agencies to respond to emerging threats.

Reducing the number of survey questions may also limit opportunities to corroborate responses across measures, potentially increasing the influence of self-report bias on program evaluation findings. Self-reported data, particularly when collected through abbreviated surveys, may introduce response bias and social desirability bias, potentially affecting the accuracy of the findings (Latkin et al., 2017). Measures to protect respondent confidentiality and minimize perceived pressure to provide favorable responses should therefore be incorporated to reduce the risk of bias.

Reference

Latkin, C., Edwards, C., Davey-Rothwell, M., & Tobin, K. (2017). The relationship between social desirability bias and self-reports of health, substance use, and social network factors among urban substance users in Baltimore, Maryland. Addictive Behaviors, 73, 133-136. https://doi.org/10.1016/j.addbeh.2017.05.005

United Nations Office on Drugs and Crime. (2026). UNODC world drug report 2026: Global drug markets transforming rapidly as technology, novel drug types and instability

present traffickers with new opportunities [Press release]. https://www.unodc.org/unodc/en/press/releases/2026/June/unodc-world-drug-report-2026_-global-drug-markets-transforming-rapidly-as-technology--novel-drug-types-and-instability-present-traffickers-with-new-opportunities.html

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Attachments

fed gov comment

From: NCIPC OMB (CDC)
To: "jeallen2@buffalo.edu"
Subject: Docket: CDC-2026-1420 - Overdose Response Strategy
Date: Friday, October 9, 2026 9:40:00 AM

Dear Jordan,

Thank you for sharing your feedback and expressing your interest in our proposed information collection. This program evaluation survey is designed to capture ORS programmatic outcomes as perceived by the program's core stakeholders (ORS teams and their partners). The survey is not a surveillance or epidemiological survey and does not aim to capture emerging drug threats. The data collected will be used to inform aggregate program enhancements and improvements and describe the extent to which expected outcomes were observed.

As a national program evaluation outcome survey of partners and ORS teams, annual data collection is appropriate for a 5-year program funding cycle. Furthermore, the outcome survey will be used in combination with quarterly progress reporting of activities through the program's reporting system, which captures details about projects and activities. Together, these two data collection activities round out the program monitoring and evaluation efforts based on the ORS program logic model and the evaluation design.

Regarding the reduction of survey questions. The goal of the survey revision was not to reduce the survey length. This was a natural result from narrowing the focus of the evaluation. The survey was revised to align with the updated evaluation plan. By narrowing the focus of the evaluation, fewer questions are needed to capture the relevant measures of interest. Therefore, the survey was not abbreviated, but rather, it represents a comprehensive data collection instrument designed to answer specific evaluation questions.

Efforts being made to minimize responder bias include:

1. Ensuring anonymity and aggregate reporting only
2. The use of balanced, bi-directional, 5-point likert-style scales
3. Allowing "not sure"/"don't know" response options

Finally, responder bias is expected to be minimized in part because of the wide range of flexibility teams have in selecting strategies and activities on which to focus. There is a clear understanding among program stakeholders that there is no expectation that all teams focus on, let alone achieve outcomes for, every strategy or activity. There is also

an understanding that achievement of intended outcomes can take a long time and can be influenced by other factors beyond the control of the teams themselves. Through quarterly reporting, tangible outputs (immediate outcomes) will be captured.

In contrast, the survey is being used explicitly to measure “perceived change” in constructs such as collaboration, information sharing, and cross-sector coordination. Findings will be described as respondent perceptions, noting the potential for response bias, while also highlighting the importance of stakeholder perceptions relative to these constructs, which the ORS is designed to improve over time.

We appreciate your input and will take your comment into consideration.

OMB/PRA Office
Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Department of Health and Human Services

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Overdose Response Strategy

Comment On: CDC-2026-1420-0001
Overdose Response Strategy 2026-17037

Document: CDC-2026-1420-DRAFT-0003
Comment from Odubunmi, Oluwapelumi

Submitter Information

Name: Oluwapelumi Odubunmi
Address:
Gainesville, FL, 32607
Email: odubunmipelumi@gmail.com
Phone: 7753427149

General Comment

Re: Docket CDC-2026-1420 — Overdose Response Strategy Data Collection; OMB Control No. 0920-1461

Thank you for the opportunity to comment on the proposed revision of the Overdose Response Strategy (ORS) data collection.

I hold an MPH in Epidemiology, and I am a doctoral student in Pharmaceutical Outcomes and Policy at the University of Florida, focusing on pharmacoepidemiology. My experience includes analyzing Medicaid buprenorphine claims through Project ECHO and contributing to a behavioral health workforce dashboard through BeHERE Nevada.

I submit these comments in my individual capacity. These views do not represent any organization with which I am affiliated.

I support CDC's efforts to streamline reporting. My recommendations address the collection's practical utility, clarity, and burden.

1. Distinguish referrals from completed treatment linkage.

If not already included, please consider a standardized quarterly indicator of completed linkage to medication treatment for opioid use disorder for relevant ORS-supported activities. A referral alone does not establish that someone attended an appointment or received medication.

Where partners already collect suitable information, distinguish people referred, people with confirmed

receipt of medication treatment within a defined follow-up window, and people whose outcomes remain unknown. Specify the eligible population, follow-up window, and acceptable confirmation sources. Reporting should use aggregate counts without transferring identifiable patient information to ORS teams or CDC.

Apply this indicator only to activities that facilitate treatment linkage. Allow “not applicable” or “data unavailable” rather than requiring teams to enter zero when they lack relevant activities or follow-up information.

2. Standardize definitions and reporting periods.

A brief data dictionary should clarify whether counts represent unique people or referral events, how repeat referrals are handled, and how referrals near quarter-end are followed into the next period.

Distinguish unknown outcomes from confirmed nonreceipt of treatment. Any linkage percentage should identify its denominator and report the proportion with unknown outcomes. This would help prevent differences in follow-up capacity from being mistaken for differences in program performance.

Where continuity information is already available, consider a separate follow-up measure. Initial linkage and continued treatment should remain distinct outcomes.

3. Reuse public data for context.

CDC could supplement reporting with CMS Medicaid State Drug Utilization Data and Medicaid enrollment reports to describe state-level buprenorphine utilization patterns. Preparing these indicators centrally could avoid asking each team to compile the same information.

Prescription counts do not identify unique patients or establish initiation, adherence, or continuity. Product selection should distinguish formulations used for opioid use disorder from those used for pain, while acknowledging that product information does not always establish indication. Document data lags, revisions, suppression, and denominator choices.

These indicators should provide context, not replace direct linkage measures or be interpreted as evidence that ORS caused changes in treatment use or overdose outcomes.

4. Minimize additional reporting burden.

Allow teams to reuse existing partner reports and submit aggregate counts through a common template where feasible. Assess which measures are already available and which would require new agreements, record review, or follow-up.

Pilot additional indicators before broader implementation. Evaluate completion time, missingness, consistency of interpretation, and usefulness for program decisions. Burden estimates should include partner time spent obtaining and validating information, rather than only time entering it into the template.

5. Make findings useful for local planning.

Standardized summaries could help identify where referrals do not lead to treatment and where technical assistance is needed. Where already documented, reasons could include appointment availability, transportation, insurance or cost problems, and pharmacy or treatment-provider availability.

Workforce information may help interpret these barriers, but provider counts alone do not establish available appointments or capacity to accept new patients. Reports should explain these limitations.

I recommend prioritizing clearly defined linkage measures where existing data support them, distinguishing unknown outcomes, using public utilization data for context, and piloting additions before expanding reporting requirements. These steps could improve program monitoring while limiting unnecessary burden.

Thank you for considering these comments.

Oluwapelumi Odubunmi, MPH

From: NCIPC OMB (CDC)
To: odubunmipelumi@gmail.com
Subject: Docket: 2026-1420 - Overdose Response Strategy
Date: Thursday, October 22, 2026 8:30:00 AM

Dear Oluwapelumi,

Thank you for your thoughtful comments and recommendations regarding the proposed revisions to the ORS (Overdose Response Strategy) data collection instruments. We appreciate your suggestions for strengthening the clarity, consistency, and usefulness of the information collected. The following responses address each recommendation within the context of the ORS program's scope and reporting capabilities.

1. Distinguish referrals from completed treatment linkages

We agree that distinguishing referrals from confirmed treatment linkages is important for accurately interpreting treatment-related outcomes. A referral alone does not establish that an individual initiated or engaged in treatment.

The ORS is a national public health and public safety partnership that supports cross-sector collaboration and the implementation of effective overdose prevention and response strategies by engaging with multi-sector partners. While ORS teams support efforts to improve connections to treatment and recovery services, they do not provide direct clinical or peer services, nor do they have access to individual-level treatment records necessary to verify completed linkages.

The ORS captures treatment-related work through outcomes that document support for the development, implementation, and improvement of overdose prevention, treatment, and recovery support services. While these efforts may contribute to increased referrals and connections to treatment, the ORS Team Reporting System (ORSTRS) does not require teams to report standardized patient-level treatment referral or linkage measures. Existing outcome reporting guidance and data review and analytic processes help ensure that reported accomplishments are appropriately described and interpreted within the scope of ORS activities and are not misinterpreted.

2. Standardize definitions and reporting periods

We appreciate the recommendation to establish clear definitions and consistent reporting periods to support meaningful interpretation of reported outcomes.

ORSTRS uses a standardized quarterly reporting structure to document ORS projects, activities, and outcomes. Additional guidance will clarify outcome definitions and reporting expectations.

ORS projects vary in scope, implementation, and available data. While standardized definitions and reporting periods can improve consistency, flexibility is necessary to accommodate

differences in jurisdictional activities and reporting capabilities. The ability of ORS teams to report patient-level treatment referrals, linkages, initiation, and retention depend on the measures tracked by ORS teams' partners who deliver direct services. The specific measures defined and tracked vary based on the partners' specific program reporting requirements as well as their own monitoring and evaluation priorities. For these reasons, the ORS program cannot require standardized data definitions or reporting by all ORS partners. While they may encourage partners to share aggregate outcome data whenever available, this may not be a priority and can create added unnecessary burden on partners. The ORSTRS is designed to allow for reporting flexibility if and when outcome data are available. Existing outcome reporting guidance and data review and analytic processes help ensure that reported accomplishments are appropriately described and interpreted within the scope of ORS activities and are not misinterpreted.

3. Reuse public data for context

We agree that publicly available data can provide valuable context for interpreting ORS activities and outcomes.

ORS teams routinely use existing public health and public safety data to identify emerging overdose trends, inform prevention and response strategies, and support jurisdictional planning. These sources can also help contextualize reported outcomes and broader community needs.

However, public data sources may vary in timeliness, completeness, and geographic coverage and may not directly measure the contributions of individual ORS projects. Their use should therefore complement, rather than replace, program-specific reporting.

4. Minimize additional reporting burden

We appreciate the emphasis on balancing meaningful data collection with reporting feasibility. The revised ORS data collection instruments are designed to capture a range of activities and outcomes while accommodating differences in jurisdictional priorities, partnerships, and available data.

ORS teams collaborate with state and local partners that maintain their own data systems and reporting processes. The ORS prioritizes capturing outcomes that teams can document through existing activities and available information. Reporting guidance will continue to be refined to improve clarity and consistency without introducing unnecessary burden.

5. Make findings useful for local planning

We agree that evaluation findings should provide actionable information to support local planning, decision-making, and program improvement.

ORS reporting helps document the activities and outcomes of jurisdictional partnerships and identify effective approaches, implementation challenges, and opportunities to strengthen

overdose prevention and response efforts. These findings can inform local planning and help teams and their partners refine strategies based on emerging needs.
At the national level, findings can also inform technical assistance priorities, identify broader trends, and support program evaluation.

Conclusion

We appreciate these recommendations and remain committed to improving the quality, consistency, and usefulness of ORS reporting. The revised instruments and accompanying guidance aim to capture meaningful program outcomes while maintaining the flexibility necessary to reflect the ORS partnership model and varying jurisdictional reporting capabilities.

OMB/PRA Office
Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Department of Health and Human Services

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Docket: CDC-2026-1420
Overdose Response Strategy

Comment On: CDC-2026-1420-0001
Overdose Response Strategy 2026-17037

Document: CDC-2026-1420-0004
Comment from Anonymous

Submitter Information

Name: Anonymous Anonymous

General Comment

CDC Docket No. CDC-2026-1420: Overdose Prevention Data Collection and Evaluation

To Whom It May Concern:
I am writing to encourage the CDC to include recovery, harm reduction, access to treatment, and lived experience when evaluating overdose prevention programs. I believe we need to measure more than the number of overdoses and deaths to understand whether these programs are actually helping people. Addiction affects the brain, behavior, mental health, and everyday life. People struggling with addiction need access to treatment and support, not judgment alone. The CDC recognizes the importance of using different prevention strategies to address overdoses (Centers for Disease Control and Prevention [CDC], 2026a). I believe our approach to measuring success should reflect that.
First, I encourage the CDC to measure recovery-centered outcomes, including access to treatment, continued participation in recovery services, mental health support, and connections to care after an overdose or release from incarceration. Housing and employment can also affect a person's ability to maintain recovery. These measures could help identify what people need to rebuild their lives.
Second, I encourage the CDC to evaluate evidence-based harm reduction strategies, including naloxone distribution, overdose education, and access to medications for opioid use disorder. These services can help prevent deaths and connect people with care (CDC, 2026a). Evaluation should examine whether these resources reach the people who need them and identify barriers to access.
Third, public health professionals and public safety agencies should work together without discouraging people from seeking help. Fear of judgment or legal consequences may prevent someone from calling for emergency assistance. Evaluation tools should examine whether people can safely seek help and whether they receive connections to treatment afterward. Saving lives should come first, and people should have opportunities to seek recovery.
Fourth, I encourage the CDC to include people with lived experience in program evaluations. People who have experienced addiction, incarceration, treatment, and recovery can identify barriers that statistics alone may not reveal. Their feedback can help communities understand what works, what does not, and what needs to change.

Finally, I encourage the CDC to examine what happens after an overdose. Data on fatal and nonfatal overdoses are important for understanding trends and improving prevention (CDC, 2026b, 2026c). However, measuring whether people are connected to treatment and support afterward could provide a fuller picture of program effectiveness.

I understand that this notice focuses on data collection and evaluation tools, not directly changing treatment or law enforcement policies. However, the information collected can help identify gaps and guide improvements. We should measure whether programs are saving lives, connecting people to care, and supporting recovery.

People struggling with addiction are more than statistics. They deserve the opportunity to recover, rebuild their lives, and contribute to their communities. I believe overdose prevention should be guided by evidence, compassion, accountability, and the understanding that recovery is possible.

Thank you for considering my comments.

References

Centers for Disease Control and Prevention. (2026a). Overdose Data to Action: Prevention strategies. https://www.cdc.gov/overdose-prevention/php/od2a/prevention.html

Centers for Disease Control and Prevention. (2026b). SUDORS dashboard: Fatal drug overdose data. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html

Centers for Disease Control and Prevention. (2026c). DOSE-DIS dashboard: Nonfatal overdose data. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/dose-dashboard-nonfatal-discharge-data.html