



Creating an Optimal  
Environment for Quality  
Healthcare for Individuals,  
Families, and Communities

# Care for Complex Patients – Clinical Approaches to Quality Improvement at the Intersection of Substance Use Disorder, Mental Illness, and Chronic Pain

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**CMS 2024**  
**Quality**  
**Conference**  
*Resilient and Ready Together*

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## Disclosures

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Opinions are my own and not those of my employers

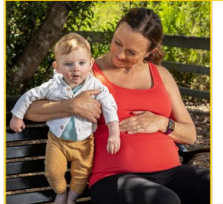


COMMUNITIES

FAMILIES



INDIVIDUALS



RESILIENT



READY



# My purpose

- I will introduce a case example to teach a decisional framework for long-term pain care when the patient's condition and history are challenging
  - There are many dimensions to the decision
  - The case introduces overlap between pain care and opioid use disorder care
  - The OUD implication should help prepare for the next few speakers
- But my **unique** objective is to illustrate
  - Some current policies that appear to be “about opioids” often wind up at odds with good, individualized care
  - Good care has to be “about this patient, the one in front of me”

## Jimmy comes to Medical Walk-In, a resident clinic

- A 59 year old “Jimmy”: requests oxycodone for back & shoulder pain
- Recently lost home in East Alabama, moved to live with brother
- 3 emergency department and 1 primary care visit in last 18 days
- Some information from the chart
  - PTSD, opioid use disorder in the past,
  - Long term pain, diabetes
  - MRI: severe stenoses at multiple lumbar and cervical levels
  - Neurosurgery consult was requested
- Teaching doctor says “we ordinarily don’t start opioids on a walk-in patient”
- In fact, this medical center reduced opioids by 75% in last 8 years

## More information from Jimmy's visit and chart

- 18 days ago, in the ED: hydrocodone (#12) + ketorolac injection + methocarbamol and an antibiotics
- 10 days ago, in the ED: oxycodone (#12) + ketorolac injection
- 4 days ago, in the primary care department: diclofenac gel, lidocaine patch, acetaminophen
- The team also managed diabetes, initiated workup for weight loss of 95 pounds
- 3 days ago in the ED: out of oxycodone. The doctor spoke to neurosurgery. Ordered: 3 days of cyclobenzaprine, a steroid “dose pack”, and an interventional anesthesia consult
- Within 24 hours, the consult was canceled by the anesthesiologist
- Jimmy sits in wheelchair, cachectic (115lbs), flinching in pain. He alludes to suicide tangentially but denies intent
- Jimmy expresses distrust and hostility

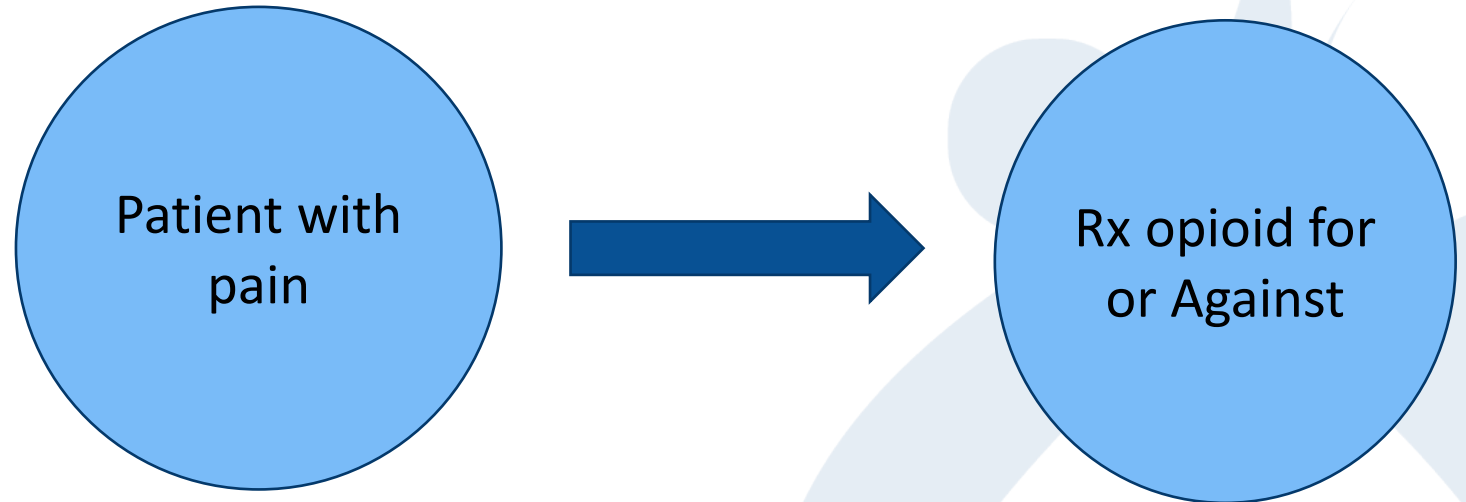
# Jimmy's story in the chart

- Other info

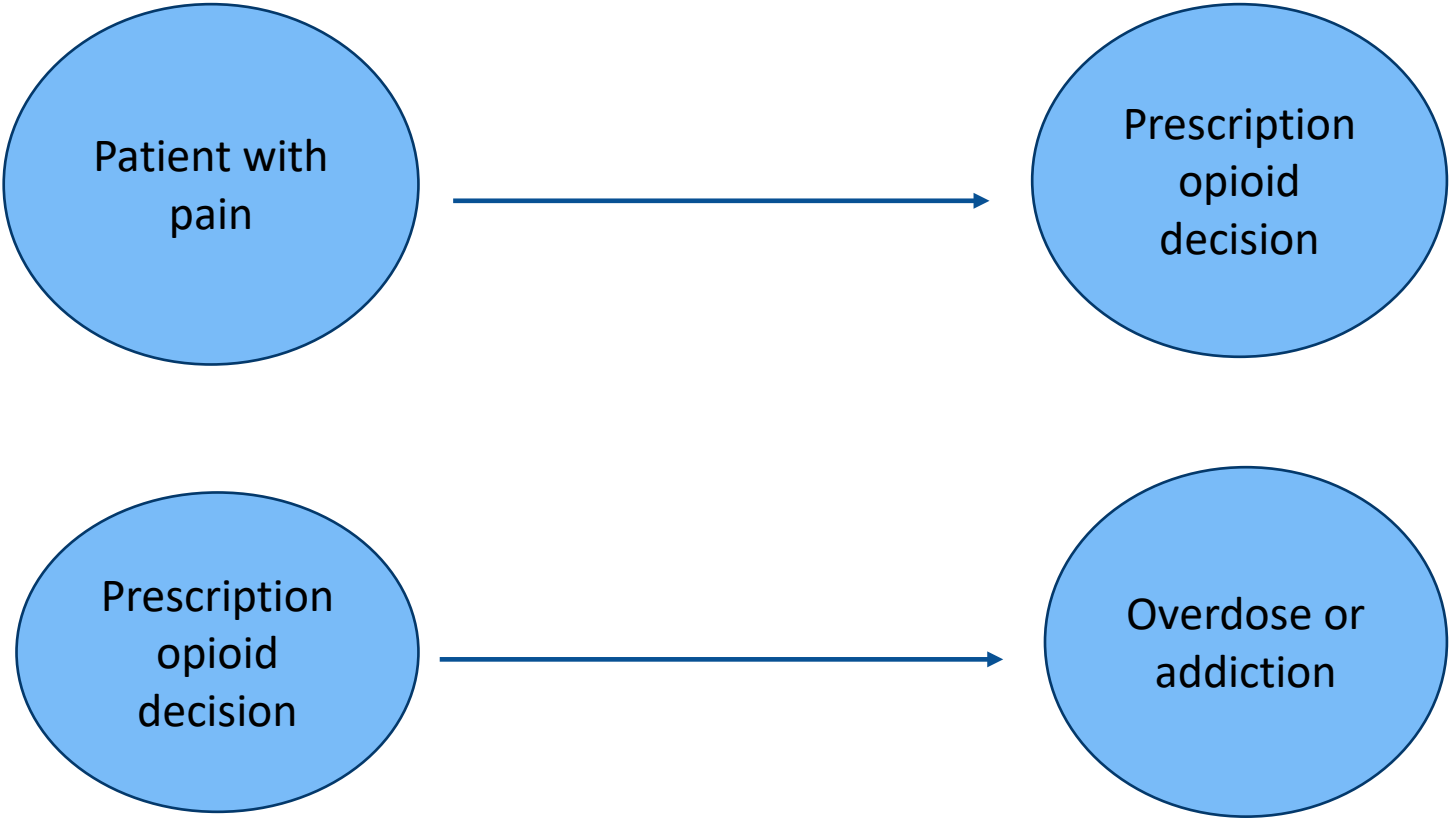
- PTSD and “Opioid Use Disorder” are mentioned in chart
- Jimmy says “yes, as a younger man, I used heroin and cocaine”
- In 12 years of health records, only marijuana mentioned
- Chronic neck/back pain started in 2006
- 2 years of opioids, stopped in 2016 when he tested positive for marijuana
- Appears to have continued in diabetes care thereafter
- Weight fell from 200 lbs in 2018, to 112 lbs in late 2023



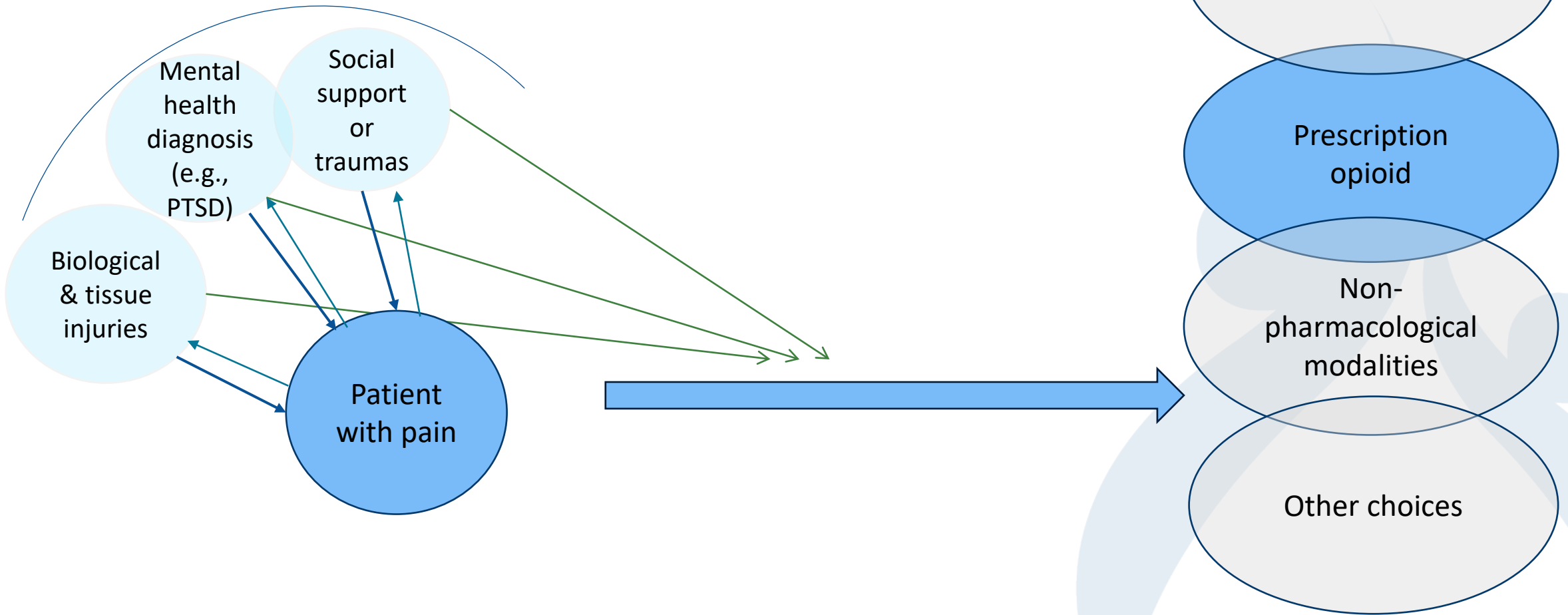
# Here's a Simple Line I Find Unhelpful



# Two Simple lines I find unhelpful

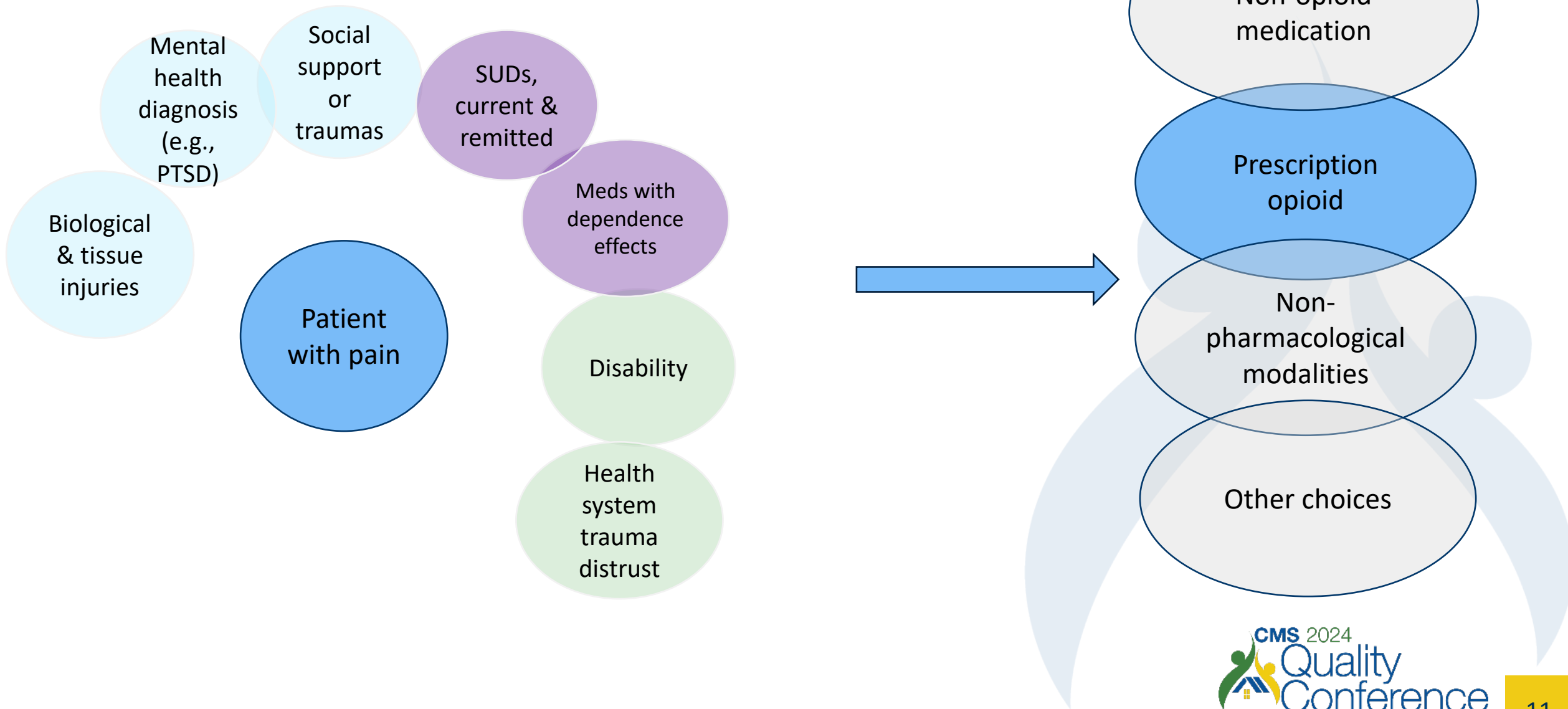


# A Series of Steps to Evaluate Pain Care Decisions

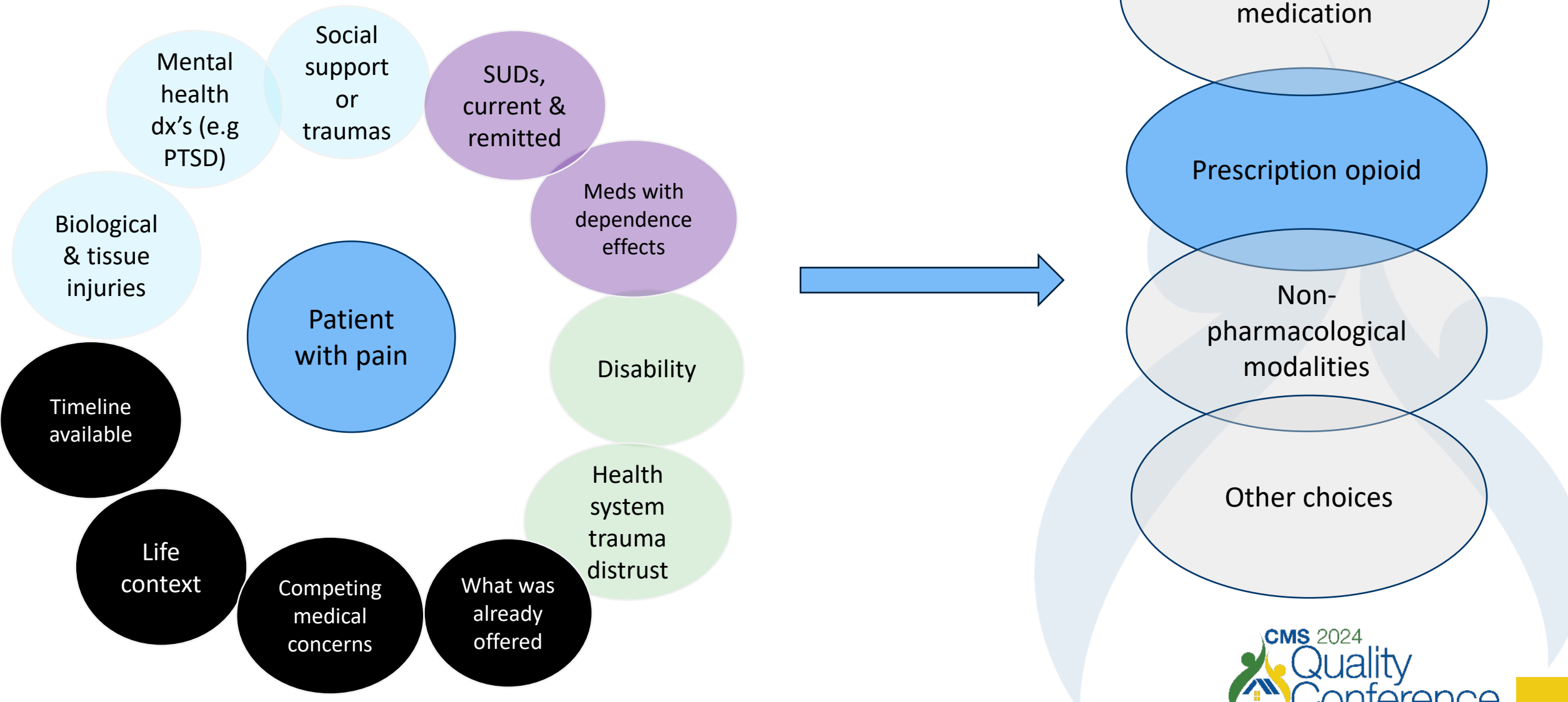


Going forward additional arrows won't be shown

# A Series of Steps to Evaluate Pain Care Decisions 2

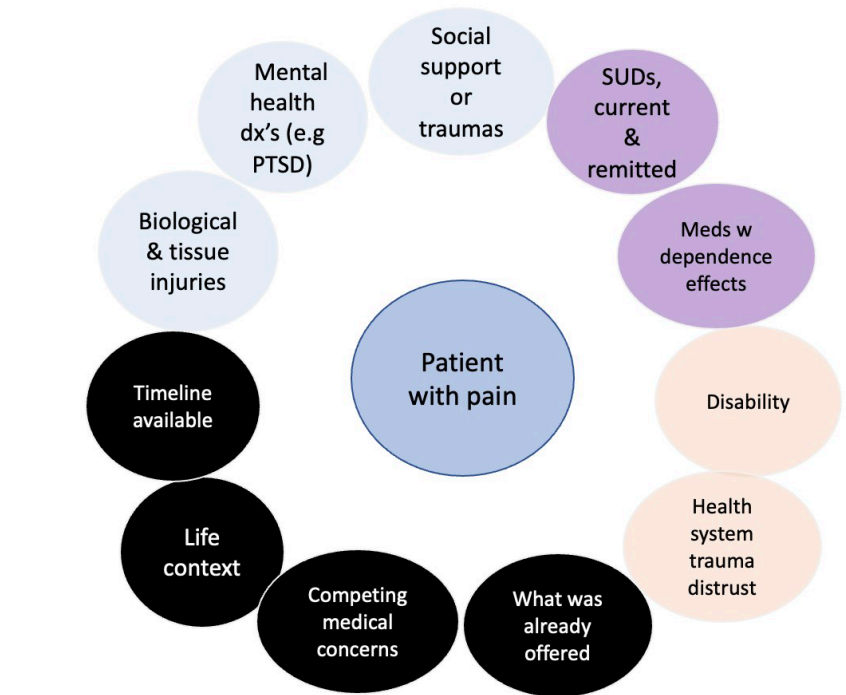
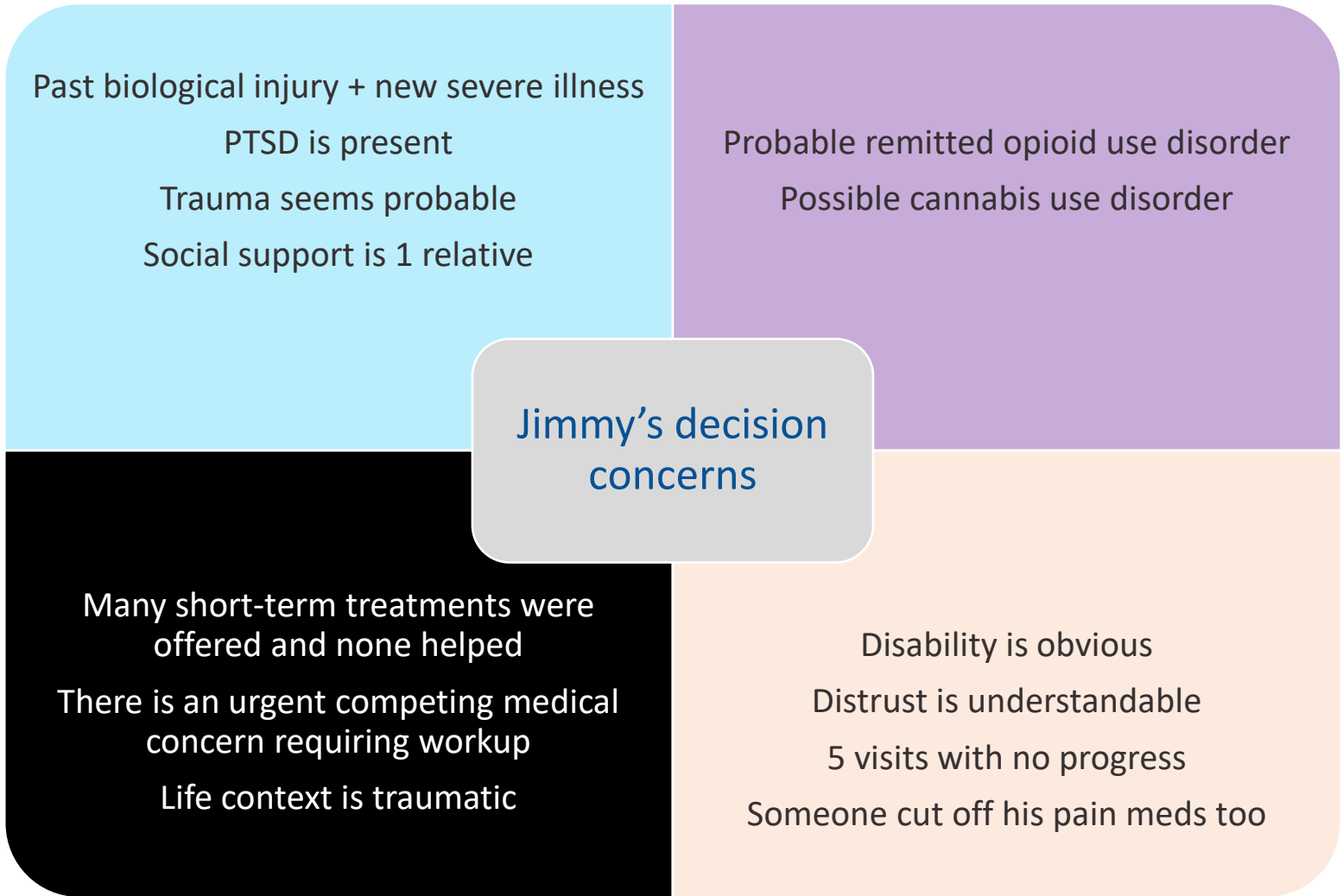


# A Series of Steps to Evaluate Pain Care Decisions 3



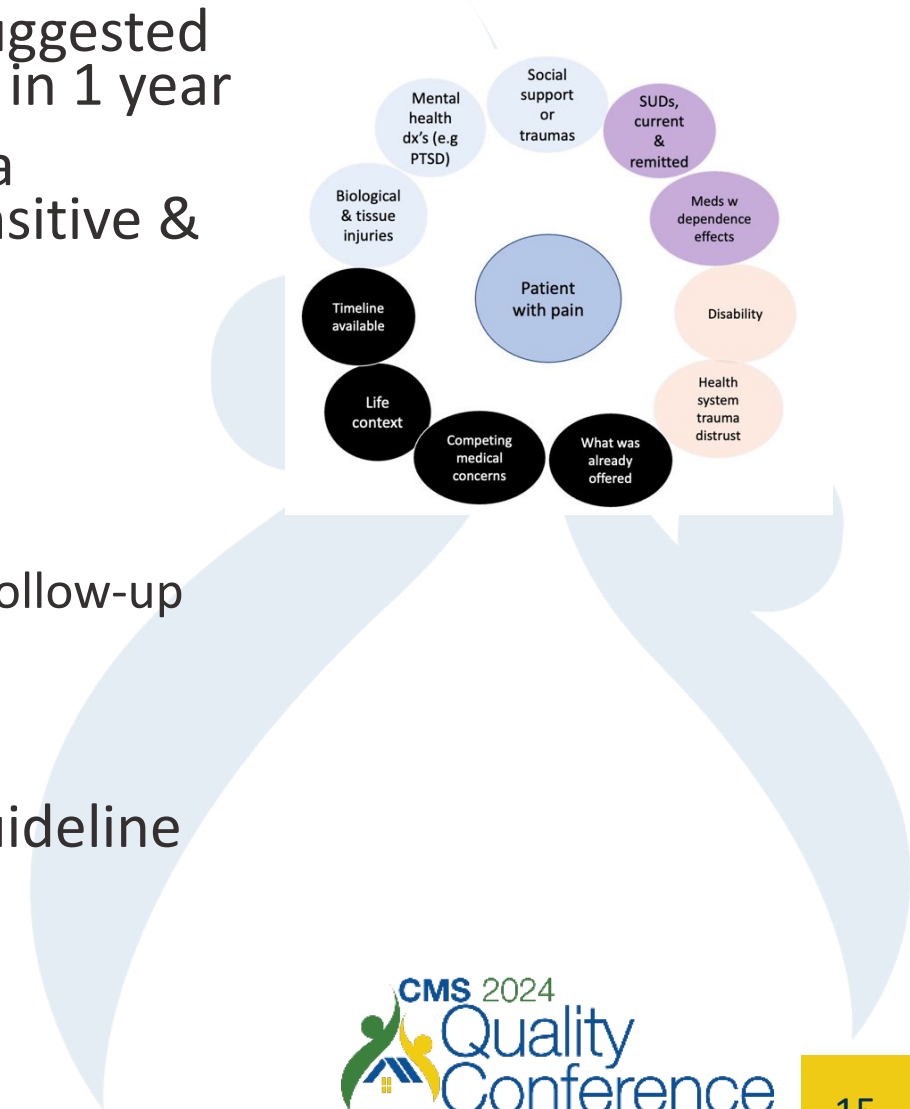
## Definitions for two domains

- **Patient Context:** *Everything* that is expressed outside of a patient's skin that is *relevant* to planning their care. This does overlap with content of the other considerations. However, it may include living environment, or financial situation, or cultural beliefs
- **What was already offered:** This refers to treatments already attempted, and whether they worked well, poorly, or not at all



# Jimmy follow-up

- The Veterans Affairs opioid risk stratification tool actually suggested lower risk than we projected: 3% risk of OD/suicide “event” in 1 year
- I kneel in front of his wheelchair & look up. I affirm he is in a devastating situation. I say any decision about opioids is sensitive & poses risks for him and is “sensitive” legally.
- **I present 4 options:**
  - (a) Hospitalize today for weight loss and pain
  - (b) Start duloxetine for pain and possible depression
  - (c) Diclofenac gel
  - (d) Low-dose off-label buprenorphine (2 mg three times a day) with follow-up
- Jimmy takes (b) and (d)
- We did informed consent
- Our decision may still look bad to my employer’s internal guideline or to payors





# Three commonly measured aspects of opioid care that may be right for Jimmy and look wrong in current policy standards

	Quality Measure or Policy	Source	What it Might Mean for Jimmy
Opioid duration	Risk of continued opioid use (>15 days in 30 day period)	National Committee for Quality Assurance	Jimmy's care may require a prescription that will be refused or held against the prescriber
Opioid dose	Initial Opioid Prescribing at High Dosage	Pharmacy Quality Alliance and CMS	Jimmy may require over 50 morphine milligram equivalents. Probably not, but the situation and history set up for that
Choice of buprenorphine	Buprenorphine should be allowed for pain only after failure of traditional opioids	Common among many health plans	He may be refused buprenorphine formulations by the payor



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# A Public Health Approach to the Overdose Epidemic

Chinazo Cunningham, MD, MS

Commissioner, Office of Addiction Services and Supports (OASAS)



# Public Health in New York State

## Physical Health



### Department of Health

Hospitals  
Emergency rooms  
FQHCs/Clinics  
Long term care facilities  
Medicaid

## Behavioral Health



### Office of Addiction Services and Supports

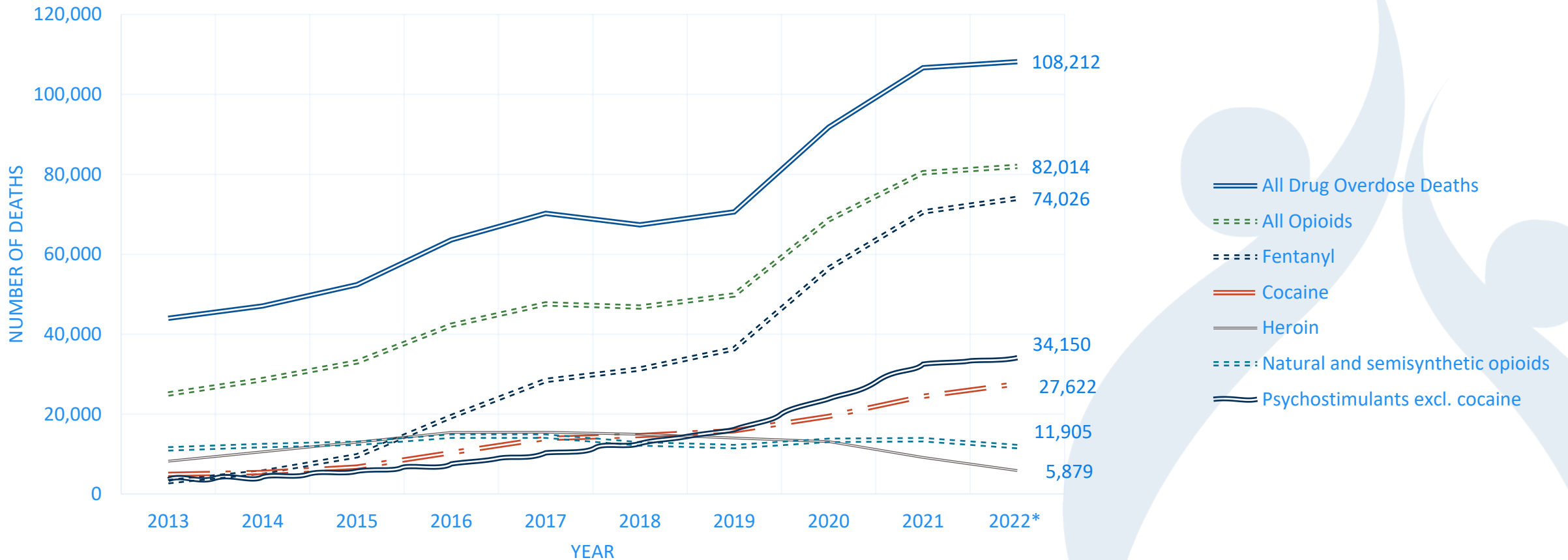
>750 staff  
>\$1 billion annual budget  
>1700 addiction programs  
>730,000 individuals

Certify, regulate, support all  
addiction services in NYS

# Epidemiology of Overdose Deaths



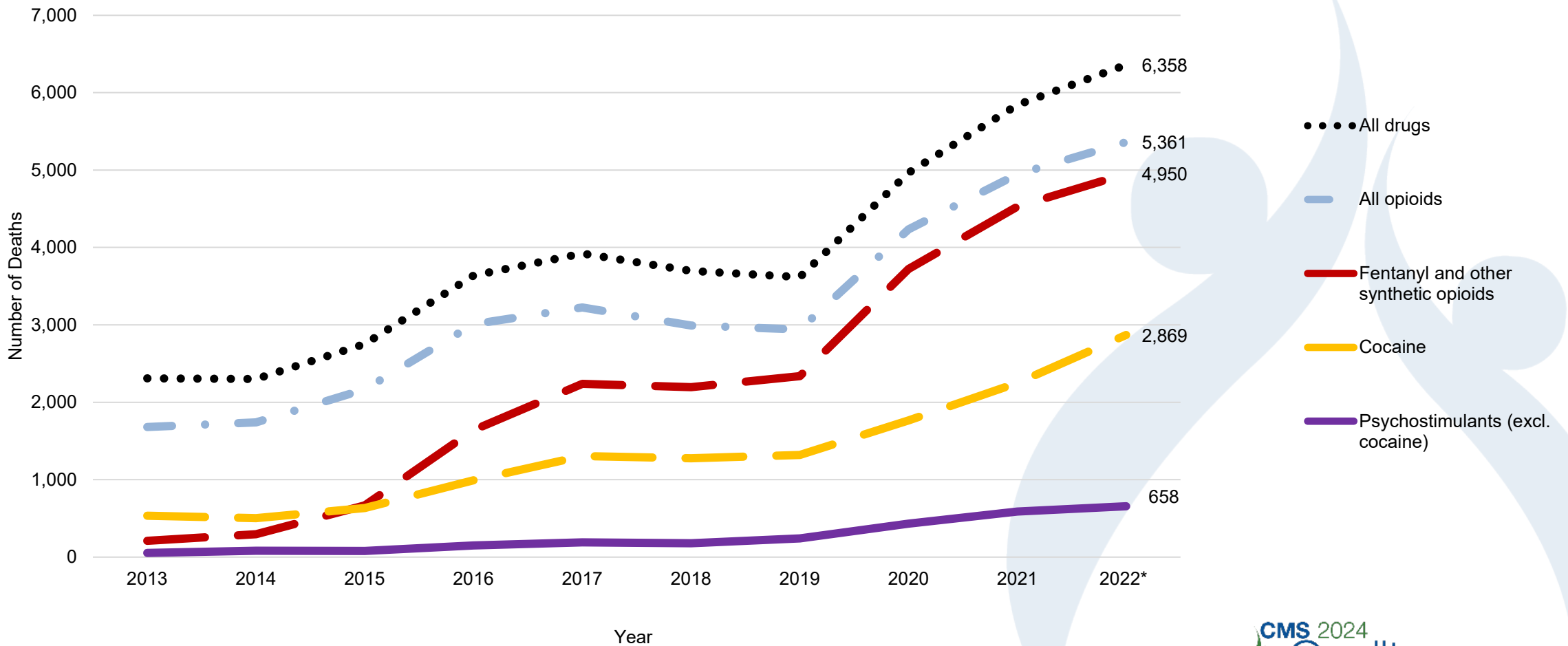
# Overdose Deaths in the U.S. (2013 – 2022)



\*Notes: Not mutually exclusive (more than one substance can be present at death); 2022 data are provisional  
 Source: Mortality Data on CDC WONDER Online Database

# Overdose Deaths in NYS Continue to Increase

Drug overdose deaths by substance:<sup>1</sup> New York, 1999 – 2022\*



Source: Mortality Data on CDC WONDER Online Database  
 Drug categories are not mutually exclusive: more than one substance can be present at death; (\*) 2022 data are provisional

# The Intersection of Substance Use and Mental Health

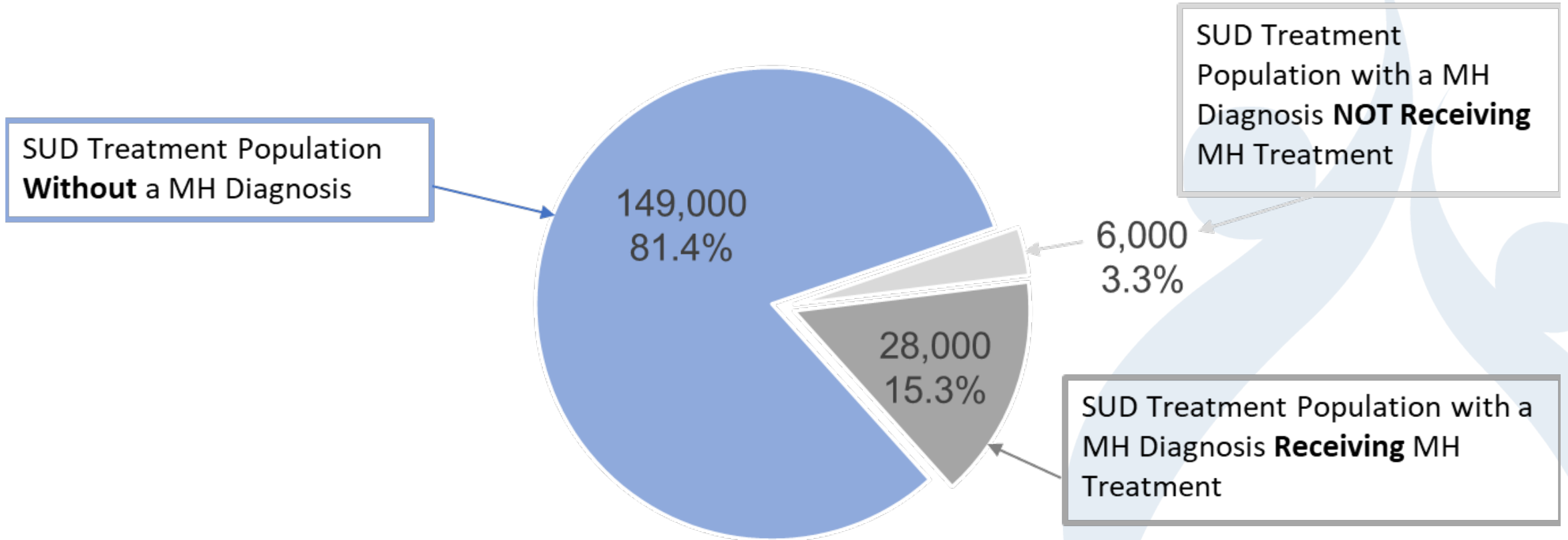
# Mental Health and Substance Use Disorders among New Yorkers with Medicaid (2022)

(N = 180,398)

Characteristics	SUD Population	
<b>ANY Co-Occurring Mental Health Disorder</b>	<b>122,497</b>	<b>68%</b>
Anxiety	63,260	52%
Major Depressive Disorder	40,824	33%
Bipolar	23,391	19%
Adjustment	21,998	18%
Psychotic Disorder	19,054	16%
Impulse control and behavioral disorder	18,583	15%



# SUD Non-Crisis Treatment Population with MH Diagnosis Receiving MH Treatment (2020)



# Integrating Treatment Services



# Initiatives to Address Mental Health and Substance Use Disorders

- Certified Community Behavioral Health Clinics
  - Tripling state clinics from 13 to 39
- Funding for 22 Crisis Stabilization Centers
- Integrated Outpatient Model
- Cross-agency training and funding opportunities across NYS health agencies
- Collaborative Prevention
- Workforce Investments & Initiatives



# Integrated Prevention Services

Working with NYS Office of Mental Health to integrate substance use disorder, mental health & suicide prevention across systems.

- In-Schools Programming: Substance use disorder prevention in Office of Mental Health school-based services
- Community-Based Coalitions: Substance use disorder & suicide prevention on community-wide level



# State-Run Addiction Treatment Centers

## Mental Health Assessment and Treatment

- All patients admitted to all 12 addiction treatment centers are screened for suicide risk and mental health disorders.
- Patients with mental health symptoms or disorders receive a complete psychiatric evaluation within 72 hours.
- One addiction treatment center focused on people with severe mental illness—with expansion into a second center.



# Opioid Settlement Funds

- ✓ ALL funds (\$192.8M) made available in 2023
- ✓ 2023 Opioid Settlement Fund Advisory Board Annual Report

## Online spending tracker

- By priority area
- By initiative
- By county
- By fiscal year (2023 & 2024)

**OPIOID SETTLEMENT FUNDS MADE AVAILABLE**  
By Date and Initiative  
(dollar amounts are expressed in thousands)

Date of Procurement	Initiatives	Amount	Number of Awards
1/20/23	Comprehensive Case Treatment & Recovery Services	\$10,828	13
		\$5,918	12
		\$2,000	1
		\$3,599	12
		\$64,006	81
		\$6,500	1
		\$1,300	1
		\$4,000	1
		\$4,000	Under review
		\$2,255	2
		\$9,331	12
		\$8,382	Under review

**OPIOID SETTLEMENT FUNDS MADE AVAILABLE**  
By Priority Area  
(dollar amounts are expressed in thousands)

Priority Area*	FY23 Allocations**	Funds Made Available via Procurement
Regional Allocation	\$14,000	\$14,000
Harm Reduction	\$26,858	\$26,858
Treatment	\$14,426	\$14,300
Investments Across the Continuum	\$16,331	\$16,331
Priority Populations	\$7,889	\$7,214
HOUSING		
Recovery		
Prevention		
Transportation		
Public awareness		
Research		
NY MATTERS		
Total		

Priority Areas for FY2025	Allocations	Prior rank	Prior allocation
1. Investments Across the Continuum	28%	3	16%
2. Harm Reduction	17%	1	22%
3. Recovery	11%	6	10%
4. Housing	10%	5	10%
5. Treatment	9%	2	12%
6. Priority Populations	8%	4	15%
7. Prevention	8%	7	7%
8. Transportation	6%	8	5%
9. Research	2%	10	1%
10. Public Awareness	1%	9	2%

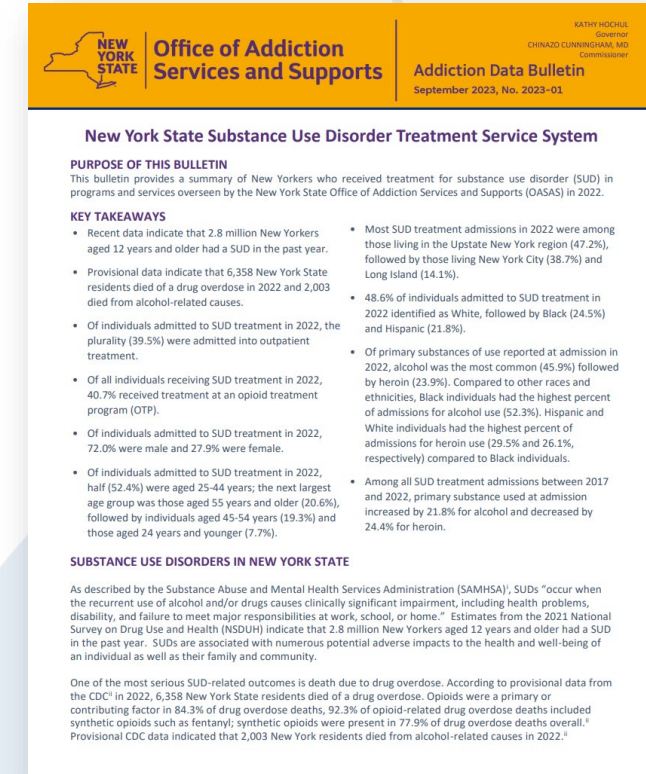
\*The priority areas listed were identified in the  
\*\*The FY23 Budget deficit liabilities reported for FY 23 supported by the fund totaled \$162.2

# Guiding Principles

- Data-driven, evidence-based approach
- Harm Reduction
- Equity

# Meaningful Data

- Make better use of data
- Make data more available and accessible
- Initiatives:
  - Addiction Data Bulletins
  - Dashboards
  - NIH-funded research





# Incorporating Harm Reduction Across New York State

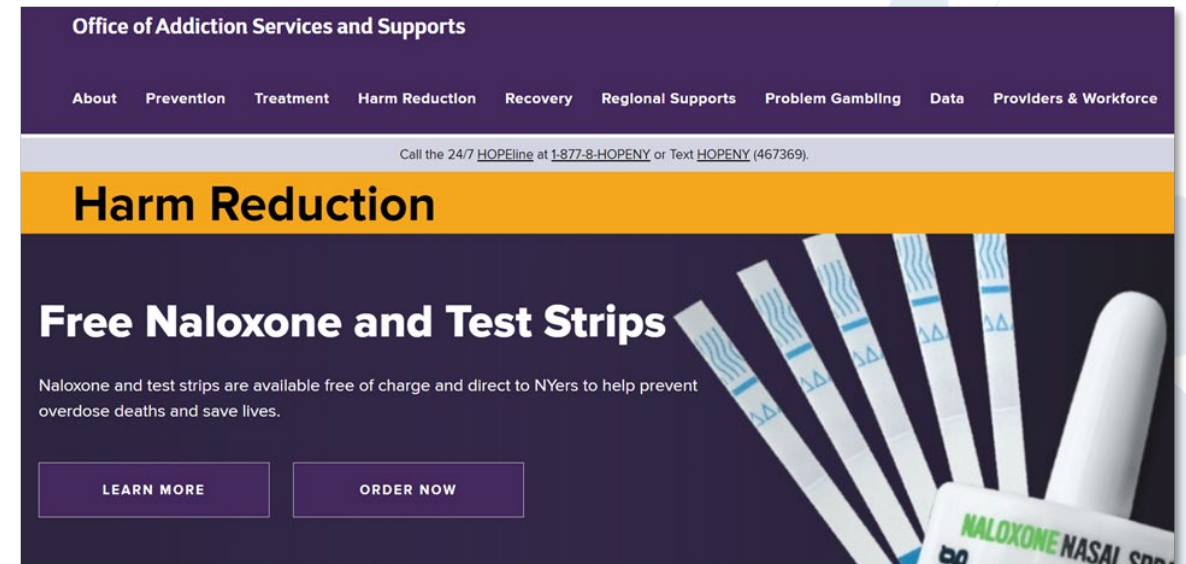
## The OASAS Division of Harm Reduction

### *Overdose Prevention*

- ✓ Naloxone
- ✓ Fentanyl & xylazine test strips
- ✓ Drug checking machines
- ✓ Drug deactivation bags
- ✓ Medication lock bags

### *Outreach & Engagement*

- ✓ Clinic- and street-level outreach
- ✓ Homeless shelter initiative
- ✓ Care coordination
- ✓ Transportation



Office of Addiction Services and Supports

About Prevention Treatment Harm Reduction Recovery Regional Supports Problem Gambling Data Providers & Workforce

Call the 24/7 [HOPEline](#) at 1-877-8-HOPENY or Text [HOPENY](#) (467369).

## Harm Reduction

### Free Naloxone and Test Strips

Naloxone and test strips are available free of charge and direct to NYers to help prevent overdose deaths and save lives.

[LEARN MORE](#) [ORDER NOW](#)

# Incorporating an Equity Lens Across New York State

## Office of Justice, Equity, Diversity & Inclusion (JEDI)

### *Internal activities*

- ✓ JEDI Advisory Council
- ✓ Organizational equity assessment
- ✓ Addressing appropriate language
- ✓ Equity procurement criteria

### *External activities*

- ✓ State-wide interagency workgroup
- ✓ Lived Experience Advisory Panel (LEAP)
- ✓ Trainings, tools, and guidance for staff providers
- ✓ Equity Leadership Institute
- ✓ Language Access



# OASAS. Every Step of the Way.



Office of Addiction  
Services and Supports



**@NYSOASAS**



**nys\_oasas**



**NewYorkStateOASAS**



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# SAMHSA: Integrated Behavioral Healthcare

Karran Phillips, MD, MSc

Deputy Director, Center for Substance Abuse Treatment, SAMHSA



# Treatment among People with Co-Occurring Substance Use Disorder and Mental Illness (NSDUH, 2022)

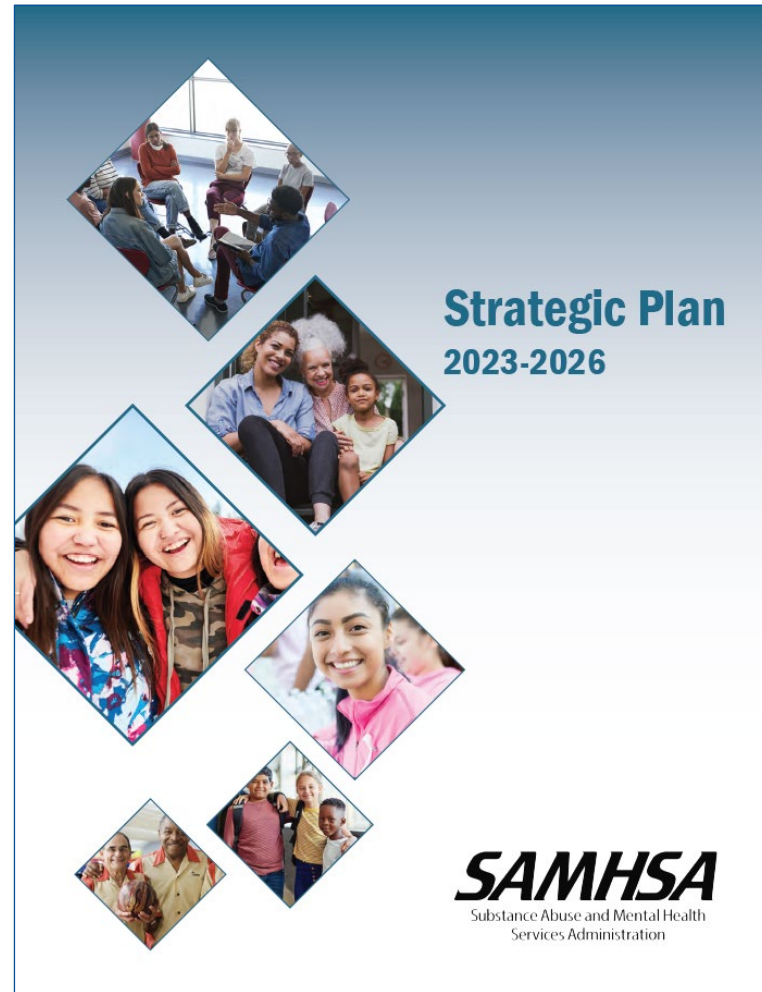
Among the 21.5 million adults aged 18 or older with co-occurring AMI and an SUD in the past year

- 59.1% (or 12.7 million people) received either substance use treatment or mental health treatment in the past year
- Most of those received only mental health treatment (64.1%)

Among the 7.4 million adults aged 18 or older with co-occurring SMI and an SUD in the past year

- 71.2% (or 5.3 million people) received either substance use treatment or mental health treatment in the past year
- Most of those received only mental health treatment (63.1%)

# SAMHSA Priorities



<https://bit.ly/410IMbe>

# Integrating Behavioral and Physical Health Care: SAMHSA Goals

Integration of behavioral and physical health care by using systematic, evidence-based, cost-effective approaches to improve person-centered comprehensive care in all settings with the aim of the creation of health and well-being – not just the absence of disease.

1. To promote whole-person care and improve health outcomes, SAMHSA will advance bi-directional integration of health care services across systems for people with behavioral health conditions.

2. To promote whole-person care and improve health outcomes, SAMHSA will advance policies and programs to address social determinants of health.

# Integrating Behavioral and Physical Health Care: SAMHSA Efforts

Grant Programs	Training/Technical Assistance
<u><a href="#">Screening, Brief Intervention, and Referral to Treatment (SBIRT)   SAMHSA</a></u>	<u><a href="#">National Center of Excellence for Integrated Health Solutions   SAMHSA</a></u>
<u><a href="#">Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS   SAMHSA</a></u>	<u><a href="#">Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness   SAMHSA Publications and Digital Products</a></u>
<u><a href="#">Adult Reentry Program   SAMHSA</a></u>	<u><a href="#">SAMHSA Harm Reduction Framework   SAMHSA</a></u>
<u><a href="#">Certified Community Behavioral Health Clinics (CCBHCs)   SAMHSA</a></u>	<u><a href="#">Your Guide to Integrating HCV Services into Opioid Treatment Programs   Addiction Technology Transfer Center (ATTC) Network (attcnetwork.org)</a></u>

Additional programs: Grants for the Benefit of Homeless Individuals Treatment for Individuals Experiencing Homelessness, Projects for Assistance in Transitioning from Homelessness, Adult Treatment Drug Court, Assertive Community Treatment Grants, Substance Use Prevention Treatment Recovery Services Block Grants



# Minority AIDS Initiative

## \$21.9 million for the Minority AIDS Initiative: Substances Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS.

This program increases engagement in care for racial and ethnic medically underserved individuals with **substance use disorders (SUDs)** and/or **co-occurring SUDs and mental health conditions (COD)** who are at risk for or living with **HIV**. Award recipients will take a syndemic approach to SUD, HIV and **viral hepatitis**. HCV testing and referral to treatment is a required activity.

## \$1.9 million for the Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project.

This pilot program provides **comprehensive healthcare** for racial and ethnic medically underserved people experiencing unsheltered **homelessness** through the delivery of portable clinical care delivered outside that is focused on the integration of **behavioral health** and **HIV** treatment and prevention services. **HCV** testing and referral to treatment is a required activity.

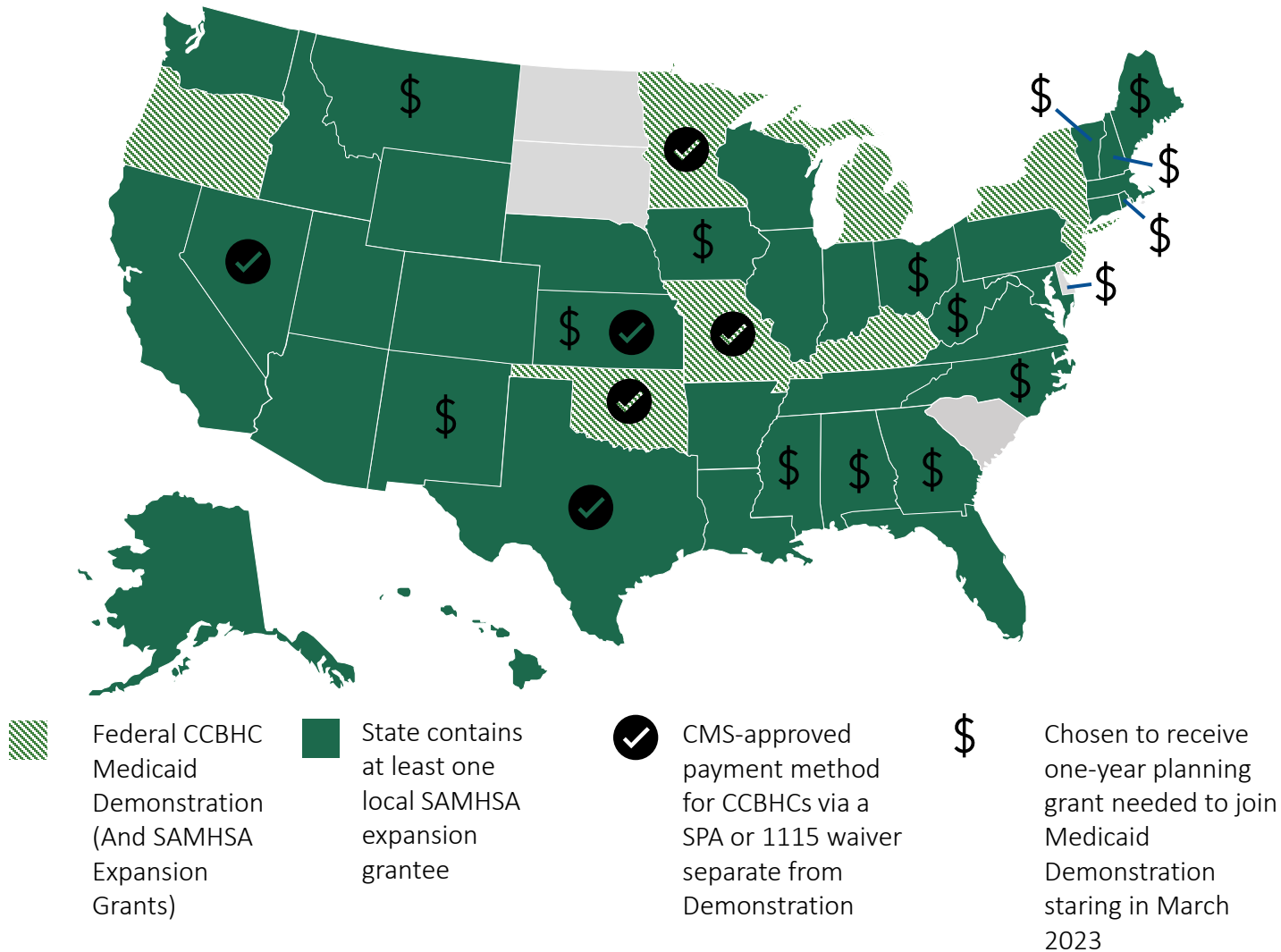
# Certified Community Behavioral Health Clinics



- Bring a comprehensive range of services together, incorporating evidence-based practices and other supports based on a community needs assessment
- Provide for improved access to mental health and substance use disorder (MH/SUD) services, including increased capacity to respond to MH+SUD crises
- Serve individuals across the lifespan with mental health and/or substance use disorders
- Meet CCBHC Certification Criteria



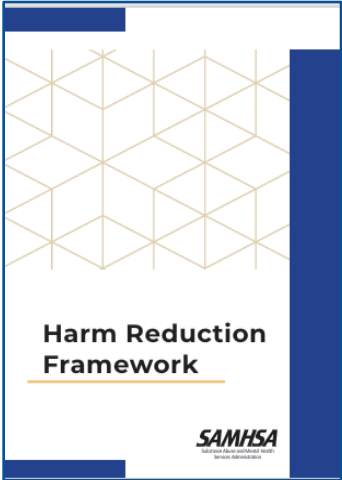
# Map of CCBHCs Across the United States (as of March 2023)



- There are now more than 500 CCBHCs across 46 States, the District of Columbia, and Puerto Rico
- CCBHCs may be a part of the Section 223 Medicaid Demonstration, Independent State programs, or participating in SAMHSA’s expansion grants.
- 15 states have been selected to participate in planning grants to prepare to join the Section 223 Medicaid Demonstration:
- Alabama, Delaware, Georgia, Iowa, Kansas, Maine, Mississippi, Montana, North Carolina, New Hampshire, New Mexico, Ohio, Rhode Island, Vermont, West Virginia.
- After year-long planning grant period, states will apply to be one of 10 states to be able to join the Medicaid Demonstration starting July 1, 2024

# SAMHSA's Harm Reduction Framework

SAMHSA's aim is to integrate harm reduction activities and approaches across its organizational Centers and initiatives, and to do so in a manner that draws on evidence-based practice and principles — while also maintaining sustained dialogue with harm reductionists and people who use drugs (PWUD).



Is led by PWUD and with lived experience of drug use

Embraces the inherent value of people

Commits to deep community engagement and community building

Promotes equity, rights, and reparative social justice

Offers most accessible and noncoercive support

Focuses on any positive change, as defined by the person

Harm reduction strategies reduce HIV and hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment.<sup>1, 2, 3</sup>



# Thank you

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatment and supports to foster recovery while ensuring equitable access and better outcomes.



[FindSupport.gov](https://www.findsupport.gov)

[FindTreatment.gov](https://www.findtreatment.gov)

[988Lifeline.org](https://www.988lifeline.org)

[www.SAMHSA.gov](https://www.samhsa.gov)

1-877-SAMHSA7 (1-877-726-4727)

1-800-487-4889 (TDD)



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# Commentary, Discussion, and Questions

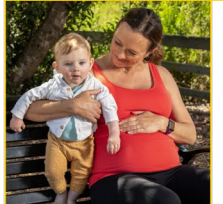


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