



PATHWAYS TO CARE PROVIDER PRACTICE CHECKLIST

SCREENING/IDENTIFICATION/ REFERRAL

- Primary care and *mental health* providers conduct universal screens for substance use disorders (SUDs) including all substances of misuse.
- Primary care and *substance use* providers conduct universal screens for mental health disorders, including depression and suicidality.
- Develop 'hub-n-spoke' models between Opioid Treatment Programs and primary care providers to increase buprenorphine providers and their caseloads.
- Conduct community outreach and establish memoranda of understanding with local institutions and other behavioral health providers to encourage identification of individuals with SUDs and facilitate rapid admissions for assessment, medication initiation/continuation, and other psychosocial interventions.
- Follow national standards for level of care determinations and referral (e.g., American Society of Addiction Medicine Criteria); align staffing requirements accordingly.
- Collect data along the cascade of care to track (at the system and individual level, across levels of care), the identification of individuals with SUD, use of addiction medication, retention in treatment, use of recovery support, and long-term recovery.
- Routinely coordinate with internal and external systems of care.

TREATMENT

- Provide on-demand assessment and admission capacity within 24-48 hours of request.
- Offer all U.S. Food and Drug Administration-approved addiction medications for all populations with alcohol use disorder and opioid use disorder, either directly or through referral.
- Provide medications in sufficient dose and for adequate duration.
- Offer counseling and recovery support services to individuals on medications.
- Actively manage peer/milieu conditions that discourage use of addiction medications; provide education to individuals, families, peers, other health professionals, and the community.
- Reduce stigma through use of appropriate language related to individuals with SUD.
- Treat each substance of misuse with drug-specific evidence-based treatment practices.
- Establish one-year treatment plans that include multiple levels of care.
- Expand outpatient and residential facilities offering MAT for all populations, including youth, pregnant women with children, and justice-involved individuals.
- Increase hospital emergency department use of addiction medications, peer recovery supports, and other innovations to stabilize and engage patients in treatment and support post-discharge long-term recovery.
- Pair inpatient/residential detoxification services with addiction medication, counseling, and recovery services to promote post-discharge stabilization.

PRE-DISCHARGE, DISCHARGE, AND FOLLOW-UP MONITORING

- Provide an adequate supply of naloxone and training on its use to patients, family and friends.
- Link patients to mutual support groups, peer recovery specialists, and other recovery support services to enable successful care transitions, adherence to treatment, and rapid treatment re-engagement when symptoms recur.
- Provide follow-up monitoring for all patients at quarterly intervals and for those who do not show up for appointments, do not continue to fill medications, or otherwise manifest risk factors of symptom recurrence.
- Collaborate with patients, peer specialists, insurance companies, and others to collect post-discharge cascade of care data related to patient transitions across the care and recovery continuum.

PARITY AND FINANCING

- Monitor denials of insurance coverage, particularly related to non-quantifiable treatment limitations and collaborate with insurers to obtain documentation of decision-making strategies and denial decisions.
- Raise parity non-compliance concerns with NABH, state insurance commissioners, and relevant federal agencies.
- Increase use of Psychiatric Collaborative Care Services billing codes for SUD treatment.
- Organize operations for new financing opportunities, such as “report cards,” dashboards, and other publicly reported quality standards that may drive enhanced insurance reimbursements.
 - Collect and report data on cascade of care across systems and levels of care.
 - Report on variety of clinical and functional outcome measures (e.g., symptom reduction, employment, family reunification, emergency room admissions, overdoses, deaths) during treatment and for one-year post-discharge.
- Offer assessment and placement services to insurance companies that may be implementing “opioid reduction programs” for individuals using high doses of opioids.
- Advocate with insurance companies for direct payment of out-of-network services, with consent of patient.

WORKFORCE

- Coordinate with state labor departments, local workforce investment bureaus, and community colleges to develop education and training opportunities and enhance the workforce pipeline.
- Collaborate with universities to provide bachelor- and master-level educational internships in specialty treatment settings to improve recruitment of qualified staff.
- Become an approved National Health Services Corp site for outpatient treatment programs to enable loan repayment for clinicians. <https://nhsc.hrsa.gov/sites/index.html>
- Develop a registered apprenticeship program to train and employ new workers (e.g., community health workers, counselors, peer support specialists, medical assistants), and reduce turnover. <https://www.dol.gov/apprenticeship/>