

ISSUE BRIEF

Challenges in Standardizing SUD Care Coordination

NATIONAL
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Wellbeing

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Introduction

Substance use disorder (SUD) recovery is a complex, lifelong process requiring coordinated support across health care, social services and community systems. Unlike other chronic conditions, SUD is episodic and has uniquely high stakes due to the lethality of the current drug supply. The lethality of today's drug supply means that a gap in care or a recurrence of symptoms can quickly become fatal. To improve outcomes and save lives, it is essential to treat SUD as a chronic condition with long-term management and sustained care coordination.

Effective care coordination addresses the overlapping challenges of SUD, including co-occurring mental health conditions, social drivers of health (e.g., housing instability, unemployment and legal issues) and transitions between treatment phases. However, current systems are fragmented and inconsistent, leaving people vulnerable to disengagement, [recurrence of symptoms](#) and overdose.

Standardizing care coordination for SUD is critical to bridging these gaps and ensuring people receive timely, integrated, lifesaving support. This brief identifies key challenges to achieving standardization in SUD care coordination and offers solutions to create a reliable and fair system of care.

Challenges to Standardization

Lack of standardization across roles and training

Care coordination is a set of activities and responsibilities that are dispersed across various roles and credentials, such as social workers, counselors, care managers, case managers, recovery coaches, peer specialists, recovery care navigators and community health workers. This dispersal means that there is no consistent scope of practice or baseline training. For a complex condition like SUD, a lack of standardized roles and training creates large variability in quality of care. Care coordinators differ widely in their knowledge of SUD, the depth of their referral networks, and how well they understand the complex continuum of care. This lack of standardization is confusing for both patients and practitioners, resulting in a fragmented system in which patients and critical tasks may be overlooked or inadequately addressed. Implementing a unified training framework or certification for SUD care coordination could help mitigate these gaps and ensure consistent, evidence-based care.

Episodic and fragmented care models

Many SUD recovery systems of care operate in silos, providing episodic care rather than treating SUD as a chronic condition. Patients often receive single-issue care rather than integrated care, meaning that co-occurring mental health and medical conditions may be addressed by different sets of caregivers, if at all. As patients transition between care settings, not all conditions may be addressed at the transfer destination, often reinforcing the fragmentation of care. Transitions between care settings, such as from withdrawal management to outpatient programs, may be poorly managed, leading to gaps in service delivery and increased risk of recovery disruption and disengagement.

Additionally, the structural separation between SUD care and the broader behavioral health system creates barriers to standardizing care coordination. Eligibility for SUD care coordination is often complicated by the way co-occurring mental health conditions are classified. When SUD is considered “secondary” to another behavioral health diagnosis, it may impact whether or how a patient accesses care coordination services. Without clear criteria, the impact of care coordination on patient outcomes across different levels of substance use severity cannot be accurately assessed.

Effectively treating SUD as a chronic condition requires care coordination to go beyond immediate interventions, ensuring sustained monitoring and long-term support. Like cancer survivorship programs, SUD care benefits from proactive risk assessments, recurrence prevention, and regular follow-ups. Seamless transitions, supported by standardized “warm handoffs” and closed-loop referrals, are essential to ensure continuity and engagement throughout the recovery journey.

Social drivers of health are not fully integrated into recovery plans

Social drivers of health (SDOH) (e.g., housing instability, unemployment, underemployment, and lack of transportation or childcare) have a direct impact on an individual's ability to sustain recovery. People facing these challenges are more likely to experience high levels of stress and trauma, which can be triggers for substance use. Studies show that people with stable housing and employment have better long-term recovery outcomes, suggesting that integrating SDOH support into recovery plans is a critical intervention. Despite their importance, these factors are often under-addressed in care coordination efforts. Many providers lack the partnerships or resources needed to connect individuals to essential community supports.

By addressing these unmet needs — through partnerships with social services, community programs and workforce development initiatives — care coordination can become more comprehensive. For example, recovery efforts that partner with social services and workforce programs can help individuals stabilize their lives, reducing the stressors that often contribute to a return to use. Formalizing activities that address unmet social needs within care coordination frameworks would help address these barriers holistically and improve long-term recovery outcomes.

Stigma and bias in care delivery

Stigma surrounding SUD continues to impact care delivery, creating environments where people may feel judged and dismissed, and therefore do not receive the resources they need. Many providers are reluctant to treat SUD patients, and medications for opioid and alcohol use disorders (e.g., buprenorphine, methadone and naltrexone) are not offered consistently. These gaps reflect the systemic stigma, biases and lack of training that make it more difficult to access evidence-based treatments.

Additionally, people with lived and living experience of SUD are often excluded from shaping care coordination processes, despite their critical insights into recovery. Recovery efforts should conduct anti-stigma training, expand access to medications, embed trauma-informed and culturally appropriate practices, and systematically value lived experience to create fair, patient-centered systems of care.

Insufficient use of technology to support coordination

SUD care coordination depends on a complex network of health care providers, community organizations, judicial systems and social services. Fragmented systems and manual processes create inefficiencies, making coordination labor intensive and difficult to scale. The prevailing one-to-one, human-driven model limits patient access, overwhelms an already over-extended workforce and delays support when it is needed most.

Digital tools like health information exchanges, telehealth and remote monitoring are widely available, yet their adoption remains inconsistent. Electronic health records often lack interoperability, real-time data sharing is rare and automation is underused. These gaps lead to duplicated efforts, missed opportunities for intervention, and reactive (rather than proactive) care delivery. Automated referrals, real-time communication and predictive analytics could streamline processes, reduce administrative burden and expand access without requiring an equivalent increase in workforce capacity. Scalable, data-driven coordination would ensure more people receive timely, comprehensive support, improving outcomes while strengthening the entire system.

Misalignment of incentives across stakeholders

To achieve economies of scale, care coordination roles are often housed within managed care organizations or insurance companies, where the focus is on cost reduction for high-acuity patients. This narrow approach leaves many people in earlier stages of recovery stranded without the support they need to stabilize, *or it incentivizes coordinators to provide less intensive or lower-cost treatment options, even when a higher level of care may be clinically appropriate.* At the same time, many care coordinators are directly employed by or financially incentivized by specific treatment centers, leading to referrals that serve provider interests rather than patient needs. Payment models such as the [Addiction Recovery Medical Home](#) or Prospective Payment Systems with value-based care incentives for patient outcomes (including patient-reported symptom reduction and satisfaction with care) could assist in better aligning incentives across stakeholders, *helping to shift the focus from cost containment or provider-driven referrals to patient-centered, clinically appropriate care.*

Legal and administrative barriers to care integration

Regulations such as 42 CFR Part 2 impose strict privacy protections that complicate data sharing among SUD care providers. While this law is vital for maintaining patient confidentiality for a highly stigmatized condition like SUD, it can inadvertently hinder care coordination efforts. Providers may lack access to critical information such as treatment plans or medication histories, which are essential for integrated care. Aligning these regulations with broader healthcare standards — a shift already underway to facilitate data sharing between providers— while maintaining privacy protections could reduce these barriers.

Lack of recurrence and crisis planning

Traditional care coordination frameworks often omit [recurrence \(i.e., relapse\)](#) and crisis planning, leaving individuals without structured strategies for managing triggers or emergencies. Without these plans, patients are more vulnerable to disengagement, return to use or overdose. Additionally, care coordination is often treated as a passive referral function rather than an active point of support. Many individuals seeking behavioral health or SUD services reach out during urgent situations or crises, sometimes for the first time, making the

initial interaction critical for trust-building and engagement. To provide patients with tools to navigate high-risk situations and sustain recovery, recurrence prevention and crisis management strategies should be embedded into care coordination processes. These include real-time support skills such as active listening, accurate empathy and motivational interviewing. Standardizing care coordination as a true support interaction rather than a brief triage step could improve patient experience, strengthen engagement and create a more seamless transition to ongoing care.

Inadequate access to peer support services

Peer support is a proven component of effective recovery care, yet it remains underused in many care coordination efforts. Peer recovery specialists, who bring lived experience and mentorship, can provide guidance and foster trust in the recovery process. Beyond mentorship, peers offer a valuable perspective, often having personally navigated the complex and fragmented system during their own help-seeking and recovery journey. This shared experience can help alleviate the fear and uncertainty that often accompany reaching out for support. Peers can also enhance the referral process by offering localized knowledge of community-based resources, such as mutual help meetings and recovery community centers, helping individuals connect with ongoing support that is both accessible and culturally relevant. Formalizing the inclusion of peer support in care teams and creating sustainable funding mechanisms for these roles would ensure their availability to all people in recovery.

Limited metrics for success

The lack of standardized metrics for SUD care coordination limits progress tracking and accountability. Clear measures can address this gap. Key metrics include completion of warm handoffs (i.e., patients attending referred appointments), substance use and mental health symptoms, social stability/recovery capital improvements and care engagement (e.g., adherence to follow-ups, medications and support groups). Tracking social stability improvements (e.g., housing or employment) and fairness in outcomes can reveal systemic gaps.

A standardized care coordination model also creates an opportunity to improve the metrics used to evaluate the providers, treatment centers and community-based resources that patients are referred into. By tracking patient progress and recovery capital during and after treatment episodes, care coordination can shift toward value-based metrics that hold providers more accountable for long-term outcomes. Additional metrics (e.g., patient satisfaction, relapse risk monitoring, family and peer support participation, duration of engagement and social needs metrics) offer insights into patient experiences and the effectiveness of support systems. These measures create a framework for evaluating and improving care coordination, ensuring patient-centered recovery.

Advancing a Standardized Approach to SUD Care Coordination

Addressing the challenges in standardizing SUD care coordination requires a focused, practical approach centered on systems-level improvements. This includes defining clear roles and training pathways, integrating SDOH and services for co-occurring disorders into care plans, reducing stigma and expanding access to evidence-based treatments, including medications for opioid and alcohol use disorder. Organizations must collaborate with community partners, leverage data to refine referral processes, and actively integrate the perspectives of those with lived experience into program design and decision-making to improve patient outcomes.

Standardizing the care coordinator role, functions and core competencies is essential to effectively serving the complex needs of patients with SUD, ensuring consistency, accountability and the delivery of high-quality, patient-centered care across a fragmented system. Beyond improving care coordination itself, standardization offers a critical opportunity to track the effectiveness of the broader treatment system, holding providers and community-based resources accountable for patient outcomes. Long-term value-based metrics will be essential for ensuring this accountability and continuously improving processes. Implementing measures like completion of warm handoffs, substance use and mental health symptoms, and social stability/recovery capital improvements will provide actionable data to guide progress.

Adopting advanced technology solutions, such as interoperable health records and remote monitoring tools, is only part of the equation. Ensuring the sustainability of these efforts requires aligning financial incentives with long-term recovery goals. Investments in value-based care models that prioritize outcomes over episodic treatment will incentivize providers to integrate care and focus on long-term recovery. Additionally, sustainable funding for peer support roles — often overlooked in traditional payment systems — is essential to ensuring fair access to this vital resource.

A focus on the steps outlined above will close critical gaps, improve patient outcomes and align SUD care coordination with the standards of other chronic health conditions. Effectively applying these solutions will require commitment and collaboration from policymakers, health care providers and community organizations.