Potential interventions/standards

Clinic Treatment Pathways (can your provider give you the drug you need)

- Every licensed provider can either prescribe MOUD and manage patient along with the interdisciplinary team, OR provide same day referral to someone accepting patients for MOUD treatment?
    - What is the role of traditional primary care – management of stable patients, and/or ability to identify and refer?
- Health plans remove financial barriers to MOUD, including prior authorizations on doses of buprenorphine and other MOUD, following ASAM clinical guidance (higher doses buprenorphine initiation and maintenance) (*included in guidelines*)
- Health plans increase reimbursement for provision of MOUD and provide prospective payments for referrals

Care Coordination

- Define care coordination versus case management - (2017 group did this already defined this – copied below)
- Defining services provided in different settings?
- Reimbursement incentives for care coordination?

Proximity to Treatment

- Guidelines on physical proximity to providers offering MOUD and supportive services?
- Guidelines for who should be required/encouraged to offer telehealth services?
- Health plan reimbursement to incent closer proximity (increased payment for rural providers, increased payment for telehealth services, prospective payments for telehealth/mobile clinics) ?

Low-barrier access

- Define ideal low barrier access requirements (hours, walk-in appointments, service locations)
- Define minimum services available at nontraditional models (*started already*)
- Identify and support payment mechanisms for low-barrier access?
- Define difference between low-barrier access models and health engagement hub - Promote health engagement hub as ideal model of integrated care?

Dedicated Support Staff

- Define dedicated support staff (care coordinators, case managers, peer support recovery services) and in what settings they should exist?
- Define and promote payment mechanisms for dedicated support staff?

Appendix D: Care Coordination Compared to Case Management (2017)

Care coordination is a set of activities by which a system of care assures that every person served by the system has a single approved care or service plan that is coordinated, not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. The goal is both managing and stretching limited resources, as well as assuring the best quality care possible to achieve the client's service goals.

- Cost effective and patient-centric in the least restrictive setting.
- Can be specialized by setting/need (medical, forensic, behavioral health, housing)
- Medical home
- Transitional and intermittent
- Collaborative
- Engagement
- Referral
- Financial/Utilization management
- Resource utilization
- Support client's ease of access to resource information
- Enhance communication among providers
- Single point of entry to multiple services

Case management is a clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper. The goal of case management is the long-term recovery of the individual and increasing the ability of the individual to cope and function independently, including managing his/her own symptoms or addictions, and finding and maintaining his/her services and community living requirements.

- Work one on one with people with chronic illness(es) or disabilities.
- Liaison between insurance companies and healthcare providers
- Assessment of need
- Create and implement plans of care
- Evaluation
- Research treatment options
- Patient advocate