

What a ‘Perfect’ SUD Care Model Would Actually Look Like

By [Ashleigh Hollowell](#) | May 30, 2025

An example of a near-perfect, high-impact model for addiction care is difficult to find even in the pie-in-the-sky film or television realms. Finding one in the real world comes with even more challenges.

The 1997 film “Gridlock’d” follows Tupac Shakur and Tim Roth as they grapple with trying to get care and reverse their heroin addiction. Scene after scene, the two are met with barriers that keep them from getting what they need. That 28-year-old film, in many ways, parallels the landscape patients still have to navigate for substance use disorder (SUD) treatment in 2025.

“Every place they go, there’s a new barrier that keeps them from getting the care they need. In the meantime, they’re in withdrawal. So what do they do between places? They use,” Dr. Daniel Sumrok, former president of the Tennessee Society of Addiction Medicine, told Behavioral Health Business. “The perfect model would give us the ability to conduct an ASAM [American Society of Addiction Medicine] analysis on every patient, decide what level of care they need, pick up the phone and get them connected to that care right away. When I have someone with chest pain in the office, I can pick up the phone and call a cardiologist. That’s not as easy in addiction medicine.”

Part of what makes connecting these dots in addiction medicine so challenging is not only stigma, but when a patient does receive care, they aren’t “cured,” as with many physical health conditions.

Addiction itself often leads to other complex physical health issues that need to be addressed in conjunction with the SUD. There is no “graduating” from addiction treatment, but rather a sense of going into “remission,” clinicians told BHB.

Even then, remission for these patients isn’t treated like being in remission from a chronic disease like [cancer](#). There is rarely ongoing monitoring or intensive intervention follow-ups to manage care on the other side.

“A perfect care model would recognize what remission and recovery from SUD looks like. It would incentivize that, and would deliver and promote [value-based care](#),” Dr. Itai Danovitch, professor and chair of the department of psychiatry and behavioral neurosciences at Cedars-Sinai Medical Center in Los Angeles, said. “Then within that care model, there’d be a lot of differing levels of care that we’re personalized to the needs of patients. Substance use disorder is a big umbrella term with a lot of different types of conditions and severities, and comorbidities. There’s not a one-size-fits-all fix.”

Creating a model that would allow addiction medicine clinicians to deliver the right care at the right time, track outcomes and make adaptations tailored to an individual’s specific situation is where to start working toward improvements, Danovitch explained.

Progress – not perfection

Episodic treatment is also something that is unique to SUD care.

While from a bottom-line perspective, offering long-term, wrap-around services could create new revenue opportunities for providers, more often than not, care happens at the intersection of a peak of symptoms and the depth of the disease.

Unlike chronic conditions, patients grappling with SUD aren't always ready to launch into recovery and immediately halt their drug use. Complete abstinence as an outcome isn't realistic for all patients to achieve, which is not something providers always understand.

“I think it's critical to be understanding that not everyone is ready for abstinence or even the level of decreased use ...,” Dr. Avik Chatterjee, assistant professor at Boston University School of Medicine and a physician at Boston Health Care for the Homeless Program, told BHB. “If they're really struggling with addiction, it's also about understanding that there's going to be a set of things we need to do for folks who are actively using and using heavily.”

Making investments in overdose prevention centers, harm reduction engagement methods, and viewing resources like housing and family reunification should also be part of the addiction care continuum in an ideal world, Chatterjee explained.

“We have to invest in that. Because you can't talk to someone about treatment unless they're alive to talk about it,” he said. “So we have to do better at keeping people alive during that phase of addiction, and if they relapse back into that phase, allowing for such supports during that time.”

Despite SUDs accounting for a [significant portion](#) of both emergency department admissions and inpatient encounters – 4% and 10%, respectively – few hospitals actually have an addiction medicine department or [addiction specialists](#) on staff.

These facilities are often [overlooked](#) as settings for initiating addiction care, despite the prevalence of patients who have an SUD at the time of hospitalization. Shifting that could alter care trajectories from the outset for millions of patients each year.

“In my opinion, every hospital in this country needs to have an addiction medicine department, with addiction medicine privileges for physicians and physician extenders,” Dr. Jason Kirby, medical director of PursueCare, an online addiction and mental health service, told BHB. “We need to make sure addiction medicine is at our hospitals when folks come in after an overdose, or if they come in with any other substance-related issue that can be addressed in that setting, so we don't lose that time.”

Evidence-based, patient-centered, value-focused

Extending care beyond the four walls of a treatment center or hospital ideally would include the seamless coordination of multidisciplinary specialists across the spectrum of whole-person patient care, experts agreed.

However, while integrating behavioral health with physical health, case management and other critical primary care screening is something the industry continues to move toward, in practice it is still taking time to flesh out.

“What we don’t have right now in addiction care is integrated and multi-level care,” Sumrok said. “But in other specialties where they have made a real effort to do that, they’ve seen successes.”

Migrating to a “hub-and-spoke model” of access in addiction care where any clinician can contact and refer a patient to an addiction specialist close by, he explained, would be the “Holy Grail” of integration.

Kirby echoed those sentiments.

“Any organization that is integrating hospital services, residential care, outpatient services and telehealth will win the race in addiction treatment,” Kirby said.

Any “perfect” model of care in SUD treatment likewise needs to have the flexibility to adjust care intensity based on patient needs, but also has to be sustainable from a funding and evidence standpoint.

“The funding mechanisms that are chosen have to be commensurate with costs and have to be sustainable,” Dr. Brian Hurley, immediate past-president of the American Society of Addiction Medicine (ASAM), told ATB. “So when we’re focused on evidence-based standards of care, as defined in the ASAM Criteria, there isn’t a particular perfect model we’re stuck on, but it does have to be in alignment based and focused on the current evidence-based standards.”

Utilizing evidenced-based practices to inform personalization in treatment may help move the needle toward value-based care models and enhancing outcomes.

“If it’s evidence-based, it’s right for patients ...,” Dr. Chad Elkin, president of the Tennessee Society of Addiction Medicine and CEO of National Addiction Specialists, told BHB. “I don’t think there’s a perfect scenario. Each patient needs individualized care. Each patient is different. Each substance use disorder is different, too, and different patients need different things. Ultimately, what patients really want is to know that you care.”

At the end of the day, a model that can also knock down barriers to allow for easier transitions between various levels of care – without complex insurance or paperwork preventing access – is what will make way for more evidence-based, quality care to take place for SUD patients, Elkin added.