ASSERTIVE FIELD-BASED INITIATION FOR SUBSTANCE USE DISORDER TREATMENT SERVICES (AFBSS)

Case Study Training Manual

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ACRONYMS

Acronym	Definition
ACT	Assertive Community Treatment
ADT	Admission, Discharge, and Transfer
AFBSS	Assertive Field-Based Substance Use Disorder Services
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BHT	Behavioral Health Transformation
BHSA	Behavioral Health Services Act
BOLO	Be On the Lookout
CFR	Code of Federal Regulations
CHW	Community Health Worker
CLR	Closed-Loop Referral
CM	Contingency Management
COPD	Chronic Obstructive Pulmonary Disease
COWS	Clinical Opiate Withdrawal Scale
CPS	Child Protective Services
DHCS	California Department of Health Care Services
ECM	Enhanced Care Management
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center

GAD-7	Generalized Anxiety Disorder 7-Item Scale
LCM	Lead Care Manager
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and Other Sexual and Gender Identities
LVN	Licensed Vocational Nurse
MAT	Medications for Addiction Treatment
MCP	Managed Care Plan
MOUD	Medications for Opioid Use Disorder
NP	Nurse Practitioner
NTP	Narcotic Treatment Program
OD	Overdose
OTOD	Opioid Treatment on Demand
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PCP	Primary Care Provider
PHQ-9	Patient Health Questionnaire-9
PSS	Peer Support Specialist
PTSD	Post-Traumatic Stress Disorder
RHC	Rural Health Clinic
SMART	Specific, Measurable, Achievable, Relevant, and Time-Bound
SMI	Serious Mental Illness
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TAY	Transitional Age Youth
VA	Department of Veterans Affairs

INTRODUCTION

Assertive Field-Based Substance Use Disorder Treatment Services (hereafter referred to as Assertive Field-Based SUD Services, or "AFBSS") are designed to bring substance use disorder (SUD) care directly to people who face the greatest barriers to accessing traditional, clinic-based treatment. AFBSS teams use proactive outreach, low-barrier engagement, and coordinated medical and behavioral health supports to reduce overdose risk, improve continuity of care, and support long-term recovery and stability. This case study training manual was developed to help teams build practical skills, shared language, and decision-making frameworks needed to deliver AFBSS safely, effectively, and consistently across settings.

This manual is intended for multidisciplinary field-based teams (including community health workers, nurses, prescribers, clinicians, care coordinators, supervisors, and program leaders) and for partners who support AFBSS workflows (such as emergency medical services [EMS], hospitals, managed care, public health, street medicine, and justice and reentry systems). It can be used for onboarding, team-based training, reflective supervision, and ongoing professional development. Each case includes a narrative scenario, discussion questions to support application to local practice, and facilitator notes to guide learning and highlight key considerations. All case scenarios included in this manual are fictional and developed for training purposes; they do not represent real individuals or actual events.

As you work through the case studies, we encourage teams to consider the following as part of your learning method:

- **Stay person-centered and voluntary:** prioritize autonomy, choice, and practical engagement over compliance.
- **Use a harm reduction approach**: focus on immediate safety and overdose prevention while supporting incremental change.
- **Be trauma-informed and culturally responsive:** consider how trauma, stigma, racism, and other inequities shape needs and trust.
- **Think in terms of systems and teams:** identify cross-sector touchpoints, handoffs, and the workflows that prevent people from falling through the cracks.
- **Reflect as you decide:** notice assumptions, emotions, and role-based perspectives that influence judgment in the field.

HOW TO USE THIS MANUAL

WHY CASE-BASED LEARNING FOR AFBSS

Case-based learning is an effective, adult learning strategy for preparing staff to deliver Assertive Field-Based Services (AFBSS) because it mirrors the complex, real-world situations encountered when working with individuals who have substance use disorders (SUD), are experiencing homelessness, are justice-involved, have co-occurring behavioral and physical health conditions or have other factors that complicate their ability to engage in treatment. Through realistic scenarios, learners practice applying clinical judgment, cultural humility, engagement techniques, trauma informed and motivational interviewing approaches, harm reduction principles, and care coordination strategies in a safe learning environment.

Case-based learning helps staff develop the skills needed to identify barriers to care, build trust, respond to overdose risk, and connect individuals to Medications for Addiction Treatment (MAT) and other supportive services. By exploring real-life situations, participants learn how to apply the low barrier, "no wrong door" philosophy, engage individuals wherever they are, and tailor interventions to meet each person's unique needs and readiness for change.

Using case studies also promotes critical thinking and interdisciplinary collaboration by encouraging learners to consider social determinants of health, safety concerns, housing instability, justice involvement, and co-occurring mental and physical health conditions when developing care plans. This hands-on approach strengthens decision-making skills and prepares field-based providers to deliver timely, person-centered care that improves engagement, reduces overdose risk, and expands access to treatment and recovery services for underserved populations.



AN ADULT LEARNING APPROACH

Adult learning describes the methods, principles and practices that are most effective when training adults. Adult learning approaches bring existing knowledge, professional experience, and lived experience into learning environments. These case studies incorporate that approach and build on that foundation by:

- Centering real-world relevance: The scenarios mirror situations staff are likely to encounter, including ambiguity, competing priorities, and system constraints.
- Encouraging problem-solving and judgment: Prompts are designed to spark analysis and discussion rather than lead learners toward a single "correct" answer.

- Honoring autonomy and expertise: Participants are invited to engage critically and reflectively, recognizing that different roles and contexts may lead to different responses.
- Supporting application to practice: Learners are encouraged to connect insights from the cases to their own work, teams, and systems.



This approach aligns with the realities of AFBSS work, where staff must make thoughtful, values-driven decisions in dynamic and unpredictable environments.

CREATING A SUPPORTIVE LEARNING ENVIRONMENT

Effective adult and reflective learning require psychological safety. Facilitators and supervisors should emphasize that:

- The goal is learning and growth, not evaluation
- Multiple responses may be reasonable depending on context
- Emotional reactions are a normal and important part of the work
- Curiosity, humility, and respect are central to discussion



This learning stance mirrors the trauma-informed, harm-reduction approach expected of AFBSS teams when engaging individuals and communities.

REFLECTIVE LEARNING AS A CORE PRACTICE



Reflective learning is a central goal of this manual. Reflection helps staff deepen self-awareness, strengthen professional judgment, and sustain effective practice over time. The case studies are designed to create space for learners to reflect not only on what they would do, but how they think and feel in complex situations.

Reflective learning within the case studies may include:

- Noticing emotional responses such as urgency, frustration, protectiveness, or uncertainty
- Examining assumptions, biases, and expectations
- Considering how trauma, stigma, power, and systems influence engagement
- Exploring parallel process between client experiences and staff experiences

By normalizing reflection and uncertainty, the case studies support professional growth while also promoting resilience and sustainability in emotionally demanding work.

USING THESE CASE STUDIES FOR TRAINING AND ONGOING PROFESSIONAL DEVELOPMENT



The case studies in this manual are designed to support learning across a wide range of roles, experience levels, and organizational contexts. They may be used to onboard new staff, train multidisciplinary teams, support reflective supervision, and strengthen ongoing professional development over time. The case studies are intentionally flexible and can be adapted for use in group trainings, individual learning, or hybrid formats depending on your staffing model and resources.

This toolkit is grounded in adult learning and reflective practice principles, recognizing that effective learning for

Additionally, you are free to change the case details to meet your population and training needs.

adults is active, relevant, and rooted in real-world experience. Rather than presenting idealized scenarios or prescriptive answers, the cases reflect the complexity, uncertainty, and emotional realities of assertive field-based substance use disorder services.

Learners are encouraged to analyze situations, explore multiple perspectives, and reflect on how values, systems, and relationships shape practice in the field.

USING THE CASE STUDIES IN GROUP TRAINING SETTINGS

When used in group trainings, team meetings, or learning collaboratives, the case studies can help build shared understanding and strengthen team-based practice.

Facilitators are encouraged to:

- Emphasize curiosity and discussion over correctness
- Normalize differing perspectives and role-based viewpoints
- Use small-group or role-specific breakouts to deepen engagement
- Pause cases at key moments to invite participants to predict next steps or explore alternatives

Group-based learning reinforces shared responsibility, mirrors interdisciplinary collaboration in the field, and supports consistent application of AFBSS principles across roles.

USING THE CASE STUDIES FOR INDIVIDUAL LEARNING AND ONBOARDING

In settings where staff are trained individually or asynchronously, the case studies can support self-directed learning and onboarding.

Individual learners may be encouraged to:

- Respond in writing to selected discussion prompts
- Reflect on what feels familiar, challenging, or uncomfortable
- Identify skills or areas for growth highlighted by the case
- Consider how the scenario relates to their own clients or role



This approach is particularly useful for onboarding new staff, supporting remote workers, or supplementing formal training with ongoing learning.

USING THE CASE STUDIES IN SUPERVISION AND COACHING

The case studies can also be used as tools for reflective supervision, coaching, and professional support.

Supervisors and coaches may use the cases to:

- Explore decision-making, boundaries, and ethical tensions
- Discuss safety considerations and risk assessment
- Examine emotional labor and secondary trauma
- Identify strengths and reinforce values-aligned practice



Using shared cases in supervision provides a common language for reflection while allowing staff to process experiences in a supportive, nonjudgmental setting.

ONGOING PROFESSIONAL DEVELOPMENT OVER TIME

The case studies are designed to be revisited over time, not used only once. As staff gain experience, their interpretation of cases may change, allowing for deeper insight and more nuanced discussion.

Reusing cases supports:

- Continued skill development
- Reflection on professional growth
- Strengthening clinical reasoning and confidence
- Reinforcement of AFBSS values and principles



In this way, studies function not only as training tools, but as ongoing resources for learning, reflection, and professional development.

AFBSS TOOLKIT AS AN ADDITIONAL TOOL

The AFBSS Case Study Training Manual is one component of a broader suite of training and implementation resources developed to support counties, providers, supervisors, and multidisciplinary teams delivering AFBSS.

In addition to the case studies contained in this manual, users are encouraged to access the **AFBSS Toolkit**, a companion resource designed to support program planning, implementation, workforce development, clinical practice, and continuous quality improvement. The toolkit provides practical guidance, tools, templates, and reference materials that can be used to strengthen service delivery and support ongoing AFBSS implementation.

The AFBSS Toolkit includes resources across multiple topic areas, including:

- An overview of AFBSS and Behavioral Health Services Act (BHSA) requirements.
- Data-informed outreach and client identification strategies.
- Mobile field-based service delivery models, informed consent and workflows.
- Workforce development, onboarding, training, and supervision resources.
- Harm reduction, motivational interviewing, and engagement tools.
- Medications for Addiction Treatment (MAT) resources and clinical guidance.
- Strategies for developing effective partnerships and collaborations
- Program implementation tools, templates, and operational checklists.
- Additional training materials, webinars, and reference resources.

The case studies in this manual highlight opportunities where AFBSS Toolkit resources can complement and reinforce the concepts explored in each case. Organizations are encouraged to make use of both resources to support staff onboarding, multidisciplinary team training, reflective supervision, and ongoing quality improvement efforts.

OVERVIEW OF AFBSS INITIATIVE & BHSA POLICY HIGHLIGHTS

Policy Acknowledgment: This training manual is informed by the California Behavioral Health Services Act (BHSA) and related state guidance that support timely, equitable, and low-barrier behavioral health services. The content reflects key policy priorities related to outreach, engagement, open access to care, and coordinated service delivery for individuals with substance use disorder who remain unengaged in care, including those who are unhoused/housing insecure, justice-involved and/or those with co-occurring mental health needs. Users of this manual are encouraged to review the BHSA policy and related

implementation guidance to understand the broader statutory and programmatic context for AFBSS design and delivery.

Counties are required to **provide rapid access to all Food and Drug Administration (FDA)-approved Medications for Addiction Treatment (MAT)** by strengthening existing and/or standing-up at least **one initiative in each of the following three areas** that comprise their assertive field-based programs:

- Data Informed and Targeted Outreach
- Mobile Field-Based Programs
- Open-Access Clinics

The AFBSS Initiatives and BHSA Policy highlights that follow were abstracted from the DHCS Policy Guidelines and can be viewed at: https://policy-manual.mes.dhcs.ca.gov/.

DATA-INFORMED AND TARGETED OUTREACH POLICY HIGHLIGHTS

Counties should conduct ongoing, targeted outreach to connect individuals with SUD services, including MAT, consistent with Welfare and Institutions Code section 5806(a)(2). Outreach should focus on priority populations, particularly individuals at elevated risk of overdose or those who are not currently engaged in treatment.



Counties are encouraged to use both traditional and nontraditional data sources to identify individuals who may benefit from outreach and engagement. Examples include overdose events and reversals, syringe services program encounters, drug-related arrests, emergency department visits, and other indicators of elevated risk.

Outreach may be conducted through mobile field-based programs, open-access clinics, or other service providers such as Full Service Partnership programs. Outreach activities may be delivered by newly established outreach teams or integrated into the work of existing teams. For example, case management teams embedded within clinics may conduct community outreach, or teams serving individuals in interim housing or permanent supportive housing may incorporate outreach and engagement into their services.

The goal of targeted outreach is to proactively identify individuals who may not otherwise access SUD treatment and connect them to appropriate services and supports, including MAT.

To identify highest-need outreach locations and populations, counties are encouraged to collaborate with:

- Emergency Medical Services (EMS)
- Federally Qualified Health Center (FQHC)
- Health systems and hospitals
- Individuals with living or lived experience
- Law enforcement
- Managed care plans (MCPs)
- Rural Health Clinics (RHCs)

MOBILE FIELD-BASED PROGRAMS POLICY HIGHLIGHTS

Mobile field-based service delivery models provide mental health and substance use disorder (SUD) services outside of traditional clinic settings. These models are designed to reach individuals with high acuity and complex needs who face barriers to accessing care through conventional service systems.

Mobile field-based programs leverage multidisciplinary teams to conduct field-based outreach and engagement activities that help connect individuals with SUD treatment services. Teams provide harm reduction support, trust building, motivational interviewing, and other engagement strategies while directly providing or facilitating rapid access to MAT and other SUD services. Counties have flexibility to determine the composition of mobile teams based on local needs and resources. Team members may include behavioral health providers, SUD counselors, peer support specialists, community health workers, nurses, physicians, and physician extenders. At a minimum, programs must ensure timely access to all FDA-approved MAT, either through embedded prescribers or referral pathways, including access to Narcotic Treatment Programs (NTPs) for methadone services.

Counties may implement a variety of mobile field-based models to meet these requirements. Examples identified in the BHSA Policy Manual include partnerships with street medicine providers that deliver healthcare services directly in community settings; street outreach programs with MAT prescribers that provide assessment, treatment, and medication services in the field; and mobile Narcotic Treatment Programs (NTPs) that deliver methadone and other medications outside traditional clinic settings. These approaches are intended to increase access to treatment for individuals who face barriers to engaging in traditional office-based care, including people experiencing homelessness and others who are disconnected from services.

OPEN-ACCESS CLINICS POLICY HIGHLIGHTS

Counties are required to support open-access clinic models that provide low-barrier, low-threshold access to Medications for Addiction Treatment (MAT) and other substance use disorder (SUD) services. These outpatient settings are designed to offer rapid access to care for individuals who may not engage with traditional appointment-based treatment models.

Counties may leverage existing programs or establish new brick-and-mortar sites within their catchment areas to expand access to MAT and related services. Open-access models are often embedded within community-based settings that individuals already trust and access.

Examples of programs operating under this model might include syringe services programs that offer drop-in clinical services, medication units (affiliated with licensed narcotic treatment programs [NTPs]) that dispense or support medication-based treatment, and outpatient clinics that use open-access or walk-in scheduling to provide rapid entry into care.

CORE CHARACTERISTICS

Open-access clinics typically share several core characteristics that support low-barrier engagement and continuity of care. These clinics often provide comprehensive primary care services, deliver integrated mental health and SUD treatment, and accept and initiate MAT for individuals seeking treatment. Many offer same-day, walk-in access and are structured to serve individuals regardless of insurance status or ability to pay.

The goal of open-access clinics is to reduce common barriers to treatment entry, allowing individuals to access care at the moment they are ready and supporting rapid engagement in MAT and other recovery services.

FDA-APPROVED MEDICATIONS FOR ADDICTION TREATMENT (MAT)

Medications for Addiction Treatment (MAT) are evidence-based, life-saving options that reduce cravings, ease withdrawal, and support stability for individuals with substance use disorders. In low-barrier settings, MAT can and should often be initiated on the same day to support rapid engagement in care. Common FDA-approved medications for opioid, alcohol, and tobacco use disorders are outlined below *(listed by generic name)*.

Condition	Generic Medication	Brand Name/Examples
Alcohol Use Disorder (AUD)	Acamprosate	Campral
	Disulfiram	Antabuse
	Naltrexone	Revia; Vivitrol

Nicotine Use Disorder	Bupropion SR	Zyban; Wellbutrin SR
	Nicotine gum	Nicorette
	Nicotine lozenge	Nicorette Lozenge
	Nicotine nasal spray	Nicotrol NS
	Nicotine oral inhaler	Nicotrol Inhaler
	Nicotine patch	NicoDerm CQ
	Varenicline	Chantix
Opioid Use Disorder (OUD)	Buprenorphine	Suboxone; Cassipa; Bunavail; Zubsolv; Subutex; Sublocade; Brixadi
	Methadone	Dolophine; Methadose
	Naltrexone	Vivitrol
Opioid Withdrawal Symptom Management	Lofexidine	Lucemyra

A WORD ABOUT DATA SHARING

Data and information sharing may support outreach, identification, engagement, care coordination, and service optimization for high-risk clients; however, any access, use, release, or sharing of client data and information related to substance use disorder treatment or services must comply with all applicable federal and state confidentiality requirements, including the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Title 42 of the Code of Federal Regulations Part 2 (42 CFR Part 2). Data and information should be limited to the minimum necessary, used only for authorized purposes, and disclosed only with valid client consent or another legally permitted basis for release of information.

CASE STUDIES

Each case study in this manual is presented as a progressive learning scenario that unfolds over time. Cases are organized to reflect common stages of engagement in Assertive Field-Based Substance Use Disorder Services (AFBSS), including identification and outreach, field-based engagement, linkage to open-access care, and ongoing follow-up or re-engagement. Throughout each case, readers will find discussion prompts designed to support reflection, team dialogue, and application to local practice. Facilitator notes are included later in the manual to guide conversation, reinforce key concepts, and highlight possible responses grounded in harm reduction, trauma-informed care, and person-centered practice.

CASE STUDIES



Each case study in this manual is presented as a progressive learning scenario that unfolds over time. Cases reflect the three areas of Assertive Field-Based Substance Use Disorder Services (AFBSS): data-informed and targeted outreach, mobile field-based programs, and open-access clinics. They also illustrate common stages of engagement, including identification, outreach, linkage to care, follow-up, and re-engagement. Throughout each case, discussion prompts support reflection, team dialogue, and application to local practice. Facilitator notes guide discussion, reinforce key concepts, and highlight responses grounded in harm reduction, trauma-informed care, and person-centered practice.

CASE STUDY - JORDAN, 25

JORDAN'S JOURNEY: PART 1

LEARNING OBJECTIVE:

1. Identify individuals at elevated overdose risk and determine when assertive field-based outreach is warranted.
2. Recognize clinical, behavioral health, and social factors that contribute to overdose risk and care disengagement.
3. Prioritize outreach and engagement needs based on an individual's strengths, risks, and stated goals.
4. Identify strengths and protective factors that may support recovery and ongoing engagement.



Jordan is a 25-year-old white, cisgender man who identifies as heterosexual and is currently unhoused. He moves between sleeping in his car, couch-surfing with friends, and staying in shelters, when space is available. He works part-time at a local car wash. The job gives him a sense of pride and normalcy, but his substance use contributes to his unreliability. He is often late, misses shifts, and sometimes shows up visibly unwell. His supervisor has warned him that he will be fired if things do not improve.

Jordan developed depression in early adolescence. His father, who struggled with alcohol use disorder, was arrested for vehicular homicide and incarcerated. Before the arrest, Jordan's home life was chaotic and violent. His father regularly assaulted his mother, and Jordan was often hurt when he tried to protect her. After his father went to prison, the violence stopped, but the family fell into poverty. His mother became severely depressed and emotionally unavailable, and Jordan was largely left to raise himself.

During high school, Jordan received school-based mental health services. He found it helpful to talk with someone who listened. After graduation, that support ended. Without it, his depression deepened. He describes feeling numb, hopeless, and disconnected.

In his senior year, Jordan was a passenger in a serious car accident. He sustained a broken leg and multiple rib fractures. In the emergency department, he was prescribed hydrocodone. The medication did more than relieve pain; it made him feel calm and "normal" for the first time in years. When the prescriptions ended, Jordan turned to street opioids and later heroin.

Jordan now injects heroin daily. When he cannot get money, he may go a day or two without using, which leads to withdrawal, characterized by nausea, sweating, anxiety, body aches, and intense cravings. These symptoms often cause him to miss work.

Jordan lives with chronic medical issues from the accident. His leg was repaired with hardware, but he never completed physical therapy. He has ongoing nerve pain in his lower leg and ankle, which worsens in cold weather and after long periods of standing. He walks with a slight limp and relies on opioids to manage pain.

He has also recently been diagnosed with hepatitis C, likely related to injection drug use, but has not received treatment. He worries about his health but does not know how to navigate care without stable housing or insurance.

Jordan has tried to stop using on his own several times but has not been able to tolerate the physical and emotional distress of withdrawal.

Despite years of adversity, Jordan has not given up. He talks about wanting to "feel normal without using" and to keep his job. Continuing to work shows persistence and a desire for dignity and stability.

PART 1: DISCUSSION QUESTIONS



1. **Would Jordan meet criteria for assertive field-based outreach?**
2. **What clinical, behavioral health, and social factors place Jordan at elevated risk for overdose or other adverse outcomes?**
3. **What data sources or system partners could help identify and locate someone like Jordan?**
4. **Which role on your team would be most appropriate to engage Jordan first, and why?**
5. **As an outreach worker, what would be your first priority when engaging Jordan? Why?**
6. **What strengths do you see in Jordan that could support engagement and recovery?**



Tip:
As you reflect on these questions, consider how data sources, client identification, partnerships and multidisciplinary teamwork strengthen care by incorporating multiple perspectives and approaches when addressing complex clinical and social challenges.

PART 1 DISCUSSION NOTES

1. **Would Jordan meet criteria for assertive field-based outreach?**
   Yes. Jordan presents with multiple factors associated with elevated overdose and mortality risk, including opioid use disorder, housing instability, chronic pain, untreated hepatitis C, depression, and a recent overdose reversal. He also faces barriers to accessing traditional care and is at risk of losing employment, one of the few stabilizing factors in his life. These factors make him an appropriate candidate for assertive field-based outreach and rapid engagement.

2. **What clinical, behavioral health, and social factors place Jordan at elevated risk for overdose or other adverse outcomes?**
   Jordan's opioid use disorder, history of withdrawal, chronic pain, and recent overdose place him at immediate clinical risk. His depression, trauma history, and limited support system increase vulnerability to continued substance use and disengagement from care. Housing instability, untreated hepatitis C, and the potential loss of employment further compound his risk and reduce his ability to access and maintain treatment.

3. **What data sources or system partners could help identify and locate someone like Jordan?**
   Jordan could be identified through EMS overdose reports, emergency department visits, hospital admission, discharge, and transfer (ADT) feeds, managed care claims data, shelter-based services, community outreach teams, and public health surveillance systems. Cross-sector collaboration among hospitals, EMS, public health, managed care plans, and community providers increases the likelihood that individuals like Jordan are identified quickly and connected to services.

4. **Which role on your team would be most appropriate to engage Jordan first, and why?**
   A peer support specialist may be the most effective person to engage Jordan first. Jordan has experienced significant trauma, struggles with shame related to his substance use, and is worried about losing his job. Someone with lived experience may be better positioned to connect with him around his fears, normalize help-seeking, and build trust after the overdose. Once rapport is established, a nurse could address his chronic pain, hepatitis C, and overdose risk, while a behavioral health clinician could support his depression, trauma history, and treatment engagement. The most effective approach is likely a team-based response, but the peer may be best positioned to make the initial connection.

5. **As an outreach worker, what would be your first priority when engaging Jordan? Why?**
   The first priority is to establish rapport while assessing immediate safety concerns following the overdose. Outreach should focus on understanding what matters most to Jordan, which may include keeping his job, managing withdrawal symptoms, reducing pain, or avoiding another overdose. Addressing his priorities while offering harm reduction and rapid access to treatment increases the likelihood of ongoing engagement.

6. **What strengths do you see in Jordan that could support engagement and recovery?**
   Jordan demonstrates persistence, resilience, and a desire for stability despite significant adversity. He continues to work, expresses a desire to "feel normal without using," and has attempted to stop using on his own. His motivation to keep his job, improve his health, and build a more stable life can serve as important foundations for engagement and recovery.

JORDAN'S JOURNEY: PART 2

LEARNING OBJECTIVES



1. Describe how data-informed outreach strategies can be used to identify and locate individuals following an overdose or other high-risk event.
2. Demonstrate how person-centered outreach approaches can engage individuals in care while respecting their priorities, readiness, and circumstances.
3. Identify harm reduction and field-based interventions that reduce risk and support overall health and safety.
4. Explain how multidisciplinary mobile outreach teams and low-barrier service models improve access to care and ongoing engagement.

One morning, Jordan uses alone in the restroom of a gas station near the car wash before his shift. He plans to "take the edge off" so he can get through the day. Minutes pass. A store clerk notices that the restroom has been occupied for a long time and knocks on the door. There is no response. The clerk calls 911.

While they wait, a man who has been standing outside approaches and says quietly, "I've got Narcan." He explains that a mobile outreach team comes through this area every week and hands out naloxone kits. He recognizes the signs immediately. The man administers naloxone. Jordan gasps and begins to breathe. By the time EMS arrives, he is conscious but disoriented. Paramedics transport him to the emergency department for observation.

Within hours, the county's behavioral health department's post-overdose surveillance system flags the event through emergency medical services (EMS) and admission, discharge, and transfer (ADT) feeds. Jordan is placed in the county's highest-risk tier for overdose. The next morning, his case appears in the county's post-overdose huddle, which includes EMS, the hospital, public health, managed care, and the assertive field-based outreach program. Jordan's address is listed as "no fixed residence." A note indicates he may be staying in his car near the car wash. A referral is generated for immediate follow-up.

Within 48 hours, a mobile field-based team locates Jordan in the parking lot where employees gather before opening. The team includes a peer support specialist, a nurse, and a behavioral health clinician. They do not arrive in an ambulance or with law enforcement. The peer approaches first.

“Hey, I’m not here to get you in trouble,” she says. “I heard you had a scary experience the other day. I just wanted to check in.”

Jordan is embarrassed. “I messed up. I can’t lose this job.”

The nurse asks about his leg. The behavioral health clinician asks what happened before the overdose. No one lectures him. No one threatens consequences.

Jordan admits, “I just want to feel normal. I can’t keep doing this.”

The team offers naloxone, clean supplies, and a brief explanation of withdrawal. The nurse looks at his leg and asks about the pain. The peer says, “There’s a place where you can walk in today, no appointment, and talk to someone about meds that can stop the sickness without making you high. I can go with you.”

Jordan hesitates. “I can’t miss another shift.”

The peer says, “I understand the pressure you are under, let’s discuss what would work best for you”. “The appointment won’t take that long, and we can write a note to your employer.”

PART 2 DISCUSSION QUESTIONS

1. **What does "meeting Jordan where he is" look like in this moment?**

2. **Who needs to be on this mobile team to address his needs?**

3. **What can be offered in the field today that reduces overall risk (e.g., OD, worsening clinical status and/or job loss)?**

4. **How does this differ from asking Jordan to call a clinic himself?**



Tip:
Someone who is focused on survival may find it difficult to engage in conversations about health or recovery. While helping with basic needs, i.e., food, clothing, include harm reduction education and emergency planning. All are powerful strategies to build trust and engagement and can save lives.

PART 2 DISCUSSION NOTES

1. **What does "meeting Jordan where he is" look like in this moment?**
   Meeting Jordan where he is means engaging him in a location that is comfortable and accessible to him, rather than expecting him to come to a clinic. It also means focusing on the concerns he identifies as most important, including keeping his job, managing pain, and avoiding withdrawal. The team approaches him without judgment, recognizes his strengths, and offers support that aligns with his immediate needs and readiness for change.

2. **Who needs to be on this mobile team to address his needs?**
   A peer support specialist can help build trust and reduce stigma by connecting through lived experience. A nurse can assess overdose risk, chronic pain, hepatitis C, and other medical concerns. A behavioral health clinician can address depression, trauma, and substance use while helping Jordan explore treatment options. Together, the team can respond to the full range of Jordan's medical, behavioral health, and social needs.

3. **What can be offered in the field today that reduces overall risk (e.g., OD, worsening clinical status and/or job loss)?**
   The team can provide naloxone, overdose education, safer-use supplies, and information about withdrawal management. They can assess Jordan's pain and medical needs, discuss treatment options such as MAT, and connect him to same-day services. Practical supports, such as a work excuse note, transportation assistance, or help navigating benefits, may also reduce barriers that could interfere with treatment engagement and employment.

4. **How does this differ from asking Jordan to call a clinic himself?**
   Traditional referrals often place the burden on the individual to navigate complex systems while managing withdrawal, housing instability, and competing priorities. In contrast, assertive field-based outreach brings services directly to Jordan, offers immediate support, and reduces barriers to care. By providing real-time engagement, warm handoffs, and same-day access, the team increases the likelihood that Jordan will accept help and remain connected to services.

JORDAN'S JOURNEY: PART 3

LEARNING OBJECTIVES



1. Explain how same-day open-access care and rapid MAT initiation can reduce overdose risk, relieve withdrawal, and support immediate engagement in treatment.
2. Identify strategies that help Jordan remain engaged in recovery, including peer follow-up, flexible scheduling, pharmacy access, and coordination between the clinic and mobile team.
3. Describe how integrated care supports Jordan's recovery by addressing opioid use disorder, chronic pain, hepatitis C, physical rehabilitation needs, and employment stability.
4. Explain how AFBSS and healthcare partners can work together to create a low-barrier pathway from outreach to treatment initiation and ongoing care.

The peer walks with Jordan to one of the county's open-access clinics located inside a community health hub near transit. No appointment or insurance is required. The clinic reserves same-day slots for post-overdose referrals and has an onsite pharmacy, allowing Jordan to receive medication and speak with a pharmacist before leaving.

At the clinic, Jordan meets with a prescriber who explains treatment options for opioid use disorder. They discuss how buprenorphine can reduce withdrawal and cravings while allowing him to continue working. He also receives information about hepatitis C treatment and physical therapy. Jordan is given time to ask questions and make an informed choice, with no pressure to begin treatment. He agrees to begin medication that day and receives his first dose before leaving. The pharmacist reviews dosing, answers his questions, and explains what to expect. The clinic schedules follow-up and notifies the mobile team.

The peer walks him back to the parking lot. "Thanks for not making me feel like a screw-up," Jordan says.

PART 3 DISCUSSION QUESTIONS

1. **What makes this clinic "open access" for Jordan?**
2. **How can MAT reduce Jordan's overdose risk and support his recovery after an overdose?**
3. **What supports will help Jordan stay engaged while working?**
4. **How will your system respond if he misses a visit?**



Tip:

The goal is not simply to reduce missed appointments. It is to redesign care so that services fit the realities of people's lives.

PART 3 DISCUSSION NOTES



1. **What makes this clinic "open access" for Jordan?**
   The clinic removes many of the barriers that often prevent people from entering treatment. Jordan can be seen the same day, without an appointment, insurance, or lengthy intake process. The clinic also provides immediate access to medication, allowing him to act on his motivation when he is ready rather than waiting days or weeks for care.

2. **How can MAT reduce Jordan's overdose risk and support his recovery after an overdose?**
   MAT can reduce withdrawal symptoms and cravings, making it easier for Jordan to avoid returning to opioid use simply to feel well enough to function. Continued treatment with MAT can significantly reduce his risk of overdose and create an opportunity for stability while other medical, behavioral health, and social needs are addressed. For many individuals, MAT serves as a bridge from crisis to recovery.

3. **What supports will help Jordan stay engaged while working?**
   Flexible scheduling, peer support, ongoing outreach, and coordination between the clinic and mobile team can help Jordan balance treatment with employment. Addressing transportation, chronic pain, and other practical barriers may also improve retention. Supporting his goal of keeping his job reinforces that treatment can fit into his life rather than compete with it.

4. **How will your system respond if he misses a visit?**
   A recovery-oriented system views missed appointments as a signal for re-engagement rather than a reason for discharge. The team should attempt outreach, explore barriers, and reconnect Jordan to care as quickly as possible. Maintaining flexibility and keeping the door open increases the likelihood that he will return when he is ready.

CASE STUDY JORDAN - IMPACT



Jordan does not become “stable” overnight. Some weeks he struggles. Some days he uses more than he plans. The mobile team checks in. The clinic keeps its door open. For the first time, Jordan begins to believe that change might be possible without losing everything he has.

CASE STUDY: CHERYL 22

CHERYL'S JOURNEY: PART 1

Learning Objectives

Participants will be able to:

1. Name at least three data-driven outreach methods.
2. Explain why close monitoring is essential during the first 72 hours after a client is discharged from the hospital following an overdose.
3. Prioritize at least four immediate needs for the client.
4. Explore the client's strengths and identify her natural supports.
5. Describe at least three care transitions steps.



Cheryl is a 22-year-old Asian Pacific Islander, cisgender woman who identifies as bisexual. She is currently living in a squat in downtown Los Angeles. Cheryl was sexually abused during childhood by her uncle, who held significant influence within the family. When Cheryl tried to speak about what happened, her family refused to acknowledge it. In response, Cheryl coped with her feelings by rebelling. She began getting into fights at school, disengaged from her coursework, started drinking, experimented with street drugs, and had unprotected sex. At age 14, she ran away from home, prompting involvement from child protective services. She lived in numerous foster homes and was never connected with a foster family that led to a successful long-term placement. Because of her uncle's continued status within the family, she was unable to return home.

At times, Cheryl relied on survival sex with strangers to meet her basic needs and used stimulants, such as methamphetamine and ice, to stay awake for safety. As a result of multiple physical assaults, she experiences persistent pain, though the source has not been identified, possibly because of incomplete medical evaluations or poor follow-up. She has been prescribed medications such as Vicodin, Norco, and methadone to manage pain. Cheryl received prescriptions from multiple providers and used prescription medications regularly in addition to stimulants. As her life became more unstable, she also began purchasing opioids on the street,

drinking more alcohol, using marijuana, taking random pills, and using party drugs. She says substances help “numb her and help her sleep,” while stimulants allow her to “stay awake at night for safety.” She also recognizes that they no longer bring relief, only escape.

Cheryl has significant behavioral health needs. She has been diagnosed with depression, anxiety, and bipolar disorder. She also experiences chronic pain and uses stimulants, opioids, and alcohol to cope with her symptoms.

When her home life was more stable, Cheryl was a strong student and active in sports. She feels betrayed by her family and by the systems that were supposed to protect her. She carries deep personal trauma, compounded by the deaths of many peers, often because of substance use or violence. She is grieving, guarded, and uncertain about whom she can trust.

Cheryl has been hospitalized multiple times for overdoses and suicide attempts. Because she has been unhoused and spent years involved with the child welfare system, she is familiar with field-based services. She often engages with services and then disappears and has had multiple case managers. The AFBSS team conducts outreach at the squat based on data indicating a high concentration of people experiencing homelessness in the area.

During her most recent hospitalization, Cheryl reported chronic pain in her abdomen and back and learned that she is pregnant. She feels deeply ambivalent about the pregnancy. A year earlier, Cheryl experienced a miscarriage after being physically assaulted on the street, a loss that still weighs heavily on her.

Sherrie, the AFBSS nurse practitioner, receives a referral from the hospital discharge coordinator before Cheryl is released. Sherrie works with the hospital’s Bridge Program to initiate buprenorphine before discharge and prevent withdrawal symptoms, which is particularly important during pregnancy. Sherrie then arranges for a peer team member to meet Cheryl at the hospital, help her return to the squat to collect her belongings, and accompany her to a hotel where the hospital has arranged a 7-day stay. Sherrie understands that this may be an important opportunity to connect with Cheryl about harm reduction, MAT, and support related to the pregnancy and family planning.

While Cheryl is still in the hospital, she speaks with her cousin Jazz, who is about ten years older and has greater stability in her life. Jazz encourages Cheryl to pursue her GED and reminds her that she is capable of more. The current pregnancy has also prompted Cheryl to think about what she wants for herself and whether she could create a different future.

Cheryl reflects:

> *"I need my life to settle down. I am so tired of constant chaos, I just can't keep living like this. You know, getting high isn't even fun anymore, but everything just races without me taking something. I used to enjoy learning and studying, but that feels like it was so long ago and I feel old. I want something more for this baby if I keep it."*

These words reveal both the depth of Cheryl's exhaustion and the emergence of hope and resilience. For the first time in years, she is imagining a future that includes greater stability, purpose, and care for herself.

PART 1 DISCUSSION QUESTIONS

1. **Which data driven methods were utilized to alert the AFBSS team of Cheryl's overdose and upcoming discharge?**
2. **Please review the data-driven outreach methods listed below.**
    a. Which additional methods could be used to reach Cheryl and connect her with the AFBSS team?
    b. Which methods would likely be most effective for reaching Cheryl, and why? Choose all that apply.

- **Predictive Risk Stratification**
    - ☐ Use EHR and claims data to identify high-risk individuals
    - ☐ Monitor emergency department utilization and repeat ER visits reports
    - ☐ Track EMS encounters, overdose reversals, and crisis calls
    - ☐ Use hospital ADT feeds for real-time alerts
- **Geospatial and Hotspot Mapping**
    - ☐ Monitor areas with high overdose or crime rates
    - ☐ Identify youth-specific neighborhoods with elevated risk
    - ☐ Target populations with high prevalence based on demographic and public health data
- **Data-informed cross-sector collaboration**
    - ☐ Coordinate with community-based organizations
    - ☐ Partner with EMS, hospitals, public health, and managed care plans
    - ☐ Collaborate with jails, probation, and reentry programs
    - ☐ Share data through regular cross-system huddles or case reviews

3. **Discuss how any of the following AFBSS requirements would be essential for meeting Cheryl's needs and stated goals?**
    a. Data informed targeted outreach



Tip:
Focus first on Cheryl's immediate safety, pregnancy-related needs, and what she says she wants. Use nonjudgmental, trauma-informed engagement to build trust and support rapid follow-up.

b. Mobile field-based programs

c. Open-access clinics

4. **Cheryl is pregnant and alone. Identify some of the services to which Cheryl may need to be referred during her 7-day hotel stay to help prevent overdose and reduce risks to herself and her pregnancy, such as resorting to survival sex.**
5. **Discuss why 72 hours is so important for follow up after discharge when a client has overdosed.**
6. **We know that Cheryl is high-risk for overdosing and self-harm. We must also remember that AFBSS is strength-based and client-centered. What have we heard from Cheryl that will help Sherrie, the NP, when she uses motivational interviewing and goal setting to assist in building a strength-based relationship with Cheryl?**
7. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Cheryl? What might a safety plan look like and why?**

PART 2 DISCUSSION NOTES

1. **Which of the data-driven methods was utilized to alert the AFBSS team of Cheryl's overdose and upcoming discharge?**

   Data-driven cross-sector outreach and collaboration. The hospital discharge planner had a relationship with the mobile team and called them. Other examples include partnering with EMS, ERs, hospital discharge care managers.



2. **Please review the data-driven outreach methods listed below.**

   a. Which additional methods could be used to reach Cheryl and connect her with the AFBSS team?

   b. Which methods would likely be most effective for reaching Cheryl, and why? Choose all that apply.

PREDICTIVE RISK STRATIFICATION

Outreach Method	Effectiveness for Cheryl and Rationale
Use EHR and claims data to identify high-risk individuals	**LESS LIKELY TO BE EFFECTIVE** The EHR may be useful; however, the AFBSS team may not have access to hospital systems or claims data.
Monitor, Admit Discharge and Transfer (ADT) data, which typically includes emergency department utilization and repeat emergency department visit reports	**MAY BE EFFECTIVE** Cheryl's recent overdose may appear in emergency department utilization data. However, she may already have been discharged or lost to follow-up before the ADT information reaches the AFBSS team.

Track EMS encounters, overdose reversals, and crisis calls	**LIKELY TO BE EFFECTIVE** Cheryl's recent overdose, overdose reversal, or emergency response could generate timely information that supports outreach.
Use hospital ADT feeds for real-time alerts	**LIKELY TO BE EFFECTIVE** Real-time admission, discharge, and transfer alerts could notify the AFBSS team of Cheryl's hospitalization and upcoming discharge.

GEOSPATIAL AND HOTSPOT MAPPING

Outreach Method	Effectiveness for Cheryl and Rationale
Monitor areas with high overdose or crime rates	**MAY BE EFFECTIVE** Geographic trends may help identify areas where outreach is needed, but the information may not be specific enough to locate or engage Cheryl directly.
Identify youth-specific neighborhoods with elevated risk	**LIKELY TO BE EFFECTIVE** This approach may help the AFBSS team focus outreach in neighborhoods or locations where Cheryl and other young people at elevated risk may spend time.
Target populations with high prevalence based on demographic and public health data	**MAY BE EFFECTIVE** Population-level data can help guide outreach planning, but it may not provide enough information to identify or reach Cheryl directly.

DATA-INFORMED CROSS-SECTOR COLLABORATION

Outreach Method	Effectiveness for Cheryl and Rationale
Coordinate with community-based organizations	**LIKELY TO BE EFFECTIVE** Community-based organizations may already know Cheryl, have established trust with her, or be able to help the AFBSS team locate and engage her.
Partner with EMS, hospitals, public health, and managed care plans	**LIKELY TO BE EFFECTIVE** Cross-sector coordination can improve timely information sharing, outreach planning, and continuity of care following Cheryl's overdose and discharge.
Share data through regular cross-system huddles or case reviews	**LIKELY TO BE EFFECTIVE** Regular communication can help partners share relevant information, coordinate outreach, and reduce duplication across systems.
Collaborate with jails, probation, and reentry programs	**LIKELY TO BE EFFECTIVE WHEN RELEVANT** This approach may support outreach and continuity of care if Cheryl has current or recent contact with the justice system.

3. **Discuss how any of the following AFBSS requirements would be essential for meeting Cheryl's needs and stated goals?**

    a) Data informed cross-sector targeted outreach and collaboration

    b) Mobile field-based programs

    c) Open-access clinics

    Both B and C are important for meeting Cheryl's needs. Mobile field-based programs can provide naloxone, overdose prevention support, safer-use supplies, and initiation or continuation of MAT when a qualified prescriber is available. This approach may be especially helpful given Cheryl's history of leaving traditional care settings. An open-

access clinic can provide ongoing MAT, medical care, and follow-up for her pregnancy, back pain, and pelvic inflammatory disease. The best approach may involve beginning care in the field and connecting Cheryl to the clinic for continued services.

4. **Cheryl is pregnant and alone. Identify some of the services to which Cheryl may need to be referred during her 7-day hotel stay to help prevent overdose and reduce risks to herself and her pregnancy, such as resorting to survival sex.**

   Cheryl may benefit from referrals and supports that address her immediate safety, health, and stability, including:

   - Enhanced Care Management and a Lead Care Manager
   - Prenatal and primary care
   - MAT and mental health services
   - Transportation and appointment support
   - Food, clothing, and medication assistance
   - Phone access
   - Emergency and longer-term housing
   - Benefits and community resources for pregnant people
   - Depression screening using the PHQ-9 and anxiety screening using the GAD-7
   - Connection to her cousin or another trusted support, if she agrees
   - Positive social connections and other community supports

   The mobile outreach team should be knowledgeable about available state, county, and city resources, including Medi-Cal managed care Enhanced Care Management and Community Supports programs. The team should also continue providing practical support while referrals are being established, such as helping Cheryl obtain food, clothing, transportation, medications, and a phone, accompanying her to appointments, and connecting her with a trusted social worker.

5. **Discuss why follow-up within 72 hours after discharge is important when a client has overdosed.**

   The first 48 to 72 hours after discharge are a critical period because overdose risk may remain high, especially if a person's opioid tolerance has decreased during hospitalization. Even clients who have started MAT may return to use because of cravings, triggers, emotional distress, or untreated mental health symptoms. In Cheryl's case, depression and anxiety may increase her vulnerability during this period, and some mental health medications may take several weeks to have their full effect.

This timeframe is especially important for the following reasons:

Peak Mortality Risk

The first 48 to 72 hours after discharge are a critical period because of elevated overdose risk and the opportunity for rapid treatment engagement.

Extreme Vulnerability

Research indicates that roughly *4.6% of deaths* occurring within a year of an overdose happen within the first *two days* post-discharge.

Loss of Tolerance

After even a brief period of abstinence in the hospital, the body's tolerance for opioids drops. If a client returns to their previous dose, it can be lethal.

The "Window of Opportunity"

The first 72 hours after discharge may provide an important opportunity to engage clients in treatment and connect them with ongoing care.

High Receptivity

A recent brush with death can serve as a powerful motivator. Clients are often most open to starting treatment or *Medications for Opioid Use Disorder (MOUD)* during this immediate post-crisis phase.

The "72-Hour Rule"

Federal regulations (21 CFR 1306.07) allow hospitals to provide up to *72 hours of methadone* or buprenorphine as a "bridge" to keep the patient stable while they transition to a long-term clinic. Programs should confirm applicable requirements and local procedures.

The team should discuss these risks with Cheryl and review practical harm reduction strategies, including:

- Provide naloxone education and kits
- Make sure Cheryl and others around her know how to use naloxone
- Do not use alone

- Do not stack doses or take another dose too quickly
- Start with a small test amount
- Use drug-checking strips when available
- Avoid injecting when possible
- Keep a phone nearby and call for help if needed
- Coordinate MAT initiation or continuation when possible
- Arrange clear follow-up within the first 72 hours

6. **We know that Cheryl is high-risk for overdosing and self-harm. We must also remember that AFBSS is strength-based and client-centered. What have we heard from Cheryl that will help Sherrie, the NP, when she uses motivational interviewing and goal setting to assist in building a strength-based relationship with Cheryl?**

   Cheryl has identified several strengths, goals, and sources of motivation that Sherrie can build upon:

   - She says, "I need my life to settle down. I am so tired of constant chaos."
   - She wants something more for herself and her baby.
   - She is tired of using substances just to get through the day.
   - She enjoys learning and was previously a strong student.
   - She has support from her cousin Jazz.
   - She has engaged with mobile teams in the past.

   These statements reflect exhaustion, hope, and a desire for stability. Sherrie can use open-ended questions, reflective listening, and collaborative goal setting to help Cheryl identify realistic next steps based on what matters most to her. Consistent follow-through will be essential for building trust.

7. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Cheryl? What might a safety plan look like, and why?**

   The first priority should be Cheryl's immediate safety, including overdose risk, self-harm risk, safe shelter, and access to urgent medical care. The team should coordinate with the hospital discharge planner, determine whether MAT can be initiated or continued before discharge, and identify who will reach Cheryl if Sherrie is unavailable.

   A collaborative safety plan may include:

   - Providing naloxone and reviewing how to use it
   - Encouraging Cheryl not to use alone
   - Making sure she has a working phone and someone to call

- Reviewing safer-use strategies and drug-checking options
- Confirming safe shelter, food, transportation, and medications
- Identifying a trusted support person, if Cheryl agrees
- Scheduling a specific follow-up time within 24 to 72 hours
- Clarifying which team member will contact her and what will happen if she misses the visit

The plan should be developed with Cheryl and reflect her priorities. Other team members, such as a social worker, outreach worker, peer advocate, community health worker, provider, or nurse, may also be introduced based on her needs. All mobile team members should be prepared to provide basic harm reduction education and support, rather than relying on one designated harm reduction specialist.

CASE STUDY CHERYL-CONTINUED

CHERYL'S JOURNEY: PART 2

LEARNING OBJECTIVES



1. Identify at least two ways to reduce Cheryl's risk of overdose.
2. Describe the benefits of the Clinical Opiate Withdrawal Scale (COWS) screening tool.
3. Name at least one way to support Cheryl's continued engagement.

Cheryl is taking her buprenorphine. She hates staying at the hotel alone; she feels lonely and scared. However, it is better than squatting. Sherrie, the NP and the AFBSS team have been making daily visits to make sure Cheryl has food, and they are assessing how she is tolerating the medications. One day prior to the end of her hotel stay, Cheryl miscarried alone. After the miscarriage she gets "high" but does not overdose and instead gets to the hospital after a 911 call. The ED confirms the miscarriage. Cheryl asks them to contact the AFBSS team. When the team arrives, Cheryl then gives the AFBSS team the number for her cousin Jazz. Cheryl verbalizes to Jazz that she is tired and needs to get off the street and needs help. Cheryl did not stop taking MAT prescribed meds. She just started using street opioids in addition to taking her MAT. She wants to go back to the clinic, tell the truth, and get on track again.

The AFBSS team, the substance use counselor, monitors Cheryl's Clinical Opiate Withdrawal Scale (COWS) score to support her in resuming buprenorphine without precipitating withdrawal. Because of Cheryl's distrust of the system, an AFBSS social worker comes to support her in processing her miscarriage and helps get her connected with her cousin.

The mobile team can continue to support Cheryl while she is with her cousin Jazz's house because she is technically "precariously" housed. Because of Cheryl's negative experiences with traditional health and social services, it may be important to consider mobile support as opposed to clinic-based services. The team ensures that Cheryl gets started on and is tolerating her MAT. They also work to get her connected to the open-access clinic, link her to a primary care provider (PCP) and an enhanced care management (ECM) program. Depending on the clinic and the relationship the mobile team has with the clinic, the team may be able to follow Cheryl

or co-manage her care until she is stabilized. Connecting with Jazz is very important and attempting to evaluate how stable the situation is for Cheryl.

PART 2 DISCUSSION QUESTIONS

1. **Cheryl has made great progress, and it appears she has connected with the AFBSS team. It is important that they begin easing support as they transition her to an open-access clinic. What are the care transition strategies the AFBSS team might consider?**

   - ☐ Warm hand-offs
   - ☐ No abrupt discharge
   - ☐ Open transparent conversations and that Cheryl is involved in all transition conversations
   - ☐ Always keep the door open
   - ☐ Documentation is current and up to date
   - ☐ Care Plan is current with all the appropriate contact information



Tip:
Focus on grief, safety, and continuity. Cheryl's miscarriage and return to using call for compassionate re-engagement, not punishment.
Keep support steady, involve Cheryl in transition planning, and use warm handoffs to maintain trust.

PART 2 DISCUSSION NOTES

1. **Cheryl has made great progress, and it appears she has connected with the AFBSS team. It is important that they begin easing support as they transition her to an open-access clinic. What are the care transition strategies the AFBSS team might consider?**



- ☐ Warm hand offs
- ☐ No abrupt discharge
- ☐ Open transparent conversations
- ☐ Always keep the door open
- ☐ Documentation is current and up to date
- ☐ Care Plan is current with all the appropriate numbers

Each of the above steps is essential.

- **Warm hand-offs** ensure that Cheryl and the new team have been introduced to each other and have all the important information. Ideally the warm hand-off happens in-person, however it can be done a) over the phone, b) via a web-based format. The important issue is Cheryl feels she is being cared for, and the new providers know about her journey.
- **No abrupt discharge**: It is critical to prepare Cheryl to the best of your ability that her care services will be transitioning, and you will be there to help her in the process. She has built trust and may become dysregulated and stressed if your regular supports are "abruptly" stopped without her having ample time to prepare. Start the transition conversation as early as it seems appropriate.
- **Open transparent conversations:** Be honest and timely with all communication. Include Cheryl and important others in the information loop. NO secrets.
- **Always keep the door open**: Let Cheryl know that AFBSS is always available and willing to help. Ensure that she has contact numbers that work.
- **Documentation is current and up to date:** Document every step of the transition plan. Make sure it is complete with numbers, emails, addresses and all essential information if you have it. If you have made referrals include in your documentation.
- **Care Plan is current with all the appropriate numbers:** Cheryl and the open-access clinic must have a current copy of the care plan. Updated with diagnosis, medications, allergies, important contact information, address, PCPs, insurance information, and Cheryl's short-, mid- and long-term goals.

CASE STUDY CHERYL: IMPACT



Cheryl has periods when she is very engaged in her recovery and consistently participates in her recovery program. However, grief, trauma, and loss continue to shape her experience, and there are periods when she struggles and uses in combination with her MAT or disappears all together. Rather than disengaging, she remains connected to the AFBSS team, supported by consistent outreach, reengagement, and a non-punitive response to setbacks. The AFBSS team and Jazz do notice that the lapses in Cheryl's recovery are longer. She circles back and continues to say she wants "a life without getting high".

The combined support of the mobile team, open-access clinic, and her cousin's help keep Cheryl engaged during the highly vulnerable period. Over time, she begins to trust that care will continue even when things are difficult. While her progress is uneven, Cheryl starts to believe that stability, safety, and a choice and may be possible—and that she does not have to face recovery alone.

CASE STUDY PAUL, 39

PAUL'S JOURNEY: PART 1

LEARNING OBJECTIVES

Participants will be able to:



1. Identify clinical, behavioral health, and social factors that place Paul at elevated risk for adverse outcomes, including overdose, medical deterioration, victimization, and premature death.
2. Recognize indicators that suggest Paul may benefit from assertive field-based outreach rather than traditional clinic-based engagement.
3. Describe how trauma, serious mental illness, homelessness, and prior experiences with systems may influence engagement and treatment readiness.
4. Identify strengths, motivations, and protective factors that can serve as entry points for engagement and relationship-building.
5. Prioritize initial outreach goals and interventions that promote safety, trust, and continued engagement.

Paul is a 39-year-old Black man living in a tent community on the edge of the city. He was diagnosed with schizophrenia at age 19 and has experienced multiple hospitalizations and periods of incarceration related to untreated symptoms, substance use, and survival behaviors. Over the years, he has been arrested for trespassing, disorderly conduct, and low-level theft. These encounters have shaped his worldview. Paul believes systems exist to control him, not help him.

Paul has limited contact with family. Most relatives have lost touch, but one sister still checks on him. She brings food or clothing when she can and worries about his health. Paul cares deeply about her, but he feels ashamed of his circumstances and does not want to be a burden.

His experiences with behavioral health care have often been coercive. He associates treatment with involuntary hospitalizations, being restrained, medicated against his will, and spoken to as

if he is dangerous or incapable. As a result, he is wary of providers and frequently disengages. The care feels like something done to him, not with him.

Paul does not access primary care. He believes medical providers see him as “disgusting” because he is unhoused and struggles with hygiene. Past encounters in emergency departments, where he felt rushed, judged, or ignored, confirmed his sense that he is not welcome. He avoids clinics unless his condition becomes unbearable.

Medically, Paul has uncontrolled type 2 diabetes. He has chronic foot ulcers from walking long distances in ill-fitting shoes and experiences frequent infections, numbness in his legs, dizziness, and fatigue. He does not understand how diabetes works or why it matters. These symptoms worsen his ability to care for himself and increase his vulnerability on the streets.

Paul smokes methamphetamine and drinks alcohol. Meth helps him stay alert and feel protected at night. Alcohol quiets the voices when they become overwhelming. He does not see his substance use as a problem. It feels like the only way to survive. When providers focus immediately on abstinence, Paul feels misunderstood and shuts down.

Paul has lived with trauma since childhood, neglect and violence at home, followed by years as the victim of assault, theft, and harassment while unhoused. He lives in a constant state of vigilance. His paranoia and hallucinations are intertwined with real threats he has faced.

Despite everything, Paul has not lost his capacity for connection. He values his sister’s care and protects her from seeing the worst of his circumstances. When he feels safe, he is thoughtful and articulate. What he wants most is dignity. He does not say, “I want treatment,” but he does say, “I don’t want to die out here,” and “I’m tired of people talking to me like I’m nothing.”

PART 1 DISCUSSION QUESTIONS

1. **Based on what you know so far, would Paul meet your county's criteria for priority outreach? Why?**

2. **What specific indicators suggest elevated risk of overdose or medical vulnerability?**

3. **In your County, what data sources could surface for someone like Paul, for example EMS calls, ED visits, street outreach logs, jail releases, public health surveillance?**

4. **Who in your system would see Paul, and what would trigger action?**

5. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Paul? Why?**



Tip:
Shared goals and mutual respect improve coordination and reduce fragmentation. Foster trusting relationships across disciplines, including primary care, behavioral health, substance use treatment, peer support, social services, housing, emergency medical services, hospitals, public health, and justice partners. Try to have or be a trusted ally with this client when meeting others face to face with this client, his mental health condition may make him distrustful.

PART 1 DISCUSSION NOTES



1. **Based on what you know so far, would Paul meet your county's criteria for priority outreach? Why?**
   Yes. Paul presents with multiple factors commonly associated with high-risk populations targeted by AFBSS, including homelessness, serious mental illness, substance use, chronic medical conditions, justice involvement, and repeated disengagement from care. He faces significant barriers to accessing traditional services and is at risk for worsening health, victimization, hospitalization, and premature death.

2. **What specific indicators suggest elevated risk of overdose or medical vulnerability?**
   Paul's methamphetamine and alcohol use, untreated schizophrenia, uncontrolled diabetes, chronic foot ulcers, and lack of regular medical care all increase his vulnerability. His homelessness, history of trauma, and limited support network further elevate risk. Even if overdose is not the most immediate concern, his overall health status suggests a high likelihood of serious adverse outcomes.

3. **In your county, what data sources could surface for someone like Paul, for example EMS calls, ED visits, street outreach logs, jail releases, public health surveillance?**
   Counties could identify Paul through EMS encounters, emergency department visits, psychiatric crises, hospital ADT feeds, jail booking and release data, homeless outreach programs, street medicine teams, and public health surveillance systems. Cross-sector collaboration increases the likelihood that individuals with complex needs are identified before a crisis occurs.

4. **Who in your team would see Paul, and what would their role be?**
   Depending on the system, Paul might be identified by a street outreach worker, peer specialist, street medicine team, behavioral health provider, homeless services program, or justice reentry partner. Action may be triggered by repeated crisis contacts, worsening medical conditions, encampment outreach efforts, jail release, or concerns raised during multidisciplinary case reviews.

5. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Paul? Why?**
   Trust and safety would likely be the first priorities. Paul has a long history of trauma and experiences with systems that felt coercive, making engagement difficult. Addressing an

immediate concern such as food, water, medical needs, wound care, clean socks, or simply listening without judgment may be more effective than focusing immediately on treatment or abstinence. Building trust creates the foundation for addressing his behavioral health, substance use, and medical needs over time.

CASE STUDY PAUL-CONTINUED

PAUL'S JOURNEY: PART 2

LEARNING OBJECTIVES

1. Identify how data-informed outreach strategies can be used to locate and engage high-acuity individuals who are unlikely to access traditional care.
2. Describe the roles of peer, nursing, and behavioral health team members in supporting engagement, safety, and stabilization in the field.
3. Develop initial care plan priorities that address Paul's immediate medical, behavioral health, substance use, and social needs.



Over the past six months, Paul has appeared repeatedly in local data streams: two EMS calls for hypoglycemia, three emergency department visits for infected foot wounds, and a brief jail stay following a trespassing charge. The county's weekly cross-sector huddle brings together EMS, the hospital, public health, street outreach, and the jail reentry team. Using predictive risk stratification, Paul is placed in the county's highest-risk cohort for overdose and medical instability. His name appears again and again.

The encampment where Paul lives is one of three locations identified through geospatial mapping of overdoses, EMS calls, and wound-care transports. It is marked as a priority hotspot for field-based outreach. Paul is also listed as "location unstable" after multiple failed clinic follow-ups, a BOLO-style flag that signals he is unlikely to be reached through routine care. A referral is generated for the county's assertive field-based program.

Two days later, a mobile team visits the encampment. This team operates seven days a week and carries shared responsibility for high-acuity individuals. It includes a peer support specialist with lived experience of homelessness, a nurse, and a behavioral health clinician. The team distributes safe use supplies and testing strips so he can test his methamphetamine. They arrive without uniforms, sirens, or clipboards.

The peer support specialist approaches first. ***"I'm not here to make you do anything,"*** she says. ***"I just wanted to check in and see how you're doing."***

Paul is guarded. He expects pressure. Instead, they ask about his feet. The nurse offers to look at the ulcers. The peer support specialist hands him clean socks and a sandwich. No one mentions treatment. No one threatens consequences.

They return the following week, and the week after that.

Trust builds slowly.

One afternoon, Paul says, ***"I don't want to die out here."***

The clinician responds, ***"What would make things even a little safer right now?"***

Paul talks about the voices, about being tired, about how alcohol helps at night.

The team offers naloxone, wound care, glucose testing, and a brief explanation of diabetes in plain language. The nurse cleans and dresses his foot. The peer support specialist asks whether he would be open to visiting a nearby drop-in clinic, with no appointment, no forms, and a place to sit, rest, and talk.

Paul hesitates. ***"They're going to judge me."***

The peer says, ***"I can go with you. You don't have to do this alone."***

PART 2 DISCUSSION QUESTIONS



1. **Who should be on the mobile team for someone like Paul?**

2. **What does "meeting him where he is" look like in this encounter?**

3. **What can realistically be offered in the field today?**

4. **How would your team avoid repeating the coercion Paul associates with care?**



Tip:
Lead with dignity, safety, and choice. Paul may not be ready to talk about treatment, but offering wound care, food, clean socks, harm reduction supplies, and respectful listening can build trust.

PART 2 DISCUSSION NOTES



1. **Who should be on the mobile team for someone like Paul?**
   A peer support specialist, nurse, and behavioral health clinician are all important members of the team. The peer can help build trust and reduce stigma through shared lived experience. The nurse can address urgent medical concerns such as wound care and diabetes, while the behavioral health clinician can support Paul's schizophrenia, trauma history, and overall engagement. Together, the team can address his complex and interconnected needs.

2. **What does "meeting him where he is" look like in this encounter?**
   Meeting Paul where he is means engaging him in the encampment rather than expecting him to come to a clinic. It also means focusing on the concerns that matter most to him, including safety, dignity, physical discomfort, and survival. The team listens first, avoids judgment, and allows trust to develop before discussing treatment or behavior change.

3. **What can realistically be offered in the field today?**
   The team can provide wound care, glucose monitoring, naloxone, safer-use supplies, food, water, clean socks, and education about his health conditions. They can assess immediate safety concerns, address basic needs, and begin building a relationship. These services reduce risk while creating opportunities for future engagement and treatment.

4. **How would your team avoid repeating the coercion Paul associates with care?**
   The team should emphasize choice, transparency, and collaboration. Rather than telling Paul what he must do, they can ask about his priorities, offer options, and respect his decisions. His goals should be reflected and prioritized in the care plan, with the team revisiting and adjusting them as appropriate. Consistent, nonjudgmental interactions help demonstrate that care is being provided with him rather than to him, which can gradually rebuild trust.

CASE STUDY PAUL-CONTINUED

PAUL'S JOURNEY:PART 3

LEARNING OBJECTIVES

1. Describe how open-access clinics reduce barriers to care and support engagement for individuals with complex medical, behavioral health, and substance use needs.
2. Identify harm reduction, medical, and behavioral health interventions that can be initiated during a same-day clinic encounter.
3. Evaluate treatment, housing, and stabilization options that best align with Paul's needs, goals, and readiness for change.



The next morning, the peer walks with Paul to one of the county's designated open-access clinics. It is co-located in a drop-in center that also offers showers, meals, and harm reduction supplies. The clinic is open 7 days a week with evening hours two nights a week. No appointment or insurance is required, and people receive treatment on demand. The clinic has coffee, water, and snacks in the event there is a wait to be seen. Paul is offered coffee. A nurse greets him by name.

That same day, Paul receives wound care, a brief mental health assessment and practical harm reduction support. Staff offer safer-use supplies, including smoking equipment, wound-care kits, and fentanyl and xylazine test strips, and review how to use them. Overdose prevention and safer use strategies are discussed in a respectful, nonjudgmental way. A prescriber is available, and they have a conversation about medication options that could help quiet the voices and support sleep without making him feel trapped. They also discuss medications that may reduce alcohol cravings and help stabilize psychotic symptoms. The clinic uses a recovery incentives program (i.e., contingency management) as an evidence-based practice to treat simulant use disorder and explain this as a potential opportunity to engage Paul when he is ready. Nothing is forced. Everything is explained.

Paul agrees to try a medication that might help him feel steadier at night. The clinic schedules follow-up and notifies the mobile team. The peer walks with him back to the encampment.

PART 3 DISCUSSION QUESTIONS

1. **What makes this clinic "open access" for Paul?**
2. **How would your County ensure same-day or next-day MAT?**
3. **If Paul is interested in contingency management, how would you operationalize referral or bridging?**
4. **If medications for alcohol use disorder (MAUD) are indicated, how would you operationalize initiation?**
5. **Which supports can the team offer that will help prevent Paul from falling through the cracks?**



Tip:

Apply person-centered decision-making principles when discussing medication, recovery supports, and ongoing care.

PART 3 DISCUSSION NOTES

1. **What makes this clinic "open access" for Paul?**
   The clinic removes common barriers: no appointment, no insurance requirement, seven-day access, evening hours, and treatment on demand. It is also co-located with practical supports like meals, showers, harm reduction supplies, and drop-in services, which makes it more accessible and less stigmatizing for Paul.

2. **How would your county ensure same-day or next-day MAT?**
   The county needs clear workflows for rapid assessment, same-day prescriber access, pharmacy access, and warm handoffs from the mobile team. If medication cannot be started onsite, the team should have standing referral pathways to open-access clinics, FQHCs, NTPs, or mobile medication units.

3. **If Paul is interested in contingency management, how would you operationalize referral or bridging?**
   The team could introduce contingency management as an option without pressure, explain how incentives work, and connect Paul directly to a program that can enroll him quickly. Bridging may include peer accompaniment, flexible scheduling, reminders, and allowing him to start with low-burden check-ins before requiring regular attendance.

4. **If medications for alcohol use disorder (MAUD) are indicated, how would you operationalize initiation?**
   The clinic could assess alcohol use, withdrawal risk, liver function, current medications, and Paul's preferences before starting medication. If clinically appropriate, a prescriber could initiate medication onsite or arrange next-day follow-up, with the mobile team supporting adherence and monitoring.

5. **Which supports can the team offer that will help prevent Paul from falling through the cracks?**
   Key supports include peer follow-up, field-based check-ins, transportation, flexible appointments, wound care follow-up, harm reduction supplies, medication support, and care coordination between the clinic and mobile team. The team should treat missed visits as a trigger for re-engagement, not discharge.

CASE STUDY PAUL-IMPACT

PAUL, 39YR.



Paul does not become “stable” overnight. Some weeks he misses appointments. Some days he uses more than he plans. The mobile team keeps returning. The clinic remains open to him without penalty. For the first time in years, Paul begins to believe that care might be something that happens with him, not to him. And that belief, fragile as it is, becomes the foundation for everything that follows.

CASE STUDY LEANNE, 55

LEANNE'S JOURNEY: PART 1

LEARNING OBJECTIVES

Participants will be able to:

1. Recognize factors that place Leanne at elevated risk for behavioral health, medical, and social crises.
2. Describe how trauma, family relationships, identity, and prior treatment experiences may influence engagement with services.
3. Identify strengths and priorities that can be used to build trust, enhance stability, and support recovery.



Leanne is a 55-year-old African American woman and the mother of three adult children. She lives with bipolar disorder and is currently treated with mood stabilizers and antipsychotics, which she takes intermittently. Her substance use pattern is intertwined. During destabilized periods she also uses cocaine and occasionally methamphetamine, especially when she feels restless, energized, or disconnected. This sets up a vicious cycle of further exacerbation of symptoms and substance use that often escalate into medical or psychiatric crises and result in emergency department visits or short hospitalizations.

Several years ago, Leanne left her 20-year marriage to be with a female partner. For the first time in her life, she felt seen and chosen for who she truly was. The relationship lasted about a year and then ended. In a short span of time, Leanne lost her marriage, her partner, and much of her sense of belonging. These relationship changes reverberated through her family.

Her children had difficulty understanding her decision to leave her husband and be with a woman and experienced the change as abrupt and destabilizing. Some family members expressed open disapproval, while others withdrew emotionally. Although contact was not entirely severed, family members became less engaged and stopped initiating communication. Leanne now feels judged not only for her mental health and substance use, but for who she loves. She worries that her children see her as unstable and morally suspect.

Without a partner, without a home of her own, and without steady work, Leanne feels untethered. She currently lives with her youngest daughter and her daughter's family. While the arrangement provides housing, the relationship is strained. Her daughter experiences Leanne as emotionally intense and unpredictable. Conflict is frequent, and there is ongoing pressure for Leanne to leave her daughter's place. Leanne fears being passed from one household to another or rejected altogether. She is currently unemployed, though she has strong skills and long experience as a waitress. She talks about wanting to work again but feels physically and emotionally depleted.

Leanne was sexually abused as a child. She has never fully processed this trauma and carries a deep sense of shame and mistrust. As an adult, she learned to manage distress by staying busy, caring for others, and suppressing her own needs. Much of her identity became wrapped up in being a wife and mother. When her children grew up, and her marriage ended, the structure that had anchored her sense of self disappeared.

Leanne also has chronic obstructive pulmonary disease (COPD) from decades of cigarette smoking. She has a persistent cough, shortness of breath, and frequent bouts of bronchitis. During manic periods, she smokes more heavily, neglects her inhalers, and ignores early signs of infection. Hospital visits related to stimulant use often reveal concurrent respiratory complications such as wheezing, hypoxia, or pneumonia. Her COPD limits her stamina and confidence about returning to work, which reinforces withdrawal and dependence on her family.

Leanne has tried both mental health therapy and substance use disorder (SUD) treatment multiple times and reports that "it doesn't help." Her daughter, however, consistently notices that Leanne is less reactive and less emotionally dependent on the family when she is engaged in either therapy or SUD treatment.

Despite her challenges, Leanne has meaningful strengths. She is warm, socially adept, and capable of deep connection. She has a long work history and takes pride in being competent and useful. She cares deeply about her children's opinions and wants to be seen as less "difficult." While she does not say that she wants therapy or SUD treatment, she does express a desire for her family to stop "walking on eggshells" around her and wants to feel steady enough to return to work.

PART 1 DISCUSSION QUESTIONS

1. **Would Leanne meet your county's criteria for assertive field-based outreach? Why or why not?**
2. **What indicators suggest elevated risk, even though she is not unhoused?**
3. **What data sources in your county could surface someone like Leanne?**
4. **How might stigma, identity, and family rupture shape your outreach strategy?**
5. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Leanne? Why?**



Tip:

Notice Leanne's risks beyond housing status, including crises, health needs, family stress, and isolation.

Focus on trust, identity, and her goals of feeling steady and returning to work.

PART 1 DISCUSSION NOTES



1. **Would Leanne meet your county's criteria for assertive field-based outreach? Why or why not?**
   Yes. Although Leanne is not unhoused, she experiences repeated behavioral health and medical crises, co-occurring mental health and substance use conditions, social isolation, and unstable living circumstances. Her frequent emergency department utilization and difficulty maintaining engagement in care suggest she may benefit from proactive outreach and support.
2. **What indicators suggest elevated risk, even though she is not unhoused?**
   Leanne experiences repeated cycles of mania, depression, stimulant use, and hospitalization. Her COPD, medication nonadherence, unemployment, family conflict, and limited social support increase her vulnerability. The risk is not only homelessness or overdose, but also worsening physical health, psychiatric destabilization, and loss of housing stability.
3. **What data sources in your county could surface someone like Leanne?**
   Leanne might be identified through hospital ADT feeds, emergency department utilization data, crisis response records, managed care claims, behavioral health treatment records, or care management programs.
4. **How might stigma, identity, and family rupture shape your outreach strategy?**
   Leanne has experienced rejection related to both her behavioral health challenges and her same-sex relationship. Outreach should acknowledge these experiences, avoid assumptions, and create space for her to discuss loss, identity, and belonging. Building trust may require demonstrating respect for her lived experience and focusing on what matters most to her rather than immediately focusing on treatment.
5. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Leanne? Why?**
   The initial priority would be to build trust while assessing immediate safety and stability. Leanne consistently expresses a desire to feel steadier, reduce family conflict, and return to work. Exploring those goals, while also assessing her COPD symptoms, mental health status, and substance use, creates an opportunity to engage her around issues she views

as meaningful and relevant.

CASE STUDY LEANNE-CONTINUED

LEANNE'S JOURNEY: PART 2

LEARNING OBJECTIVES

1. Identify ways the outreach team demonstrates person-centered, "meet them where they are" engagement.
2. Describe strategies that build trust and avoid re-traumatization during outreach encounters.



One evening, Leanne is brought to the emergency department by her daughter after several days of escalating agitation, sleeplessness, and heavy stimulant use. She is treated for shortness-of-breath and discharged the next morning with instructions to restart her COPD and psychiatric medications.

Within hours, the county's ADT feed flags the visit. Leanne is already known to the system from prior ED encounters. The alert routes her into the county's "frequent crisis" cohort, a predictive risk tier for individuals with repeated emergency use and co-occurring needs. Each morning, a cross-sector huddle reviews this list, including representatives from hospitals, crisis services, managed care, and the county's assertive field-based program. Leanne's name appears again and a re-engagement referral is generated.

Two days later, a mobile field-based team reaches out. This team operates seven days a week and carries shared responsibility for individuals with high-acuity, co-occurring needs. It includes a peer support specialist, a nurse, and a behavioral health clinician. They call ahead and ask if it is okay to stop by. Leanne is wary but agrees.

The peer begins, ***"We heard you had a rough night at the hospital. We're not here to make you do anything. We just wanted to check in and see how you're feeling today."***

Leanne is defensive at first. ***"I'm fine. They always overreact."***

The nurse notices her cough and asks about her breathing. The clinician asks what the hospital visit was like. No one lectures. No one demands compliance.

Leanne admits she is exhausted. ***"I just want my kids to stop treating me like a bomb that could go off. And I'm tired of being judged for who I am."***

The peer reflects, ***"You want steadiness, and you want to be seen for who you really are."***

They talk about what "steady" would look like. Leanne says she wants to work again and wants to feel like herself without everyone watching her.

The team offers practical, in-the-moment support. The nurse reviews Leanne's inhalers, observes how she uses them, and offers gentle coaching to improve her technique, helping ensure the medication is reaching her lungs. The nurse also checks her oxygen level.

The peer asks if Leanne would be open to visiting a nearby drop-in clinic, a place where she could talk to someone about her medications and her goals without waiting weeks for an appointment.

"It's not like those other places?" Leanne asks.

The peer pauses. ***"What have those other places been like for you?"***

Leanne hesitates, then begins to describe feeling rushed, judged, and overwhelmed in past settings.

"This is different," the peer says. "No appointments. You walk in. You leave when you're done. And I can go with you."

PART 2 DISCUSSION QUESTIONS

1. **What does "meeting Leanne where she is" look like in this encounter?**

2. **Who needs to be on this mobile team to address her needs?**

3. **What can be offered in the home today that builds trust and affirms identity?**

4. **How does this differ from traditional clinic-based follow-up?**



Tip:
Recognize opportunities to address immediate health, behavioral health, and recovery needs while supporting ongoing engagement.

PART 2 DISCUSSION NOTES

1. **What does "meeting Leanne where she is" look like in this encounter?**
   The team engages Leanne in her home after asking permission to visit, rather than expecting her to come to a clinic. They focus on the issues that matter most to her, including feeling steady, improving family relationships, and returning to work. Rather than focusing immediately on compliance or treatment, they listen to her experiences and build the conversation around her goals and concerns.



2. **Who needs to be on this mobile team to address her needs?**
   A peer support specialist can help build trust, reduce stigma, and connect around shared experiences. A nurse can address COPD management, medication use, and other health concerns. A behavioral health clinician can support Leanne's bipolar disorder, substance use, trauma history, and recovery goals. Together, the team can address the full range of her medical, behavioral health, and social needs.

3. **What can be offered in the home today that builds trust and affirms identity?**
   The team can provide respectful listening, validation of her experiences, education about her medications and COPD, and practical support tailored to her goals. Acknowledging the impact of stigma, family rejection, and previous negative treatment experiences can help Leanne feel seen and understood. Helping her identify meaningful next steps toward stability and independence may be more engaging than focusing solely on symptoms or treatment adherence.

4. **How does this differ from traditional clinic-based follow-up?**
   Traditional follow-up often relies on individuals scheduling appointments, arranging transportation, and navigating systems on their own. In contrast, the mobile team brings services directly to Leanne, reduces barriers, and creates opportunities for engagement in a familiar environment. This approach allows the team to build relationships, address immediate concerns, and respond to needs in real time rather than waiting for Leanne to seek help.

CASE STUDY LEANNE-CONTINUED

LEANNE'S JOURNEY: PART 3

LEARNING OBJECTIVES

1. Describe the role of peer support specialists in facilitating engagement, trust, and continuity of care.
2. Explain how same-day, open-access services reduce barriers and support treatment engagement.
   Identify low-barrier and recovery-oriented interventions that support Leanne's behavioral health, substance use, and medical needs.



The next afternoon, the peer meets Leanne at her daughter's house and walks with her to one of the county's designated open-access clinics. The clinic is housed in a community wellness center that also offers peer navigation, recovery groups, and primary care. No appointment or insurance is required.

That same day, Leanne meets with a prescriber who listens to her concerns about feeling "flat." They discuss options for mood stabilization that preserve her sense of self. She also speaks with a counselor who asks about her goals, not just her symptoms. The clinic connects her with smoking cessation support and schedules a follow-up for her COPD. The mobile team receives confirmation that she came in. The peer walks with her to her home. On the way, Leanne comments, "They didn't make me feel crazy."

PART 3 DISCUSSION QUESTIONS

1. **What makes this clinic "open access" for Leanne?**
2. **How does same-day care change the likelihood of engagement?**
3. **What role does the peer play in continuity?**
4. **How will your system respond if Leanne misses her next visit?**



Tip:
Notice how same-day, open-access care and peer support help Leanne act on trust before barriers or hesitation return.

Think about how your system can keep the door open if she misses a visit.

PART 3 DISCUSSION NOTES



1. **What makes this clinic "open access" for Leanne?**
   The clinic removes barriers that often prevent engagement, including appointment requirements, insurance requirements, and long wait times. Leanne can be seen the same day, receive integrated services in one location, and access care that addresses her behavioral health, substance use, and medical needs. The setting is designed to be welcoming, flexible, and responsive to what matters most to her.

2. **How does same-day care change the likelihood of engagement?**
   Same-day care takes advantage of the brief window when Leanne is willing to consider help. Delaying care by days or weeks increases the likelihood that competing priorities, symptoms, or ambivalence will interfere with follow-through. Immediate access allows the team to build on the trust established during outreach and convert motivation into action.

3. **What role does the peer play in continuity?**
   The peer serves as a consistent and trusted connection across settings. By accompanying Leanne to the clinic, helping her navigate services, and maintaining contact afterward, the peer reduces anxiety and helps ensure that transitions between outreach and treatment feel seamless.

4. **How will your system respond if Leanne misses her next visit?**
   A recovery-oriented system treats missed appointments as an opportunity for re-engagement rather than a reason for discharge. The team should reach out, explore barriers, and reconnect Leanne to care in a supportive and nonjudgmental manner. Maintaining flexibility and keeping the door open reinforces that setbacks are expected and that support remains available.

CASE STUDY LEANNE-IMPACT

LEANNE, 55YR.



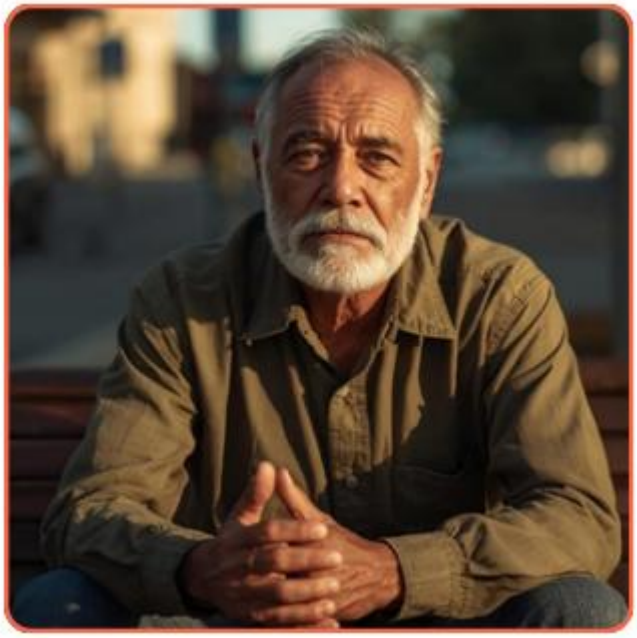
Leanne does not become consistent overnight. Some weeks she cancels. Some days she smokes more cannabis than she plans. The mobile team checks in. The clinic keeps its doors open. For the first time in years, Leanne begins to believe that care might help her feel steady without losing herself.

CASE STUDY JOSE, 70

JOSE'S JOURNEY: PART 1

LEARNING OBJECTIVES

1. Participants will name at least three factors that may make this client more vulnerable than other AFBSS clients
2. Participants will explore and identify at least four opportunities that may assist with keeping this client engaged in services
3. Participants will name at least two opportunities to demonstrate cultural humility with this client
4. Participants will name at least three areas that may present barriers for this client and provide possible solutions
5. Participants will be able to identify at least one other health plan related resource for client.



Jose is a 70-year-old Native American/Mexican, identifies as "two-spirit" and is Vietnam veteran. He has lived for decades with opioid use disorder (primarily heroin) and alcohol dependence and is a pack-a-day smoker. For many years, Jose maintained periods of stable recovery when he was housed, engaged in treatment, receiving methadone, and staying busy with structured daily routines. During those times, he also reconnected with his Native roots, which gave him a sense of identity, meaning, and belonging. That stability unraveled when his estranged daughter became seriously ill and died. The loss reopened old wounds and grief, and Jose's recovery collapsed. He lost his job, disengaged from care, and is now living in homeless shelters and spends occasional nights in the local encampment.

Jose lives with complex, overlapping medical, behavioral health, and social challenges. He has long-standing opioid use disorder (OUD) (heroin), alcohol and nicotine dependence, along with Hepatitis C liver disease, diabetes, chronic pain, arthritis, and nutritional deficits. He also has a history of post-traumatic stress disorder (PTSD) and depression related to his military service. He was formerly successful on methadone and reports that his substance use, and drinking

were more controlled when he was consistently engaged in his methadone treatment program. His recovery periods were when he was housed and getting his methadone from a Narcotic Treatment Program (NTP)/Opioid Treatment Program (OTP), and he was connected to services via his Federally Qualified Health Center (FQHC).

Jose carries deep bitterness and anger toward the Marines and the United States government. He feels betrayed by how he was treated during and after his service and by the ongoing struggle to access the healthcare and financial benefits he believes he rightfully earned. Navigating complex systems has felt humiliating and exhausting, reinforcing his belief that he has been used and discarded.

Since his time in the military, Jose has engaged on and off in psychiatric care and has been treated for OUD, alcohol dependence, PTSD, and depression. Over the years, he has been prescribed sertraline, metformin (later adjusted due to age and health status), naltrexone, gabapentin, folic acid, and thiamine. He has opted not to pursue treatment for hepatitis C. Following the loss of his daughter, and the subsequent loss of his job and housing, his medication adherence deteriorated. He carries deep grief and guilt, blaming himself for her death.

Living in shelters and encampments as a senior makes it nearly impossible for Jose to manage his health. His medications are often stolen, and keeping track of multiple pill bottles feels overwhelming. He reports that he currently has no medications, no primary care provider, and no reliable way to get to one. He adds quietly, “I don’t even think I have medical insurance anymore.” Despite this, Jose expresses his desire to try again. He wants safer, more stable housing and knows that structure helps him do better. He shares that he has an elderly aunt who might allow him to stay with her temporarily, but only if he is “in better shape.” He does not want to burden her or frighten her. “If I could just get myself together,” he says, “maybe I could stay with my aunt and we could help each other. She goes to church, and that would probably be good for me, but I need a doctor.” Jose finds comfort in music, which helps him relax and regulate his emotions. His words reflect both the weight of his losses and a fragile but real hope: he understands what has helped him before and wants another chance to reclaim stability, dignity, and connection.

The AFBSS team was walking through the encampment offering hygiene kits and telling people about their services. This is the 1st time he has heard of assertive field-based services.

PART 1 DISCUSSION QUESTIONS

1. **Now, after meeting and talking with Jose, what are his priority goals?**

2. **How would you collaborate with Jose to prioritize his goals?**

3. **We know that Jose is vulnerable senior with many health conditions. Can we identify some emergency services that can get him into safer accommodation as soon as possible?**

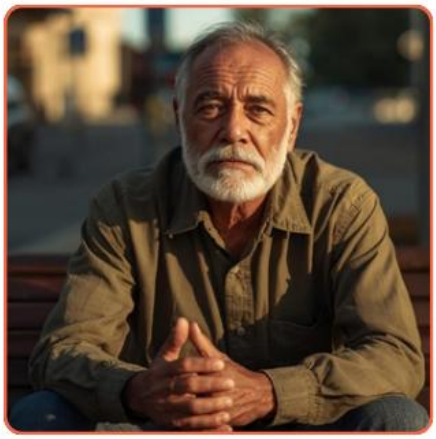
4. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Jose? Why?**



Tip:
Medical field-based staff must always "center" interventions around the choices of the client and safety.

PART 1 DISCUSSION NOTES

1. **Now, after meeting and talking with Jose, what are his priority goals?**



   - **Safety and Stabilization:** Reduce Jose's immediate risk of street violence, develop a basic safety plan, connect him with crisis supports, and support consistent engagement with at least one trusted person or program.
   - **Culturally Aligned Referral:** Because Jose is Native American and has shared that connecting with his heritage and cultural roots is important to him, Indian Health Services or another culturally responsive provider may be an appropriate referral.
   - **Medical Care:** Connect Jose with a provider who can evaluate him for MAT and establish a consistent source of medical care. Until longer-term care is identified, he should remain connected to the mobile team and an open-access clinic, with the VA explored as another potential resource.
   - **Housing and Basic Stability:** Help Jose access safer and more stable housing, such as veteran housing, transitional housing, or a temporary stay with his aunt. Enhanced Care Management may help assess his needs, identify service gaps, and coordinate referrals. A housing coordinator could also explore whether his previous housing program would accept him again and help place him on other housing waitlists.
   - **Veteran Benefits and Systems Navigation:** Help Jose reconnect with the VA or other veteran-specific services and clarify his eligibility for health care, housing, and financial benefits.

2. **How would you collaborate with Jose to prioritize his goals?**

   The team should center interventions around Jose's choices by asking which needs feel most urgent and what he wants to work on first. Beginning with the field-based team's agenda rather than Jose's priorities would not reflect cultural humility or trauma-informed care. Engagement is more likely when goals are based on what Jose wants.

   The team can help Jose develop Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) goals that reflect his priorities and build confidence through early success. Once trust is established, staff can offer additional suggestions, help Jose build on past wins, and revisit or adjust his goals as his needs and circumstances change.

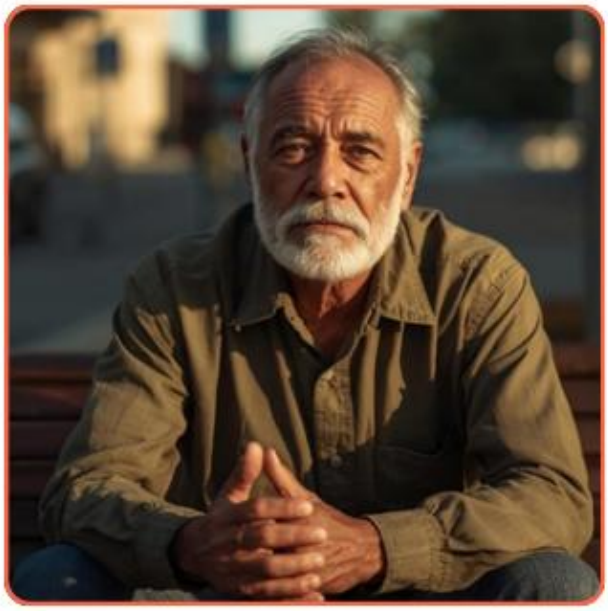
3. **We know that Jose is a vulnerable senior with many health conditions. Can we identify some emergency services that can get him into safer accommodation as soon as possible?**
   AFBSS teams must have relationships with MCPs and CBOs. Many have special access or programs for seniors, e.g. a soup kitchen may have early meals or special seating, cooling stations. Shelters may have preferential lodging or extended hours for seniors and finally some low housing facilities may put Jose higher on the list based on age and his health conditions.

4. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Jose? Why?**
   Based on the information presented in the case, the team must prioritize safety. More specifically, medical and physical safety. Jose has numerous health conditions that could make him extremely sick and even cost him his life. Moreover, his health conditions could result in altered mental status that might put his physical safety at risk. As this case is discussed, other areas of concern may surface.

CASE STUDY #5-CONTINUED

JOSE'S JOURNEY: PART 2

LEARNING OBJECTIVES



1. Participants identify how they will help this client address his trauma by naming at least to interventions.
2. Participants will explore the steps required when they encounter a client that needs immediate medical services.
3. Participants will discuss how they will work with clients that might be reluctant to get the medical care they need due to fear, stigma, and small or past traumas.

Jose has determined that connecting with the mobile team and restarting methadone are priorities. He also wants to enter a long-term shelter, if possible, and schedule an appointment with primary care. Perhaps he can start with an open-access clinic if his former primary care provider is not available. As part of the AFBSS team, you will also need to identify which benefits he may be eligible to receive.

Once we establish the type of insurance Jose has, it will be important to collaborate with community-based organizations and social workers. There are many programs that prioritize the elderly and Community Supports and housing coordinator will be helpful. In addition, Jose has a family member that may be able to help at least in the short term and with his permission could be contacted.

Jose connected with AFBSS staff members at the encampment after leaving the extended-stay shelter he frequents. A team member completed an assessment, but Jose is now reluctant to continue engaging with the AFBSS worker. Eventually, Jose discloses that he has not been feeling well. He ran out of his medications for chronic health conditions and lost his phone and naloxone. He is unsure whether his former primary care provider or methadone clinic will see him again because he missed two appointments that the AFBSS team arranged for him. He also says that he has started "skin popping" and drinking alcohol because it is cheaper and he believes he will not overdose. Jose now has an open wound that needs care, and his blood sugar

was very high when the AFBSS worker checked it. Jose remains adamant that he only wants to take methadone.



PART 2 DISCUSSION QUESTIONS

1. **Jose is not feeling well today. What immediate steps would you take to help him access care?**
2. **Which of the three AFBSS program areas would be helpful for Jose? Select all that apply and explain why.**
3. **Based on the case, what strengths, relationships, experiences, and other assets could support Jose's recovery?**
4. **Jose is a proud Native American, a Vietnam War veteran, and an older adult who feels tremendous guilt over the loss of his daughter and betrayed by his country. How would you assess and respond to his depression, grief, guilt, and sense of betrayal using a trauma-informed and culturally responsive approach?**



Tip:
Consider Jose's cultural identity, veteran experience, family connections, and past success in treatment. How might these strengths support his recovery?

PART 2 DISCUSSION NOTES

1. **Jose is not feeling well today. What immediate steps would you take to help him access care?**
   With Jose's consent, the team must first assess Jose's immediate medical needs, i.e., take his vitals, evaluate his open wound, check his blood sugar, and hydration status. After this brief assessment, determine whether emergency care is necessary. The team should attempt to find out the names of his missing medications and call pharmacy to see if he has any refills available. Staff should arrange an open-access clinic medical evaluation and help reconnect him with his primary care provider and methadone clinic. If his needs cannot be safely addressed in the field or at an open-access clinic, the team should call for transfer to a hospital.

2. **Which of the three AFBSS program areas would be helpful for Jose? Select all that apply and explain why.**

   All three AFBSS program areas could support Jose:

   - **Data-Informed and Targeted Outreach**: The team can use outreach at the encampment to locate and re-engage Jose. Staff can also coordinate with his primary care provider, opioid treatment program or methadone clinic, CA Bridge, and other partners to clarify his care history, reschedule missed appointments, and identify service gaps.
   - **Mobile Field-Based Programs**: Mobile health care providers can assess Jose's immediate medical needs, check his blood sugar, provide basic wound care, replace his naloxone, and help address medications for his chronic health conditions. When clinically appropriate and within the team's capacity, they may also evaluate him for medications for alcohol use disorder and support continuation of methadone.
   - **Open-Access Clinics**: An open-access clinic can provide same-day medical evaluation, wound care, laboratory testing, prescriptions, and connections to ongoing treatment. Given Jose's current medical concerns, a team member should consider accompanying him to the clinic today to reduce barriers and support follow-through.

3. **Based on the case, what strengths, relationships, experiences, and other assets could support Jose's recovery?**

   Jose has several strengths and potential supports that the team can build upon:

   - He has expressed interest in recovery and has been successful in treatment before.
   - He has prior work and volunteer experience that may provide purpose and structure.
   - He has family members who may be willing to support him.
   - He has a connection to his spirituality, Native American identity, heritage, and cultural roots.
   - He is a Vietnam War veteran and may qualify for health care, housing, financial, peer, or behavioral health supports through the VA or other veteran programs.

- He may qualify for additional services and benefits as an older adult.
- He previously had health care coverage and was connected to an opioid treatment program.
- He continues to express clear preferences about his care, including his desire to remain on methadone.

The team can help Jose identify which strengths and supports feel most meaningful to him. With his permission, staff may explore culturally responsive services, veteran resources, trusted family connections, and opportunities that restore purpose and belonging.

4. **Jose is a proud Native American, a Vietnam War veteran, and an older adult who feels tremendous guilt over the loss of his daughter and betrayed by his country. How would you assess and respond to his depression, grief, guilt, and sense of betrayal using a trauma-informed and culturally responsive approach?**

   The team should approach Jose with empathy, cultural humility, and respect for the experiences that shape his current needs. Staff should assess for depression, suicide risk, grief, trauma symptoms, and immediate safety concerns without pressuring him to disclose more than he is ready to share.

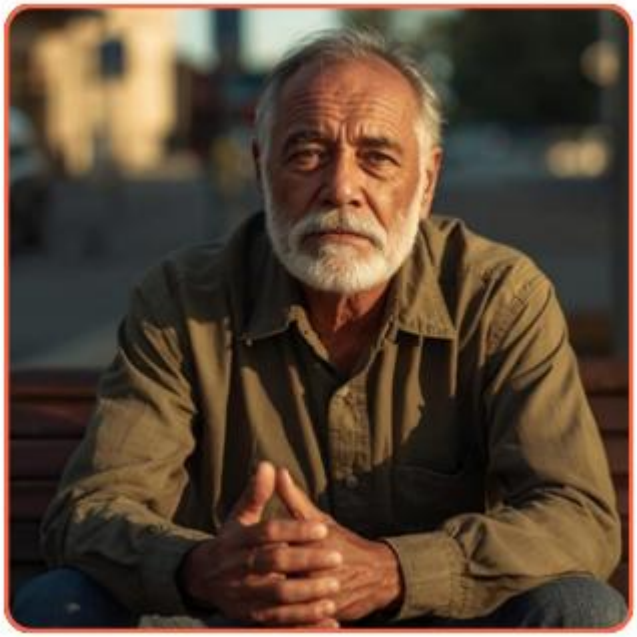
   The team can ask how the loss of his daughter, his Vietnam War experience, his Native American identity, and his sense of betrayal affect his health, substance use, trust, and recovery goals. His feelings should be acknowledged rather than minimized or reframed too quickly.

   With Jose's permission, the team may connect him with:

   - Culturally responsive behavioral health services
   - Native American community, cultural, or spiritual supports
   - Veteran-specific mental health and peer services
   - Grief counseling
   - Trusted family members
   - A consistent provider or team member who can build trust over time

   Care planning should remain centered on Jose's priorities. The team should offer choices, follow through on commitments, and revisit his goals as trust develops.

CASE STUDY JOSE-IMPACT



Jose does not become stable overnight. Some days he misses appointments or loses medications; some weeks grief and pain pull him back toward alcohol or opioids. But with a consistent AFBSS presence, practical harm reduction supports, and a low-barrier path back to methadone and primary care, he begins to regain structure. The team helps address urgent medical needs (including wound care and diabetes), rebuilds medication routines, and reconnects him to veteran and/or ECM services or community services that reduce isolation and system fatigue. Over time, Jose starts to see that help can be reliable and respectful, making it more likely he will stay engaged long enough to move toward safer housing, restored benefits, and the dignity and cultural connection that have supported his recovery in the past.

CASE STUDY MARISOL, 17

MARISOL'S JOURNEY: PART 1

LEARNING OBJECTIVES



Participants will be able to:

1. Recognize factors that place Marisol at elevated risk for ongoing crises and treatment disengagement.
2. Describe how identity, stigma, family rejection, and housing instability may influence engagement with services.
3. Identify strengths, motivations, and goals that can support outreach, engagement, and recovery.

Marisol is a 17-year-old transgender, Latina woman (male to female) currently living in short-term transitional housing. She left her family home after years of conflict related to her gender identity. Her family are devout Catholics and believe that her gender identity is inconsistent with their religious beliefs. They see her transition as a rejection of family values and have struggled to accept her. While Marisol occasionally speaks with her mother, the relationship is strained and unpredictable. She relies primarily on friends, peers, and informal support networks.

Marisol has a history of methamphetamine use that began in her mid-teens. She describes using meth to stay awake, feel confident and connected, and cope with anxiety and gender dysphoria, particularly in spaces where she feels unsafe or judged. She also carries a deep sense of shame about disappointing her family.

"I hate that I'm such a disappointment to them," she says.

Marisol does not view her substance use as the primary problem in her life. Instead, she sees it as one piece of a much larger struggle involving housing instability, family rejection, loneliness, and uncertainty about her future. At the same time, she admits feeling exhausted by the cycle of using, crashing, and trying to start over.

Marisol also has a history of survival sex in exchange for food, money, transportation, or a place to stay. Over the past year, she has visited the emergency department multiple times for anxiety, insomnia, dehydration, and sexually transmitted infections.

Through a review of emergency department utilization and managed care claims data, Marisol was identified as a high-risk youth experiencing repeated crises. Her managed care plan referred her to Enhanced Care Management (ECM), where she was assigned a Lead Care Manager (LCM).

The LCM completed a comprehensive assessment with Marisol and learned that she wanted stable housing, a GED, and a life that felt less chaotic. Together, they completed enrollment paperwork for an outpatient substance use disorder treatment program that offered Contingency Management (CM) for stimulant use disorder.

Marisol attended her intake appointment and one group session. At first, she seemed hopeful. "I think I want things to be different," she told her care manager. But after that first week, she stopped showing up, her phone stopped working, voicemails went unanswered and text messages were never opened. Staff attempted several follow-up calls but could not reach her.

After approximately two weeks, the ECM team learned that Marisol had returned to methamphetamine use and had not returned to the outpatient program.

PART 1 DISCUSSION QUESTIONS



1. **Does Marisol meet criteria for assertive field-based outreach? Why?**
2. **What population(s) prioritized under AFBSS does Marisol represent?**
3. **What barriers to engagement are already visible?**
4. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Marisol? Why?**



Tip:
Focus on Marisol's safety, age, and immediate needs while noticing the systems and supports that could help her engage. Look for strengths, trusted connections, and low-barrier ways to build trust early.

PART 1 DISCUSSION NOTES

1. **Does Marisol meet criteria for assertive field-based outreach? Why?**
   Yes. Marisol has several factors that support assertive field-based outreach, including stimulant use, housing instability, repeated emergency department utilization, treatment disengagement, and significant barriers to traditional care. She has also had difficulty remaining connected to services despite Enhanced Care Management support and initial treatment engagement, suggesting that a more proactive outreach approach may be appropriate.
2. **What population(s) prioritized under AFBSS does Marisol represent?**
   AFBSS priority populations include the following:

   Eligible adults and older adults who:
   - Are chronically homeless or at risk of homelessness
   - Are involved with or at risk of involvement with the justice system
   - Are reentering the community from prison or jail
   - Are at risk of conservatorship
   - Are at risk of institutionalization

   Eligible children and youth who:
   - Are chronically homeless or at risk of homelessness
   - Are involved with or at risk of involvement with the juvenile justice system
   - Are reentering the community from a youth correctional facility
   - Are involved with the child welfare system
   - Are at risk of institutionalization

   Marisol appears to meet the criteria for a youth (17 yrs.) who is chronically experiencing homelessness or is at risk of homelessness. She may also be involved or at risk of involvement in juvenile justice system due to survival sex work.

   She also has additional factors that increase her vulnerability such as her substance use and difficulty remaining connected to care. Marisol needs targeted outreach and harm reduction strategies to help her with dealing with stimulant use, treatment disengagement, limited natural supports, ramifications of survival sex work, repeated crisis utilization, and experiences of stigma or discrimination related to her gender identity.

3. **What barriers to engagement are already visible?**

   Marisol faces several barriers to engagement, including unstable housing, limited family support, changing contact information, transportation challenges, and stigma related to her gender identity. She has also described feeling uncomfortable, unseen, and misgendered in treatment settings. These experiences may contribute to distrust and disengagement, along with the practical challenges of staying connected to care.

4. **Based on what you know so far, what issue would you prioritize during your first outreach encounter with Marisol? Why?**

   The initial priority should be to establish safety, build trust, and understand what matters most to Marisol right now. She has identified goals related to housing, education, stability, and belonging, while also expressing exhaustion with the instability in her life.

   Beginning with her immediate needs and priorities is likely to be more effective than focusing first on abstinence or program compliance. A respectful, affirming relationship can create a foundation for later conversations about treatment and recovery.

CASE STUDY MARISOL-CONTINUED

MARISOL'S JOURNEY: PART 2

LEARNING OBJECTIVES



1. Identify factors that contribute to treatment disengagement among transition-age youth experiencing substance use, housing instability, and identity-related stress.
2. Describe how peer outreach and relationship-based engagement can support re-engagement following relapse or missed appointments.
3. Recognize how gender-affirming and identity-affirming care can improve engagement, trust, and retention in services.

Because Marisol had become difficult to locate, her case was discussed during a multidisciplinary care coordination meeting involving ECM staff, managed care representatives, behavioral health providers, and community outreach partners. The team identified her as a youth at risk of falling through the cracks.

An AFBSS outreach referral was initiated.

Rather than continuing to rely on phone calls, the AFBSS team began working through locations and organizations Marisol was known to frequent. They contacted staff at the transitional housing program, a local LGBTQIA+ youth drop-in center, and community partners who regularly worked with youth experiencing homelessness.

Two weeks later, a peer support specialist recognized Marisol sitting alone at a youth resource center. The peer sat down nearby.

"Hey Marisol, I haven't seen you in a while. How have things been?"

Marisol immediately looked nervous.

"Am I getting kicked out of the program?"

The peer shook her head.

"No. We were worried about you."

Marisol stared at the floor.

"I messed everything up."

As the conversation continued, Marisol described relapsing shortly after starting treatment. She said she felt embarrassed about missing appointments and assumed she would be discharged. She also described feeling uncomfortable during group sessions.

"People kept calling me 'he.' Nobody corrected them. I felt invisible."

For the first time, the team began to understand that her disengagement was not simply about substance use. It was also about belonging.

PART 2 DISCUSSION QUESTIONS



1. **What factors contributed to Marisol's disengagement?**
2. **How might shame impact re-engagement efforts?**
3. **What role did identity affirmation play in her treatment experience?**
4. **How should the outreach team respond?**



Tip

Notice which supports can reduce immediate risk while keeping Marisol connected without pressure. Is contingency management a consideration for Marisol?

PART 2 DISCUSSION NOTES

1. **What factors contributed to Marisol's disengagement?**



Marisol's disengagement was influenced by multiple factors, including housing instability, relapse, shame about missing appointments, difficulty maintaining contact, and feeling unsafe and unseen in treatment. Her experience of being misgendered and not having that corrected contributed to a sense that she did not belong. The issue was not simply substance use, but the cumulative impact of stigma, instability, and lack of connection.

2. **How might shame impact re-engagement efforts?**
Shame often leads people to withdraw, avoid contact, and assume they are no longer welcome after setbacks. Marisol believed she had "messed everything up" and expected to be discharged after relapsing and missing appointments. Effective re-engagement requires normalizing setbacks, reducing judgment, and communicating that support remains available regardless of relapse or missed visits.

3. **What role did identity affirmation play in her treatment experience?**
Identity affirmation played a significant role in whether Marisol felt safe and connected in treatment. Being repeatedly misgendered and feeling invisible undermined her sense of belonging and trust. When individuals feel respected, affirmed, and understood, they are more likely to engage, remain connected to services, and view treatment as a place where they can be themselves.

4. **How should the outreach team respond?**
The outreach team should respond with curiosity, compassion, and persistence rather than focusing on noncompliance. They should acknowledge Marisol's experiences, validate the impact of being misgendered, and reinforce that she is welcome to re-engage without punishment. Outreach should focus on rebuilding connection, addressing immediate needs, and helping Marisol access services that are affirming, flexible, and responsive to her goals.

CASE STUDY MARISOL-CONTINUED

MARISOL'S JOURNEY: PART 3

LEARNING OBJECTIVES

1. Identify age-appropriate harm reduction strategies that support safety, health, and engagement for youth experiencing substance use and housing instability.
2. Recognize strengths, motivations, and protective factors that can support Marisol's recovery journey.
3. Describe how person-centered outreach can help individuals reconnect with their own goals and reasons for change.



The outreach team continued meeting with Marisol in places where she felt comfortable. Rather than insisting she return immediately to treatment, they focused on her immediate priorities. The peer asked what she wanted most right now.

"A place that's mine," Marisol answered.

The team discussed housing options, educational opportunities, and ways to reduce harm while she decided what she wanted to do next. They provided naloxone and overdose education. They discussed safer sex practices and connected her to STI testing. They talked about safer substance use practices and strategies for staying safe when sleeping in unfamiliar places. The conversations felt different from treatment. No one was telling her what to do. No one was threatening consequences.

One afternoon, the peer asked, "What made you go to treatment in the first place?" Marisol was quiet for a moment. "I wanted things to stop feeling so chaotic." The answer surprised her. It also revealed that her goals had not disappeared. They had simply been buried under shame and instability.

PART 3 DISCUSSION QUESTIONS



1. **What harm reduction strategies are appropriate for Marisol?**
2. **What strengths are emerging?**
3. **How might housing and educational goals support recovery?**
4. **What does "meeting her where she is" look like here?**



Tip

Focus on practical harm reduction, safety, and trust while supporting Marisol's goals for housing, school, and stability.

PART 3 DISCUSSION NOTES



1. **What harm reduction strategies are appropriate for Marisol?**
   Appropriate harm reduction strategies include overdose education, naloxone distribution, safer substance use education, STI testing and prevention, safer sex education, and safety planning related to housing instability and survival sex.

2. **What strengths are emerging?**
   Marisol demonstrates resilience, self-awareness, and a desire for a different future. She continues to express goals related to housing, education, and stability, even after disengaging from treatment. Her willingness to reconnect with the outreach team and reflect on what originally motivated her to seek help suggests hope and readiness that can be built upon.

3. **How might housing and educational goals support recovery?**
   Stable housing can reduce exposure to unsafe situations, improve consistency in care, and create a foundation for addressing other challenges. Educational goals, such as obtaining a GED, can increase self-efficacy, future opportunities, and a sense of purpose. Focusing on these goals may feel more relevant and motivating to Marisol than focusing exclusively on substance use.

4. **What does "meeting her where she is" look like here?**
   Meeting Marisol where she is means focusing on the goals and concerns she identifies as most important, rather than insisting on immediate treatment re-entry. The team prioritizes housing, safety, education, and belonging while continuing to offer support around substance use. By respecting her pace and maintaining a relationship without judgment, the team creates conditions that make future engagement and recovery more likely.

CASE STUDY MARISOL-CONTINUED

MARISOL'S JOURNEY: PART 4

LEARNING OBJECTIVE

1. Explain how open-access and low-barrier service models support re-engagement following treatment disengagement.
2. Identify barriers that may prevent Marisol from accessing or remaining connected to care and strategies to reduce those barriers.
3. Describe the role of peer support in promoting engagement, belonging, and continuity of care.



Several weeks later, the outreach team introduced Marisol to a youth-friendly open-access clinic that specialized in serving LGBTQIA+ young adults. The clinic offered same-day appointments without lengthy intake requirements. Services included mental health treatment, substance use disorder treatment, Contingency Management, peer support, STI screening and treatment, and gender-affirming care. The peer offered to accompany her. This time, Marisol agreed.

When they arrived, no one asked why she had missed previous appointments. No one told her she had failed treatment. No one required her to restart the entire process. Instead, staff welcomed her back. A counselor met with her that day. She was re-enrolled in services, connected to Contingency Management, and scheduled for follow-up care.

For the first time, treatment felt less like a test she could fail and more like a resource she could return to.

PART 4 DISCUSSION QUESTIONS

1. **What makes this clinic truly open access?**
2. **What barriers were removed?**
3. **How did the peer support specialist contribute to successful re-engagement?**
4. **How can counties support continuity after relapse?**



Tip:
Use harm reduction strategies, emergency planning, and continue outreach and engagement even when though the individual may not be ready change.

PART 4 DISCUSSION NOTES

1. **What makes this clinic truly open access?**
   The clinic provides same-day access without requiring appointments, lengthy intake processes, insurance verification, or proof of readiness for treatment. Marisol is able to return to care quickly after disengagement and receive services immediately. The clinic also offers integrated services that address multiple needs in one location, including mental health, substance use treatment, peer support, STI services, and gender-affirming care.

2. **What barriers were removed?**
   The clinic removed both practical and emotional barriers to care. Marisol did not have to restart the enrollment process, explain missed appointments, or justify her relapse. The clinic also reduced barriers related to stigma and identity by providing affirming services and creating an environment where she felt welcomed rather than judged.

3. **How did the peer support specialist contribute to successful re-engagement?**
   The peer support specialist built trust through consistent, nonjudgmental support and maintained contact even after Marisol disengaged from treatment. By accompanying her to the clinic, normalizing setbacks, and helping her navigate services, the peer reduced anxiety and increased the likelihood that Marisol would return to care. The relationship helped bridge the gap between outreach and treatment engagement.

4. **How can counties support continuity after relapse?**
   Counties can create systems that view relapse and missed appointments as opportunities for re-engagement rather than reasons for discharge. Strategies may include assertive outreach, peer follow-up, open-access clinics, flexible re-entry pathways, and coordinated communication among providers. When services remain available without punishment or excessive barriers, individuals are more likely to reconnect and continue their recovery journey.

CASE STUDY MARISOL-IMPACT



Marisol does not stop using methamphetamine overnight. She misses another appointment several weeks later, but this time, she answers the phone. The peer already knows her. The clinic already knows her. The system no longer treats disengagement as failure.

For the first time, Marisol begins to believe that asking for help does not mean losing her place, and that belief becomes the foundation for staying connected. Rather than being discharged or labeled non-compliant, she remains connected through assertive outreach, identity-affirming engagement, and flexible support that meets her where she is.

With continued coordination between ECM, mobile outreach, and outpatient care, Marisol begins to experience care as relational rather than punitive. Over time, she starts to trust that missing a visit does not mean losing support. While her progress is uneven, Marisol begins to believe that stability and dignity are possible, and that she does not have to navigate recovery alone.

CASE STUDY BEHAVIORAL HEALTH ORGANIZATION

BEHAVIORAL HEALTH ORGANIZATION: PART 1

LEARNING OBJECTIVES



1. Participants will explore the role of leadership and identify how to keep leadership engaged in the AFBSS project
2. Identify workforce competencies and role-specific [field-based] selection criteria needed to support safe and effective mobile field-based substance use disorder services.
3. Describe how a staffing plan, guided onboarding, ongoing training, coaching, and reflective supervision can prepare and sustain staff delivering services outside traditional clinic settings.
4. Analyze strategies to retain staff and leverage existing open-access clinic infrastructure to support continuity, collaboration, and workforce readiness.
5. Develop priorities for workforce safety, team support, and field-based operational readiness, including communication protocols, de-escalation, and role clarity.

Health Community Services (HCS) is an outpatient substance use treatment program serving patients ages 18 to 70. HCS currently provides American Society of Addiction Medicine (ASAM) Level 1.7 services. The agency prioritizes rapid access to medications for addiction treatment (MAT) and provides toxicology monitoring, counseling, peer support, and referrals to community-based organizations and health care partners.

Within the HCS patient population, individuals ages 18 to 30 are most likely to test positive for fentanyl, and women have higher rates of fentanyl and amphetamine positivity than men. HCS serves people across biopsychosocial backgrounds and racial and ethnic groups, including

individuals with disabilities, pregnant people, veterans, people reentering the community after incarceration, and people who are unhoused or precariously housed.

HCS's mission is to collaborate closely with underserved and under-resourced communities and provide essential education about effective substance use disorder treatment. The organization strives to guide patients through care that is free from discrimination and stigma often associated with substance use disorder, medications for addiction treatment, mental health needs, co-occurring mental health and substance use disorder needs, and social drivers of health. Services include counseling, peer support, telehealth, and referrals to community-based organizations and health care partners.

Clients often experience meaningful improvements in recovery capital through engagement in treatment and support services. HCS reports that after six months of care, many clients achieve greater stability, including progress toward service plan goals and maintaining housing and employment.

Like many organizations, **HCS continues to face workforce and financial challenges** stemming from the pandemic and shifting political and policy environments, pressures that are expected to continue. HCS leadership is **now charged with expanding services to reach individuals who require mobile field-based care for SUD in California**. This expansion will require staff to develop new competencies and receive additional training to deliver services safely and effectively outside the clinic. For example, Peer Support Specialists may now be required to leave the clinic and work on mobile units and in the field with the team.

As a manager, you are in the early stages of *planning for workforce stabilization and development*. After reviewing supervisor and manager feedback, leadership interviews, and staff surveys, the organization has determined that training should be *focused on developing a training curriculum and on how to select, train, retain, and support workforce talent*.

PART 1 DISCUSSION QUESTIONS

1. **How might you start to determine staff selection criteria?**
2. **How and when program leadership would incorporate training into staff development?**
3. **What areas of training would be essential for a mobile field-based team?**
4. **Describe strategies to retain the mobile field-based team and leverage the already established open-access clinic?**
5. **Explore important safety supports you would put in place for the workforce.**



Tip:
Focus on how the organization can use data, training, workflows, staffing, and partnerships to move from reactive care to proactive, low-barrier outreach.

PART 1 DISCUSSION NOTES

1. **How might a manager start to determine staff selection criteria?**



- **The First step** is to determine the services your field base team is going to provide. The **Second step is to** identify the roles and skills required to meet the service needed. The **Third step is to** develop job descriptions or modify existing job descriptions for the new program.
- **In collaboration** with human resources develop a list of work-related competencies specific to the new program, and staff input will determine content for the training program. The content must include the hard and soft skills needed to be successful in the job and how workers will be evaluated and supported.

To better understand how harm reduction can be used in this case please refer to:

- **SAMHSA Advisory: Low-Barrier Models of Care for Substance Use Disorders**

  Practical guidance on designing and implementing low-barrier engagement, treatment access, and recovery support services for

2. **How and when would program leadership incorporate training into staff development?**

   HOW

- Consider using different modalities such as in-person, live virtual, asynchronous, case-study, etc.
- Make sure to track the training completed (including P&Ps) in an appropriate application. Also include an iterative process, staff need refreshers and updates to reduce drift.

WHEN

- Onboarding-this is an opportunity to use the case studies. Consider Jose or Marisol to assist in concept grasp.
- Decide on a "Ramp-up" period. This is a time for new hires to acclimate to the organization and the work.
- Training should be annual training and consider changing the methods and the content to keep it fresh, current and interesting.
- Training should be incorporated in staff meetings or and in case conferences. Training does not always have to be provided in long periods of time. Short updates and trainings can be very helpful.

3. **What areas of training would be essential for a mobile field-based team?**
   - Providing medical field-based services is challenging and different than the work inside the 4-walls. Unless HCS anticipates the challenges of this work and institutes interventions, they may experience turnover and burnout.
     - Gather information from established field-based teams
     - Conduct a short Literature Review
     - Reviewing the DHCS Guidelines
     - Asking the current staff their opinions
     - Joining a collaborative

4. **Describe strategies to retain the mobile field-based team and leverage the already established open-access clinic?**
   Strategies may include workload, consistent training, debriefs, case conferences, and work schedules.

   - Ask participants if they can think of other ways to support staff in the field
   - Field-Based Community Safety Training that includes community cultural humility training and personal safety and emergency activation rules.

5. **Explore important safety supports you would put in place for the workforce.**
   - Clear protocols for safety and communication
   - TEAMSTEPPs training
   - Huddles, Debriefs and Check-ins
   - De-escalation.

- Defining roles and workflows for care outside
- Simulation-based competency training and clinic Reflective supervision training

Consider having the participants develop goals that are Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) related to:

- **Workforce Recruitment and Selection** (defining competencies for field-based and clinic-based roles; identifying candidates with the right mix of clinical skill, cultural humility, and resilience; increasing the pipeline of qualified candidates for hard-to-fill roles)
- **Retention and Staff Well-Being** (strengthening support for emotional labor and secondary trauma; Improving job satisfaction and sense of purpose; creating career pathways and growth opportunities)
- **Field-Based Service Readiness** (establishing clear protocols for safety, communication, and escalation; defining roles and workflows for care outside the clinic; ensuring staff feel competent and protected when working in the community)

CASE STUDY BEHAVIORAL ORGANIZATION-CONTINUED

BEHAVIORAL ORGANIZATION: PART 2

LEARNING OBJECTIVES

1. Participants will be able to name at least two pre-planning steps
2. Participants will be able to list at least three strategies to help manage resistance



The HCS's manager and supervisor-both new in their roles-worked to develop a staffing and onboarding plan. They decided to share the NEW mobile field work plan at the staff meeting. It was here that they announced the new hires, job changes and the field base outreach go-live date. To be cost effective the physician's assistant and the community health worker were reassigned to 50% fieldwork. The peer support specialist, social worker and LVN are new to the organization and field base work.

The field-based team will include: A full-time (1) peer support specialist with lived experience, (1) full-time associate social worker (1) part-time community health work, (1) part-time physician's assistant (1) part-time licensed vocational nurse (LVN) worker. All members are new to field-based work.

Both the manager and supervisor are inundated with negative feedback from various members of the team. Clinic staff are concerned that reassigning staff to the mobile field-based team will compromise the clinic's daily operations. They also want clarity on who will manage client panels, drop-ins, and urgent care visits. In addition, staff are concerned about how the clinic will absorb new clients generated by the mobile team when it is already short-staffed.

The manager and supervisor correctly diagnose the problem as staff resista



BH ORGANIZATION PART 2: DISCUSSION QUESTIONS

1. **When planning a new program, what are important first steps of the leadership team?**

2. **What are important strategies for getting buy-in when planning new work for a team?**

3. **How must this leadership team "re-boot" and get the team on board with a program that must be implemented and one that the community needs?**



Tip:
Consider how the organization can turn lessons from the cases into clear workflows, staffing roles, and partner handoffs. An inclusive Communication that allows for feedback is key to staff-buy.

PART 2 DISCUSSION NOTES

1. **When planning a new program, what are important first steps of the leadership team?**



   - One of the 1st actions for leadership is to develop a communication plan. The communication plan must be developed early and designed to be transparent, inclusive and iterative. Some managers put a timeline on the wall and mark the milestones.
   - Staff need to understand:
     - **The Why** — Why the program is being implemented and how it will benefit individuals served, the community, and the organization.
     - **The How** — How the program will operate, how workflows and roles may change, and what supports will be available. When details are still being developed, leadership should communicate transparently about what is known and what remains under development.
     - **The What** — The intended outcomes of the program and what success will look like for clients, staff, the organization, and the broader community.
   - Leadership must identify team members champions. It is important to have both clinical and administrative champions. Champions are often individuals that staff respect and sought out when questions arise in the clinic.
   - Recognizing the "resistance" and managing resistance are normal when making change.

2. **What are important strategies for getting buy-in when planning new work for a team?**

   - One strategy for developing and sustaining programs is collaborative planning at the beginning. The planning must include research, finance, and listening sessions with staff/community and frequent transparent communication from the top to bottom of the organization.
   - Another strategy is visiting other programs similar to one your organization wants to develop and bringing lessons learned back to your teams.
   - Consider starting the project as a small pilot and build it from there. Pilots give the team a chance to identify and fix problems, assess whether they have the correct team, workflows, equipment and resources in a more controlled environment.

3. **How must this leadership team "re-boot" and get the team on board with a program that must be implemented and one that the community needs?**

- Accept that it is not uncommon for projects to get off on the wrong foot. **Getting a Struggling Healthcare Program Back on Track After Staff Resistance.** When a new healthcare program faces staff resistance, the key is to **address the root causes of resistance while aligning the change with staff needs and organizational goals**.

Drawing on change management best practices and healthcare innovation strategies, here are proven approaches:

- **Understand and Address the Root Causes of Resistance**
  Staff resistance often stems from fear of the unknown, loss of control, lack of inclusion, perceived threats to job security, or lack of trust in leadership. Use surveys, focus groups, and one-on-one conversations to identify specific concerns.
- **Involve Staff Early and Often**
  Engage clinicians and support staff in the design and rollout of the program. Co-creating solutions builds ownership and reduces perceived imposition. This can include forming cross-functional task forces or advisory committees.
- **Communicate Transparently and Consistently**
  Clearly explain the *why*, *what*, *how*, and *benefits* of the change. Use multiple channels (emails, town halls, posters, FAQs) and be ready to answer questions. Emphasize how the program improves patient care, efficiency, or work-life balance.
- **Lead with Empathy and Trust**
  Leaders should model the behaviors they want to see—openness, accountability, and respect. Acknowledge staff's expertise and past contributions and show that their voices are valued.
- **Provide Training and Support**
  Equip staff with the skills and resources needed to adapt. Offer hands-on training, mentorship, and access to technology or tools that make the new process easier.
- **Pilot and Iterate**
  Start with a small pilot group to test the program, gather feedback, and make adjustments before full rollout. This reduces risk and builds confidence.
- **Recognize and Reward Early Adopters**
  Celebrate successes and highlight staff who embrace the change. Recognition can motivate others to follow.
- **Leverage Digital Health Tools**
  If the program involves new technology, use interoperable EHRs, telehealth, or AI-

enabled workflows to streamline processes, reduce administrative burden, and improve outcomes.

- **Monitor and Adapt Continuously**
  Track adoption rates, staff feedback, and patient outcomes. Be prepared to pivot if certain aspects are not working.
- **Align with Broader Workforce and System Goals**
  Frame the program within the context of workforce sustainability, quality improvement, and patient-centered care to make it part of a larger, positive narrative.
- **Bottom line:**
  Combining **change management rigor** with **staff engagement, empathy, and practical support** can turn resistance into momentum. The most successful programs are those that make staff feel heard, valued, and equipped to succeed.

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GLOSSARY

Assertive Engagement	A proactive, person-centered approach to connecting with individuals who are experiencing or at risk of homelessness, have serious mental health needs, or are in crisis. It involves building trust, maintaining consistent contact, and using collaborative strategies to encourage participation in services, housing, and treatment. The goal is to reduce barriers to care and support sustained engagement in recovery-oriented services. www.calbhbc.org
Assertive Field Based Substance Use Disorder Services (AFBSS)	A low-barrier, mobile outreach and initiation programs designed to bring treatment—particularly Medications for Addiction Treatment (MAT)—directly to individuals wherever they are, such as on the street, in homeless encampments, or in hospital emergency departments. https://www.ochealthinfo.com/sites/healthcare/files/2025-10/FSP%20-%20Assertive%20Field%20Based%2010.8.2025%20updated.pdf
Bridge Program (AKA California Bridge Model)	A statewide initiative to transform hospital emergency departments (EDs) into primary access points for (SUD) and co-occurring mental health treatment. Key components include Immediate, **Low-Barrier MAT:** providing rapid access to (MAT) (such as buprenorphine for opioid use disorder) 24/7. Treatment is initiated without waitlists, regardless of a patient's insurance status, lab results, or commitment to abstinence. **Behavioral Health Navigators:** utilizing trained peer navigators to guide patients through the treatment process and link them to outpatient community-based services within 72 hours of hospital discharge. Also include, **Harm Reduction Culture:** promoting a non-stigmatizing environment where SUDs are treated as treatable, life-threatening chronic illnesses rather than moral failures. https://californiaopioidresponse.org/matproject/california-bridge-program/

Care Transitions	Care transitions are broadly defined as the movement of a Medi-Cal member from one setting or level of care to another. Further, an individual transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, jail/prison to community or street services to clinic, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or LTC settings. https://www.dhcs.ca.gov/wp-content/uploads/2025/10/PHM-Transitional-Care-Webinar-Slides-Jan192023.pdf
Change Management	A discipline that involves preparing, supporting, and helping individuals and organizations navigate changes in processes, technologies, or organizational structures. A structured approach to supporting staff, teams, and partners in adopting new practices, workflows, or models of care to improve outcomes. It is essential to ensure that changes are implemented smoothly and effectively, minimizing disruption and resistance among employees. https://pmc.ncbi.nlm.nih.gov/articles/PMC9462626/
Closed-Loop Referral	**Closed-Loop Referral (CLR)** is a referral initiated on behalf of an individual that is actively tracked, supported, monitored, and results in a Known Closure (e.g., verifying that the member successfully received the referred services). The CLR framework ensures that the referring agency and/or care provider and community providers maintain bidirectional communication. For example, the sending provider confirms the individual successfully connects to the receiving service and receives feedback on the outcome. https://www.dhcs.ca.gov/wp-content/uploads/2025/10/2-10-2024-CLR-All-Comer-Webinar.pdf

Community Health Worker (CHW)	A frontline public health worker, who is a trusted member of and/or has an unusually close understanding of the community served—often with lived experience. CHWs work in interprofessional teams. The trusting relationship enables the CHW to serve as: A liaison/link/intermediary between health/social services and the community. A facilitator for access to services and to improve the quality and cultural competence of service delivery. They are trusted community members who support outreach, education, engagement, and connection to care. https://www.dhcs.ca.gov/community-health-workers
Contingency Management (Recovery Incentives Program)	The California Department of Health Care Services (DHCS) defines the Recovery Incentives Program as a Contingency Management (CM) benefit for Medi-Cal beneficiaries diagnosed with stimulant use disorder (e.g., cocaine, methamphetamine). It is an evidence-based behavioral therapy that provides financial incentives (such as low-denomination gift cards) for abstaining from stimulant drug use. https://www.dhcs.ca.gov/recovery-incentives-program-californias-contingency-management-benefit
Continuity of Care	Ensuring people stay connected to services over time, even as they move between settings such as street, jail, hospital, and community care. Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.208
Field Based Services	Services delivered outside of traditional clinics, including in homes, encampments, shelters, jails, or community spaces, to reduce barriers to care. Source: http://www.publichealth.lacounty.gov/sapc/bulletins/START-ODS/23-14/Attachment-I-FBS-Standards-Practices.pdf

Harm Reduction	An approach focused on reducing the negative health impacts of substance use, even if someone is not ready or able to stop using. Source: https://library.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf
Health Equity	The goal of reducing disparities in access, quality, and outcomes for populations historically excluded from behavioral health care, including people experiencing homelessness or justice involvement. Source: https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/about/index.html
Intersectionality	The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group. More, the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups Source: https://www.merriam-webster.com/dictionary/intersectionality
Low Barrier Access	Service design that minimizes requirements such as appointments, paperwork, sobriety, or transportation so people can engage more easily. Source: https://library.samhsa.gov/product/advisory-low-barrier-models-care-substance-use-disorders/pep23-02-00-005
Medication for Addiction Treatment (MAT)	The use of medications, often combined with counseling and support, to treat substance use disorders and reduce overdose risk. Source: https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002

Multidisciplinary Field Based Teams	Teams that may include clinicians, peers, CHWs, and medical providers working together to deliver coordinated services in community settings. Source: https://pmc.ncbi.nlm.nih.gov/articles/PMC7100151/
Natural Support	People in an individual's life who provide informal support, such as family, friends, and community members, and help foster engagement, stability, and recovery. Source: https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf
Peer Support Specialist	A worker with lived experience of substance use or recovery who provides support, encouragement, and connections to services. Source: https://library.samhsa.gov/sites/default/files/peer-support-mh-addictions-workforce-pep24-08-005.pdf
Public Health–Driven Data	The use of population level and real time data to identify need, guide outreach, and target services for high-risk populations. Source: https://www.cdc.gov/ophdst/data-research/index.html
Recovery Incentives Program	The California Department of Health Care Services (DHCS) defines the Recovery Incentives Program as a Contingency Management (CM) benefit for Medi-Cal beneficiaries diagnosed with stimulant use disorder (e.g., cocaine, methamphetamine). It is an evidence-based behavioral therapy that provides financial incentives (such as low-denomination gift cards) for abstaining from stimulant drug use. https://www.dhcs.ca.gov/recovery-incentives-program-californias-contingency-management-benefit/

Substance Use Disorder (SUD)	A treatable, chronic disease characterized by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. https://www.cdc.gov/overdose-prevention/treatment/index.html
Two-Spirit	Though Two-Spirit may now be included in the umbrella of LGBTQI+, The term "Two-Spirit" does not simply mean someone who is a Native American/Alaska Native and gay. A modern, pan-Indigenous umbrella term used by some North American Indigenous people to describe having both a masculine and a feminine spirit in one body. Traditionally, Native American Two-Spirit people were male, female, and sometimes intersexed individuals who combined activities of both men and women with traits unique to their status as Two-Spirit people. In most tribes, they were considered neither men nor women; they occupied a distinct, alternative gender status often representing a sacred third or fourth gender role within their communities. https://www.ihs.gov/lgbt/twospirit/#:~:text=Traditionally%2C%20Native%20American%20Two%2DSpirit%20people,their%20status%20as%20Two%2DSpirit%20people.