From Requirements to Practice: County Insights for Implementing Assertive Field-Based SUD Services

County Insights Manual

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HEALTH MANAGEMENT ASSOCIATES

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EXECUTIVE SUMMARY

California counties are implementing Assertive Field-Based Substance Use Disorder Treatment Services (AFBSS) as part of a broader shift toward more accessible, person-centered, and community-based behavioral health care. This manual is a companion publication of the Assertive Field-Based Initiation for SUD Treatment Services Toolkit, and captures early lessons from counties, technical assistance partners, and implementation stakeholders as they translate Behavioral Health Services Act (BHSA) requirements into practical service models for individuals who may be disconnected from traditional systems of care, including people experiencing homelessness, serious mental illness (SMI), severe substance use disorders (SUD), and co-occurring conditions. The document is intended to support state and county leaders, implementation teams, providers, and community partners by sharing emerging strategies, common challenges, and practical considerations drawn from interviews and focus groups, technical assistance engagements, workshops, webinars, and peer-learning activities.

A consistent lesson across the document is that successful AFBSS implementation requires counties to move beyond clinic-based service delivery and build models that meet people where they are. Technical assistance partners, including USC Street Medicine and CA Bridge, emphasized that field-based care requires new workflows, staffing models, safety protocols, referral pathways, and partnerships across behavioral health, health care, housing, emergency response, and community-based organizations. They also identified AFBSS as an opportunity to advance California's behavioral health system by strengthening street medicine partnerships, expanding access to medications for addiction treatment (MAT), supporting county champions, and developing more coordinated regional approaches.

County examples demonstrate several promising approaches. San Diego County highlights the importance of distinguishing outreach from engagement, emphasizing consistent relationship-building, trust, harm reduction, low-barrier access, and near real-time overdose surveillance data to direct outreach resources. Del Norte County illustrates how empathy interviews and qualitative pattern recognition can turn community conversations into actionable system improvements. Los Angeles County demonstrates how large systems can begin building integrated co-occurring care through dedicated leadership, standardized screening, workforce development, field-based MAT protocols, and cross-agency collaboration. San Joaquin County provides examples of both street medicine and integrated behavioral health models that combine medical care, harm reduction, psychiatric services, MAT, intensive field-based supports, and housing connections. Sacramento County highlights how counties can connect

outreach, harm reduction, mobile medicine, same-day MAT, community education, and open-access clinics into a coordinated continuum of care.

The manual also identifies recurring implementation challenges. Counties and partners described the complexity of building field-based service models while addressing workforce shortages, prescriber limitations, provider credentialing, documentation and billing requirements, fragmented information systems, and the need for effective care coordination across multiple systems. Several sections underscore that individuals served through AFBSS may require repeated outreach, flexible engagement, and supports that are essential to treatment connection but not always easily reimbursable. These realities make operational design, data-sharing, documentation infrastructure, and financing strategies central to long-term implementation success.

Sustainability is a major theme across county spotlights. Lake County's rural planning approach emphasizes building from existing behavioral health, mobile crisis, public health, peer support, MAT linkage, and care coordination infrastructure rather than creating a stand-alone program. Its experience highlights the importance of braided funding, flexible non-billable engagement support, practical use of existing assets such as mobile medical clinics, and careful distinction between mobile crisis and AFBSS claiming structures. Orange County similarly demonstrates how counties can sustain implementation by enhancing existing services and delivery assets, expanding data-driven outreach, aligning outpatient clinics as rapid-entry access points, incorporating mobile narcotic treatment program units, and using multiple funding streams to support long-term fiscal stability.

Overall, the early lessons in this manual suggest that **AFBSS is most effective when treated not as a discrete program, but as a systems-change strategy**. Counties are better positioned for success when they build multidisciplinary teams, strengthen community and clinical partnerships, use data to focus outreach, create low-barrier access to treatment, integrate substance use and mental health services, invest in workforce development, and plan for sustainability from the outset. While local conditions vary, the experiences captured here show that field-based, relationship-centered care can help counties bridge gaps between policy requirements and real-world access, advancing more responsive behavioral health systems for Californians with complex needs.

INTRODUCTION

California counties are actively working to implement Assertive Field-Based Substance Use Disorder Treatment Services (hereafter referred to as Assertive Field-Based SUD Services, or "AFBSS") in accordance with the requirements outlined in the Behavioral Health Services Act (BHSA) Manual. While the BHSA establishes the expectations and framework for these services, counties face the complex task of translating requirements into effective, real-world programs that meet the needs of individuals who may be disconnected from traditional systems of care.

The County Insights for Implementing AFBSS manual was developed to support that effort by capturing the experiences, strategies, challenges, and innovations emerging across California. It is intended as a practical resource for state and county behavioral health leaders, program managers, supervisors, providers, and implementation teams who are designing, launching, refining, or expanding AFBSS.

METHODS AND SOURCES

This document highlights how counties are interpreting and operationalizing BHSA requirements within their unique local contexts. The insights presented here are drawn from interviews and focus groups; technical assistance engagements, including Solution Teams who met on a wide-range of AFBSS-related topics; regional in-person workshops; webinars; and peer-to-peer learning opportunities conducted with counties throughout the state during the implementation period. Collectively, these experiences offer valuable lessons about what has worked, what challenges have emerged, and what considerations may help other counties advance their implementation efforts.

DISTINCTION BETWEEN FINDINGS AND LESSONS LEARNED

The examples and practices included in this manual are not intended to interpret regulatory guidance or establish compliance standards. Rather, they reflect both findings—common themes and observations emerging across counties—and lessons learned—practical insights gained through implementation experience. Together, they illustrate a range of approaches counties have used to address common implementation questions, including:

- Building multidisciplinary field-based service teams.
- Conducting outreach and engagement with individuals who are unwilling or unable to access traditional services.
- Integrating SUD treatment with mental health, housing, medical, and social support systems.

- Developing staffing models and workforce strategies.
- Establishing partnerships with community-based organizations and other local systems.
- Collecting data and monitoring program performance.
- Sustaining services through ongoing funding and organizational support.

Throughout this document, readers will find practical insights, examples of emerging and promising practices, implementation considerations, and reflections from county partners who are doing this work in communities across California. While local conditions and resources vary, many counties have encountered similar opportunities and challenges. By sharing these experiences, we hope to strengthen cross-county learning and accelerate the development of responsive, person-centered services that advance the goals of the BHSA.

Implementation is an ongoing process of learning, adaptation, and improvement. As counties continue to refine their approaches, new strategies and innovations will undoubtedly emerge. This document is intended to contribute to that learning journey by providing a snapshot of the collective experience of and a platform for continued knowledge sharing among California's behavioral health community.

ACKNOWLEDGMENTS

HMA is grateful to the county leaders, staff, providers, and community partners who contributed their time, expertise, and candid reflections to inform this resource. Their willingness to share their experiences has made it possible to create a guide grounded not only in policy requirements, but also in the realities of implementation.

Together, these insights can help move counties from requirements to practice—and ultimately, to more effective outreach, engagement, and treatment services for unhoused Californians living with substance use disorder.

We also extend our appreciation to the individuals recognized below (in addition to individuals who preferred to remain anonymous) who generously shared their expertise and implementation experiences. With their permission, we have included them in acknowledgment of their valuable contributions to this resource.

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AFBSS TTA PARTNER PERSPECTIVES

PARTNERS' ROLE IN AFBSS TTA

As key technical assistance partners in the AFBSS initiative, USC Street Medicine USC Street Medicine - Street Medicine and CA Bridge CA Bridge - Bridge to Treatment brought specialized expertise in street-based behavioral health care and medication treatment for SUD. Through direct engagement with counties, providers, and community partners, both organizations offered valuable insights into the opportunities and challenges associated with implementing field-based behavioral health services across California. The perspectives summarized below reflect their observations from supporting counties throughout the initiative and highlight broader lessons for advancing community-based, person-centered models of care.

OVERALL LEARNINGS

USC Street Medicine and CA Bridge both viewed the AFBSS Training and Technical Assistance initiative as an important catalyst for advancing California's behavioral health system through stronger field-based and community-centered models of care. Both organizations emphasized that successful implementation requires moving beyond traditional clinic-based approaches and strengthening partnerships across counties, healthcare providers, and community organizations. They also shared the perspective that AFBSS highlighted opportunities to build local capacity through education, technical assistance, and stronger regional collaboration, while reinforcing the importance of tailoring implementation to each county's unique infrastructure, workforce, and needs.

From USC Street Medicine's perspective, AFBSS represents a significant systems-level shift in California's approach to serving people experiencing unsheltered homelessness with SMI and severe SUD. USC Street Medicine viewed the transition from the Mental Health Services Act (MHSA) to the BHSA as an important evolution because it expanded the state's commitment to both SMI and serious SUD while prioritizing field-based care for populations that have historically faced substantial barriers to accessing specialty behavioral health services. USC Street Medicine also noted that many counties initially had a limited understanding of street medicine, often equating it with traditional outreach or existing Full-Service Partnerships (FSPs). Through the initiative, counties became increasingly receptive to recognizing street medicine as a specialized, clinically intensive model that complements county behavioral health systems. USC Street Medicine further concluded that stronger partnerships between county behavioral health departments and street medicine programs will become increasingly important as anticipated Medi-Cal coverage changes increase the need for coordinated care.

CA Bridge's experience complemented these observations by demonstrating that expanding MAT requires flexible, locally tailored implementation strategies rather than a single statewide model. CA Bridge observed significant variation in how counties approached MAT expansion but found that cross-county partnerships produced meaningful results, such as connecting the Merced Department of Behavioral Health with an addiction medicine practice in Monterey County to expand treatment capacity. The initiative also identified common knowledge gaps among county providers, particularly around treating younger patients with MAT and establishing clinical workflows, reinforcing CA Bridge's role in providing ongoing education and technical assistance. Similar to USC Street Medicine, CA Bridge viewed AFBSS as an opportunity to strengthen relationships with county champions and reflected on the importance of balancing targeted services for individuals with the greatest needs with broader, systems-level strategies that expand access to treatment across the population.

CHALLENGES

USC Street Medicine and CA Bridge identified many of the same implementation and sustainability challenges, particularly the complexity of launching new field-based service models, coordinating across multiple systems, and ensuring long-term financial sustainability. Both organizations emphasized that successful implementation requires counties to rethink existing workflows, invest in partnerships, and develop sustainable funding strategies rather than viewing AFBSS as a temporary or stand-alone initiative.

From USC Street Medicine's perspective, delivering behavioral health services in unsheltered settings requires fundamentally different workflows, staffing models, safety protocols, and partnerships than traditional clinic-based care. USC Street Medicine emphasized that many counties are effectively building an entirely new service delivery model that depends on close collaboration across healthcare, behavioral health, housing, emergency response, and community organizations. USC Street Medicine also highlighted concerns that AFBSS could become an unfunded expansion of existing responsibilities unless reimbursement models adequately reflect the complexity and intensity of field-based care. Additional barriers identified by USC Street Medicine include fragmented information systems that limit care coordination, persistent workforce shortages, and the unique challenges of engaging individuals experiencing unsheltered homelessness who often lack the stability and supports needed to participate in traditional models of care.

CA Bridge similarly emphasized the operational complexity of implementing assertive field-based MAT services, identifying administrative burdens such as provider credentialing, patient assessments, and workflow integration as significant barriers for already stretched county

behavioral health systems. CA Bridge also noted that integrating MAT into broader mental health and SUD services requires sustained coordination across organizations and systems. Like USC Street Medicine, CA Bridge identified long-term sustainability as a central concern, noting that while BHSA provides substantial investments, counties will need financing strategies that extend beyond time-limited implementation funding.

OPPORTUNITIES

Looking ahead, USC Street Medicine and CA Bridge see AFBSS as creating a strong foundation for more coordinated, community-based behavioral health systems built on partnerships, workforce development, and sustainable infrastructure. Both organizations emphasized that California already possesses many of the building blocks for success—including engaged county leaders, existing provider networks, and growing investments—and that future efforts should focus on strengthening connections among these resources rather than creating entirely new systems.

USC Street Medicine believes the greatest opportunity lies in formalizing partnerships between counties and established street medicine programs through referral pathways and contractual relationships that leverage street medicine teams' expertise in engaging unsheltered individuals while allowing county behavioral health departments to focus on specialty treatment. USC Street Medicine also recommends redesigning workflows to integrate California's existing street medicine network into behavioral health care, investing in equitable reimbursement for field-based services, expanding behavioral health training for primary care clinicians practicing in street medicine, and improving interoperability among housing, healthcare, and behavioral health information systems to strengthen care coordination.

Similarly, CA Bridge sees opportunities to build on the relationships and momentum established through AFBSS by expanding regional collaboration through initiatives such as CA Bridge Connect, strengthening referral networks, and continuing to support county champions through education and technical assistance. CA Bridge identified opportunities to increase county awareness of Healthcare Effectiveness Data and Information Set (HEDIS) and other quality metrics that can generate financial incentives to support long-term program sustainability. It also recognized opportunities to strengthen future technical assistance by better assessing participants' roles in advance so training can be more effectively tailored to clinicians, administrators, and data managers. More broadly, CA Bridge emphasized the importance of complementing targeted interventions for high-need populations with population-wide strategies that expand access to medication for addiction treatment across California. Both organizations agreed that sustaining the partnerships, workforce investments, and systems

improvements established through AFBSS will be critical to ensuring that the initiative produces lasting improvements in behavioral health care beyond its initial funding period.

COUNTY READINESS AND CONDITIONS FOR IMPLEMENTATION

Counties began implementing AFBSS from different starting points, with varying levels of policy understanding, infrastructure, workforce capacity, leadership support, and cross-system coordination. This section examines the conditions that shape readiness and counties' ability to translate AFBSS expectations into practical, coordinated service models.

UNDERSTANDING OF DHCS EXPECTATIONS

Participants consistently recognized the three AFBSS domains: data-driven targeted outreach, field-based MAT and other SUD services, and open access. Understanding of the policy intent was generally stronger than understanding of the operational roadmap. Counties and providers raised questions about how compliance would be assessed and demonstrated in practice. Key areas of uncertainty included whether implementation could occur in phases across the three domains; minimum requirements for service hours, field sites, and staff certifications; expectations for payment and reimbursement; mobile service delivery standards; documentation and recordkeeping requirements; pharmacy operations; and the respective responsibilities of counties, contracted providers, managed care plans, and other departments in meeting compliance obligations.

Specific examples of county and provider efforts to define the "operational roadmap" for themselves include:

- Assessment of how existing services could satisfy each domain.
- Expectations to integrate AFBSS delivery into field-based behavioral health programs.
- Whether counties may begin with one component and progress toward all three.
- Using AFBSS to integrate SUD engagement into outreach rather than treating it as a referral-only or compliance exercise.
- Uncertainty about model design, staffing, after-hours expectations, certification, payment, and mobile services.

Some providers and smaller counties reported that technical assistance and workshops clarified the framework.

- Some participants understood AFBSS as bridging people to whole-person supports beyond traditional office-based models.

- Some provider participants initially lacked familiarity with the specific AFBSS criteria but recognized that their community health worker (CHW), targeted outreach, MAT-linkage, and low-barrier activities aligned with the framework.
- Experienced field providers sometimes viewed AFBSS as formalizing existing work and wanted clearer differentiation between current Drug Medi-Cal field services and new expectations.

ATTITUDES TOWARD AFBSS

Attitudes were supportive of reaching people earlier, in the field, and outside traditional clinic pathways. Concerns were more often associated with workload, unfamiliarity, staffing, safety, scope of practice, stigma, prescriber willingness, billing, and infrastructure than with disagreement about the purpose of AFBSS. Below is a description of the general attitudes by region.

Regional Attitudes Toward AFBSS

North Region	Central Region	South Region
Described strong enthusiasm and alignment with rural outreach and trauma-informed care, while noting front-line concerns about field conditions and technology. Identified stigma, burnout, limited understanding, and the need for a local champion and administrative support.	Expressed interest in more flexible, integrated, and accessible service models, while noting practical workforce, financing, safety, supervision, and quality concerns. Described a cautious, reactive, and compliance-oriented environment in which existing contracted services could reduce urgency for broader change.	Reported relief that several existing programs aligned with AFBSS, although same-day MAT and prescriber readiness remained challenging. Described a proactive internal culture alongside human resources, salary, community, political, and information-sharing barriers. Reported stronger adoption in some FSP and street psychiatry programs than in other programs.

READINESS FOR SYSTEM CHANGE

Reported readiness was associated with the presence of usable outreach and field infrastructure, low-threshold access, rapid medication pathways, data capacity, partner

relationships, flexible contracting, and leadership support. Counties with these assets could adapt existing services, while counties without them described earlier-stage needs related to model design, certification, staffing, contracting, financing, and executive education.

Regional Readiness for System Change		
North Region Described outreach, harm reduction, mobile crisis, telepsychiatry, enhanced care management (ECM) experience, and data capacity that had not yet been assembled into a defined AFBSS model. Described multiple existing programs or capabilities that could be adapted or expanded, while still identifying integration and workforce gaps.	**Central Region** Described street medicine, mobile MAT, embedded SUD staff, an access point of entry, and MAT clinic certification work. Described an existing open-access MAT clinic, a planned 24/7 START Hub, integrated outreach planning, and a future mobile MAT procurement. Had contracted street medicine and field-based MAT activity but reported less development in county-operated open access and data-driven outreach. The county providers described an operating CHW model across housing, shelter, and interim settings. Described rural constraints, limited staffing, dispersed populations, and adaptation through partnerships or existing outreach and	**South Region** Providers described established field capabilities whose integration into county implementation depends on funding, referral pathways, data sharing, and governmental guidance.

	institutional settings rather than immediate creation of a full street medicine model.	

CULTURE, LEADERSHIP, COMMUNICATION, AND ORGANIZATIONAL CHANGE NEEDS

Leadership support varied from county-to-county. Some Central Region Counties described strong executive or Board support, while other Central Region County reported limited urgency to change existing contracted arrangements and resistance to braided funding. South Region County participants said county legal and executive stakeholders needed clearer legal and operational direction before moving forward with mobile medication approaches. Another Central Region County described cross-program communication and community partnerships as assets but emphasized the need for sustainable resources and broader community engagement. More specifically, counties reported the following needs regarding AFBSS implementation:

System Change Conditions for AFBSS Implementation
1. Field-Based Access Mindset Shift from facility-dependent access to services delivered where people are, with engagement and harm reduction recognized as meaningful even when abstinence is not the immediate goal.
2. Integrated Operations Integrate mental health, SUD, physical health, housing, outreach, crisis, justice, public health, managed care, and contracted-provider operations through shared goals, coordinated pathways, clear handoffs, and interoperable or aligned documentation.
3. Cross-Functional Leadership Support Pair program champions with executive, medical, nursing, pharmacy, fiscal, legal, compliance, HR, IT, and contracting support so operational barriers can be resolved.
4. Shared Accountability

Clarify responsibilities for care coordination, information sharing, payment, monitoring, and accountability across county departments, providers, and managed care plans.

5. Field Staff Support Infrastructure

Support field staff with role clarity, supervision, mobile technology, safety and crisis protocols, vicarious trauma support, realistic productivity expectations, and measures that recognize incremental engagement.

6. Stigma Reduction Through Policy and Practice

Address stigma through practice and policy changes affecting prescribing, hiring, referrals, eligibility, law enforcement interactions, facility policies, and continued access after treatment changes.

BREAKING DOWN MENTAL HEALTH AND SUD SILOS

Efforts to implement AFBSS are creating new opportunities for counties to strengthen coordination between mental health and SUD systems. Individuals served through AFBSS frequently have co-occurring behavioral health, medical, housing, and social needs, yet services may remain organized across separate programs, departments, and provider networks. Through discussions, intake surveys, and county input gathered by the Breaking Down Mental Health and SUD Silos Solutions Team, participants identified several recurring challenges and opportunities that influence counties' ability to deliver coordinated, whole-person care. The following themes reflect those experiences and highlight areas where greater integration may support AFBSS implementation:

Key Integration Themes: Breaking Down Mental Health and SUD Silos	
1. System Alignment Counties are trying to move toward co-occurring care but remain organized around separate mental health and SUD systems.	**2. Workforce Capacity** Workforce capacity and cross-training are among the largest barriers.
3. Field-Based Integration Field-based services create unique opportunities for integration.	**4. Data Sharing** Data sharing and confidentiality remain major barriers.

5. Stigma	6. Practical Tools
Stigma continues to impede integration.	Counties want practical implementation tools.

Taken together, these themes point to a central lesson: integration is most effective when it occurs wherever people are likely to be engaged**.** Field-based SUD services, street medicine, homelessness outreach, housing programs, mobile crisis teams, and reentry services offer important opportunities to operationalize a countywide No Wrong Door behavioral health model. Through integrated access, a dual-capable workforce, coordinated information systems, multidisciplinary field teams, shared leadership, and co-occurring disorder treatment approaches, counties can begin replacing disconnected service pathways with a more coordinated response for individuals with complex needs.

Based on the themes mentioned above, there are several implementation considerations counties may consider.

IMPLEMENT A NO WRONG DOOR ACCESS MODEL

Nationally, the Substance Abuse and Mental Health Services Administration (SAMHSA) and DHCS both emphasize that individuals with co-occurring disorders should receive screening, assessment, and linkage to services regardless of where they enter the behavioral health system.

Every behavioral health entry point should:

- Screen for both mental health and SUD conditions.
- Conduct integrated assessments.
- Provide warm or hot handoffs.
- Support rapid/low barrier access to treatment as a primary operational goal.

MAKE AFBSS, STREET MEDICINE, AND OUTREACH PROGRAMS THE FRONT DOOR TO INTEGRATED CARE

The AFBSS Solutions Team, a topic specific working group created to develop practical guidance for California counties implementing AFBSS, repeatedly discussed challenges engaging individuals with co-occurring disorders through traditional clinic-based systems. Many individuals are first encountered through community/field-based outreach, encampment engagement activities, mobile crisis, housing programs, street medicine, and field-based treatment services. The recommended practice is intentional integration of teams and protocols

through structured collaboration and processes and shared accountability for outcomes rather than handoffs between mental health and SUD departments.

National models increasingly utilize multidisciplinary outreach teams that address in an integrated model:

- Mental health
- SUD
- Physical health conditions
- Housing instability
- Social determinants of health

Recommended County Actions

Action steps counties can adapt:

☐ Integrate universal mental health and SUD screening into all field-based encounters.

☐ Utilize multidisciplinary outreach teams.

☐ Provide co-occurring disorder assessment in the field.

☐ Use street medicine programs as access points for behavioral health treatment and management of comorbid chronic and other healthcare conditions.

DEVELOP A DUAL-CAPABLE WORKFORCE

Workforce development emerged as one of the most consistent themes from county surveys and Solutions Team discussions. Counties noted shortages of staff trained to address both mental health and SUD needs. SAMHSA's Integrated Treatment model recommends developing a workforce capable of addressing co-occurring disorders regardless of primary discipline.

Recommended County Actions

Action steps counties can adapt:

☐ Crosstrain mental health and SUD staff.

☐ Develop formal co-occurring disorder competencies and related job descriptions, evaluations, and supervision to support integrated mental health and SUD staff competencies and service delivery.

☐ Expand peer support services to enhance engagement across sites of service.

☐ Train outreach workers, housing staff, and mobile crisis teams on both mental health and SUD.

CREATE INTEGRATED SCREENING, ASSESSMENT, AND CARE PLANNING PROCESSES

Separate assessments and treatment plans perpetuate service fragmentation. Solutions Team participants identified inconsistent screening processes as a barrier to coordinated care. Shared protocols reduce variability and prevent clients from being redirected based on diagnosis. The SAMHSA Integrated Treatment model recommends:

- Universal screening
- Integrated assessment
- Shared treatment planning
- Simultaneous treatment of mental health and SUD conditions

Recommended County Actions

Action steps counties can adapt:

☐ Adopt universal co-occurring disorder screening protocols.

☐ Develop integrated care plans.

☐ Create shared service planning processes across mental health and SUD programs.

☐ Standardize referral workflows reflective of "no wrong door" regardless of primary mental health or SUD presentation.

INTEGRATE DATA SYSTEMS AND INFORMATION SHARING

Counties consistently identified electronic health record (EHR) limitations and information-sharing barriers as major integration challenges. Solutions Team discussions highlighted concerns regarding return on investment (ROI) processes, confidentiality requirements, and disconnected systems. A better integrated data system and improved information sharing would allow providers to act on a common understanding of client needs and progress. Counties may benefit from centralized guidance and exemplar protocols for consents and related information sharing processes to support consistently accessible integrated mental health and SUD patient

records. Integrated care requires coordinated information exchange while maintaining confidentiality requirements.

Recommended County Actions

Action steps counties can adapt:

- ☐ Develop countywide data-sharing agreements.
- ☐ Standardize consent and ROI workflows.
- ☐ Create shared dashboards and outcome monitoring systems.
- ☐ Support interoperable EHR systems.

ESTABLISH SHARED LEADERSHIP AND GOVERNANCE STRUCTURES

Nationally, administrative separation between mental health and SUD systems is recognized as a major contributor to fragmented services. Many counties continue to manage mental health and SUD through separate leadership structures. Integration from shared leadership and governance structures could become an organizational expectation rather than a frontline workaround.

Recommended County Actions

Action steps counties can adapt:

- ☐ Create joint mental health and SUD leadership teams.
- ☐ Develop countywide integration workgroups.
- ☐ Align quality improvement initiatives.
- ☐ Establish shared performance measures.

EMBED CO-OCCURRING SERVICES INTO HOUSING, HOMELESSNESS, AND REENTRY PROGRAMS

Solutions Team participants frequently discussed the challenges and opportunities associated with serving individuals experiencing homelessness and those involved in the justice system. These populations often experience some of the highest rates of co-occurring disorders, and

require housing and reentry supports alongside behavioral health treatment. Housing can therefore act as a unifying platform that naturally brings mental health and SUD teams together around common client goals. Integrated behavioral health, housing, and care coordination services produce stronger engagement and retention outcomes than separate service models.

Recommended County Actions

Action steps counties can adapt:

- ☐ Embed mental health and SUD staff in housing teams.
- ☐ Coordinate outreach lists and share care coordination resources across relevant programs.
- ☐ Integrate MAT into outreach and reentry services.
- ☐ Utilize FSPs and Assertive Community Treatment (ACT) models.
- ☐ Incorporate peer support and recovery services.

REDUCE STIGMA THROUGH ORGANIZATION-WIDE CULTURAL CHANGE

Solutions Team members identified stigma as an ongoing barrier to integrated care, especially regarding SUD treatment, co-occurring disorders, and medications for addiction treatment. Research consistently identifies stigma reduction as a cornerstone of successful integrated behavioral health systems.

Recommended County Actions

Action steps counties can adapt:

- ☐ Implement ongoing training to reduce stigma.
- ☐ Incorporate recovery-oriented language standards.
- ☐ Engage peers and individuals with lived experience.
- ☐ Embed stigma reduction into supervision and quality improvement activities.

REGIONAL THEMES

Based on collective county interviews, the following regional themes were observed regarding county readiness and conditions for AFBSS implementation.

Regional Readiness and Conditions for Implementation		
North Region Northern participants emphasized smaller staffing pools, long travel distances, cross-county access issues, transportation barriers, telehealth limitations, and limited specialized providers. Needs included practical examples from similarly sized counties, co-location, regional capacity, and scheduled service routes.	**Central Region** Existing street medicine, Mobile MAT, access points, hospital partnerships, outreach teams, and integrated assessment provided foundation for AFBSS implementation. Reported needs include stronger street medicine and behavioral health integration, field medication capacity, reimbursement, transportation, housing, documentation, continuity, supervision, and workforce sustainability.	**South Region** Southern participants described greater infrastructure in some places alongside scale, coverage, prescriber capacity, medication logistics, EHR integration, and the need to embed addiction services across multiple teams and geographies.
Across Regions Across regions, including rural, desert and frontier communities, and large systems, participants requested models and peer examples matched to county size, geography, governance, workforce, infrastructure, and population needs rather than a single universal approach. Cross-cutting issues included rural and frontier constraints, large-system silos, desert geography, transportation, recruitment and compensation, mobile narcotic treatment programs (NTPs), mobile integration, distributed or county-owned sites, community opposition, peers, and tailored regional or cross-county arrangements.		

COUNTY IMPLEMENTATION APPROACHES ACROSS THE THREE AFBSS DOMAINS

Counties and providers described county-operated services, contracted providers, embedded professionals, consultation teams, mobile programs, telehealth, co-located services,

pharmacies, hospitals, jails, federally qualified health centers (FQHCs), peers, CHWs, navigators, and community partnerships. A recurring approach was to connect existing assets into a lower-threshold continuum rather than create an entirely separate AFBSS system.

DATA DRIVEN TARGETED OUTREACH

Data approaches ranged from geographic and utilization analyses to early-stage efforts to combine existing information. Across many county data approaches, participants paired quantitative data with field observations, client experience, partner knowledge, and community intelligence. Below describes several approaches counties have taken in their data approaches:

County Data Approaches for Targeted Outreach

North Region

Cross-System Data Sharing

Strong data capabilities and developing data-sharing arrangements, with plans to combine homeless outreach, harm reduction, housing, ECM, and health-plan information.

Central Region

Multi-Source Outreach Data

Uses overdose mapping, EMS and death data, by-name lists, homelessness databases, known encampments, and community knowledge to place services and reach remote populations.

Community Partner Intelligence

Revisiting spending, service, outcome, and reporting data and described the need to use community partners to identify people dispersed across remote areas.

Site Selection + Partner Meetings

Providers select sites using vulnerability, substance use, housing and health needs, staff observations, client feedback, case manager information, and displacement patterns, then

South Region

Geographic Need Mapping

Maps overdose fatalities, estimated substance use prevalence, poverty, and service utilization by Service Planning Area to identify unmet need and target capacity.

Surveillance + Outreach Targeting

Uses the Riverside Overdose Data to Action (RODA) dashboard and monthly surveillance information, including drug trends, naloxone administrations, geographic concentrations, high-risk areas, and high utilizers. A Public Service Engagement Team uses the information to focus outreach and linkage to bridge services.

Overdose Patterns + Tribal/Eastern Communities

	adjust priorities in recurring partner meetings. **HMIS / Outreach Coordination** Examines Camp2Home and HMIS-related information and coordinating multiple outreach teams. **Outreach Data Visibility** Uses county and city outreach information, SJ Cares, Access and Linkage, and co-occurring outpatient resources.	uses overdose patterns and geographic unmet need to focus on northern communities and the eastern tribal area, supported by peers and Sheriff's Office partnerships.

Participants also recommended using Admission, Discharge, and Transfer (ADT) notifications and shared information on hospital and jail utilization, overdose hotspots, housing status, medications, service history, and reasons people decline, discontinue, or re-engage. Separate EHRs and limited data-sharing infrastructure were repeatedly identified as barriers to seeing where individuals are connected and coordinating outreach.

COUNTY SPOTLIGHT

Outreach and Engagement in San Diego County

What this example illustrates: San Diego County demonstrates how counties can distinguish outreach from engagement, build trust over time, use low-barrier pathways to care, and target outreach resources using near real-time overdose surveillance data.

San Diego County emphasizes that outreach and engagement are distinct but inseparable. Outreach is the initial effort to make contact, while engagement is the ongoing process of building trust through consistency, persistence, and authentic relationships. Staff are encouraged to show up reliably, even when individuals are not ready to accept treatment or services, recognizing that trust often develops over time. Rather than focusing on immediate enrollment in care, successful outreach prioritizes becoming a trusted and dependable presence that can support future behavior change and recovery.

A central principle is to meet people where they are, both physically and personally. Providers are encouraged to respect the identities, social roles, and strengths that individuals have developed within their communities, including encampments and street networks, instead of viewing homelessness solely as a problem to be solved. Flexible, participant-centered approaches, such as hosting informal discussion groups in parks on topics people care about, help reduce barriers and strengthen relationships. San Diego has also demonstrated that existing programs can often be adapted to support field-based substance use services, transforming an existing county-funded harm reduction team into a targeted outreach team rather than creating a new program from scratch.

The county also focuses on creating low-barrier pathways into care once trust has been established. Embedding outreach teams within treatment systems, expanding access to field-based medication for addiction treatment and mobile narcotic treatment services, and fostering partnerships with outpatient providers, street medicine teams, and health centers help ensure individuals can access services when they are ready. At the same time, San Diego uses near real-time overdose surveillance data—including Overdose Detecting Mapping Application Program (ODMAP), emergency medical services (EMS) overdose response data, medical examiner reports, vital statistics, and hospital utilization data—to

proactively identify overdose hotspots and direct outreach resources where they are most needed.

Finally, San Diego highlights that the effectiveness of outreach depends as much on the workforce as on the service model itself. While foundational training in motivational interviewing, relapse prevention, harm reduction, and field safety is essential, the most successful outreach workers are characterized by their authenticity, humility, patience, compassion, and commitment to serving vulnerable populations. County leaders also noted the importance of developing reimbursement structures that better support field-based engagement, while ensuring that billing limitations do not prevent providers from delivering the flexible, relationship-centered services that people need.

COUNTY SPOTLIGHT

Turning Conversations into Impact in Del Norte County

What this example illustrates: Del Norte County demonstrates how empathy interviews and qualitative data can turn community conversations into actionable system improvements.

Del Norte County developed a practical approach to community engagement called "Turning Conversations into Impact," which uses empathy interviews and qualitative data to ensure that outreach and service decisions are shaped by the experiences of the people most affected. The work began through a cross-sector planning effort involving behavioral health, justice, and community partners, but county leaders recognized that their initial vision reflected the perspective of service systems rather than the community itself. Before making opioid settlement funding decisions, they intentionally sought input from people with lived experience, family members, frontline workers, Tribal communities, and other high-risk populations. This marked a shift from designing services for people to designing them with people.

The county's approach follows four key steps: collect, listen, pattern, and act. Through empathy interviews, participants were encouraged to share their experiences, barriers, supports, and ideas without the interviews becoming problem-solving sessions. Instead of searching for statistical representation, Del Norte focused on identifying recurring themes across interviews. Leaders found that consistent patterns began emerging after only a handful of conversations, demonstrating that pattern saturation—not large sample size—is often the most valuable indicator for understanding system-level issues. Community stories were treated as qualitative data, allowing repeated experiences to guide decisions alongside evidence-based practices, available funding, and local capacity.

Del Norte also emphasized that this process is not limited to large planning efforts and can be integrated into everyday outreach practice. Outreach teams can begin by identifying a specific question, such as why individuals do not return after an initial outreach contact, and then use open-ended, curiosity-driven conversations to understand what happened, what barriers emerged, what supports were helpful, and what people wish had been

different. By listening for common patterns rather than isolated anecdotes, teams can identify practical improvements such as adjusting outreach hours, simplifying intake processes, strengthening peer navigation, coordinating transportation, or improving follow-up communication. The process transforms individual conversations into actionable system improvements.

A key lesson from Del Norte County is that community members often already know where service systems are falling short and can identify practical solutions based on their lived experience. Quantitative data can describe outcomes such as overdoses or hospitalizations, but it cannot fully capture why people disengage from care or what changes would make services more accessible. By systematically gathering community perspectives, identifying recurring themes, and translating those patterns into operational changes, counties can continuously improve outreach efforts and ensure that services are responsive to the needs and realities of the people they are intended to serve.

FIELD-BASED MAT AND OTHER SUD SERVICES

Participants described field-based MAT within broader whole-person work that may include SUD screening, mental health services, contingency management (CM), primary and wound care, housing support, transportation, crisis services, harm reduction supplies, social services, navigation, and repeated relationship-based engagement. The table below highlights several activities counties are doing around field-based MAT and SUD services.

County Approaches to Field-Based MAT and Other SUD Services

North Region	Central Region	South Region
Wellness Van + Telehealth Partnerships	**Day Center + Virtual MAT Access**	**FSP + Field Program Integration**
Considering a wellness van, SUD counselors with mobile crisis, telepsychiatry, FQHC and health-plan partnerships, and expanded walk-in primary care MAT.	Co-locates outreach and SUD engagement at a day center, embeds a contracted SUD counselor, uses a virtual MAT provider for rapid prescribing, conducts encampment and hotel	Integrates addiction services into FSP and other field programs, operates a MAT consultation line, deploys a Street Addiction Consultation Team, and permits structured

	outreach, and connects jail MAT to community follow-up. **Mobile MAT + Street Medicine** Mobile MAT and street medicine activities including wound care, prescribing, medication inductions, and medications brought into the field, with behavioral health liaisons supporting connection to continuing care. **Contracted Street Medicine + NTP** Contracted street medicine offering MAT and engagement supplies, along with an NTP provider delivering field-based methadone. **Mobile Van + Visiting Psychiatrist** An Aegis mobile van and exploration of field MAT with a visiting psychiatrist. **Multidisciplinary Outreach** Provides multidisciplinary outreach and linkage, but not field medication services.	Drug Medi-Cal services at county-reviewed field sites. **Mobile Crisis + Rapid Prescriber Access** Uses mobile crisis, American Society of Addiction Medicine (ASAM)-capable staff, co-occurring FSP and ACT/forensic assertive community treatment (FACT) programs, field teams, medical residents, and contracted providers adding MAT, with attention to rapid prescriber access. **Mobile Crisis + Peer Outreach** Plans to integrate SUD services into mobile crisis and use peers and opioid-settlement-supported outreach in isolated communities.

Counties and implementation partners identified the need for multiple, flexible pathways to medications for addiction treatment, particularly for individuals who are unlikely to initiate care through traditional facility-based services. Through the Unconventional Methods of Prescribing MAT Solutions Team, participants explored field-based initiation, street medicine, telehealth, mobile services, open-access care, emergency department bridge pathways, and medication access lines. Their experiences suggest that these approaches depend not only on prescriber

availability, but also on multidisciplinary staffing, medication logistics, pharmacy coordination, clearly assigned workflows, strong community partnerships, and ongoing follow-up.

Across the Solutions Team discussions, several interconnected themes emerged regarding how counties can expand access to MAT through flexible, low-barrier service pathways. The themes below summarize key implementation insights and identify practical considerations that counties may adapt based on local needs, infrastructure, workforce capacity, and partnerships.

CREATE MULTIPLE, LOW-BARRIER PATHWAYS TO MEDICATIONS FOR ADDICTION TREATMENT

Individuals who are least likely to engage in traditional treatment may benefit from having multiple ways to initiate and continue medications for addiction treatment. Solutions Team participants identified mobile and field-based services, street medicine programs, telehealth, open-access clinics, emergency department bridge pathways, and medication access or navigation lines as promising approaches for expanding access. Participants emphasized that these pathways should connect medication initiation with outreach, rapid assessment, follow-up, care coordination, and ongoing treatment rather than operating as stand-alone prescribing services.

Considerations for Counties

- Identify where individuals currently encounter behavioral health, health care, homelessness, housing, emergency response, and justice systems.
- Establish multiple entry points for same-day or rapid access to medications.
- Integrate medication access into existing trusted service settings, including street medicine, outreach, harm reduction, and open-access programs.
- Develop backup pathways for situations in which a field-based or outpatient prescriber is not immediately available.
- Define how individuals will receive follow-up and connection to continued treatment after medication initiation.
- Account for transportation and technology barriers when designing access pathways.

STANDARDIZE CORE PRACTICES WHILE ALLOWING CLINICAL FLEXIBILITY

Participants consistently emphasized that clear clinical protocols, prescribing algorithms, decision-support tools, and operational workflows can reduce uncertainty and support provider confidence. At the same time, protocols need sufficient flexibility to reflect the individual's

clinical presentation, recent substance use, withdrawal status, readiness, treatment preferences, and circumstances in the field. Participants also noted that protocols should evolve as evidence, regulations, field experience, and population needs change.

Considerations for Counties

- Establish adaptable protocols for field-based, mobile, telehealth-supported, emergency department, open-access, and street medicine settings.
- Include decision points that help clinicians select an appropriate initiation pathway based on clinical assessment and field conditions.
- Use standardized practices for clinical safety, medication workflows, documentation, follow-up, and training.
- Permit local adaptation based on geography, staffing, pharmacy access, population needs, and available infrastructure.
- Identify consultation and escalation resources that prescribers can access when managing complex cases.
- Review and update protocols as evidence, regulations, and local implementation experience evolve.

BUILD MULTIDISCIPLINARY TEAMS WITH CLEARLY DEFINED RESPONSIBILITIES

The Solutions Team emphasized that successful field-based medication treatment depends on coordinated multidisciplinary teams, not only prescribers. Peers, Substance Use Navigators, nurses, behavioral health clinicians, substance use counselors, outreach workers, care coordinators, housing specialists, community health workers, prescribers, and other team members may contribute complementary skills that support engagement, clinical access, medication logistics, safety, follow-up, and continuity of care. Clearly defining ownership helps prevent gaps when multiple staff or organizations share responsibility for an individual's care.

Considerations for Counties

- Conduct outreach and support initial engagement.
- Complete screening and facilitate clinical assessment.
- Connect the individual with a prescriber.
- Provide patient-side support during telehealth encounters.
- Coordinate medication procurement, storage, transportation, or administration.
- Support staff and patient safety in field settings.

- Conduct follow-up after medication initiation.
- Link the individual with ongoing behavioral health, medical, housing, Enhanced Care Management, and recovery services.
- Address workflow problems or escalate complex clinical and operational questions.

TREAT PARTNERSHIPS AND MEDICATION LOGISTICS AS CORE INFRASTRUCTURE

Field-based and low-barrier medication access requires both strong partnerships and reliable operational infrastructure. Solutions Team participants identified primary care providers, federally qualified health centers, emergency departments, bridge clinics, pharmacies, street medicine programs, behavioral health providers, housing services, correctional partners, probation, emergency medical services, and community-based organizations as potential contributors to a broader MAT access network. They also emphasized that medication procurement, inventory, secure storage, refrigeration, field transportation, chain of custody, administration, documentation, and pharmacy coordination should be addressed before services begin.

Considerations for Counties

- Map existing MAT prescribers, initiation sites, pharmacies, bridge programs, mobile services, and referral partners.
- Establish shared expectations for referrals, rapid access, communication, handoffs, and follow-up.
- Identify primary and backup pharmacy partners with reliable medication availability.
- Clarify medication procurement, inventory, refrigeration, temperature monitoring, secure storage, transportation, and chain-of-custody procedures.
- Define which team members are permitted and responsible for medication-related activities.
- Develop contingency processes for medication delays, unavailable prescribers, pharmacy barriers, and unsuccessful handoffs.
- Explore opportunities to share specialized staff, training, technology, outreach resources, and referral infrastructure across agencies or regions.

PLAN FOR SUSTAINABILITY, FEEDBACK, AND CONTINUOUS IMPROVEMENT

Participants identified sustainable funding and continuous learning as essential to maintaining flexible MAT pathways. Field-based models may require resources for outreach, prescriber coverage, mobile medication services, technology, transportation, medication infrastructure, care coordination, and activities that may not be supported through traditional reimbursement alone. Participants also emphasized the importance of reviewing client experience, implementation barriers, clinical protocols, and operational results over time.

Considerations for Counties

- Distinguish start-up expenses, ongoing staffing needs, reimbursable services, and non-reimbursable infrastructure.
- Explore braided funding approaches that may include reimbursement, grants, opioid settlement or remediation funds, foundation support, and local partnerships.
- Begin with essential infrastructure and scale services as staffing, funding, partnerships, and community needs become clearer.
- Collect client feedback at multiple points in the treatment process.
- Review cases, access barriers, medication delays, follow-up patterns, and operational challenges.
- Monitor relevant implementation and service data.
- Update protocols, training, workflows, and partnership agreements based on findings.
- Participate in cross-agency or cross-county learning opportunities to share protocols, barriers, and emerging practices.

Taken together, these insights suggest that unconventional MAT prescribing is less about adopting a single new clinical approach and more about creating a flexible system of access. Counties may strengthen these pathways by combining multiple entry points, adaptable clinical protocols, multidisciplinary teams, reliable medication infrastructure, clearly defined partnerships, sustainable financing, and continuous learning. The appropriate combination will vary based on local geography, workforce capacity, existing services, pharmacy access, and community need.

COUNTY SPOTLIGHT

Building Toward Integrated Co-Occurring Care in Los Angeles County

This example illustrates: Los Angeles County demonstrates foundational steps involved in moving a large and complex behavioral health system toward more integrated co-occurring care.

Los Angeles County is advancing a long-term vision for a more integrated behavioral health system in which individuals with co-occurring mental health and substance use disorders (SUD) can receive coordinated, whole-person care. Given the size and complexity of the County's service system, achieving this vision will require sustained planning, cross-agency partnership, workforce development, and changes to service delivery infrastructure.

Building on work associated with CalAIM and the Drug Medi-Cal Organized Delivery System, the County is planning for BHSA implementation and identifying opportunities to reduce longstanding silos between mental health and substance use treatment. At Los Angeles County's Department of Mental Health (DMH), these early efforts have led to the establishment of a dedicated Co-Occurring Disorders Unit, which is tasked in helping lead the department's integration of mental health and substance use care. The County is also developing standardized screening approaches, training resources, and data infrastructure to support more consistent care over time.

Initial efforts in field-based settings include work related to a level-of-care tool based on the ASAM Criteria, access to medications for addiction treatment, direct-to-inject buprenorphine protocols, and the development and coordination of workforce training. Specialized training pathways are also being developed for psychiatrists, clinicians, case managers, SUD counselors, peer support specialists, and other frontline staff. These activities are intended to strengthen the ability of multidisciplinary teams to identify and respond to co-occurring needs wherever individuals enter the system.

This work is taking place within a broader countywide effort involving the Department of Mental Health, the Department of Public Health's Substance Abuse Prevention and Control division, the Department of Health Services, community providers, and other partners. These partnerships are particularly important to efforts involving field-based care, housing, reentry, homelessness, and connections across mental health, SUD, physical health, and recovery services.

Much of this work is in the early stages, and continued coordination, implementation, and evaluation will be needed to realize the County's broader vision. Nevertheless, the County's experience illustrates the foundational steps involved in moving a large and complex behavioral health system toward more integrated co-occurring care, including establishing leadership, developing workforce capacity, building shared infrastructure, and strengthening cross-agency partnerships.

COUNTY SPOTLIGHT

Expanding Access Through Innovation and Field-Based Care in Los Angeles County

This example illustrates: Los Angeles County demonstrates how a large SUD system can expand access through field-based care, navigation, MAT access, and innovative service infrastructure.

Los Angeles County's Substance Abuse Prevention and Control (SAPC) Bureau has transformed the County's substance use disorder (SUD) system by building an accessible, person-centered continuum of care that reaches individuals wherever they are in their recovery journey. As the County's dedicated SUD authority, SAPC serves approximately 275,000 people each year and has made sustained investments in prevention, treatment, recovery, and harm reduction. Since 2017, the County has expanded prevention services by 260%, treatment capacity by 275%, medications for addiction treatment (MAT) by 205%, recovery housing by 550%, and harm reduction services by 500%, demonstrating a long-term commitment to increasing access and improving outcomes for residents.

A cornerstone of this success has been SAPC's "No Wrong Door" approach, ensuring that individuals can connect to treatment regardless of where they first seek help. The County's 24/7 MAT Call Line provides immediate access to SUD counselors, care coordination, and on-call medical providers who can initiate treatment, prescribe medications, and connect individuals to ongoing services. Serving approximately 1,000 unique callers each year—including referrals from emergency departments, street medicine teams, outreach programs, and hospitals—the call line removes barriers that often delay care and creates a seamless pathway into treatment.

Recognizing that many individuals face challenges navigating complex systems, Los Angeles County also developed Client Engagement and Navigation Services (CENS), embedding more than 100 dedicated SUD counselors within courts, probation offices, housing programs, psychiatric urgent care centers, child welfare settings, and other community locations. These counselors provide in-person assessments, care navigation,

and direct linkage to treatment, helping prevent individuals from falling through service gaps during critical transitions. Complementing these efforts include innovative tools such as the Service & Bed Availability Tool, which provides real-time information on treatment facility availability by geographic region. These programs have proven especially effective for people experiencing homelessness, housing instability, or previous barriers to engaging in care.

Los Angeles County has further expanded access by bringing treatment directly into the community. Through Medi-Cal billable field-based services, providers can deliver substance use treatment where individuals live, including people experiencing homelessness and others who have traditionally been excluded from care. Furthermore, SAPC launched the Street Addiction Consultation Team, which offers expert clinical consultation, field-based MAT support, and care coordination for frontline providers. Together, these initiatives reflect Los Angeles County's commitment to meeting people where they are, reducing barriers to treatment, and building a comprehensive, equitable behavioral health system that prioritizes engagement, recovery, and long-term wellness.

COUNTY SPOTLIGHT

Bringing Healthcare Directly to People Experiencing Homelessness in San Joaquin

What this example illustrates: San Joaquin County demonstrates how street medicine can bring low-barrier, relationship-based medical care, harm reduction, and social supports directly to people experiencing unsheltered homelessness.

San Joaquin County is redefining healthcare access through an innovative street medicine program that delivers medical care and social services directly to individuals experiencing unsheltered homelessness. Rather than expecting patients to navigate traditional healthcare settings, interdisciplinary teams of providers, nurses, medical assistants, and community health workers meet people where they live—in encampments, parks, tents, and on the streets. This low-barrier, patient-centered model removes obstacles to care while building trusting relationships that encourage ongoing engagement and improve long-term health outcomes.

The County's street medicine program provides far more than immediate medical treatment. Teams deliver health screenings, wound care, vaccinations, medications, medication delivery, and infection control while also connecting individuals to housing resources, Enhanced Care Management, behavioral health services, and other critical supports. Harm reduction strategies—including Narcan distribution, fentanyl test kits, and the planned expansion of harm reduction kits—help reduce overdose risk while creating opportunities to engage individuals in additional care. Whether services are delivered on foot or through the MOBY mobile clinic, every encounter is designed to address both immediate health needs and the broader social factors that impact recovery and wellness.

A defining strength of San Joaquin County's approach is its commitment to quality, continuity, and compassion. Rather than focusing solely on the number of people served, street medicine teams prioritize meaningful relationships and consistent follow-up. In 2025, mobile clinic teams recorded nearly 2,400 patient encounters across San Joaquin and Stanislaus counties, with approximately 40 percent involving wound care—a critical

service that helps prevent infections, avoid emergency department visits, and improve quality of life for individuals living in challenging conditions. Through ongoing medication delivery, care management, referrals, and regular follow-up visits, the program supports patients well beyond their initial encounter.

By combining healthcare, social services, harm reduction, and advocacy into a single field-based model, San Joaquin County is addressing healthcare disparities for one of its most vulnerable populations. Despite the challenges of serving highly mobile populations and operating in complex field environments, the County continues to demonstrate that compassionate, flexible, and relationship-driven care can improve health outcomes while serving as a gateway to housing, behavioral health treatment, and long-term recovery.

OPEN ACCESS CLINICS

Participants described open access as immediate or rapid entry, lower administrative burden, a specific same-day service offer, and active navigation. Models included walk-in clinics, access lines, crisis centers, same-day telehealth, mobile teams, emergency department bridge services, field-site initiation, and co-located day centers. The table below describes several open access related activities taking place across California counties.

County Approaches to Open Access Clinics

North Region	Central Region	South Region
24/7 Access + Same-Day Telehealth A 24/7 access line, same-day telehealth MAT, a day-center walk-in pathway, community assessment and intake, transportation, and clinic or hospital alternatives. **Various Access Points** Has potential access through primary care, telepsychiatry,	**Open-Access MAT + START Hub** A weekday open-access MAT clinic and a planned 24/7 START Hub. **Phone Line + Walk-In Access** A 24-hour phone line, walk-in access point, MAT clinic certification work, and potential expansion of contracted provider hours.	**Same-Day MAT + Crisis Walk-In** Expanding same-day MAT through crisis walk-in procurements requiring on-site prescribers, a South Region provider, hospital bridge services, and the Mead Valley Wellness Village planned for January 2027.

mobile crisis, FQHCs, external NTP access, and expanded walk-in hours, while noting the loss of the county hospital as a bridge site.	**County-Operated Open-Access MAT** Considering Drug Medi-Cal certification for a county-operated open-access MAT clinic offering medications beyond NTP services. **Community Drop-In + Flexible Geography** Provider is developing drop-in hours across community sites. Emphasized geographic flexibility and access based on the nearest practical service location, including across county lines.	**Open-Access Clinic + Jail Transitions** Operates an open-access clinic with walk-ins and jail transition linkages and is developing a county-owned SUD clinic. **Consultation Line + Field Navigation** Uses a MAT consultation line, field teams, pharmacy coordination, navigation, Medi-Cal enrollment, and county-reviewed field sites to reduce dependence on facility-based intake.

Provider and county perspectives emphasized trusted entry points, assisted telehealth rather than technology alone, repeated conversations before treatment acceptance, transportation, warm handoffs, and access during jail, hospital, housing, or county transitions. Participants cautioned against recreating a complete facility intake as the prerequisite for initial engagement.

COUNTY SPOTLIGHT

Expanding Assertive Field-Based Substance Use Treatment in Sacramento County

What this example illustrates: Sacramento County demonstrates how outreach, harm reduction, mobile medicine, and same-day medications for addiction treatment can be connected into a coordinated continuum of care.

Sacramento County has built a coordinated, community-centered approach to substance use disorder (SUD) treatment by connecting outreach, harm reduction, mobile medicine, and same-day medications for addiction treatment (MAT) into a seamless continuum of care. Through partnerships across Behavioral Health Services, public health, fire departments, healthcare providers, schools, and community-based organizations, the County has strengthened its ability to reach individuals where they are—particularly those in high-risk, underserved communities.

The county's targeted outreach efforts have significantly expanded access to prevention, education, and treatment. Behavioral Health Services staff and community partners provide screenings at CORE Community Wellness Centers, deliver culturally responsive opioid prevention education for the Iu Mien community, and have participated in more than 50 community outreach events, including Recovery Happens and the Fentanyl Action and Awareness Summit. By focusing outreach on neighborhoods with the greatest need, Sacramento County is reducing barriers to care and increasing awareness of available treatment and recovery resources.

Sacramento County has also strengthened its field-based treatment network by bringing together mobile medicine providers, harm reduction teams, fire department response units, and healthcare organizations to improve collaboration and rapid access to care. The County's Mobile Medicine Summit and ongoing Mobile Medicine Provider Meetings have created lasting partnerships, while programs such as SANE and Harm Reduction Services connect individuals to FDA-approved medications for opioid use disorder through the Transitions Buprenorphine Clinic. These coordinated efforts ensure that people

experiencing homelessness and other vulnerable populations can receive timely treatment in community settings.

Complementing these outreach efforts is a robust network of open-access MAT clinics that provide same-day, walk-in services across Sacramento County and neighboring communities. Individuals can access medications such as methadone and buprenorphine without lengthy wait times, supported by telehealth services and referrals from mobile outreach teams. Looking ahead, Sacramento County is continuing to strengthen its system through provider incentives that expand outreach and by exploring integrated Full Service Partnership models for individuals with co-occurring mental health and substance use disorders. Together, these initiatives demonstrate the County's commitment to building an accessible, equitable, and responsive behavioral health system that meets people where they are and connects them to recovery without delay.

COUNTY SPOTLIGHT

Integrating Treatment and Outreach to Improve Recovery in San Joaquin

What this example illustrates: San Joaquin County demonstrates how MAT, psychiatric care, targeted outreach, and intensive field-based services can be integrated to support individuals with complex behavioral health needs.

San Joaquin County has built an integrated behavioral health system that combines medications for addiction treatment (MAT), psychiatric care, targeted outreach, and intensive field-based services to better serve individuals with substance use disorders, serious mental illness, and co-occurring conditions. By bringing together psychiatrists, psychiatric nurse practitioners, mental health clinicians, SUD counselors, case managers, peer support specialists, and medical providers, the County has created a coordinated model that meets people at every stage of recovery while reducing barriers to care.

A key strength of the County's approach is its Medication Clinic, which provides timely access to both psychiatric services and MAT for individuals entering treatment as well as those with ongoing behavioral health needs. The clinic offers evidence-based medications for alcohol, opioid, stimulant, and nicotine use disorders alongside comprehensive psychiatric medication management, ensuring that individuals with complex behavioral health needs receive integrated, whole-person care. Looking ahead, San Joaquin County is expanding the clinic through open-access drop-in hours, increased provider availability, and on-site medication administration to further improve timely access to treatment.

The County's commitment to meeting people where they are is reflected in its robust outreach infrastructure. Multidisciplinary teams conduct outreach in homeless encampments, shelters, hospitals, and throughout the community, using data from the Homeless Management Information System, community referrals, and local agencies to identify individuals most in need of services. Partnerships with local hospitals allow Substance Use Navigators to engage individuals following emergency department visits

and connect them directly to treatment, while embedded staff at homeless shelters provide screening, assessment, and care coordination for residents who may otherwise face significant barriers to accessing services.

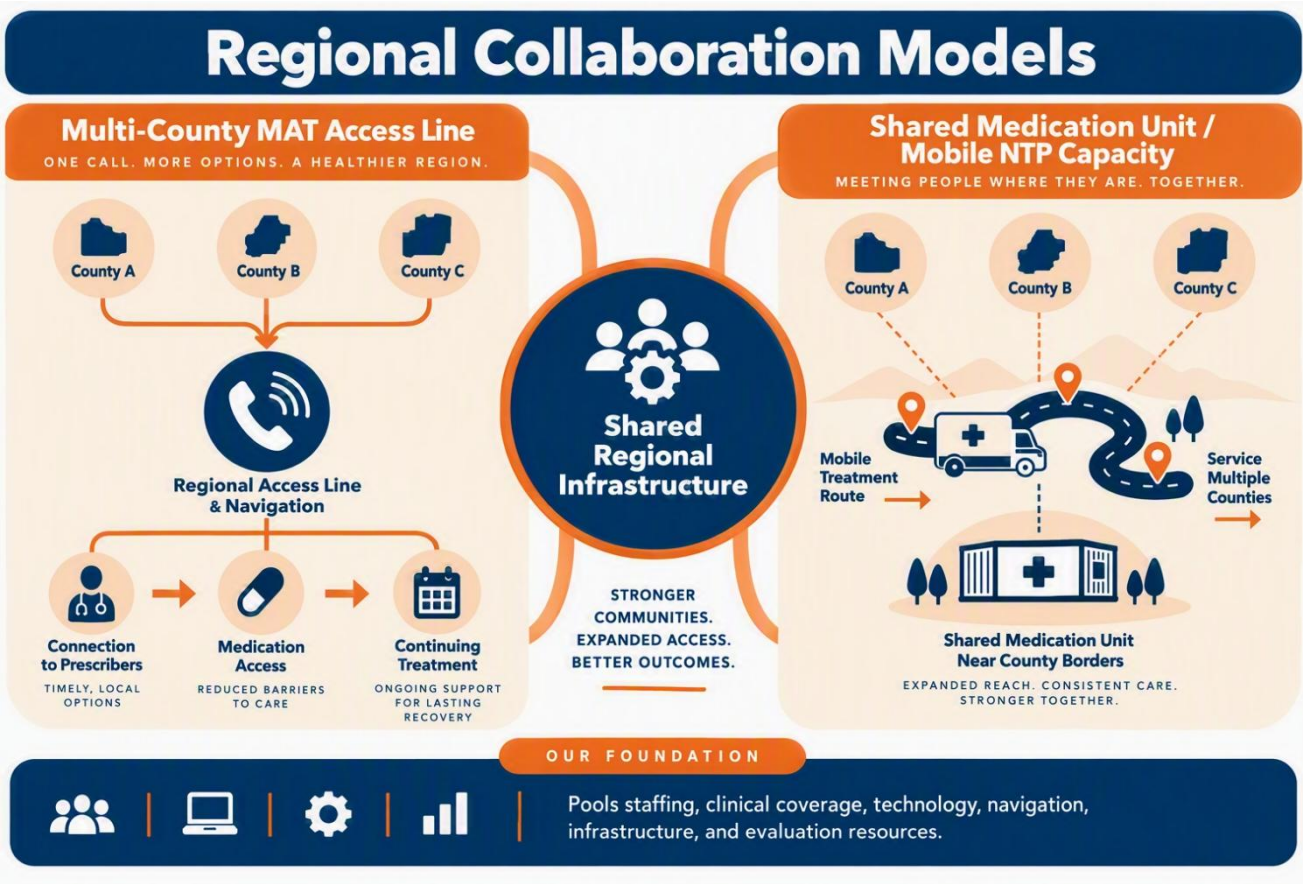
San Joaquin County has further strengthened outcomes through its Co-Occurring Services Team, which delivers intensive field-based care for individuals experiencing both serious mental illness and substance use disorders. Beginning with comprehensive screening in residential treatment programs, the team follows individuals as they transition back into the community, providing ongoing case management, therapy, psychiatric care, MAT, substance use counseling, and housing support. With regular in-person engagement and access to a range of housing options, the County's multidisciplinary teams help individuals maintain stability, strengthen recovery, and reduce the likelihood of future crises. Together, these efforts demonstrate San Joaquin County's commitment to delivering coordinated, compassionate, and accessible behavioral health services that improve outcomes for some of its most vulnerable residents.

REGIONAL AND CROSS-COUNTY DELIVERY MODELS

Counties and providers identified regional collaboration as one potential strategy for addressing limited workforce and prescriber capacity, long travel distances, transportation barriers, dispersed populations, and other service-access challenges that may be difficult for a single county to address independently. These considerations may be particularly relevant in rural and geographically dispersed communities, although cross-county arrangements may also benefit larger systems seeking to share specialized expertise, infrastructure, or referral capacity.

Cross-county collaboration can strengthen AFBSS by helping counties share scarce resources, reduce duplicative costs, build economies of scale, and reach individuals whose lives, service needs, and care-seeking patterns do not stop at county lines. A regional approach can also create structured opportunities for counties and providers to learn from one another, test practical workflows at a manageable scale, and identify which models are most effective before investing in broader expansion. At the same time, cross-county collaboration presents challenges related to governance, policy alignment, funding, data sharing, and implementation that require clear agreements among participating counties and provider partners.

Through the Building Regional Partnerships Solutions Team, participants explored two potential applications of regional collaboration[1]:



These models illustrate how counties might pool staffing, clinical coverage, technology, navigation, infrastructure, and evaluation resources rather than developing separate systems in each jurisdiction. They are intended as options for consideration rather than as a single approach appropriate for every county.

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[1] *Image created using Microsoft CoPilot. Accessed 2026-09-07. Prompt: Create a clean professional infographic for a behavioral health implementation manual. Title: "Regional Collaboration Models". Design: central hub labeled "Shared Regional Infrastructure" in the middle, with two curved branching pathways going left and right. Left pathway labeled "Multi-County MAT Access Line" with simple icons for counties connecting to one shared phone/navigation hub, then to prescriber connection, medication access, and continuing treatment. Right pathway labeled "Shared Medication Unit / Mobile NTP Capacity" with simple icons showing neighboring counties connected by a mobile treatment route and a shared medication unit near county borders. Bottom foundation bar reads: "Pools staffing, clinical coverage, technology, navigation, infrastructure, and evaluation resources." Generated using httpss://copilot.microsoft.com.*

MODEL ONE: MULTI-COUNTY MEDICATIONS FOR ADDICTION TREATMENT ACCESS LINE

A multi-county MAT access line could provide a low-barrier pathway from an initial request for help to prescriber connection, medication access, and referral for continuing treatment. Individuals may contact the service directly, or field-based teams, hospitals, jails, emergency responders, and other referral partners may initiate a warm handoff while they are with the individual. Counties considering this approach may first assess existing statewide and local access resources, including CA Bridge Connect, and determine whether a regional model would supplement existing capacity or address a gap not otherwise covered.

MODEL TWO: REGIONAL MEDICATION-UNIT AND MOBILE NARCOTIC TREATMENT PROGRAM

Regional medication-unit and mobile NTP arrangements may help expand access in communities located far from existing NTPs. Depending on geography, service volume, provider capacity, and available resources, neighboring counties could explore a shared medication unit near county borders, a mobile unit operating across multiple counties, or smaller local medication units that share clinical staff and other specialized resources. Service locations and mobile routes may be informed by travel distance, treatment-access gaps, transportation barriers, treatment disengagement, and demonstrated community need rather than county boundaries alone.

Regardless of the model selected, participating counties would need to clarify leadership, funding, staffing, service coverage, referral pathways, follow-up responsibilities, data sharing, documentation, and performance reporting. Beginning with a limited pilot may allow counties to test core workflows, identify operational barriers, assess demand and feasibility, and refine the model before expansion. Shared measures may help participating counties understand whether differences in access and outcomes are associated with geography, pharmacy availability, provider capacity, transportation, or referral-partner participation.

Regional collaboration is not a single service model, but an implementation strategy that counties may use to extend specialized capacity, reduce duplication, respond to geographic barriers, and strengthen continuity across county boundaries. The appropriate approach will vary based on county size, geography, infrastructure, workforce, partnerships, and population needs. Counties interested in pursuing these models can refer to the regional partnerships companion resource for more detailed considerations related to governance, pilot design,

staffing, workflows, pharmacy and transportation coordination, evaluation, financing, and phased implementation.

REGIONAL THEMES

Regional implementation themes show that counties and providers are working toward the same AFBSS domains under very different operating conditions. The points below highlight how geography, system size, provider mix, service infrastructure, and local access barriers shape the practical strategies needed to connect targeted outreach, field-based services, and open access into a coordinated continuum.

Regional and Cross-County Delivery Themes

Rural Delivery	Large Systems	Contracted Providers
Rural delivery may rely on shared staff, mobile NTPs, co-location, telehealth with an in-person connector, cross-county payment arrangements, and scheduled regional routes rather than a continuously staffed mobile team.	Large systems described consultation teams and hub-and-spoke expertise as ways to extend addiction capability across many existing programs without placing a specialist on every team.	Contracted providers can contribute specialized experience and implementation flexibility, while counties continue to need clear quality, data, referral, payment, and accountability structures.

Cross-Cutting Delivery Considerations

Service placement should reflect overdose, utilization, and field information while accounting for isolated communities, tribal areas, transportation networks, displacement, and local opposition.

Across settings, targeted outreach, field initiation or linkage, and open access were described as connected functions: identifying need has limited value unless teams can offer or arrange a meaningful service when a person is ready.

IMPLEMENTATION CHALLENGES, GAPS, AND LESSONS LEARNED

DESIGN AND IMPLEMENTATION CHALLENGES

Participants noted that retrofitting established teams can require changes to job descriptions, EHR access, billing and documentation practices, training, and clinical workflows. Southern

Region participants observed that building a model from the ground up may sometimes be easier than revising existing structures. Multiple counties requested practical workflows, legal examples, and peer consultation rather than high-level descriptions alone. More specific examples noted by counties included:

- Translate broad AFBSS expectations into county-specific service hours, sites, staffing, partner roles, referral and escalation pathways, documentation, and follow-up workflows.
- Choose among county-operated, contracted, regional, and hybrid delivery arrangements while maintaining county visibility, accountability, quality, and sustainability.
- Integrate SUD functions into mental health, crisis, homeless outreach, street medicine, hospital, jail, primary care, housing, and managed care systems without duplicating services or losing people in handoffs.
- Balance flexible, relationship-based field practice with requirements for safety, privacy, supervision, quality, scope of practice, clinical escalation, and compliance.
- Address DEA licensing, mobile medication storage and transport, van placement, chain of custody, pharmacy fulfillment, early refills, administration, county-reviewed field sites, consent, certification, and billing questions.
- Operate in remote settings with limited connectivity, long travel times, small populations, low after-hours volume, and limited facilities while still providing timely access.
- Address political or community opposition to clinics, recovery housing, harm reduction, and services for unsheltered populations, along with housing availability and eligibility constraints.

WORKFORCE AND PRESCRIBER CAPACITY

Participants identified workforce and prescriber capacity as a core constraint on AFBSS implementation, shaping whether counties and providers can sustain field-based, low-barrier services beyond pilot efforts. The challenges below reflect recurring needs related to recruitment and retention, role fit, prescriber readiness, team-based capacity, supervision, staff safety, and supports that make field work feasible over time.

- Counties and providers reported vacancies, low salaries, limited negotiating flexibility, pay disparities, limited administrative staff, and difficulty recruiting and retaining SUD counselors, therapists, nurses, CHWs, peers, and in-person physicians.
- Santa Clara's interviewed provider network described three CHWs across the county context discussed, while serving six sites and reporting demand beyond available

capacity. Calaveras described a small behavioral health team, and Monterey described limited internal Drug Medi-Cal administrative staffing.

- Field roles require relationship-building, situational awareness, harm reduction knowledge, crisis response, resilience, safety judgment, and comfort working in uncontrolled environments. Not every clinic-based staff member is suited to this work.
- Prescriber barriers include limited availability, reluctance to provide MAT, uncertainty about addiction treatment roles, and difficulty providing medication in mobile or street settings. Newer prescribers need protocols, consultation, mentorship, continuing education, and escalation pathways.
- CHWs, peers, navigators, SUD counselors, LCSWs, pharmacists, medical assistants, crisis workers, and care coordinators can extend clinical capacity, support telehealth, build trust, navigate intake, provide transportation, and maintain engagement.
- Field teams need safety procedures, supervision, crisis preparation, debriefing, vicarious trauma support, realistic caseloads and productivity expectations, and measures that recognize incremental progress.

PROVIDER BUY-IN AND ADAPTATION OF FIELD-BASED PRACTICES

Participants reported that buy-in improved when staff understood the purpose of the model, heard lived-experience or peer examples, received practical training, and could reach leaders who were able to resolve operational barriers. Support for the mission did not automatically translate into readiness to prescribe, document, bill, supervise, or work safely in field settings.

- Field practice should adapt to patient location, technology limitations, competing needs, safety conditions, and variable readiness rather than reproduce a clinic encounter outdoors.
- Teams described patient-defined goals, harm reduction, continued engagement, transportation, basic-needs support, repeated outreach, and warm handoffs as important parts of practice.
- Participants emphasized maintaining access to broader care when a person declines medication, discontinues treatment, changes goals, or returns to use.
- Rigid, stigmatizing, or poorly explained requirements can deter engagement. Practice change may require revisions to job duties, referral processes, prescribing expectations, documentation, supervision, and program policies.
- Central Region County raised the need to balance relationship-based field engagement with boundaries and staff safety. Another Central Region County raised concerns about staff acclimation, supervision, quality, burnout, and supporting counselors across

multiple sites. A separate county identified prescriber culture as a barrier to broader MAT access.

ENGAGING INDIVIDUALS WITH STIMULANT USE DISORDER IN FIELD-BASED SETTINGS

Counties and the "How to Address Stimulant Use in the Field" Solutions Team participants identified stimulant use disorder (StUD) as an area requiring more tailored field-based approaches. Although many counties have experience engaging individuals with SUD, participants reported that StUD is frequently addressed through models developed primarily for opioid or alcohol use disorders. This can reinforce the perception that individuals who use stimulants are more difficult to engage or treat, rather than recognizing that StUD may involve different patterns of use, functional needs, health risks, engagement pathways, and treatment approaches.

The Solutions Team discussions helped identify several areas where counties may need additional guidance and implementation support.

STIMULANT USE DISORDER REQUIRES A DISTINCT ENGAGEMENT APPROACH

Participants emphasized that StUD should not be treated simply as a variation of opioid or alcohol use disorder. One county described a prevailing "one-size-fits-all" approach to SUD in which current methods appear less effective for stimulant use, contributing to a perception that StUD is more difficult to address. Participants instead emphasized the importance of understanding StUD as a distinct condition with different signs, symptoms, engagement challenges, health risks, and treatment considerations.

This distinction has practical implications for field-based services. Unlike opioid use disorder (OUD), StUD does not currently have an FDA-approved medication that can serve as the central organizing intervention. Field teams may therefore need to place greater emphasis on sustained engagement, harm reduction, behavioral interventions, CM, when available and appropriate, physical and mental health needs, and connection to broader supports. The absence of an approved medication does not mean that providers have nothing to offer. Teams can address immediate medical and safety risks, reduce harm, treat symptoms, connect individuals to behavioral care, and maintain a relationship through changes in readiness and treatment interest.

Participants also noted that stimulant use may serve functional purposes for individuals living in unsheltered settings, including staying awake for safety, managing exhaustion, sustaining daily functioning, creating social connection, or coping with untreated physical or mental health

needs. Engagement approaches that focus only on stopping substance use, without understanding or addressing the concern that stimulant use is helping the individual manage, may be less likely to succeed.

ENGAGEMENT IS OFTEN THE INTERVENTIONS

A central lesson from the Solutions Team was that, for individuals who use stimulants and are not connected to clinic-based services, engagement is not simply a preliminary step before treatment. Engagement may be the primary intervention for a substantial period. Participants emphasized that this work should be intentionally staffed, resourced, documented, supported, and measured.

Individuals encountered in field settings may have longstanding negative experiences with health care, behavioral health, housing, law enforcement, and social service systems. Initial contacts may therefore need to focus on demonstrating reliability and trustworthiness rather than completing an assessment or securing immediate treatment enrollment. Basic and person-defined needs such as food, water, clothing, wound care, telephone access, identification documents, pet supplies, mail access, safe storage, housing navigation, or transportation may provide the starting point for an ongoing relationship.

Participants identified consistency as more important than intensity. Predictable outreach by familiar staff can allow trust to develop over repeated contacts, while rotating personnel, appointment-only availability, repeated retelling of personal histories, eligibility requirements, and referrals without active assistance may undermine engagement. Participants also emphasized that missed contacts or declined services should not automatically be interpreted as failure or lack of motivation. They may instead indicate that the relationship, service offer, or system response does not yet meet the individual's needs or readiness.

This perspective also requires a broader definition of success. Reduced use, safer use, accepting naloxone, meeting a self-defined goal, attending one appointment, completing an assessment, establishing repeated contact with a trusted worker, or accepting linkage to health, mental health, housing, or social services may all represent meaningful progress. Abstinence-only measures can obscure effective engagement and make field-based work appear unsuccessful even when teams are reducing risk and strengthening connection to care.

FIELD-BASED IDENTIFICATION IS RECOGNITION AND CONVERSATION, NOT DIAGNOSIS

Solutions Team participants distinguished field identification from clinical diagnosis. The role of outreach workers, peers, community health workers, care navigators, and other field staff is to recognize when stimulant involvement may be relevant, begin a respectful conversation, attend to immediate safety and health needs, and support connection to assessment when the individual is willing. Diagnosis of StUD remains the responsibility of qualified staff.

Recognition in the field may be complicated by co-occurring mental health conditions, sleep deprivation, medical illness, trauma, and the effects of unsheltered living. Agitation, prolonged wakefulness, paranoia, low mood, exhaustion, weight loss, dehydration, wounds, cardiovascular symptoms, or other observed conditions may have multiple explanations. Participants cautioned against using behavioral or physical cues to make assumptions about stimulant use or attempting to distinguish stimulant-induced psychiatric symptoms from primary mental illness in the field. Immediate safety, support, and connection to clinical evaluation should take precedence.

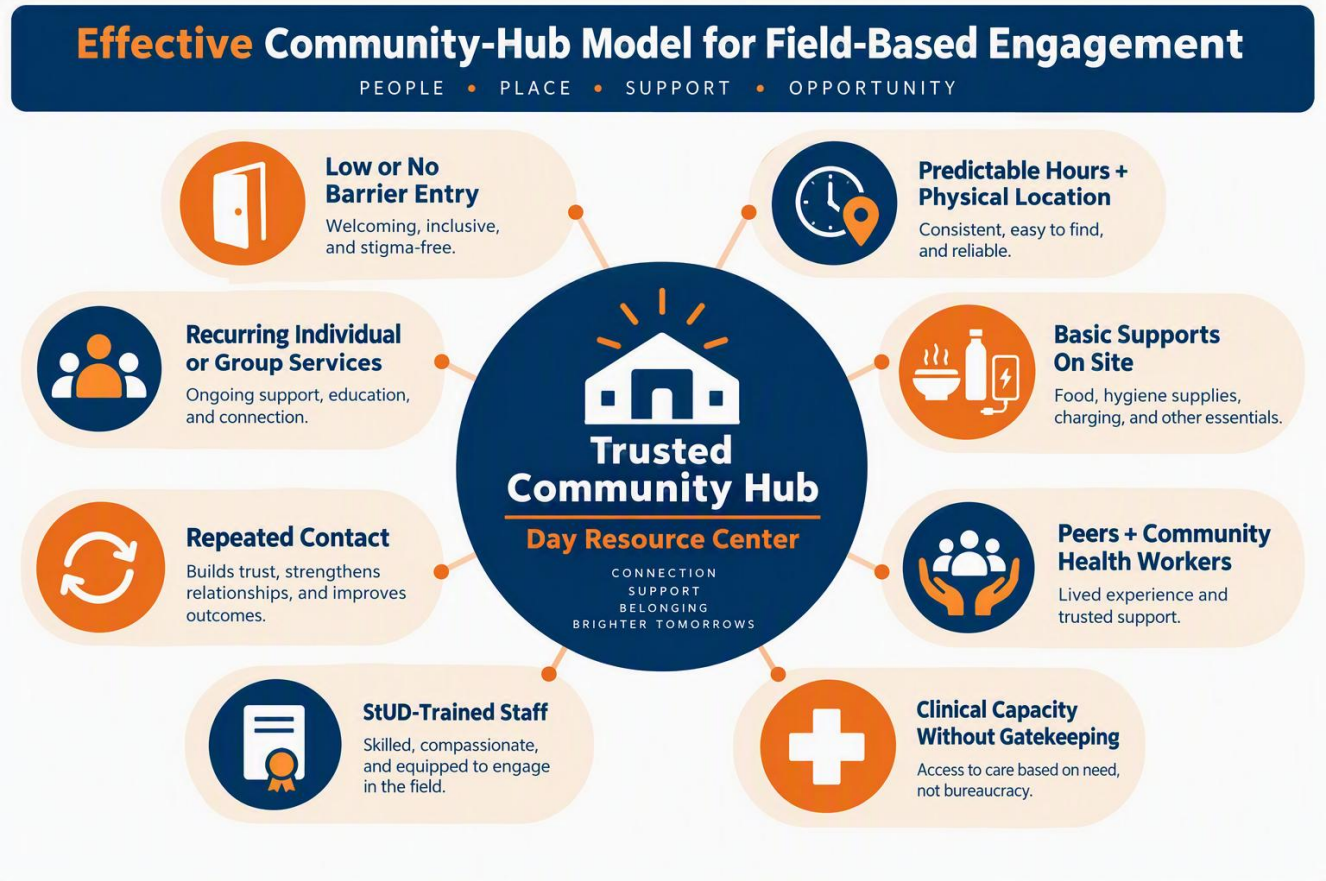
Participants further emphasized that structured intake may need to occur over multiple contacts. Requiring completion of a comprehensive assessment during an initial encounter may conflict with the conditions of field-based engagement. Screening tools are most useful when they support conversation rather than become an administrative barrier. Counties also identified the importance of screening for both substance use and mental health conditions, given the high prevalence of co-occurring needs among individuals served through field-based programs.

TRUSTED COMMUNITY LOCATIONS CAN SUPPORT SUSTAINED ENGAGEMENT

Participants identified community hubs and day resource centers as promising settings for engaging individuals who may not enter traditional clinics. These locations can provide a predictable and accessible place where individuals receive tangible supports, build relationships with familiar staff, and connect with health and behavioral health services when ready.

One Northern County reported that a provider was establishing a presence in a new day resource center intended to provide a consistent, safe, and accessible location for people to receive care from personnel trained in StUD. The model was described as an opportunity to remove barriers, address multiple needs, and build trust-based relationships at the individual's pace.

Participants identified several characteristics of an effective community-hub model[2]:



Other participating counties described complementary approaches. A Central county reported mobile MAT clinics, hospital MAT liaisons, a Housing Outreach Team, and assessment forms that staff could access on phones and tablets in the field. A Southern county described using a homeless services outreach team to expand assessment and treatment linkage, along with

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[2] *Image created using Microsoft CoPilot. Accessed 2026-09-07. Prompt: Create a polished infographic. Title: "Effective Community-Hub Model for Field-Based Engagement". Center: a large circle labeled "Trusted Community Hub / Day Resource Center". Around the center, arrange eight clean icon callouts connected by soft lines, not a table. Use concise labels: "Low or No Barrier Entry", "Predictable Hours + Physical Location", "Basic Supports On Site", "Peers + Community Health Workers", "Clinical Capacity Without Gatekeeping", "StUD-Trained Staff", "Repeated Contact", "Recurring Individual or Group Services". Include subtle icons: open door, clock/map pin, food/hygiene/charging, peer support hands, medical cross, training badge, repeat arrows, group circle. Generated using httpss://copilot.microsoft.com.*

partnerships involving emergency departments, a bridge clinic, and the SUD provider network. These examples illustrate how counties are using existing outreach, health care, housing, and treatment infrastructure as engagement points rather than relying exclusively on specialty clinics.

WARM AND IMMEDIATE CONNECTIONS ARE CRITICAL

Participants emphasized that referral alone is often insufficient for people who have limited trust in systems, experience transportation or communication barriers, or may lose readiness while waiting for services. An effective warm handoff includes a direct introduction to a named receiving provider, confirmation of the date and location of the next contact, appropriate information sharing with consent, and continued involvement by the referring worker until the new relationship is established. A hot handoff, in which the service is delivered at the time and place of contact, was identified as the preferred design goal when feasible.

The effectiveness of a handoff also depends on whether the practical realities of the individual's life are addressed. Relevant considerations may include where the person can be found, the preferred method of contact, transportation, belongings, pets, mobility limitations, and the timing of other obligations. Participants emphasized the importance of closing the referral loop by confirming whether contact occurred and reengaging the individual when it did not.

WORKFORCE CAPACITY AND TRAINING REMAIN SIGNIFICANT

Participants reported that stimulant-specific capacity has not developed at the same pace as broader co-occurring-disorder capacity, with reported gaps in stimulant-specific training resources. Participants also indicated that available SUD training is frequently oriented toward clinic-based practice and may not address the workflows, documentation, safety, confidentiality, or engagement skills required in field settings.

The findings suggest that training should extend beyond SUD clinicians. Outreach workers, peers, community health workers, homeless services personnel, mental health clinicians, supervisors, emergency department personnel, emergency responders, law enforcement

partners, and organizational leaders may all encounter individuals with StUD or influence access to care. Participants identified several priority training areas, noted in the graphic below[3].



People with lived experience were identified as especially important members of field-based teams because they can contribute credibility, relationship-building, navigation, and recovery perspective. Participants also identified roles for CHWs, SUD counselors, care navigators, street medicine clinicians, behavioral health clinicians, and outreach personnel. At the same time, counties cautioned that workforce instability is an active implementation constraint. Field-based models should therefore account for turnover through documented protocols, accessible onboarding, ongoing supervision, and training structures that do not depend on a single individual.

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[3] *Image created using Microsoft CoPilot. Accessed 2026-09-07. Prompt: Create a clean professional infographic. Title: "Priority Training Areas". Create a non-table visual with ten rounded cards or connected nodes arranged around a central training icon. Use exact text labels only, no paraphrasing: "Stimulant use disorder as a distinct condition." "Field-based workflows and service delivery." "Motivational interviewing." "Harm reduction and overdose prevention." "Stimulant-related health risks and emergencies." "Trauma-responsive and recovery-oriented engagement." "Co-occurring mental health and substance use conditions." "Confidentiality and documentation in field settings." "De-escalation and staff safety." "Stigma and therapeutic pessimism." Generated using httpss://copilot.microsoft.com.*

DATA SHARING AND INTEGRATED CARE MAY DIFFER FROM WRITTEN POLICY

Participants reported having consent or release-of-information processes and EHR functionality in place. However, county narratives indicated that mental health and SUD staff may still be unable to access one another's records or consistently use integrated assessment tools. This suggests that the existence of a policy, consent form, or technical function does not necessarily mean information is available to the field team when needed.

Counties may therefore need to assess data-sharing readiness through operational questions, including whether mental health and SUD staff can view relevant information for shared participants, whether field documentation entered on mobile devices reaches the appropriate record, and whether integrated tools are used consistently. Participants also requested greater clarity related to confidentiality in encampments, mobile settings, and cross-agency field work.

Within-county variation further complicates readiness assessment. Two respondents from a South region county provided materially different accounts of screening and integrated treatment-planning practices. This variation suggests that counties should assess practice by program, provider, and staff role rather than relying on a single respondent to characterize the entire system.

STIGMA IS AN OPERATIONAL BARRIER TO INTEGRATED CARE

As noted previously, participants describe stigma not only as a matter of language or attitudes, but as an operational barrier that can affect screening, treatment planning, referrals, eligibility, and continued access to services. They reported that stigma may operate in both directions, with some mental health staff holding stigmatizing views toward people with SUD and some SUD staff viewing SMI as outside their scope or responsibility.

Participants identified ongoing training, supervision, team discussion, person-first language, and policy review as potential strategies. A North county described using a designated champion or advocate to identify when policies or decisions reflect stigma and bring those issues forward for discussion and change. This approach treats stigma reduction as an organizational and service-integration function rather than limiting it to one-time staff education.

ENGAGEMENT WORK IS NOT FULLY REFLECTED IN EXISTING SYSTEMS

A recurring challenge was the mismatch between field-based engagement and systems designed around clinic-based treatment. Participants reported that individuals encountered in the field may not yet be ready to enter a formal level of care, while counties may spend

substantial time building trust, addressing immediate needs, reducing risk, and supporting movement toward assessment or treatment. The absence of a clear service classification or level-of-care framework for this pre-engagement work is a significant concern.

Participants also identified documentation timeframes, field confidentiality, information-system separation, site-of-service questions, workforce capacity, and the classification of outreach and education contacts as areas requiring additional clarification or support. These barriers may make essential engagement work difficult to document, finance, evaluate, or sustain.

MEASURING PROGRESS BEYOND TREATMENT ENROLLMENT AND ABSTINENCE

Participants emphasized that field-based programs need measures that reflect the progression from initial contact to sustained engagement and, when the individual is ready, connection to treatment and other services. Participants identified a potential tiered approach that includes:

- **Reach and contact:** Unique individuals contacted, total and repeat contacts, and contacts occurring before initial service acceptance.
- **Engagement and risk reduction:** Tangible needs addressed, overdose education, naloxone and fentanyl test-strip distribution, safer-use support, and person-defined goals.
- **Linkage:** Closed-loop referrals, assessments completed, treatment connections, and linkage to mental health, primary care, housing, or benefits.
- **Treatment and health outcomes:** Retention, changes in use, health service utilization when data are available, and housing outcomes.
- **Person-defined outcomes:** Progress toward goals identified by the individual and the individual's experience of care, safety, and quality of life.

For field-based programs, early measures of reach, repeat contact, engagement, risk reduction, and successful linkage may provide a more accurate picture of implementation than treatment enrollment or abstinence alone. These measures can also make visible the labor-intensive work that occurs before a person enters formal treatment.

The findings and Solutions Team input suggest several overarching lessons for counties developing field-based approaches for individuals with StUD:

Overarching Lessons for Field-Based Stimulant Use Disorder Engagement

1. Treat stimulant use disorder as a distinct condition. Training and program design should not assume that opioid- or alcohol-oriented models transfer without adaptation.	**6. Create immediate and supported pathways to care.** Warm and hot handoffs, named receiving providers, active accompaniment, and closed-loop follow-up reduce the likelihood that individuals will be lost during referral.
2. Recognize engagement as a meaningful intervention. Trust-building, repeated contact, safety support, and meeting tangible needs should be intentionally staffed, documented, and measured.	**7. Train the full network of first-contact partners.** Stimulant-specific and field-specific education should reach outreach, mental health, housing, health care, emergency response, justice, and community partners, not only SUD treatment staff.
3. Begin with the individual's priorities. Engagement is more likely to develop when teams respond to the need identified by the individual rather than requiring immediate focus on substance use or treatment.	**8. Test integration in practice, not only on paper.** Counties should examine whether staff can access information, use shared tools, coordinate plans, and communicate across programs.
4. Define success beyond abstinence. Reduced risk, repeat contact, accepted support, person-defined progress, and connection to care are meaningful outcomes.	**9. Address stigma through organizational practice.** Policies, eligibility rules, discharge practices, supervision, and service design should be reviewed for assumptions that inhibit access or integration.
5. Distinguish field recognition from diagnosis.	**10. Measure the work that precedes formal treatment.**

Field staff can recognize concerns, initiate conversation, address immediate needs, and facilitate assessment without making diagnostic assumptions.	Without measures of contact, trust-building, risk reduction, and readiness development, counties may underestimate the resources and value involved in field-based engagement.

These lessons suggest that effective field-based engagement for StUD depends less on moving individuals rapidly into a predetermined program and more on creating a reliable, low-barrier continuum of relationships, supports, clinical connections, and opportunities for treatment. Counties are better positioned to engage individuals when services are designed around the realities of field settings, staff are equipped with stimulant-specific knowledge, and progress is recognized throughout the engagement process rather than only after formal treatment begins.

DATA, TECHNOLOGY, QUALITY, AND EVALUATION CHALLENGES

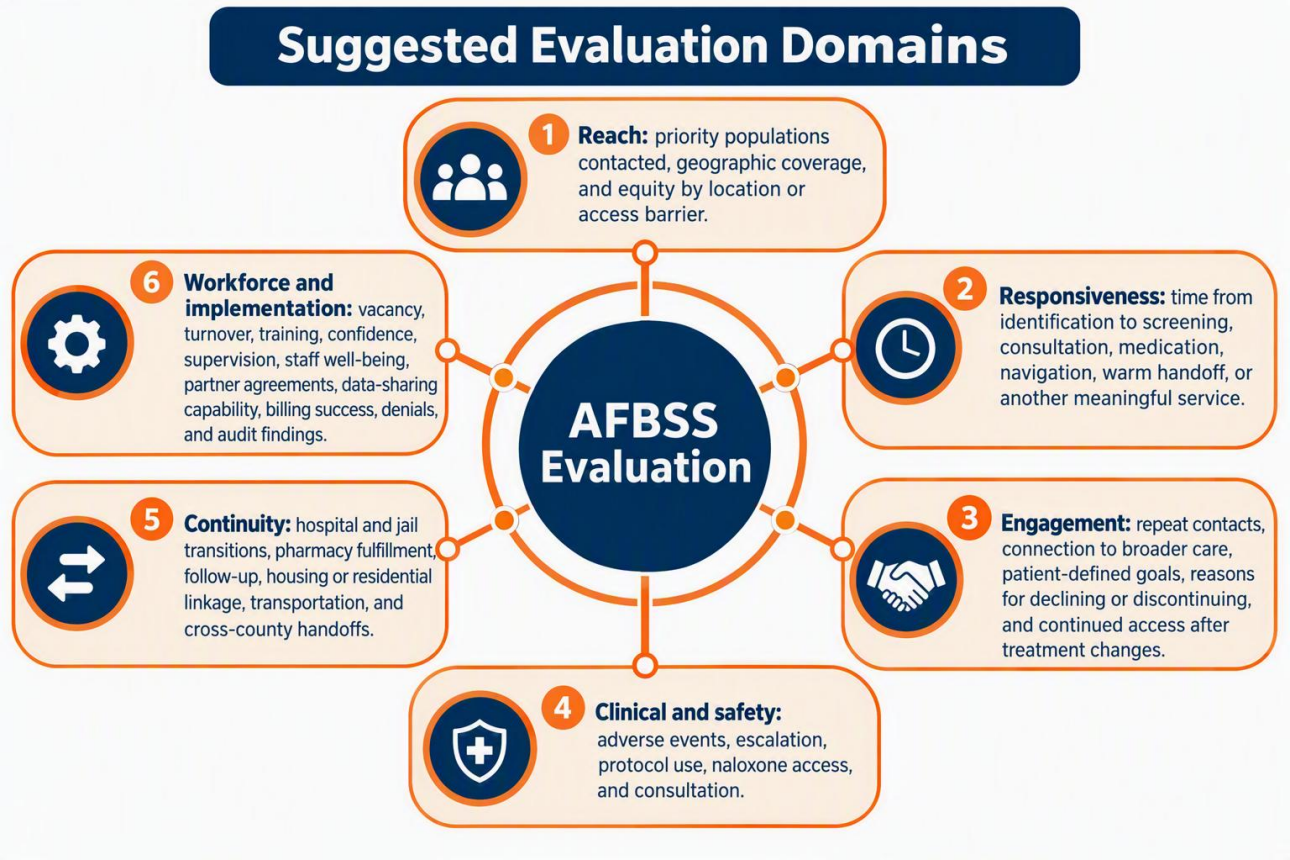
Participants described data, technology, quality, and evaluation challenges as central implementation issues because they affect both day-to-day coordination and the ability to understand whether AFBSS is reaching the intended populations. The challenges below reflect recurring barriers to sharing timely information, documenting field-based services, supporting distributed teams, and using common measures to guide improvement while preserving local flexibility.

- Relevant information is fragmented across counties, managed care plans, hospitals, jails, providers, public health, mental health, SUD programs, HMIS, outreach teams, and law enforcement.
- Separate EHRs, confidentiality requirements, limited data exchange, and uneven staff access impede integrated care and make it difficult to determine where a person is connected or whether interventions are working.
- Field teams may provide multiple consecutive services without workflows that consistently capture service type, location, time, outcome, and billing basis. Staff crossing mental health and SUD functions may lack the correct documentation access or training.
- Clients may lack phones, connectivity, identification, reliable pickup locations, or private space. Field teams may also lack secure mobile hardware and record access.
- Quality concerns include supervision across distributed sites, safety, protocol use, clinical escalation, staff burnout, continuity through handoffs, and whether performance expectations reflect the pace of relationship-based engagement.

- Participants requested clearer definitions, minimum data elements, accountability mechanisms, and evaluation guidance, while preserving local flexibility.

SUGGESTED EVALUATION DOMAINS

Based on collective interviews and focus groups, and Solution Teams discussion, the following areas are proposed for further evaluation. These are participant-derived considerations rather than validated AFBSS performance requirements[4].



[4] *Image created using Microsoft CoPilot. Accessed 2026-09-07. Prompt: Create a clean professional infographic. Title: "Suggested Evaluation Domains". Use a six-domain hub-and-spoke or circular infographic, not a table. Center circle reads: "AFBSS Evaluation". Around it, six numbered domain cards with exact wording below. 1. "Reach: priority populations contacted, geographic coverage, and equity by location or access barrier." 2. "Responsiveness: time from identification to screening, consultation, medication, navigation, warm handoff, or another meaningful service." 3. "Engagement: repeat contacts, connection to broader care, patient-defined goals, reasons for declining or discontinuing, and continued access after treatment changes." 4. "Clinical and safety: adverse events, escalation, protocol use, naloxone access, and consultation." 5. "Continuity: hospital and jail transitions, pharmacy fulfillment, follow-up, housing or residential linkage, transportation, and cross-county handoffs." 6. "Workforce and implementation: vacancy, turnover, training, confidence, supervision, staff well-being, partner agreements, data-sharing capability, billing success, denials, and audit findings." Generated using httpss://copilot.microsoft.com.*

MOST SIGNIFICANT LESSONS LEARNED

The lessons below synthesize the most consistent implementation insights participants shared across county and provider contexts. Together, they point to the importance of designing AFBSS around real-world service conditions: meeting people where they are, connecting existing assets into a coordinated continuum, supporting the workforce, and resolving operational barriers early enough to preserve timely access and continuity of care.

- **Start with the population and place.** Design around where people are, the barriers they face, and the service that can be offered when they are ready.
- **Use existing assets but connect them intentionally.** Outreach, crisis, field medicine, MAT, peers, housing, jail, hospital, and clinic programs require explicit workflows to operate as a continuum.
- **Relationships and repeated engagement are central.** Providers cannot force readiness, and successful engagement may require sustained presence over long periods.
- **Count incremental progress.** Traditional timelines and outcome expectations may not reflect the realities of people living unsheltered or facing multiple barriers.
- **Select and support the right workforce.** Role fit, training, supervision, practical tools, staff safety, appropriate compensation, and manageable workload are essential.
- **Champions need authority and cross-functional partners.** Executive sponsorship must be paired with medical, pharmacy, nursing, compliance, fiscal, HR, IT, contracting, provider, and community participation.
- **Whole-person care is resource-intensive but necessary.** Medical, behavioral health, SUD, housing, transportation, documentation, legal, and social needs frequently intersect.
- **Protect immediate access and continuity.** Delays, referrals, and handoffs can result in missed opportunities when a person is ready for help.
- **Make data actionable.** Define what happens when a signal is identified, who responds, what can be offered, how quickly, and how the outcome is documented and used for improvement.
- **Clarify billing, documentation, legal, and certification requirements early.** Uncertainty and fear of recoupment or noncompliance can stop implementation.
- **Plan sustainability from the start.** Grant, settlement, or start-up funding can launch effective services but does not resolve long-term staffing and reimbursement needs.
- **Adapt delivery to county context.** Rural, urban, desert, frontier, and multi-county settings may require different structures while pursuing the same domains.

REGIONAL THEMES

Based on collective county interviews, the following regional themes were observed regarding county challenges and implementation priorities.

Regional Challenges and Implementation Priorities		
North Region Northern implementation priorities included regional sharing, assisted telehealth, transportation, cross-county payment and referral solutions, and examples from similarly sized counties to support phased implementation using existing outreach and data assets.	**Central Region** Street medicine and behavioral health integration, continuity at readiness, transportation, documentation, housing constraints, reimbursement, safety, supervision, and workforce sustainability.	**South Region** Southern implementation priorities included DEA and licensing clarity, field medication logistics, prescriber capacity, EHR and billing integration, ASAM training, same-day access, and practical guidance for retrofitting teams and workflows across varied geographies.
Across Regions Across regions, participants identified the need for a consistent but adaptable framework, authoritative operational guidance, regional clinical mentorship, minimum data standards, and clear expectations for cross-system coordination. This category consolidates cross-cutting content related to rural delivery, large-system implementation, desert and frontier conditions, mobile NTP access, consultation capacity, distributed access points, recruitment and compensation, county-owned infrastructure, community opposition, recovery housing delays, and scalable coordination across many providers and teams.		

CONSIDERATIONS FOR FUTURE IMPLEMENTATION

Across interviews and focus groups, and Solution Team discussions, participants emphasized that future implementation support should move beyond general guidance to provide practical, context-sensitive tools that counties and providers can adapt to their local infrastructure, workforce, geography, and stage of readiness. The considerations below reflect recurring needs

for clearer operational direction, field-tested workflows, cross-system coordination, and implementation supports that preserve flexibility while reducing uncertainty. Some suggestions include:

- Publish an authoritative implementation toolkit with adaptations for county size, geography, infrastructure, and stage of readiness.
- Provide sample policies and workflows for field prescribing, pharmacy fulfillment, medication transport and storage, administration, early refills, clinical escalation, consent, safety, supervision, and follow-up.
- Issue practical billing and documentation guidance for Drug Medi-Cal and Specialty Mental Health services, including co-occurring care, field settings, and activities occurring before a complete assessment.
- Develop provider-focused training, clinical consultation, and mentorship for MAT, field safety, ASAM implementation, complex cases, and newer prescribers.
- Create readiness, implementation planning, staffing, partner-role, data, evaluation, and phased-launch templates.
- Support regional and cross-county approaches for mobile treatment, prescriber access, after-hours coverage, transportation, payment, and data sharing.
- Provide guidance on CHW, peer, and navigator roles, including supervision, financing, training, HR considerations, and integration with clinical teams.
- Promote common data elements and evaluation approaches that include engagement, responsiveness, patient-defined goals, harm reduction, safety, continuity, workforce conditions, and implementation progress.
- Address EHR, confidentiality, and data-sharing barriers that impede integrated mental health and SUD care.
- Clarify managed care plan coordination, ECM alignment, county-agnostic access, minimum data-sharing expectations, implementation sequencing, and responsibilities across partner systems.
- Facilitate peer mentorship, communities of practice, legal and clinical consultation, and site-based learning using examples matched to county context.

FINANCING AND SUSTAINABILITY CONCERNS

Financing and sustainability emerged as cross-cutting concerns throughout county interviews, focus groups, and Solution Team discussions. Counties consistently emphasized that AFBSS requires more than start-up funding or a single reimbursement pathway. Field-based models depend on outreach, engagement, travel time, care coordination, documentation support, medication logistics, technology, supervision, safety protocols, and repeated contacts that may

occur before an individual is ready for a billable service. As a result, counties need financing strategies that distinguish between reimbursable clinical services, start-up infrastructure, ongoing staffing, and non-billable engagement activities that make treatment access possible.

Participants also cautioned against assuming that existing funding streams can be easily redirected to support AFBSS. Counties described local match obligations, already-committed Realignment funds, limited staffing flexibility, provider capacity constraints, and uncertainty about how field-based services should be documented, claimed, and audited. Rural counties face additional sustainability pressures related to small staffing pools, long travel distances, limited prescriber availability, and lower service volume, while larger counties must sustain coordination across multiple providers, departments, clinics, mobile teams, and contracted partners. Across settings, counties noted that fear of noncompliance, denied claims, or future recoupment can slow implementation unless financing, billing, documentation, and compliance expectations are clarified early.

The county examples that follow illustrate two complementary sustainability strategies. Lake County highlights the importance of building from existing behavioral health, mobile crisis, public health, peer support, MAT linkage, and care coordination infrastructure while preserving flexible funding for non-billable outreach and engagement. Orange County demonstrates how counties can strengthen sustainability by enhancing existing SUD service assets, aligning outpatient clinics as rapid-entry access points, incorporating mobile NTP capacity, and using braided funding to support long-term system stability. Together, these examples suggest that AFBSS sustainability is strongest when counties pair reimbursement maximization with flexible funding, operational alignment, cross-sector partnerships, and realistic recognition of the work required to engage individuals in field-based settings.

COUNTY SPOTLIGHT

Financing and Sustainability in Lake County

This example illustrates: Lake County demonstrates how a small rural county can plan for AFBSS sustainability by building from existing infrastructure, coordinating related services, and preserving flexible funding for non-billable engagement work.

Lake County's emerging rural planning strategy for AFBSS is centered on integrating AFBSS into existing behavioral health and community infrastructure rather than creating a new standalone program. As a small rural county, Lake County is approaching implementation with a focus on sustainability, phased development, and practical use of existing resources.

The county is exploring how AFBSS can build upon current Mobile Crisis, Medi-Cal DMC-ODS care coordination, outreach, peer support, medications for addiction treatment (MAT) linkage, and post-crisis or post-overdose follow-up services. A guiding principle is that Mobile Crisis and AFBSS can be closely coordinated while remaining clinically and fiscally distinct. Mobile Crisis responds to immediate behavioral health emergencies, while AFBSS can support ongoing engagement, SUD treatment initiation, MAT linkage, and follow-up intended to reduce future crises.

Lake County's sustainability planning is based on a braided funding approach. The county is evaluating how to maximize Medi-Cal reimbursement for covered and medically necessary services, including appropriate DMC-ODS and Mobile Crisis services, while identifying other funding sources to support outreach, engagement, start-up costs, and activities that may not be billable. Potential funding sources include BHSA; Opioid Settlement Funds; Substance Use Prevention, Treatment, and Recovery Services Block Grant funds; managed care or community reinvestment opportunities; and other allowable local or state resources. Lake County also notes that 1991 and 2011 Realignment funds are already heavily obligated for local match and non-Medi-Cal reimbursable services and should not be assumed to be broadly available as flexible start-up funding for new AFBSS costs.

A key emerging strategy is partnership with County Public Health. Lake County Public Health has a fully outfitted mobile medical clinic that is not currently in use. Behavioral Health and Public Health are exploring whether this existing asset can be activated as a shared mobile platform for AFBSS and public health services. If funded, this approach could help expand access in rural and geographically isolated communities while minimizing capital investment. The county is also planning to pursue Managed Care Plan community reinvestment funding to support start-up costs associated with activating the mobile clinic.

Workforce and provider capacity remain the most significant sustainability challenges. Lake County's rural geography, limited provider network, prescriber shortages, and difficulty absorbing vacancies all affect the pace and scale of implementation. The county is considering strategies such as cross-training staff, leveraging telehealth for MAT prescribing and psychiatric consultation when appropriate, strengthening partnerships with local agencies and providers, and using shared infrastructure to reduce duplication. Peer support specialists are viewed as an important part of the model because of their ability to build trust, support engagement, and help connect people to treatment, though training, supervision, documentation support, and technology access remain important implementation considerations.

Lake County is also focused on operational efficiency as a sustainability strategy. For AFBSS to be viable in a rural environment, workflows must support field-based documentation, mobile access to the electronic health record, accurate claiming, and timely care coordination. The county is also considering opportunities to reduce documentation burden, including potential future use of AI-assisted documentation tools where appropriate and compliant. These operational supports are important because field-based work often includes travel time, missed appointments, repeated outreach, and engagement activities that may be necessary but not always billable.

Lake County's planning approach highlights several lessons for rural AFBSS implementation. First, counties should avoid assuming that AFBSS has one funding source or one rate. Instead, field-based encounters should be mapped to the underlying service activity, such as screening, assessment, care coordination, MAT linkage, peer support, Mobile Crisis, housing coordination, or non-billable engagement. Second, fee schedule rates should not be confused with net new county revenue. Actual patient revenue depends on beneficiary eligibility and aid code, federal match, local match requirements, provider

type, documentation, and claim adjudication. Third, flexible funding is essential because the outreach and engagement work required to reach individuals in the field often occurs before a billable service can be generated.

Overall, Lake County's emerging strategy illustrates the practical realities of planning AFBSS in a small rural county. Sustainability depends on building from existing infrastructure; coordinating Mobile Crisis and AFBSS without blending their claiming structures; partnering across Behavioral Health, Public Health, managed care, and community providers; and preserving flexible funding for the non-billable work that makes treatment engagement possible.

COUNTY SPOTLIGHT

Financing and Sustainability in Orange County

This example illustrates: Orange County demonstrates how counties can sustain AFBSS by strengthening existing service infrastructure, using braided funding, and aligning outreach, access, clinical workflows, and partnerships.

Orange County's approach to financing and sustaining AFBSS demonstrates how counties can expand access to care without building entirely new systems from the ground up. Rather than creating a parallel service structure, Orange County focused on strengthening and integrating existing infrastructure across the SUD continuum. This strategy allowed the county to maximize existing investments while creating a more coordinated and responsive system of care for individuals experiencing substance use challenges.

A key component of Orange County's sustainability strategy was its emphasis on enhancing existing service delivery assets. The County is strengthening outreach efforts through a more data-driven approach, using overdose surveillance data, heat maps, and coordinated field engagement planning to target resources where they were most needed. Existing County SUD outpatient clinics are being expanded and aligned to function as rapid-entry access points for treatment, helping ensure a "no wrong door" approach for individuals seeking care. Mobile Narcotic Treatment Program (NTP) units are also being incorporated as an extension of the broader treatment continuum, increasing access to medication-assisted treatment and other services in community settings.

From a financing perspective, Orange County is building sustainability through a braided funding model that leveraged multiple funding streams, including Medi-Cal and DMC-ODS reimbursement, the Substance Use Prevention and Treatment Block Grant (SUBG), Realignment funding, County General Fund resources, and Behavioral Health Services Act (BHSA) funding. By diversifying funding sources, the county is reducing reliance on any single revenue stream while positioning the program to maximize federal financial participation and long-term fiscal stability.

County leaders also recognized that operational infrastructure is just as important as funding when sustaining new services. During implementation planning, stakeholders emphasized the importance of strengthening walk-in access, streamlining intake paperwork, and aligning clinical workflows to reduce barriers to engagement and accelerate service delivery. Special attention is being given to documentation and billing processes so reimbursable services could be captured quickly and accurately, supporting timely reimbursement and helping ensure financial viability. At the same time, Orange County is focused on improving care coordination through warm handoffs, referral pathway development, staff training, and workflow alignment across field-based service teams and clinic-based providers.

Finally, Orange County has a strong network of partnerships across SUD treatment providers, managed care plans, federally qualified health centers, and community-based organizations. These partnerships create shared accountability for system development and strengthen connections across outreach, treatment, recovery, and ongoing support services. By combining strategic financing, operational alignment, data-driven planning, and cross-sector collaboration, Orange County is establishing a sustainable model for expanding access to substance use treatment while building on the strengths of its existing behavioral health infrastructure.