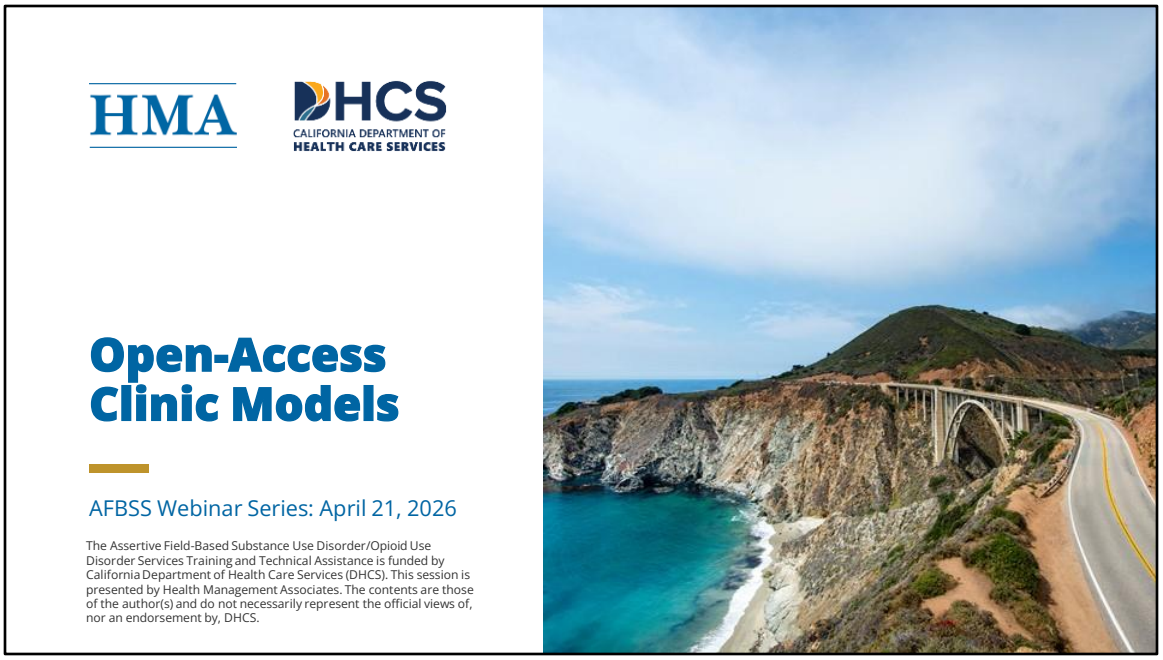

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Disclosures

Faculty	Nature of Commercial Interest
Greg Vachon, MD, MPH	Dr. Vachon discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Aimee Moulin, MD	Dr. Moulin discloses that she is a principal investigator of CA Bridge, a program of the Bridge Center.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

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[Slide Image Description: This slide shows Continuing Education disclosures.]

- Greg Vachon, MD, MPH: Dr. Vachon discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Aimee Moulin, MD: Dr. Moulin discloses that she is a principal investigator of CA Bridge, a program of the Bridge Center.
- Jeanene Smith, MD, MPH: Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

Presenters

Aimee Moulin, MD, MAS
Founder, Principal Investigator
CA Bridge

Greg Vachon, MD, MPH
Principal
Health Management Associates

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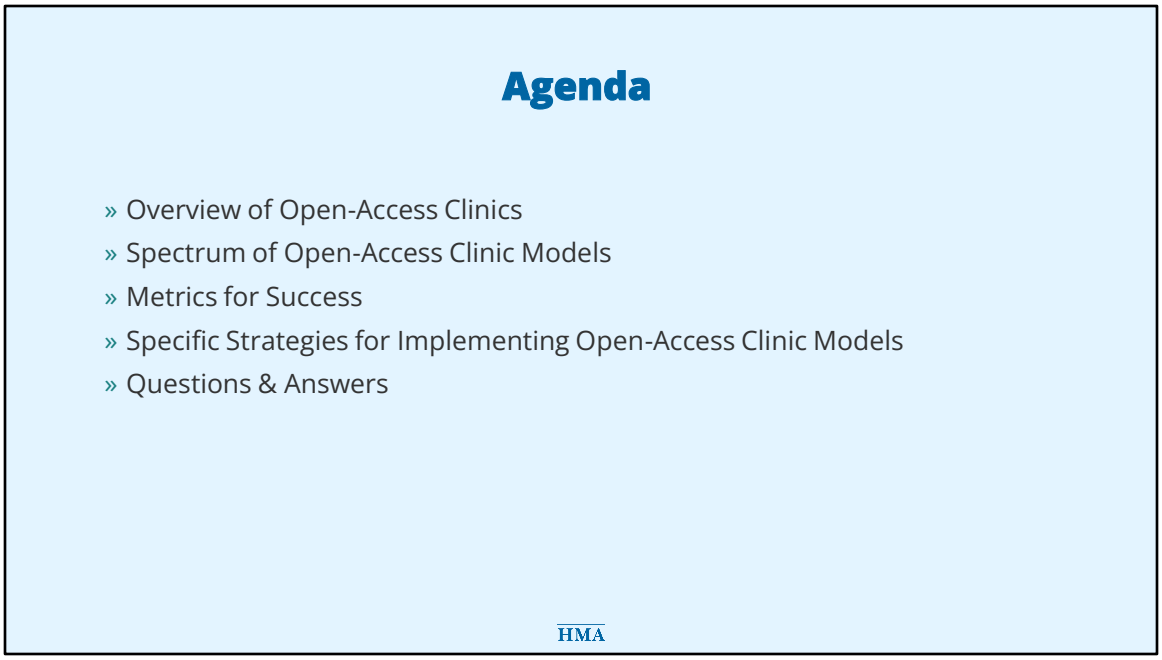
[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

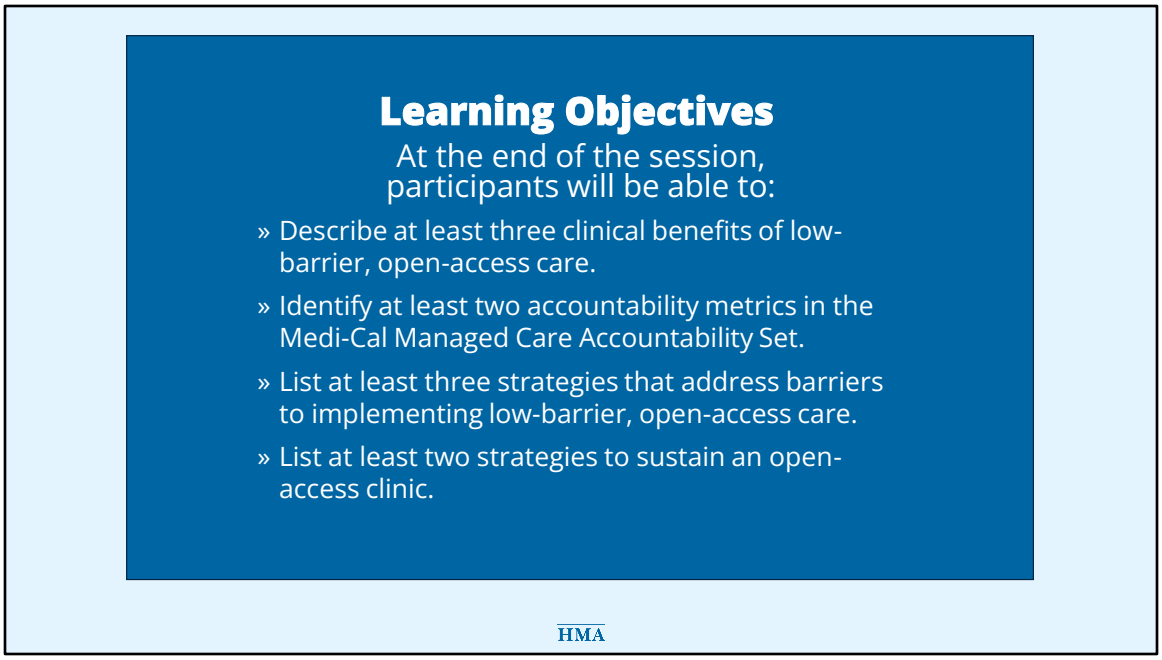
Dr. Greg Vachon has 25 years in patient care, 20 years in leadership, and a decade in consultancy. He has led innovative clinical initiatives—including a pioneering diabetes care model using open-access group visits with community partners that improved adherence to recommended care—and has guided large public hospital systems in defining ambulatory staffing ratios across clinical and non-clinical roles, implementing complexity-based primary care panels, and conducting specialty-care capacity assessments grounded in benchmarks, population needs, and operational data. Dr. Vachon's work spans the full lifecycle of population-health program development, from concept and business planning to implementation, including designing population assignments for community health workers and establishing staffing ratios for nurses and behavioral health managers. He has also served as an external data analyst for blue-ribbon committees, helping organizations understand shifting demographics and plan for future facility and service needs.

Dr. Aimee Moulin is a co-founder of Public Health Institute's Bridge Center and CA Bridge. She has been instrumental in promoting and securing funding to support workforce development for emergency department-based navigators, a vital role that connects patients with substance use treatment and care, often filled by a person with lived experience. Dr. Moulin is also a professor at UC Davis with appointments in Emergency Medicine and Psychiatry. As Chief of the Division of Addiction Medicine for the UC Davis Emergency Department, she pioneered the engagement of substance use navigators and launched the hospital's buprenorphine program. Dr. Moulin holds an MD from the University of Southern California, a master's in applied science from UC Davis, and has completed fellowships on Healthcare Policy and Quality Safety and Comparative Effectiveness Research.



[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

Agenda:
- Overview of Open-Access Clinics
- Spectrum of Open-Access Clinic Models
- Metrics for Success
- Specific Strategies for Implementing Open-Access Clinic Models
- Questions & Answers



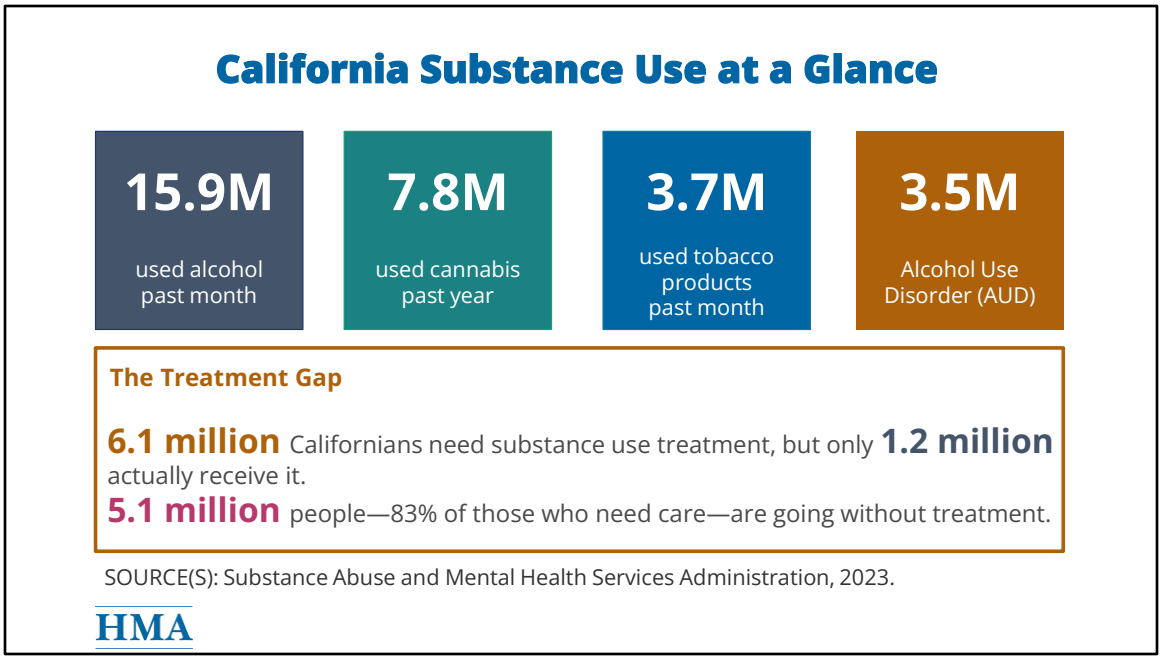
[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

At the end of the session, participants will be able to:

- Describe at least three clinical benefits of low-barrier, open-access care.
- Identify at least two accountability metrics in the Medi-Cal Managed Care Accountability Set.
- List at least three strategies that address barriers to implementing low-barrier, open-access care.
- List at least two strategies to sustain an open-access clinic.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section provides an overview of open-access clinics.



[Slide Image Description: This slide lists data about California substance use, with colorful boxes.]

California substance use at a glance:

- 15.9 million people used alcohol in the past month.
- 7.8 million people used cannabis in the past year.
- 3.7 million people used tobacco products in the past month.
- 3.5 million people have alcohol use disorder (AUD).

The Treatment Gap:

- 6.1 million Californians need substance use treatment, but only 1.2 million actually receive it.
- 5.1 million people—83% of those who need care—are going without treatment.

SOURCE(S): Substance Abuse and Mental Health Services Administration, 2023.

Behavioral Health Services Act (BHSA)

- Counties are required to provide rapid access to **all FDA-approved medications for addiction treatment** (MAT) by strengthening existing and/or standing-up at least **one initiative in each** of the following three areas that comprise their assertive field-based programs:
  - Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with Substance Use Disorder (SUD) needs to engage them in SUD services, including MAT, if needed
  - Mobile field-based programs
  - Open-access clinics

SOURCE(S): California Department of Health Care Services, 2025.

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[Slide Image Description: This slide lists details from the Behavioral Health Services Act, with an image of the California state capitol building.]

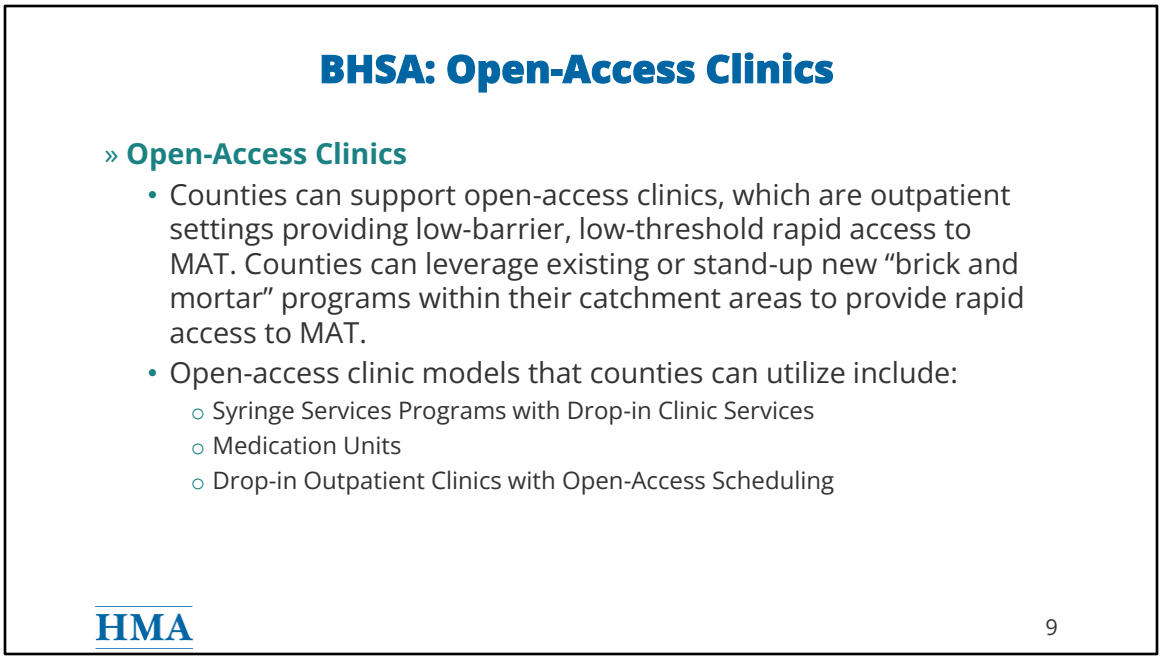
The Behavioral Health Services Fund (BHSA) builds on the Mental Health Services Fund (MHSA) and expands the program to include mental health and substance use disorder (SUD) services. There are specific requirements around engaging the hardest to reach populations through Assertive Field-Based Initiation for SUD Treatment Services (AFBSS). Counties need to prioritize those at highest risk of overdose.

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

1. Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs to engage them in SUD services, including MAT, if needed
2. Mobile field-based programs
3. Open-access clinics

Counties are required to strategically locate assertive field-based outreach and program models in settings where significant numbers of individuals living with SUD are located and/or areas with high rates of overdose reversals, which may include hospital and emergency departments, encampments, SSPs, jails, etc.

SOURCE(S): California Department of Health Care Services, 2025.

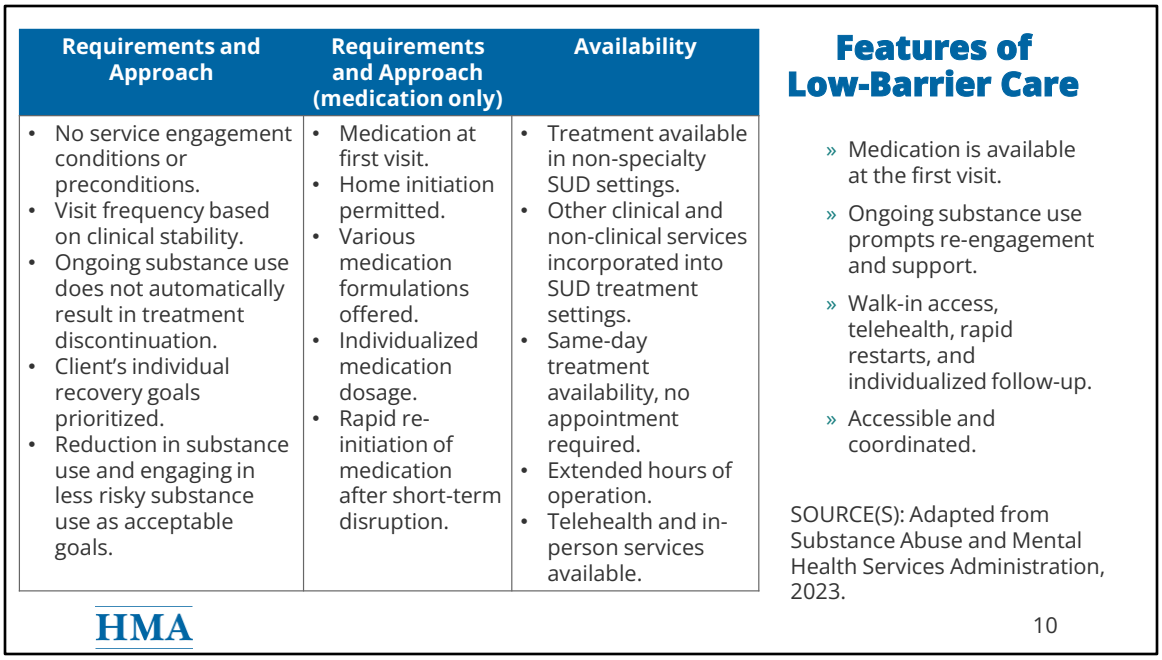


[Slide Image Description: This slide details three areas for county BH AFBSS implementation.]

Open-Access Clinics

Counties can support open-access clinics, which are outpatient settings providing low-barrier, low-threshold rapid access to MAT. Counties can leverage existing or stand-up new “brick and mortar” programs within their catchment areas to provide rapid access to MAT.

- Syringe Services Programs with Drop-in Clinic Services
- Medication Units
- Drop-in Outpatient Clinics with Open-Access Scheduling

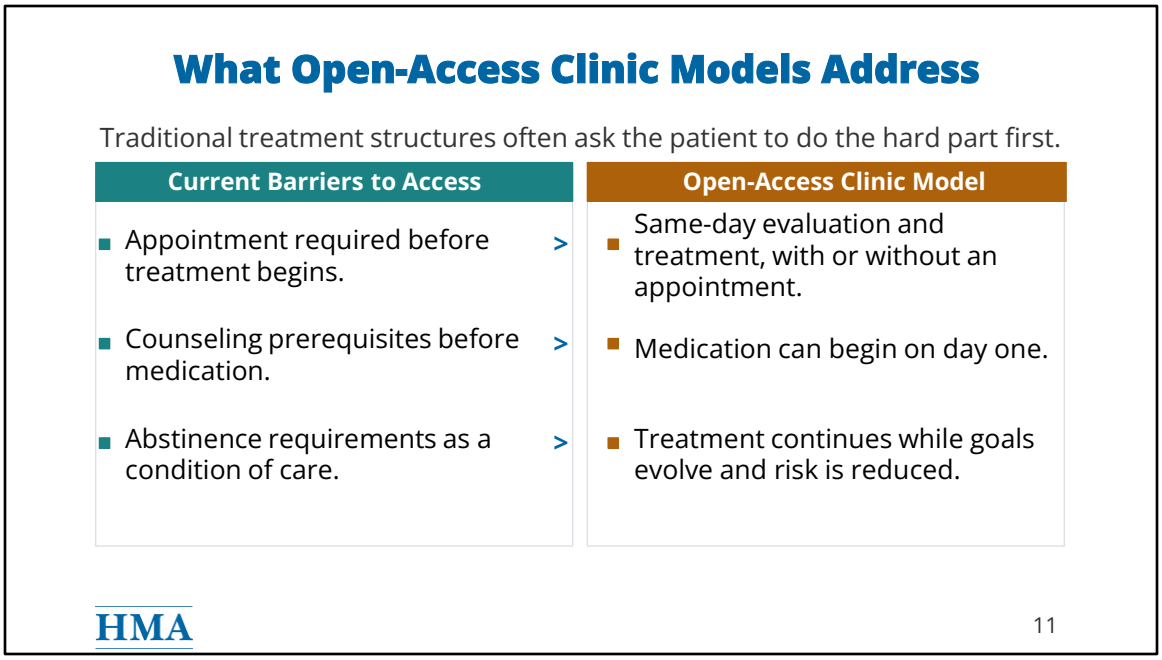


[Slide Image Description: This slide defines "low-barrier," with a SAMHSA chart.]

Now, what does "low-barrier" actually mean?

A practical definition for county systems and community providers:

- Medication is available at the first visit, without counseling or abstinence preconditions.
- Ongoing substance use prompts re-engagement and support, not discharge from care.
- Walk-in access, telehealth, rapid restarts, and individualized follow-up reduce friction.
- Accessible and coordinated.



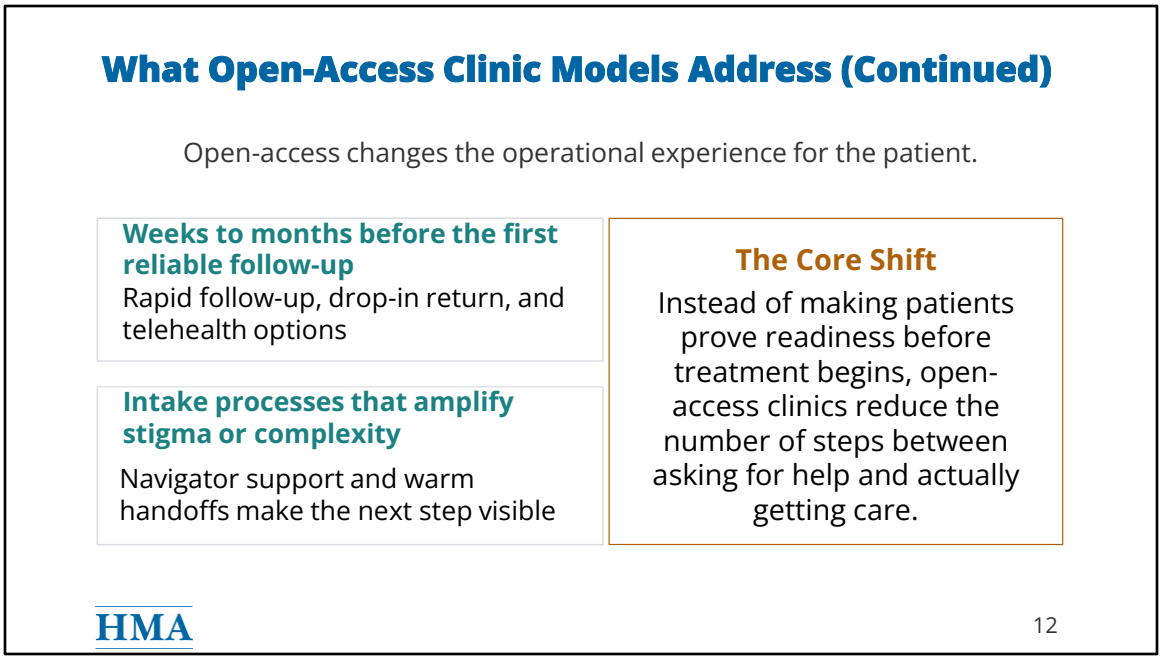
[Slide Image Description: This slide shows a list of current barriers to access that are addressed by the open-access clinic model.]

What do open-access clinic models address?

Traditional treatment structures often ask the patient to do the hard part first.

Current barriers to access:
- Appointment required before treatment begins.
- Counseling prerequisites before medication.
- Abstinence requirements as a condition of care.

Open-Access Clinic Model:
- Same-day evaluation and treatment, with or without an appointment.
- Medication can begin on day one.
- Treatment continues while goals evolve and risk is reduced.

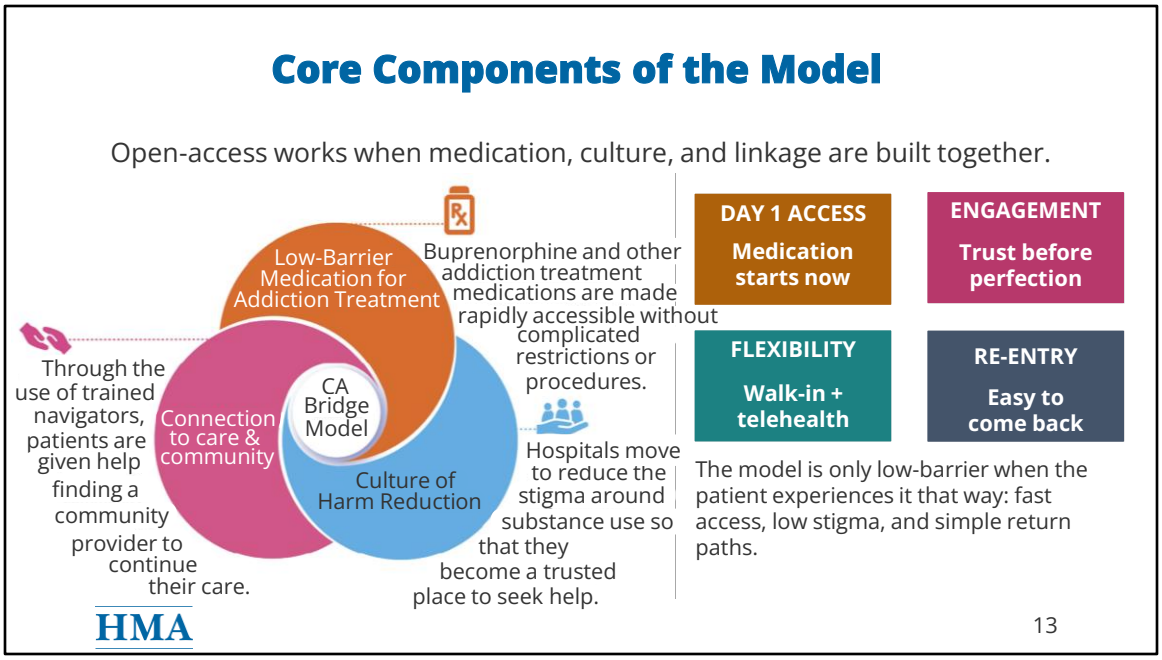


[Slide Image Description: This slide lists what open-access clinic models address, with colorful boxes.]

Open-access changes the operational experience for the patient.

- Weeks to months before the first reliable follow-up
    - Rapid follow-up, drop-in return, and telehealth options
- Intake processes that amplify stigma or complexity
    - Navigator support and warm handoffs make the next step visible

The Core Shift: Instead of making patients prove readiness before treatment begins, open-access clinics reduce the number of steps between asking for help and actually getting care.



[Slide Image Description: This slide lists core components of the model, with a CA Bridge Model graphic.]

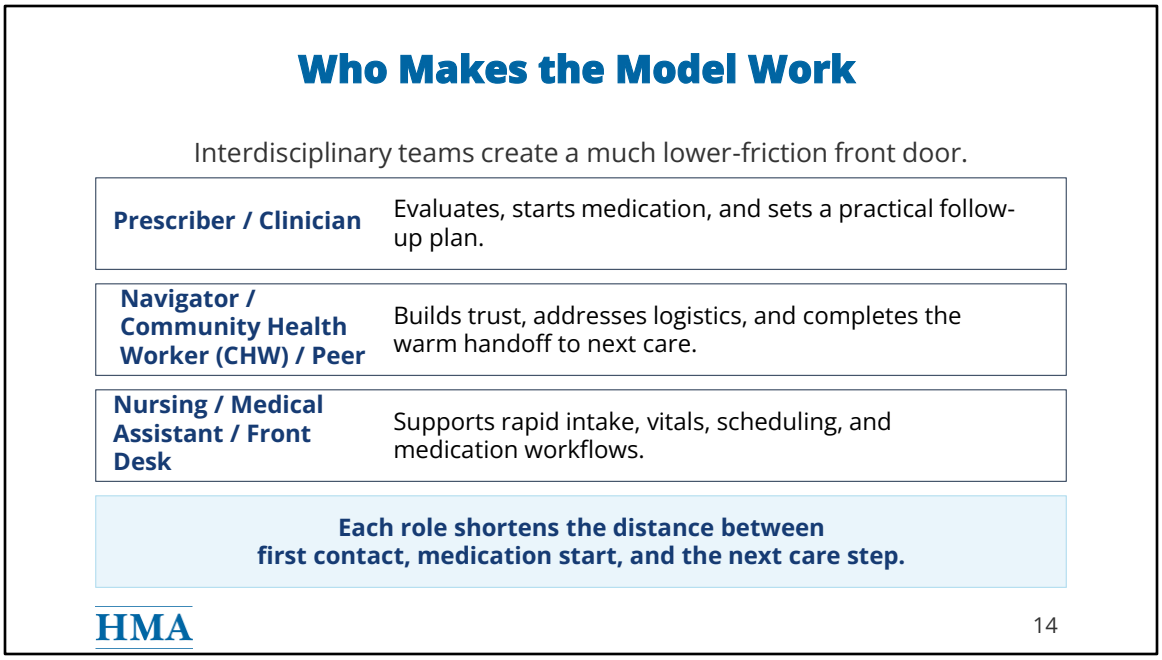
Open-access works when medication, culture, and linkage are built together.

Three components are at the heart of the CA Bridge Model:

1. Low-barrier medication for addiction treatment – buprenorphine and other addiction treatment medications are made rapidly accessible without complicated restrictions or procedures.
2. Culture of harm reduction – hospitals move to reduce the stigma around substance use so that they become a trusted place to seek help.
3. Connection to care and community – through the use of trained navigators, patients are given help finding a community treatment provider to continue their care.

The model is only low-barrier when the patient experiences it that way: fast access, low stigma, and simple return paths.

- Day 1 Access: Medication starts now.
- Engagement: Trust before perfection.
- Flexibility: Walk-in and telehealth.
- Re-entry: Easy to come back



[Slide Image Description: This slide lists components of interdisciplinary teams, with colorful boxes.]

Who makes the model work?

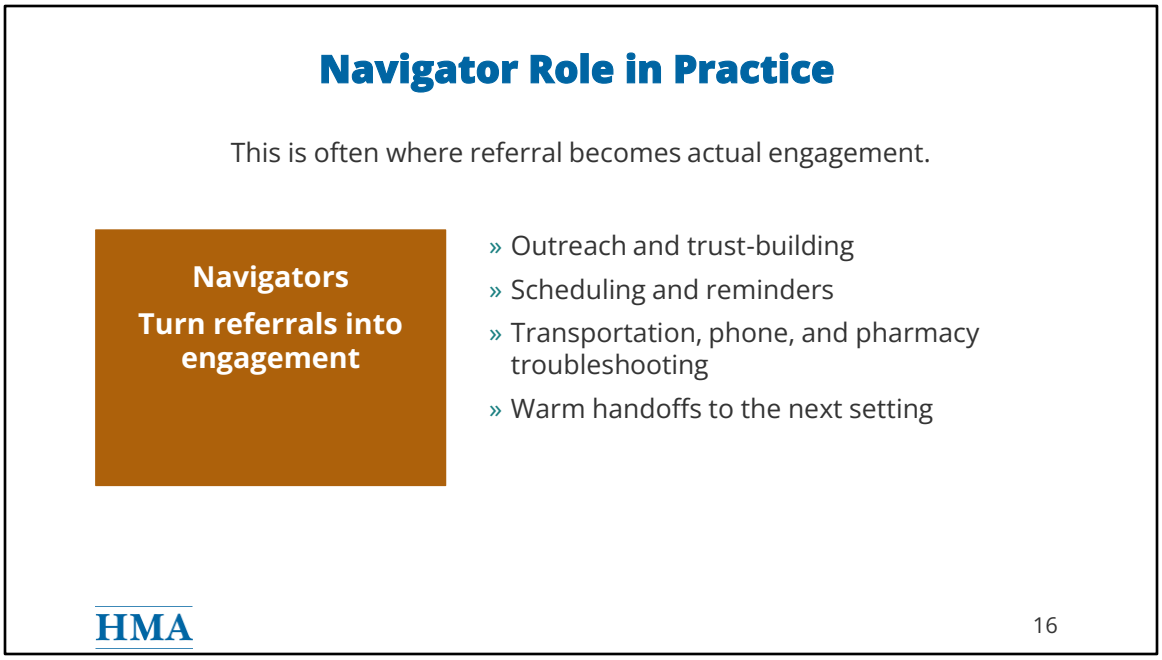
Interdisciplinary teams create a much lower-friction front door.

- Prescriber / Clinician: Evaluates, starts medication, and sets a practical follow-up plan.
- Navigator / Community Health Worker (CHW) / Peer: Builds trust, addresses logistics, and completes the warm handoff to next care.
- Nursing / Medical Assistant / front desk: Supports rapid intake, vitals, scheduling, and medication workflows.

Each role shortens the distance between first contact, medication start, and the next care step.

[Slide Image Description: This slide describes empowering navigators, with images of CA Bridge navigators.]

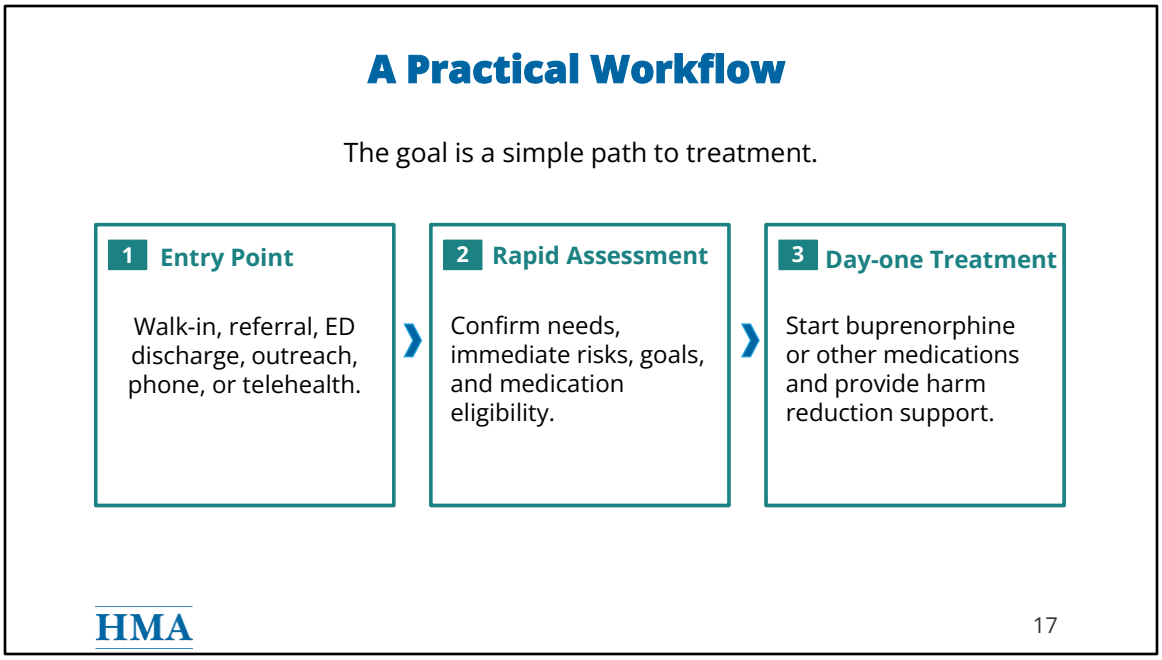
Empower navigators to reach people in need and link them to available clinicians.



[Slide Image Description: This slide highlights navigators with a colorful box]

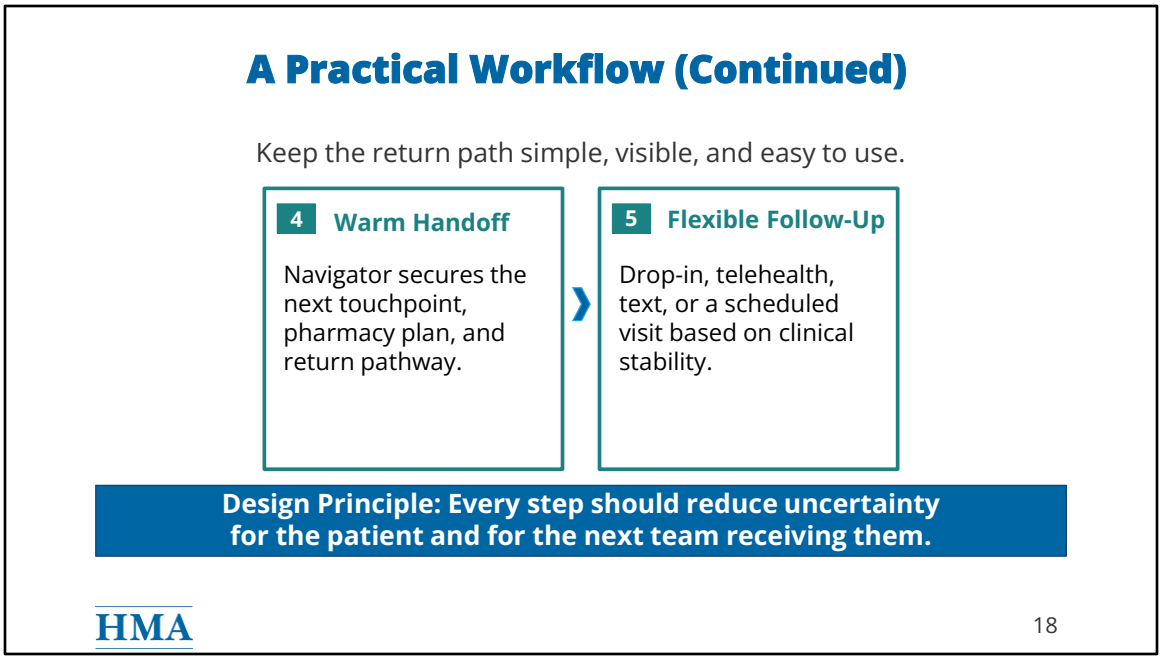
Navigator Roles: This is often where referral becomes actual engagement.

Navigators help with:
- Outreach and trust-building
- Scheduling and reminders
- Transportation, phone, and pharmacy troubleshooting
- Warm handoffs to the next setting



[Slide Image Description: This slide highlights a practical workflow with colorful boxes.]

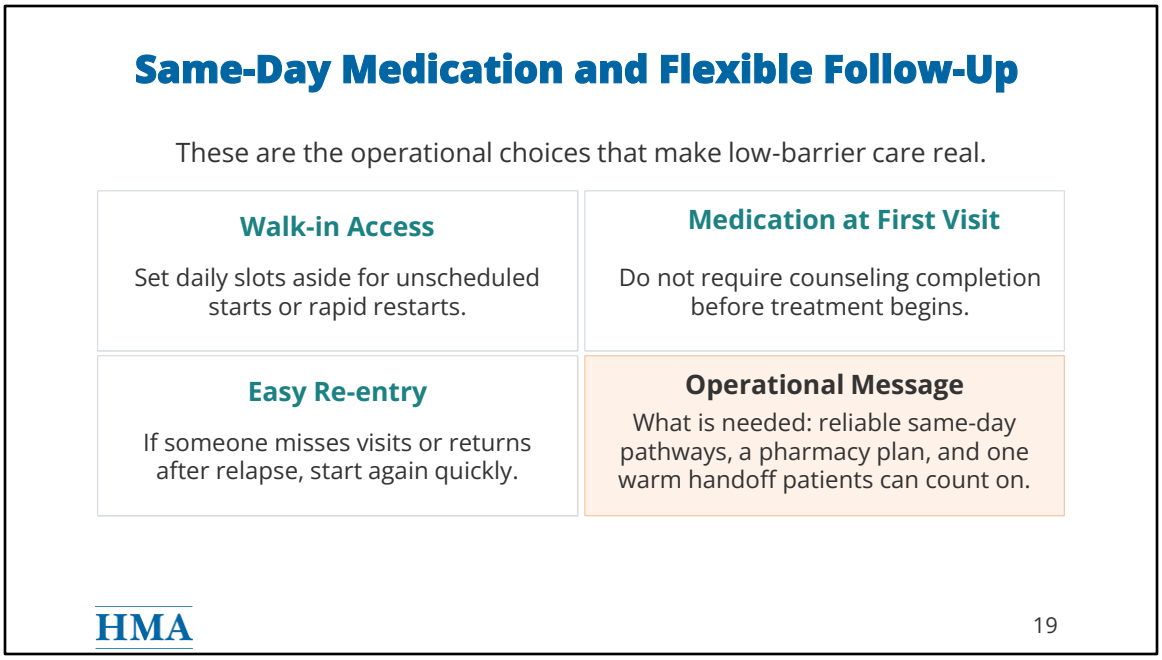
For a practical workflow, the goal is a simple path to treatment:
1. Entry Point: Walk-in, referral, emergency department (ED) discharge, outreach, phone, or telehealth.
2. Rapid Assessment: Confirm needs, immediate risks, goals, and medication eligibility.
3. Day-one Treatment: Start buprenorphine or other medications and provide harm reduction support.



[Slide Image Description: This slide highlights a practical workflow with colorful boxes.]

Keep the return path simple, visible, and easy to use.
4. Warm Handoff: Navigator secures the next touchpoint, pharmacy plan, and return pathway.
5. Flexible Follow-Up: Drop-in, telehealth, text, or a scheduled visit based on clinical stability.

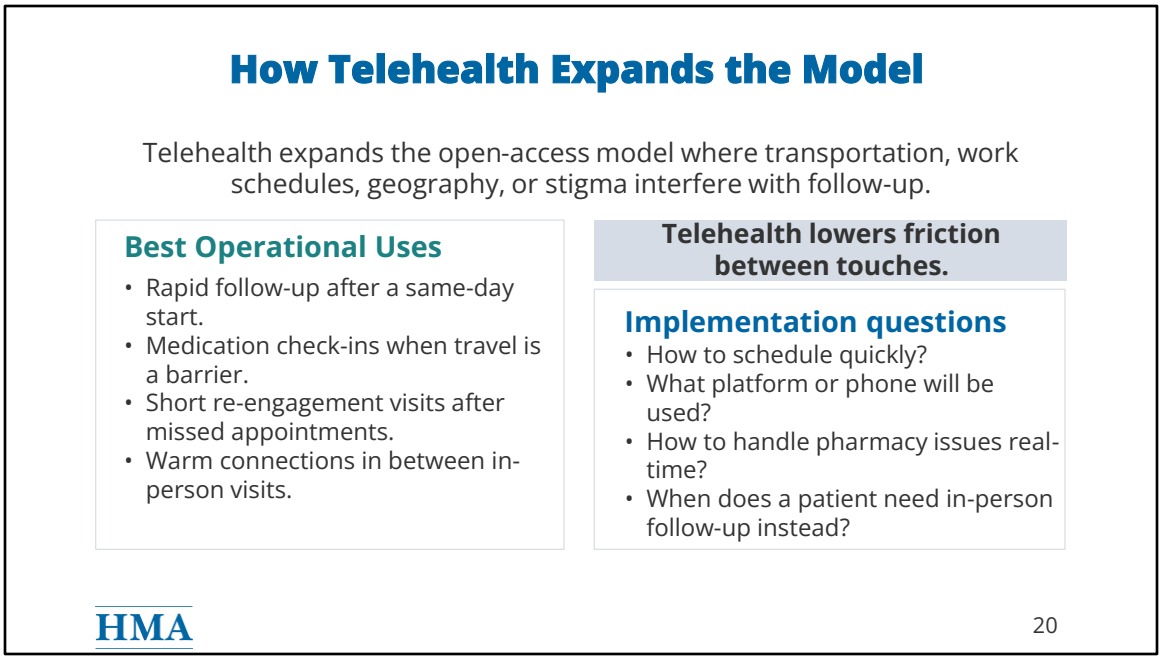
Design Principle: Every step should reduce uncertainty for the patient and for the next team receiving them.



[Slide Image Description: This slide highlights same-day medication and flexible follow-up with colorful boxes.]

For same-day medication and flexible follow-up, the following are the operational choices that make low-barrier care real:

- Walk-in Access: Set daily slots aside for unscheduled starts or rapid restarts.
- Medication at First Visit: Do not require counseling completion before treatment begins.
- Easy Re-entry: If someone misses visits or returns after relapse, start again quickly.
- Operational Message: What is needed: reliable same-day pathways, a pharmacy plan, and one warm handoff patients can count on.



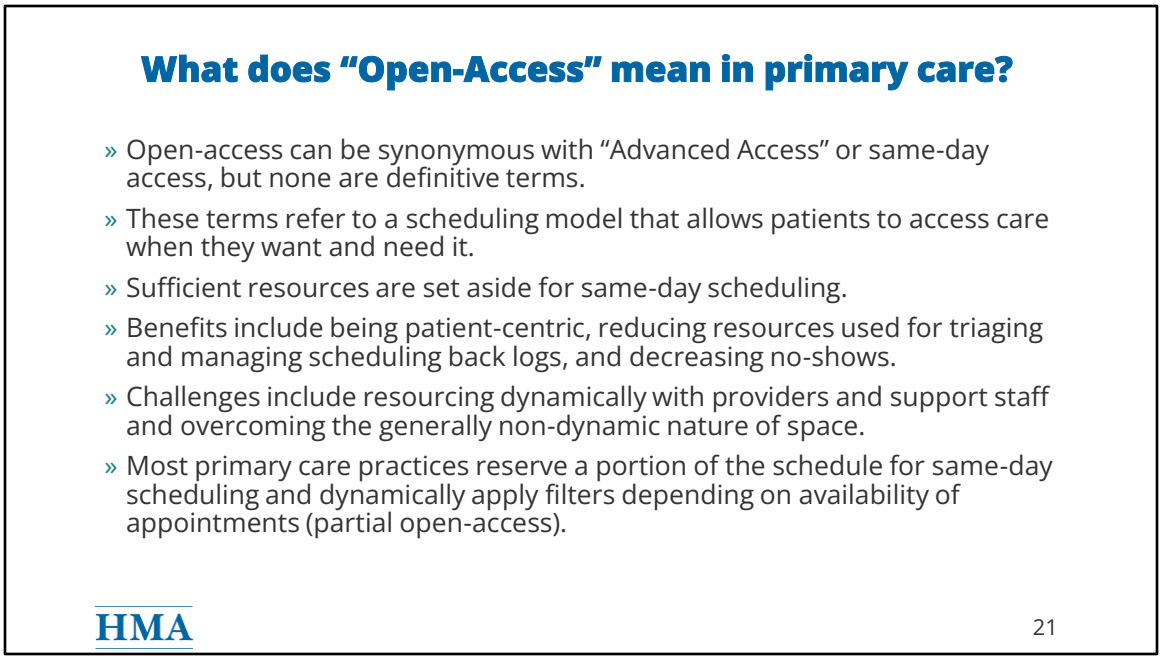
[Slide Image Description: This slide highlights telehealth with colorful boxes.]

Telehealth expands the open-access model where transportation, work schedules, geography, or stigma interfere with follow-up.

Best operational uses:
- Rapid follow-up after a same-day start.
- Medication check-ins when travel is a barrier.
- Short re-engagement visits after missed appointments.
- Warm connections in between in-person visits.

Keep in mind telehealth lowers friction between touches.

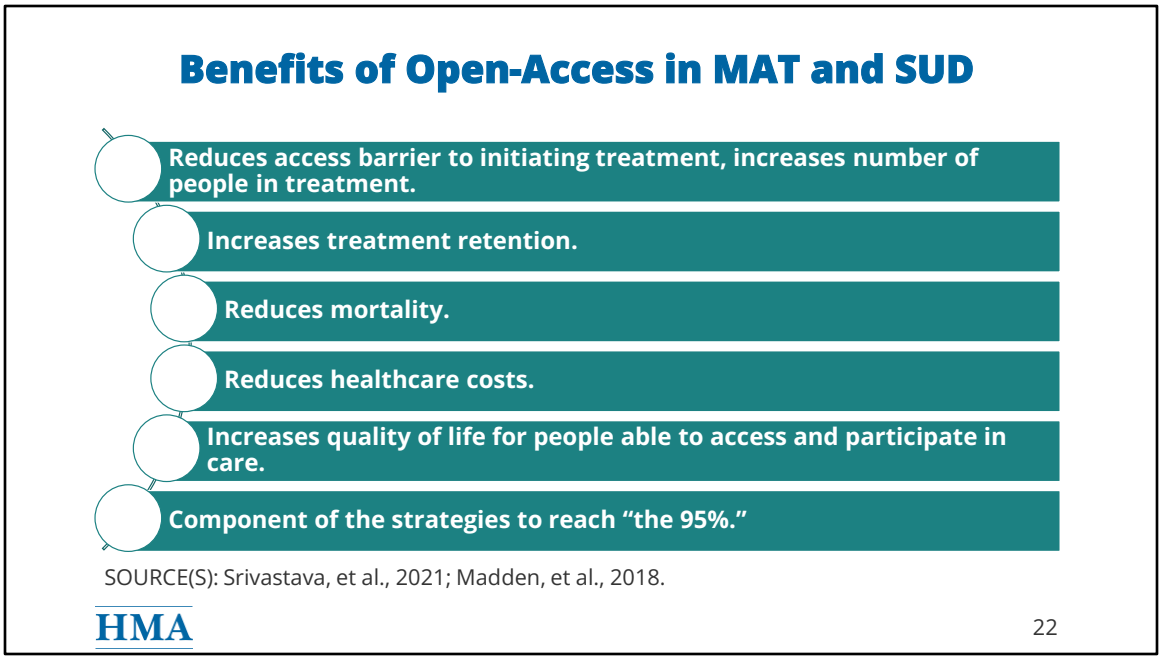
Implementation questions:
- How to schedule quickly?
- What platform or phone will be used?
- How to handle pharmacy issues real-time?
- When does a patient need in-person follow-up instead?



[Slide Image Description: This slide describes open-access in primary care.]

What does “open-access” mean in primary care? Open-access can be synonymous with “Advanced Access” or same-day access, but none are definitive terms.

- What: For primary care, open-access is a scheduling model (and care paradigm) that allows patients to access care when needed and/or wanted, and to have the primary care practice perform today’s work today.
- How: Sufficient resources (provider time and scheduling capacity) are set aside for same-day scheduling.
- Benefits: Being patient-centric, reduction in resources used for triaging and managing scheduling back logs, and decreasing no-shows.
- Challenges: Demand projections inaccurate day to day resulting in under or over resourcing; space and support staff need to be adequate for high demand periods.
- Take-home: Most primary care practices reserve a portion of the schedule for same-day scheduling and dynamically apply filters depending on availability.

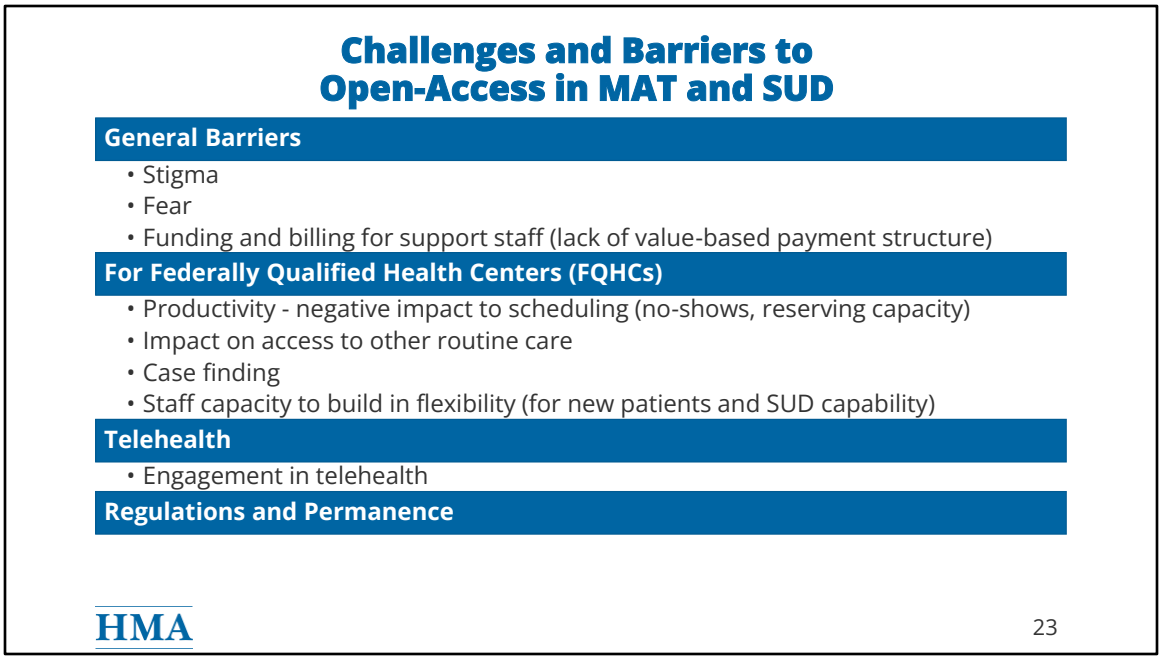


[Slide Image Description: This slide lists the benefits of open-access in MAT and SUD with colorful boxes.]

Consider the following benefits of open-access in MAT and SUD:

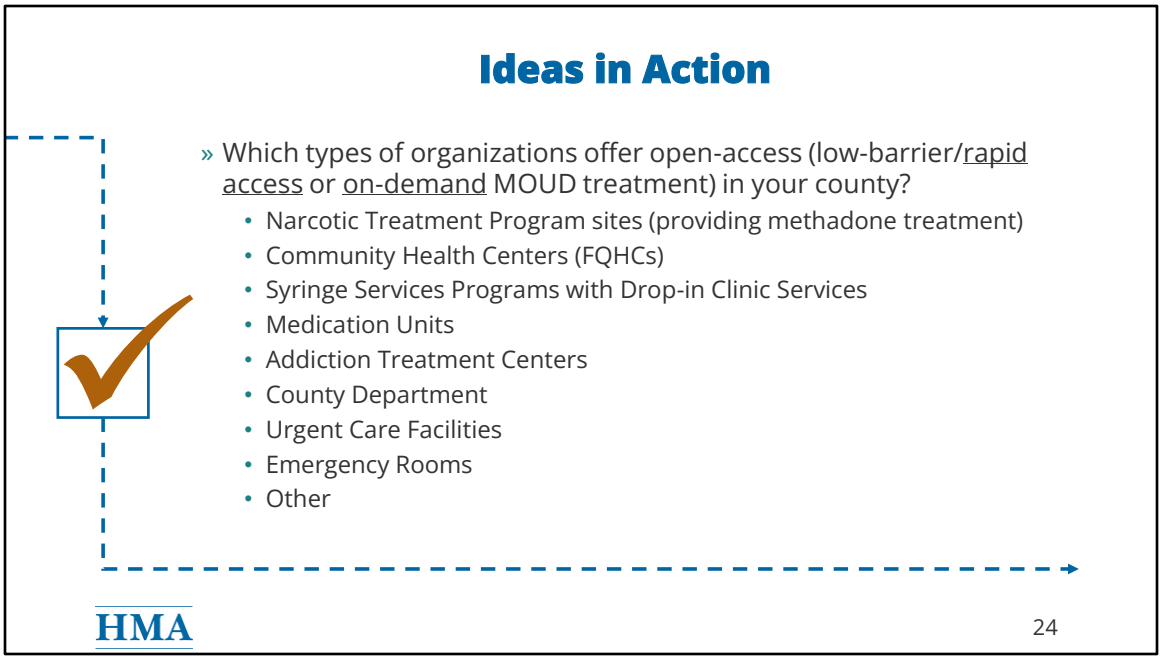
- Reduces the access barrier to initiating treatment, which in turn increases the number of people in treatment.
- Increases treatment retention.
- Reduces mortality.
- Reduces healthcare costs.
- Increases quality of life for people able to access and participate in care.
- Open-access, low-barrier care is a component of the strategies to reach "the 95%."

SOURCE(S): Srivastava, et al., 2021; Madden, et al., 2018.



[Slide Image Description: This slide lists the challenges and barriers of open-access models with colorful boxes.]

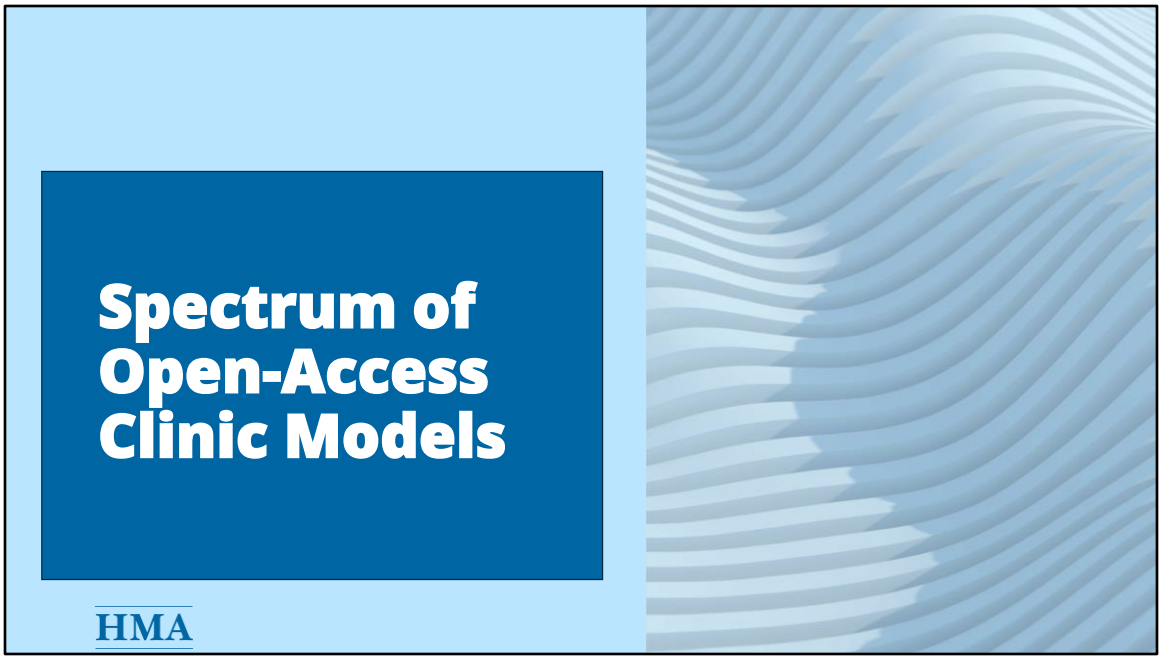
Recognize that some parts of the system of open-access care will experience challenges to implementing. Attitudes about the patient population can contribute to hesitancy in offering better access. Stigma about being a provider of SUD treatment patients could contribute. Fear of impact on rest of practice. Funding may not be matched to level of effort needed to create open-access.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Which types of organizations offer open-access (low-barrier/rapid access or on-demand MOUD treatment) in your county? (y/n each and sum the yeses for each to display during webinar)

- Narcotic Treatment Program sites (providing methadone treatment)
- Community Health Centers (FQHCs)
- Syringe Services Programs with Drop-in Clinic Services
- Medication Units
- Addiction Treatment Centers
- County Department
- Urgent Care Facilities
- Emergency Rooms
- Other

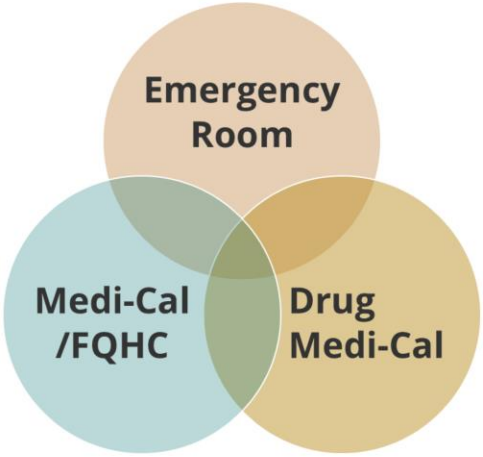


[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This second section outlines the spectrum of open-access clinic models.

Expanding Access and Opening Doors

- Emergency Department = Same Day Low Threshold Access
- Drug Medi-Cal Organized Delivery System / Hub and Spoke
  - Opioid Treatment Program (Methadone)
  - Residential and Intensive Outpatient Programs
- FQHCs and Primary Care
- Activate real-time, crisis treatment ecosystem (CA Bridge Connect)



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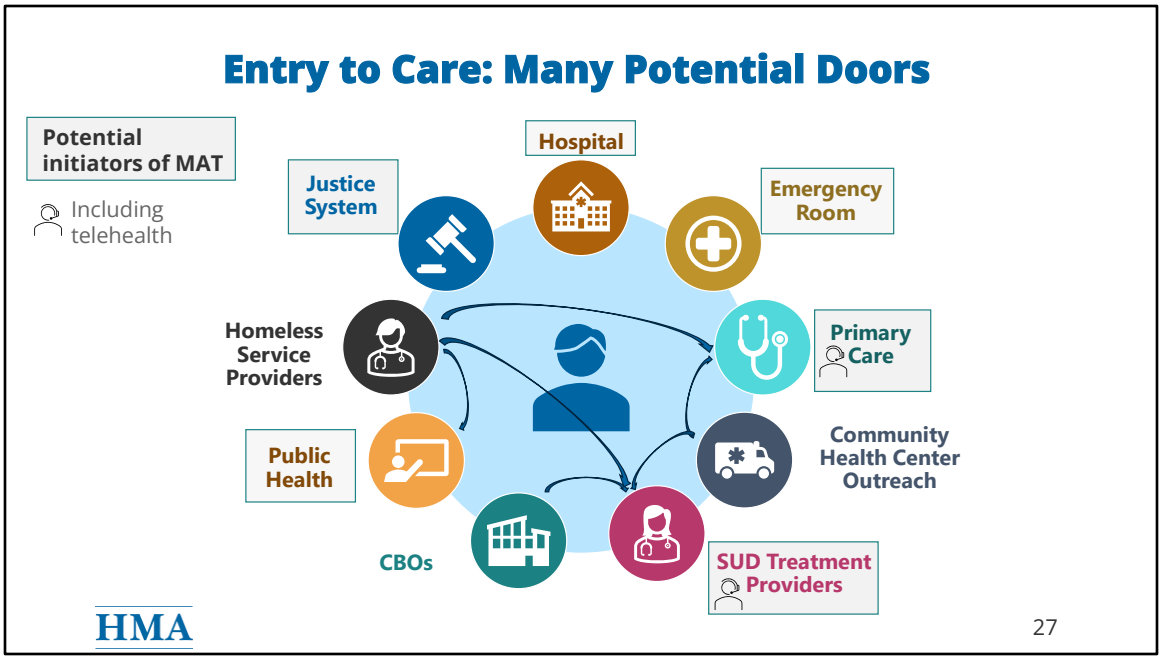
[Slide Image Description: This slide details steps to expand access, with a Venn diagram including “emergency room,” “drug Medi-Cal,” and “Medi-Cal/FQHC.”]

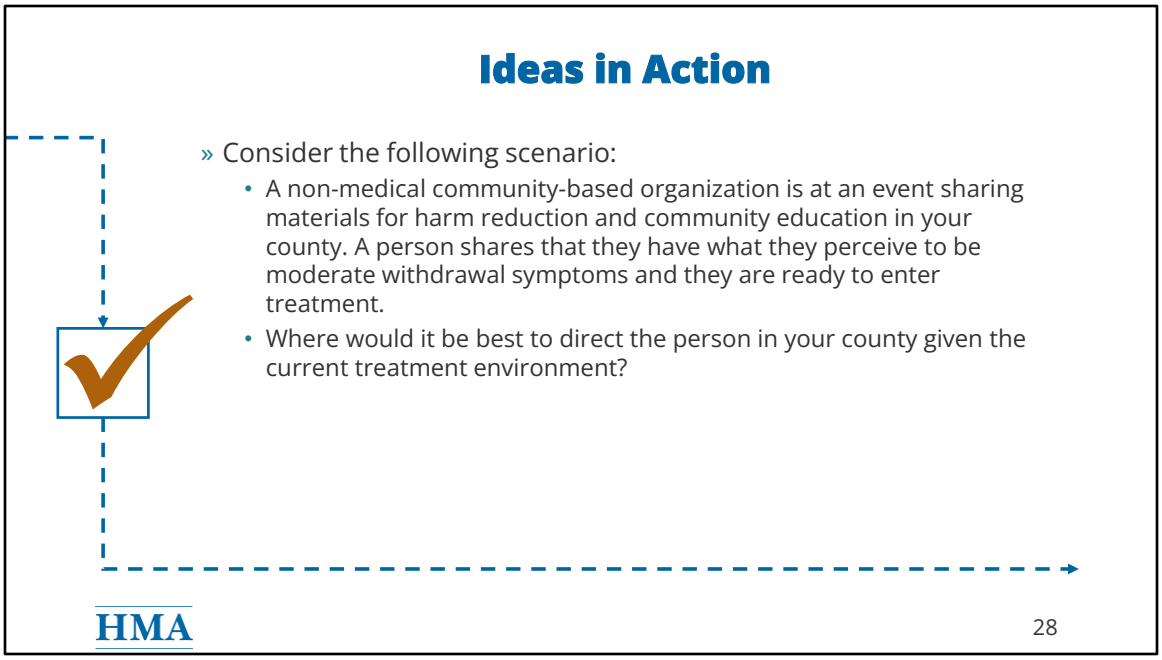
Expanding access and opening doors through the following:

- Emergency Department = Same Day Low Threshold Access
- Drug Medi-Cal Organized Delivery System (ODS) / Hub and Spoke
  - Opioid Treatment Program (Methadone)
  - Residential and Intensive Outpatient Programs (IOP)
- Federally Qualified Health Centers (FQHCs) and Primary Care
- Activate real-time, crisis treatment ecosystem (CA Bridge Connect)



[Slide Image Description: This slide details options for entry to care, including a graphic with an individual surrounded by icons representing a hospital, emergency room, primary care, community health center outreach, SUD treatment providers, CBOs, public health, homeless service providers, and justice system.]

Open-access, low-barrier entry should be thought of not just as a scheduling method at a single entity (walk in capacity in primary care), but as a system status across entities. People ready to enter care may enter through hospital/ED, SUD provider, or primary care, but they may also enter through a community-based organization, or the public health and justice system. Ideally, each should incorporate concepts of low-barrier care and have low friction methods to initiate medication through others in the system.



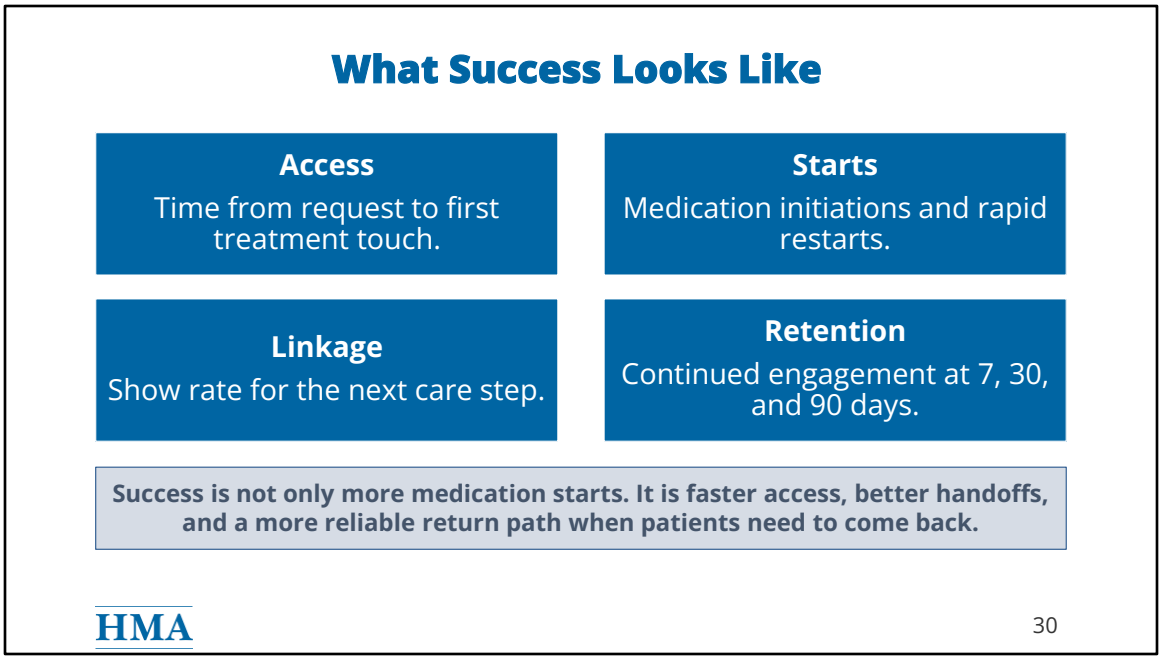
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Consider the following scenario:

- A non-medical community-based organization is at an event sharing materials for harm reduction and community education in your county. A person shares that they have what they perceive to be moderate withdrawal symptoms and they are ready to enter treatment.
- Where would it be best to direct the person in your county given the current treatment environment?

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This third section highlights metrics for success.

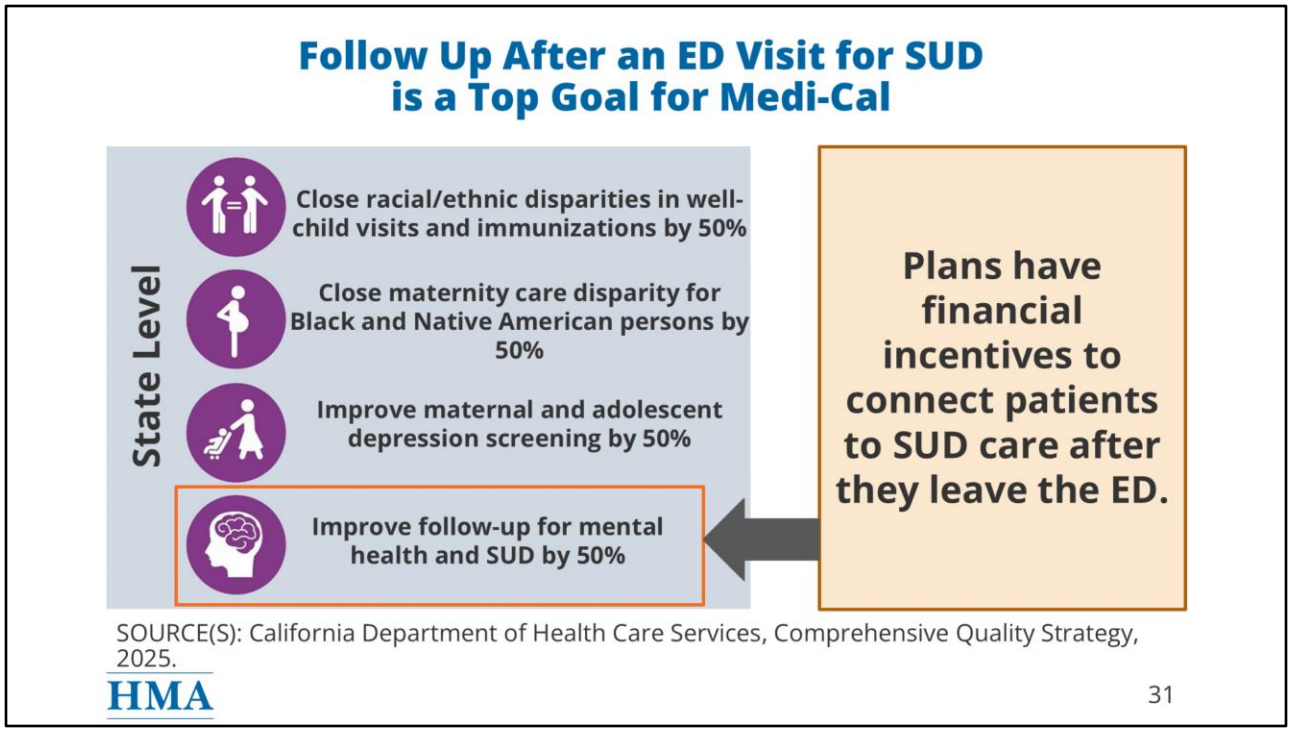


[Slide Image Description: This slide lists metrics for success with colorful boxes.]

What does success look like?

- Access: Time from request to first treatment touch.
- Starts: Medication initiations and rapid restarts.
- Linkage: Show rate for the next care step.
- Retention: Continued engagement at 7, 30, and 90 days.

Keep in mind success is not only more medication starts. It is faster access, better handoffs, and a more reliable return path when patients need to come back.

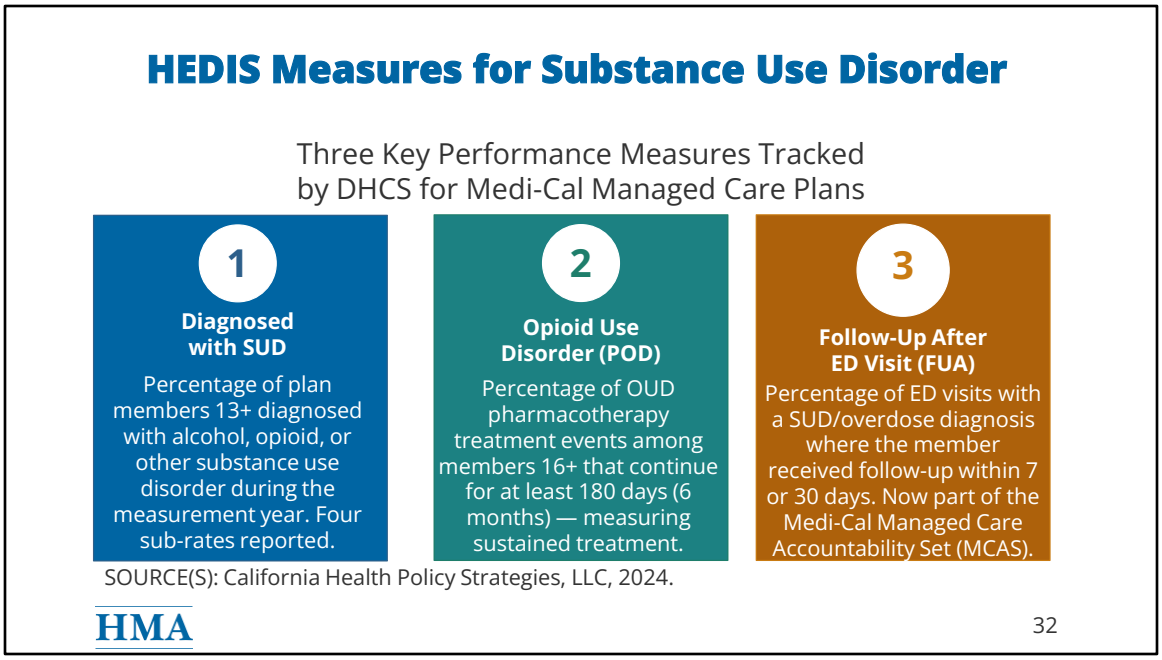


[Slide Image Description: This slide lists follow-up metrics for SUD with various graphics and colorful boxes.]

This is the state's Comprehensive Quality Strategy for Medi-Cal that elevates the HEDIS Follow-Up After
ED Visit (FUA) metric "follow up after ED visit for substance use" to one of the top four goals.

This document outlines the required measures for Medi-Cal Managed Care Plans for 2022 and shows that plans are held to a minimum performance level (MPL) for follow up after ED visit for substance use at 30 days but are not held to an MPL for 7 days.

SOURCE(S): California Department of Health Care Services, 2022.

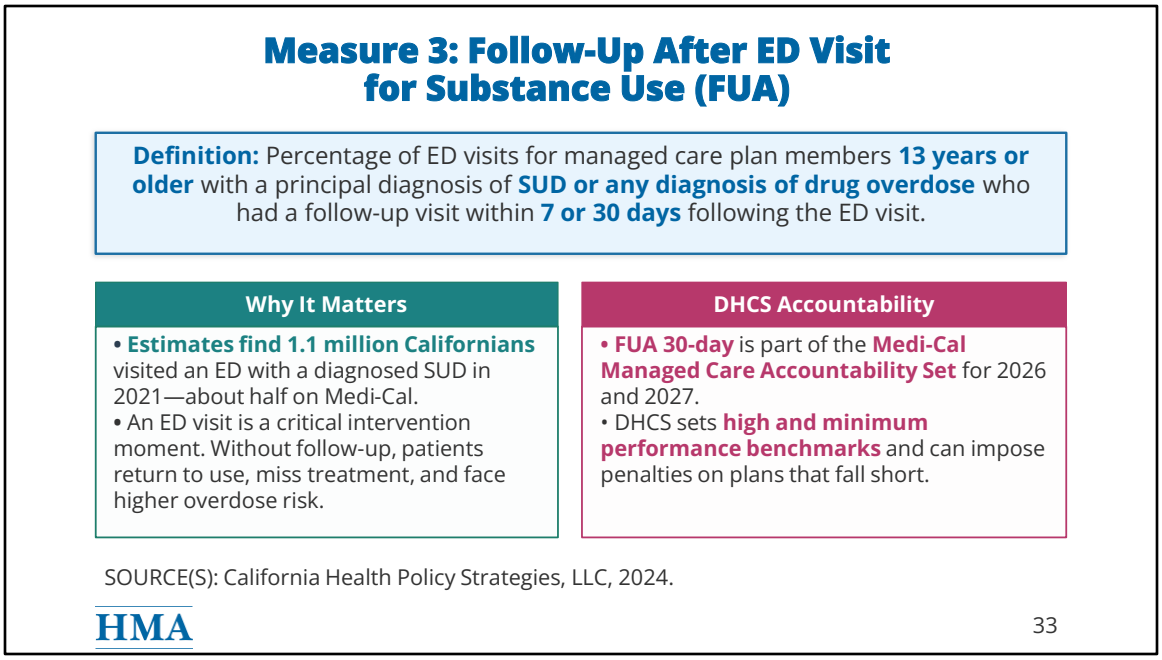


[Slide Image Description: This slide lists HEDIS measures for SUD with colorful boxes.]

Three Key Performance Measures Tracked by DHCS for Medi-Cal Managed Care Plans:

1. Diagnosed with SUD: Percentage of plan members 13+ diagnosed with alcohol, opioid, or other substance use disorder during the measurement year. Four sub-rates reported.
2. Percentage of Opioid Use Disorder: Percentage of OUD pharmacotherapy treatment events among members 16+ that continue for at least 180 days (6 months) — measuring sustained treatment.
3. Follow-up After ED Visit (FUA): Percentage of ED visits with an SUD and/or overdose diagnosis where the member received follow-up within seven or 30 days. Now part of the Medi-Cal Managed Care Accountability Set (MCAS) with financial accountability.

SOURCE(S): California Health Policy Strategies, LLC, 2024.

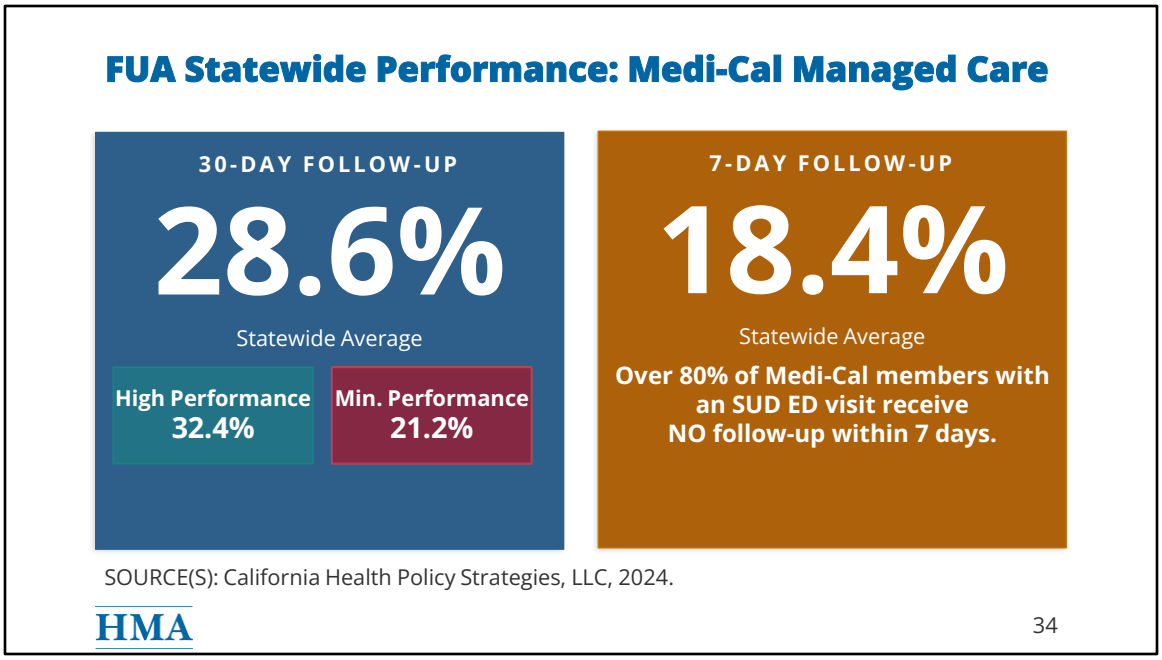


[Slide Image Description: This slide lists measure three with colorful boxes.]

Measure 3: Follow-Up After ED Visit for Substance Use (FUA):

- Definition: Percentage of ED visits for managed care plan members 13 years or older with a principal diagnosis of SUD or any diagnosis of drug overdose who had a follow-up visit within 7 or 30 days following the ED visit.
- Why it Matters: Estimates find 1.1 million Californians visited an ED with a diagnosed SUD in 2021—about half on Medi-Cal. An ED visit is a critical intervention moment. Without follow-up, patients return to use, miss treatment, and face higher overdose risk.
- DHCS Accountability: FUA 30-day is now part of the Medi-Cal Managed Care Accountability Set (MCAS) for 2024. DHCS sets high and minimum performance benchmarks and can impose penalties on plans that fall short.

SOURCE(S): California Health Policy Strategies, LLC, 2024.

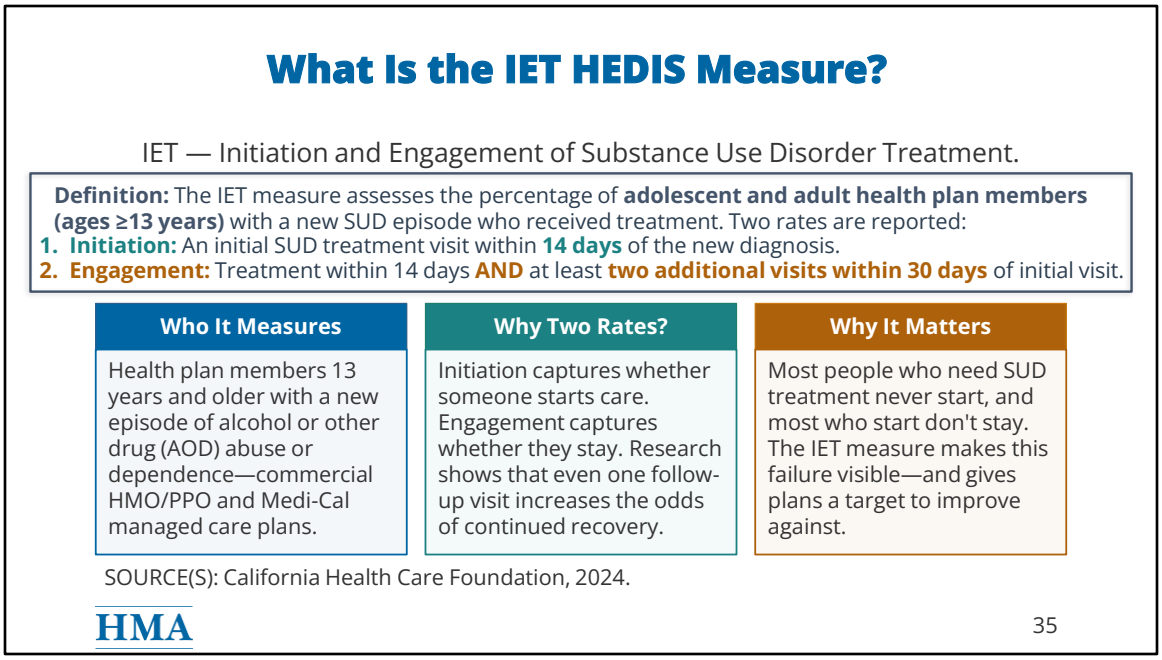


[Slide Image Description: This slide lists FUA statewide performance with colorful boxes.]

FUA Statewide Performance: Medi-Cal Managed Care:

- 30-Day Follow-up: 28.6% statewide average.
    - High Performance: 32.4%.
    - Minimum Performance: 21.2%.
- 7-Day Follow-up: 18.4% statewide average.
    - Over 80% of Medi-Cal members with an SUD ED visit receive no follow-up within 7 days.

SOURCE(S): California Health Policy Strategies, LLC, 2024.



[Slide Image Description: This slide shows the IET HEDIS Measure with colorful boxes.]

Initiation and Engagement of Substance Use Disorder Treatment (IET) HEDIS Measure. These are California Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) commercial plans.

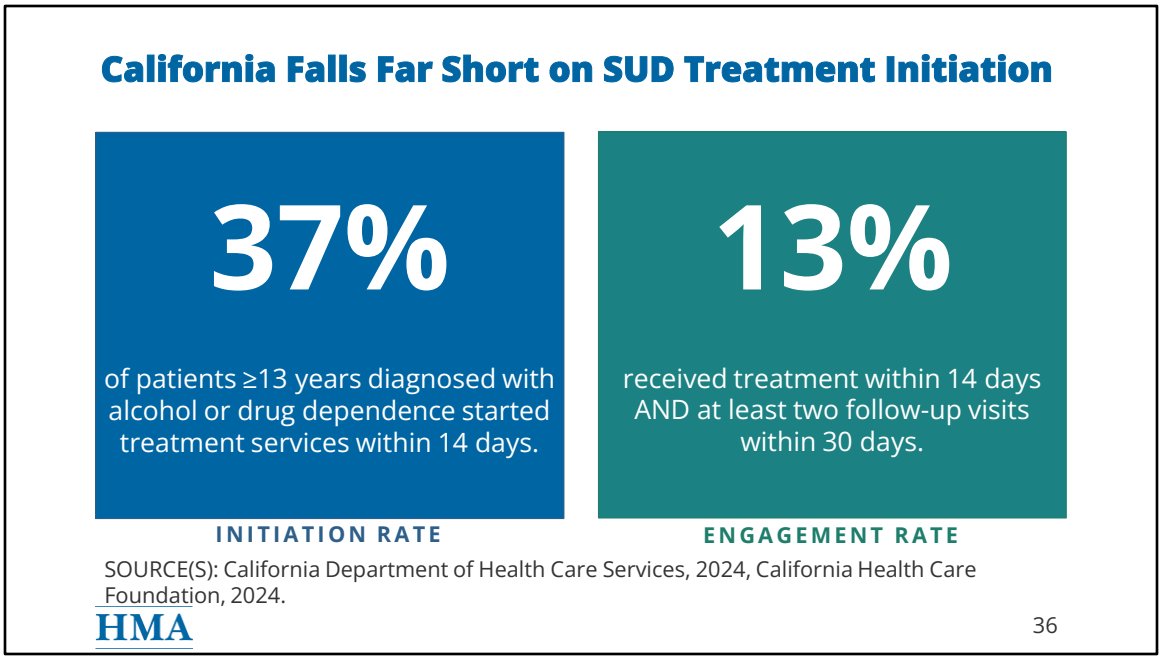
Definition: The IET measure assesses the percentage of adolescent and adult health plan members (ages 13+) with a new SUD episode who received treatment. Two rates are reported:
1. Initiation: An initial SUD treatment visit within 14 days of the new diagnosis.
2. Engagement: Treatment within 14 days AND at least two additional visits within 30 days of initial visit.

Who it measures: Health plan members 13 years and older with a new episode of alcohol or other drug (AOD) abuse or dependence—commercial HMO/PPO and Medi-Cal managed care plans.

Why two rates: Initiation captures whether someone starts care. Engagement captures whether they stay. Research shows that even one follow-up visit increases the odds of continued recovery.

Why it matters: Most people who need SUD treatment never start, and most who start don't stay. The IET measure makes this failure visible—and gives plans a target to improve against.

SOURCE(S): California Health Care Foundation, 2024.

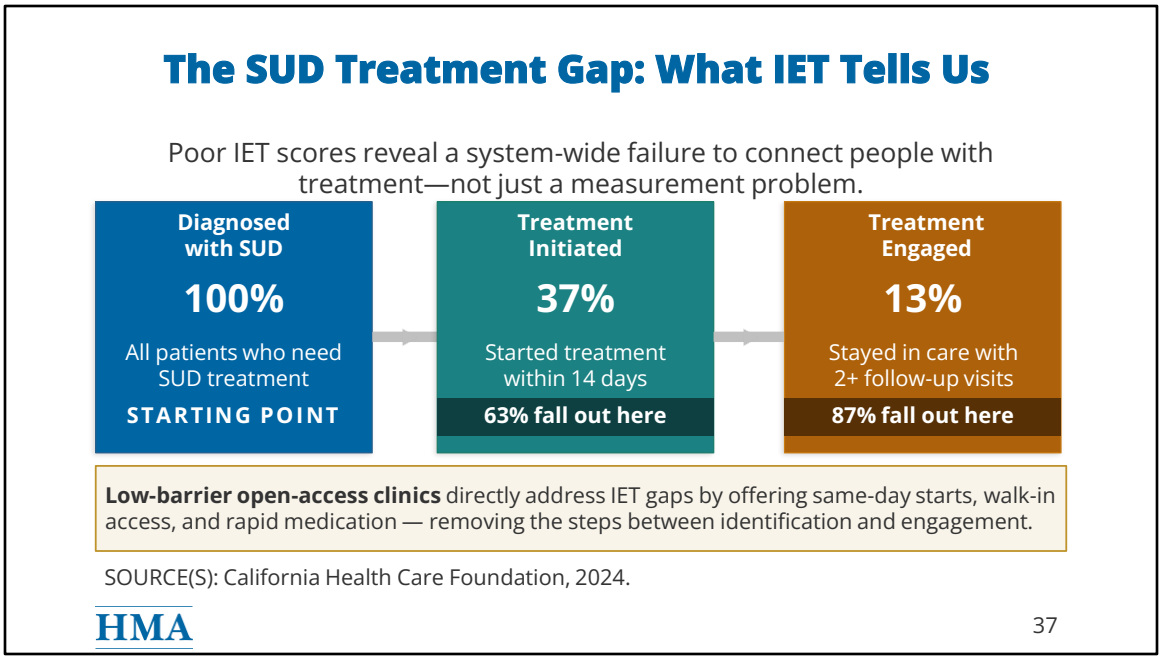


[Slide Image Description: This slide shows the SUD initiation rate and engagement rate in California.]

California Falls Far Short on SUD Treatment Initiation.

- Initiation Rate: 37% of patients 13yo+ diagnosed with alcohol or drug dependence started treatment services within 14 days.
- Engagement Rate: 13% received treatment within 14 days AND at least two follow-up visits within 30 days.

SOURCE(S): California Department of Health Care Services, 2024, California Health Care Foundation, 2024.



[Slide Image Description: This slide shows the SUD treatment gap with colorful boxes.]

Poor IET scores reveal a system-wide failure to connect people with treatment—not just a measurement problem.

Of the patients diagnosed with SUD, only 37% started treatment within 14 days. From there, only 13% are engaged in treatment with 2+ follow-up visits.

Low-barrier open-access clinics directly address IET gaps by offering same-day starts, walk-in access, and rapid medication — removing the steps between identification and engagement.

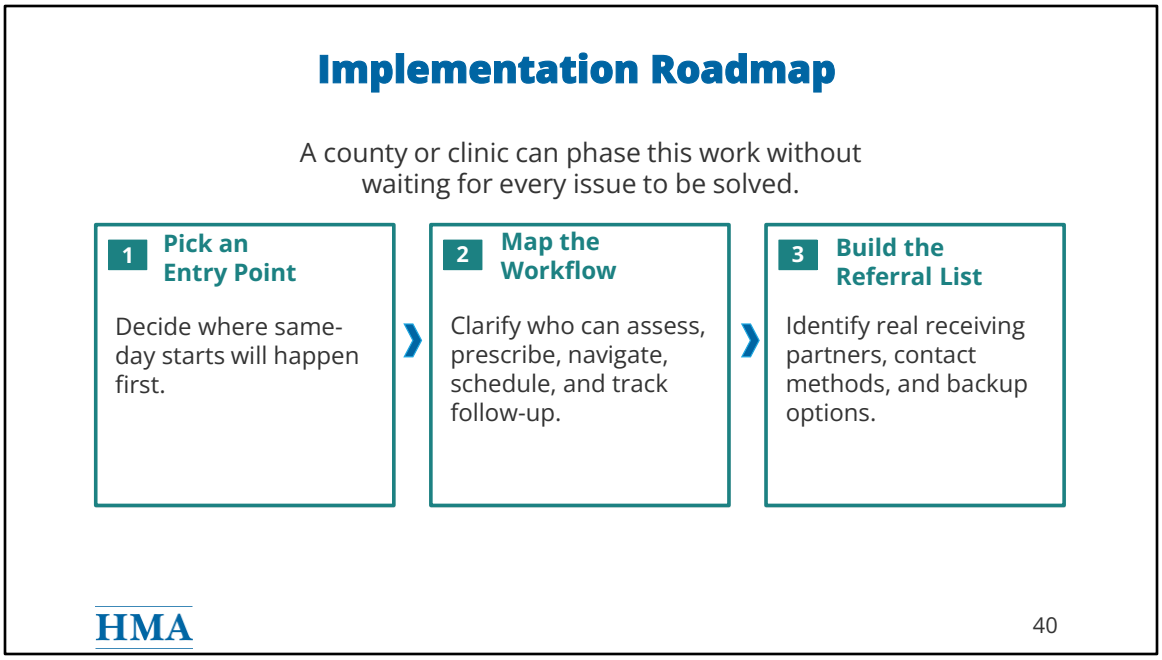
SOURCE(S): California Health Care Foundation, 2024.

[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

- Where is the most realistic same-day entry point in your local system?
- What currently delays medication start or first follow-up?
- How can telehealth or navigator support reduce friction?
- What is one implementation step your team could take this quarter?

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

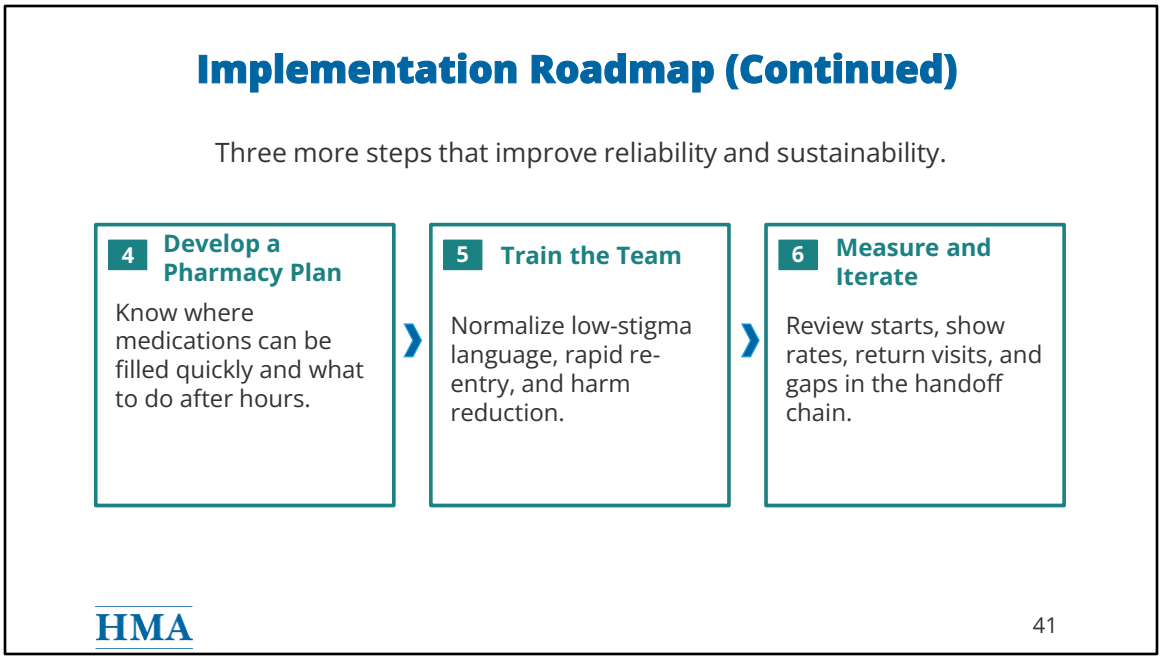
This fifth section details specific strategies for implementing open-access clinic models.



[Slide Image Description: This slide shows an implementation roadmap with colorful boxes.]

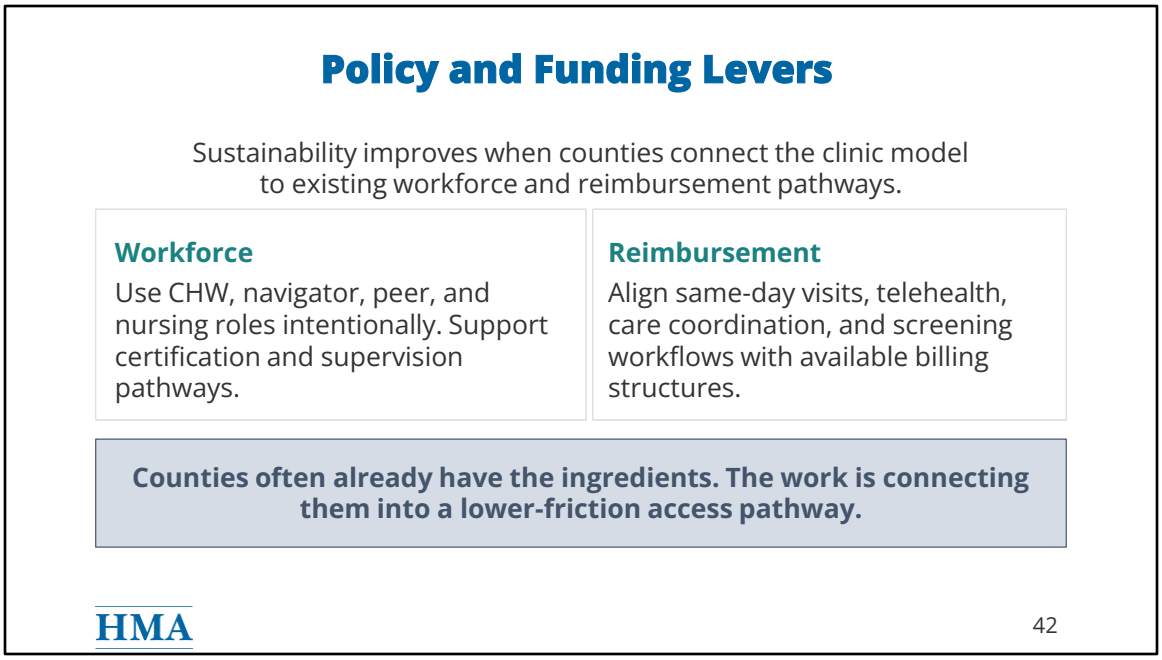
A county or clinic can phase this work without waiting for every issue to be solved.

Consider the following implementation roadmap:
1. Pick an entry point: Decide where same-day starts will happen first.
2. Map the workflow: Clarify who can assess, prescribe, navigate, schedule, and track follow-up.
3. Build the referral list: Identify real receiving partners, contact methods, and backup options.



[Slide Image Description: This slide shows an implementation roadmap with colorful boxes.]

Three more steps that improve reliability and sustainability:
4. Develop a pharmacy plan: Know where medications can be filled quickly and what to do after hours.
5. Train the team: Normalize low-stigma language, rapid re-entry, and harm reduction.
6. Measure and iterate: Review starts, show rates, return visits, and gaps in the handoff chain.

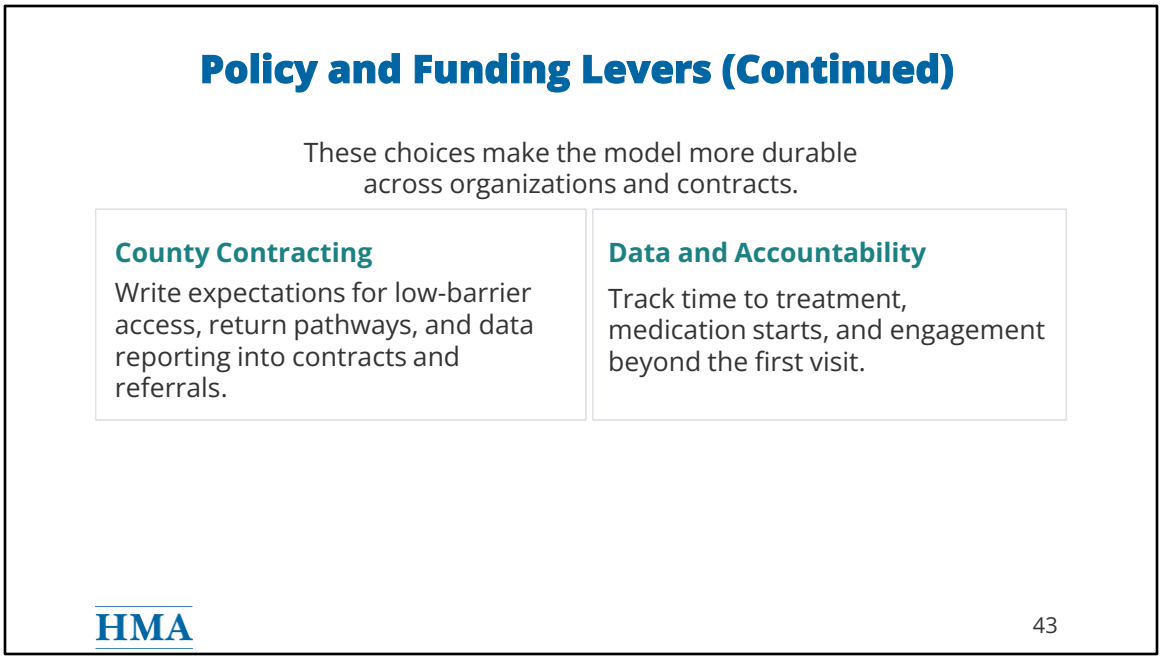


[Slide Image Description: This slide shows policy and funding levers with colorful boxes.]

Sustainability improves when counties connect the clinic model to existing workforce and reimbursement pathways.

- Workforce: Use CHW, navigator, peer, and nursing roles intentionally. Support certification and supervision pathways.
- Reimbursement: Align same-day visits, telehealth, care coordination, and screening workflows with available billing structures.

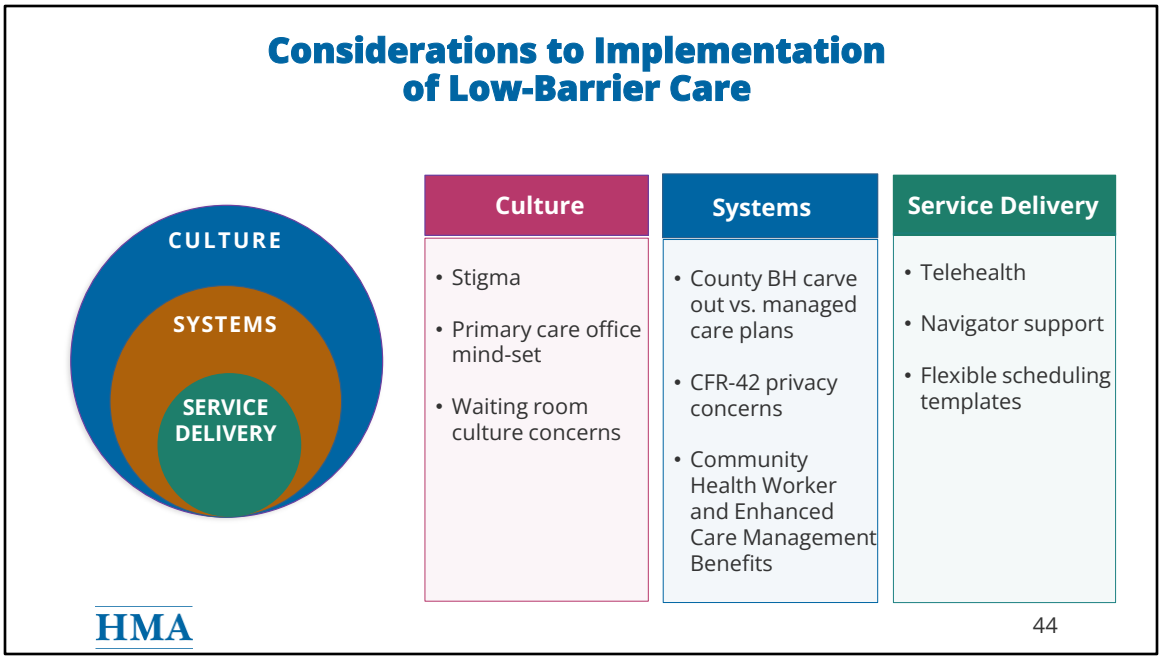
Counties often already have the ingredients. The work is connecting them into a lower-friction access pathway.



[Slide Image Description: This slide shows policy and funding levers with colorful boxes.]

The following choices make the model more durable across organizations and contracts:

- County contracting: Write expectations for low-barrier access, return pathways, and data reporting into contracts and referrals.
- Data and accountability: Track time to treatment, medication starts, and engagement beyond the first visit.



[Slide Image Description: This slide shows considerations to implement low-barrier care, with a chart and colorful boxes.]

Considerations to implementation of low-barrier care:

- Culture:
  - Stigma
  - Primary care office mindset – nonurgent, highly structured and scheduled visits makes it difficult to implement low-barrier care
  - Waiting room culture concerns – having people who use drugs in the waiting room along with other populations/patients
- Systems:
  - County BH carve out vs. managed care plans
  - CFR-42 privacy concerns
  - Community Health Worker and Enhanced Care Management Benefits
- Service delivery
  - Telehealth
  - Navigator support
  - Flexible scheduling templates

Urgent Cares and Harm Reduction Sites as Open-Access Clinics

» These settings already reach people who avoid traditional care — and can serve as low-barrier entry points for SUD treatment.

Urgent Care as Open-Access	Harm Reduction Sites as Entry Points
Why It Works No appointment required. Patients arrive in moments of need. Already staffed with prescribers who can initiate buprenorphine.	**Why It Works** Trusted by people who avoid clinical settings. Syringe services, naloxone, and fentanyl test strips bring people through the door.
Low-Barrier Opportunities Same-day MAT initiation; SBIRT-trained staff; patient navigator co-location; warm handoff to ongoing care.	**Low-Barrier Opportunities** Buprenorphine initiation; peer-delivered navigation; telehealth prescribing integration; warm handoff to FQHCs or urgent care.
Key Challenges Short visit windows; limited continuity for relationship building; MAT follow-up requires coordination; staff training on harm reduction.	**Key Challenges** Challenges with documentation and billing for services, often reliant on grant funding.

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[Slide Image Description: This slide shows depicts urgent cares and harm reduction sites as open-access clinics with colorful boxes.]

Urgent cares and harm reduction sites as open-access clinics.

These settings already reach people who avoid traditional care — and can serve as low-barrier entry points for SUD treatment.

Urgent Care as Open-Access:

- Why It Works: Walk-in by definition — no appointment required. Patients arrive in moments of need. Already staffed with prescribers who can initiate buprenorphine.
- Low-Barrier Opportunities: Same-day MAT initiation; SBIRT-trained staff; patient navigator co-location; warm handoff to ongoing care (FQHC, primary care, or telehealth).
- Key Challenges: Short visit windows; limited continuity; MAT follow-up requires coordination; staff training on harm reduction.

Harm Reduction Sites as Entry Points:

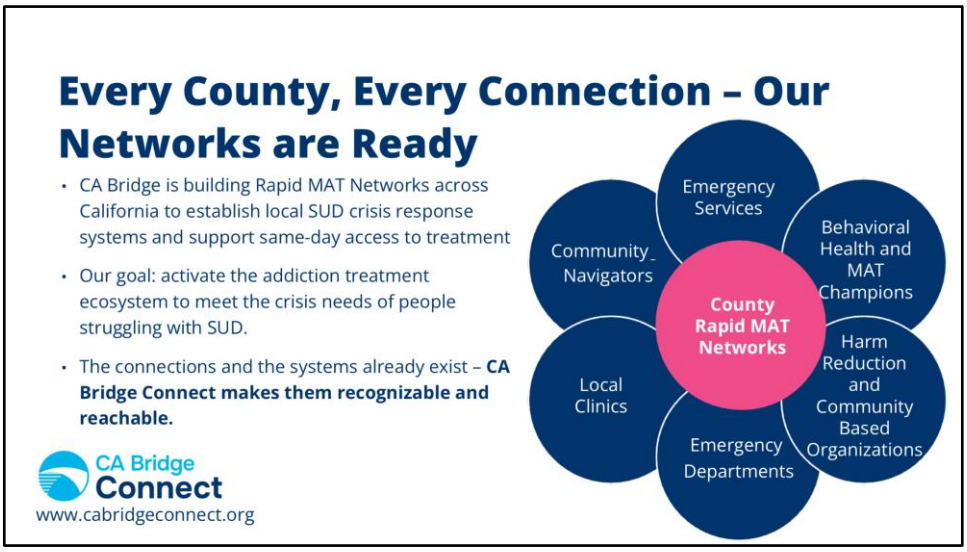
- Why It Works: Trusted by people who avoid clinical settings. Syringe services, naloxone, and fentanyl test strips already bring people through the door repeatedly.
- Low-Barrier Opportunities: Buprenorphine initiation on-site (low-dose induction); peer-delivered navigation; telehealth prescribing integration; warm handoff to FQHCs or urgent care.
- Key Challenges: Challenges with documentation and billing for services, often reliant on grant funding.

Both settings meet patients where they are. When connected to billing, navigation, and follow-up infrastructure, urgent cares and harm reduction sites become measurable, sustainable open-access entry points.

[Slide Image Description: This slide shows information about CA Bridge connect with an image of a provider.]

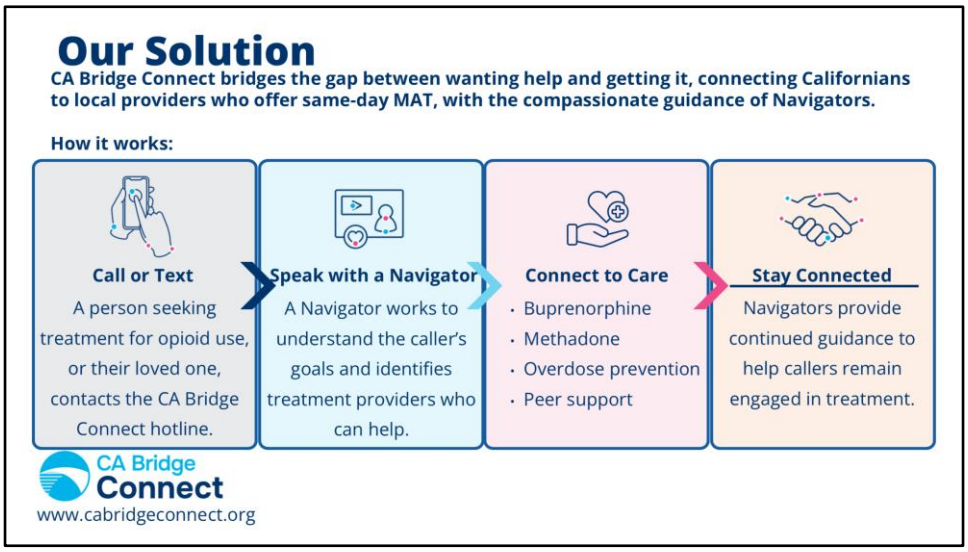
CA Bridge Connect is a first-of-its-kind hotline that quickly connects people to same-day, low-barrier opioid use disorder treatment.

Building a crisis response network—no one is alone. This is an extended provider CA Bridge network.



[Slide Image Description: This slide shows information about CA Bridge connect with a graphic highlighting emergency services, behavioral health and MAT champions, harm reduction and community based organizations, emergency departments, local clinics, and community navigators circling around county rapid MAT networks.]

CA Bridge is building Rapid MAT Networks across California to establish local SUD crisis response systems and support same-day access to treatment. The goal is to activate the addiction treatment ecosystem to meet the crisis needs of people struggling with SUD. The connections and the systems already exist – CA Bridge Connect makes them recognizable and reachable.



[Slide Image Description: This slide shows information about CA Bridge connect with a graphic and various icons.]

CA Bridge Connect bridges the gap between wanting help and getting it, connecting Californians to local providers who offer same-day MAT, with the compassionate guidance of Navigators.

How it works:

- Call or Text: A person seeking treatment for opioid use, or their loved one, contacts the CA Bridge Connect hotline.
- Speak with a Navigator: A Navigator works to understand the caller's goals and identifies treatment providers who can help.
- Connect to Care: Buprenorphine, Methadone, Overdose prevention, and Peer support
- Stay Connected: Navigators provide continued guidance to help callers remain engaged in treatment.

[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. Our email address is **info@afbsstraining.org**.

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