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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Open-Access Clinic Models

AFBSS Webinar Series: April 21, 2026

The Assertive Field-Based Substance Use Disorder/Opioid Use Disorder Services Training and Technical Assistance is funded by California Department of Health Care Services (DHCS). 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, DHCS.

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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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Presenters

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Founder, Principal Investigator
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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

Learning Objectives

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.

Overview of Open-Access Clinics

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California Substance Use at a Glance

15.9M
used alcohol past month

7.8M
used cannabis past year

3.7M
used tobacco products past month

3.5M
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.

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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.

BHSA: Open-Access Clinics

» 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.
- Open-access clinic models that counties can utilize include:
  - Syringe Services Programs with Drop-in Clinic Services
  - Medication Units
  - Drop-in Outpatient Clinics with Open-Access Scheduling

Requirements and Approach	Requirements and Approach (medication only)	Availability
• No service engagement conditions or preconditions. • Visit frequency based on clinical stability. • Ongoing substance use does not automatically result in treatment discontinuation. • Client's individual recovery goals prioritized. • Reduction in substance use and engaging in less risky substance use as acceptable goals.	• Medication at first visit. • Home initiation permitted. • Various medication formulations offered. • Individualized medication dosage. • Rapid re-initiation of medication after short-term disruption.	• Treatment available in non-specialty SUD settings. • Other clinical and non-clinical services incorporated into SUD treatment settings. • Same-day treatment availability, no appointment required. • Extended hours of operation. • Telehealth and in-person services available.

Features of Low-Barrier Care

- Medication is available at the first visit.
- Ongoing substance use prompts re-engagement and support.
- Walk-in access, telehealth, rapid restarts, and individualized follow-up.
- Accessible and coordinated.

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

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What Open-Access Clinic Models Address

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

Current Barriers to Access		Open-Access Clinic Model
Appointment required before treatment begins.	>	Same-day evaluation and treatment, with or without an appointment.
Counseling prerequisites before medication.	>	Medication can begin on day one.
Abstinence requirements as a condition of care.	>	Treatment continues while goals evolve and risk is reduced.

What Open-Access Clinic Models Address (Continued)

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

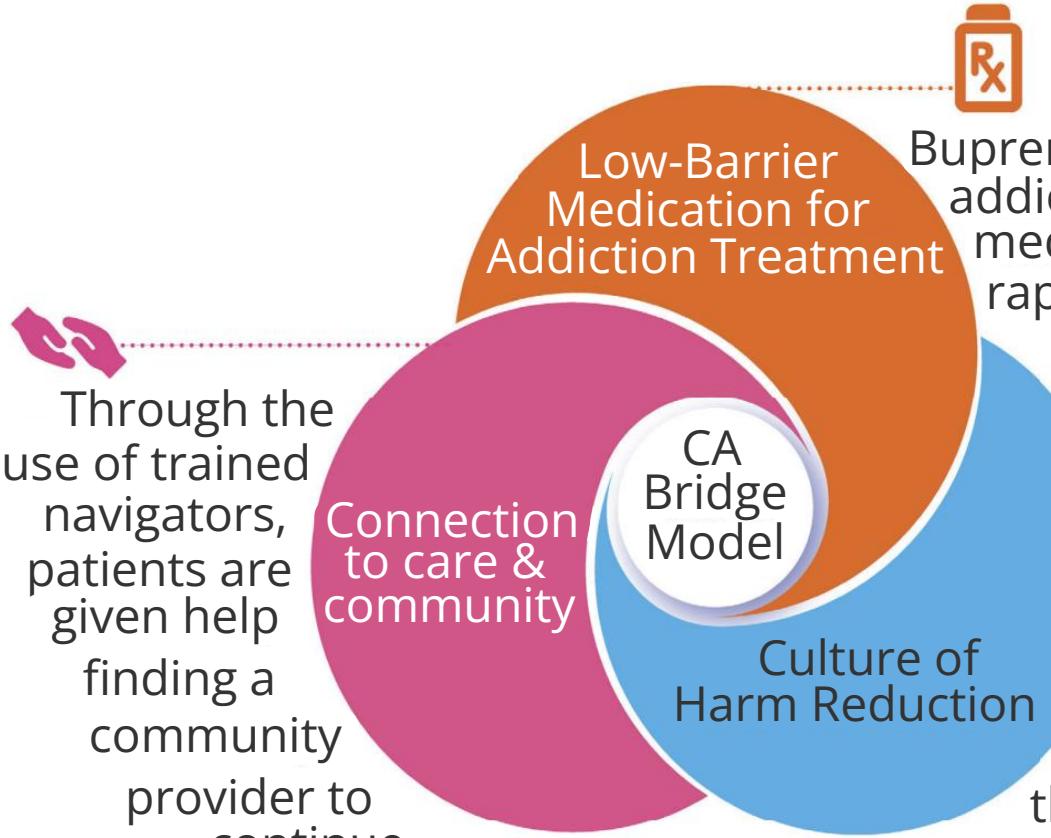
Navigator support and warm handoffs make the next step visible

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.

Core Components of the Model

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



Buprenorphine and other addiction treatment medications are made rapidly accessible without complicated restrictions or procedures.

Through the use of trained navigators, patients are given help finding a community provider to continue their care.

Hospitals move to reduce the stigma around substance use so that they become a trusted place to seek help.

DAY 1 ACCESS

Medication starts now

ENGAGEMENT

Trust before perfection

FLEXIBILITY

Walk-in + telehealth

RE-ENTRY

Easy to come back

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

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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.

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NAVIGATORS ARE THE KEY!

Images from CA Bridge Connect.

Navigator Role in Practice

This is often where referral becomes actual engagement.

Navigators

Turn referrals into engagement

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

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A Practical Workflow

The goal is a simple path to treatment.

1 Entry Point

Walk-in, referral, 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.

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A Practical Workflow (Continued)

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.

Same-Day Medication and Flexible Follow-Up

These 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.

How Telehealth Expands the Model

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.

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?

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.
- These terms refer to a scheduling model that allows patients to access care when they want and need it.
- Sufficient resources are set aside for same-day scheduling.
- Benefits include being patient-centric, reducing resources used for triaging and managing scheduling back logs, and decreasing no-shows.
- Challenges include resourcing dynamically with providers and support staff and overcoming the generally non-dynamic nature of space.
- Most primary care practices reserve a portion of the schedule for same-day scheduling and dynamically apply filters depending on availability of appointments (partial open-access).

Benefits of Open-Access in MAT and SUD

- Reduces access barrier to initiating treatment, increases 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.
- Component of the strategies to reach "the 95%."

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

Challenges and Barriers to Open-Access in MAT and SUD

General Barriers

- Stigma
- Fear
- Funding and billing for support staff (lack of value-based payment structure)

For Federally Qualified Health Centers (FQHCs)

- Productivity - negative impact to scheduling (no-shows, reserving capacity)
- Impact on access to other routine care
- Case finding
- Staff capacity to build in flexibility (for new patients and SUD capability)

Telehealth

- Engagement in telehealth

Regulations and Permanence

Ideas in Action

» Which types of organizations offer open-access (low-barrier/rapid access or on-demand MOUD treatment) in your county?

- 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

Spectrum of Open-Access Clinic Models

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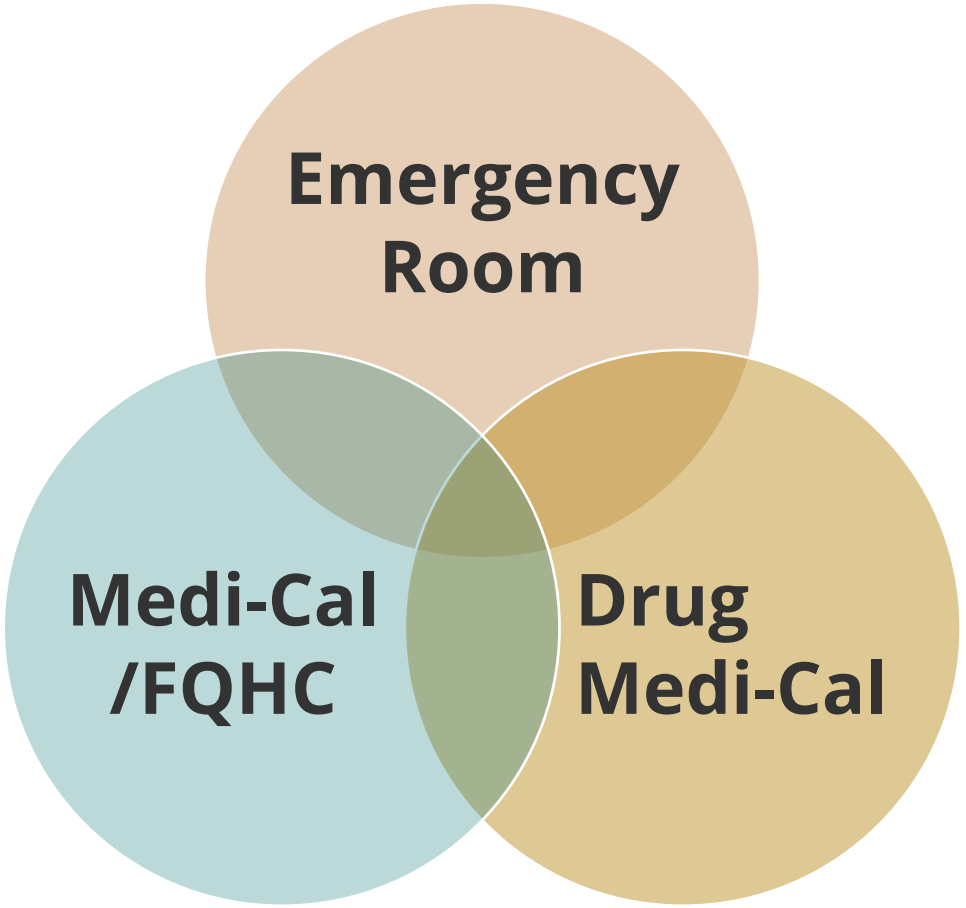
Expanding Access and Opening Doors

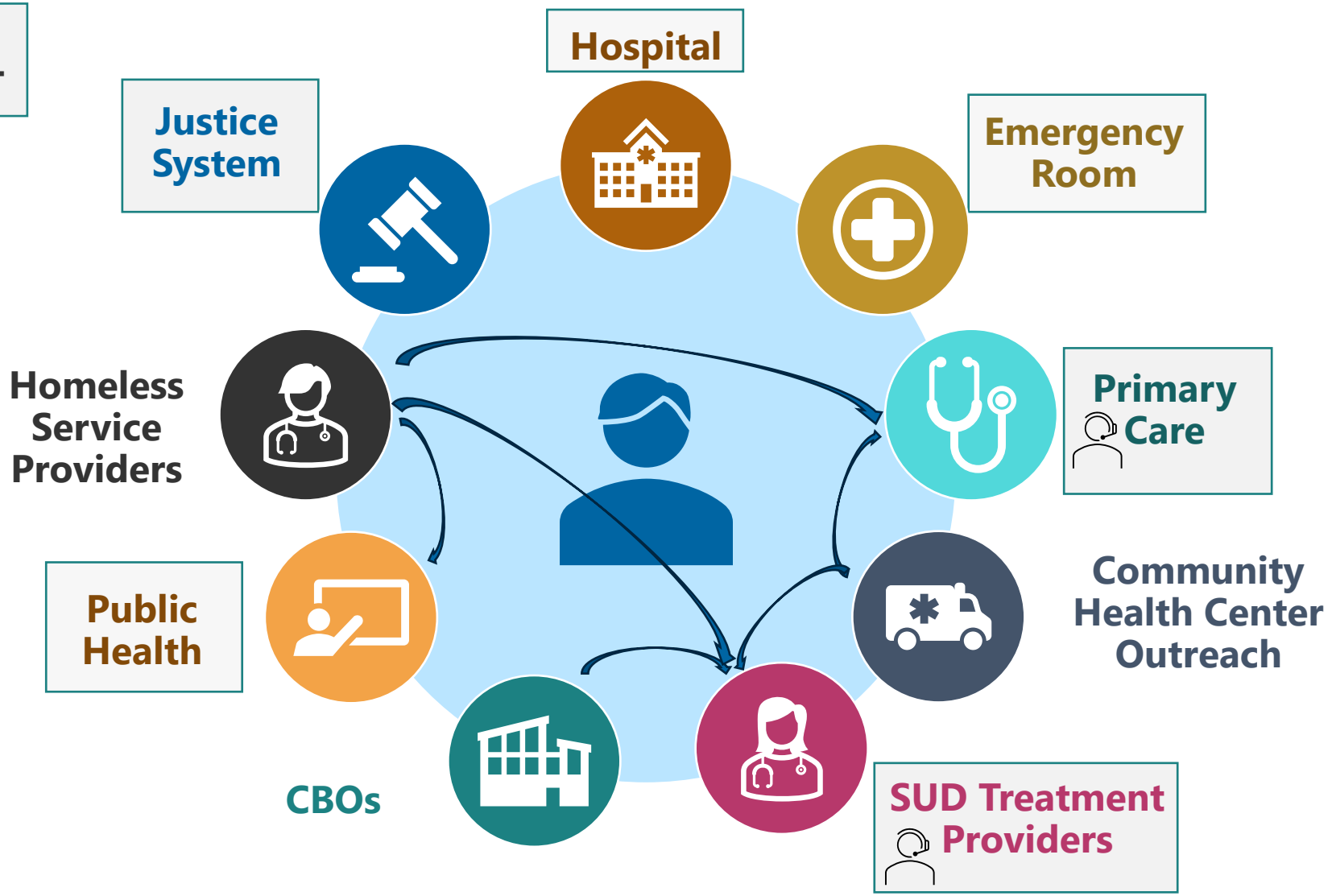
- Emergency Department = Same Day Low Threshold Access
- Drug Medi-Cal Organized Delivery System / Hub and Spoke
  - Opioid Treatment Program (Methadone)
  - Residential and Intensive Outpatient Programs
- FQHCs and Primary Care
- Activate real-time, crisis treatment ecosystem (CA Bridge Connect)



Entry to Care: Many Potential Doors

Potential initiators of MAT

Including telehealth



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Ideas in Action

» 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?

Metrics for Success

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What Success Looks Like

Access

Time from request to first treatment touch.

Starts

Medication initiations and rapid restarts.

Linkage

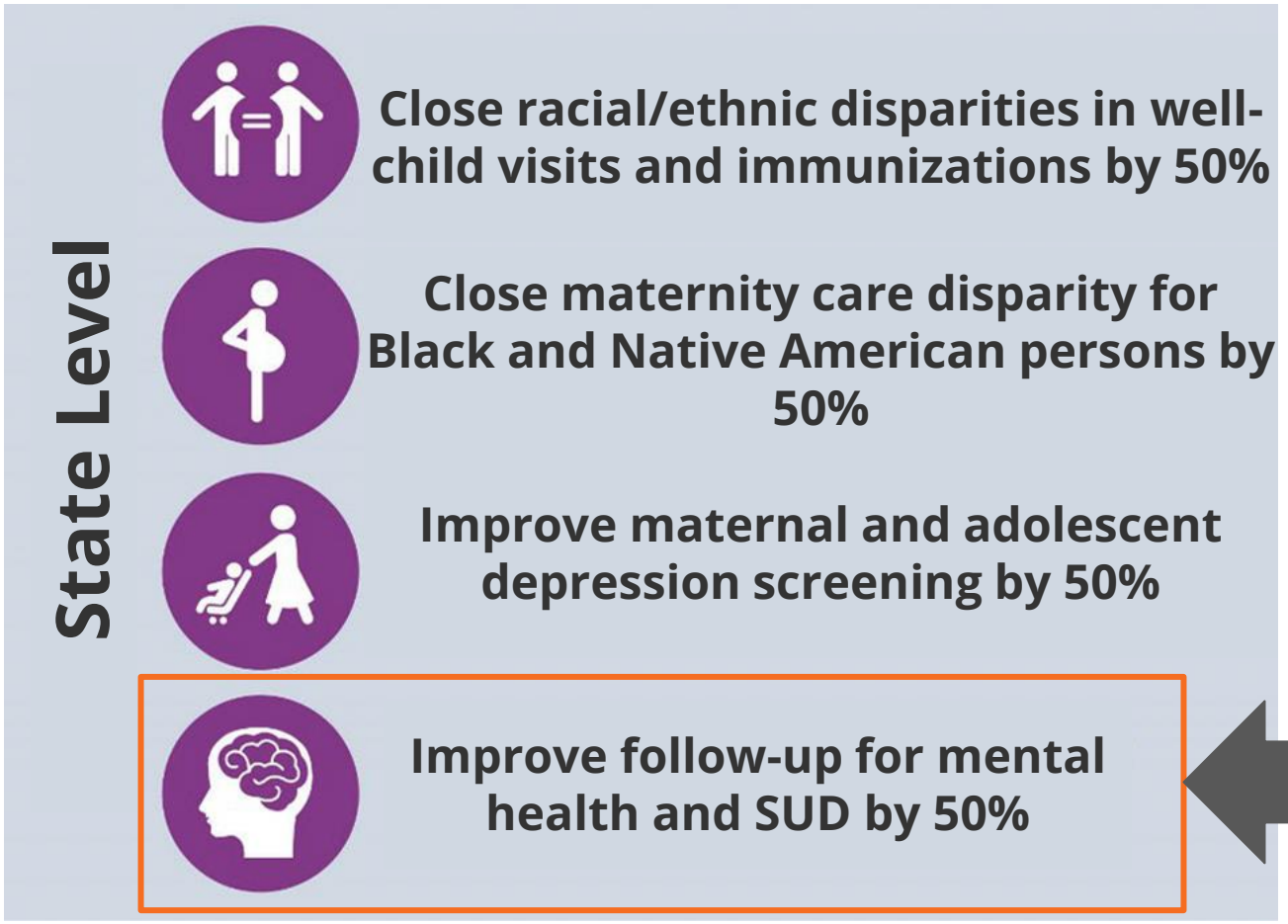
Show rate for the next care step.

Retention

Continued engagement at 7, 30, and 90 days.

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.

Follow Up After an ED Visit for SUD is a Top Goal for Medi-Cal



Plans have financial incentives to connect patients to SUD care after they leave the ED.

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

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HEDIS Measures for Substance Use Disorder

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

Opioid Use Disorder (POD)

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 a SUD/overdose diagnosis where the member received follow-up within 7 or 30 days. Now part of the Medi-Cal Managed Care Accountability Set (MCAS).

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

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 part of the **Medi-Cal Managed Care Accountability Set** for 2026 and 2027.
- DHCS sets **high and minimum performance benchmarks** and can impose penalties on plans that fall short.

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

FUA Statewide Performance: Medi-Cal Managed Care

30-DAY FOLLOW-UP

28.6%

Statewide Average

High Performance
32.4%

Min. 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.

What Is the IET HEDIS Measure?

IET — Initiation and Engagement of Substance Use Disorder Treatment.

Definition: The IET measure assesses the percentage of **adolescent and adult health plan members (ages ≥13 years)** 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	Why Two Rates?	Why It Matters
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.	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.	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.

California Falls Far Short on SUD Treatment Initiation

37%

of patients ≥13 years diagnosed with alcohol or drug dependence started treatment services within 14 days.

INITIATION RATE

13%

received treatment within 14 days AND at least two follow-up visits within 30 days.

ENGAGEMENT RATE

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

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The SUD Treatment Gap: What IET Tells Us

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

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.

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Ideas in Action

- 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?

Low-barrier care is an operational commitment to making treatment easier to begin.

Specific Strategies for Implementing Open-Access Clinic Models

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Implementation Roadmap

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

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.

Implementation Roadmap (Continued)

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.

Policy and Funding Levers

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.

Policy and Funding Levers (Continued)

These choices make the model more durable across organizations and contracts.

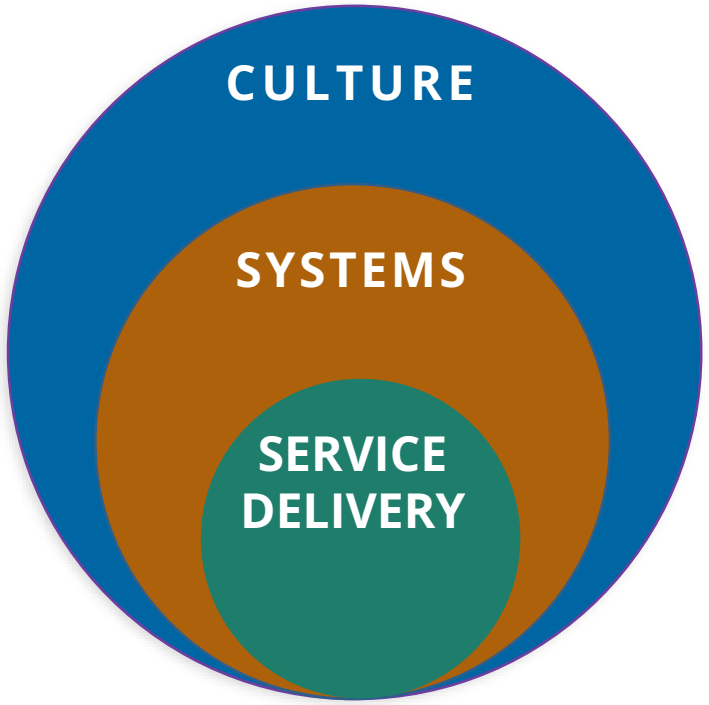
County Contracting

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.

Considerations to Implementation of Low-Barrier Care



Culture	Systems	Service Delivery
• Stigma • Primary care office mind-set • Waiting room culture concerns	• County BH carve out vs. managed care plans • CFR-42 privacy concerns • Community Health Worker and Enhanced Care Management Benefits	• Telehealth • Navigator support • Flexible scheduling templates

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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.

What is CA Bridge Connect?

California's hotline for same-day medications for addiction treatment (MAT), backed by CA Bridge's network of Behavioral Health Navigators and providers.

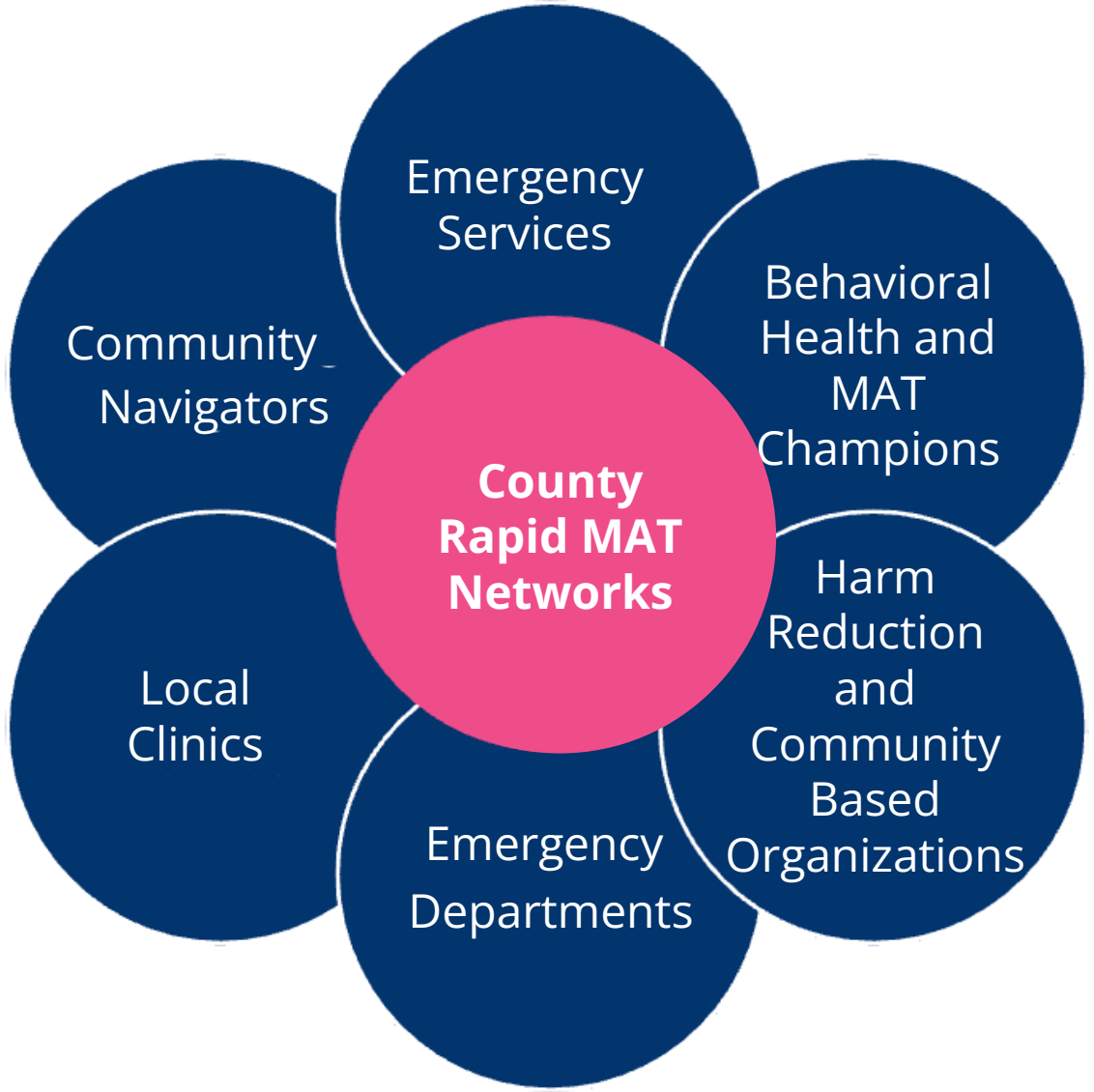
We can help people struggling with opioids like fentanyl to stop or reduce use.

CA Bridge Connect

www.cabridgeconnect.org

Every County, Every Connection – Our Networks are Ready

- CA Bridge is building Rapid MAT Networks across California to establish local SUD crisis response systems and support same-day access to treatment
- Our goal: 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.**



CA Bridge Connect

www.cabridgeconnect.org

Our Solution

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
- Peer support

Stay Connected

Navigators provide continued guidance to help callers remain engaged in treatment.

CA Bridge Connect

www.cabridgeconnect.org

Questions?

info@afbsstraining.org

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