Center for Addictions Triage and Treatment
A Feasibility Study

WASHINGTON COUNTY
OREGON
Department of Health and Human Services
Human Services Division

Program Development Work Group

November 5, 2020
10:30 a.m. - 12:00 p.m.
Zoom Meeting
Meeting #5

Facilitators: Walt Peck, Kristin Burke
Support Team: Aika Fallstrom, Kelly Cheney, Naomi Hunsaker

Participants: Dave Mowry, Dustin Sluman, Fidel Escalante, Greg Bledsoe, Hannah Studer, Jeremy Koehler, Kathy Prenevost, Lydia Cortez-Hickox, Sean Fields, Sheila Clark, Stacy Andoniadis, Steven Youngs, Tristan Sundsted

The PowerPoint served as the agenda

Welcome	Introductions. The collective work of this group is really helping to inform this project and make it better. We thank you!
Meeting Overview	a. Distinguishing programs from services b. Programs update i. Responding to PDWG feedback c. Defining key programs and services i. Let's get on the same page
Defining Programs and Services	Discussion: Definitions are on point
Core Services: "The Heart of the Program," should be included in the CATT from the outset	Discussion: Group agrees the update is on target.
Core Plus: very important, but if there are funding constraints, these are the next tier to be implemented	Discussion: • Feedback on the update prompted many thumbs up. • Target group for CATT is those who are receiving public funds (such as OHP (Medicaid)) but will not preclude those with commercial insurance. • CATT will serve as a central access point for any resident of Washington County that has needs related to SUD. • More discussion needed on whether CATT can be a truly viable alternative to incarceration.

Co-located and Integrated: may be run by other service providers, ideally on the CATT campus	Discussion: The update received a thumbs up from all
Community/County Partner-Provided: intentional relationships to remove barriers to access services and address more of the social determinates of health	Discussion: • List is not exhaustive, but this is where we would start. • How do we get historically underserved people to come in and use these services? Outreach and engagement to various groups. Peers at every level. Have staff look like community. We are holding focus groups now and asking this question and will circle back to these groups in the project development stage. Lots more work to come on this topic.
Terminology:	**The group agreed it was important to develop commonly agreed to terminology, particularly as it applies to CATT programs and services. Time constraints resulted in some terms not being addressed. A follow-up email will be sent to the group to encourage further interaction and suggestions.** **Detox (Withdrawal Management)** Discussion: the word Detox can be intimidating and has a bad connotation, especially with clients with lived experience. Align with SAMHSA definition. Withdrawal Management is a better phrase. **Residential** There was no discussion. The group agrees with the provided definition. **Medication Assisted Treatment (MAT)** Discussion: consider including reference to Harm Reduction. It is important to lead with most trauma informed language, so Medication Supported Recovery is better. ASAM (American Society of Addiction Medicine www.asam.org) and CareOregon (www.careoregon.org) use **Medication for Addiction Treatment.** We would need medication services on off-hours (such as evenings and weekends). **Outpatient Stabilization** Discussion: (Jail interface) This would be a great service to link people to, who have detoxed in the jail and want to stay sober. Immediate access is the key to avoiding relapse. Sheila will ask about data (abscond rates).

	(Hospital ED) Here again, it would be great to have rapid access (same day) to care. The success rate is very high if someone gets help within 24 hours after hospital care. How will we track outcomes? **Sobering/Alcohol & Opioids** Services listed here received a thumbs up. **Crisis Stabilization (Meth Sobering {and other stimulants})** Discussion: YES, very excited to see this on the list as it is very needed in our community. Officers need to be able to bring in people who need this. Having two separate spaces is critical (Detox AND Meth Sobering). This space will suitable and safe for the physical challenges posed by agitated clients. After meeting with Hooper, we learned that this space needs to be trauma informed. What is a better -- more trauma informed – name for this space? Maybe drop "crisis" and just use "stabilization" then combine with Respite bullet points. **Respite** Discussion: Needs another name that aligns the program with community needs. Maybe combine the stabilization slide with the respite slide? The bullets on this slide is what stabilization means and is a friendlier word than inpatient treatment. What is a name that is trauma informed and engaging to those that will access these services? CONTINUED DISCUSSION: Do we need a group of beds that are flexible? Yes, but will need a matrix to help prioritize if we have more people than beds. Resource Allocation: will need to know who has beds in the community that we could shift people to (CATT is immediate need and Service Providers are the next level). Admission Criteria: it will be very important to define and develop criteria about bed use, otherwise ED and Jail will send a lot of people to CATT. Measure 110 impacts – it makes sense to fold this into the Feasibility Study. Will discuss more in future meetings.

WHAT'S NEXT?

a. Meeting #6: December 3 (Zoom Meeting)
   1.) 10:30 a.m. to 12:00 p.m.
   2.) Topics: Size and Scale
b. Meeting #7: January 7 (Zoom Meeting)
   1.) 10:30 a.m. to 12:00 p.m.
   2.) Topics: Facility Features