Fentanyl Summit #2 Report

Theme: Culturally Specific and Linguistically Specific Care

10.01.2024 || 8:30am - 1:00pm

The Avenue: 631 NE Grand Avenue

Portland, OR

Hosted by the

Multnomah County Health Department

Multnomah County
Health Department

Executive Summary

On March 13, 2024, more than 150 community members, government staff, and clinicians gathered for a Fentanyl Summit hosted by the Multnomah County Health Department (MCHD) at the request of the 90-Day Fentanyl Emergency Unified Command. The Summit convened partners for a facilitated dialogue about how to address the fentanyl crisis and to develop recommendations to inform work during and after the emergency declaration. Group discussions identified gaps in the community, approaches to addressing these gaps, and the resources needed to make those approaches successful.

A clear call for additional similar convenings was made by many participants, with a request for a focus on culturally and linguistically specific services rising to the top of suggested themes. In response to this call, the Multnomah County Health Department provided logistical support and facilitation for a group of leaders from local community organizations to plan a subsequent summit in response to recommendations and requests from participants from the first summit. The planning team took to heart feedback from the first session—fewer speakers and more focus on folks providing direct services, longer sessions at tables and a less frantic pace, culturally specific leadership and organizations —and wove it throughout their collaborative planning.

The culmination of this work was that on October 1, 2024, more than 200 community members—people with lived and living experience with substance use, peer specialists, treatment providers, local and state public health, law enforcement, and representatives from local government—gathered for a second Fentanyl Summit hosted by the Multnomah County Health Department. Based on feedback from the first Summit the second focused on strengths and gaps in local culturally and linguistically specific services. Leadership from both Multnomah County Public Health and Health Share of Oregon provided updated data and an overview of trends in overdose and other health impacts of substance use in Multnomah County to ground the discussion and build upon earlier good work. The event centered around three separate panel discussions focused on culturally specific services, community-specific services, and updates on the Coordinated Care Pathway Center (Deflection Center). These panels' facilitators and expert panelists were community members and service providers, either from or caring for communities disproportionately impacted by substance use. Attendees then participated in group breakout sessions on issues related to fentanyl use from prevention through treatment. Panelist suggestions and participant discussions resulted in a list of twelve recommendations.

RECOMMENDATIONS

Overall, there were hundreds of concerns and ideas discussed and considered by partners in the sessions. Their invaluable expertise identified critical needs in an effort to shape the broader response to this work. No single organization or governmental agency can achieve all of these recommendations alone—we all share a role in actualizing them. Some recommendations that rose to the top of the discussions included:

1. **Increase representation** of communities served at all levels of Substance Use Disorder (SUD) work: policy and program development, funding, and administration and leadership. Ensure people in positions of power are grounded in the work.
2. **Focus on data equity** to enhance equitable investment and resource allocation.
3. **Lift up smaller organizations more intentionally, explicitly**. Improve accessibility of funding streams by design, including increased technical assistance.
4. **Center work on connection**: Break down silos between services and service-providers, strengthen peer services and networks, find opportunities to build-up communities and reduce isolation.
5. **Improve health education** and health literacy not just of youth, but of families and communities regarding the causes and mitigating factors for substance use and overdose. Consider the appropriate messages, mediums, and messengers.
6. **Continue work to decolonize structures, processes, and funding** to reduce the drivers of substance use and the obstacles to addressing it successfully.
7. **Ensure access to prevention measures**. Make sure that current tertiary (downstream) prevention measures, such as Narcan (naloxone), are reaching those who need it the most.
8. **Convene ongoing meetings** to highlight existing service excellence, address emergent concerns, and further advance this work.
9. **Incorporate community wisdom**, and especially people with lived and living experience, into discussions, policy decisions, and recommendations.
10. **Improve clinical, outreach, and behavioral health workforce recruitment**, development, and retention, especially for culturally specific care.
11. **Streamline single access points** for connecting communities with substance use services ("no wrong door" approach).
12. **Remove barriers for outreach services,** both improved policy barriers for labor and safety and logistical barriers in coordinating agency collaboration.

These recommendations are intended to reflect key priorities identified by many of the participants, and especially emphasize the perspectives of those providing culturally specific care and those with lived and living experience.

We are focused on a collective reimagining of efforts to combat this crisis, including challenging dominant norms, shifting outcomes, and creating lasting change.

Participant Organizations (listed alphabetically)

1. Alcohol and Drug Policy Commission (ADPC)
2. Boulder Care
3. Bridges to Change
4. Caminos Diferentes
5. CareOregon
6. Central City Concern (CCC) including Puentes Program, Imani Center, and Karibu Stabilization Program
7. City of Portland - City Shelter Services Team
8. Clackamas County - including Public Health
9. Comagine Health
10. Community Living Above
11. Confederated Tribes of Grand Ronde
12. Ecumenical Ministries of Oregon - including HIV Day Center, Slavic Oregon Social Services, SOAR Immigration Legal Services
13. Going Home 2
14. Great Circle Recovery
15. Harmony Academy
16. Health Share of Oregon
17. Impact NW
18. Iron Tribe Network
19. Juntos NW
20. Latino Network
21. Legacy Medical Group - including Project Nurture
22. LifeWorks NW - including Project Network Site
23. Lines for Life
24. Mental Health & Addiction Association of Oregon (MHAAO)
25. Multnomah County Chair Jessica Vega Pederson's Office
26. Multnomah County, District 3 - Commissioner Julia Brim-Edwards's Office
27. Multnomah County Health Department
28. Multnomah County Library
29. Multnomah County and City of Portland Joint Office of Homeless Services (JOHS)
30. Multnomah County Health Department Office of Consumer Engagement
31. Multnomah Education Service District (MESD)
32. Multnomah Friends Meeting (Quaker)
33. Native American Rehabilitation Association (NARA) NW
34. Native Wellness Institute/Future Generations Collaborative
35. Native American Youth and Family Center (NAYA)
36. New Narrative
37. Oregon Department of Human Services - Child Welfare Division
38. Oregon Chinese Coalition (OCC)
39. Oregon Health Authority - including Public Health Division
40. Oregon Latino Health Coalition

Participant Organizations cont'd. (listed alphabetically)

41. Painted Horse Recovery
42. Portland All Nations Canoe Family
43. Portland Fire & Rescue's Community Health Assess and Treat (CHAT) Team
44. Portland Police Bureau
45. Portland Public Schools
46. Portland Street Response
47. Project Red
48. Quest Center for Integrative Health
49. Recovery Works NW
50. Safe Families for Children
51. Song for Charlie
52. Sunstone Way
53. The Everly Project
54. The Faith Center
55. The Highland Haven
56. Transcending Hope
57. Trillium Community Health Plan
58. U.S. Pretrial Services
59. U.S. Probation Office
60. UNIDOS
61. Upstream Public Health
62. Urban Alchemy
63. Volunteers of America Oregon
64. Washington County - including Public Health
65. Zion Lutheran Church

Format and Agenda

This event was planned with intentional incorporation of feedback from the March 13, 2024 Fentanyl Summit, with specific attention to the following requests from participants:

- Fewer speakers and more focus on folks providing direct services.
- More time for large/small group discussion, longer sessions at tables, less frenetic pace.
- More streamlined processes around organizing discussion tables, explaining/encouraging voting (nonverbal input) on things.
- Offers for collection of new data/information, potentially more meaningful data.
- Space for other culturally specific leadership and organizations, maybe a culturally specific summit.

FORMAT

Event organizers approached the format and content of the event from the understanding that no one individual or organization has all of the answers; but that by convening, codiscovering, and collaborating we can bring a greater sense of equity to our discussions.

The agenda for the second summit was intentionally structured to focus on dialogue and wisdom-sharing from leaders living in and serving the communities experiencing the greatest inequities from fentanyl use and overdose, with a majority of time spent hearing from subject matter expert panelists. Real-time storyboarding was provided by Fry from Drawbridge Innovations as visual representations of the wisdom shared.

Small groups met during lunch to discuss specific areas of focus related to addressing the fentanyl crisis locally. A facilitator and notetaker gave each group the tools and grounding needed to encourage conversation and capture ideas. This report synthesizes those notes, along with feedback provided during and after the event.

"The culturally specific providers panel was absolutely golden. I'm going to carry that information with me and use their feedback to inform my work." ~ Summit Participant

LOCATION

The Avenue in NE Portland provided a centrally-located, Americans with Disabilities Act (ADA)-accessible event space for the summit, with ready access by streetcar and bus and several parking options. Breakfast, coffee, water, and lunch were provided, and included gluten-free, allergy-friendly, vegetarian, and vegan options—in attempt to meet registrants' requests. Live Spanish interpretation was available via provided headsets, and emotional support was available on-site in a private space for anyone in need. Breastfeeding/chestfeeding space with a refrigerator was also available, and honoraria were provided to external partners who performed.

Goals

1. Gain insights, learn from, and network with substance use disorder (SUD) providers, community-based organizations, people with lived/living experience, government staff, law enforcement, health insurance payers, hospital and health systems, schools, and youth service providers.
2. Learn about programs and initiatives happening at the state and local level to better align systems, coordinate funding, and share data to address SUD on the ground.
3. Learn about what data are collected, how data are used, how data are trending, and how results are shared.
4. Hear direct feedback from a panel of culturally specific community providers who work with people with SUD around their experience, access barriers, and ways to improve policy efforts.
5. Participate in forward-thinking conversations with peers, including opportunities for structured idea exchange on topics around prevention, harm reduction, treatment, and recovery.
6. Plan for future opportunities for connection and collaboration.

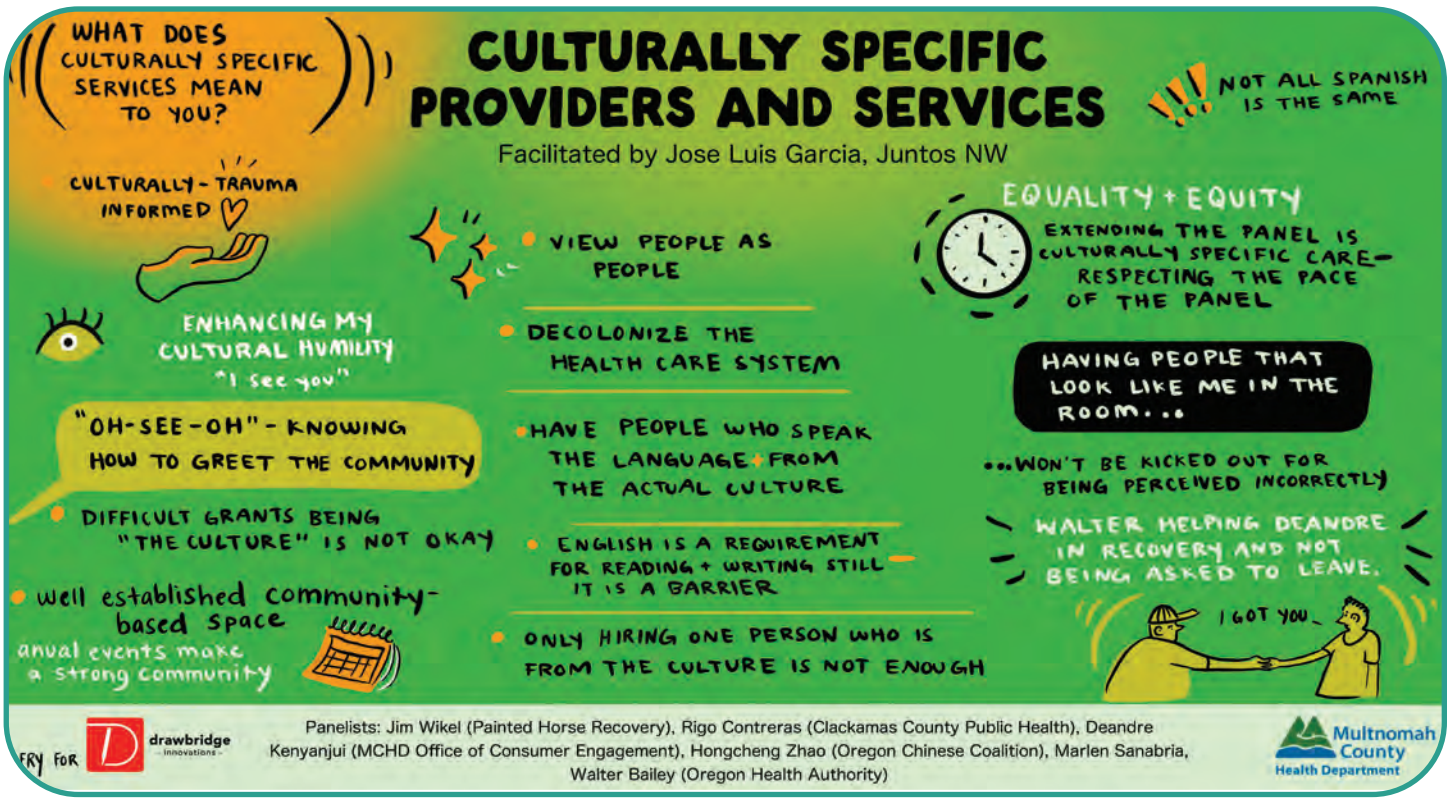
"Events like this bring our voices and challenges to the forefront."
~ Summit Participant

AGENDA

- Centering, welcome, introductions, background
  - » Breakfast, networking, Peruvian harp music performed by Antonio Centurion
  - » Song of welcome and centering, moment of remembrance for those we've lost by Irvin Wilson, Tashina Stahi, and Emanuel Darcel from Painted Horse Recovery
  - » Welcome, appreciations, level-setting, logistics from Dr. Richard Bruno, Health Officer, Multnomah County Health Department
  - » Updated Fentanyl-related Overdose Trends in Multnomah County, Dr. Emily Mosites, Multnomah County Health Department
  - » Speaker #1: Welcome, context of culturally specific care, CCC's Culturally Specific Programs: Albert Parramon, Central City Concern
  - » Speaker #2: A Perfect Storm: Health Share's Ecosystem Data Analysis: Dr. Cat Livingston, Health Share of Oregon
  - » Speaker #3: OHA Update: Opioid Settlement Investments: Lisa Shields and Annaliese Dolph, Oregon Health Authority
- Facilitated Subject Matter Expert Panel Discussions
  - » Panel 1: Culturally Specific Providers
    Facilitator: Jose Luis Garcia (Juntos NW)

    Panelists (listed as seated left to right in photo below):
    - ◊ Jim Wikel (Painted Horse Recovery)
    - ◊ Rigo Contreras (Clackamas County Public Health Department)
    - ◊ Deandre Kenyanjui (MCHD Office of Consumer Engagement)
    - ◊ Hongcheng Zhao (Oregon Chinese Coalition)
    - ◊ Marlen Sanabria, Latina woman in recovery
    - ◊ Walter Bailey (Oregon Health Authority)

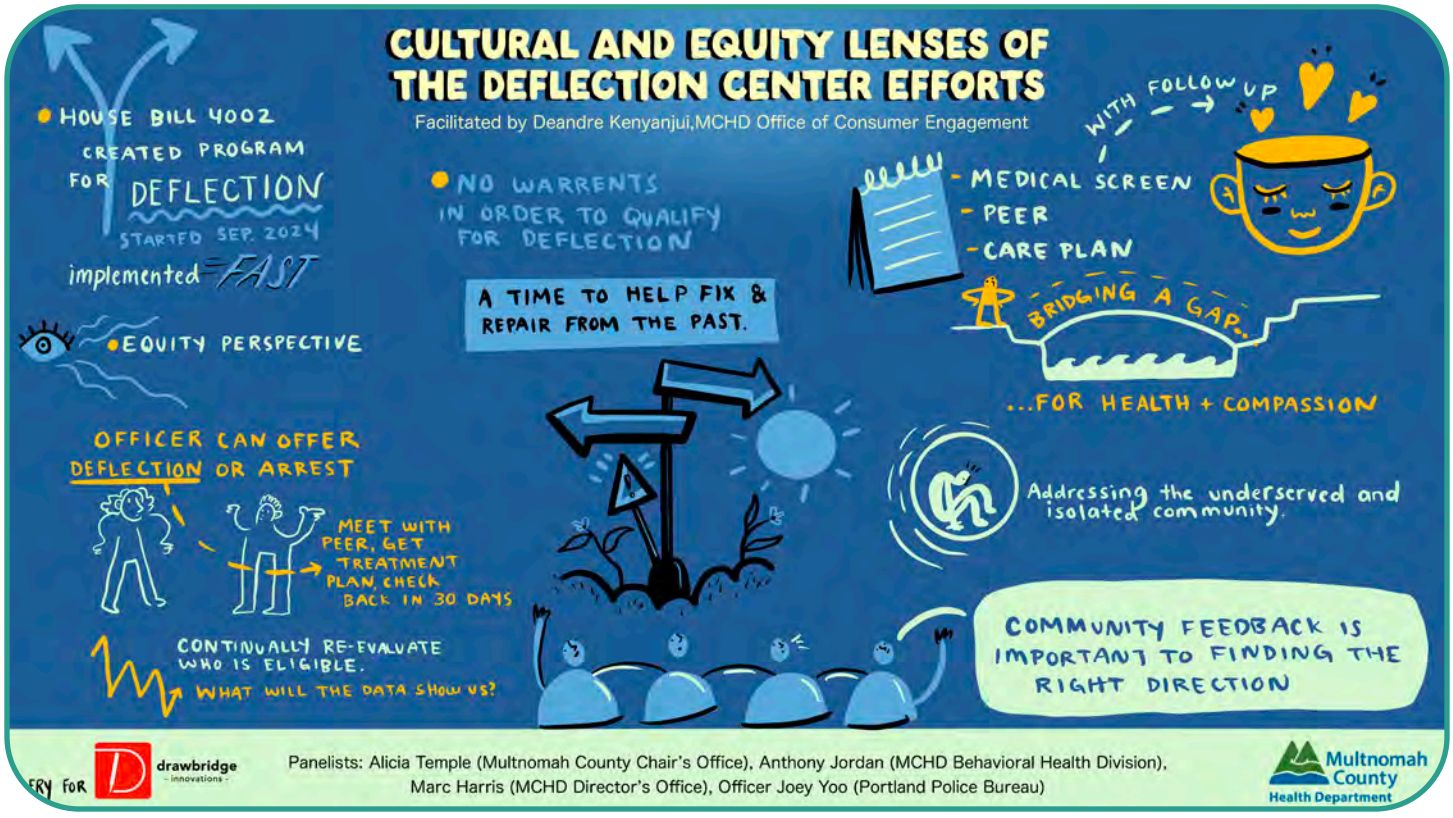
Drawbridge Innovations Storyboarding: Culturally Specific Providers Panel



- Facilitated Subject Matter Expert Panel Discussions
  - » Panel 2: Deflection Center Updates, discussion of cultural and equity lenses applied to that work
    Facilitator: Deandre Kenyanjui (MCHD Office of Community Engagement)

    Panelists (listed as seated left to right in photo below):
    - ◊ Alicia Temple (Multnomah County Chair's Office)
    - ◊ Anthony Jordan (MCHD Behavioral Health)
    - ◊ Marc Harris (MCHD Director's Office)
    - ◊ Officer Joey Yoo (Portland Police Bureau)

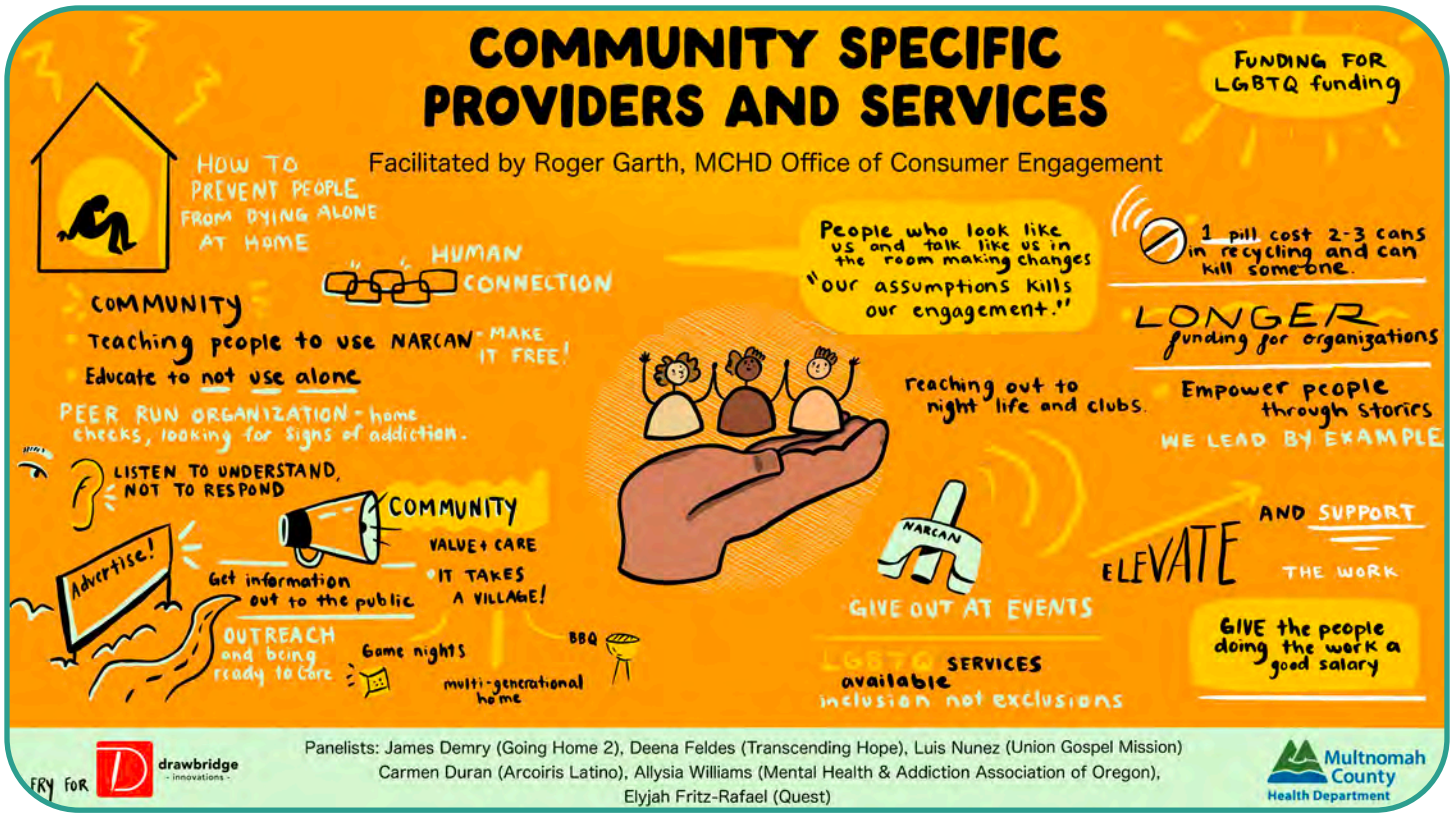
Drawbridge Innovations Storyboarding: Deflection Center Updates Panel



- Facilitated Subject Matter Expert Panel Discussions
  - » Panel 3: Community Specific Providers
    Facilitator: Roger Garth (MCHD Office of Community Engagement)

    Panelists (listed as seated left to right in photo below with Roger Garth standing):
    - ◊ James Demry (Going Home 2)
    - ◊ Deena Feldes (Transcending Hope)
    - ◊ Carmen Duran (Arcoiris Latino)
    - ◊ Allysia Williams (Mental Health & Addiction Association of Oregon)
    - ◊ Elyjah Fritz-Rafael (Quest)

Drawbridge Innovations Storyboarding: Community Specific Providers Panel



- Lunch, Tabling, Networking, Facilitated Small Group Breakouts
- Small Group Breakouts (topic details in next section below)
- Organizations Tabling:
  - Multnomah County Health Department Naloxone Distribution Specialist (free naloxone and instruction provided)
  - Central City Concern
  - Mental Health & Addition Association of Oregon (MHAAO)
- Closing Remarks, Dr. Bruno

Small group discussions

For each of the 10 small group discussion topics facilitators had prompts to begin and encourage conversation, but discussion was not limited to these prompts.

Small Group Breakout Topics:

- Outreach
- Prevention
- Harm Reduction
- Treatment
- Reversals
- Recovery
- Supportive Housing
- Justice System Involved
- Deflection Process
- Data

The following are highlights from those discussions and common themes that emerged across small groups, but do not capture the entire range of information, experiences, and emotions shared during these discussions.

- Primary prevention (prevention of first use) efforts should continue to be focused on early childhood and support of social-emotional learning.
- Prevention work should be responsive to how children and youth receive information, including use of relevant social media and apps, and should be transparent and straight-talk.
- Prevention work must include outside-of-the-box thinking, such as:
  - Using sports and other activities to teach coping mechanisms and build resilience.
  - Consideration of non-Western/capitalist models of learning.
  - Support and education of people who support and educate children and youth—including families, elders, and other trusted community members.
  - Support of communities, building community resilience.
  - De-isolation strategies, building connection and community cohesion.
- Stigma still prevents proportional responses to the overdose epidemic compared to things like COVID.
  - Funding needs to be realistic for programs to achieve goals, and needs to include smaller organizations and non-Western traditional models.
- There is a need for more recovery-oriented places welcoming to people who are not abstinent, either because they are in a contemplative stage or because that is not their recovery goal.
- Building trusting relationships and continuity with service providers is key—sweeps of encampments interrupt connections with outreach workers.
- Transportation is a major barrier to accessing services.
- "Harm Reduction" can be a loaded term in recovery communities—more education is needed to increase understanding, broaden definitions of recovery, and recognize we are all working toward the same things.

- It is important to bring services into a community—meeting people where they're at both literally and figuratively.
- Faster, smoother, stronger connection to treatment and supportive resources for people who are ready.
- Intersectional treatment, ideally in a single setting—recognition that a substance use disorder often coexists with other factors and conditions that need to be addressed not just concurrently, but ideally by someone/some place that understands how those factors are interwoven and is trained in the unique approaches required to address that.
  - » Specific examples of houselessness and SUD—unhoused individuals are asked to give up more when they enter treatment (kids, pets, etc).
- Ongoing/more focus on the importance of lived experience in recovery staff and spaces.
- We need a focus not just on more workforce—prescribers and counselors—but on more culturally specific services as well.
- Importance of understanding our data—not overgeneralizing REAL-D categories and missing important details, such as populations categorized as "white" or "black" that need tailored services (for example: Slavic communities, Somali and other African immigrant communities).
- More support for nontraditional spaces where people receive treatment for Substance Use Disorders (for example: churches and community centers)
- There is a need for outreach focused on specific communities to increase access to naloxone.
- Peer-to-peer support with incentives (for example: referral rewards) is impactful.
- Include naloxone distribution with education at free, open, community events.
- Naloxone boxes or vending machines with naloxone and other supplies would help increase access and reduce barriers.

- It would be helpful for people to have a place to go and recover after experiencing an overdose.
- Additional staff are needed in harm reduction programs/agencies to increase services.
- Recovery services are not one-size fits all, and there are a number of gaps in existing services including youth, women, parents/caregivers in addition to the need for more culturally and linguistically-specific services.
- Approaches to recovery need to be more holistic and not just focused on the Substance Use Disorder. Substance use does not occur in a vacuum and is often intersectional with things like housing instability, mental health, and/or physical health diagnoses.
- Existing school policies such as zero-tolerance are rigid and may underscore existing inequities.
- Transitions from inpatient to outpatient care for SUD could be more streamlined and holistic, including ensuring stable housing to optimize success.
- Workforce turnover impairs the quantity and quality of recovery services available in our communities.
- Stable housing is fundamental for recovery—sustainable and long-term, not just temporary.
- Measure 110 funding is a resource for housing, including staffing and extended services.
- Data is power, so hoarding data is hoarding power.
- Strength in culture is not reflected in current data stories.

Observations, feedback, and reflections

SELECTED QUOTES FROM PARTICIPANTS

- Excellent forum and format.
- The panelists were really good.
- I'm grateful to you all for holding the space.
- I've enjoyed learning about different agencies.
- It was incredibly insightful to hear [lived experiences] along with the data.
- It was very informative, the panels were well-done.
- The culturally specific providers panel was absolutely golden. I'm going to carry that information with me and use their feedback to inform my work.
- It is incredibly important to continue being in spaces with other culturally specific providers. Events like this also bring our voices and challenges to the forefront. Platforms like this one allow me to elevate my voice, especially when key stakeholders are present and willing to listen.
- What's next?

SUMMIT STRENGTHS IDENTIFIED BY PARTICIPANTS

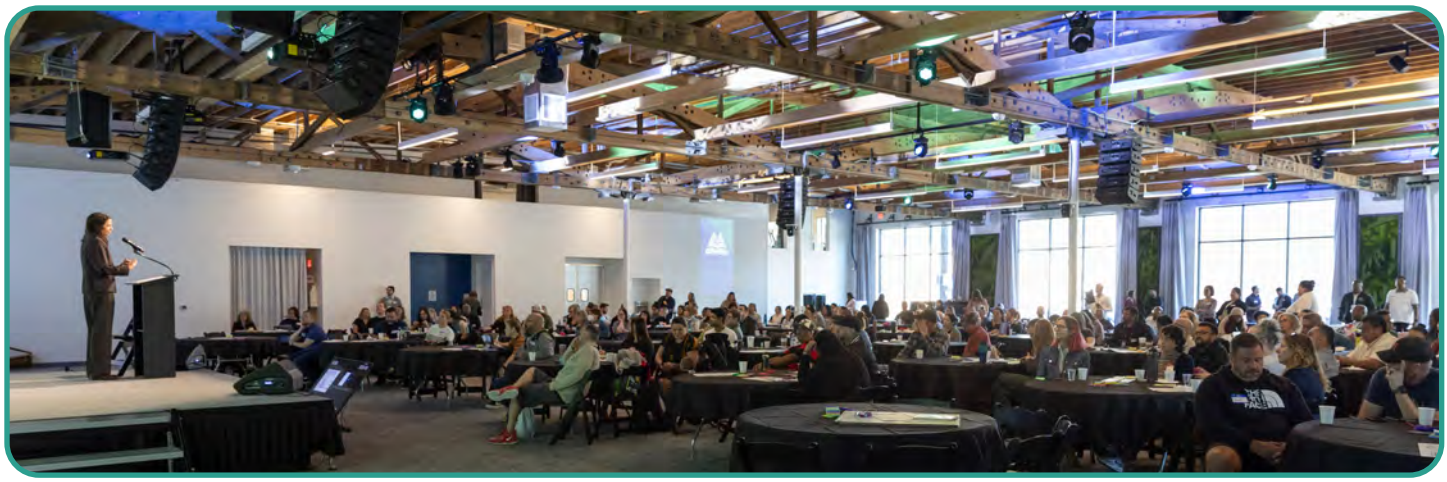
- The focus on panels of experts was appreciated—panels of people with lived/living experience with substance use and/or professionals working for and leading organizations committed to serving people who use drugs.
- The venue had good sound, light, and A/V capabilities.
- Summit facilitators were flexible to the needs of the audience and speakers— extending time with panelists when needed.

SUMMIT OPPORTUNITIES IDENTIFIED BY PARTICIPANTS

- More time for attendees to ask questions of panels.
- Not enough representation from black/African American community.
- More Native representation.
- Parking could have been easier/clearer.
- More culturally specific food options.
- There was live translation for speakers and panels, but not for small groups.

ADDITIONAL REFLECTIONS FROM THE PLANNING TEAM

- Folks had a lot to say, they were glad to have an opportunity to participate.
- There was skepticism around actions resulting from the Summit.
- There was a yearning for more conversation.
- Some people were nervous to share due to law enforcement being in the room. They didn't want to be called out as individuals.
- Some people expressed frustration with the focus of the data gathered, and the focus on data in general. Some people do not trust data.
- The trust level went up in the end.



Post-Summit commitments to action from participants

- Expand my knowledge about how to treat a person under the influence of fentanyl.
- Continue to honor the hard work of grassroots BIPOC organizations and refer to them as much as possible.
- Learn more and educate the community.
- Gain more understanding of data equity and commit to supporting data equity.
- Carry Narcan at my home.
- Continue to attend places where I can advocate for change.
- Bring more intentionality of cultural specificity to my programs/initiatives/projects/work.
- Promote translation validation and the willingness of the community and [encourage] partners to participate in translation validation.

Post-Summit commitments to action from the Multnomah County Health Department

In response to recommendations (bolded) from the first Summit earlier this year, the Multnomah County Health Department took the following actions:

- **Communication and connection are important, but not enough.**
  - » MCHD has launched a public dashboard of opioid overdose data.
  - » MCHD has hosted multiple press conferences, community events (through the Community Partnerships and Capacity Building team), and attended Tribal opioid and fentanyl summits.
- **We can't arrest or Narcan our way out of this crisis.**
  - » MCHD has released their Opioid Prevention & Response Plan, a department-wide approach that focuses on all aspects of this work, from focusing on healthy families and communities to reduce substance use, to harm reduction services for those in the midst of their use, to treatment and recovery supports for people ready for those steps.
  - » New positions filled or in the hiring process (project managers and preventionists in the Behavioral Health and Public Health divisions).

- **We need a single, up-to-date database of services.**
  - Behavioral Health division and the PATH team have a list of services and referrals to internal and external partners.
  - Continue refining feedback loop for clients coming through the Coordinated Care Pathway Center to follow up on referrals for substance use services.
  - Street Roots' Rose City Resource Guide updates every 6 months.
  - MCHD has referred people to many partners listed on www.recoverynetworkoforegon.org.
- **We should continue to map available services.**
  - Recovery Network of Oregon is a mapped directory of support services, providers, peers, and meetings designed to assist people with their recovery from drugs and alcohol.
  - A new mobile van collaborative among 18 mobile van operators is mapping their locations, services, and appointment availability to help expand access to substance use treatment.
- **More culturally and linguistically specific services are needed.**
  - MCHD proposed a spotlight and microscope on these services for the second Summit—highlighting current successes from various organizations and identifying/elevating service gaps.
- **More access to care and facilities are needed across the spectrum.**
  - MCHD is expanding access to Medications for Opioid Use Disorder (MOUD) in its primary care clinics and Corrections Health jails.
- **More people with lived and living experience leading the work.**
  - The planning committee for this second Summit was intentionally composed of leaders from community-based organizations in this work, many with lived experience (see Appreciations section).
- **Increased funding and workforce is needed for this work.**
  - MCHD leadership has further developed relationships with both Portland State University and OHSU to streamline opportunities for learners interested in our work, and have participated in events that encourage high school students to consider careers in healthcare and/or public health.
- **More spaces to connect, collaborate, and coordinate services.**
  - MCHD committed to facilitating future Summits to provide that invaluable space.

In response to feedback and recommendations from this second Summit, the Multnomah County Health Department further commits to:

1. **Increase representation** of communities served at all levels of SUD work, including:
   - A commitment to continuing internal recruitment, hiring, and leadership development practices that achieve this.
2. **Focus on data equity.**
   - MCHD's Community Epidemiology Services team is working on launching a public dashboard on public health indicators mapped out in our region.
   - MCHD's Community Partnerships and Capacity Building teams work closely with impacted community groups, especially those disproportionately impacted by fentanyl overdoses to partner on data collection and analysis.
   - MCHD staff attended the Data Sovereignty Gala hosted by the Northwest Portland Area Indian Health Board.
3. **Lift up smaller organizations more intentionally, explicitly, including more technical assistance for grant writing.**
4. **Center work on connection:** Break down silos between services and service-providers; strengthen peer services and networks; find opportunities to build up communities and reduce isolation.
5. **Improve health education** and health literacy not just of youth, but of families and communities regarding the causes and mitigating factors for substance use and overdose. Consider appropriate message, medium, and messenger.

6. **Continue work to decolonize structures, processes, and funding.**
    - » Leadership of the Public Health and Health Officer divisions will continue work with the Indigenous Health Equity Institute on mechanisms for decolonizing our work and the systems and structures in which we work.
7. **Ensure access to prevention measures.** Make sure that current tertiary (downstream) prevention measures, such as Narcan (naloxone), are reaching those who need it the most.
    - » MCHD has committed to a naloxone distribution plan that prioritizes the marginalized, minoritized, and historically-underserved individuals and communities who need it most.
8. **Convene ongoing meetings** to highlight existing service excellence, address emergent concerns, and further advance this work.
    - » MCHD commits to subsequent summits with administrative and financial support.
9. **Incorporate community wisdom**, and especially people with lived and living experience, into discussions, policy decisions, and recommendations.
10. Improve clinical, outreach, and behavioral health **workforce recruitment**, development, and retention, especially for culturally specific care.
11. **Streamline single access points** for connecting communities with substance use services ("no wrong door" approach).
12. **Remove barriers** for outreach services, both improved policy barriers for labor and safety and logistical barriers in coordinating agency collaboration.

Planned Follow-Up

"What's next?" ~ Summit Participant

- ☑ Solicit participant feedback of event: 1 week.
- ☐ Compile and share Summit report with planning team and organizational leadership before releasing publicly: 6 weeks.
- ☐ Convene smaller group of planners for recap and feedback: 6 weeks/after event report has been completed and circulated.
- ☐ Planning meeting to decide next Summit theme: 3 months.

Appreciations

We hold a genuine appreciation for those with lived and living experience who keep showing up even when systems have failed them, for community-based organizations, communities of color, and participants for their time, and truth and wisdom shared.

We express deep gratitude to the performers and presenters: Antonio Centurion, Irwin Wilson, Tashina Stahi, Emanuel Darcel, Emily Mosites, Albert Parramon, Cat Livingston, Lisa Shields, and Annaliese Dolph. We are deeply appreciative of the panelists and facilitators, tabling organizations, interpreters, illustrator, venue staff, and catering staff.

Planning Committee: Alexis Ball, Allysia Williams, Antonio Centurion, Brianna Bragg, Carmen Duran, Charlene McGee, Charlie Hanset, Christopher Hamel, Deandre Kenyanjui, Deena Feldes, Dolores Segura, Elizabeth Maldonado, Fortaleza Atravez Barreras, James Demry, Jen Worth, Jennie Brixey, JerMichael Riley, Jesus Navarro Meza, Jim Wikel, Jose Luis Garcia, Kelsi Wyatt, Leah Drebin, Leticia Longoria-Navarro, Lorena De Garay, Luis Nuñez, Mario Cardenas, Miguel Tellez, Nayantara Arora, Racheal Nakhbala, Ricardo Garcia, Rigo Contreras, Roger Garth, Rudy Ramirez, Teresa Everson, Tyler Swift, Quete Capuia, and Veronica Lopez Ericksen.

We thank Rachael Banks, MCHD Director, for solidifying funding for the space and food, and for the incredible MCHD staff and other agencies who served as greeters, facilitators, notetakers, and cleaners: Jennie Brixey, Viviane Cahen, Leah Drebin, Heather Fara, Deena Feldes, Cesilee Fidler, Katherin Flower, Sara McCall, Charles Miller, Patch Perryman, Mauricio Somilleda, Katie Thornton, Mike Velasquez, Melissa Walker, Gayle Wilson, and Ryan Yambra.

Report compiled by Dr. Teresa Everson, Dr. Tyler Swift and Dr. Richard Bruno.
Editing and formatting by Amy Gredler, Melissa Walker and Jeannine Munkres.
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