>> MURLEAN TUCKER: Welcome to addressing racial equity in overdose prevention. My name is Murlean Tucker, and I'm running this with my colleague Kasey Deems. Thank you to our partner, the National Overdose Prevention Network.

We are pleased to have back again with us Dr. Carmen Nevarez, today's moderator. Dr. Nevarez is the director of the California Opioid Safety Network and the National Overdose Prevention Network. She's the public health institute's Vice President of external relations and preventive medicine. Director of the center for health leadership and practice and director of Dialogue For Health. Welcome, Carmen.

>> CARMEN NEVAREZ: Thank you. So, welcome, everybody. This is a very important -- very important webinar at a very important time, and so I'd like to start this webinar today with a moment of silence in solidarity with the family of Jacob Blake.

Thank you.

This is an important day of reckoning. When President Nixon started the war on drugs over 40 years ago, he launched a national movement creating a double standard approach to mental health conditions, where incarceration became the treatment of choice for substance use disorder in communities of color.

There's no question that this national policy launched a trajectory, resulting in massive incarceration instead of treatment in communities of color across the nation. As a result of these policies, the United States leads the world in incarcerating its community of color members at rates that are as high as ten times that of other community members. This impacts
denying child custody, voting rights, employment, business loans, licensing, 
student aid, and public housing, as well as other public assistance, to people 
with criminal convictions in our communities. 

Today, especially today, we're going to give voice to this topic. 

Today, the National Overdose Prevention Network, NOPN, is focusing our 
conversation in addressing racial equity in overdose prevention. NOPN was 
born out of the need to apply the best learnings about community-driven 
leadership in -- about community-driven leadership in collaboration with 
broad community sectors, in service of understanding what needs to change, 
and how we can prevent overdose deaths. Next slide, please. Next slide. 

NOPN's work is about developing a local response based on local priority, 
strengthening systems, and generating dialogue between sectors, and 
sustaining action for focusing on long-term solutions. Next slide. 

NOPN understands that strengthening community capacity to respond 
with practices proven effective and developed by the communities 
themselves is what is needed to stop needless deaths from substance use 
disorder. 

Evidence is clear that for all communities, new addictions can be 
prevented, better ways to manage pain, effective treatments are available, 
and deaths from disease and substance use disorder can be stopped. Next 
slide. 

The National Overdose Prevention Network is here to work with you to 
build knowledge and share best practices. 

But the conversation about best practices for substance use disorder in 
communities of color has to be grounded in hearing from these communities 
themselves. Today, we bring you the beginnings of a conversation, 
grounded in the experiences of black, Latinx, and Native American 
communities. We're excited about today's conversation and the opportunity 
to work together to build a robust national learning community for us to 
connect to and learn from one another. 

Participate in the discussion, sign up for a digest, and stay tuned for our 
webinars, website, and programs that can help to guide us in understanding 
issues you face and how to advance and support your work. 

I'd like to start by introducing our speakers. Our first speaker is Kimá 
Joy Taylor, who is an MD and MPH, master's of politic health, a board 
certified pediatrician, and founder of Anka Consulting, a healthcare 
consulting firm, and a nonresident at the urban institute. 

She most recently served as the drug addiction treatment and harm 
reduction program director at the Open Society Foundation. 

I'd like to welcome to the podium here Dr. Kimá Joy Taylor. Thank you. 

>> KIMA TAYLOR: Thank you so much. First, I want to thank PHI for 
inviting me to speak on this webinar. Recent events have definitively 
affected me, so bear with me. Yes, racial and ethnic inequities exist, but this 
is not the talk where I'm going to rattle off statistics, peer reviewed articles, 
or give my pedigree that believe people and other black people are dying. 

I've done this in the past using bios and other people's articles to prove 
our voice's legitimacy, but not today. You can and should look up the 
statistics. 

Today, we're going to launch into talking about history and how we got to 
and how we perpetuate the racist systems and inequitable outcomes. Today
is the day where I ask each of us to be a bit more introspective, and also wonder how we got to these current discussions about racial and ethnic disparities and inequities. These inequities have existed for decades, for centuries.

I worked in Baltimore, and black folks were and continue to die of opioid overdoses for decades.

Outside of Baltimore, other major cities cared, so why now? Is it because of George Floyd? Because we realize that someone casually sitting on the neck of a black man for nine minutes is wrong. God bless that we're having the conversation now, but black people and other people of color and white people have called out, researched, written about justice, health, economic, and other disparities for centuries.

Why were they not heard? Who do we hear and why? I ask us to reflect on those questions and their answers for these two solutions and really get to the point that Carmen was talking about of needing to listen to voices of community.

If it takes nine minutes of sitting on someone's neck to wake us up as a country, we've really got to regroup. We have to look at black, indigenous, Latinx, social orientation, gender identity statistics to see who's missing, who's dying, if we're really going to change health and public health systems to equitably improve overdose in overall health outcomes.

So now I want to talk to you a little bit about history. Prior racialized drug histories and the history of this current opioid crisis and our responses have preordained racial inequities and overdose deaths. Drug epidemics are not new. And this is not the first time our response is based in demographics.

In the 1800s, the San Francisco opium ordinances targeted Chinese people secondary to racism, but secondary to fear that Chinese people were going to take the jobs and they needed a reason to punish, isolate, and banish them.

Early state marijuana laws in the 1900s were meant to target Mexican Americans, again, for racist reasons, but also for job fears and the need to punish, isolate, and banish.

I bring this up now at a time we have an opioid crisis, and much job loss due to COVID. And people were using drugs, everyone is using drugs, but only certain groups were targeted, and then because they were meant to be criminalized, isolated and removed because of job fears. A true cautionary tale for today. But I digress.

I want to get back to what Carmen was talking about in terms of the war on drugs, embrace and perpetuated. Also set in stone punitive, criminalized approaches to drugs, especially for black people and other people of color. This approach steeps into all aspects of our systems, completely. Into the separation of children, education, housing, public health, and health systems, and the most reported, the criminal justice system.

The policy promoted by government created disparate -- in outcomes that harms black people, to individuals, communities, and families. These criminal justice responses were meant to punish, not to treat people. Nixon's policy advisor admits the war on drugs was meant to vilify black people. Black people were disproportionately put in the justice system, and something that's deemed a chronic health concern was criminal for black
people.

And even if you're going to have this unjust response, it seems to me maybe you'd at least give treatment in prison. No. No treatment. Nothing to prevent the increased risk of overdose.

Poor outcomes were compounded by the trauma of being in jail, in prison, and the collateral of consequences, again, race-based, upon release, affecting job opportunities, education, employment, and all of that again, at higher rates for black people and other people of color.

This is lost as people talk about ways to tinker with the justice system to make it softer and warmer for people who use drugs. It is a punish targeted at black people and other people of color for health concerns. Using justice system outcomes and parameters as a baseline for the efficacy of health, or public health improvements, simply perpetuates and increases racism, by bringing it into the healthcare systems, which already have enough of their own racism and are already producing disparate responses and outcomes and so many other conditions.

Prison is punishment, it is not treatment. But there have been some rays of hope. Communities have supported their own survival with or without limited health and public health support and dollars. The HIV epidemic, another source of state-sponsored discrimination, federal and state governments actively exploited hatred and death because they did not like the people affected by HIV, gay men and IV drug users, especially IV drug users of color.

Harm reduction measures, including but not limited to [indiscernible] exchange, saved lives, leading to cities like Baltimore, New York, and Chicago, embracing and creating service programs that have long included access to Naloxone and long included services for black people and other people of color.

Communities in the face of state sponsored discrimination created change. This shows that any program focused on overdose or larger substance use and health concerns must listen to, work with communities who have devised culturally and linguistically effective solutions of their own for their survival.

Will they always be perfect? No. Will they always be inclusive of, say, LGBTQI or other populations? No. But when we have the data to see what's working, we then work to support culturally effective solutions for subsets of those communities, working with communities is key.

Substance use is a health concern, pushed by federal legislation, reinforced by the ACA, which is that people with insurance receive mental health parity [indiscernible] physical health services. Those few important caveats that are linked, unfortunately, to race and ethnicity.

Access does not always mean access to evidence and linguistically effective substance use services. Parity is often limited because people didn't have insurance due to non-Medicaid expansion, lack of affordability, and now current COVID job losses.

Finally, much of that parity advocacy was really focused on treatment, with no emphasis on prevention, harm reduction recovery services. But nonetheless, parity was a great feat.

So along comes the current opioid crisis, which was headlined as a predominantly white prescription drug epidemic. The epidemic led to a
different society response that left out people who used other drugs or illicit opioids. Those who previously viewed drugs through a moral lens began to talk about public health responses for opioids.

I think this is in part -- and they claim that now there's new research to show substance use was a health disease, but I reject that claim because there's a myriad of studies prior to that showing it was a health concern.

The public health emergency was in part because it impacted populations that were predominantly white, but I say also in part because it could be framed as a doctor's or manufacturer's fault. And it created this dichotomy that the black people that you previously viewed as the only viewed as the drug users are bad and blameworthy. While the white people are blameless and deserve public health. I know we screwed up, did a bad job, but our biggest failure was not embracing substance use as a chronic disease from the beginning, and we weren't screening, providing access to harm reduction, and doing interventions which could have saved myriads of lives along the way in ways that after the fact providing Naloxone does now, but we would have saved people earlier.

On the flip side, articles came out that claimed that the lack of insurance and health system discrimination that made providers assume all black people were drug seeking, when they asked for leave, they created this narrative that we were lucky to have escaped the current prescription drug epidemic. No. Now black people still have a hard time getting pain medicine when needed because of bias, and they still have a hard time getting culturally effective health if they deal with substance use disorder and are using illicit opioids or other drugs.

The racism of the healthcare system is simply a wrong narrative. Even if the crisis affected white populations and even if they moved to heroin and deadly Fentanyl, the responses were slow. Society has not easily embraced Naloxone or medications. Even though is research demonstrating their efficacy. I think this is part because their efficacy was proven among the blameworthy populations and populations of color that were at risk for HIV.

No one ran to Baltimore and said what does harm reduction look like, even though they've had services in place for decades. No one said to Chicago, how can we save lives and improve health amongst all people? The focus of substance use really allowed folks to believe that Reagan's trickle down economic theory also worked with a trickle down health theory, putting remedies in place for all people, including those predominantly white, and somehow that's going to trickle down to communities of color, even though we haven't talked to them, engaged them in our processes and our outcomes.

So this is the historical backdrop of our work. This is the purposeful inclusion of discrimination within all systems that, of course, led to inequitable outcomes. Lots of people are talking about health equity now. Let's take advantage of that fact and the fact that COVID has shown that the health system actually can change, and take this space to be courageous, and with innovative ways and support current community responses to substance use in ways that not only improve individual lives, but family lives and community.

We want to look at ways that the communities can help prevent overdoses, not just with Naloxone, but with a culturally and linguistically
preventive strategies. And we know data that will show improved outcomes in an equitable manner, whether they never used drugs or not.

Thank you.

>> CARMEN NEVAREZ: Thank you so much.

I would like to just lift up a couple of points that were raised by the audience in response to the questions to talk about what strategies you might be using. I think there are some very good ones that were put forward.

Thinking about using principles of harm reduction and trauma-informed care in the work that you're doing. Mainstreaming equity and racial justice across all materials. Using mobile outreach to go where people really are.

And then just a reminder to all of us who are listening to this and participating today. Not everybody on the call here is actually involved in the work by the treatment or prevention.

There's probably a lot of people that are involved because they just want to know more. They work in other sectors. And they want to know what they can do and how they can understand this issue better.

So I'd like to go ahead and pivot our conversation over to Hannah Youngdeer. I'm really pleased to have you with us, Hannah.

Hannah is master's in public health, Public Health Program Coordinator at the California Consortium for Urban Indian Health.

She completed her master's of public health with a concentration in American Indian health at North Dakota State University and currently oversees the tribal medication assistive treatment expansion process. And it's been involved in substance abuse work in AI communities in multiple capacities, including program development, capacity building, and research.

Welcome to the podium, Hannah.

>> HANNAH YOUNGDEER: Thank you, Carmen, and thank you for allowing American Indian voices to be at this table and to bring up some of the issues. So I'll just get started here.

So I'm going to talk a little bit about connecting our historical racial injustices in American Indian communities, and some of those injustices.

So, like Dr. Taylor here, I can't talk about the current issues without first talking about the history. And kind of what led us here. So there are a couple of policies that really impact the American Indian communities in the past, which has kind of led to a loss of our culture and some of our identity and our language. So the first one I'll talk about is the Indian Removal Act of 1830. And this policy essentially caused the movement of eastern tribes to the west of the Mississippi River, and when you think of the history books and the Trail of Tears, this is the policy that caused that.

And then we also have the 1883 Code of Indian Offenses, and essentially what this code did, and the language, if you look back in the history of this document, made it illegal for us to even practice our cultures and our ceremonies and it made it a punishable offense.

And the last one is the Indiana Relocation Act of 1956. And so this act stated that native communities should transfer from their reservations that the government put them on, into urban communities in an effort to assimilate into those communities, and that comes with a promise of education in healthcare, and resources for survival in these urban communities.
And unfortunately we know now that that did not happen. And we see now large rates of homelessness in these urban communities.

So with that being said, all of this led to huge cultural impacts. I think the 1883 Code of Indiana Offenses speaks for itself in our ceremonies and how those practices were passed on. The things that we come to know and live by were removed from us. And so a lot of those have led to cultural impacts in our lives today, which we see culture as a large form of healing for us. And a large form of therapy and treatment, and coping.

And so we don't have a lot of those methods anymore, and so you see our high disparity rates in substance use and alcohol use.

So I just want to talk a little bit about those policies, because we can't talk about the current issues without mentioning these. So some of our current issues, I definitely can't touch all of them. The first one is underfunding. Our American Indian communities have a subset of healthcare facilities that we go to and that we utilize the most.

And these are among some of the lowest funded facilities in the United States. We only see a fraction of healthcare funding dollars, which leads to an estimate of about 13,000 per person that might use these facilities, and as we know, healthcare is super extensive. It's not enough.

Our access to care, the communities that we grow up in and that we live in as American Indians are very rural. We don't have a lot of access to transportation. We might not have a whole lot of access to those things.

We know that culture is healing for us. But that is not westernized medicine. Those are not things that are easily accessible for us.

And in addition to that, they're not billable services. So they're not sustainable -- it's not sustainable care that we can keep, you know, and it's difficult to bring in medicine people to those westernized areas, because they aren't billable in the same way that an MD would be, or any other billable professional.

And as far as equity, you know, we recognize that this is our form of healing, and our medicine people do deserve to be paid in that rate to be to that same standard.

So I'm going to talk a little bit about our trip. Our project is called the tribal medication assistance expansion project, and this is a multi-pronged approach. It's a partnership between us, the California Indian rural health board, UCLA, USC, Telewell Behavioral Medicine, and Two Feathers.

And so we partnership with all of these facilities in order to meet the laid out goals here. The opioid use prevention, opioid use treatment, and the treatment expansion. Naloxone access expansion, and support system development and involvement.

A lot of what I do and a lot of what our team does is make sure that our programs that we work with -- the programs throughout the state of California that we work with for our urban Indian health clinics, two access and referral centers, and two residential treatment centers.

We assist these programs in expanding their MAT services and expanding Naloxone access to the communities that they work in.

And so one of our largest responsibilities to get materials that will culturally responsive and reflective of the communities that they're serving.

So, a little bit about our culturally adapted opioid campaign. And so these materials are generally to address general opioid education, opioid
overdose prevention and reversal training, safe opioid use, and safe opioid prescribing and disposal.

And so all of these materials are created in a way to reduce stigma around opioid use disorder. So I just wanted to show a quick example of what our materials look like.

And so this is one of the booklets that we give out to our programs to give out to the community. We work with a local American Indian residential artist who is located in San Francisco, and she developed the backdrops and the characters that you see here in this material.

And we want to make sure that this is reflective and that people see themselves in these materials and see a person of color and American Indian represented in these materials. So that's the cover there.

And also, a lot of the things that we want to make sure that we include in our materials is the integration of harm reduction methods. And so it's not enough to educate on what Naloxone is, what does Naloxone do, how to use it, but we also have to educate on how you can safely use and how that also prevents overdose.

So you can see here, this is just a small example of what we used to hand out to our clinics and to the communities in California.

I wanted to share a couple of our posters, too, but I just didn't have enough room. But if you take a look here, you can see what causes an overdose, and then the rest of the page are reflected to how to use Naloxone.

I think that's all I've got for you guys. Thank you.

>> CARMEN NEVAREZ: Thank you so much, Hannah. Very much appreciate it, and appreciate so much what you have lifted up in the materials you've got listed here are truly excellent. So, thank you for that.

I want to make sure that we have a chance to hear from Herminia Ledesma, who is the program manager for Vista Community Clinic, overseeing Vista Community Clinic's Migrant Health and Community Engagement Programs. She's been with VCC for over six years, and during that time, has focused on various efforts -- various efforts, supporting access to healthcare from migrant workers and their families.

She's also been highly involved in community health worker programs, encompassing the training, facilities, and -- training facilitation of community organizing, advocacy, and peer education efforts.

Please, Herminia, take the microphone.

>> HERMINIA LEDESMA: Thank you, Carmen, and thank you to my panelists. You set me up beautifully.

And so I think similar to what you all have shared, the Latino community, Latinx community lives the opioid crisis differently, and I think that each of the panelists brought that sense from all of the communities that we're talking about today.

I'm going to kick us off just by sharing a little bit about the organization that I work for, partly because it describes the reason why we came into this work.

I work for Vista Community Clinic, and we're a federally qualified health center and migrant health center in North County, San Diego. I think all of you might be thinking San Diego ports, water, bay, but we're actually located in North County, San Diego, which is a little bit more rural, and a lot of my
work is working towards supporting our migrant and farm worker communities really happens.

We are -- other things that I want to call out is that we are the backbone organization for the group that you'll hear me talk about, and they're really the magic sauce behind all of the work that we do, and really keep us community centered.

And of course, as a migrant health center, we offer MAT treatment, and our goal was really to ensure that the community that we were serving was connected to those resources.

One thing that I'm probably preaching to the choir here in terms of sharing this data, but I just thought it was so important to share, is that in Latinx communities, opioid use is increasing and really following national trends. I won't read everything I have on here on the slide, but we do have the source for you all in case you wanted to get a chance to take a more thorough look in terms of that report that SAMHSA shared just this year.

So it's all, you know, current data.

The use of opioids in the Latinx community is increasing, like I shared, and more starkly and more, you know -- something that's really alarming in calling our attention is the death rates involving synthetic opioid use, and nationally, it increased by 617%.

But for the Latinx community, it was the second highest. And so really, you know, of course a call to action.

So, I think in terms of looking at the whole picture and really kind of making a nod to what brought us here and how we're going to move forward is specifically when working in the Latinx community, there's a lot of things that are still at play. So, you know, you already heard about some policy implications that affected other communities and the Latinx communities, not new to that.

And we still actually have a -- you know, the current political climate that doesn't support accessing healthcare especially directed, out of resources. And I'm going to use a census deadline that was moved up a month as an example for our communities to be undercounted, which directly resulted into lack of access of resources in our community.

And more specific to our region is being in San Diego, we are a border region. The border region is defined as 100 miles from the border, and we're still within that. But more importantly, in our communities, we're seeing ICE enforcement on a regular basis, going into our communities, safe places, and really affecting folks on their way to work. And really trying to make a living.

And you all can imagine all of those playing a role into whether folks access resources, especially MAT resources.

So, where we started and kind of going off of that, what we knew, we wanted to go to the community first. We didn't want to -- our approach and we were grateful to have funding that allowed us to really go back and hear from the community members and those that have been affected by opioid use.

And also hear from our group which you heard me mention earlier. So, some of the things which came up were about opioid use and even treatment being a taboo subject.

Folks that came in for an interview, we found that folks would rather go
to a church and see if religion could help that treatment, rather than an actual medical facility to receive care.

The other thing that we found were that problems were often in our community, were that problems were often identified too late. So, you know, family members caught on after years of knowing that somebody in their family directly related was affected, or was using opioids.

And relative to the Latinx community is that the family unit has to be considered intercare for a lot of the success and adherence to treatment.

So what we did, we asked ourselves some questions and really kind of a call to action for all of us to ask with whether our response that we are about to implement on the field, and our individual and collective efforts, proving accessibility, true accessibility, because I think that -- you know, we have a lot of programs that are rolled out, and then folks are still not connected to it.

And then the other question is, are we repeating history and exacerbating what we already know of the communities that we're serving by the program that we're getting ready to implement. And we really look to our community to help us answer those questions, and ensure that we were giving proper access.

So some of the things that we did was ensure that throughout all of our efforts, whether that was collecting data and later informing the community that it was all community-centered. Our opportunities were, of course, community input and really not moving this project along without having that.

And then really imbedding all of that feedback and things that we learned from into our approach, into our curriculum, and into our outreach strategy.

And then, of course, another opportunity that came our way in the middle of our program project was our COVID -- you know, COVID pandemic affecting the way we were going to engage in outreach.

A lot of our agencies, I'm sure others on the panel here, and some of your agencies that are joining us today are front-facing, community-facing, and aren't used to delivering messages out into the field. We know that a certain level in the engagement is to connect folks to resources, and we really believe in that model, especially the trusted messenger model, working with community health workers and promotores to really drive those messages home.

So we're really at a loss when we have to shift gears a little bit. And we still wanted to do the popular education model. We know that folks in the Latinx community don't receive messages well from folks that aren't an authority figure or are not folks that they can connect with.

It's not a hard and fast rule, but we know that trust really is an underlying factor for how folks engage in the system. And when we're talking about a subject that really stigma prevents folks from engaging, trust was what we decided we wanted in all of our efforts.

And so what we really got into, based on the COVID opportunity that shifted us to innovate, was really reaching out to our leaders and promotores and community health workers to use their social networks.

So let's talk about it. We know that in our area, there is still opportunity to do a lot of prevention work, and so can we talk to your neighbor, your friend, anyone who is near you to really work on that? Especially as COVID
has exacerbated opioid use during this time, which we've already mentioned by the past panelist.

And another point was leveraging community partnerships. We definitely didn't do this alone and we worked through a coalition to really deliver our messages out there, and we actually have our last training happening later on this week.

So I wanted to show you all in terms of what really developing trust in the community looks like for us and what we applied for our project. So we have -- all of these pictures that you see here are from our community health workers who deliver the MAT training. So they were actually trained to provide the health education on the field with us, whether that was through social networks, through, you know, safe food distribution, and so on. And so this is -- all of these pictures, though, are pre-COVID, I should note. So that's why nobody's wearing masks and not at a distance.

But one of the things that we wanted to do was keep their efforts at the heart, and we know that it's so much more powerful model. And so our goal is to keep working on these efforts, both from a community engagement site.

So now through this project, through our MAT outreach project, we've gotten a new tool to add to our toolbox. And, you know, that's really important because there isn't enough being done in the Latinx community around this.

A culturally correct curriculum was developed. We'll be happy to share my contact information for where you can access that curriculum. Over 300 social service providers and promotores trained in San Diego County and over 5,000 individuals reached.

So, even though that is great outcomes, I think the one thing I want to just leave you all with is the nod and call to action for all of us as public health providers and those who are supporting and really joining the work, to commit to sustained work. Our work has been work that has developed over 20 years, and it was mobilization that we could reshift and apply to MAT outreach to make sure that our community was informed and connected.

But again, that's long-term sustainability. And long-term investment into these communities. And so we're really proud of what we've done, but we know there's still a lot more work to do and hope that, you know, there's funders listening. If there's other folks that are stakeholders, policymakers, especially, or providers, any -- all of the stakeholders are important.

And I think as shared earlier in our presentation, it really will take all collective efforts to really make a dent into what we're seeing happen in our communities.

And that's the last that I want to leave with you.

>> CARMEN NEVAREZ:  Okay. Thank you so much, Herminia.

I want to thank all three of you for what you said so far, and what you're going to add to the conversation going forward in our remaining minutes. There are a number of really good issues raised by the audience, and one thing I want to say, so that everybody knows, all the materials will be available and posted on this website and there will be a recording of this webinar posted.

So there's a few questions that I wanted to get to before we finish up, and the way that we'll do this is I'll ask each of you -- I will ask the
questions and then if Kimá and Hannah and Herminia can just answer in sequence, that would be perfect.

So, let me start with this one. Could you -- would you be able to lift up for me one of -- and I know there are many, but one of the effective or respected care strategies that you think are important in your communities?

So how do you provide effective care and respectful care, and whether that care is treatment or the care is prevention, or the care is organizing. Please address that for me.

>> KIMA TAYLOR: Thank you. I think Herminia and Hannah also talked about it. It’s really having that capacity to listen and meet people where they are, where they gather. Often, that is in places of worship, religious places.

Often that's on the street. A lot of the harm reduction is going to the street, being in the community, being able to provide the services on the ground. But it's really having that capacity to listen and not come in with preconceived notions of what that's going to be, because communities -- the black community is so diverse and different and had so many subsets in understanding what the reality is in terms of substance use in that community, and then having the capacity to listen.

I know that sounds like a cop-out, but it truly -- that humility I think is one of the most important pieces.

>> CARMEN NEVAREZ: Hannah, are you still with us?

>> HANNAH YOUNGDEER: Yes, yes, I am. I'm going to go off of what Dr. Taylor has already shared. And making sure that you're getting to know the communities that you're working with first.

And that's even speaking for, you know, BIPOC, Brown Indigenous People of Color. I would say even for myself going in as someone who is already American Indian, even as an American Indian, I can't just go into another American Indian community and expect them to, you know, know everything about their culture there, because we're so vastly different.

And so it's really getting to know that community before you go in there, and making sure that you know what effective measures and preventative methods they have in their communities already, because what I found in working in a lot of American Indian communities is that they already have the answers. They know they want to support funding, additional TA, and that's it.

I mean, we already have our practices in our community, but it really is just lending that listening ear, and knowing what they want and making sure that you come in with a way to help and not a way to be a savior.

>> CARMEN NEVAREZ: Go ahead, Herminia.

>> HERMINIA LEDESMA: I think the one thing in terms of listening, I definitely want to just re-echo that. But the other thing that I wasn't able to really touch on is aside from really being out there in the community, having a real grass roots effort, like community-centered, is how can we shift this into policy work that's going to call for long and sustained community change.

And so our Poder Popular model focuses also on local policy and state level advocacy to ensure that as we're out there informing the community about these resources and connecting them and really being that trusted message in the community, we're also being a trusted messenger and taking
the long-term approach.

And I would think, you know, because of time I wasn't able to share more of those efforts, but I think that as practitioners, we have the responsibility to really look at the continuum of care and to understand that our communities have immediate needs. The opioid crisis is killing our communities, and there's the immediate need there, and urgency.

There's also, you know, change that needs to be effectuated in the long-term.

>> CARMEN NEVAREZ: Thank you for your insights on that. I'm going to pivot a little bit and ask you to touch again on something you already touched on, which is to talk about how has -- what is happening with COVID changed your practices, changed your outlook, made some things work, maybe made some things better in terms of reaching the communities that you work with. Kimá?

>> KIMA TAYLOR: Sure. This is something I think about a lot. You know, telehealth is definitely that sword. But a lot of the changes in terms of the way you prescribe NAT, the way that people can access it, could be an opportunity.

However, they're built foundationally. So buprenorphine -- research has shown that more often, it's prescribed to white people as opposed to black people. Black people are more likely to be provided methadone. I won't get into the reasons for that, but that is reality. And so buprenorphine is the drug you can get without an in-person visit on telehealth, much easier to get prolonged take-home.

Sometimes you do have to go in, even though black populations and other populations of color are at higher risk of COVID, and you do have to go in for the first visit, and it's up to the doctor's discretion, which we already said there was implicit bias, but it's up to the doctor's discretion whether they're going to give you the take-homes.

So I say that to say that COVID can lead to policy changes that you want to keep, but it still requires us to look at the data, stratify data, sexual orientation, gender identity, to make sure the outcomes that we think and we hope to see are actually being achieved equitably across our population.

>> CARMEN NEVAREZ: Yes, thank you. Hannah?

>> HANNAH YOUNGDEER: I think the COVID pandemic has shown us a lot about the systems that we work in. It's shown a lot of things that we were doing wrong. And so I think it has allowed us the opportunity to create new policies. But just going off the same -- that Dr. Taylor said, we're not doing enough yet. We're still having access problems.

And so I think that's something we need to continue to consider moving forward in how we can create better access.

I think in the harm reduction realm, it's definitely made a difference in how we really are going and meeting people where they are. You know, it's not feasible for people -- it's not feasible for people to come into the services and exchange programs right now. In terms of risk for COVID.

And so we really are going out to those communities, and we really are meeting them where they are. And making sure that we're getting in the streets, where these people really need these resources.

And so I think that's something that we can bring from this pandemic that we weren't doing enough before.
>> CARMEN NEVAREZ: Thank you. Herminia?

>> HERMINIA LEDESMA: So, I think -- I want to just echo -- and I had it here, too, just like Hannah, we -- I think in the Latinx community, we had a need, a more urgent need to go out. I know that's probably counterintuitive and of course all was done in safe manners, but what happens, specifically in our area, is that COVID caused that challenge in a barrier for us to engage in the community in the typical ways that we normally do. And then couple that with our -- with public charge with the current political climate.

With all of these other things that, quote unquote, make our communities go into hiding, we have to do double the work to really connect with the folks.

And so some of the things that we did was really get creative and couple our MAT outreach efforts with other essential needs like food distribution, like, you know, diaper distributions, all the things that we can think about, and partly because we saw these opportune engagement chances with our community. We have them here, let's talk about and connect them to all the resources that we can while they're there.

That's the one thing. And I think the other thing is, I mean, this webinar is an example, we're able to connect virtually as practitioners. So I'm going to steal this from Dr. Kimá in our earlier conversation before the webinar is that all of us are able to connect more and are challenged to connect more. And so I think this conversation in terms of highlighting these key communities in our country is really important. And this being an example of more conversations that need to happen.

>> CARMEN NEVAREZ: Thank you for your answer to that question.

My next question is to ask each of you to lift up one policy change that you think would really impact the community that you serve. Let's start with Dr. Kimá.

>> KIMA TAYLOR: Wow. One. I guess, actually, to require the collection of stratified data in a way that seeks to improve outcomes, not punish communities.

And by that, I mean, a lot of times we collect data to say how bad we are and what we've done wrong and why we should -- and why we're not. But instead, looking at public health and health process and outcomes to say, this is where the gaps are and we want to save all people and not just save their lives, but help people thrive within education, healthcare, and all the context of our communities.

And so looking at data as a source to improve outcomes, which means getting rid of the black, non-Hispanic, white, and Latinx and other. Like, how we have white, black, and other -- like, that other category needs to go.

So, really being able to look at data and using it as a force for good would be a great policy, I think. Though, I have myriads. But you only let me have one.

>> CARMEN NEVAREZ: Only because we have a few minutes left, because we could probably go on this for an hour. That's great. Thank you. Hannah?

>> HANNAH YOUNGDEER: I'll go a little bit of a different route. I mentioned it earlier in my presentation, that we really don't have billable services nationwide for our cultural practices. And that is a policy that really
needs to be put in place. It depends on which community you're in, whether that's feasible for the community itself. But that's something we really need, and I've seen integrating it into our recovery programs, making a huge difference in people's recovery, and that needs to be a system that is supported and that needs to be a system that's sustainable.

So that would be my one policy change.

>> CARMEN NEVAREZ: Thank you. Herminia?

>> HERMINIA LEDESMA: I think the one is definitely hard. I think for me, kind of keeping to kind of -- in the work that we're doing is representation, especially along policy. And of course, I know that that's, you know, a separate conversation, but it all comes into play. We know policies are one of our biggest public health tools that we can use to really affect wait long-term change.

And so I think it's, one, important to make policy, but also to have representation of who is making that policy and who informs it.

So, you know, as an example, committee oversights, community advisory boards, in terms of projects and so on, to really have a community centered perspective, both in policy and in other projects that can imbed those best practices.

>> CARMEN NEVAREZ: Okay, thank you. Before I get to the last question, I want to just remind the audience that everything will be available.

And also, if you would sign on to the NOPN site and subscribe, we will make sure that you get the announcements of our future conversations. This webinar today only scratches the surface.

Our intention is to go deeper in the next few webinars and look at each community, and bring in people who can speak to some of the nuances and variances in each community, and really think more deeply.

This was an overview. It was just a taste. And we're glad that you all came with us.

So each of you have one minute now as your last question. Tell me a story that gives you hope. Let's start with Dr. Kimá.

>> KIMA TAYLOR: A story that gives me hope. You know, I'm a very hopeful person, but a friend passed away, so I'm in a dark spot. I think the thing that gives me hope is actually seeing people like Hannah and Herminia and others out there who, despite -- that despite what the world is throwing at us, like you're out there and keep fighting and keep loving and keep making sure communities are heard and have a space. And so people give me hope.

And I hold onto that so dearly at the same time where people are killing the Jacobs and killing the people that, you know, protest because of it. And so it's them and people like them that I thank and honor, and it gives me hope.

>> CARMEN NEVAREZ: Thank you for that. Hannah?

>> HANNAH YOUNGDEER: Thank you for that, Kimá. We are very lucky to have your voice out here as well.

One of the things that has given me hope in the midst of all of this is seeing the programs that we work with really be innovative and with the pandemic and the social injustices that are happening, knowing how this could have impacted their programs, how this could have impacted their
work, they've kept going. And so I know, you know, that we have the work out there and they've given me hope, and just seeing them, you know, move forward with their work and be really innovative.

I know that we have those power makers in our communities, and that gives me hope.

>> CARMEN NEVAREZ: Thank you, Hannah.

Herminia?

>> HERMINIA LEDESMA: That's a very easy question for me today. Last night, I met with our Poder Popular leaders, and these are all folks that are super committed to our work, and we figured out how to provide simultaneous translation. And not so much of how we provide it, but how we can engage and really teach people how to turn on that feature.

And so just being around our unit alone and seeing that little action makes such a difference in the way we engage with them, and this group that's already powerful is going to be even more powerful and doing more things in the community is what gives me hope.

>> CARMEN NEVAREZ: Thank you for that. I want to thank all of our panelists. I want to thank our producers. I want to thank our audience for getting this conversation started. It is a really important conversation. And we plan on having many more.

So, thank you to everybody, and let's keep this fight going forward. Thank you, goodbye.