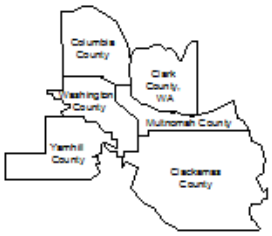
**Portland Area HIV Services Planning Council**

*Advocacy and planning for people affected by HIV in the Portland metro area*

***Ryan White Program, Part A***




# Meeting Minutes

## Meeting Date: April 2, 2024

## Approved by Planning Council: May 7, 2024

## Grantee: Multnomah County Health Department

Multnomah County

**Portland Area HIV Services Planning Council**
**MEETING MINUTES**

Tuesday, April 2, 2024, 4:00 – 6:00 pm
Zoom meeting

## AGENDA

| Item** | Discussion, Motions, and Actions |
|---|---|
| Call to Order | Scott Moore called the meeting to order at 4:05 PM. |
| Welcome & Logistics | Scott Moore welcomed everyone to the meeting and reviewed meeting logistics.<br>• Please say your name each time you speak<br>• Please raise your hand<br>• Meetings are recorded for accurate meeting minutes. |
| Candle Lighting Ceremony | Carlos Dory lit the candle in honor / memory of unknown people who have lost their lives to this disease. |
| Announcements & Introductions | Announcements:<br>See slides.<br><br>Attendees introduced themselves.<br><br>Announcements<br>• Welcome new member Fabian Primera<br>• Awareness Days<br>o Youth April 10<br>o Transgender HIV Testing 4/18<br>• PSRA training 4/25 or 4/26 – choose one<br>• National Transgender HIV Testing Day event: Oaks Park Skating Rink, Mon. 4/15, 7:00-9:30 PM, free<br>o https://www.instagram.com/nthtdpdx/<br>o https://www.facebook.com/nthtdportland/<br><br>The group reviewed the Council Participation Guidelines (see slide). |
| Public Testimony | To the Secretaries of the HIV Services Planning Council, the Multnomah County Public Health Advisory Board, the Health Evidence Review Commission, and Multnomah County Board of Commissioners:<br><br>I wish this communication be provided to members of the council at the next noticed meeting as Public Comment and included in the meeting minutes.<br><br>On July 17, 2023, Oregon's AIDS Czar Dr. Timothy Menza sent a letter to all Oregonian health providers on OHA stationary pushing off-label prophylactic use of doxycycline as prophylaxis "DoxyPEP" against bacterial STI's. These have been on the rise, especially |

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| | among a subset of gay men who have multiple sexual partners and have abandoned condoms due to the HIV-prevention pill "PrEP."<br><br>Omitted from Dr. Menza's letter and the Oregon Health Authority's website is mention that DoxyPEP is an FDA off-label use. This is also not disclosed on the fliers of the Multnomah County Health Department distributed at county STI clinic as well as Multnomah County's website. I find this reckless, and it puts consumers and the public at risk. It was only a few years ago the OHA cracked down on off-label use of Ivermectin, so it's also hypocritical. Dr. Menza also made his recommendation without consulting the Health Evidence Review Commission, which was required under the Oregon Administrative Code (as is revealed in the August 16, 2023 minutes of the End HIV/STI Statewide Planning Group). The FDA has a fast-track approval process and if DoxyPEP was so wonderful, manufacturers of Doxycycline could apply for an expanded use authorization. Because DoxyPEP is off-label, insurers do not track the indication - a problem that exists with HIV post-exposure prophylaxis (which is also off-label and has never actually been proven to work in an RCT). Off-label use also raises the cost of health insurance for everybody because insurers do not cover off-label use. Without an FDA indication and thus insurance code, there is no way to aggregate data on DoxyPEP prescriptions and use in Oregon by separating out DoxyPEP prescriptions and those for confirmed/suspected cases. DoxyPEP has also not been recommended by the US Preventative Services Task Force - which is also the case with HIV post-exposure-prophylaxis which is pushed by the OHA and available at the county's STI clinic. I would ask my county supervisors: why are my taxpayer dollars covering off-label drugs at a time when I have to vote on three tax increases?<br><br>The Food and Drug Administration, unlike the CDC, is a consumer-protection entity with a legal requirement since 1962 to base its indications on placebo-controlled double blinded studies. The CDC, as an advocacy agency, does not have any requirement to base any of its statements on science, and although Dr. Menza cited "studies" one was a non-blinded non-peer reviewed study delivered as a conference report that was stopped early - a red flag for anyone who knows the history of ACTG 1976 or the Fischl study in AID$ medicine not to mention the indicator trial for PrEP. No study had long-term follow-up to evaluate the cumulative health consequence of repeated DoxyPEP use over the course of a sexual lifetime, and I would say stopping the only controlled doxyPEP trial early was itself unethical. The problem with DoxyPEP and PrEP prophylactics is public health agencies are not bound by the FDA's marketing limitations that must balance the risks and benefits of a medical intervention.<br><br>Although there is no reason to believe DoxyPEP to be ineffective, there are significant public health concerns with community DoxyPEP promotion. These include:<br><br>1. The development of antibiotic resistant strains to STI's.<br>2. Whether prophylactic use of antibiotics increases risk of HIV or viral hepatitis by weakening the rectal lining due to its effect on gut bacteria.<br>3. The enabling of risk behaviors. I should note condom abandonment due to PrEP created the environment among gay sexual networks allowing for Mpox to become epidemic when it evolved to be transmitted by semen. Dr. Menza and the OHA got it wrong when they communicated to the public Mpox was transmitted by "close personal contact" and failed to promote condoms early enough to control the outbreak. In fact, telling the public "everyone is at risk" in order to avoid stigma |

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| | promotes gay bashing. Having to be treated for an STI from time to time can influence a pull back from the unhealthy "fast track" lifestyle.<br>4. Alteration of the community microbiome including antibiotic-resistant C-Diff and Staph - meaning DoxyPEP promotion puts others at risk.<br>5. Overuse by "worry worts" feeling shame after every single sexual encounter - as we've seen with obsessive-compulsive at home HIV testing.<br>6. Dispensation of DoxyPEP at sexual health clinics on the basis of false claims in order to obtain antibiotics for other nonmedically-supervised uses (leading to more resistance) or for third parties who do not want STI's to go into their medical record or sent to their insurance company.<br><br>I should note in the 1970's, off-label prophylactic use of Tetracycline was very common in the urban gay bathhouse scene, leading to the phenomenon of "gay bowel syndrome." It was exactly among this small subset of gay men that AIDS first emerged, meaning for HIV positives, it is probable heavy antibiotic use is a co-factor for the progression to AIDS.<br><br>As a veteran activist with ACT-UP/San Francisco and longtime critic of the AIDS Establishment, I am disappointed Oregon's various advisory boards are packed with representatives of that establishment employed by organizations receiving money from the drug companies and who rubber-stamp anything the CDC says and fail to both follow actual science and think critically. My application to the Statewide Planning Group was rejected precisely because I do not see eye-to-eye with the establishment - even though an outsider not funded by Pharma who can ask hard questions about Dr. Menza's premature proclamation from on high or take action that the OHA's website should disclose off-label status of its recommendations as well as include consumer protection information such as side effects.<br><br>April 23rd marks the 40th birthday of HIV, and with over 20 years of activism, I have become convinced everything the AIDS Establishment is doing is wrong. If their policies worked, we would not see rising levels of STI's and blood borne pathogens. The OHA's EndHIV Oregon initiative, which Dr. Menza represents, does not want to be in the business of putting itself out of business by actually ending HIV. Dr. Menza has no interest in health or healing - he is part of a Medical Mafia interested in customer creation, disease maintenance, and symptom management - essentially healthcare racketeering.<br><br>DoxyPEP is more of the same, and I urge you to advise the OHA to reconsider its recommendation until DoxyPEP has been reviewed by the FDA and the US Preventative Services Task Force and as more evidence comes in about its long-term community impact in places where it is pushed such as San Francisco.<br><br>Respectfully,<br>Tom Busse |
| Agenda Review and Minutes Approval | The agenda was reviewed by the Council, and no changes were made.<br><br>The meeting minutes from the March 5 meeting were approved by unanimous consent, with the following additions:<br>• 58 incarcerated PLWH in Oregon<br>• Still using paper charts |

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| Panel Takeaways from March 2024 | **Medical Case Management**<br>• **Caseloads are large & growing** with no plan to mitigate this, so care may be more reactive, focused on crisis management, with clients either receiving a lot of contacts or only a few<br>• **Insurance work has become larger, ongoing** (e.g., Medicare, educating providers & clients on medication access, prior authorization process, cost of meds, OHP and CAREAssist renewals)<br>• **More support for clients to access needed resources:** mental health care, shelter beds, housing (navigators, supportive housing, other resources), food, cell phones, interpretation services, aging and disability resources, dual diagnosis resources, family support.<br>• Also increased need related to poverty, mental health, drug use for some because lack of services in the system- housing, mental health, substance use, etc<br><br>**Care for PLWH who are or have been recently incarcerated**<br><br>• **Key need is anything that would help adults in custody reach resources before they are released** or immediately after they are released (*e.g., access to OHP, address for early release*)<br>• **Prioritize people who are or have been incarcerated for sooner appointments** (*i.e., Clients are often released with 30 days of meds, and often need a primary appt, then a referral*)<br>• **Providers need to establish relationships with people in correctional facilities** (all levels of administration) and clinicians need both education and relationships established to provide optimal care. |
| Elections Review | *Presenter: Grace Walker-Stevenson*<br>*See presentation slides.*<br>*Summary of Discussion:*<br><br>Positions available:<br>• Co-Chair (currently Bri Williams)<br>• 3 Operations Committee members (currently Tom Cherry, Greg Fowler, and Jamal Muhammad)<br><br>Co-Chair<br>• Eligibility<br>o Member who has completed at least one full term (2 years) as a Council member in good standing<br>o Proven ability to preside at meetings, oversee complex work plans and timelines, and supervise and direct the work of Council or committee members<br>o Agree to adhere to principles of employee supervision consistent with MCHD personnel policies<br>• Responsibilities |

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| | ○ Official public rep and spokesperson of the Planning Council, in consultation with Council Staff*<br>○ Preside at meetings of the full Council and Operations Committee (Ops)*<br>○ Appoints Committee Co-Chairs (i.e., Evaluation & Membership Committee), and other Committee members as needed*<br>○ Work with Council Staff and Grantee to:<br>▪ Ensure compliance with Ryan White Program requirements and other federal guidance<br>▪ Establish priorities for Council, committee and staff work<br>**May delegate this duty to others*<br>Operations Committee responsibilities<br>• Must be willing to serve on a committee if appointed by Co-Chairs<br>• 3 At-large member positions (2 year terms)<br>○ Eval Chair, to be appointed<br>• Meet regularly to plan the meetings of full Planning Council<br>• Determine committee membership<br>• Review and update Council's Bylaws, Policies and Procedures<br>• Co-develop work plans to move Council work forward<br>• Identify Council knowledge gaps that are essential to perform high quality planning and decision-making<br><br>Membership Committee responsibilities<br>• Review applications & conduct interviews for Council Membership<br>• Work with Council staff to:<br>• Meet orientation and training needs of new Council members<br>• Coordinate ongoing training and member development<br>• Support Council's retention plan so as to improve member attendance, participation, and retention<br>• Review the membership roster of the Council regularly to prevent and address member attrition<br>• Lead the annual Council Co-Chair election process<br><br>Timeline<br>• Nominations by 4/30<br>• If you nominate someone else, please ask them first<br>• Elections at 5/7 meeting<br>• Vote on Co-Chair is done first<br>• Any unelected candidate can still run for Ops<br>• Vote on Ops members done second – top 3 are elected<br><br>If you have any questions, ask current members:<br>Scott Moore — Tom Cherry<br>Bri Williams — Greg Fowler<br>Julia Lager-Mesulam — Jamal Muhammad<br>Robb Lawrence — Kris Harvey<br>Shaun Irelan — Megan Von Tersch |

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| Housing Panel | *Facilitators: Scott Moore, Bri Williams*<br>*Panelists: Preston Garner, he/him, CAP Davis Street; Amy LeSage, she/her, CAP Davis Street; Meghan Von Tersch (for Ruth Henry), she/her, CAP SW Washington; Dandy Wegener, they/them, HSC; Jamie Christianson, she/they, PATH*<br>*Summary of Discussion:*<br><br>Aubrey shared context information about housing for PLWH – see slides.<br>• An estimated 9415 people living in the 6-county TGA were "homeless" by the 2023 point-in-time count (~0.38% of about 2.5 million residents)*<br><br>*While an important metric, this "snapshot" census includes only people who are unsheltered or residing in a shelter or transitional living program on the night of the annual count<br><br>Current Funding Breakdown<br>• Part A goes to Clark County, mostly rent assistance.<br>• Part B program income pays for services in the 5 Oregon Counties, including:<br>• navigation/assistance accessing available shelter, housing navigation, case management, and peer specialists, home- based recovery units, rent assistance, medical motel vouchers, and associated costs<br><br>PANEL QUESTIONS:<br><br>1. Please describe your role in housing services for people living with HIV (PLWH), and provide an overview of these services.<br>2. For folks who have been houseless, what supportive or wraparound services are available (e.g., medical, case management, mental health, dental, life skills training like managing budget)?<br>3. What are some successes, such as coordination into stable housing & support services including outcomes, or unique opportunities?<br>4. What are key gaps and challenges, and what resources are needed to support addressing these?<br><br>Preston Garner, he/him, CAP Davis St.<br>• Manager of Long Term Housing at CAP<br>• Serves all 6 counties in TGA<br>• Receives money from HUD HOPWA<br>• Project-based rental assistance (subsidy attached to unit)<br>• Tenant-based rental assistance (subsidy moves with tenant throughout TGA)<br>• Oregon Housing Opportunities<br>o OSSCR (Oregon Statewide Supportive Community Reentry) for people in parole or probation, felony in last 5 years<br>o OHBHI (Oregon Housing & Behavioral Health Initiative) for people participating in mental health program<br>• High Hope program for permanent supportive housing (HUD chronically homeless)<br>• Program through recent Supportive Housing Services measure<br>o We provide case management while Home Forward pays rent at Joyce Hotel (20 of 66 SRP units reserved for CAP clients) |

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| | ○ HOBMO Housing Opportunities for Better Medical Outcomes – 30 vouchers, 2 case managers supporting, funding for 7 years – lots of success, only 4 people left to house in that program<br>• Participants for Joyce and HOBMO and High Hope are identified through Coordinated Access and prioritized by score received on Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)<br>• Sub & MH peers<br>• Housing retention peers<br>• Housing pathways to help people sign up for waitlists<br>• Employment services – SSI, vocational rehab, employment<br>• Successes<br>○ 50 PLWH households moved into housing in last six months<br>○ We almost have as many people in our housing as on our waitlists<br>• Gaps<br>○ Staffing<br>▪ Getting qualified applicants<br>▪ Retaining people has become a bit easier<br>○ CAP used to be at the forefront of salaries for housing assistance, but not so much now due to funding<br>○ Concerned utility allowances are not going to keep pace with current prices for utilities<br><br>Meghan Von Tersch, she/her, CAP SW Washington<br>• Presenting on behalf of Ruth Henry, Housing Team Lead,<br>• Emergency rental assistance coordinator in SW Washington<br>• Oversees our HOPWA program in Vancouver and Clark County<br>• Also have Tenant-based vouchers, project-based vouchers, as well as Project-based Section 8 vouchers (someone else pays rent, we provide case management)<br>• We also provide housing services in Longview – all tenant based<br>• Utility and mortgage assistance to help people maintain housing<br>• Housing Navigation (e.g., avoiding eviction, move into housing, landlord notices)<br>• Clark, Cowlitz, Skamania, and Wahkiakum<br>• At CAP SW office, everyone who enters our housing services comes through MCM<br>○ Last year 144 Emergency Rental Assistance referrals<br>○ 172 housing navigation referrals<br>○ 12 new housing waitlist referrals in last 6 months<br>○ Caseload is currently<br>○ 12 in Clark and 6 in Cowlitz County<br>○ Our waitlist hasn't moved in 14 months<br>• Supportive housing program – help with waitlists, navigation, accessing other housing / social service agencies, help with move in costs for people who make enough to maintain housing<br>• Employment services, including assisting with employment-related costs<br>• Twice monthly peer support groups<br>• Success stories<br>○ 3 clients recently able to receive SU treatment<br>○ 2 of 3 clients were able to take time off in order to complete treatment, which they would not have been able to afford without housing assistance |

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| | ○ 1 was able to receive surgery due to sobriety<br>• Gaps<br>○ Increasing cost of living – increasing rent = decreasing numbers of people we can assist<br>○ Frequent rent increases<br>○ Mandatory rent insurance for WA state residents – WA doesn't have income protections like OR does, and we are not able to pay rent insurance<br>○ Challenges working with landlords / property managers – lack of knowledge, unwillingness to work with vouchers<br><br>Amy LeSage, she/her, CAP<br>• Manager of short term housing and Latine/x services<br>• Oversee Emergency Rent Assistance (ERA), Housing pathways, Community warehouse, and supervise a Short-Term Housing Specialist, back-up Manager on Motel team<br>• For ERA, there is a Bilingual ERA coordinator<br>○ Serve a few hundred clients a year<br>○ Eviction prevention – can't make rent, or rent arrears, move in cost assistance, in some cases property debt (money due on properties not currently living in)<br>○ Try to reserve our funds for housing – there is a lot less housing assistance than there is utility assistance out there<br>• Housing pathways coordinator<br>○ Housing drop in hours – get help getting on waitlists, barriers to housing<br>○ If need more help, can make referral to housing navigation<br>○ Teaching Rent Well currently at Day Center (a couple times a year)<br>• Short Term Housing specialist<br>○ 10-15 person caseload<br>○ Half is folks with a RW transitional housing voucher (24 months in any unit that fits the criteria)<br>○ Other half is substance free caseload – in partnership with PATH<br>▪ 24 months of rent assistance for people interested in sober living group home<br>• Motel Team - Can help people stay in hotel up to 14 nights a year if dealing with acute medical issue<br>Supportive or Wraparound Services (for folks who have been houseless)<br>• Community Warehouse- Get furniture and supplies available at no cost (e.g., beds, kitchen supplies, table and chairs)<br>• Bilingual Case Manager has caseload about 30 people<br>○ Services supporting Latinx community clients who need help addressing barriers to care (not necessarily houseless)<br>○ Help support access to mental health, medical resources etc.<br>• Reencuentro monthly dinner for Latinx community (does not require being on MAI caseload)<br>Successes<br>• Substance free housing voucher<br>○ 2 people recently graduated, able to gain income and pay rent on own or get housing on their own (program has only been around a couple years)<br>○ People referred when coming out of treatment – 90 days of abstinence |

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| | • Gaps<br>  o Security deposits – RW used to cover these, and now it's a bit clunky that they cannot pay for that with the housing voucher; now have to go through ERA process to cover these<br>  o Lack of affordable housing is huge barrier<br><br>Dandy Wegener, they/them<br>• Housing Coordinator at HSC<br>• No housing funds, all administered through CAP<br>• I fill in cracks<br>• Connecting people to shelter<br>• Connecting to CAP<br>• Work with people unable / unwilling to work with CAP<br>• Providing extra support for clients who are really high need – memory loss, mental illness, acute medical conditions, active substance use<br>• Clinic serves people all over state, approx. 1600 patients<br>• Mostly work with housing stuff in Mult Co<br>• Have connections with people who work with housing in Washington and Clackamas County<br>• We also have BH therapist and psychiatric prescriber<br>• We refer to CAP for other supportive services<br>• We have clothes closet, shelf stable food pantry, cold weather supplies<br>• Successes<br>  o Joyce is amazing program, have worked with some very complex clients who have been housed there<br>• Gaps<br>  o I haven't been working in housing specifically for very long<br>  o A lot of siloing in social service areas<br>  o Need to create more success by improving conditions for housing workers (not specifically for CAP, just in general)<br>  o Need housing that comes with abundant access to MH and substance use treatment<br>  o Affordable housing with adequate soundproofing – putting people with PTSD in housing in which you can hear everything from surrounding apartments – penny wise and pound foolish<br><br>Meghan (CAP SW)- As someone providing housing services, I can confirm that noise is the most often complaint from individuals that leads to neighbor arguments, notices from landlords, paranoia about being followed, etc.- definitely a valid point to bring up!<br><br>Jamie Christiansen, she/they, PATH<br>• Helping PLWH access substance use treatment<br>• First figuring out where people sleep at night<br>• I have access to help people into shelter beds – PATH has priority access<br>• I can generally get a shelter bed Monday through Thursday<br>• Their substance use may have caused them to lose their housing<br>• If you complete substance use treatment, you can receive reasonable accommodation for future housing |

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| | • Can help people get into treatment<br>• "Outpatient + housing"<br>• RW Part B pays for 2 spots at Volunteers of America<br>• CCC Blackburn<br>• Six month transitional treatment<br>• Can start working after first month<br>• CAP – I encourage them to call my cell if they have someone who I may be able to help<br>• Substance Free Living – can look very different at different places<br>• Successes<br>  o Person with meth use disorder, completed treatment, now has a job<br>  o People to applying to go back to school<br>  o "It's a relief to be sane again, it hurts to be crazy"<br>• Challenges<br>  o Not enough resources<br>  o A lot of these programs have abstinence requirements<br>  ▪ Relapse / return to use is part of recovery<br>  ▪ It is traumatic to relapse, and go back to program and be threatened with eviction<br><br>Questions:<br>• Q: For Preston, what happens after seven years? Do you have conversations about this with clients? A: We haven't had conversations about this. We do goal plan stability conversations with clients. A: We prioritize clients for other vouchers if a client's transitional voucher (shorter term of 2 years) is running out.<br>• Q: Preston, what is this housing opportunity? A: Supportive housing measure a few years ago – emphasize smaller caseload (we have 15), usually high acuity / vulnerability.<br>• Comment: There is endless need.<br>• We don't have things for people who want to continue to use substances.<br>• Need to keep calling every day. This is a horrible thing to need to say to people who have been on a waitlist for 2 years.<br>• Q: Jamie, are we able to refer clients who want to stay in Washington County? What services are available to people outside of Portland Metro? A: I serve all people in the TGA, and try to work with people where they are. PATH has discretionary funds to pay for various things – cell phone bill, storage unit, whatever is a barrier to them receiving treatment. |
| FY23-24 Preliminary Expenditures | *Presenters: Jon Basilio*<br>*Summary of Discussion:*<br>See slides.<br><br>Current state of spending<br>• Total $3,316,417 (89%)<br>• Unspent $420,714 (11%)<br>• Deadline for invoices for grant year is April 15 |

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| | Total Part A Unspent vs. 5% target for allowable Part A Carryover<br>Total unspent $420,714<br>Target $186,857<br>Difference $233,857<br>Three month average for Total Part A Invoices = $253,833<br><br>Part B<br>Total $2,963,315 (81%)<br>Unspent $688,340 (19%)<br><br>Final expenditures will be on the June Planning Council meeting agenda.<br><br>Questions:<br>Q: What happens to Part B income carryovers? A: It's readily rolled over into next grant year. There is no rollover cap.<br>Q: Why is oral health at only 40% Are we concerned about them not spending the money? A: Oral health gets a very small pot of money, so the percentages fluctuate a lot. We don't anticipate any issues with them spending down these funds. |
| Awareness Days | *Presenters: Scott Moore, Bri Williams*<br>*Summary of Discussion:*<br>See slides.<br><br>Youth Awareness Day VIDEO LINK<br><br>LOCAL CONTEXT<br><br>• In the Portland TGA… People who are under 24 years old comprised about 2% (99) of all PLWH and 17% (25) among all newly diagnosed clients.<br>• The proportion of RW clients ages 13-24 is about equal to PLWH in the TGA (2%)<br>• Clients aged 13-24 experienced a(n):<br>o Steady increase in Annual Lab Rates since 2020 towards 95% goal, &<br>o Increase in viral suppression in 2021 to 90% target and a decrease in 2022 (~85%)<br><br>Q: Youth as percentage of new cases seems pretty high. Is that similar to last year?<br><br>Transgender HIV Testing Awareness Day – VIDEO LINK<br>• In 2022, people who identify as transgender comprised about:<br>o 1% (53) of the PLWH in the TGA<br>o 3% among newly diagnosed people<br>• 2022 saw a slight increase of transgender clients accessing RW services (3% or 96)<br>• Transgender clients experienced a:<br>o Continued decrease in Annual Lab Rates from 2019-2022 (~89%) towards 95% goal<br>o Decrease in viral suppression from 2021 to 2022 (~83%) towards 90% goal |

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| Evaluation and Closing | *Presenter: Bri Williams*<br><br>Thank you for participating in this meeting. If you have feedback / comments / ideas, please include them in your evaluation.<br><br>Next meeting: May 7, 2024, Time & Location TBD |
| Adjourned | 6:00 PM |

## ATTENDANCE

| Members | Present | Absent* | Members | Present | Absent* |
|---|---|---|---|---|---|
| Tom Cherry, he/him | **X** | | Robert Middleton, all pronouns | **X** | |
| Jamie Christianson, she/her | **X** | | Scott Moore, he/him | **X** | |
| Claire Contreras, she/ella | | **L** | Jamal Muhammad, he/him | **X** | |
| Steven Davies | | **E** | Fabian Primera | | **A** |
| Carlos Dory, him/his | **X** | | Diane Quiring, she/her | **X** | |
| Michelle Foley, they/them | **X** | | Tessa RoAbinson, she/her | **X** | |
| Greg Fowler, he/him | **X** | | Jake Schmieder, he/him | | **E** |
| Jeffrey Gander, he/him | | **A** | Taylor Silvey, she/her | **X** | |
| Kris Harvey, he/him | **X** | | Nick Tipton, he/him | **X** | |
| Shaun Irelan, he/him | **X** | | Bee Velazquez | **X** | |
| Zachary Jones | | **A** | Meghan Von Tersch | **X** | |
| Julia Lager-Mesulam, she/her | **X** | | Shane Wilson, he/him | **X** | |
| Robb Lawrence, he/him | **X** | | Joanna Whitmore, she/her | **X** | |
| Heather Leffler, she/her | **X** | | Abrianna Williams, she/her (Co-Chair) | **X** | |
| Sean Mahoney, he/him | **X** | | | | |
| | | | | | |
| **PC Support Staff** | | | **Guests** | | |
| Sandra Acosta Casillas | **X** | | Preston Garner, he/him, CAP Davis St. | **X** | |
| Jonathan Basilio | **X** | | Amy LeSage, she/her, CAP | **X** | |
| Aubrey Daquiz, she/her | **X** | | Dandy Wegener, they/them | **X** | |
| Jenny Hampton, she/her (Recorder) | **X** | | Mel Parker Anderson, she/her, OHA, HIV Housing Strategist | **X** | |
| Sara McCall, she/her | | | Dennis Torres | **X** | |
| Eric Richardson, he/him | | | ASL Interpreters | | |
| Derek Smith, he/him | **X** | | | | |
| Kim Toevs, she/they | | | | | |
| Grace Walker-Stevenson, they/them | | | | | |

* R = Attended Remotely (for an in person meeting); A = Unexcused Absence; E = Excused Absence; L = On Leave