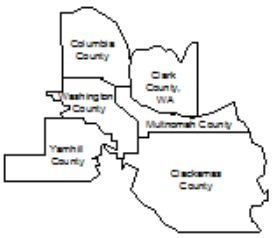
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: July 10, 2025

Approved by Planning Council: October 7, 2025

Addendum approved: November 4, 2025

Grantee: Multnomah County Health Department

Multnomah County

Portland Area HIV Services Planning Council
MEETING MINUTES

Thursday, July 10, 2025, 10:00am – 4:00pm
Melody Event Center

AGENDA

Item**	Discussion, Motions, and Actions
Call to Order	Scott Moore called the meeting to order at 10:00 AM.
Welcome & Logistics	Scott Moore welcomed everyone to the meeting and reviewed meeting logistics. • Please say your name when you speak, and turn on your camera, when possible. • Please raise your hand (physically or virtually) or type questions in the chat box. • We will mute/unmute folks (online) as needed during the meeting. • If you're calling in, please mute yourself to minimize background noise, unless you have a question/comment. • We will be recording this meeting.
Public Testimony	No public testimony today. Please invite members of your community to provide public testimony. Community members may share for up to 3 minutes, either remotely or in person. Complete the form at https://tinyurl.com/PC-YourVoice or send a chat message to "Host"/Aubrey, "Raise your hand", or unmute yourself. We will call on anyone who has signed up to speak. Key reasons for public testimony • identifying an unmet need • providing feedback on a type of service offered • (focus on service not provider) • giving input on where funding should be prioritized
Candle Lighting Ceremony	Chris Keating lit the candle in memory of an anonymous young man she cared for at SF Kaiser on Geary St. in 1981.
PSRA Process Improvement & Pop Ed Introductions	*Presenters: Scott, Aubrey & April* See slides. GET TEXT FROM SLIDES

<table>
<tr><th>Item**</th><th>Discussion, Motions, and Actions</th></tr>
<tr><td colspan="2">
<table>
<tr><th>PSRA Process Improvement - Key Issues Identified</th><th>Key Solution - Popular Education is…</th></tr>
<tr><td>

People may feel they don't know enough/insufficient training/different levels of experience (1 broad action item)
Not enough incorporation of materials/presentations/info we get throughout the year into funding decisions (1 broad action item)
Inputs from HGAP are unclear and/or incorrect or take a lot of time to digest (e.g. Scorecards) (1 broad action item)
Purpose of small groups is unclear and/or co-facilitators are unclear on tasks/expectations & Some voices speak louder/sooner and some voices may not be as comfortable speaking up (10 action items)**
We have always started with last year's allocations + 5% as a baseline for this year's allocations - do we want to change that? (1 broad action item)
People have different learning styles (1 broad action item)
Physical space is less than ideal (1 action item)

</td><td>
A community organizing philosophy with many sources, mostly from Latin America. The goal of Pop Ed is to take organized action to change the world.

The main ideas are that we all have knowledge to share and we can all learn from one another, and when we act on what we learn together we can make our communities better for everyone:

It is important to create an atmosphere of trust so that people can share their ideas and experiences.
We are all teachers and we are all learners
Everyone knows a lot as a result of their life experience
This knowledge is as important as formal education.
We are holistic, interconnected beings who learn with our heads, hearts, and bodies, so many of the methods promote interaction, movement, and play.

</td></tr>
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<tr><td>Announcements & Introductions</td><td>Announcements:
See slides.

Attendees introduced themselves (including pronouns), stated any conflicts and access needs, and shared a preferred activity and accompanying movement for the attendees to mimic.

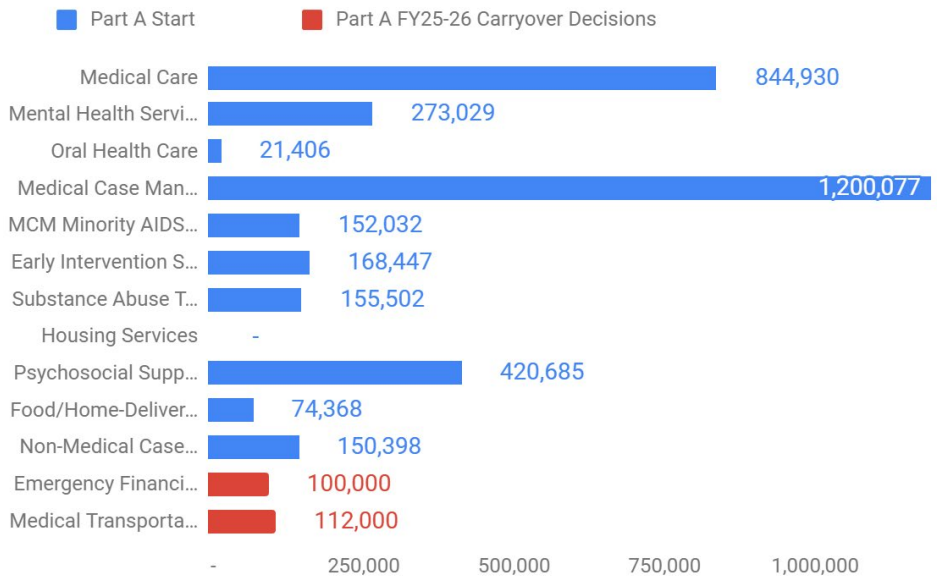
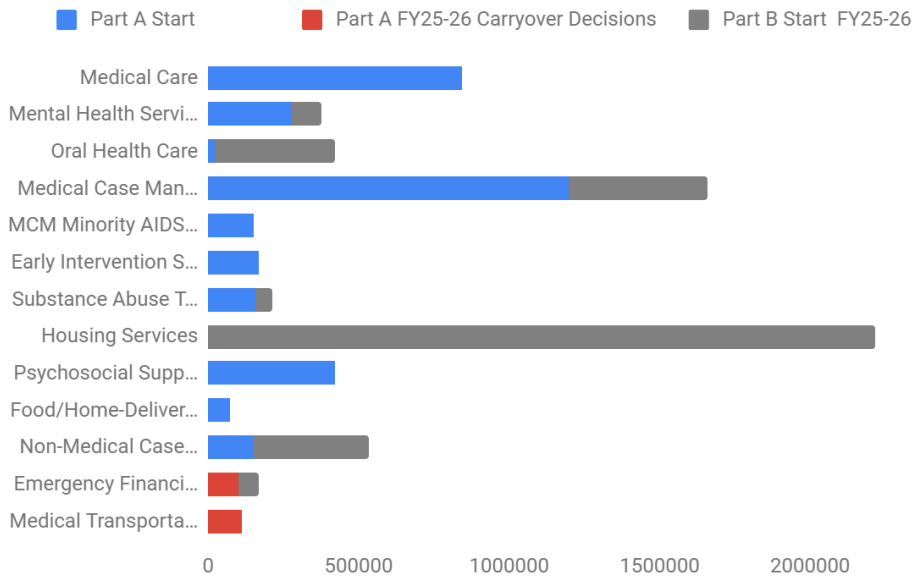
Announcements

Optional Year-End PC gathering, location TBD. Possibly July 31, but could be changed – Aubrey will send out survey again.
Reminder – please fill out your evaluation.

The group reviewed the Council Participation Guidelines (see slide).</td></tr>
<tr><td>Agenda Review and Minutes Approval</td><td>The meeting minutes from June 3, 2025 were approved by unanimous consent.

The agenda was reviewed by the Council, and no changes were made.</td></tr>
</table>

Item**	Discussion, Motions, and Actions
Planning Council Values Review	*Presenters: Julia* The group reviewed the Planning Council Core Values. **We value…** • The most effective use of both financial and human resources. • A coordinated continuum of care at all stages of HIV/AIDS. • A culture in which coordination and collaboration, among individuals, agencies and communities, is prized above competition. • Conversations that include dissenting voices while also working to ensure that these conversations are free from harassment. • All voices & perspectives regardless of age, gender identity, gender expression, sexual orientation, race, ethnicity, literacy, income, education, religious affiliations, physical or mental functionality, ability, and citizenship status. • A culture which supports the independence and dignity of consumers of HIV services, and which supports consumer choice in all areas of service and uses a trauma-informed lens. • A system which provides high quality care for people living with HIV/AIDS, their families and caregivers; a system that promotes services that are evidence-based and user-friendly. We value effectiveness and accountability at all levels. • Simplicity in our decision-making process, and in the design and delivery of services. • The wide range of cultural diversity among us, and we value services which are culturally specific and culturally relevant. • An equitable distribution of services, information and other supports throughout the entire six-county Transitional Grant Area. • We value the proactive distribution of easily accessible information appropriate to all styles of learning. Individuals then selected 2-3 values that they would focus on during the day's meeting, discussing those values in small groups, then indicating their selections on a wall chart. All values were selected by at least one attendee. The large group then discussed their experiences in reviewing and selecting these values.
Finalize FY26-27 Service Priorities	*Presenters: Scott & Aubrey* See slides. • Discuss focus on baseline funding • Review FY25-26 Allocations charts

Item**	Discussion, Motions, and Actions
	Part A Allocations Only  **Part A and B Allocations**  Emergency Financial Assistance – this $100,000 has already been reallocated, and is being dispersed into the community Medical Transportation – this $112,000 is planned if our carryover is approved by HRSA Preliminary Vote on Service Priorities 1) Mental Health (9 votes) 2) Medical Case Management (8 votes) 3) Medical/Outpatient (7 votes) 4th (tie): Emergency Financial Assistance & Medical Transport (5 votes each) **Decision: these service priorities approved by consensus.**

Item**	Discussion, Motions, and Actions
Finalize FY26-27 Service Guidance	*Presenter: Scott* See slides. A preliminary vote was held on the service guidance. While the majority of participants voted yes, there was no consensus in the online vote. By consensus, the group decided to vote on these service guidance changes as an entire package. **Decision: the group approves all of the service guidance changes by consensus.**
Review Scorecards	*Presenters: Aubrey* Stations were set up around the room with two service scorecards and their corresponding needs assessment data. With their 2-3 Planning Council Values in mind, individuals either (a) visited at least 3-4 scorecards to review data and made notes on the collective sheet, or (b) reviewed scorecards at their own seat and wrote on sticky notes to add to the collective sheets.
Small Group Summaries	*Presenters: Aubrey* Attendees then split into small groups, with each group using the comments from the previous activity to create summaries of two assigned scorecards.
Scorecard Summary Shareout	*Presenters: All* Oral Health • Small dollar allocated, but spent 95% of all Part A allocations • Program Income Part B dollars = bulk of the funding • High viral load suppression • Long term, aging PLWH population will need more oral health support • Q: Do we know yet if Part F will be pulled? • Rural counties seem to be underserved • People of color seem to be served well Food / Home Delivered Meals • Part A funds not fully expended, remainder of over $36K unspent due to contractor delay in signing agreement • There were additional dollars reallocated to this category • Most funds spent on home delivered meals • Case manager offering home delivered meals based on need • Some special needs may include post-surgery or other mobility issues • More women served; More served in Clark County

Item**	Discussion, Motions, and Actions

	Substance Use Disorder
	• Category provides peer services referral to care, specialty, case management, and support to vulnerable people who use drugs.
	• Client demographics are fairly similar to TGA
	• 51 clients served in 2024
	• Good use of available funds
	• About 95% spent pretty consistently
	• Still access needs outside Mult Co
	
	Mental Health
	• Services much needed
	• Well spent category – 94%
	• Need more access to services outside Mult Co
	• 150 hours spent on therapy
	• MH important because it works with housing and SUD treatment as well as HIV services
	• Disproportionately spent in Mult Co
	• Whatever we are spending, there is still a lack of access to MH services
	
	Early Intervention Services
	• Q: Even though testing for VL was consistent, only 80% were virally suppressed. If labs increase, but viral load results going down, this may need to be examined. Is it connected to long acting injectables?
	  ○ Clarification: EIS clients don't generally have a high viral suppression rate, because they are newly diagnosed. The data we really need to keep an eye on is rate of annual lab.
	• Q: By the time an individual has connected with a pharmacy and are on medication, have they moved out of EIS? A: Usually yes.
	• CORRECTIONS- People who are enrolled in EIS services are typically more complex cases, struggling to get into services.
	
	Housing services
	• Part A not fully expended, 90.93% spent
	• Part B support large number of people served
	• Maybe we need to focus more on long term survivors
	  ○ Develop a portfolio for people with major mobility issues, seniors and those who are aging (e.g., retirement properties with activities, social engagement)
	  ○ Could include emergency rent relief, mortgage payments
	Medical Case Management (MCM)
	• Serves a large number of clients, the most of any current RW service

Item**	Discussion, Motions, and Actions
	• Does a massive amount behind the scenes – system navigation, open enrollment through OHP • Especially important for those with limited resources to access and stay connected to care • Large caseloads and need for more staff Non-Medical Case Management • Supports people and families to connect with resources in community • E.g., substance use treatment navigation, health insurance enrollment • Q: Do we know why they're underspent? A: Part A amount underspent is pretty small. • A lot of people with HIV have co-occurring substance use disorder; these funds also pay for a substance use counselor to assist in getting them into treatment – readiness and support. Vs. substance use service category, that actively gets people into treatment. Notes from HGAP ** No underspending is due to lack of need ** HGAP will be being more strict about pulling back unspent funds. Medical • Part A funds fully expended • Receives no Part B funding • High VL suppression • Serve about half of people in TGA • Not enough funding & access beyond Mult Co • Need to reach more people of color based on Latinx/Black clients Minority AIDS Initiative (MAI) • Always spend all their money • Flat funded for last several years • Several programs support clients who are Latinx, Black/African American, Immigrants & Refugees • People who look like them – important to build trust • Potentially will receive decrease/cut from HRSA Psychosocial • Ex. Support groups, drop in meals, long term survivor workshops • A category with tremendous need and benefits • Not enough transportation support to help keep community engaged • Many of these offered in Mult Co; not enough access in other counties Emergency Financial Assistance (EFA) • Ex. Cell phones, IDs, birth certificates, utility bills

Item**	Discussion, Motions, and Actions
	• We generally know this money will get spent • The same or more funding needed • Paying for utilities is a big problem • Can be difficult to access support for medical procedures, life events Q: What do we know about Program Income Part B funding right now? A: No specific cuts just yet. The overall dollars will decrease in future years, due to no longer having carryover.
PC Year in Review	Shared via handout on the Portland Ryan White TGA, which includes information on presentations, panels, funding, and staff updates.
Baseline allocations for FY26-27 (Flat Funding scenario)	HGAP proposes: • Not funding EFA with Part B. It's difficult to meet the state requirements. The state only allows EFA for a couple of purposes. • Leave MAI as is, as this group does not determine how much MAI funding we receive (HRSA uses a formula to calculate this) SEE SLIDE FOR HGAP PROPOSAL • 6% cut to services to accommodate EFA and Medical Transportation • If the Planning Council wants to fund EFA and Medical Transportation funded, you need to make cuts somewhere else. • This proposal is a straight 6% reduction, with the except of MAI. • You do not have to take this recommendation • There is no perfect solution • We don't know the final allocation amount Aubrey provided instructions on small group breakouts.
Small Group Draft Allocations	*Facilitators: Diane Quiring & Sean Mahoney (blue group), Greg Fowler & Chris Keating (green group), Julia Lager-Mesulam & Steven Davies (red group)* Attendees split into three groups, and each drafted an allocation proposal.
Movement Activity	*Presenter: April*
Large Group Allocation Proposals	*Presenter: Scott* Each small group shared back their proposals. Red group • Decided to keep EFA and Medical Transportation • Very challenging conversation about decreases in funding • Keep Medical Transportation at $80K • Removed $20K from EFA to balance budget (HGAP's initial proposal was actually a bit higher than flat funding)

Item**	Discussion, Motions, and Actions
	• Decreased all others by 6% Blue group • Had a lot of discussion about the medical transportation pilot • We ultimately came to a consensus to support HGAP proposal • In justification, we made a comment in medical transportation ○ Continued funding of pilot. If initial funding is not available, or if HGAP determines pilot is not feasible or if the funding and the need do not match, reallocate 50% to EFA, then increase all other categories proportionally. • Guidance for reallocated EFA funds to be used for transportation? • Note: the total spending for this proposal is slightly over target (as was the HGAP proposal) Green group • There was a lot of pushback that funding is being cut all over, so funding a new category may not be a good idea at this time • We decided to fund Medical Transportation at $40K, so put a little money into it and see how it functioned • We also decreased EFA assistance to $120,000 • This resulted in a 5% cut in all other categories (reduced cut compared to HGAP proposal) • PC was initially told that Medical Transportation would require a certain amount for staffing. We need to be more creative about use of funding (e.g. how to provide services without increasing staffing) Comments • Current allocation for EFA (including Part B) is $170K, so these other amounts ($120K, $140K) would be decreases • EFA: this is a very emotional and impactful category. It pays for IDs for houseless individuals, utility bills to prevent utilities from being cut off. • Medical transportation vs EFA: in MT, a caseworker can arrange for mileage reimbursement, multiple instances; in EFA, have more limited usage for transportation. • We need to realize that in the future, we'll have less money to spend. • Looking at equity between counties in the TGA, EFA is used much more in Multnomah County than in other counties. Proposal: starting with green group's proposal, change 5% to 5.5% cut, put this money back into EFA • Clients often seek out EFA and Medical Transportation, which can bring people back into care.
Finalize Allocations	*Presenter: Scott*

Item**	Discussion, Motions, and Actions

	• Proposal: Add all three proposal amounts then divide by 3 for both medical transportation and EFA.
	  ○ That would be the fastest proposal – let's put a bit more thought into it.
	• Proposal: Start with HGAP proposal, decrease EFA from $80K to $50K, return those $30K funds to original service categories
	  ○ Consider what will be sustainable with reductions next year
	  ○ Let's try to focus today's discussion on the current year
	• Remember: small amounts are going to mean more to smaller categories than to larger categories
	• Motion: 140K to EFA, 50K to MT, remaining proportional
	  ○ Consensus not reached
	• Suggestion: 120K to EFA, 50K to MT, remaining proportional
	  ○ 140K appears to be double the 70K it was previously awarded from Part B Program Income
	• Q: How much of EFA is being spent how fast?
	• A: One provider ran out in a couple of months, the other is rationing
	  ○ There's been quite an additional need for EFA.
	• FY24-25: Base amount for Part B Program income was $70K then $60K
	• FY25-26: This year start = $70K; added $100K from Part A (first time)
	  ○ Q: Can we give guidance about what EFA is spent on, to try to prioritize how these funds are spent?
	  ○ A: Absolutely. We're looking for equity between providers.
	• Guidance committee will provide guidance to both EFA and MT
	• Motion: 140K to EFA, 50K to MT, remaining categories get proportional decrease
	• **Decision: motion passes with consensus**
	
	5% increase proposal
	• Suggestion: 5% COLA increase across the board
	• Motion: base budget plus 5% COLA increase across the board
	• **Decision: motion passes with consensus**
	
	See Addendum for Allocations Table

Community Building	*Presenter: April* Group activity: Head, heart, hands – what is one thing you're thinking, feeling, and/or planning to do?
Evaluation and Closing	*Presenter: Scott* Thank you for participating in this meeting. Please complete your evaluation. Next meeting: Tuesday, Oct 7 from 3:00 to 6:00 PM at Southeast Health Center (3653 SE 34th Ave., Portland, OR)
Adjourned	4:00 PM

ADDENDUM - PSRA Allocation decision (Baseline/Flat Budget)

(voted to add on November 4, 2025)

FY26-27

Priorities	Service	Change by percent?	$ Increase by %	Specific Changes	Total Request
	Across the Board % of decrease				FINAL
	-6.00%		Total % Change		-0.06%
X	Medical Care	y	(50,696)		794,234
X	Mental Health Services	y	(16,382)		256,647
	Oral Health Care	y	(1,284)		20,122
X	Medical Case Management	y	(72,005)		1,128,072
	MCM Minority AIDS Initiative		-	6,468	158,500
	Early Intervention	y	(10,107)		158,340
	Substance Abuse Treatment	y	(9,330)		146,172
	Housing Services		-		-
	Psychosocial Support Svcs	y	(25,241)		395,444
	Food/Home-Delivered	y	(4,462)		69,906
	Non-Medical Case Management	y	(9,024)		141,374
	Emergency Financial Assistance		-	140,000	140,000
	Medical Transportation			**50,000**	50,000
	Total Service Allocation		**(198,531)**	**196,468**	**3,458,811**
	Subtotal Core Services	enter % change			2,662,088
	Percentage in Core Services	allocation goal	3,460,874		77.0%
	Subtotal Support Services	difference	2,063		606,724
	Percentage in Support Services				17.5%

As noted in the minutes, the 5% increase scenario would be the base budget (above) plus 5% COLA increase across the board.

ATTENDANCE

Members	Present	Absent*	Members	Present	Absent*
Jamie Christianson, she/they	**X**		Robb Lawrence, he/him		**E**
Chautauqua Cabine, she/her	**R**		Heather Leffler, she/her		**E**
Steven Davies	**X**		Sean Mahoney, he/him	**X**	
Carlos Dory, him/his	**X**		Robert Middleton, all pronouns	**X**	
Michelle Foley, she/they	**X**		Scott Moore, he/him	**X**	
Greg Fowler, he/him	**X**		Jamal Muhammad, he/him	**X**	
Jeffrey Gander, he/him	**X**		Diane Quiring, she/her	**X**	
Kris Harvey, he/him	**X**		Scott Strickland, he/him	**X**	
Shaun Irelan, he/him	**X**		Tessa Robinson, she/her	**X**	
Lorne James, he/him	**X**		Nick Tipton, he/him (Co-chair)		**E**
Chris Keating	**X**		Bee Velazquez, she/her/ella	**X**	
Julia Lager-Mesulam, she/her	**X**		Abrianna Williams, she/her	**R**	
HGAP Staff			**Guests**		
Sandra Acosta Casillas	**X**		ASL Interpreter – Claire, she/her	**X**	
Aubrey Daquiz, she/her	**X**		ASL Interpreter – Amy, she/her	**X**	
Jenny Hampton, she/her (Recorder)	**X**				
Britt Sale, she/her	**X**				
Neisha Saxena, she/her					
Derek Smith, he/him	**X**				
Grace Walker-Stevenson, they/them	**X**				
Sophie Homolka, she/they					
Niko Noga, he/him	**X**				

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