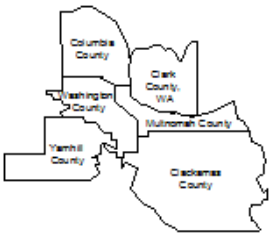
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: April 7, 2026

Approved by Planning Council: June 2, 2026

Grantee: Multnomah County Health Department

Multnomah County

Portland Area HIV Services Planning Council
MEETING MINUTES

Tuesday, April 7, 3:00 – 6:00 pm
Lloyd Corporate Plaza
919 NE 19th Ave. Room 380

AGENDA

Item**	Discussion, Motions, and Actions
Call to Order	Scott called the meeting to order at 3:04 PM.
Welcome & Logistics	Nick welcomed everyone to the meeting and reviewed logistics.
Candle Lighting Ceremony	Barry shared a memory of the early days of HIV. Jim Hatch was the first person with HIV in his life. People were ignorant about HIV at the time, and that propelled Barry to being more brave in his own identity as a gay man and person living with HIV. Recalling a family of folks living with hemophilia who were strongly affected by HIV. Honoring those who we have lost through the years.
Announcements & Introductions	Attendees introduced themselves and their favorite stretch. Announcements ● Please send your scheduling preferences for an (optional) appreciation picnic, the July PSRA meeting, and a presentation from Graham Harriman for townhall data being shared back to PC on paper or virtual form. ● Reminder to please complete your evaluation. ● Highlight awareness days upcoming: National Youth HIV Awareness Day, and Transgender HIV Testing Day. ● May 5 elections- nominations due April 27, Nick Tipton (co-Chair), Greg Fowler (Ops) and Diane Quiring (Ops) are eligible to be nominated again. Please speak with someone before nominating them. One additional available seat (Jamal moving out of the area).

Item**	Discussion, Motions, and Actions
Agenda Review and Minutes Approval	The previous meeting minutes were shared in advance via email. The minutes were reviewed. Barry motions to approve. Scott Strickland seconds the motion. Minutes adopted by consensus.
Public Testimony	Please invite community members to provide public testimony.

Review Key Data

Update from May 5 meeting**: Please see the following notes on client counts that apply to all Service Category Scorecards for FY24-25.

- *NOTE: For Fiscal/Expenditures and Service Utilization, the period covered is the grant year (March 2024 - February 2025).
- For Clients Served, Performance Measures, and Demographic Data, the period covered is the calendar year (January 2024 - December 2024).

Note: HGAP will work to ensure the upcoming Scorecards more clearly outline which client count is being referred to where, who is being included in viral suppression measures, and some potential implications to consider in interpretation

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Grace presents key data related to the panels upcoming.

- For Mental Health services, about 77 folks (3% of clients) received 2721 hours of support. More folks of color, greater viral suppression. Those in MH often have medical support.
- Substance Use services is also fairly small, about 50 folks served (or 2% of the TGA). Demographics are similar but with more young folks. 1430 hours of services provided in total. Slightly higher labs and strong suppression rates.
- Non-MCM is about 71 clients (3% of TGA clients). More folks of color, younger clients and more folks out of care. This includes lower viral suppression overall, which makes sense as needs tend to be more complex for this population.
- Food services- about 119 clients served (4% of clients) More women and more Clark County residents. With changes to funding, this may change in the coming year. Similar rates of viral suppression. Food is about 2% of the budget overall.
- Psychosocial support- about 204 clients (8% of TGA clients). Higher American Indian services, lower lab rates and viral suppression. When we see lower annual labs and viral suppression, that tends to be a higher need for linkage to care. About 12% of the budget overall.

Item**	Discussion, Motions, and Actions
	● EFA services- about 296 clients or 14% of clients. Tends to be more Native, Black, Latine, trans, female. Also higher annual labs. Makes sense because the folks tend to be referred from MCM. A smaller segment of budget.
Panel 1: Mental Health & Substance Use (and non-MCM) related services *Panel presentation presenter(s): Sean Mahoney, The Peer Company; Stephani Workman, Quest Center; and Ulices Cardenas, Cascade AIDS Project.*	
Summary of Presentation: **What services do you offer related to mental health and substance use?** -Previously in-house, now refer out, critical need now. Providers are overwhelmed. -Quest has both services onsite. We provide services that are abstinence-based and not. Peers familiar with Quest can help combine services and provide extra support. -Primarily providing peer support while folks are in the hospital. Folks tend to be in a tough spot. There are limited resources to connect folks to when they leave back to the community. Up to 90 days after hospital follow up care. **How would you describe needs and unmet needs/gaps?** -Primarily harm reduction and being able to access those things. Federal issues around Narcan. More education needed for health professionals who don't always have great insights into folks who are queer and active in drug use. -Housing situation is a big factor. Folks who are unhoused and cannot get started as they need peers and also have their housing needs met. -Accessing MH and SU treatment, lots of want and need. Peers in general do a great part of getting folks referrals to where they can access and help to get them there. Important to take that first step and have someone take the step with you. Q&A: ● What's the Narcan update? Federal distribution is ending. We had a 20% decrease in overdose deaths for several years, and predict a setback. ● What's the history of offering substance treatment at CAP? Used to have Cascadia and a staff member in-house and peer support, but we lost that staff. ● How are referrals made at CAP now? Tend to send people to Jamie and navigate for substance use. ● Is this an adequate process? Insurance is an issue. If a person is ready for a treatment program, we refer to Jamie, who evaluates and encourages clients not to drop out. If serious, a peer will support them for onboarding. Will give	

Item**	Discussion, Motions, and Actions

them extra support as a client. More community building when we don't know what's going on.

- What are Quest's challenges in helping navigate peer support in our RW system? Not enough beds or programs. Do our best to stay in contact with folks, help them navigate the system and keep them engaged until those needs can be met. Key obstacles are waiting lists and finding a program that is a fit.

What support is given after a person gets into housing?

- Not currently, we see the need for more to help prevent overdoses. Goal to identify supports while moving folks in. If folks get a community referral, that person can be the follow up and walk alongside them to appts and help access meetings, make sure they have food, etc. Treatment isn't a magic wand. We set them up to fail if we drop them in housing without support.
- Quest has Stephani supporting Women of Wisdom group and Alex with Men's group. We do in-home visits for those clients who need them. Various group services throughout the week. Try to stay in touch with folks. Peers will support one another that results in long term clients.
- Julia reports that MCM stays connected to folks as long as they want as part of the safety net, even though case loads are very big.

What are reasons clients don't get follow-up after becoming housed?

- We follow for 90 days, but everything has a waitlist. In Multnomah, reversing Measure 110 gutted programs (e.g. one went from 30 employees to 7). So when folks are motivated in the hospital, they are often discharged to homelessness because there's nowhere to send them.
- Housing case managers have long waitlists and cannot spend time one-on-one. If possible, we will work with the clients since we as peers see them more often.

3. If you had funding, what is one pilot you would want to try and why?

-Psychosocial services can help people safely engage with others and stay connected.
-A mobile all-in one team and nurse practitioner/housing support in community to offer services. Provide twice a year injectable for those with adherence problems & get them connected. Engage culturally competent providers (e.g., Spanish-speaking immigrant providers); Bring all the services to folks to meet where they are.
-For those looking to change substance use, sober living with cultural consideration is key. (i.e., getting sober with your people, for example: queer living).

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-Peers doing Hep-C testing & becoming a case manager. Would love to see that with HIV. Folks who are cis or straight identifying may have limited HIV knowledge and use drugs. Having a place for peer-led introduction and support would be helpful.

What culturally-specific resources are available?
-Some exist, but not always available. Don't want them to hear more rejection.
-Peers are a key resource, learning from community and about new programs and recovery services; Native-specific medication assisted treatment (MAT) program.
-Measure 110 funded culturally specific services that got cut; LGBTQ not really added. despite having double the risk of straight folks. Other funding prioritizes queer folks.

-Data comment: Client data presented says MH has overrepresentation of people of color. Don't like pulling together Black, American Indians, and other communities. As an American Indian/Native American, we need to be careful in how we speak about brown folks living with HIV and services given. Many aren't getting services we need.

Where could additional support be delivered while folks wait for other services?
-Esthers is 4-5 hours waiting; could maybe layer on support as well.
-Mobile methadone in Washington County, services with Portland People's Outreach Project (PPOP) as well- housing, food, people can get needles without judgement
-Clark County has Martha's Pantry and a women's group. HIV clients were not particularly comfortable with extra services, so they changed their schedule to a half day to service HIV clients, which decreased stigma and increased comfort/support

4. Lessons or successes you have learned:
-A client needing care for substance use & HIV was part of a contingency management approach pilot program for folks who use meth. It's a reward system to give gift cards. Person went from non-responsive to being motivated and receiving something.
-Difficult client who was expecting the worst. Found them creating goals, staying on meds, getting sober. They transitioned from lost to being someone who is engaging in the world. Realized how important this work is.
-When you are scared and don't know where to go, and need MH services- one client went to three different services. Finally found a location that was a good fit and a spot opened up. We took that time to connect and I feel like change is possible.

Has any opioid settlement funding arrived/offered support?
-Don't believe peer services were ever granted these.

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-Counties receive funds and decide on those. Washington County isn't using for harm reduction, but on the front end. Not sure where Multnomah County is using them. -Settlements can have restrictions on utilization, and displace general County funds. So we may think we're getting more resources, but then taxes are in freefall, so counties may remove our general fund dollars. No increase in services at this moment.	
Panel 2: Meeting Basic Needs: Food & Emergency Financial Assistance (will also share some info on related Psychosocial Support services *Presenter(s): Brent Blackwell, Esther's Pantry; Chautauqua Cabine, Ecumenical Ministries of Oregon Day Center; Jacob Schmeider, Quest Center; and Nicki Turk, Cascade AIDS Project.*	
Summary of Presentation: **1. What services do you offer and who is accessing** -EMO clothing closet, shower, peer support, laundry services, and opening space to other organizations, DBX is a home delivery program for a week of food every Wednesday/Thursday. Serve about 80 clients regularly. Have a waiting list now. -Housing case management, short and long term housing case management and navigation. Waitlist and peer support by RW and other programs attached to housing. Eviction prevention. Medical navigation with CareLink of newly diagnosed or out of care. Culturally specific Minority AIDS Initiative for Latine clients and partnership with Urban League for Black/African American community as well. Service center for computers and phones. Also connecting folks to health-related social needs (HRSN) Medicaid benefit. CAP also does prevention and benefits navigation. -Esther's Pantry partnered with Oregon Food Bank and was required to open the pantry to everyone 6 years ago. Todd's corner is still once a month for folks who are HIV+ (anything except for furniture, medical equipment, anything that is dirty or stained). Expediting home delivery of food boxes with case workers. Partner with CAP and others like Partnership Project to deliver culturally-specific food to folks afraid to leave home due to immigration status. -Quest Center has a robust Emergency Financial Assistance (EFA) program. That means utilities, phones, eye exams and eyeglasses, government IDs, etc. Also last year with the SNAP crisis were distributing $100 food vouchers. No tent requests in years. Folks in the region with HIV who are below 300% federal poverty level (FPL), mostly Health Services Center refers but also CAP, Day Center and Partnership. Question on Day Center-is this only for people with HIV? Do they need an intake?	

Item**	Discussion, Motions, and Actions

-Yes, they fill out an information release and we usually know due to a doctor sending them over, then send a verification.

2. Describe food, basic needs and EFA needs for folks and anticipation of gaps?

-Increase in EFA need and spent the budget quickly. EFA is a vital service for many folks
-Food and housing are key gaps due to cost of living, inflation, all services increasing
-Seeing folks who didn't need our services for a long time expands need. Food, wagons, sweatpants, comforters, suitcases. Spending faster due to growing needs
-Housing a huge need. Demand is far exceeding ability. Rents are increasing and folks are accessing eviction prevention more. Seeing dollar amount of requests increasing in recent 5-8 years. People are needing multiple months of assistance in a way they didn't previously. Folks may be 4 months behind, so they need $6k to catch up. Used EFA funds to someone with mobility issues who needed a rollcart for groceries.
-Not as many houseless clients as before. Some are coming back due to slowdown getting them (back) into housing or not being counseled on responsible renting. Eviction restarts the cycle. (e.g. One client lived there for a year and didn't know how to pay the rent). Need counseling when housed so they aren't in a recurring cycle.
-Food prices are soaring, meat products rarely available. Wednesday food distribution at EMO site used to have chicken and fish; now it's snacks and veggies. Offer side items so they can use funds for protein. DBX has seen a big RW increase (18% more folks than last year). Aging and Disability supports 33% of older clients with HIV and also diabetes and also have a waiting list now.

3. If you had funding and resources, what's a pilot project you would want to try and why?

-Supporting clients with housing issues (e.g., counseling, taking classes for staff to provide support), more donations for home. If more funding, more counseling and more staff to support housing (e.g., 3 tiny houses and pods for the Day Center).
-Vision of a shuttle bus that takes people living with HIV to various food sources. (Delivering to clients and/or taking a but takes a lot of time and/or labor).
-OHSU partners with Lyft to deliver food boxes to new parents who are food insecure. Delivered those for a fee; could expand that, but need funds, food or capacity, staff.
-CAP also has Aging Well and a warehouse program. In a dream world, we'd purchase furniture. Housing Opportunities for People with HIV/AIDS (HOPWA) removed this as an eligible expense 9 years ago. Now rely on donations or community warehouse. CAP has very limited resources for moving assistance to move between apartments. Warehouse program people have to abandon items because they cannot move them.
-Day Center offers hygiene items, so clients can then come get those items.

Item**	Discussion, Motions, and Actions

4. Any recent successes/lessons you have experienced?

-Moving to new location. Learn from clients all the time not to underestimate them.
-Food box delivery program at Partnership Project- Oregon Food Bank created culturally specific food boxes so we don't have to use our budget. Project became a statewide initiative because Lauren figured out a solution for this problem.
-Client story earlier was good example of various entry points that folks come through. Developing a relationship can help you determine other connections. New client listed their primary need of housing and food at intake. They got referred to housing pathways and nearing the end date for shelters after a year. Got on waitlists and referral to Tod's Corner. Mobility issues, so shared the Food Finder website for closer pantries. CareLink navigator took him to Esther's and they needed an HIV MCM. Missed appts with Partnership, and then was able to get scheduled.
-Quest EFA clients come from other services, so less connection to clients but there are impactful stories (e.g., Somebody without glasses can't see their prescription bottles or is getting migraines). 815 EFA transactions last year; lots of success stories.

Question about Day Center location- It's on Ainsworth and NE 29th. DBX is on 71st.

More resources for food
-Folks could advertise more (e.g., Tuesdays, Wednesday; both places have capacity)
-Community navigators connect them to any services available with comprehensive resource guides. Non-HIV services are great, but it's helps to have culturally specific orgs that understand the challenges that folks with HIV have
-Reminder: RW are funds of last resort. Refer to places closer than Esther if applicable. Leslie at intake tries to share the resources and not drain that one resource.
-They may love the resource, but may need a nearer resource. Doesn't guarantee the location is sensitive to HIV+ or LGBT folks.
-Food box requests- Esther's ask about dietary, health, or religious needs and 75% of the time these can be accommodated to maximize resources.
-Quest has a nutrition program: Psychosocial preparation of meals & eating together; Nutrition coordinator works across programs. Cooking demo and recipe to take home. Cooking, fresh ingredients, mental health, wellness. Fermentation workshops, anti-inflammatory workshops. These are currently in-person, closed meetings.

Question on clients who have dementia, in studies a lot of women with HIV have a higher chance of dementia; healthy food can be key, is there an approach to that?
-Counties usually have disability and aging program that clients can access first.

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-Important to utilize the resources that are available and make sure they are culturally specific as needed. Aging & HIV are different areas as managed in the state.	
Panel Reflection in small groups	Members are invited to reflect on the takeaways from the panels; meet in groups; assign roles; and determine a takeaway.
Summary of Discussion: Individual conversations within the groups.	
Large Group Shareback	Presentation of group findings
Summary of Presentation: Application of PSRA for the currently expected funds. -Group 1: Panel 1- continuity of care from start to aftercare, specifically Ulices ideas. Panel 2- availability of food and housing go up, getting less for more money. -Group 2: Service providers need to know about the needs (e.g, culturally specific community engagement). BIPOC folks not being grouped together in data. Importance for a guiding person in peer support or case management, taking journey with you. Mobile clinic approach with peer support. Clients feel tossed between organizations. -Group 3: Isolation and lack of community for mental health. Psychosocial services, needs are overwhelming. For housing: transportation in services is important. Delaying the disruption in services. Prioritizing money and having the means to make it. Relying on EFA funds, which run out a lot. Scarcity. -Group 4: Convo about how there were more volunteer peers and hopefully ways folks with lived experience can volunteer in that. Want to make sure Part B Program Income is there and we can ensure those funds are available on behalf of the TGA. -Group 5: Always greater need than what we have funds to do with compressing budget. Asking folks to do more with fewer funds. Make sure that services are culturally specific. MH and food, meet folks where they are at.	

Item**	Discussion, Motions, and Actions
Evaluation and Closing	Thank you for participating in this meeting. If you have feedback / comments / ideas, please include them in your evaluation. Next meeting: virtual Tuesday, May 5, 3:00-6:00 PM.
Adjourned	6:03 PM

ATTENDANCE

Members	Present	Absent*	Members	Present	Absent*
Jamie Christianson, she/they		**E**	Sean Mahoney, he/him	**X**	
Chautauqua Cabine, she/her	**X**		José Maidana Cejas		**A**
Eric Cockley	**X**		Robert Middleton, all pronouns		**E**
Steven Davies	**X**		Scott Moore, he/him (Co-chair)	**X**	
Carlos Dory, him/his	**X**		Jamal Muhammad, he/him		**E**
Michelle Foley, they/them	**X**		Troy Preble		**E**
Greg Fowler, he/him	**R**		Diane Quiring, she/her		**R**
Jeffrey Gander, he/him	**R**		Tessa Robinson, she/her		**R**
Kris Harvey, he/him	**X**		Adie Steckel, they/them	**X**	
Shaun Irelan, he/him	**X**		Scott Strickland, he/him	**X**	
Lorne James, he/him	**X**		Nick Tipton, he/him (Co-chair)	**X**	
Chris Keating	**X**		Bee Velazquez, she/her/ella		**R**
Julia Lager-Mesulam, she/her	**X**		Barry Walden	**X**	
Robb Lawrence, he/him	**X**		Jeffery Wells	**X**	
Heather Leffler, she/her			Abrianna Williams, she/her		**R**
HGAP Staff			**Guests**		
Sandra Acosta Casillas		**X**	ASL Interpreters	**X**	
Aubrey Daquiz, she/her	**X**		Ulices Cardenas	**X**	
Sophie Homolka		**X**	Stephani Workman	**R**	
April Kayser, she/her		**X**	Justine DaCosta	**R**	
Britt Sale, she/her	**R**		Niko Templer	**X**	
Derek Smith, he/him	**X**				
Grace Walker-Stevenson, they/them	**X**				

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