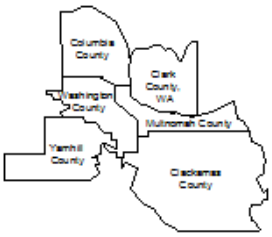
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: February 3, 2026

Approved by Planning Council: March 3, 2026

Grantee: Multnomah County Health Department

Multnomah County

Portland Area HIV Services Planning Council
MEETING MINUTES

Tuesday, February 3, 4:00 – 6:00 pm
Zoom meeting

AGENDA

Item**	Discussion, Motions, and Actions
Call to Order	Scott called the meeting to order at 4:00 PM.
Welcome & Logistics	Nick welcomed everyone to the meeting and reviewed logistics.
Candle Lighting Ceremony	Jamal offered the Candle Lighting in remembrance of Dr. Ron Sable. Cook County, Chicago HIV clinic founder. Ran for City Council as an openly gay man and narrowly lost. Died of AIDS in 1993. Founded the clinic that has been renamed Core Center. Honoring him today.
Announcements & Introductions	Attendees introduced themselves. Announcements ● Introducing Adie Steckel, newest member. ● At 30 members of the PC currently. ● Reminder to please complete evaluations of the meeting. ● Elections in June- 3 committee members and 1 co-Chair position are open for election, more information upcoming.
Agenda Review and Minutes Approval	The previous meeting minutes were shared in advance via email. Correction offered: Add new member Jeffrey Wells to the list of attendees. The minutes were reviewed. Bee motions to approve. Shaun seconds the motion. PC adopts the minutes by consensus.
Public Testimony	Please invite community members to provide public testimony. We had a request, but the person was not in attendance.

Item**	Discussion, Motions, and Actions
Presentation on New Diagnoses and Not in Care	*Presenter(s): Jeff Capizzi & Lea Bush (Oregon Health Authority), Grace Walker-Stevenson (HIV Grant Administration & Planning)* *See slides.*

Summary of Presentation:

Jeff presents that OHA tracks and reviews trends, and attempts to predict and track these data. These numbers represent people, and acknowledges sensitivity to the trauma and lived experiences of people. All references to our Transitional Grant Area (TGA) in this presentation refer to the 5 Oregon Counties only (not Clark, in WA).

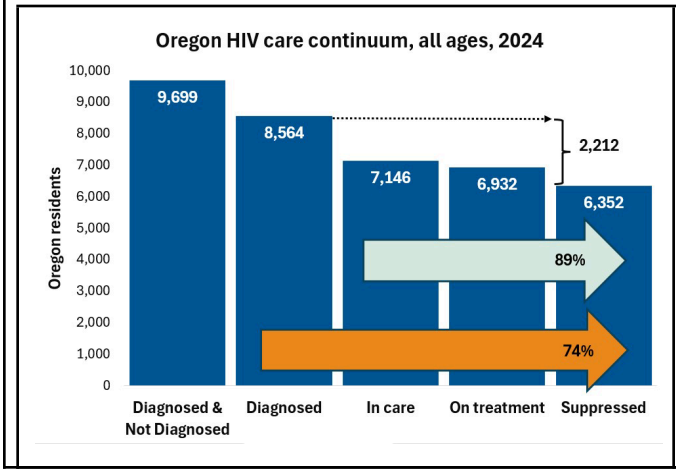
People living with HIV and those newly diagnosed (2025 data)

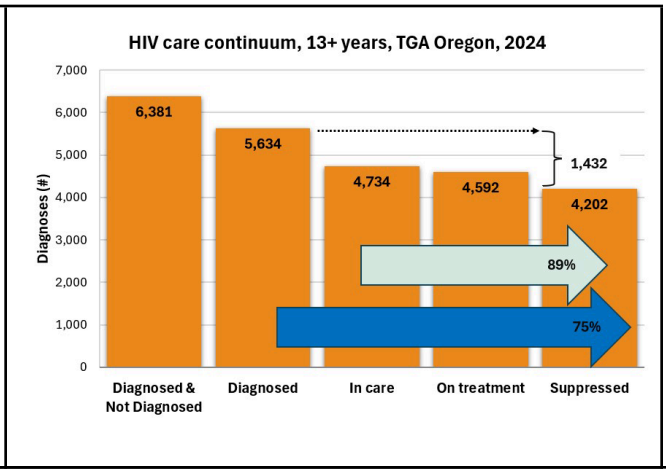
- 66% of people living with HIV in the Oregon are in the TGA (5,637 of 8,564)
- 224 Oregonians were newly diagnosed in 2025, and this number isn't final yet.
    - 129 of these new diagnoses are in the TGA (up from 111 in 2024)
- The TGA may have been more affected by COVID, due to population density.
- Estimated 747 people in the TGA are living with HIV and are undiagnosed.
    - Source: CDC looks at reporting delay and past studies of random testing and outreach to determine who didn't know they were positive.
- 2017-2025 we see some jumps in total HIV cases in the TGA.
    - May be connected to COVID data collection as well as clients moving (e.g., moving to Oregon/TGA due to safety issues, finding sanctuary here)

Morality Data

- Death rate was flat until about 2019 when they started increasing slightly.
- Cause of death types within those living with HIV included an increase of overdose and substance use deaths as a major contributing factor. Presentation includes trends in 10-year survival.

HIV Continuum shared (see Oregon and TGA- Oregon-only continuums).





Item**	Discussion, Motions, and Actions

Summary of factors impacting more likely to be out of care, lower viral suppression, and lower 10-year survival rates:

Associated Factor	More likely to be out of care	Lower Viral Suppression	Lower 10-year survival rates
Experiencing houselessness or unstable housing	X	X	X
20-29 years of age	X	X	
With American Indian/Alaska Native race/ethnicity		X	
Reporting injection drug use (IDU)			X
Reporting injection drug use (IDU) who were male		X	X
Reporting male-to-male sexual contact and injection drug use (MMSC/IDU)		X	X
Reporting non-injection drug use		X	
Reporting sex with a person who injects drugs		X	
Residents outside of Clackamas, Multnomah, and Washington counties			X
Residents in rural counties		X	
Reason for testing: Contacted by partner/county		X	
Diagnosed in the hospital		X	X
Diagnosed in corrections			X
Older when diagnosed			X
Reported with hepatitis C and HIV			X
Diagnosed late (CD4 count < 200)			X
Not virally suppressed within 90 days of diagnosis			X

Item**	Discussion, Motions, and Actions

Not in Care

Lea presents that the Not In Care group has a longer standard (16 months) to review people who are not receiving labs within the clinically prescribed period (12 months). Refers these lists over to DIS at the County level for accessing clients.

Overview of analysis of multiple data sources that are used to determine who is Not In Care (see visual from presentation). No longer use Facebook.

Initial 2025 Not in Care list: 856 people
Many were addressed (top reasons: 228 moved out of state and 264 presumed out of state, 144 had a lab result during investigation).

100 remaining persons in the state are believed to be out of care.

- Sent those to the 16 health jurisdictions statewide with at least one person
- 3 jurisdictions in the TGA had 8 or more people on their list.

Analysis of the 100 who were found to be actually Not In Care didn't show any clues to demographic variation in communities of greater concern. Most had connected with the medical system in some way, but were not interested in HIV care.

Questions
Q: Re: the limits to our system of care, why do we still have Not In Care folks?
A: One-on-one interaction from local health departments will help clarify those.

Q: What is your engagement with prisons?
A: Coffee Creek engagement listed and when folks are actively incarcerated it is possible to work with the staff and try to engage.

Q: Re: Elite controllers
A: There is encouragement from Public Health to take meds even for those who are showing non-detectable viral loads.

Jeff indicates that 94% or so of those in care are virally suppressed. There can be viral suppression then loss. There is ~86% consistent viral suppression when those without annual labs are counted as "not suppressed." That means about 14% of folks are a bit more out of care, or not consistently suppressed.

Item**	Discussion, Motions, and Actions
Reflection & Large Group Discussion	*Reflection & Large Group Discussion (*Mural Board) *Summary of Discussion:* Sharing the Mural link to folks, encourage them to add ideas/thoughts/questions here or in evaluation form.
BREAK	
FY25-26 Spending Update	*Presenter(s): Derek Smith* *See slides.*

Summary of Discussion:
Overall Spending to Date (including December invoices)
Expectation: 83% spent, Current: 81%

Service Category	Allocation	Expenditure	%	Notes on perceived underspend
Medical	$855,928	$775,483	91%	
Mental Health	$295,220	$233,712	79%	One provider behind; submitted spend plan
Oral Health	$21,406	$14,634	68%	Low but guarantee of spend and small amount
Medical Case Management	$1,200,077	$964,110	80%	
MAI-MCM	$159,071	$125,038	78%	Low due to staffing but catching up- reallocation between providers ($30K)
Early Intervention Services	$161,447	$137,034	85%	
Substance Use Treatment	$155,502	$125,568	81%	
Psychosocial	$420,685	$277,503	66%	Staffing gap, spending plan and corrected expenses
Food/Home Delivered Meals	$89,558	$81,239	91%	Category spend leader vs. last year underspend!

Item**	Discussion, Motions, and Actions

Service Category	Allocation	Expenditure	%	Notes on perceived underspend
Non-Medical Case Management	$150,398	$109,289	73%	Low ($16k), correction of expenses expected
Emergency Financial Assistance	$100,000	$84,581	85%	
TOTAL	**$3,609,292**	**$2,928,193**	**81%**	

Q: Re: Non-Med Case Management, are you concerned about it being spent down?
A: Not, because we've spoken with the provider and corrections will get resolved.

Q: For those pushed out of Legacy/Pacific Source and moved to Healthshare/ CareOregon, are you looking at that as influencing expenditures?
A: We don't fund health insurance directly, and don't exactly know what comes next. RW dollars appear to be stable, but shifts in health insurance, etc. elsewhere will affect folks. We keep monitoring needs, and PC will need to advise on changes re: what's happening in community.

- Comment: Oregon is pretty good at helping people maintain some insurance.
- Clarification: Flex funds were shut down, so people may need more EFA.
- Comment: Flex funds were slow so some agencies were not relying on them.
- Comment: This is the start of recissions of benefits that get at social determinants of health work where cuts will be felt most at this time.

Client Experience Survey	*Presenter(s): Derek Smith, Britt Sale monitoring chat* *See slides.*

Goal: getting brief, important, actionable info, and offering space for additional information. Minimize client & provider time needed.

Overview

- Shifting from 70+ question survey every 2 years, to a much shorter survey at least annually with focused sampling; available in both English and Spanish

Sampling Plan

- Surveys will be sent to a RANDOM SAMPLE of 50 clients for each of the 7 racial/ethnicity categories.

Item**	Discussion, Motions, and Actions
	● 350 total surveys needed- using MyChart when possible first, then email/telephone, then in-person provider outreach (e.g. paper and iPads), mail ● If we don't reach the first 50, will pull other clients to complete 50 per group. Questions were developed based on: ● Previous Client Experience Surveys ● Awareness of provider surveys/Client Advisory Boards ● Best practices/surveys from other Part A regions ● Key areas of focus in our region ● Key areas that our federal funder (HRSA) requires Survey questions ● Introductory Provider Question- "Which organization do you receive services from?" check all that apply (Option: "I do not receive services at any of these") ● 6 multiple choice questions- Will have an open text box to share more ● 6 open-ended questions, and a needs assessment question: Which 3 services do you think are most important for people living with HIV in our region? *Summary of Discussion:* No time, lots of questions/comments in chat; HGAP will develop a response summary and we'll send that out to the PC.
Evaluation and Closing	Thank you for participating in this meeting. If you have feedback / comments / ideas, please include them in your evaluation. Next meeting: Tuesday, March 3, 3:00-6:00 PM, in person at Lloyd Corporate Plaza Rm 380
Adjourned	6:00 PM

ATTENDANCE

Members	Present	Absent*	Members	Present	Absent*
Jamie Christianson, she/they	**X**		Sean Mahoney, he/him	**X**	
Chautauqua Cabine, she/her	**X**		José Maidana Cejas		**E**
Eric Cockley	**X**		Robert Middleton, all pronouns		
Steven Davies	**X**		Scott Moore, he/him (Co-chair)	**X**	
Carlos Dory, him/his	**X**		Jamal Muhammad, he/him	**X**	
Michelle Foley, they/them	**X**		Troy Preble		**E**
Greg Fowler, he/him	**X**		Diane Quiring, she/her	**X**	
Jeffrey Gander, he/him	**X**		Tessa Robinson, she/her	**X**	
Kris Harvey, he/him	**X**		Adie Steckel, they/them	**X**	
Shaun Irelan, he/him	**X**		Scott Strickland, he/him	**X**	
Lorne James, he/him			Nick Tipton, he/him (Co-chair)	**X**	
Chris Keating	**X**		Bee Velazquez, she/her/ella	**X**	
Julia Lager-Mesulam, she/her	**X**		Barry Walden	**X**	
Robb Lawrence, he/him			Jeffery Wells	**X**	
Heather Leffler, she/her			Abrianna Williams, she/her	**X**	
HGAP Staff			**Guests**		
Sandra Acosta Casillas		**X**	ASL Interpreters	**X**	
Aubrey Daquiz, she/her	**X**		Dennis Torres, Gilead	**X**	
Sophie Homolka		**X**	Emmett, MD/MPH student	**X**	
April Kayser, she/her	**X**		Jeff Capizzi, OHA	**X**	
Britt Sale, she/her	**X**		Axel Cervantez, PSU student	**X**	
Derek Smith, he/him	**X**		Dale Sattergren, ORPCA	**X**	
Grace Walker-Stevenson, they/them	**X**		Lea Bush, OHA	**X**	

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