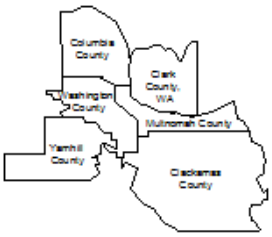
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: March 3, 2026

Approved by Planning Council: April 7, 2026

Grantee: Multnomah County Health Department

Multnomah County

Portland Area HIV Services Planning Council
MEETING MINUTES

Tuesday, March 3, 3:00 – 6:00 pm
Zoom meeting

AGENDA

Item**	Discussion, Motions, and Actions
Call to Order	Scott called the meeting to order at 3:00 PM.
Welcome & Logistics	Nick welcomed everyone to the meeting and reviewed logistics.
Candle Lighting Ceremony	Lorne shared a beautiful candle lighting honoring all of those who are living with HIV and those who we have lost. He acknowledged March 10th as National Women and Girls HIV/AIDS Awareness Day in recognition of women as the life bearers. Lorne shares the impacts of HIV on the Native American community, March 20th as National Native HIV/AIDS Awareness Day and our strength building community together.
Announcements & Introductions	Attendees introduced themselves and their favorite stretch. Announcements ● Introducing Jasmine Gruenstein, new Multnomah County Communicable Disease Program and Service Director ● Jamal Muhammad will be moving to Seattle ● 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. ● Guidance Committee and PSRA Committee seeking members; details about frequency and commitment.
Agenda Review and Minutes Approval	The previous meeting minutes were shared in advance via email. The minutes were reviewed. Jeffrey G. 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
Panel: Engaging Clients in Care: The State of HIV Testing, New Cases, & Not in Care	*Panel presentation presenter(s): Malley Nason, Clackamas County Public Health; Chris Keating, Washington County Public Health; David Cuevas, Multnomah County Disease Investigation; Tessa Robinson, Washington County Public Health; and Joe Duarte, Clark County Public Health.*

Summary of Presentation:

Budget impacts to the prevention work

-Clark County has no budget impacts so far

-Washington County lost a full time nurse because OHA funding was modified to expand funding to all counties, not just the ones most affected by HIV and STIs.

-State dollars as well as Multnomah County funds are used to fund County STI Clinic- the main one in the state which treats all those who need services.

-Clackamas operates more like Marion County- don't do direct, but contract with CAP and Outside In to do direct testing with state dollars- Program Element 81 or HIV/STI Statewide Services (HSSS). Large reduction in the coming fiscal year July- have lost epi and a manager in CD. Pursuing Rural Health Transformation Grant.

-Multnomah- the HSSS dollars are focused on prevention, like testing, resources, linkage to care, serving folks not in care, etc. STI Clinic is funded by general tax funds (County General Fund), and some portion from prevention dollars. Some years ago there were 9 investigators, now there are 6 people.

PC member comments

-Scott notes that HSSS budget is a large portion of the funds that come from the CAREAssist/340B program income bucket.

-Nick clarifies that County General Fund is the overall tax base- and becomes much more rare during difficult budget years.

Changes in needs/new demand for services

-Washington County: high methamphetamine as a key risk factor as it can lead to people not sleeping much with an increased sex drive, and dry mucous membranes which can all lead to increased susceptibility and other risk factors.

-Clark County is seeing more folks who are newer immigrants from places where they already had HIV diagnosis.

-Multnomah County is seeing more folks who are older, who have AIDS diagnosis to start and maybe have been missed for many years with a diagnosis. They may have never been tested for HIV in their lives, COVID gap, lack of insurance, etc.

Item**	Discussion, Motions, and Actions

-Washington County also indicates that during COVID folks ruled out everything else and got to an HIV test earlier. Treatment as prevention- folks are not able to transmit due to their viral suppression. Partner services can also uncover new cases.
-Incarceration history is a major factor as well.
-Clackamas is less about houseless folks, but more about people who have unstable housing, those who contract syphilis, and/or have a carceral history. Latino community are also among those we have less access to.

Funding needs and remaining a priority
-Funding situation- we aren't mandated services or core requirements, but we are related to these programs. Corrections Health, HIV prevention, outreach services for housing settlements and other services are among the first things to be cut.

-*PC member comment* about reaching out to Gilead and other services to make sure we are backfilling budget cuts. If a shell game, incumbent upon us to find the money to continue to fund testing, prevention, and treatment to end this epidemic.
-Question: What percentage of these are new folks coming into the state?
-Immigrants to some degree, a smaller number of folks from other countries. A person who was HIV+ from Hawaii isn't a new case, they are just setting up with a new provider. We really work with new cases as well as out-of-state and international cases.
-Grace (HGAP Epidemiologist) indicates that the growth of Oregon cases is mainly folks making their way into Oregon versus new cases necessarily.

Complexity of needs for clients
-What occurs with folks who are long-term diagnosed and don't trust the system versus newly diagnosed?
-Multnomah County harm reduction offers services with and for people searching for a place to belong and receive care.
-Washington County tracks newer cases, relies on case managers more for keeping folks virally suppressed and longer term care. DIS prevents transmission and gets folks on meds quickly. Trust takes a long time, and bad experiences are hard to fight.
-Linkage of high prevalence of new HIV diagnosis for folks who have become gonorrhea positive within 24 months per a study.
-Need for provider education about sexual health and discussions at PCP prevention side, versus the public health systems. AETC has these services but not enough.

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-*PC question about PrEP and PEP*: Folks are given many opportunities to access PrEP. Some clients are engaged and others feel that PrEP is too much. Issues around creating their own insurance approach and hard convos about relationships and sex. -Multnomah County finds 25% of new HIV cases are white. And they represent 62% of folks on PrEP. Black and BIPOC are 15% of PrEP while 38% of the new HIV cases. Still working on the match of prevention and those who are at greatest risk. -Younger cases (below 30) also a trend. Sexual education doesn't always include PrEP. **What is missing? What do you need?** -Clark County is mainly Disease Investigation Specialist work and are with newly diagnosed folks into Rapid Start as well as CAP SW patients who have been lost to care. Can refer to agencies for that. -Multnomah County needs additional rapid start navigators in the medical realm. -Washington County and folks have a variety of needs- so PrEP and Rapid Start are both lower on the list of needs for folks who are disconnected. Nobody comes in with just one need, sexual health needs can be bottom of their list. -*PC question about transportation in rural areas?* -Washington County has a rural and urban mix. Different reasons why folks don't want to go to Portland, staying sober, very long transit, needing safety with a provider. -Clackamas- transportation tends to be a theme. We go out to Government Camp. But providers in that area are also a concern.	
Review Key Data from OHA presentation	*Presenter(s):* *Grace Walker-Stevenson* *(HIV Grant Administration & Planning)* *See slides. We will share a couple slides highlighting some key data, with a focus on data from the TGA.*
Summary of Presentation: Most new HIV cases as well as the bulk of people living with HIV live in the TGA. Multiple risk factors are amplified. An estimated 11.7% of people don't know they are HIV+ (747 people in the TGA and 1135 in Oregon). Viral suppression rate is 16.8% for those who are Not in Care versus 89% for the whole TGA. People who are out of care are: younger (aged 20-29, houseless or unstably housed). Scott notes: there is a significant increase in PLWH in the last 10 years or so. Something like 15% and we have roughly flat funding during that time. Grace notes that the bulk of the growth is related to folks moving here (e.g., Florida ADAP change, Sanctuary states, folks who are trans are more safe, Oregon has Medicaid expansion.)	

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Question- how quickly is the Not in Care list updated? Grace- it's pretty rare, used to be annual. It's just two people who are working on it. Larger presentation from Lea and Jeff refers to not everyone being actually out of care, due to many moving out of state or accessing care elsewhere. The definition of "Not in Care" is very rigid from OHA, that might be folks without labs or those who are on vacation and cannot get a lab. NIC is a snapshot in time, doesn't change as folks get new labs. Will find they just got labs done and the list is outdated.	
DINNER BREAK	
Reflections on New Case/NIC presentations	Members are invited to find a group of 4 members to discuss how we might incorporate the two presentations (data and panel) into future decision-making on service priorities and guidance.
Summary of Discussion: Group 1- Linkage to care concerns. How as a PC we fund early intervention services. What we would take funding away from: treatment, etc. We don't currently have a lot of funding to be able to spare for prevention. Do folks come into the office or are there also service delivery models on site? Carceral folks as well, we have some needs. Also structural things we can do to make the most impact without harming other services. Group 2- Talked about how from the panel perspective folks are very passionate, and we want to keep focus on client-centered and data-driven perspectives. Resonate with that and why we are here. Where can we strengthen these issues. Need more robust culturally specific services for Black folks who fall through the cracks. Group 3- Linkage to care and making sure folks are navigated to services, even if those are decreasing (e.g., in Multnomah, that may be going from the McCoy Building's 2nd Floor STI Clinic to 3rd Floor Health Services Center). Resources for prevention have disappeared over time. Connections have ended, and it's hard to build trust back. Group 4- Similar themes, spoke about the need for peer support and navigation. Decisions based on data. What is the data that are these points people are making, where is that data stored and where are things anecdotal trends being observed versus things that are grounded in data. What are the rural needs and medical transportation and whether those funds ended up being used as they were intended to be. Talked about PrEP and benefits navigation as well as the loss of Oregon Health	

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Plan (OHP) benefits that we are all about to see falling off a cliff. How to respond to that need and continuity of care with new enrollment periods, etc. Documentation that folks don't have, etc. HR 1. Theme was community health workers and peer support specialists as well as using Guidance language to make sure we are guiding our grantees in a strong direction for folks living with HIV Group 5- Interested in demographic info like housing instability. Also key factors like viral load suppression and how it could affect our projects. No statistical significance in demographic categories. Rural counties and those who are diagnosed in hospitals. Specific genetic concerns for the African American community. Comment: In general, the funding is determined and handed over to HGAP. Guidance is helpful in determining how services are delivered. Early Intervention Services (EIS) is one example, and we can determine how our services are to be activated. The PC has power to influence there. Question on how often the Guidance Committee presents to the PC: Scott indicates some changes were introduced, but also review and affirm the Guidance annually. Tessa is the Chair and has suggested that once subject matter panels are completed, look at gaps in the services and guidance.	
FY26-27 Budget Updates	*Presenter: Derek Smith, HGAP Manager*
Summary of Presentation: Application of PSRA for the currently expected funds. FY 26-27 Budget Year starts March 1st! ● In July 2025, Planning Council set FY26-27 baseline funding allocations as follows: ○ Add $140K in Emergency Financial Assistance ○ Add $50K in Medical Transportation ○ Decrease all other services by 6% to fund additions ● Medical Transportation ○ Since $50K cannot fund a new program (and the PC's contingency plan includes a possible cut to this service), funds were offered to all providers ○ Service categories that have these added funds have less than a 6% cut overall See Budget Table on next page.	

FY26-27 - Part A Initial Allocated Budget*

1) 6% cut 2) Medical Transportation 3) Budget reduction/no carryover

Service Category	Initial 2026-2027	Notes
Medical	$794,234	
Mental Health	$256,647	
Oral Health	$22,622	$2,500 Medical Transportation funds added.
Medical Case Management	$1,186,503	$32,500 Medical Transportation funds added. (*Note: Program Income from Part B is decreasing, so Part A is covering about $45K of these services.)*
Minority AIDS Initiative (MAI) Medical Case Management (MCM)	$152,032	This is a specific federal allocation amount; this is currently expected to increase.
Early Intervention Services	$158,340	
Substance Abuse Treatment	$146,172	
Psychosocial Support	$405,444	$10,000 Medical Transportation funds added.
Food/Home Delivered Meals	$68,623	
Non-Medical Case Management	$146,374	$5,000 Medical Transportation funds added.
Emergency Financial Assistance	$140,000	
TOTAL	**$3,476,991**	

Item**	Discussion, Motions, and Actions
Quality Management Presentation	*Presenter: Britt Sale, HGAP* *See slides.*
Summary of Presentation: We have several QI projects, increasing linkage to care for folks getting out of jails, working on eligibility, and PSRA project. CQM plan outlines our work for 4 years. Goals are also outlined in this work. New 2026-2028 CQM Plan Goals 1) Conduct a housing project to increase understanding of Housing services processes 2) Continue exploring the current Portfolio Measures Portfolio, making updates as appropriate 3) Engage in an Eligibility Quality Improvement Project with the goals of streamlining processes and increasing provider collaboration 4) Explore opportunities to increase Annual Lab rates across the TGA	
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, April 4, 3:00-6:00 PM, in person at Lloyd Corporate Plaza Rm 380
Adjourned	6:06 PM

ATTENDANCE

Members	Present	Absent*	Members	Present	Absent*
Jamie Christianson, she/they	**X**		Sean Mahoney, he/him		**E**
Chautauqua Cabine, she/her	**R**		José Maidana Cejas		**E**
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	**X**	
Michelle Foley, they/them		**E**	Troy Preble		**E**
Greg Fowler, he/him	**R**		Diane Quiring, she/her		**E**
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	**X**		Nick Tipton, he/him (Co-chair)	**X**	
Chris Keating	**X**		Bee Velazquez, she/her/ella	**R**	
Julia Lager-Mesulam, she/her		**E**	Barry Walden	**R**	
Robb Lawrence, he/him	**X**		Jeffery Wells	**X**	
Heather Leffler, she/her		**A**	Abrianna Williams, she/her	**R**	
HGAP Staff			**Guests**		
Sandra Acosta Casillas	**virtual**		ASL Interpreters	**X**	
Aubrey Daquiz, she/her	**X**		David Cuevas- DIS	**X**	
Sophie Homolka		**X**	Dale Sattergren, ORPCA	**R**	
April Kayser, she/her	**X**		Emmett - medic	**R**	
Britt Sale, she/her	**X**		Eric Gray	**R**	
Derek Smith, he/him	**X**		Edith Daku	**R**	
Grace Walker-Stevenson, they/them	**X**		Alex Marisca- Friendly House	**R**	
County Staff			Malley Nason- Clackamas	**X**	
Chris Hamel he/him	**X**		Joe Duarte- Clark County	**R**	
Jasmine Gruenstein	**X**				

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