

End HIV/STI Oregon Statewide Planning Group (OSPG) Meeting Notes

September 16, 2026, 1:00 – 4:00 p.m.

Announcements

- Opening New Doors is a new statewide Community of Practice for people with HIV who are interested in building skills, sharing knowledge, and helping strengthen HIV services, care and leadership across Oregon and Southwest Washington. [Sign up here.](#)
- The Oregon Perinatal Collaborative (OPC), in partnership with Comagine Health, was awarded an OHA Public Health Equity Grant to lead the Oregon Congenital Syphilis Prevention Initiative, which addresses persistent gaps in syphilis screening and timely treatment during pregnancy, particularly in emergency departments and other non-obstetric settings that are often critical touchpoints for pregnant and reproductive-age patients who aren't otherwise engaged in prenatal care.
OPCA has worked statewide with a workgroup of clinical, public health, and community partners to develop the following best-practice guides for congenital syphilis prevention:
 - [Guide for Emergency Departments](#)
 - [Guide for Local Public Health Authorities](#)
 - [Guide for Community Organizations](#)

CDC Supplemental Funding for Health Departments

- STD PCHD (PS19) Supplemental Funding
 - In late May, states were notified of one-time, time-limited funding available as part of existing PS19-1901 grant.
 - Timeline: Funds available for 7 months - 7/1/2026 to 2/28/2027
 - Amount: Oregon was eligible to apply for ~\$30,000- \$50,000
 - Activities: Congenital syphilis (CS) prevention; focus to expand testing in non-traditional settings (such as emergency departments [EDs]) and treat pregnant people with syphilis.
 - Very short turn around to apply
 - HST did not apply:



- Existing grant funds were available to conduct the same work and meet goals, and
 - With the Bicillin shortage, funds would primarily support testing; HST can cover this without supplemental funds.
- HIV P&S (PS24) Supplemental Funding
 - In June, states were notified of one-time, time-limited funding available as part of existing PS24-0047 grant.
 - Timeline: Funds available for 9 months - 9/1/2026 to 5/31/2027
 - Amount: Oregon was eligible to apply for up to \$675,670
 - Activities: Focus on expanding HIV prevention and testing
 - Very short turn around to apply
 - Then, Office of Management and Budget (OMB) announces the end of PS21-2102 funding as of 9/30/2026.
 - Funds supported 96 CBOs across the US to do HIV testing, linkage to care, and PrEP support.
 - In Oregon, CAP NW and HIV Alliance are recipients, with awards totaling \$880K/year to serve Multnomah, Clackamas, Washington, Douglas, Lane, and Marion Counties.
 - State health departments were strongly advised/encouraged to use supplemental funds to mitigate the loss of PS-21-2102 funding in their communities.
 - CDC re-issues its supplemental funding guidance and extends the application deadline.
 - HST applies for \$675,670 in supplemental funds.
 - Support CAP NW and HIV Alliance as they seek alternate funding and/or allow for more strategic service changes.
 - Each CBO would receive \$337,835 through May 31, 2027, to provide same HIV prevention and testing as currently offered under PS21.
 - Notice of Award (NOA) received on 9/11/2026.
 - We started the administrative work to subcontract with CAP and HIVA for HIV prevention and testing.
 - Service end date would be 5/31/2027.
 - Until funding ends, no immediate impacts expected on services in these six counties.
 - No information from CDC re: funding after May 31, 2027.



Discussion

- What is the impact on testing services in those counties? Will the CBOs offer testing on fewer days or in fewer locations?
 - OHA has requested a work plan from HIV Alliance. The plan indicated that they will provide roughly the same services they've been delivering in those counties. CAP NW has shared that their programs will continue.
 - HIV Alliance or CAP NW might need to adjust service hours or locations, but we don't know at this point.
- How will the loss of other funds impact HIV Alliance and CAP NW?
 - OHA can only speak to changes to OHA's funding.
- Washington County funds CAP NW for testing, but that will likely stop on June 30 with the decrease in HSSS funding.
- CAP NW's and HIV Alliance's existing funding goes through September 30. OHA is getting contracts in place as quickly as possible.
- It might be helpful to invite partners to speak about their testing programs at a future OSPG meeting.
- What is the role of HSSS in testing at the local public health level, as a compliment to CDC-funded activities?
 - HIV/STI Statewide Services (HSSS) is OHA's new statewide service model. It prioritizes integrated testing and partner services and includes outbreak response. Enhanced activities include outreach, targeted testing, and condom distribution.
 - Each LPHA receiving HSSS funds is expected to offer or refer to testing services.
 - LPHA awards range from \$17,000 – \$2.3 million per county. The availability of testing looks different depending on where you are in the state
- HIV Alliance and CAP NW are not the only agencies doing this work.
 - OHA issued about \$3 million in Public Health Equity Grants to CBOs statewide. Thirteen agencies were funded to do HIV prevention activities, and many are supporting testing and outreach in their communities.



CAREAssist: Open Enrollment Update & Impacts to the Care System

- OHA staff discussed key points related to federal and state policy changes and how these are affecting the CAREAssist (AIDS Drug Assistance Program) in Oregon. Key points include:
- House Resolution 1 (HR-1) is federal legislation passed in July 2025 that requires states to implement [new rules](#) related to Medicaid. The rules include more frequent member renewals and work and activity reporting requirements for some members.
- The two rules of most concern to community members – work and activity rules and more frequent renewals – take place in 2027. [The OHA website](#) provides a more comprehensive list of changes with their implementation dates.
- The number of CAREAssist clients who will be impacted by these policy changes is difficult to determine, as outcomes will be influenced by individual choice, capacity, and behavior. Applying estimates from [OHA](#) and [Health Care for All Oregonians](#), we believe between 61 and 122 CAREAssist clients may be disenrolled from OHP in 2027.
- Insurance carriers are leaving the marketplace.
 - Oregon's regulatory and cost containment standards exceed federal standards.
 - PacificSource and Providence are leaving the Oregon market.
 - Insurance plan information is available in October. With these two plans leaving and information on other plans not available until October, it's difficult to plan ahead.
- What plans are left as options for CAREAssist clients?
 - Moda, Regence, Bridgespan.
 - These plans might not work with the CAREAssist in-network pharmacy, which means we can't maximize cost savings.
 - OHA needs to work with carriers that most effectively support the CAREAssist model, to help clients afford medication and to prevent the program from operating at a deficit.
- CAREAssist is a 340B agency, which means the agency can purchase medications at a discounted price and reinvest the funds saved into the community.
 - 80% of CAREAssist costs are supported by 340B cost savings. Individuals using the pharmacy network allow us to maximize cost savings.



- These funds also support other statewide programs in the HIV care continuum.
- CAREAssist is successful because it's built on rebates and insurance premium reimbursement cost savings. Most other states only use rebates.
- CAREAssist's successes:
 - Top viral suppression outcomes in the US (96% of clients are virally suppressed).
 - Higher income eligibility than most AIDS Drug Assistance Programs (ADAP).
 - Consistently high client satisfaction.
 - Commitment to choice and access, ensuring flexibility to client needs.
 - Supporting work along the HIV continuum, including enhanced Ryan White services.
- CAREAssist's challenges:
 - Some plans don't generate cost savings for the program. CAREAssist has supported these to maximize client choice but must reconsider.
 - Certain carriers place a disproportionately high impact on the program. Continuing support of these programs leads to CAREAssist losing money.
 - CAREAssist must change policies to allow the program to continue.
- Changes that are coming:
 - Beginning in 2027, CAREAssist will no longer support new Kaiser enrollments.
 - Kaiser costs have increased by 338%.
 - Anyone who is enrolled in CAREAssist and on Kaiser going into 2027 can maintain coverage. This is roughly 570 individuals.
 - CAREAssist clients who are offered new workplace coverage through Kaiser during open enrollment can choose to pay for the Kaiser plan or switch to an off-exchange plan that CAREAssist will cover.
 - Other states have four or fewer designated insurance plans.
 - HRSA requires OHA to assist with medication access for PLWH in the most cost-effective method possible. The Kaiser cost increase doesn't meet this requirement.
 - CAREAssist may support plans this year that can't be supported in the future.
- CAREAssist sends open enrollment letters each year. Clients with Providence and PacificSource will get a letter explaining the need to switch to a different carrier.
- How many people will be affected by carrier changes this year?



- Approximately 418 clients currently insured by PacificSource, Providence, and Providence Medicare must transition to new plans.
 - Enrollment will happen during Open Enrollment.
 - New plans will start at the beginning of 2027.
- How have enrollments changed over time?
 - For context:
 - Enrollments may double next year compared to 2025-26 but are minimal compared to the rollout of the Exchange, when staff assisted about 1800 clients to enroll in insurance.
 - CA still invests in the infrastructure built during the Exchange rollout.
- Standard Open Enrollment communications with clients will start in September.
 - Letters start with Medicare clients, then all other clients.
 - CAREAssist will share the letter via ListSrvs, as in prior years, so staff working with PLWH can see their contents.
 - Work with the CAREAssist caseworker or case managers.
 - CAREAssist will need auto enrollment letters for clients keeping the same coverage for off exchange, new insurance information and start date, summary of coverage for new coverage, copy of Insurance ID card, Premium bill for off exchange or Medicare clients.

Discussion

- A house bill is going to the Oregon state legislature to mandate free healthcare for all Oregonians. How would that impact CAREAssist?
 - The bill could be changed before it's implemented, but HST is watching it. If the bill seems like it will pass, we can discuss it at a future meeting.
- Does CAREAssist have a reserve of funds in case there's a deficit in the future?
 - Part of the job is monitoring and making plans for different situations. CAREAssist staff are always forecasting with fiscal staff.
- What about drug companies that want to get rid of the drug rebate program?
 - HST staff continue to monitor. There haven't been any recent high-impact situations.
- What if Kaiser agreed to carve out CAREAssist?
 - HST staff hope to meet with Kaiser in the next week. It would be great if they agreed to carve out the ADAP, which means that CAREAssist could see some cost savings on prescriptions filled by Kaiser clients at Kaiser pharmacies.



- Does CAREAssist get information in advance?
 - No, CAREAssist gets the same information as the public, often from OHA's Medicaid website.
- When will OHP clients see changes?
 - Changes for Medicaid/OHP clients will be phased in, depending on clients' CAREAssist enrollment date. Might have to make changes when recertifying in 2027.
- Medicaid now requires clients prove they are going to school or seeing work. If a client can't fulfil that requirement and is disenrolled by Medicaid, what do they do?
 - CAREAssist can pay for an off-exchange plan for clients who have been denied Medicaid, unless they are denied for not submitting a recertification.
 - If a CAREAssist client loses insurance coverage, regardless of the plan, the client or case manager should call their CAREAssist case worker immediately. The client might be eligible for the Uninsured Person Plan (UPP), or CAREAssist can help them find a new plan.
- How to share accurate information with clients? Sometimes clients are overwhelmed by misinformation and don't reach out.
 - CAREAssist is creating a FAQ about these insurance changes and will add questions that come up during this meeting.
 - Possibly incentivize opportunities for clients to come to hear accurate information.
- OHA's goal is to keep CAREAssist services stable and to plan for whatever might be coming. OHA can't control carrier changes, manufacturer policies, healthcare plans, etc., but the entire program is built off leveraging those systems, so we must react whenever there are changes to these systems.
- Will OHA discuss all changes with OSPG in advance?
 - Changes happen very fast and OHA does not get information ahead of time. In general, our value is to share with community and get input, but sometimes, OHA must move very quickly to research and respond to impacts.
 - CAREAssist's goal is to provide the best service to clients, continue insurance and services for PLWH, and find the solution that's the least harmful to the entire systems. When there's time, OHA will bring discussions to this group before making decisions.
- OHA has heard comments in various meetings about CAREAssist "making money" on clients – 100% of pharmacy cost savings are reinvested in the ADAP program and other services for PLWH, like housing and case management.



These allocations have been shared with OSPG, the CAREAssist Advisory Group, and the Part A Planning Council in the past 12 months. CAREAssist does not “make money.”

OSPG Policies & Procedures Update, Including Community Co-Chair Election

- Why update the policies and procedures now?
 - Group membership isn't balanced.
 - OHA used to require LPHA contractors to attend these meetings, but that felt unreasonable. Some contractors don't get much money and need to decide between serving clients and attending meetings.
 - CivCom managed membership for a few years. Now that OHA manages membership, we realize some people listed as members aren't attending.
- What changes are proposed?
 - OSPG Members: participating as a community or organizational representative.
 - We know there's intersectionality and that people belong to multiple groups. That's a strength. But it's best practice to know what interests people are representing when they speak and vote.
 - We want to ensure that we have at least one representative from key organizations doing the work, as well as community members.
 - Community representatives will prioritize membership from priority populations.
 - OSPG partners: we're going to start asking partners to fill out an application
 - Guests: Reinstate public comment in November meeting.
 - Breakdown of roles: OHA staff people.
- How do proposed changes compare to existing membership? (pretty close, but adding tribal/indigenous representative, aiming to increase LPHA and rural representation)
- What are we currently recruiting for?
 - Members: community representatives, LPHA, people from outside the Portland metro area)
 - Operations Committee: HIV Alliance rep, LPHA reps, one community member at-large
 - OSPG Co-Chair



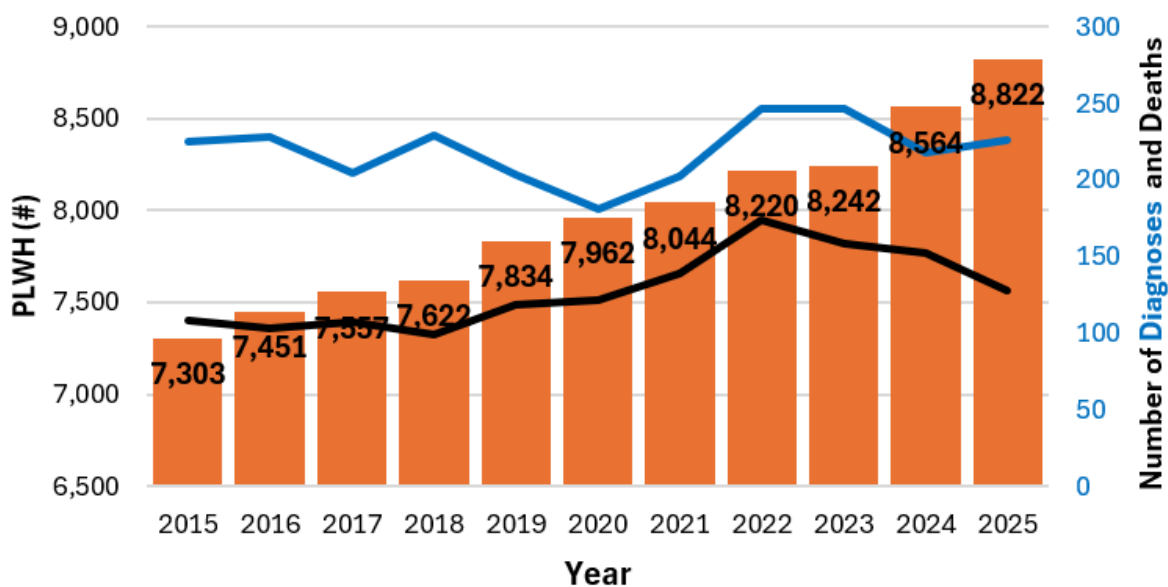
- Request that we send out something with info about the commitment for the roles of Co-chair and Operations Committee members.
- What are requirements for community co-chair position?
 - Community members from a community highly impacted by HIV/STI. People living with HIV are encouraged to apply.
- Send self-nominations for community co-chair by Oct 30.

Aging with HIV in Oregon: A Population View

- Acknowledgement:
 - The purpose of collecting HIV data is to inform public health decisions, track the impact of HIV prevention, testing, and treatment services
 - The objective of HIV Epidemiology is to react to and predict changes in the epidemic without being too invasive
 - The Oregon Health Authority, HIV/STI/TB Section is charged with protecting these data
 - Mortality is a key health outcome
 - Acknowledge people who have had family and friends die of HIV or of substance use
 - 32% of US adults reported knowing someone who died of an overdose (Experience of Personal Loss Due to Drug Overdose Among US Adults; Kennedy-Henricks et al, JAMA Health Forum, 2024 5(5))
 - Key to improving outcomes among people living with HIV (PLWH) and supporting evidence-based successes in HIV services, substance use treatment and harm reduction interventions
- Objectives:
 - Share descriptive information that will help discussion not found elsewhere
 - Show trends in people diagnosed with HIV in Oregon by age
 - Describe trends by underlying cause of death among people with HIV
 - Characteristics of people living with HIV by age
- Oregon HIV diagnoses, deaths and PLWH

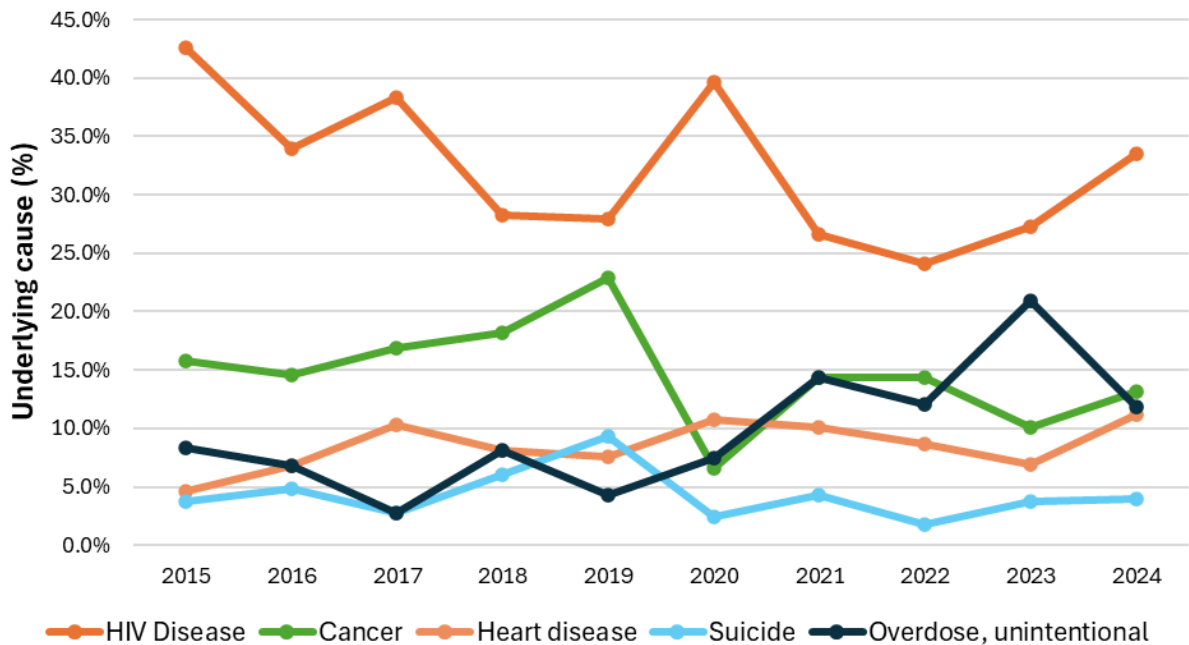


People living with HIV, diagnoses and deaths Oregon 2015–2025 (PLWH as of year end)



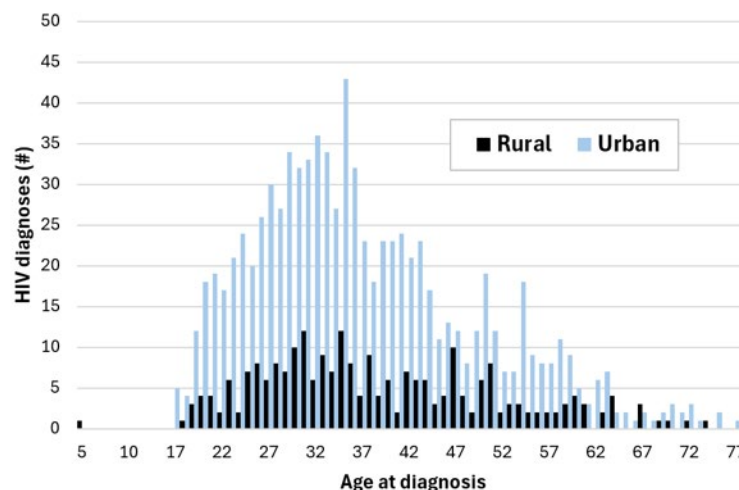
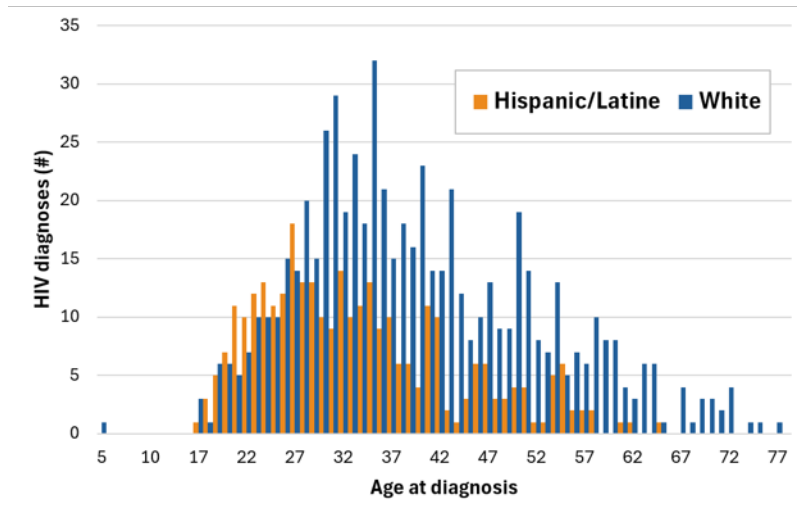
- The number of diagnosed PLWH stepped up in 2025 to 8,822 living as of the end of the year
- CDC estimates that 1,169 Oregonians are undiagnosed with HIV of total n=9,991 with HIV
- 226 diagnoses in 2025
- Deaths per 100,000 were flat until 2019, before COVID-19
- Median age of death in 2024:
 - All Oregon residents: 77.0 years
 - Was 79.0 years in 2010
 - Residents with HIV: 60.0 years
 - Was 49.0 years in 2010
 - The difference was attributable to HIV and other factors which increased the likelihood of acquiring HIV (HIV within the context of the syndemic)
- Underlying cause of death among people with HIV, 2015–2024, Oregon

Underlying cause of death among people with diagnosed HIV, Oregon, 2015–2024



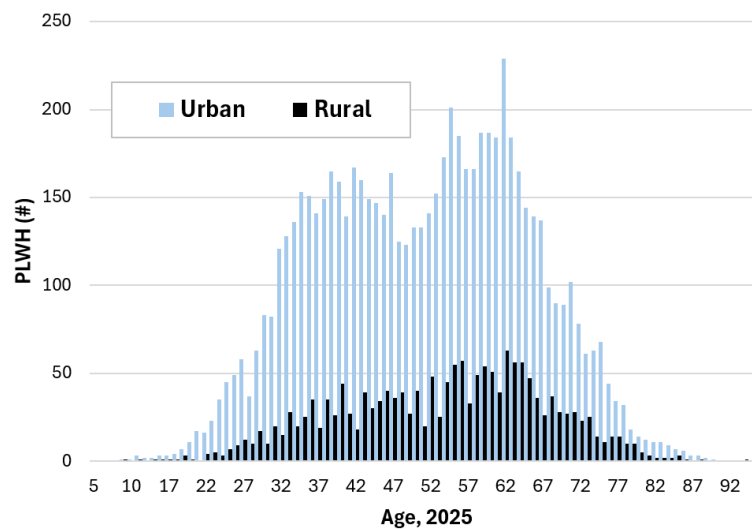
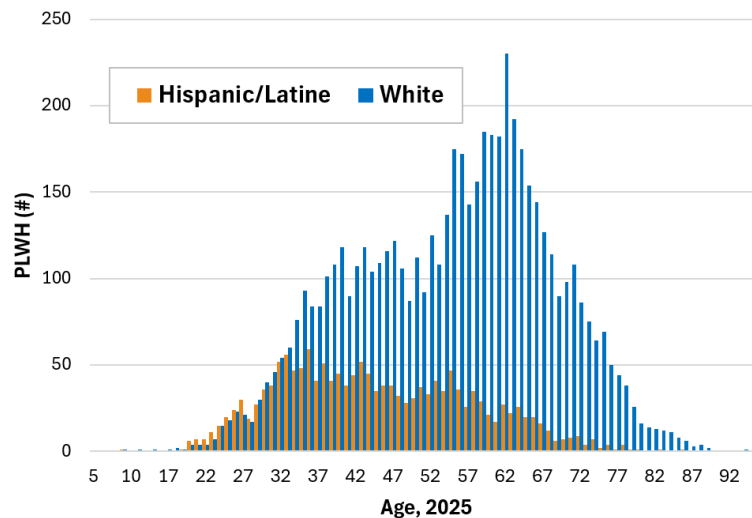
- The ‘underlying cause’ is defined by Oregon Vital Statistics based on the Death Certificate and autopsy/test results
- Deaths due to HIV increased in 2023–2024 to up to 34% of all deaths
- Non-intentional overdoses had trended upward but decreased in 2024 to 12% of deaths
- Additional drug-related deaths included those that died of HIV disease, suicide, heart disease, and injuries, primarily due to methamphetamine use among younger people
- Ten-year survival among people diagnosed 2016–2025, Oregon
 - 10-year survival rates were lower among those:
 - Older when diagnosed, survival increasing the younger people were at diagnosis
 - Reporting injection drug use (IDU), male and female
 - Reporting male-to-male sexual contact and injection drug use (MMSC/IDU)
 - Reported with concurrent hepatitis C and HIV
 - Experiencing homelessness/unstable housing
 - Residents outside of Clackamas, Multnomah, and Washington counties
 - Residents of rural zip codes

- Diagnosed with HIV in the hospital or in corrections
 - Diagnosed late with a first CD4 count less than 200 cells/mm³
 - No differences by sex, race/ethnicity, Linkage to care in 30 days, viral suppression in 90 days, or HIV treatment within 7 days of diagnosis
 - *Method: Age-stratified Kaplan-Meier survival analysis for HIV diagnoses in Oregon, 2016–2025
- Age distribution among people diagnosed with HIV in Oregon, 2021–2025



- 35.0 years median age at diagnosis, n=1,138
 - Male 35.0 and Female 38.0 years
 - Hispanic/Latine 32.0 years
 - American Indian/Alaska Native 32.0 years
 - Asian 32.5 years
 - Black/African American 35.0 years

- Native Hawaiian/Pacific Islander 28.0 yrs
- White 38.0 years
- Two or more race/ethnicities 35.0 years
- Zip codes Rural 36.0, Frontier 39.0, and Urban 35.0 years
- People 45 years and older more likely to get an AIDS diagnosis within 90 days ('late diagnosis' or faster progression).
- No differences in early linkage to care (in 30 days) or viral suppression (in 90 days) by age at diagnosis.
- Age distribution among people living with HIV in Oregon



- 53.0 years, Oregon median age 12/31/2025, n=8,822
 - Male 53.0 and Female 52.0 years
 - Hispanic/Latine 43.0 years
 - American Indian/Alaska Native 49.0 years

- Asian 45.0 years
 - Black/African American 48.0 years
 - Native Hawaiian/Pacific Islander 42.0 years
 - White 56.0 years
 - Two or more race/ethnicities 45.0 years
 - Zip codes Rural 55.0 and Urban 52.0 years
- 55.4% (4,891/8,822) of PLWH were Long-term Survivors, diagnosed with HIV for 15 or more years
- 17% (824 diagnosed 50+/4,976 PLWH 50+ years old
- Issues to address (not inclusive list):
 - Stigma of ageism and of HIV
 - Social isolation, loneliness, and cognitive decline
 - Exposure to the virus, HIV medications, and drug interactions
- PLWH differences
 - Oregon PLWH more likely to be out of care were those (no CD4 or VL in 2025)
 - No differences by sex, age, or other demographic.
 - Viral suppression was lower among those (200+ copies/mL)
 - 30-34 years of age compared to those 60-69 years
 - Reporting injection drug use (IDU), male and female
 - Reporting male-to-male sexual contact and injection drug use (MMSC/IDU)
 - Experiencing homelessness or unstable housing at diagnosis
 - Who were residents in rural zip codes and counties
 - Living outside Clackamas, Multnomah, and Washington counties
 - Reporting heterosexual contact with a PLWH with no reported risk
 - Reason for testing: Contacted by partner/county
 - No differences by sex, race/ethnicity, facility of diagnosis, or first CD4 after diagnosis
- About a third of people over age 50 reported at least one unmet medical or social service need
 - People over age 50 with at least one unmet medical need and social service need were more likely to be/have:
 - No bachelor's degree
 - Homeless
 - Unemployed
 - Tested positive for HIV after 1996

- Current smoker
 - Major depressive symptoms in the past two weeks
 - Used injection drugs in the past 12 months had at least one unmet medical need
 - Admitted to the hospital in the past 12 months had at least one social service need
- Unmet needs of over 10% were among Dental care and Mental health services,
- Less than 10% for Ryan White, case management, food, meal services, and shelter
- *Method: Medical Monitoring Project (2015–2021), n=714, interviews and chart reviews
- Conclusions:
 - Poorer survival and viral suppression among people who
 - reported injection drug use
 - were experiencing houselessness/unstable housing at diagnosis
 - lived in rural zip codes
 - had delayed access to care
 - People diagnosed with HIV 45+ years were less likely to be virally suppressed at 90 days
 - 55.4% (4,891/8,822) Long-term Survivors, 15 or more years with HIV
 - 17% of PLWH 50+ years old were diagnosed at 50+ years
 - PLWH with medical & service needs have barriers to needed services
- Aging and HIV resources:
 - [The Glasgow Manifesto, International Coalition of Older People with HIV, 2022](#)
 - [Enhancing HIV Inclusion in Multisector Plans on Aging, June 2026, Sage; Advocacy for Services for LGBTQ+ Elders](#)
 - [Aging HIV & Long-term Survivors, June 2019, Oregon Health Authority](#)
 - [Adults living with HIV in Oregon Over Age 50, Medical Monitoring Project, Oregon](#)
 - [LetsKickAss AIDS Survivor Syndrome](#)
 - [National Indian Council on Aging, NICOA](#)
 - [HealthHIV Survey information and reports](#)
 - [National AIDS Treatment Advocacy Project \(NATAP\) Aging & HIV Resource Center](#)
 - [HIV.gov: Aging with HIV](#)
 - Centers for Disease Control and Prevention HIV reports:
 - [Social determinant infographics and slide-set](#)



- [Current CDC data/reports](#)

Aging Well with HIV: An Individual & Community View

- Questions and answers with two long-term HIV survivors.
- HIV doesn't look the same in 2026 as it did when you were diagnosed. What is one thing that gives you hope or makes you say 'wow' when you look back on your life as a person living with HIV?
 - Living through moments I didn't think I'd see, like seeing my daughter grow up and celebrating 25 years with my husband.
 - New advancements like U=U and the ability to have babies naturally with zero transmission.
 - We've come a long way with drug treatment. When I was diagnosed, there were no meds, then there was AZT, and now there are a plethora.
 - I see an overburdened healthcare system that can't deal with the number of HIV clients. It's difficult to see a doctor in a timely fashion.
 - I never thought I'd live to be 72 years old.
- What are some of the challenges you face as someone who's aging with HIV?
 - It's hard to know what's connected to aging, to HIV, and to medications. I've lived through many generations of medications and have become resistant to some. I'm not sure how long the current meds will work.
 - Other things about aging – chronic health conditions, menopause, mental health. Quality of life matters as well as length of life.
 - Many long-term survivors have lived through decades of changes.
 - Other things that come with aging, like tiny type on prescription bottles.
 - HIV stigma was bad, then got better, and now seems like it's come back around to be stronger.
 - Living through losing so many people and the trauma of watching the community around you shrink. I lost my first partner after 10 years. My current partner is HIV negative.
 - Looking at the healthcare system. I might have to switch away from the doctor I've been going to for years. I had bad experiences with previous providers, but I might have to go back to them.
 - I've gone through so many things, including chemo and lymphoma. It's kind of a life crushing thing you can't understand fully unless it happens to you. You're faced with your own mortality.

- I worry that things will go back to how they were in the 90s.
- I live in Section 8 housing, so I can't just pick up and move. I can't live on the coast because there aren't HIV providers. You're limited in your choices when you're living with HIV.
- There aren't enough studies done about women's health in general, like menopause and bone density. These conversations need to happen.
- [There was just a survey report released about people aging with HIV.](#) The conclusion was PLWH are living longer, but the systems around them are not yet fully built to support aging well. From your perspective, what specific HIV prevention or care services are lacking for people with HIV who are older? Where do you see gaps in our systems for PLWH who are aging?
 - More than half of the people living with HIV in Oregon are over age 55. We need to prepare for experiencing geriatric conditions earlier than those without HIV.
 - We need better plans for caregivers, home health care, etc. We should build these systems now rather than waiting until people need them.
 - We haven't set up systems like independent living. What if I can't take care of myself and I don't have a partner? A lot of people end up on the streets. A lot of us had to stop working, so it's hard to plan. Who gets your groceries when you can't drive or walk all the way to the store?
 - I don't want to have to move into general assisted living and have to explain HIV to people who don't understand it.
 - We don't have coverage for glasses and we have restricted dental coverage.

Discussion:

- As a dietitian, there is a lot of new information on living well as we age. Food can support the immune system, prevent sarcopenia (muscle wasting with age, etc.). Talk to a dietitian, especially those with experience with HIV.

Meeting Poll:

The information shared today was useful and relevant to the OSPG's mission.

- a. Strongly Agree – 83%
- b. Agree – 17%



- c. Neutral
- d. Disagree
- e. Strongly Disagree

There were enough opportunities for discussion.

- a. Strongly Agree – 38%
- b. Agree – 48%
- c. Neutral – 14%
- d. Disagree
- e. Strongly Disagree

