

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

April 8, 2026, 1:00– 4:00 p.m.

Announcements

- PrEP Connect will be online on the morning of June 24. Registration is not open yet. [Join the mailing list here](#) to be notified when registration opens.
- [The SANAR Network](#) is a new network that is helping connect people to culturally specific mental health care for the Latine community in Oregon. According to their website, all care is Pro-bono.
- Multnomah County Health Department HIV Clinic celebrated having >100 patients now on IM Cabenuva treatment!

Community Townhalls: Oregon Consumer and Provider Priorities

Full report will be shared, including SWOT (strengths, weaknesses, opportunities, threats) analysis and literature review.

Project Purpose:

- Amid recent changes in Federal policy and funding affecting HIV care and support services, the Oregon Health Authority sought input on Ryan White-funded services across the state. The effort included:
 - urban and rural areas,
 - race/ethnicity,
 - age,
 - gender,
 - geography, and
 - service delivery models.

Methodology & Scope

- Four town halls were conducted:
 - RWHAP Part A Providers (Portland Metro).
 - RWHAP Part B Providers (Balance of State).
 - English-speaking Consumers.
 - Spanish-speaking Consumers.
 - Data collection included a preliminary literature review, a SWOT analysis, virtual town halls, and an additional online survey for low-attendance groups (providers in the Portland TGA and the Balance of State).



Participant Demographics:

- English-speaking consumers:
 - **Sample Size:** 23 participants; mean age of 56.4 years.
 - **Years since Diagnosis:** Average 23.7 years
 - **Geography:** 60.8% from Multnomah County (8.6% Malheur, 4.4% in each: Josephine, Clatsop, Washington, Union, Jackson, Columbia, and Douglas Counties were also represented)
- Spanish-speaking consumers
 - **Sample Size:** 6 participants; mean age of 56.5 years
 - **Years since Diagnosis:** Average 24 years
 - **Geography:** 67% from Multnomah, 33% from Washington County.

Listening Session Medical and Support Service Priorities

For ease of prioritizing services, eligible services were grouped into broader categories of medical services and social support.

- Core Medical Services:
 - HIV testing and linkage
 - Home and community-based health services
 - Medical Case Management, including treatment adherence services
 - Mental health services
 - Oral health care
 - Outpatient/ambulatory health services
 - Drug and alcohol treatment (outpatient)
- Support Services, including:
 - Childcare
 - Emergency financial assistance
 - Food bank/home delivered meals
 - Health education/risk reduction
 - Housing
 - Legal services
 - Medical transportation
 - Support groups and peer support
 - Drug and alcohol treatment (residential)



Medical Service Priorities:

Service Category	Consumer (Spanish speakers)		Consumer (English Speakers)		Part B Providers		Part A Providers		Total	
	n	% of column total	n	% of column total	n	% of column total	n	% of column total	n	% of column total
HIV Testing and Linkage	2	14.29%	0	0	5	33.33%	5	27.78%	12	10.81%
Home & Community Based Health Services	1	7.14%	10	15.63%	3	20.00%	1	5.56%	15	13.51%
Medical Case Management	3	21.43%	20	31.25%	5	33.33%	4	22.22%	32	28.83%
Mental Health Services	3	21.43%	12	15.63%	1	6.67%	4	22.22%	20	18.02%
Oral Health Care	2	14.29%	10	15.63%	0	0.00%	1	5.56%	13	11.71%
Outpatient/ Ambulatory Health services	3	21.43%	11	17.19%	0	0.00%	3	16.67%	17	15.32%
Drug & Alcohol treatment (outpatient)	0	0.00%	1	1.56%	1	6.67%	0	0.00%	2	1.80%
Total	14		64		15		18		111	

- Medical Case Management is the overall priority, cited by 28.83% of all participants.
- Mental Health Services ranked second overall (18.02%) and were prioritized by Spanish Speaking (21.43%) English-speaking consumers (15.63%) and Part A providers (22.22%).
- Outpatient/Ambulatory Health Services (15.32%) and Oral Health Care (11.71%) follow as clinical needs.
- HIV Testing and Linkage was a focus for providers (averaging ~30%), but was largely absent from consumer priority lists.



- HIV testing and linkage tends to be a higher priority to providers than consumers since consumers have already been diagnosed and linked and, generally, no longer need that service.

Support Services Priorities:

Service Category	Consumer (Spanish speakers)		Consumer (English Speakers)		Part B Providers		Part A Providers		Total	
	n	% of column total	n	% of column total	n	% of column total	n	% of column total	n	% of column total
Child Care	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Emergency Financial Assistance	2	18.18%	16	28.07%	2	14.29%	6	37.50%	26	26.53%
Food Bank/Home Delivered meals	2	18.18%	11	19.30%	4	28.57%	3	18.75%	20	20.41%
Health Education/Risk Reduction	1	9.09%	7	12.28%	1	7.14%	0	0.00%	9	9.18%
Housing	5	45.45%	19	33.33%	5	35.71%	7	43.75%	36	36.73%
Legal Services	0	0.00%	2	3.51%	0	0.00%	0	0.00%	2	2.04%
Medical Transportation	1	9.09%	2	3.51%	2	14.29%	0	0.00%	5	5.10%
Total	11		57		14		16		98	

- Housing ranked the highest for all groups, 36.73% of the total priority votes, and the top choice for Spanish-speaking consumers (45.45%) and Part A providers (43.75%).
- Emergency Financial Assistance (EFA) ranked second (26.53%), cited by English-speaking consumers (28.07%) and Part A providers (37.50%).



- Food Bank/Home Delivered meals remain significant needs, particularly for Part B providers (28.57%).
- Childcare received no priority votes across all surveyed groups.

Group-Specific Priority Observations:

- Spanish-Speaking Consumers: Primarily focused on Housing (45.45%), Outpatient care, Mental health services, and Case Management (21.43% each).
- English-Speaking Consumers: Heavily emphasized Housing (33.33%) and Medical Case Management (31.25%).
- Part A (Urban) Providers: Identified HIV Testing and linkage (27.78%) and focused most on the intersection of Emergency Funding Assistance (EFA) (37.50%) and Housing (43.75%) to support their client base.
- Part B (Rural/Statewide) Providers: Identified HIV Testing & Linkage along with Medical Case management (33.33%) as key medical needs. Food Bank service needs (28.57%) surpass their urban counterparts.

Service Impacts & Valued Resources

- EFA was cited as a critical barrier in preventing homelessness and a key resource for security deposits and utilities.
- Spanish-speaking consumers reported high satisfaction with housing services.
- Generally favorable feedback regarding reliable medication and pharmacy access.
- Strong consensus that support groups and peer-led care are highly valued, particularly for long-term survivors.

Barriers Shared by Spanish-Speaking Consumers:

- Systemic Inequity: Persistent belief that White patients receive better quality treatment and medications.
 - HIV medications were mentioned specifically.
- Language Access: Specialists often lack Spanish-speaking staff, forcing reliance on unqualified interpreters.
- Fear & Immigration Status: Patients often avoid reporting poor care or advocating for themselves for fear of impacting immigration.
- Administrative Neglect: Lengthy wait times for medical supplies (e.g., two months for diabetic shoes) and unresponsive case workers.

Spanish Speaking Consumer Quotes

- “I think White people have access to higher quality medications.”
- “My doctors have simply told me that my insurance isn’t very good”
- “I’ve felt discriminated against by my HIV provider. I don’t think I’m getting the best care from them.”
- “We’re vulnerable and people take advantage of that.”



- “My HIV care has been very good.”
- “Sometimes I feel I speak better English than the interpreter.”
- “We need more options...specifically for my dentist and optometrist.”

Barriers Shared by English-Speaking Consumers:

- Frustration with a shift away from peer-led models toward bureaucratic case management.
- Concerns that new support staff lack basic knowledge of HIV or gender issues, possibly due to high turnover and not hiring from within the community.
- Portland residents in specialized housing (e.g., HOPWA units) report feeling geographically isolated from resources, community, and daily supports.
- Rural residents feel resources are disproportionately focused on harm reduction (related to the opioid epidemic) rather than clinical care.

English Speaking Consumer Quotes

- “Emergency financial assistance has been a lifeline.”
- “I’ve benefitted a lot through men’s groups. I came to Portland not knowing anyone, but the groups really helped.”
- “Now that I’m in my 70s, there’s not a lot of services for people who are older”
- “We need case managers who know what they’re doing ... who aren’t just there to pull a paycheck”
- “We need support for everyone, regardless of if they have HIV or AIDS, regardless of ethnicity, race, nationality. We’re all in this together and we should have more support for everyone”
- “I have a lot of hope because I’ve seen a lot in my life that’s changed.”
- “Even though I have AIDS or HIV, it doesn’t define who I am because I still live life abundantly.”

Challenges Shared by Part A Providers:

- Limited capacity for a variety of services, especially housing.
- Insurance: Coordinated Care Org. (CCO) across systems can be challenging.
- Improve relationship between the state and care/support providers. Not currently seen as partners.
- In the future the aging population will be difficult: care and housing.
- Concern about funding services for immigrants.

Challenges Shared by Part B Providers:

- Challenges to engagement in care due to poor cell coverage, lack of internet, and high data costs in remote areas.
- Rural primary care doctors are often unwilling to be trained in HIV care, forcing multi-hour commutes for patients.



- Medicaid transport is unreliable; gas card reimbursement is administratively taxing.
- Frustration that statewide pilots are announced but remain exclusive to the Portland Metro area.

Provider Quotes:

- “Clients worry about the uncertainty of changes to Medicare, or OHP, or SNAP benefits...”
- “Understandable concern at the state about federal overreach and sometimes that concern comes across to the rest of us as protecting the dollars at the cost of getting services.”
- “The amount of paperwork our staff have to do...limits their care of them/providing more services to clients.”

Healthcare Infrastructure & Specialized Care Concerns:

- Lack of communication between agency electronic health record systems prevents coordinated care.
- Finding psychiatrists who understand the specific needs of PLWH is extremely difficult.
- Health systems reported as having years'-long waiting lists.
- Growing need for training in de-escalation as drugs trigger more frequent psychosis in patients.
 - Street drugs including meth were mentioned.
- Significant travel times (1.5+ hours) for rural patients to see Infectious Disease (ID) specialists.

Emerging Threats & Anxiety

- Providers expressed concern that individuals are moving to Oregon to seek services from states that are restricting access
- Policy Hurdles:
 - New 80-hour monthly work requirements threaten access to SNAP and Medicaid.
 - Increasing income to meet rising living costs often results in a total loss of benefits.
- Funding Uncertainty: Deep alarm regarding federal shifts that restrict services for transgender individuals and immigrants.
- Call for increased collaboration between providers, consumers and state.

Summary:

- Community Needs & Priorities:
 - Medical Case Management (28.83% priority).



- Housing (36.73% priority), followed by Emergency Financial Assistance (26.53%).
- Systemic Barriers:
 - Spanish-Speaking Consumers: Reported perceived discrimination, language barriers (including with interpreters), and concerns that White patients receive higher-quality medications and care.
 - English-Speaking Consumers: Highlighted the need for staff trained in HIV and gender-affirming care.
 - Infrastructure Issues: Lack of communication between agency Electronic Health Records (EHR) and CAREWare and years'-long waitlists for specialized care.
- Regional & Policy Challenges:
 - Rural Disparities: Rural providers feel excluded from pilots that are often Metro-only; they also face poor cell/internet and rural primary care doctors are often unwilling to do HIV care
 - Policy Anxiety: Regarding new 80-hour work requirements for SNAP/Medicaid and federal shifts affecting transgender individuals and immigrants.
 - A request among consumers and providers to engage and work collaboratively with state.

Discussion and Questions

- Did telehealth come up?
 - It was discussed as a barrier for rural residents with limited cell phone/internet coverage and computer access.
- How can we improve collaboration between providers, consumers and the state?
 - English-speaking group requested more information about what's going on at the state and more opportunities to engage in advocacy.
 - Providers reported a lot of anxiety in the community. Bringing people together to discuss this is important.
 - Participants in consumer sessions were very appreciative to get the chance to come together/meet.
- What pilot programs specifically are not extended statewide?
 - There might be more information in the full report, but one program that came up was based at OHSU.
 - Perception becomes reality – if programs are offered statewide but rural residents don't know about them or don't believe they qualify, this is a barrier.
- What did OSPG meeting attendees find surprising about this information?
 - Comments that services are too focused on harm reduction.
 - Opioid prevention and harm reduction services are often located at Ryan White-funded organizations, and consumers can feel like their HIV needs are put to the side to prioritize substance use support. Especially when those consumers don't need substance use support.



- When housing is such a high need, harm reduction might seem like a luxury.
 - Many consumers aren't aware of funding streams. There was a perception that harm reduction takes funds away from services for people living with HIV.
 - OHA has heard feedback that screening forms focus heavily on harm reduction and is working with providers to skip questions as appropriate/not ask repeatedly about substance use needs.
- Will the report differentiate between services provided in TGA vs balance of state? This would be helpful to direct funding.
 - Yes. More reports of services being unavailable outside of the TGA, including medical transportation.
 - Many people drive a long way to get to their providers.
 - Medical transportation was listed as a need in Part B, not in Part A.
- Any comments about people going into Portland to access services and socialize?
 - This was mentioned by providers but not consumers.
- Discussion of lack of services provided by PLWH:
 - The introduction and funding of peer support services have professionalized this work. Services that were built out of community have now paid careers. There's a sense of loss of being able to participate in a more active way.
 - Participants looked back to the 1990s, when PLWH were working with PLWH. There aren't services entirely provided by people with HIV now (although PLWH do have paid jobs in this field, providing services).

Oregon Priorities & Priority Populations

What Is the Integrated Plan?

- Our roadmap for ending new HIV/STI transmissions in Oregon
- Required by federal funders (CDC & HRSA) every 5 years
 - This plan covers 2027 - 2031
 - Developed with OSPG, Part A Planning Council, and broad community input
- We brand this plan locally as our End HIV/STI Oregon Strategy
 - There's a 10-page Executive Summary of the 2022-2026 plan on OHA's website, as well as on endhivoregon.org (in English and Spanish)
 - Each year on World AIDS Day, we put out an Annual Report

Who Is Involved?

- The Ryan White Part B grantee (= OHA) is responsible for developing, submitting, and monitoring the plan.



- Prevention (OHA), Surveillance (OHA), and Ryan White Part A (Multnomah County Health Department) are “joint authors” and contribute data and input to this integrated plan.
- Oregon’s Statewide End HIV/STI Oregon Planning Group (OSPG = us!) will review and submit a letter verifying the information.
- Part A Planning Council (PC) will review and submit a letter verifying the information.

Key Priorities: Types of Data

- Key priorities were identified through overlapping themes from four key types of current primary data:
 - PLWH Town Halls
 - Provider Town Halls
 - Planning group feedback
 - Planning & Resource Services Allocation info from the PC
 - Survey data from OSPG
 - Supplementary surveillance studies
 - HIV Medical Monitoring Project for PLWH services
 - Chime In for HIV prevention services
- All data evaluated for resonance with surveillance data and Oregon context

Key Priorities: Client Services

- Mental health and substance use treatment
- Medical case management
- Housing
- Linkage to care for newly diagnosed

	PLWH Townhalls	Provider Townhalls	Planning Groups	MMP
Mental Health & Substance Abuse Treatment	X	X	X	X
Medical Case Management	X	X	X	X
Housing	X	X	X	
Linkage to Care		X	X	

Key Priorities: Prevention

- Integrated HIV testing in various settings (e.g., medical offices, urgent care/ER, community/outreach ...)
- Services for people who use drugs
- Strategies to increase HIV awareness



	PLWH Townhalls	Provider Townhalls	Planning Groups	Chime In
HIV testing	*	*	X	X
Syringe exchange & services for people who use drugs	*	*	X	X
HIV awareness	*	*	X	X

*Townhalls focused on RWHAP services, not prevention topics

Priority Populations – New Language

- Priority Populations is the language we have used in past iterations of plans
- For the 2027-2031 plan, we will use the federally-required language of “people and communities disproportionately affected by HIV.”

People & Communities Identified

- Feedback received that too many groups were identified in previous plan
- Attempts made to narrow list and answer the question: “Priority for what?” based on epidemiologic and other data
- Proposed list narrowed from 12 to 7 (no new populations added)
- Based on trends/larger themes: it does not mean that groups not on the list will not be served or have “lesser” needs
- Priority pop: people under 30 – that should be more under “disproportionate rates of new diagnoses.” (the Prevention” section)

Key Goal	People & Communities Disproportionately Affected	How People & Communities Identified
Diagnosis	<ul style="list-style-type: none"> • People who inject drugs • People who live in rural & frontier areas 	late diagnosis with HIV
Prevention	<ul style="list-style-type: none"> • People who are Black/African American • People who are Hispanic/Latine • Men who have male sexual contact (MMSC) • People who inject drugs • People under 30 	disproportionate rates of new diagnoses, low PrEP use
Treatment	<ul style="list-style-type: none"> • People with unstable housing • People living in rural & frontier areas • People who use drugs (PWID + non-injection drugs) 	Lower rates of linkage to care and viral suppression
Response	Varies based on real-time surveillance	ongoing surveillance activities, cluster analysis



Proposed “People & Communities ...” (for 2027-2031 Plan)

- Black/African American people
- Hispanic/Latine people
- Men who have male sexual contact (MMSM)
- People who use drugs
- People who live in rural & frontier areas
- People under 30
- People with unstable housing

Reminder: Plan = High-Level Strategy

- Does NOT replace grant guidance and goals
- Does NOT indicate where funds will be allocated
- IS a synthesis of existing data sources, plans, and activities
- DOES take into consideration other contextual factors

Discussion:

- What else should we consider?
 - We focus so much attention/funding on prevention, but we don't fund PrEP.
 - PrEP is covered by Medicaid in Oregon with no cost sharing.
 - Not everyone has Medicare or Medicaid or insurance until they are positive.
 - Billing coding is tricky for the labs. Injectables are also tricky to get covered.
 - Issues exist around billing through the pharmacy vs. medical benefit.
 - [NASTAD's Billing and Coding Guides for HIV Prevention page](#) (now updated with a supplement on Lenacapavir PrEP)
 - Could PrEP billing/costs be a future discussion/presentation topic?
 - [PrEP has increased dramatically - but most current data show that 60% of Oregonians who could benefit from PrEP aren't receiving it.](#)
 - See the prevention and care demographics tabs.
 - Intersectionality – houseless folks, people of color, people who use drugs.
 - Trans folks and other gender minorities, refugees from other states.
 - People are coming from other states that are less safe for trans people. We should be ready for more PLWH to come into Oregon.
 - People who are uninsured.
 - Folks who engage in street economies and sex work.
 - ACES assessment and looking at mental health needs/substance, etc.
 - Maybe how we intake folks and prioritize those with greatest needs.
 - Access to providers who prescribe PrEP, increasing PrEP awareness outside of LGBTQ communities.



- Report of female patient asking their provider at OHSU Women's Health Center about PrEP – doctor didn't respond and made patient feel uncomfortable/judged for asking. No follow up on why she wanted it.
 - Women as a priority population.
- PrEP is a great tool but there are a lot of reasons that it doesn't always work for everyone.
- Omission of rural community.
 - Access to providers outside of TGA/tri-county,
 - What does HIV care and prevention look like in rural communities, especially as we see people using emergency departments as primary care and hospitals are closing?
 - How will Rural Health Transformation Funds impact the rural population and how will OHA be able to use the funds in rural areas?
- Need for case management and ensuring access to case management.
 - Ensuring that access is important before adding extra/new services.
 - Having a case manager could help Hispanic/Latine folks feel like someone has their back and that they're getting equitable access.

Small Group Discussion – Housing:

What do people see around current housing initiatives?

- Housing is health care, healthcare is housing, and continued advocacy is needed.
- Clackamas County used to have Rent Well class, but lots of CBO's have dropped their Rent Well supports and are not engaged any more. They are valuable and should be reinvested in.
- What does housing look like for those with HIV who are aging, how do we support their loved ones and immediate families who do not have HIV but also benefit from supports provided? Often family members provide care for their HIV family members who are aging.
- In Eastern Oregon, low inventory of housing and a lot of landlords are using property management companies. They advocate for client to be accepted into units but when clients are accepted they feel like the property management is giving them a hard time or being discriminative and the client is unhappy and wants to leave—but there is nowhere else to go or limited options.
- Housing needs to focus on older adults. Aging into homelessness. “If something medically happened to me as a gay man, I don't know where I would go in Eastern Oregon.”
- Need for low barrier housing, housing programs and units.
- More opportunities for agencies to apply for grants to expand housing inventory. Own properties they could steward to assist those living with HIV.
- Previously, EOCIL was relying on private landlords. Most people are moving toward using property management companies.
- Would like to see more supportive, permanent housing facilities: places for people to live with its own cafeteria, mental health etc. onsite all built into the



same facility. Would be helpful to have in other parts of the state “Our House” in Portland.

- The group echoed the need for more places like Our House
- CAP’s programs are not long-term, most are not permanent housing although they are called permanent housing. Would like to see rent to own options and/or lease to own instead of moving from place to place because your time is up in a program. The burden it creates to relocate.
 - Habitat for Humanity. And/or additional homeowner options
 - Income qualifications are too high for Habitat for Humanity and it would be helpful if there was a partnership that bridged the gap to support a transition program from supportive housing programs to homeownership.
 - EOCIL has tried to connect with HH before too and were unable to get anyone connected.
 - People could benefit from having an agency or someone walk you through the process of moving into homeownership or lease to own options.

Summary:

- Need to continue focusing on housing as healthcare.
- Need for agencies to acquire housing/facilities to be used for PLWH. Limited acquisition dollars.
- Need for long-term permanent supportive services instead of 2-year programs.
- Concern regarding aging adults (assisted living options), limited skilled nursing facilities
- Need to support the family as a unit instead of just isolating services to the individual living with HIV.
- Education opportunities to increase rental options for PLWH. Rent Well classes & certifications

Positives:

- Housing Programs! OAK, Cultivate and OHOP!

Small Group Discussion – Syringe Exchange & Other Services for People who Use Drugs:

- People who use drugs (PWUD) remain a priority population due to late diagnosis, higher rates of new diagnosis, low PrEP use, low/slow linkage to care, lower likelihood of viral suppression, injection drug use (IDU) as transmission pathway for HIV/HCV infection.
- Shifting the focus from injection drug use to polysubstance use disorder is important in the next five years.
 - Focus has traditionally been on opioids and IDU. Need to expand focus to methamphetamine use and non-injection drug use.
 - Substance use is a core risk factor aside from transmission risk associated with IDU.
- Focus on whole drug user health. This includes sexual health, wound care, mental health, behavioral health. Treat the person, not the disease.



- Break down silos of care. Build better partnerships with behavioral health. This links to all other topics – housing, testing, mental health/behavioral health care.
- Develop and invest in peer support and telehealth. This is an important way that drug users could connect, especially in rural areas.
- “Yes, and”: Keep what’s working well and build on it. We have good access to naloxone, syringe exchange in Oregon. And we should also think more expansively than just syringe exchange.
- Meds for addiction treatment, access to mental/behavioral healthcare, HIV/STI care (including DoxyPEP) and carceral linkage to care (focus on jails as an entry point for building linkages).
 - More focus on jail in-reach. Opportunities for testing, building community in-reach to establish relationships between clients and community partners.

Small Group Discussion – Mental Health:

What should/could we specifically and practically be doing in the shorter term (next 1-2 years) to ensure MH services and help meet our overarching HIV/STI prevention and care goals? What about in the longer term (3-5 years)?

- Provider shortage, but in-house handoff to support helpful.
- Increase MH training/skill building for Medical Case Managers (MCM) and nurses who interact with clients.
- Increase street access and outreach where folks are now.
- Telehealth expansion to meet needs (but keep in mind importance of in person visits).
 - In TGA, only 1 MH program offers telehealth.
- Increase collaboration with NAMI or other partner agencies – help them understand our community, increase our trust in referring to them.
- Increase peer support and availability. Use peers to assist connecting people to more formal MH services. Peer supports and psychosocial while folks are working toward providers
- Integrated MH as part of medical care.
- Low barrier MH services.
- Fill gaps of MH with Medicare patients – need more of this.
- Improve MH access to more rural areas.
- Increase overall access to prescribers and to culturally competent prescribers.

What are some current and primary challenges you see in your community re: MH access and services?

- Not enough providers.
- Not enough credentialed providers (who can get paid).
- Long wait times (6 month wait).
- Inability to get to someone while in crisis (only hotlines).
- Appointment but not enough support to get people to appointments: reminders, help with transportation, etc.



- Expect people to go to a brick-and-mortar offices – need transportation assistance or alternatives to meeting in person.
- MH agency flexibility
- Racial/cultural or HIV/LGBTQ competency may be missing
- Not enough MH prescribers in different languages and throughout the state.
- Prescribers/psychiatrists and medication management.

Successes:

- When patients do manage to get a prescriber and have insurance coverage, staying in treatment isn't generally difficult.
- PSU does a great job with mental health support for students/getting them connected to care right away. Very quick to connect to a provider, and then you can stay with that provider.
- Peer Assisted Telemedicine Health in Substance Users (PATHS) has added MH services with no requirement for HIV/HCV status.
 - Not limited to Portland area – any county that has a PATHS site.
 - Peers reach out to clients and follow up with them, help clients make the calls and get things done.
 - No requirement that clients stop using drugs, which takes away a barrier.
- Central City Concern (CCC) has peer support that drops people off at appointments and walks them to the lab, etc. Many clients would not have made it without that help.

Small Group Discussion – Integrated Testing:

What should we be doing in the next 1-2 years to meet our goals in this area?

- IndigiKit mail order pregnancy tests with other mail order testing kits. Good way to get folks to take other tests. PR work- perception of risk for HIV and perception of risk for Hep C. Automatically including HIV with Hep C is a good idea and should continue.
- Opt-out model in general.
 - Priority in emergency departments even if challenging.
 - Opt-out at (CCC) intake screening (every single person gets these ordered).
 - Metropolitan Pediatrics started doing opt-out screening at their facilities.
 - One person championed it and brought it forward. Layers to this specifically for youth but really important.

What about in 3-5 years?

- Similar goals are because of time getting folks on board of an opt-out model. See it more as a five-year goal.
- It would be cool to include HIV screening in alternative settings (dentist office, hair stylists, etc.). Even take-home kits in those spaces.



What are some positive things happening in your community related to this topic (specific activities or programs, policies or systems)?

- Oregon SAFE (Sexual Assault Forensic Examiners) workers have great legal reps and providers that are open to seeing them on a regular basis. They do outreach as well for those that may be at higher risk. Doing quite a bit for STI testing and prevention.
- Relationship with CAP (Familias en Accion). Staff person who is an integrated position as CHW and testing in clinic and community-based testing. Specifically Spanish-speaking clients in community.
- HIV testing through STI clinic and HIV testing – outreach van for HIV/STI testing.

What are the main challenges you see in your community related to this topic?

- Reliable and sustainable funding.
- Opt-out testing seems impossible in EDs even if they are interested
- Not having E.H.R. systems set up – not sure who follows up. Workflows if someone tests positive.
- Without a champion at that agency, it is really challenging.
- People don't seem to know where to go for testing even when available.

Post-Meeting Survey Responses:

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

- Strongly Agree – 68%
- Agree – 26%
- Neutral – 5%

There were enough opportunities for discussion.

- Strongly Agree – 53%
- Agree – 26%
- Neutral – 16%
- Disagree – 5%

Free-type feedback:

- Breakout times are always too short!
- Great job Shelley! You rocked it for your first time, you pro!
- Would love an in person meeting. Realize this is challenging.
- Thanks. Far more interactive than usual and most appreciate the pivot to more breakout time.
- More time in breakouts
- There was enough opportunity for discussion but not enough time to dig deep into topics. But, with the time we have, I think you did what we could! Better to leave people wanting more discussion....
- 18 months OSPG meeting in Person

