



CFHPC Data Presentation Parking Lot

September 17, 2026

Section	Questions
Epidemiology By Yasmin Andre	Q: (Slide 28) When the data is separated out, are transgender females put under male, and transgender males put under female? <i>A: There were changes on how this data was reported. We used to have additional breakdowns for the different transgender and non-binary communities; we are not receiving data broken down in that way anymore. The data we are presenting reflects the person's sex assigned at birth.</i> Q: (Slide 28) This presentation shows the data as it was reported by the state? <i>A: Yes.</i> Q: (Slide 56) It'd be good to see the data on how many black heterosexuals with HIV-related deaths were unhoused. <i>A: We do not currently have demographic-level data by housing status.</i> Q: (Slide 56) We can tell from the data that black heterosexuals with HIV are dying. What new initiatives in the RWHAP are addressing this issue? <i>A: The newer data that will be reviewed reported from clients themselves (in the HIV Care Needs Survey and the Provider Capacity & Capability Survey) will give us a better idea of what services are needed and where efforts need to be directed to address these issues.</i> Q. (Slide 56) Curious about possible co-morbidities with the HIV-related deaths in the Black Heterosexual group. <i>A. If we can pull that data we can bring it next week. The Unmet Need presentation may give more information on this priority population. Data provided is unable to give us this breakdown. We will put in a request to the State.</i> Q. (Slide 47) – Where is the data on homelessness coming from? <i>A. We get all this data from the epidemiology tables, and do not have a further breakdown of the data. This homelessness data relies on self-report, and some people do not feel comfortable sharing that information.</i>

Outcomes & Care Continuum By Laura Perez	Q: (Slide 9) Brevard VLS vs In Care VLS - How is the VLS 94% if 281 people are out of care? <i>A: Out of 1,998 PWH in Brevard County in 2024, 281 people (14%) are considered Out of Care, meaning they had no documented medical encounter for that year. Out of the 1,998 PWH in Brevard County in 2024, 1,600 people (80%) are considered Retained in Care, meaning they had two or more documented medical encounters at least three months apart for that year. Of those PWH who are Retained in Care, 94% were considered Virally Suppressed in 2024. The overall Community VLS, which includes all PWH in Brevard County both in and out of care, is 79% for 2024.</i> Q: Will the comorbidity data help us understand why Black MMSC are still not meeting the In Care and Retained in Care targets? <i>A: Yes, it could, however the data provided by the state does not give the comorbidity breakdowns for the Black MMSC group.</i> Q: Can we drill down on age and zip code for the Black MMSC outcomes? <i>A: Not with the data provided by the state.</i> Q: Do we have enough EIS resources in the area to meet the need of the +3,000 people who are out of care? <i>A: We don't have access to the client-level out-of-care data that the state shares out. The state has a system where they can track these individuals, but we can only track our success with interventions for the people we know are out of care locally based on our Part A and Part B systems. The state has data sharing agreements with the Ryan White systems, but we don't always receive the data in real-time, so by the time the data gets to the system of care, it could be many months down the road and we may not be able to reach those individuals anymore.</i> Q: Can it be an issue that Hispanic/Latino MMSC are not in care because of concerns about immigration status? <i>A: Yes. However, this data is from 2024, and immigration enforcement efforts may not have had as much of an impact then as it could in 2025 or 2026.</i>
Client Needs Survey By Whitney Marshall	Q: (Slide 13) Is this data broken down by county? <i>A: It is not broken down by county, but information on respondent's zip code was collected, so there may be a way to determine the county of residence for respondents using that data.</i> Q: (Slide 22) We have the same top 5 services as last time? <i>A: Yes. The item lists all available services, and respondents had the option to choose between "I did not need this service," "I needed this service and I received this service," and "I needed this service but could not get this service." This slide shows the top 5</i>

	<i>services where respondents chose “I needed this service and I received this service.” The top 5 most important services is a different question.</i> Q: (Slide 22) Is this counting the survey that went out last month? <i>A: After some clarification, this individual was asking about the AAM Survey sent to Planning Council members, which is a separate survey from the HIV Care Needs Survey.</i> Q: (Slide 24) Is this data showing the services that received the least number of “I needed this service and I received this service” responses, or is this based on people saying that they did not need this service? <i>A: This data is reflecting the services where people chose the option “I did not need this service.”</i> Q: (Slide 24) How is the question asking about “Outreach to find people with HIV not in care and help them visit their doctor and get services” set up? <i>A: The item lists all available services, and respondents had the option to choose between “I did not need this service,” “I needed this service and I received this service,” and “I needed this service but could not get this service.”</i> Q: (Slide 26) When it says Health Insurance, is it referring to the copays and premium assistance offered through ADAP? <i>A: Yes.</i>
Unmet Need By Doris Huff	Q: When do we think we will get updated data? <i>A: It depends on when the state gets it to us.</i>
Part A Client Satisfaction Survey By Pedro Huertas-Diaz	Q: Is the survey available in Spanish? <i>A: Currently only available in English, but Part A is working on a professionally translated survey for the future.</i>
EIIHA By Laura Perez	Q: (Slide 10) In 2024, it says 206 newly diagnosed. Is that just for Orlando? Because before, you shared that we had 669 new infections. <i>A: That's publicly funded tests. So, that's individuals that were tested who would use a 1628. The data doesn't account for any community-based testing that might have happened.</i> Q: (Slide 10) It depends on where you get newly diagnosed, right? And what type of services were given to them afterwards? Could that be a factor? <i>A: This data is focused just on the publicly funded testing events. Because they got the information at the public testing events, it doesn't necessarily mean that they did all the</i>

	<i>other steps at a publicly funded provider. They might have gone through a private provider instead. So, that could account for some of the drop off in some of these numbers.</i> Q: (Slide 17) Where we see the linkage happening, but then it drops off with the rest of it with the confirmatories, etc.-- Could that be part of the result of us being more successful with test and treat where we've linked them to a doctor and then they've gone to that doctor to get the medication and testing done, confirmatories, etc., that may not have been entered into the system? <i>A: That could be a possibility. It could also be that a lot of people aren't going the path of state funding anymore so that wouldn't be listed in the data. Also, they could be going directly to an infectious disease doctor which isn't a publicly funded tester.</i> Q: (Slide 17) The lab is back open? <i>A: It is, but it's slow. So, most people want the lab back within 2-3 days versus having to do snail mail all the way to Jacksonville and then wait.</i>
Funding Streams Report By Doris Huff	Q: Funding Streams Tables (Page 4) Is there any reason why you don't have the 340b form in there? <i>A: Not a part of this data because it is agency-specific.</i> Q: Is this what we provided to you that says different agencies have different funding or is this a different form? Because on that one where you asked what other funding sources are out there, as part of an agency, I reported a number. Potentially, we can add those agencies that have a MOU and they can report what you have invested back into the community. <i>A: You can't really do that because there are different qualifications for different agencies depending on how they're qualified. The funding/patient access dollars that are received can be used however the agency determines to use it. So, there's not a standard across the board that says you have to spend a certain amount.</i> Q: Is this what Claudia gave us? <i>A: Yes. You guys get to look at those numbers monthly for the Part A, but the good thing about this is that Doris is going to show you all of the different funding that you may not get to see every month.</i> Q: All of this went away for MAI? <i>A: Just for part B.</i> Q: (Page 14) What is Part C?

	<i>A: It's an Early Intervention Services grant. It's for geographical areas. So, for instance, Part B can be spent for the whole state of Florida. Part C can only be spent for the geographical area that it's been designated to. But it follows the same rules.</i> Q: ADAP no longer has premium assistance? <i>A: Yes</i> Q: (Pages 37-38) When you say no data (for the AHA) does that also mean that we don't have funding either? <i>A: Yes</i> Q: Is there a summary sheet for the funding streams report? <i>A: No, but we can work on it.</i>
Part A AAM Response By Claudia Yabrudy	No questions.
Provider Capacity & Capability By Whitney Marshall & Anthony McNeil	Q: (Slide 22) Do Case Managers have to bill by units? Is it allowed for a staff to spend up to 3 hours with a client? <i>A: Yes</i> Q: (Slide 22) I wonder if there is a way to capture access time outside of appointment time? <i>A: We (Part A) have that data and can provide more information in a future committee meeting.</i> Q: (Slide 39) The clients are saying that housing is not a top 2, and the case managers are saying housing is #2, how can the case managers assume that, and the clients are putting that it's not. Who is making the judgement? Are we going with the clients or case manager's perspective when making decisions? What's the priority? <i>A: It's the difference in perception and the numbers. As far as the judgement, it is important to take in both perspectives as well as all the other information to make the decisions. Looking into the discrepancies could be a potential special project that the Planning Council looks into.</i>
Utilization & Expenditures By Claudia Yabrudy & Whitney Marshall	Q: The decline in services doesn't add up to what was spent, does it? <i>A: It all depends on services. For example, with Outpatient Ambulatory Healthcare, we spent more money than the prior year and we served slightly more clients. So, it just goes along with it.</i> No questions about Part B presentation.

Part A Presentation By Claudia Yabrudy	Q: Which clinic are we referring to? <i>A: All OAHS providers</i> Q: Who assigns a client their acuity level? <i>A: The referral specialist has a 5-question assessment that is used to determine acuity level. If a certain threshold is reached, then the client is assigned to a Medical Case Manager.</i> Q: This has been in place for how long? <i>A: This has been in place for at least the past 10 years. What we're proposing now isn't something different. We're trying to align it because it's challenging for those who aren't dually funded to coordinate that service.</i> Q: Even if you have a private doctor? <i>A: If someone has a private doctor then the MCM role is different.</i> Q: Will they also be able to work with those who are doing outreach? <i>A: There are different initiatives to put faces to those we don't know. This particular initiative is to work with the clients we do know.</i> Q: For the 505 Part A clients that are not virally suppressed, their coordinator will be working directly with those in the clinics? <i>A: Not all 505 go to our doctors.</i> Q: What percentage of those go to the ones that have a grant with Ryan White? <i>A: Right now, 89% of clients outside provider are virally suppressed. For the clients that are within our provider network, it's around 90%. So, it's pretty close, but that 505 is divided by individuals who are in our network and not in our network. It's like 50/50.</i> Q: What's going to determine the success of this? <i>A: We have done a really close look at our case management case load. On average, it's around 35. That doesn't mean that they're touching every client every day. We do have data on that. Those who are dually funded will be transferred to a care coordinator.</i>
Q&A Sessions (General)	No questions.