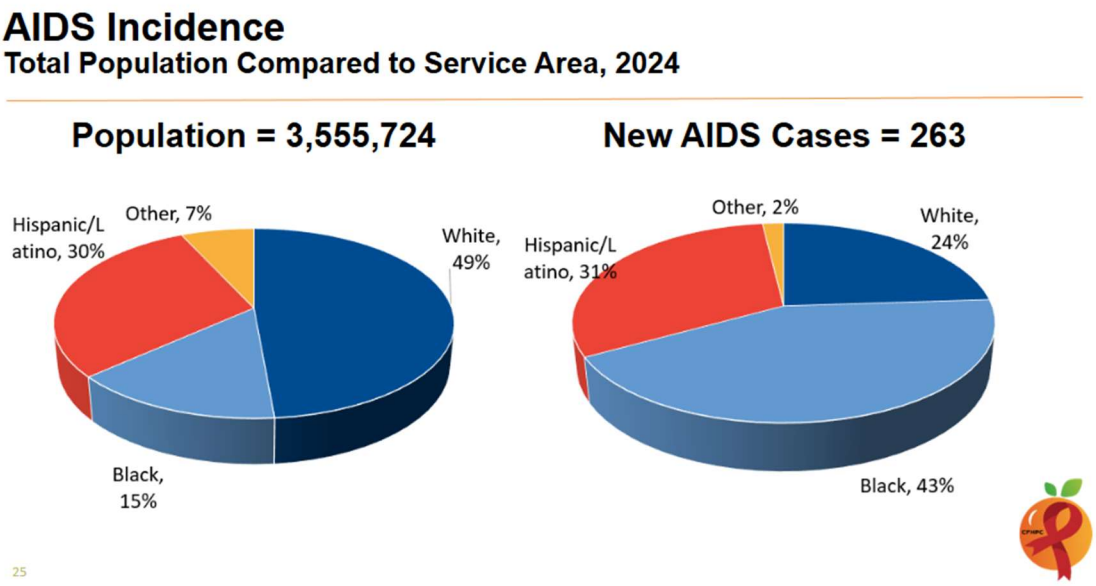
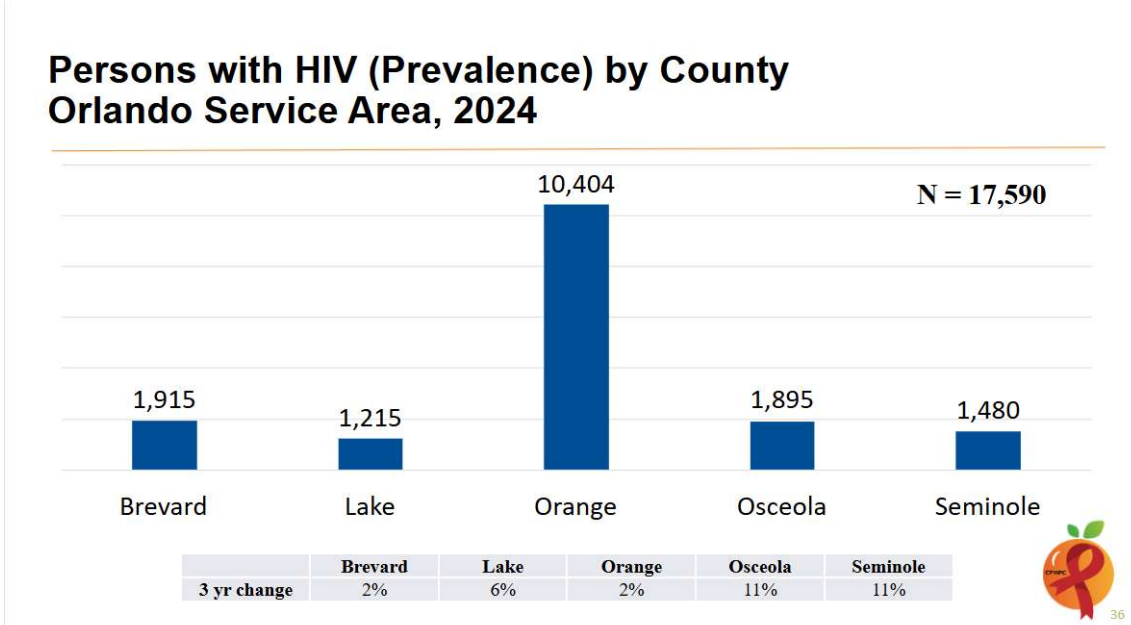
CFHPC Data Presentation Parking Lot

September 19, 2025

Section	Questions
Epidemiology By Yasmin Andre	**Q: On the first bullet (of slide 6), where is Hispanic & Latino?** *A: Hispanic/Latino cases are reported, this is just the distinction between race and ethnicity.* **Q: Are the people being [diagnosed] now [to HIV] in treatment or undetectable?** *A: If a person is undetectable or virally suppressed then transmission is extremely not likely. Transmission is more likely if PWH are not virally suppressed. What this data is showing us is that an increase in new HIV cases could mean that too many people are out of care and not virally suppressed. We will explore that data in the Outcomes – Care Continuum presentation.* **Q: (slide 12) What could be the logic behind the increase and decrease [of new HIV cases] in each county? Is it because more agencies are out there with mobile units testing in those counties?** *A: The data doesn't tell us why, but there are many different factors, including the availability of testing. If there's more testing, we identify more cases. There are also other social determinants of health impacting access to testing, so this data may not tell us the whole story, but we can dig in further.* **Q: (slide 12) Would someone who moved to Orlando from out of state be counted towards the numbers in the Orange County incidence?** *A: They would not be counted as a new case if they moved to Orlando from another state where they were originally diagnosed. However, the individual would be included in the prevalence numbers if they were living in Orlando at the end of that year.* **Q: (slide 13) What is the takeaway? Does this mean we're reaching more African Americans (AA) with HIV testing? What does it mean that they are over-represented?** *A: It means that there is a disproportionate impact on AA. It does not necessarily mean that any one population is or is not being reached (as far as prevention, education, treatment, testing, etc.). We cannot completely identify a single reason for overrepresentation- it is a combination of factors, but we do know from the data that AAs make up a greater percentage of new HIV cases when compared to the overall*

	population in the OSA. What this data tells us is that populations that are more impacted by HIV/overrepresented require targeted interventions and outreach efforts. **Q: Could we find out zip codes of highest incidence?** *A: Incidence by zip code is not included in the epi profile, but it can be requested from State Surveillance.* **Q: Does the data for 13-19 year old incidence include victims of human trafficking?** *A: We don't know the method of transmission for each age group, but the cases are included if it was reported.* **Correction to AIDS incidence (slide 25) pie charts.**  **Q: (slide 36) With the current political climate do we feel that these numbers [overall incidence or prevalence data or AIDS incidence] are going to change?** *A: Recent immigration changes could make people more reluctant to get tested or seek care overall, and it's possible but we won't know for sure until we see the data for 2025.* **Q: (slide 36) Do we know what the rate of growth for the total population is in each of the counties?** *A: Prevalence data by county vs. Total Population by County below*



Population by County	2022	2023	2024	3 yr change
Brevard	628,035	638,491	652,925	3.96%
Lake	417,576	411,761	428,234	2.55%
Orange	1,495,047	1,513,466	1,523,866	1.93%
Osceola	426,772	444,475	457,776	7.26%
Seminole	485,395	491,029	492,923	1.55%

Q: (slide 37) How can a number go down? (In reference to PWH by Race/Ethnicity slide)

A: Prevalence is based on the total number of HIV cases in the OSA. It is possible that people move out of an area and that could cause a decrease.

Q: Why isn't herpes represented?

A: Herpes or HSV isn't included with the epi profile, although we don't know why. It could be that providers don't routinely encourage testing for HSV.

Q: (slide 46) Is this new diagnoses?

*A: Comorbidity includes PWH who were diagnosed with HIV **AND** another condition in 2024, however we cannot add them up to match the total incidence. History of mental illness, substance use, homelessness, and release from jail/prison includes all PWH. (See technical notes below).*

Comorbidity includes PWH who received a diagnosis of an additional condition in 2024.

Hepatitis B comorbidity includes acute hepatitis B cases reported in 2024 with an HIV diagnosis date before or within 6 months after the acute hepatitis B event date and chronic hepatitis B cases in 2024 with an HIV diagnosis date at any time before or after the chronic hepatitis B event date.

Hepatitis C comorbidity includes acute hepatitis C cases reported in 2024 with an HIV diagnosis date before or within 6 months after the acute hepatitis C event date and chronic hepatitis C cases in 2024 with an HIV diagnosis date at any time before or after the chronic hepatitis C event date.

Early syphilis, gonorrhea, and chlamydia comorbidity includes early syphilis, gonorrhea, and chlamydia diagnoses in the period specified with an HIV diagnosis date before or within 30 days after an early syphilis, gonorrhea, or chlamydia initial lab specimen collection date.

TB comorbidity includes TB diagnoses occurring in 2024 with an HIV diagnosis date before or coinciding with TB diagnosis.

Homelessness is based on the current address at the end of 2024 and includes addresses labeled as Homeless, Shelter, Temporary, or with a zip code of 99999.

Q: With the history of the substance abuse how specifically is "history" defined?
A: This is based on the client self-reporting substance use and also based on how the person completing the 1628 form records the response. The 1628 asks about use in the last 12 months, but does not define which substances are counted.

There has been a 0.6% decrease in reported cases since 2022.

Year	*# of History of Substance Use co-occurring with HIV*
2022	*2,621*
2023	*2,592*
2024	*2,605*

Q: What is meant by "Early Syphilis"? If it includes primary or secondary?
A: Early syphilis is used to describe syphilis that has been acquired in the previous 12 months and includes three stages of syphilis: primary, secondary, and early non-primary non-secondary.

Q: Is late testing part of the data?
A: Yes, late testing as it related to HIV diagnosis will be shared in the Unmet Need presentation.

<table>
<tr><td></td><td>Q: What service counties are covered by Ryan White Part A, Part B, Part C, and Part D?
A: RWHAP Part A includes Orange, Osceola, Seminole, and Lake. RWHAP Part B includes Orange, Osceola, Seminole, and Brevard. RWHAP Part C is available in Brevard and in Orange, Osceola, and Lake. RWHAP Part D includes Orange and Lake.</td></tr>
<tr><td>Client Needs Survey

By Whitney Marshall & Angie Buckley</td><td>Q: (slide 21) Do we know if this is from men or women? (What services were received by those released from jail/prison)
A: Data for this slide is broken down by sex and zip code in the tables below.

<table>
<tr><th></th><th>Male</th><th>Female</th><th>Other</th></tr>
<tr><td>I did not receive information or assistance</td><td>3</td><td>2</td><td></td></tr>
<tr><td>Information about finding housing</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Information about finding housing, Referral to medical care, A supply of HIV medication to take with you</td><td></td><td>1</td><td></td></tr>
<tr><td>Referral to medical care, Referral to case management</td><td></td><td></td><td>1</td></tr>
<tr><td>Referral to medical care, Referral to case management, A supply of HIV medication to take with you</td><td>2</td><td></td><td></td></tr>
</table>

<table>
<tr><th></th><th>Zip codes</th></tr>
<tr><td>I did not receive information or assistance</td><td>32810, 32901, 32922, 34736, 34744</td></tr>
<tr><td>Information about finding housing</td><td>32803, 32804, 33619</td></tr>
<tr><td>Information about finding housing, Referral to medical care, A supply of HIV medication to take with you</td><td>32805</td></tr>
<tr><td>Referral to medical care, Referral to case management</td><td>32817</td></tr>
<tr><td>Referral to medical care, Referral to case management, A supply of HIV medication to take with you</td><td>32926</td></tr>
</table>

Q: When did the jail linkage program start in Orange County?
A: It started in 2020.

Q: We don’t have anybody [linkage staff] in the jails in Brevard?
A: We do not. Some jails are privatized and have specific agencies working with them.</td></tr>
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	Suggestion for survey to change the question to make a distinction between jails and prisons, because inmates are treated differently upon intake in each.
Outcomes- Care Continuum By Yasmin Andre	**Q: Is VLS the same as undetectable?** *A: Everyone who is undetectable is VLS, but not everyone who is VLS is undetectable. VLS is under 200 copies/mL, and Undetectable is under 20 copies/mL.* **Q: That's out of care for all people who were recently diagnosed HIV+?** *A: The out of care data reported here is based on prevalence, meaning all PWH and not new HIV cases.* **Q: (slide 28) Where is the transgender data?** *A: This slide is by county. However, we did not receive continuum data on people who identify as transgender or an additional gender with this year's epi profiles.* **Q: What research is being done on how and why VLS is meeting/exceeding the target with hispanic/latino MMSC?** *A: We do not have the answer to that in this data, but it is definitely worth looking into as the Planning Council explores successful interventions for the next Integrated Plan.* **Q. When do we get these numbers?** *A: The data for this year is as of June 30, 2025 and we receive them in September each year.* **Q: Regarding the trans community, was their data redistributed into sex at birth?** *A: Yes, they are included in that data, but we don't have that breakdown.* **Q: Do you think the HIV incidence is related to the success of Brevard county + their VLS?** *A: It could mean we're keeping folks in care more successfully and should look at what has been successful in that area. We may also want to look at how much testing is available in the area to ensure that newly diagnosed PWH can more quickly be identified and linked to care, which impacts the VLS in the area.*
Unmet Need By Laura Perez	**Q: (slide 13) If the number goes up (unmet need), it means that more people are out of care? Does this mean that Black MMSC are dropping out of care at a higher rate than other groups?**

	A: Yes, an increase here represents an increase in the number or % of people who know their status, but are not in medical care. Black MMSC and Black Heterosexual PWH had the highest rate of unmet need (20.7%). **Q: Why don't we have a number on people who pass from HIV and why they passed from HIV? (wants to know the contributing factors)** *A: Information on HIV-related deaths is provided in the epidemiology presentation. We do not receive information about what complications from HIV caused their death, only that HIV was listed as the underlying cause of death.* **Q: Do we know why people are in care, but not virally suppressed?** *A: This data does not tell us the reasons why PWH are in care, but not VLS. We do know that this percentage captures PWH who were recently diagnosed and are still on their way to achieving viral suppression.*
Part A Client Satisfaction Survey By Pedro Huertas-Diaz	**Q: Who enters the responses/information from the paper surveys?** *A: The Part A CQM team enters responses from the paper surveys into the online portal.* **Q: Are the responses separated by race or age to better understand the demographics of the respondents?** *A: Yes, race/ethnicity, sex, and age are asked on the survey. It will be noted that members may want to see a breakdown of the responses by demographic categories. The responses are also shared throughout the year with the agencies.* **Q: How do clients know about the survey?** *A: Surveys are shared in provider spaces, and case managers are encouraged to get clients to take the surveys. The goal is to have every client fill out a survey after they receive a service.* ***Q: Is it possible to offer the survey to patients after their doctor's visits over the phone?*** *A: Yes, every provider offers the survey in different ways and we don't have that information, but RWHAP Part A talks to providers about their strategies and is constantly exploring more ways to engage clients through the survey.*
EIIHA By Doris Huff	**Q: Why is the percentage of confirmed positive tests so much lower for newly diagnosed people than they were in 2022? (95% in 2022 to 47% in 2024)** *A: There are community-based providers who do not use the 1628 form (publicly funded test report) when conducting testing and some of those tests are not being reported through the state labs.*

	Q: Are the 1628s not being filled out? *A: Most providers have transitioned away from using the 1628 forms and have started entering results in CTLS, which could be skewing the data.* **Q: Who are they charging $50 to?** *A: Providers who conduct HIV testing may purchase HIV tests from the state or they may order tests from private labs such as LabCorp or Quest. Some providers may be able to secure a better rate for HIV tests through these private labs than through the state labs.* **Q: Is this also true for Hepatitis testing?** *A: We don't have that information at this time.* **Q: Is this why interview for partner services are low as well? (Referring to the first question)** *A: Yes.* **Q: (Slide 10) What's the difference between this newly diagnosed and the newly diagnosed from the Epi profile?** *A: This is publicly funded testing. The reason these are so different is that this slide represents the number of newly diagnosed individuals who received a publicly funded tests in the Orlando EMA (Orange, Osceola, Seminole, Lake).* *Update all slides to say EMA not OSA- completed* **Q: (Slide 14) – Within the Hispanic/Latino MMSC group, if 4 people were newly diagnosed and 4 were linked to medical care, why were there 0 for confirmed positive test, interviewed for partner services, referred to prevention services, or received CD4 or viral load test?** *A: We do not have that information in this data.* **Q: Does this data include the home-testing kits?** *A: No, only tests reported through the state lab.* **Q: Why would a person who has been previously diagnosed why wouldn't they go through the state labs?** *A: This is because most previously diagnosed clients might be referred to a private provider for linkage and services where they will draw labs through private providers instead of state labs. This is due to the cost of state labs and length of time to receive lab results.*

	Q: Is Data-2-Care not including private labs anymore? *A: For anyone who does not have a lab or medication pick-up, D2C refers those clients to linkage to follow up with them. They do not follow new tests.* **Q: What is the linked to prevention services? Why is it always so low?** *A: Referrals to prevention services can include things like PrEP, behavioral interventions, risk reduction counseling services, and medical services. If a newly diagnosed or previously diagnosed client went to a private provider for linkage and services, it might not get noted in the HIV Counseling & Testing system. These services can be offered, but clients do not always accept a referral.* **Q: Regarding home testing, are they effective? How is that data being captured? How accurate is the home test?** *A: Both home testing kits and lab-drawn tests require a confirmatory test. The home tests are very sensitive, but it is up to the individuals to self-report their results and follow up with a confirmatory test.*
Provider Capacity & Capability By Whitney Marshall	**Q: What is permanency planning?** *A: Permanency planning helps clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney & preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption*
Funding Streams Report By Doris Huff	**Q: Did they extend the Part B Grant to HFUW?** *A: Yes, the Part B grant was extended for another 6 months.* *Update pg 12 – $425,592 final grant reported by Jessica Seidita* **Q: Which of our PC committees allocates the General Revenue funding that County Health Depts receive?** *A: The Planning Council does not have authority over those funds. Tallahassee allocates General Revenue funding.* **Q: Is $243,156 all that is available to ADAP Orange for the 2025-2026 year?** *A: Tallahassee allocates the money quarterly and additional funding may become available if there are expenditures.* **Q: Is the Seminole County one (ADAP) the first year they're doing it?** *A: No.*

	Q: Is this saying that we didn't spent the 5 million we got for HOPWA in the EMA? *A: The money was spent. There were some carryover funds that were spent in the next year.*
Part A AAM Response By Claudia Yabrudy	**No questions.**
Utilization & Expenditures By Claudia Yabrudy & Yasmin Andre	**Q: (Health Insurance) Was the funding that was used to pay premiums ($2M) in 2022 eliminated once we were no longer paying for them?** *A: No, the funding was moved to another category, and a portion was left in Health Insurance to only cover co-payments.* **Q: Did you see an increase of people using insurance for mental health services?** *A: The increase is from increased mental health staffing.* **Q: How is Home Delivered Meals going?** *A: It started out as a pilot, and it was a huge success so we kept it going. Now that we have funding limitations, we have set more limitations on how the service is utilized.* **Q: How did you get the avg unit cost to be $10 on Food Bank/Home-Delivered meals?** *A: This is because most people are getting the home-delivered meals than the food bank. Costs are lower because food for the home-delivered meals is purchased in bulk from the food provider.* **Q: Who cooked the food?** *A: It's from a Medicaid-approved vendor. The meals are nutritious, and clients have a menu to choose from.* **Q: Are you going to fund Substance Abuse Residential Services again?** *A: That is up to the Planning Council to decide during PSRA next week.* **Q: Should we keep in mind what's happening in the future with health insurance?** *A: It is important to understand what is considered speculation vs. data-informed decisions. The Planning Council must make decisions based on what is currently known about available resources. Funds can always be reallocated by the Planning Council as funding streams change.*