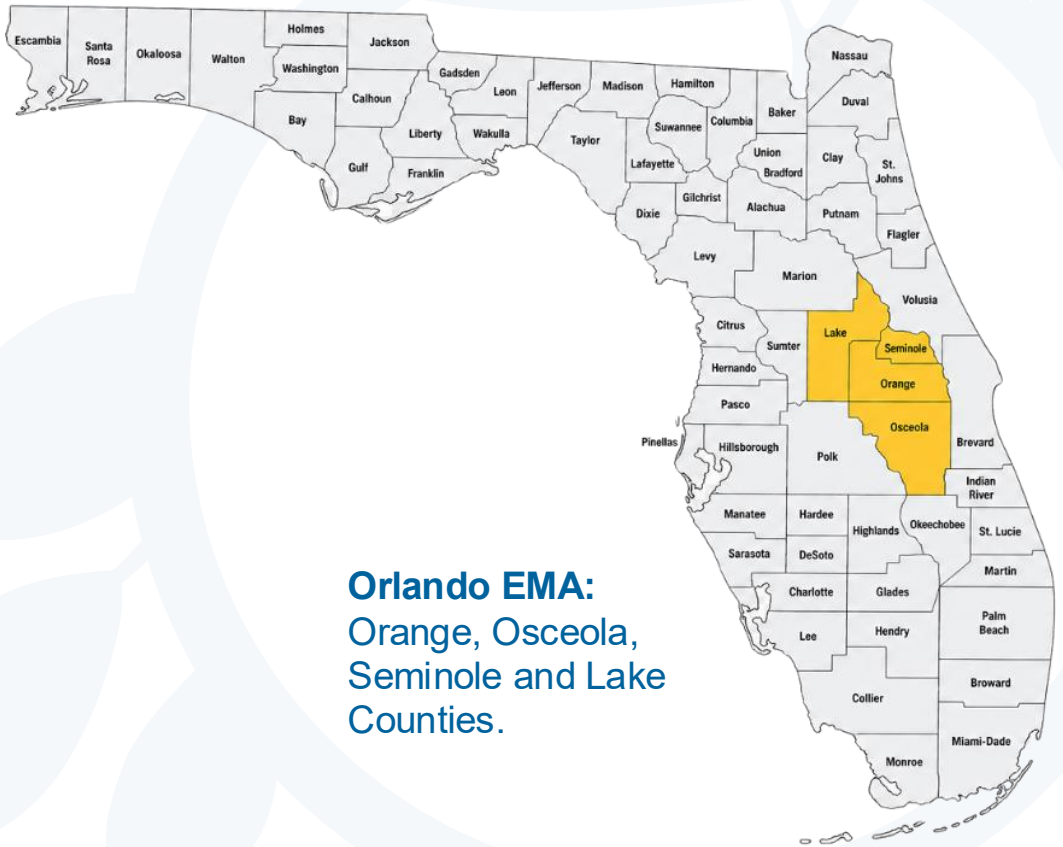
ORANGE COUNTY FLORIDA

Case Management Services

September 17, 2026

Background

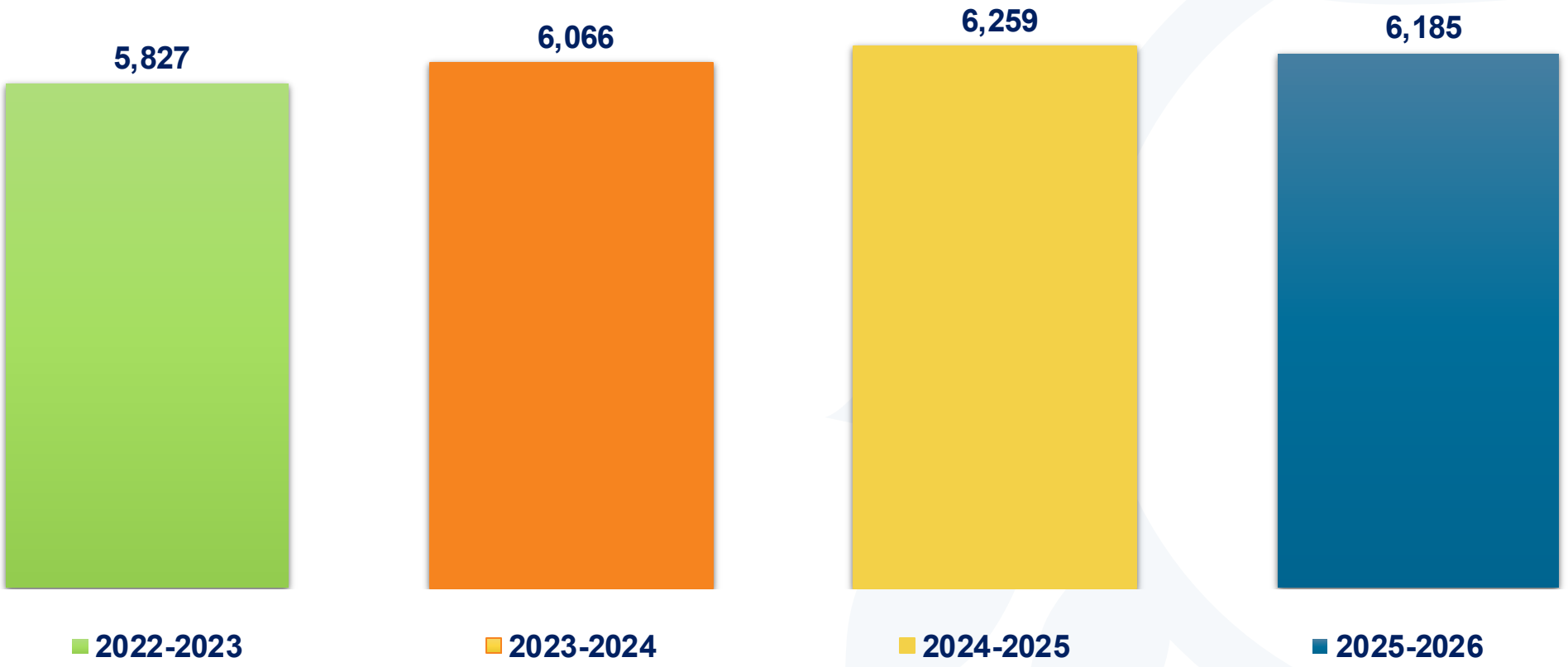
- Ryan White Part A serves clients throughout the Orlando Eligible Metropolitan Area (EMA).
- All clients receive support from a Referral Specialist, and higher-acuity clients may also be assigned a Medical Case Manager.
- Medical Case Managers coordinate with the client's medical provider, but communication can be more difficult when services are provided by separate organizations.
- A new case management model is proposed to better align services and improve coordination for clients.



Orlando EMA:
Orange, Osceola, Seminole and Lake Counties.

Utilization

Number of Clients served under Ryan White Part A



Outpatient Ambulatory Health Services

6,185

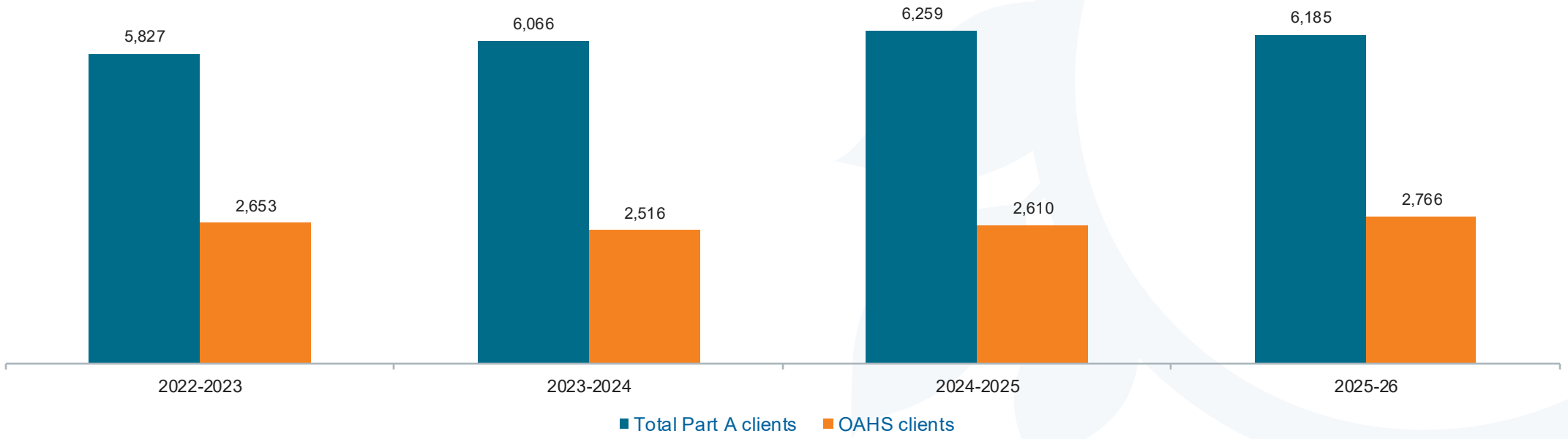
Clients served under Ryan White Part A in 2025-2026

2,766

Clients served in OAHS in 2025-2026

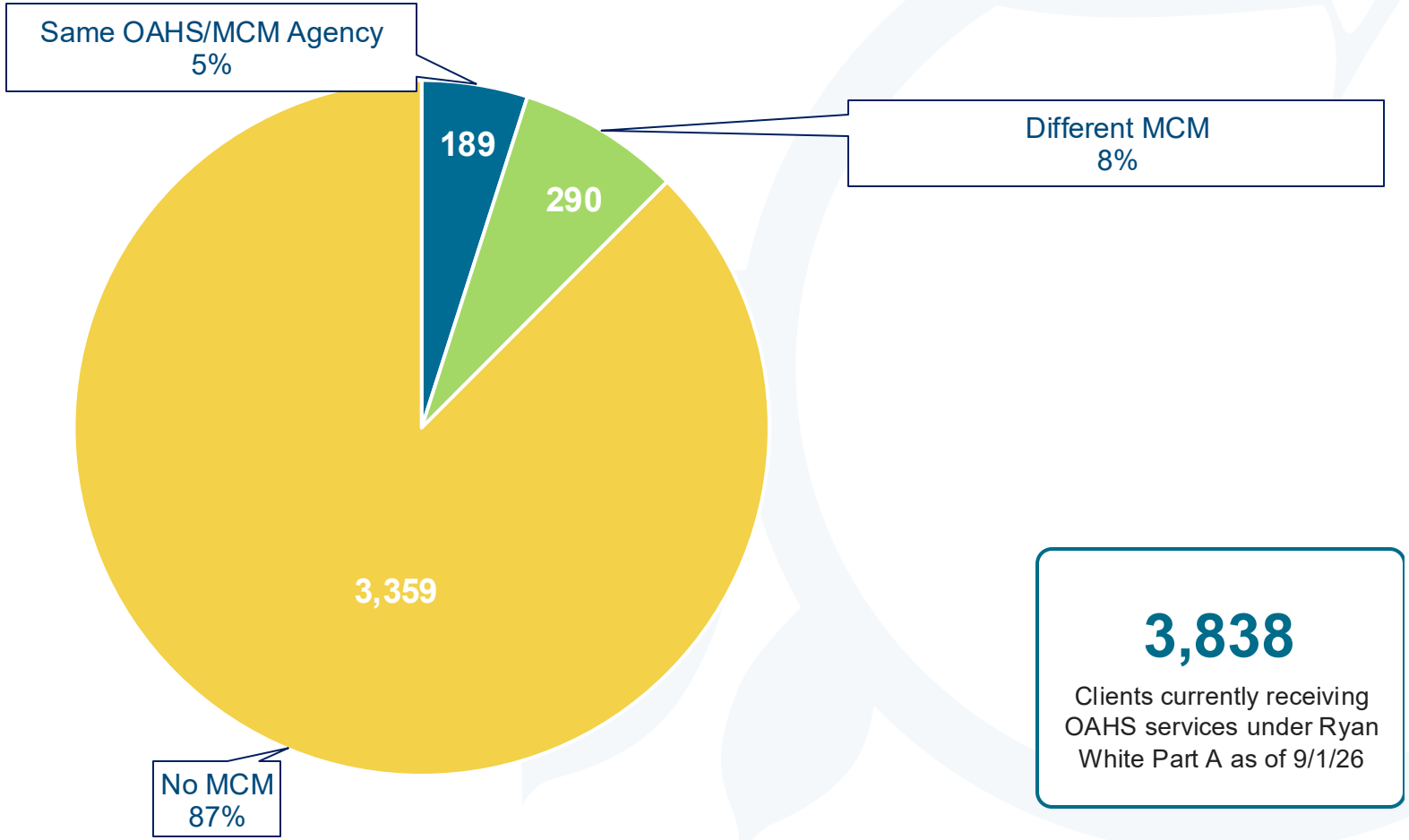
44.7%

Part A clients receiving OAHS in funded medical settings



Outpatient Ambulatory Health Services

2026-2027 OAHS Enrollments



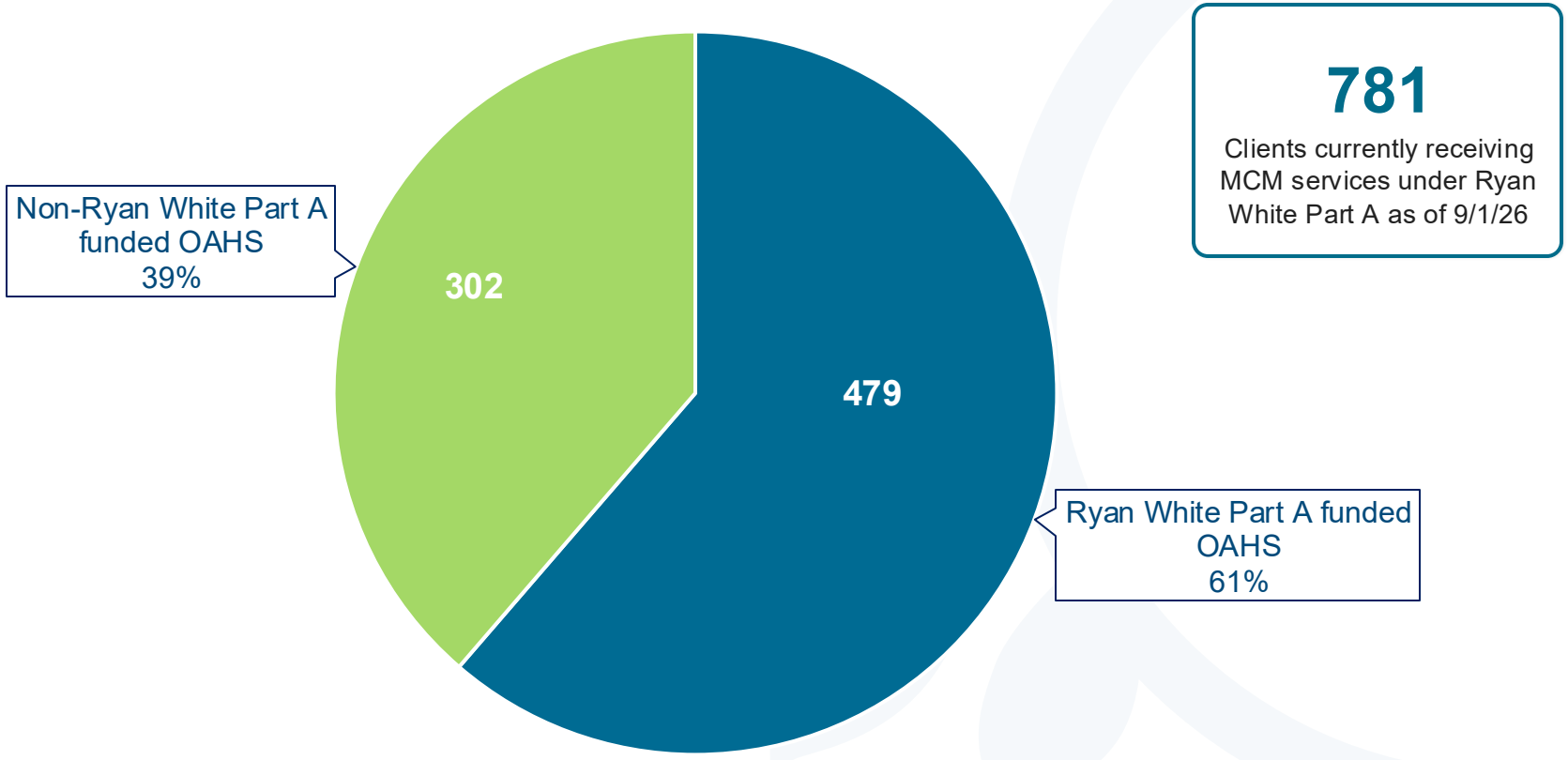
Depending on the Part A contract, Agencies can provide OAHS, MCM or both.

3,838

Clients currently receiving OAHS services under Ryan White Part A as of 9/1/26

Medical Case Management Services

2026-2027 MCM Enrollments



781

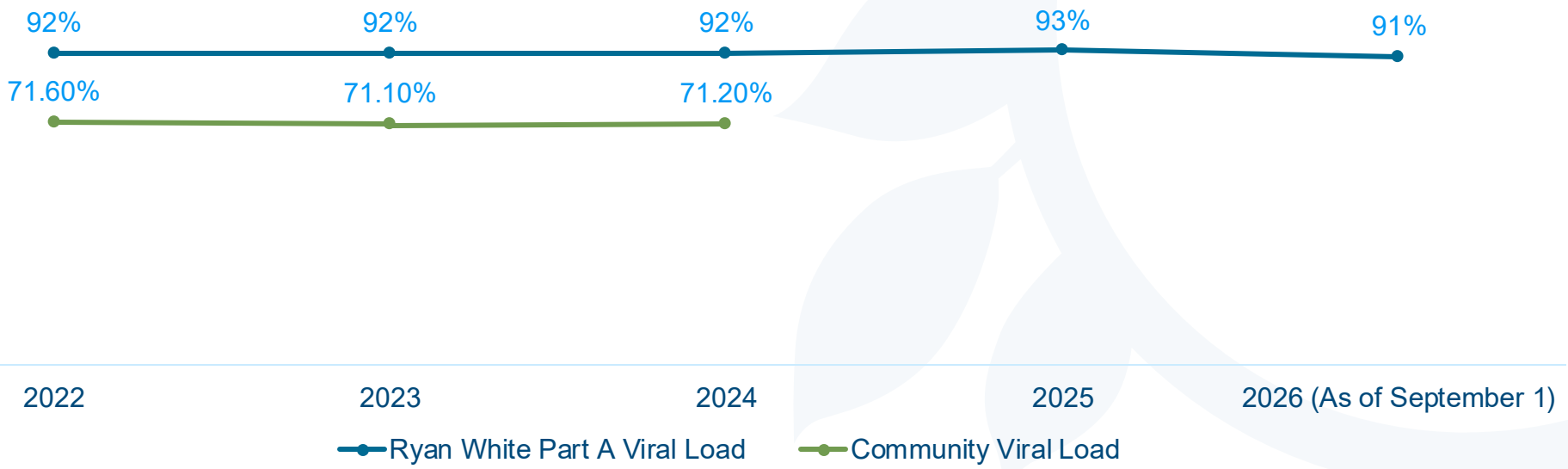
Clients currently receiving MCM services under Ryan White Part A as of 9/1/26

Viral Load Suppression

Viral suppression remains high, but the remaining gap represents clients who need focused coordination.

505

Approximately total Part A clients not virally suppressed as of September 1, 2026



*2025 and 2026 data not available for the Community.

Current Challenges

- Among clients currently receiving OAHS, 479 also receive MCM services.
  - 185 clients receive MCM and OAHS from the same provider
  - 290 receive MCM from a different provider.

- When MCM and OAHS are provided by different organizations, coordination with the medical provider can be more challenging.

- Separate organizations may have different workflows, documentation systems, and communication processes.

- Medical Case Managers may have limited access to timely clinical information, including appointments, treatment changes, and viral load results.

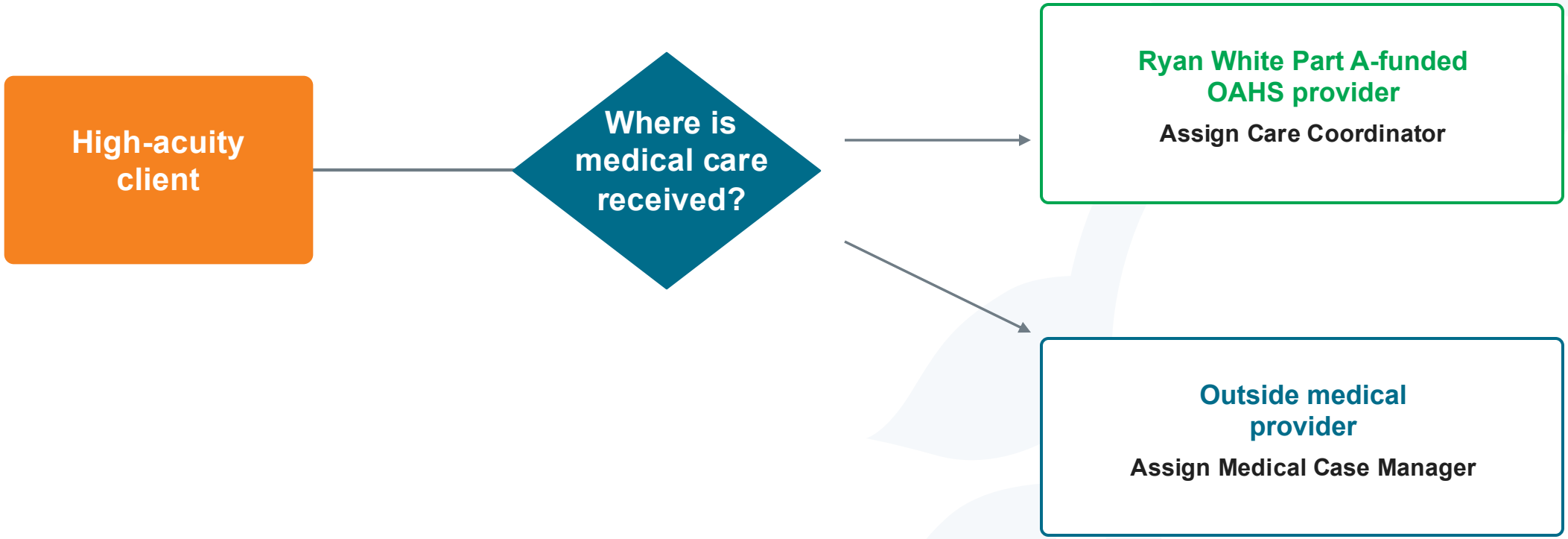
- Delays in communication can make it harder to quickly address missed appointments, medication adherence, and other barriers to care.

- Clients may need to communicate with multiple organizations to coordinate medical care and support services.

Proposed Solution

- Create a new Care Coordinator role embedded within Ryan White Part A-funded medical providers.
- Care Coordinators will focus on clients who are not virally suppressed and receive care within the Ryan White Part A-funded OAHS network.
- Embedding Care Coordinators with the clinical team will strengthen adherence support, access to care, and follow-up.
- Medical Case Managers will continue to focus on high-acuity clients receiving HIV medical care outside the funded OAHS network.
- The model better aligns case management with where clients receive medical care while reducing duplication and improving coordination.

New Process Flow



Clients continue to receive referral specialist support for eligibility, referrals, food and transportation vouchers.

What This Change Does and Does Not Do

This change DOES

- Align support with the client's medical care team
- Prioritize clients who are not virally suppressed
- Improve access to timely clinical information
- Reduce duplication and strengthen follow-up

This change DOES NOT

- Remove Referral Specialist support
- Eliminate MCM for high-acuity clients outside funded OAHS
- Require clients to lose services during transition
- Reduce client access to needed referrals or supports

Bottom line: aligned support, protected continuity of care, and clearer coordination for clients.

Examples of Care Coordination

Selected HIV care examples in which care coordinators, patient navigators, nurse navigators, or medical case managers were embedded in or closely integrated with medical providers. These examples emphasize measurable clinical outcomes such as viral suppression, retention in care, re-engagement, medication renewal, and CD4 improvement.

Example	Model	Clinical Result	Why It Is Relevant
Los Angeles County Medical Care Coordination Program	Clinic-based multidisciplinary care coordination across 35 Ryan White clinics	Program designed to improve viral suppression among high-risk patients; analyses included more than 6,400 patients.	Closely resembles an embedded Ryan White care-coordinator model within HIV medical care.
NYC Ryan White Part A Care Coordination Program	Medical case management, patient navigation, and health education integrated with HIV care organizations	Among previously diagnosed clients, viral suppression increased from 32.3% to 50.9%; engagement in care increased from 73.7% to 91.3%.	Large real-world Ryan White program showing improvement in both clinical and engagement outcomes.
NYC - Patients Previously Out of Care	Intensive care coordination compared with matched usual-care patients	87.2% vs. 48.2% re-engaged in care; 58.3% vs. 49.3% achieved viral suppression.	Especially relevant for targeting embedded coordinators to clients who are out of care or unsuppressed.
NYC - Newly Diagnosed Patients	Comprehensive HIV care coordination	Patients receiving coordination achieved viral suppression more rapidly than matched patients receiving usual care (HR 1.17).	Shows an effect on a direct clinical endpoint, not only appointment attendance.
VA HIV Nurse Navigation Program	Nurse navigator integrated into an HIV primary-care clinic	Viral suppression increased from 47.6% to 69.0% in one year; medication renewal increased from 40.9% to 80.6%; clinic visits doubled; CD4 measures improved.	One of the clearest examples of a coordinator embedded in the medical setting improving multiple clinical measures.
Ryan White Medical Case Management - Infectious Disease Clinic	Medical case management operating through an HIV specialty clinic	Among 2,773 patients, those engaged in medical case management had significantly faster improvement in viral load and CD4 counts.	Direct evidence linking Ryan White medical case management to biological clinical outcomes.
Multi-State HIV Patient Navigation Programs	Navigation/care coordination for people newly diagnosed, out of care, or at risk of falling out of care	All five programs had significant increases in viral suppression; relative increases were approximately 48%-91% from baseline.	Supports targeted navigation for populations with poor baseline outcomes.

Next Steps

- All clients will continue to be assigned a Referral Specialist and higher-acuity clients may also receive Medical Case Management **OR** Care Coordination Services depending on where they receive their medical care.
- New model intends to streamline services by aligning medical care and case management within the same provider whenever possible.
- Services will prioritize clients who are not virally suppressed.
- Medical Case Managers will focus on high-acuity, unsuppressed clients receiving care from outside medical providers.
- Transition period for clients to maintain continuity of care.
- Central Florida HIV Planning Council will need to establish a new Care Coordinator Service Standard.

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