2027–2031

INTEGRATED HIV PREVENTION AND CARE PLAN

ORLANDO SERVICE AREA

THE 2027–2031 ORLANDO SERVICE AREA INTEGRATED HIV PREVENTION AND CARE PLAN FOLLOWS THE GUIDANCE SET FORTH BY THE CENTER FOR DISEASE CONTROL (CDC) AND THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) AND WILL ACCELERATE REACHING THE GOALS IN THE NATIONAL HIV/AIDS STRATEGY.

Central Florida HIV PLANNING COUNCIL

Table of Contents

Figure 1. Table of Acronyms and Definitions 3

SECTION I. EXECUTIVE SUMMARY OF THE INTEGRATED HIV PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED 5

A. Executive Summary of the Integrated HIV Plan and SCSN 5

B. Acknowledgements 6

C. Documents Submitted to Meet Requirements 6

SECTION II. COMMUNITY ENGAGEMENT AND PLANNING PROCESS 7

A. Jurisdictional Planning Process 7

B. Entities Involved in the Planning Process 7

C. CFHPC Leadership in Design and Implementation of the Integrated HIV Plan 11

D. Methods Used by CFHPC to Conduct Town Hall Meetings and Focus Groups 12

E. Role of Planning Bodies and Other Entities 14

F. Collaboration with RWHAP-Funded Parts- SCSN Requirement 15

G. Engagement of people with HIV- SCSN Requirement 15

H. Priorities 15

I. Updates to Other Strategic Plans Used to Meet Requirements 15

SECTION III. CONTRIBUTING DATA SETS AND ASSESSMENTS 16

A. Data Sharing and Use 16

B. Epidemiologic Snapshot 16

C. Needs Assessment 21

D. Priorities 23

E. Actions Taken 23

F. Approach 23

G. Financial and Human Resources Inventory 23

H. Analytic Specifications Used by FDOH to Calculate the HIV Care Continuum of Counties in the OSA 25

SECTION IV. SITUATIONAL ANALYSIS 27

A. Summary of the Situational Analysis 27

B. Application of Status-Neutral Approach to HIV Prevention and Care 27

C. Priority Populations 30

SECTION V. 2027-2031 GOALS AND OBJECTIVES 31

A. Goals and Objectives Description 31

B. Updates to Other Strategic Plans Used to Meet Requirements 31

SECTION VI. 2027-2031 INTEGRATED HIV PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP 36

A. 2027-2031 Integrated HIV Planning Implementation Approach 36

SECTION VII. LETTER OF CONCURRENCE 42

Figure 1. Table of Acronyms and Definitions

Acronym	Definition
ACA	Affordable Care Act
ACS	American Community Survey
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHEC	Area Health Education Center
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy/Treatment
ARTAS	Antiretroviral Treatment and Access to Services
ARV	Antiretroviral Medication
ASO	AIDS Service Organization
BNH	Black Non-Hispanic/Latinx Person
BPHP	Bureau of Public Health Pharmacy
BRTA	Business Responds to AIDS
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
CFHPC	Central Florida HIV Planning Council
CHAG	Community HIV Advisory Group
CHD	County Health Department
CHW	Community Health Worker
CPS	Current Population Survey
CQM	Continuous Quality Management
DCF	Department of Children and Families
DIS	Disease Intervention Specialist
DOC	Department of Corrections
DSA	Data Sharing Agreement
EBI	Evidence-based Interventions
ED	Emergency Department
EFA	Emergency Financial Assistance
EHE	Ending the HIV Epidemic
EIIHA	Early Identification of Individuals with HIV/AIDS
EMA	Eligible Metropolitan Areas
FCPN	FL Comprehensive Planning Network
FDC	FL Department of Corrections
FDCF	FL Department of Children and Families
FDEA	FL Department of Elder Affairs
FDOE	FL Department of Education
FDOH	FL Department of Health
FOCUS	Frontlines of Communities in The United States Initiative
FQHC	Federally Qualified Health Centers
FRTA	Faith Responds to AIDS
HAPC	HIV/AIDS Program Coordinator
HAV	Hepatitis A Virus
HBCU	Historically Black Colleges and Universities
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIE	Health Information Exchange
HIP & CSA	Health Insurance Premium and Cost Sharing Assistance
HIP	High-Impact Prevention

Acronym	Definition
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HPG	HIV Planning Group
HRSA	Health Resources and Services Administration
ID	Infectious Disease
IDU	Injection Drug Use
IPC	Integrated Prevention and Care
LAPA	AIDS Pharmacy Assistance Program- Local
MAI	Minority AIDS Initiative
MIS	Management Information System
MMP	Medical Monitoring Project
MMSC	Male to Male Sexual Contact
MSA	Metropolitan Statistical Area
NHAS	National HIV/AIDS Strategy
NIR	No Identified Risk
nPEP	Non-Occupational Post-Exposure Prophylaxis
OSA	Orlando Service Area
OCHSD	Orange County Health Services Department
PCS	Planning Council Support
PE	Provide Enterprise
PEP	Post Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PWH	Person with HIV
PWID	Person Who Inject Drugs
RWHAP	Ryan White HIV/AIDS Program
SCSN	Statewide Coordinated Statement of Need
SPNS	Special Projects of National Significance
SSP	Syringe Services (Exchange) Program
SSPQ	Service Systems Planning & Quality
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TAI	The AIDS Institute
T&T	Test and Treat
TB	Tuberculosis
TOPWA	Targeted Outreach for Pregnant Women Act
UCF	University of Central Florida
UM-AETC	University of Miami AIDS Education and Training Center
US	United States
VA	US Department of Veteran's Administration
VL	Viral Load
WCBA	Women of Childbearing Age
WICY&F	Women, Infants, Children, Youth, and Families
WNH	White Non-Hispanic/Latinx Person

SECTION I. EXECUTIVE SUMMARY OF THE INTEGRATED HIV PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED

A. Executive Summary of the Integrated HIV Plan and SCSN

The Orlando Service Area (OSA) is pleased to submit its ***HIV Integrated Prevention and Care Plan, 2027-2031*** to the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The OSA Integrated HIV Plan reflects the culmination of intensive local planning efforts and community engagement. The planning effort was designed to ensure that people with HIV, CDC and HRSA-funded prevention and care systems, recipients and subrecipients, front-line workers, local government officials, and other stakeholders participated. Community and provider engagement activities included town hall meetings, focus groups, and surveys.

The OSA Integrated HIV Plan addresses the current and emerging HIV epidemic in the OSA, comprised of Brevard, Lake, Orange, Osceola, and Seminole Counties. The Central Florida HIV Planning Council (CFHPC) members actively participated in the design and development of the Integrated HIV Plan and partnered with The AIDS Institute (TAI) to conduct community engagement activities to ensure that people with HIV had input into the design of the planning process. CFHPC committee members, including people with HIV designed and convened town hall meetings and focus groups throughout the OSA. People with HIV contributed to questions addressed and TAI moderated the events.

In addition to community engagement activities, people with HIV also actively served on an Integrated HIV Plan Ad Hoc Committee. Members were briefed on RWHAP and CDC-funded prevention, linkage, care, retention, and reengagement activities.

The Integrated HIV Plan Ad Hoc Committee collaborated to develop Integrated Plan goals, objectives, strategies, timeframes, responsible parties, and data indicators. Populations of focus were identified.

A proposed implementation plan was developed that describes the infrastructure, procedures, systems, and tools to support the key phases of integrated HIV planning to accomplish the OSA Integrated HIV Plan's goals and objectives. The key phases include: (1) implementation, (2) monitoring, (3) evaluation, (4) improvement, and (5) reporting and dissemination. The roles of the CFHPC and committees in implementing the Plan were also operationalized.

The CFHPC adopted four goals and related objectives and strategies to be the focus of the Integrated HIV Plan for 2027-2031. A status-neutral approach will be applied to undertaking goals and objectives including:

- Prevent new HIV Infections by (1) expanding the availability of PrEP through workforce training and the addition of new PrEP providers to reach more people, and (2) expanded HIV testing.
- Improve HIV-related health outcomes among people with HIV by (1) expanding the number of providers who offer basic HIV care, (2) identifying, engaging, or reengaging people with HIV not in care or in care but not virally suppressed, and (3) increased retention and adherence to treatment to achieve and maintain long-term viral suppression.
- Increasing the number of people who know their HIV status by (1) expanding prioritized testing; (2) expanding routine testing, and (3) increasing the number of healthcare facilities that provide comprehensive sexual health screening and counseling.
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and interested parties by: 1) developing a cluster and outbreak detection and response

(CDR) plan, 2) collaborating with FDOH epidemiologists to detect clusters, 3) re-establishing and expanding data sharing agreements, and 4) implementing HIV testing based on identified clusters.

B. Acknowledgements

Many thanks to the following for making this document happen: each member of the Integrated Plan Ad hoc Committee for their dedication to developing this document, Heart of Florida United Way Planning Council Support staff for their time and effort to organize and plan convenings and committee meetings, Orange County Government for their support, Florida Department of Health staff for their guidance, Alanova Solutions for supplying the zip code heat map figure, and finally, to every person who lives with HIV and strives to make the world a better place.

C. Documents Submitted to Meet Requirements

Figure 2 summarizes all documents used to meet submission requirements, as well as existing and newly developed materials applied for each requirement.

Figure 2. Supporting Documentation Submitted to Meeting Requirements

Document	Description	Developed for plan?
CDC and HRSA Integrated HIV Prevention and Care Planning Guidance, 2027-2031	Developed to support the submission of the OSA Integrated HIV Plan for states and EMAs for the 2027-2031 cycle	No (Existing)
Florida's Unified EHE Plan, 2020	Unified plan representing FL and counties identified as Phase 1 EHE jurisdictions (including Orange County EMA)	No (Existing)
OSA Integrated HIV Plan, 2022-2026	Developed collaboratively in the OSA among stakeholders to eliminate HIV transmission and reduce HIV-related deaths in 2017-2022	No (Existing)
Orlando EMA Early Identification of Individuals with HIV/AIDS (EIIHA) Plan, January 2026	Orlando EMA RWHAP Part A integrated prevention and care plan submitted as part of the Part A Supplemental Grant Application	No (Existing)
Provider Capacity and Capability Survey, September 2025	Developed to identify the extent to which HIV-related services in the area are accessible, available, and appropriate for people with HIV,	No (Existing)
Meeting Notes from CFHPC Integrated HIV Plan Ad Hoc Committee meetings	Minutes of the September-November Committee meetings to identify OSA-specific activities to address the Goals, Objectives, and Strategies identified in the CDC/HAB Guidance	Yes (New)
Presentations Made to the CFHPC in RWHAP Part A Priority Setting and Resource Allocation (PSRA) Meeting	Presentations summarizing the HIV/AIDS epidemic in the Orlando EMA, Parts A and B FY 2021-2022 use and expenditures, EIIHA service use and process measures, results of Part A process and outcome measures, community engagement events, and RWHAP client satisfaction	No (Existing)
OSA Community Engagement	Summaries from local area community engagement	Yes (New)
Discussion Tools and Written Summaries Documenting Results	activities including two Town Hall Meetings and two focus groups	
Local Area Resource Inventory and OSA federal, state, and local funding	Resource inventory of HIV prevention and care recipients, subrecipients, and other community resources in the five OSA counties	Yes (New)

SECTION II. COMMUNITY ENGAGEMENT AND PLANNING PROCESS

This section describes how the OSA approached the 2027-2031 Integrated HIV Plan development process through engagement of community members and other stakeholders in the five-county area. The section also describes measures to fulfill legislative requirements including:

- Statewide Coordinated Statement of Need (SCSN),
- RWHAP-funded Parts A and B planning requirements, including those requiring feedback from key stakeholders and people with HIV; and
- CDC planning requirements.

A. Jurisdictional Planning Process

The OSA includes Brevard, Lake, Orange, Osceola, and Seminole Counties. The OSA has a long history of engaging people with HIV and other stakeholders in developing and implementing HIV prevention and care. These efforts have been accomplished through representation of people with HIV on the CFHPC and its committees, as well as extensive and ongoing community engagement.

The CFHPC membership consists of about 30% conflicted people with HIV, 70% un-conflicted members and a total of 13 people with HIV without conflicts. The CFHPC hosts monthly Ryan White Community Meetings, which attracts people with HIV and front-line workers, including CFHPC members. The Community Meetings serve as an ongoing venue for people with HIV to provide feedback to RWHAP and CDC recipients and the CFHPC about effective HIV prevention and care services, geographic disparities in accessible services, barriers to care, and other issues.

Populations of focus are well represented on the CFHPC.

CFHPC convenes multiple committee meetings monthly. Outreach for new CFHPC members is ongoing. Applicants for membership are interviewed by CFHPC members. Skills, lived experience, geographic representation, and ability to meet statutorily required representation from key stakeholders are considered in the application process.

The group ensured the process and participants were reflective of the people with HIV population and vested stakeholders. Meetings are held in accessible locations near public transportation systems. Meetings are hybrid, offering a virtual meeting platform as well as in-person space. Participants attend via computer, smart phone, telephone, or in person ensuring access to the meetings needed to conduct Integrated HIV Plan efforts.

B. Entities Involved in the Planning Process

Figure 3 summaries CFHPC membership, vacancies, and other information about entitles involved in the planning process. Participants in the planning process include the CFHPC and its Integrated HIV Plan Ad Hoc Committee, Orange County Health Services Department RWHAP Part A Program, Housing Opportunities for People with AIDS (HOPWA), RWHAP, Part B Consortium Lead Agency, RWHAP Part C recipients, RWHAP Part D recipient, CDC and RWHAP-funded subrecipients, people with HIV, STI director, organizations directly funded by CDC and/or HRSA, advocates and community leaders, and front-line providers. These entities and individuals have committed to participate in the OSA Integrated HIV Plan

in 2027-2031 to undertake: (1) implementation, (2) monitoring, (3) evaluation, (4) improvement, and (5) reporting and dissemination activities.

Figure 3. RWHAP Requirements for Planning Council Appointments and Status, April 2026

CFHPC Membership Categories	Vacant ?	Vacancy duration?	Challenges in filling position (if applicable)
Healthcare Providers, Including FQHCs	No	NA	NA
CBOs Serving Affected Populations/ASOs	No	NA	NA
Social Service Provider: Housing and Homeless Services	No	NA	NA
Social Service Provider – Other	No	NA	NA
Mental Health Provider	No	NA	NA
Substance Abuse Provider	No	NA	NA
Mental Health and Substance Abuse Provider	No	NA	Seat filled jointly.
Local Public Health Agencies	No	NA	NA
Hospital Planning Agencies or Other Healthcare Planning Agencies	No	NA	NA
Affected Communities, including people with HIV and Historically Underserved Groups	No	NA	NA
Non-Elected Community Leaders	No	NA	NA
State Medicaid Agency	No	NA	NA
State Part B Agency	No	NA	NA
State Part B Agency and State Medicaid Agency	No	NA	NA
Part C Recipient (s)	No	NA	NA
Part D Recipients	No	NA	NA
Other Federal HIV Programs, Including HIV Prevention Programs	No	NA	NA
Representatives of/or Formerly Incarcerated people with HIV	Yes	Jan-26	Application for this seat was received in March 2026. Individual has met all membership requirements.

Figure 4 illustrates the extent to which CFHPC members are representative of the demographic characteristics of people with HIV in the OSA. The CFHPC membership is aligned with HIV prevalence in the OSA by race, ethnicity, age group, and sex.

Figure 4. CFHPC Membership and Comparison of Demographic Characteristics with OSA HIV Prevalence

Demographic Characteristics	HIV Prevalence in OSA		Total CFHPC Membership		Unaffiliated Part A Clients on CFHPC	
	#	%	#	%	#	%
Race/Ethnicity						
White, not Hispanic	4,887	28%	5	18.5%	1	12.5%
Black, not Hispanic	6,795	39%	14	51.9%	4	50%
Hispanic	5,497	31%	7	25.9%	3	37.5%
Asian/Pacific Islander	150	0.8%	0	0%	0	0%
American Indian/Alaska Native	15	0.08%	0	0%	0	0%
Multi-Race	230	1.3%	1	3.7%	0	0%
Other/Not Specified	16	0.08%	0	0%	0	0%
Total	17,590	100%	27	100%	8	100%
Sex						
Male	13,268	75%	14	51.9%	6	75%
Female	4,322	25%	12	44.4%	2	25%
Unspecified	0	0%	1	3.7%	0	0%
Total	17,590	100%	27	100%	8	100%
Age (in Years)						
Under 13	20	0.09%				
13-19	49	0.2%	0	0%	0	0%
20-29	1,364	7.7%	1	3.7%	0	0%
30-39	3,829	21.8%	4	14.8%	0	0%
40-49	3,422	19.4%	11	40.7%	0	0%
50-59	4,042	23%	7	25.9%	5	62.5%
60+	4,864	27.7%	4	14.8%	3	37.5%
Total	17,590	100%	27	100%	8	100%

Figure 5 summarizes the roles and responsibilities of CFHPC Committees, their meeting structure, standing committee membership, and the percent of members that are people with HIV. The figure illustrates the extent to which people with HIV are well-represented, with people with HIV making up a proportion reflective of the HIV epidemic in the OSA. The figure also underscores the substantial participation of people with HIV in HIV prevention and care planning efforts.

Figure 5. CFHPC Committees, Meeting Structure, Standing Committee Membership, and Percent people with HIV

Executive Committee (n=7, 57% people with HIV)	
	Members include the CFHPC's Senior and Junior Co-Chairs, current Committee chairs, Prevention and people with HIV Representatives
	Oversees all work passed to the CFHPC from the standing committees
	Approves work to be reviewed at the next CFHPC Business Meeting
CFHPC Business Meeting (n=26, 50% people with HIV)	
	Updates presented on all CFHPC business conducted within the current month
	CFHPC members review and comment on reports from each standing committee, Community Meeting, Part A Recipient, FDOH prevention and Part B HAPC, HOPWA, and more
Membership & Engagement (n=14, 7% people with HIV) CFHPC Junior Co-Chair serves as ex-officio member.	
	Recruits new CFHPC members and supports retention of current members
	Oversees an open nominations process
	Provides member orientation and training
	Recommends CFHPC committee assignments
	Develops marketing and recruitment strategies including community engagement in developing and implementing the Integrated HIV Plan
	Maintains CFHPC social media and website
	Disseminates public information and education
	Coordinates community events and activities.
Service Systems & Quality, (n=16, 38% people with HIV) CFHPC Senior Co-Chair serves as ex-officio member.	
	Summarize and make recommendations to the Planning Council on HRSA approved service categories and provide guidance on prioritizing RWHAP Part A, RWHAP Part A MAI, and RWHAP Part B service categories.
	Make recommendations to the Planning Council regarding potential federal, state, local, and private resources available to meet unmet service needs and gaps and recommend action to the Planning Council as appropriate.
	Oversee the development and implementation of the annual Priority Setting and Resource Allocations (PSRA) processes, including data presentations.
	Recommend allocations of RWHAP Part A, RWHAP Part A MAI and RWHAP Part B funds to allowable service categories in the OSA, including consideration of costs associated with implementing recommended ways to best meet needs. Develop funding scenarios that will allow for rapid disbursement of funds in the case of level funding, decrease in funding, and increase in funding.
	Ensure that all PSRA-related activities follow approved processes as specified in the Planning Council's Policies and Procedures.
	Review monthly expenditures by service category as provided by the RWHAP Part A recipient representative and RWHAP Part B Lead Agency representative and recommend reallocations across service categories as required during the program year.
	Review utilization of service categories quarterly to determine gaps in services and unmet need to inform the Needs Assessment & Planning Committee.
	Monitor and assess the impact of RWHAP Part A, RWHAP Part B, and General Revenue funds and programs within the service area as outlined in the current Integrated Plan.
	Maintain input and information exchange with the Ryan White Community Meeting.
	Review clinical quality management reports, including disparities, and recommend strategies to improve outcomes. Elect a committee member to represent the Planning Council at the RWHAP Part A Recipients CQM meetings. In collaboration with the recipients, develop and maintain Service Standards, in accordance with available best practice standards for the relevant service categories

Figure 5. Continued

Ryan White Community Meeting	
	Monthly informational and resource-centered meetings for people with HIV across OSA
	While the public is welcomed to the Community Meetings, these meetings are designed as a safe space for local people with HIV to be informed on the latest CFHPC activities; design and implementation of the Integrated HIV Plan, receives Parts A and B updates, receive monthly life-focused presentations. The Community Meetings participated as an informal focus group to provide feedback about unmet needs, priorities, effective strategies, and methods for community engagement throughout the OSA.
Needs Assessment & Planning (To be Formed in 2026)	
	Develop, regularly review, and update the jurisdiction's Integrated Plan for HIV Prevention and Care, in collaboration with the RWHAP Part A recipient and RWHAP Part B Lead Agency representatives.
	Work with Planning Council Support to carry out needs assessment efforts, identifying unmet needs, service gaps, and the needs of special populations, and presenting findings to the full Planning Council.
	Facilitate collaborative planning between all RWHAP Parts and other governmental and community-based agencies.
	Recommend, develop, and prioritize special studies and projects based on the Comprehensive/Integrated Plan.
	Maintain input and information exchange with the Ryan White Community Meeting.
	Assess the effectiveness of the service delivery system within the service area in meeting identified needs via aggregated data provided by the recipient; and make strategic recommendations for improvement.
	Monitor and assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the service area.
	Monitor and assess the processes of the Planning Council.
	Initiate planning, review reports, and provide recommendations on the Assessment of the Administrative Mechanism.

C. CFHPC Leadership in Design and Implementation of the Integrated HIV Plan

In late 2025, CFHPC formed an Integrated Plan Ad Hoc Committee including CFHPC members as well as volunteering community members. Other participants include people with HIV, Area 7 HAPC, RWHAP-funded Part A Recipient's Office, RWHAP-funded Parts C and D representative, Housing Opportunities for People with AIDS (HOPWA) representative, STI provider representative, mental health and substance abuse providers, and HIV prevention providers. The Integrated Plan Ad Hoc Committee's composition reflects the demographic characteristics of the Central Florida HIV epidemic.

To prepare for their role, the Integrated Plan Ad Hoc Committee attended a mandatory one-day data presentation in September 2025 prepared by the RWHAP Part A Recipient's office, Part B Lead Agency (Heart of Florida United Way, or HFUW), CFHPC staff, and other key programs. Participation in the data presentations was required for Committee members to vote on approving the Integrated HIV Plan for CFHPC review.

The Integrated Plan Ad Hoc Committee was responsible for planning and providing input on community engagement activities. They co-developed the questions for the town hall meetings and focus groups with TAI and assisted with material preparation. They also assisted CFHPC staff to select dates and accessible locations for the town hall meetings and focus groups. Once the meetings were scheduled, the Committee assisted with outreach in OSA counties.

The Committee guided development of the Integrated HIV Plan. They also made

recommendations to the CFHPC about developing goals, activities, strategies, and process and outcomes measures to be included in the Plan, as well as collaborative methods for implementing the Plan.

Standing monthly reports were made by the Chairperson of the Integrated Plan Ad Hoc Committee to the full CFHPC to ensure CFHPC members were involved in the process from inception to submission of the Plan to the CDC and HRSA HAB. The CFHPC also reviewed and commented on the Plan's goals, objectives, strategies, and activities. The writing team reviewed and incorporated CFHPC comments and recommendations as applicable.

The final draft of the Plan was presented to the CFHPC during the June meeting for review and approval. Upon CFHPC approval, the Letter of Concurrence from the Chairs of those planning bodies was obtained (see **Appendix A**). The completed OSA Integrated HIV Prevention and Care Plan was then submitted to FDOH in Tallahassee for inclusion into the Statewide Plan. The Plan will also be submitted to CDC and HRSA/HAB.

D. Methods Used by CFHPC to Conduct Town Hall Meetings and Focus Groups

The AIDS Institute (TAI) was retained as a consultant to assist in the facilitation of the townhall meetings and focus groups conducted over a three-month period. The CFHPC collaborated with RWHAP Part A and RWHAP Part B staff as well as TAI to engage various community members and counties in the OSA in the Integrated HIV Plan assessment and priority setting process. The meetings were designed to educate people with HIV, other community members, providers, and case managers about the purpose of the Integrated HIV Plan and offer an opportunity to offer feedback to be used as qualitative data for the Integrated HIV Plan.

Participants at each town hall meeting and focus group were asked a set of questions that were developed by the Integrated Plan Ad Hoc committee and TAI staff. Each town hall meeting and focus group lasted approximately two hours. During the meetings, attendees were provided with dinner or refreshments. At every event the participants received presentations on the importance of the Integrated HIV Plan, including the impact of HIV on the OSA over the last five years.

Each meeting was carefully planned to ensure that people with HIV had free transportation to the meeting sites and the venues were physically accessible. All venues adhered with Americans with Disabilities Act (ADA) accessibility standards. The venues were located on a bus route with a stop nearby and centrally located within their respective counties. Attendees provided a combination of verbal, written, and online responses collected from Mentimeter, a virtual polling application. Multiple methods for submitting feedback were used to ensure the events were as accessible as possible, specifically for people who might not want to speak. **Figure 6** lists the locations, number of attendees, and topics discussed.

Figure 6. OSA Community Engagement Strategies, Locations, and Presentation Topics at Town Hall Meetings and Listening Sessions by County, 2025-2026

Community Engagement Strategies	Location	Presentations Given
Orange County Town Hall Meeting: 46 attendees		
• Social media pushes from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies • In-person outreach efforts by CFHPC members • Flyers posted in providers' offices • Provide transportation	Holden Heights Community Center	• Introduction to the Integrated HIV Plan by TAI
Area 7 Rapid Start Mini Town Hall Session: 48 attendees		
• Collaborated with HAPC and Part B Lead Agency to discuss needs with rapid HIV testing site, medical providers, and PrEP providers.	Lake Ellenor Drive DOH	• Introduction to the Integrated HIV Plan by PCS/part B Office
Seminole County Focus Group: 8 attendees		
• Social media campaigns from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies • In-person outreach efforts by CFHPC members • Flyers posted in providers' offices • Provide transportation	Seminole County Health Department	• Introduction to the Integrated HIV Plan by TAI
Lake County Focus Group: 7 attendees		
• Social media campaigns from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies • In-person outreach efforts by CFHPC members • Flyers posted in providers' offices • Provide transportation	Lake County Health Department	• Introduction to the Integrated HIV Plan by TAI
Brevard County Town Hall Meeting: 40 attendees		
• Social media pushes from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies • In-person outreach efforts by CFHPC members • Flyers posted in providers' offices • Collaborated with the Chair of the Integrated HIV Plan Ad Hoc Committee to determine effective outreach strategies for Brevard County residents • Provide transportation	Compre-hensive Healthcare	• Introduction to the Integrated HIV Plan by TAI

CFHPC staff organized the town hall meetings and focus groups and were facilitated by TAI. The same set of open-ended questions were used to gather responses. **Figure 7** outlines the questions used.

Figure 7. Questions Addressed in OSA Community Engagement Activities, 2026

1) From your observations and experiences, what are major obstacles as it relates to HIV prevention?

    a. What do you think could be done to address them?

2) From your observations and experiences, what are major obstacles as it relates to HIV care?

    a. What do you think could be done to address them?

3) How can the community be more involved in HIV prevention? What roles or actions would make the biggest impact?

4) How can the community be more involved in HIV care? What roles or actions would make the biggest impact?

5) What keeps people from starting HIV care after diagnosis?

    a. What can be done to make it easier for people to start HIV care?

6) What keeps people from staying in HIV care?

    a. What can be done to make it easier for people to stay in HIV care?

Qualitative methods were used to identify key themes identified in summaries of each of the community engagement activities. This was conducted by TAI. Results of the key themes identified in the qualitative analysis of the community engagement activities are summarized in **Section III. Contributing Data Sets and Assessments.**

E. Role of Planning Bodies and Other Entities

Orange County Government is the RWHAP Part A Recipient for the Orlando Eligible Metropolitan Area (EMA). The Florida Department of Health (FDOH) is the RWHAP Part B Program Recipient in which it directly funds care services in counties focused outside of the RWHAP Part A EMA. Heart of Florida United Way (HFUW) is the Lead Agency for Partnership Area 7. FDOH also operates the statewide AIDS Drug Assistance Program (ADAP).

FDOH organizes Florida counties into 14 HIV Partnership Areas, each with an HIV/AIDS Program Coordinator (HAPC) to oversee prevention and care program operations in each HIV partnership area. HAPCs ensure that program activities are planned in an inclusive and collaborative manner to ensure other local resources and specific client needs are considered and addressed. Two HAPCs are assigned from Partnership Areas 7 and 3/13, respectively, due to inclusion of Lake County in the OSA.

FDOH RWHAP Part B consortia are community-based regional planning entities established by the RWHAP Part B recipient. The consortia plan and prioritize RWHAP Part B funds allocated to their area, promote service coordination, and serve as a community forum. Representatives of local public and non-profit health and support service providers serve as consortium members. Lead agencies are member agencies within the consortium designated by FDOH to perform contract administration as a fiscal agent. Upon receiving RWHAP Part B funds from FDOH, each lead agency is required to provide administrative assistance to the planning body (consortium) in the program area. The planning bodies serve as the entities

that meet the RWHAP planning requirements for the program area and advise the lead agencies in the Priority Setting and Resource Allocation (PSRA) process. Lead agencies facilitate the provider selection process through a network of local partners (CBOs, CHDs, people with HIV, planning bodies, etc.).

The FDOH HIV Prevention Program collaborates with the Patient Care, Medical, and Surveillance programs to deliver comprehensive high impact prevention (HIP) strategies and services with overarching goals of reducing the number of new HIV transmissions, increasing the proportion of persons living with HIV who know their status, linking people with HIV to care and support services, and reducing risk behaviors that may lead to HIV and STI diagnoses. Florida's HIP program is multi-faceted and includes HIV testing, linkage to care, peer navigation programs, comprehensive prevention interventions for people with HIV, PrEP/PEP, perinatal HIV prevention, corrections initiatives, physical and chemical preventive barrier distribution, community outreach (traditional and Internet-based) and engagement, and other services. The Prevention Program also collaborates with the RWHAP Part A, FQHCs, CBOs, academia, people with HIV, and other stakeholders to implement many HIP interventions and strategies. These essential partnerships help to ensure individuals receive comprehensive HIV prevention services along the HIV care continuum, leading to improved health outcomes for those living with HIV.

Orange County Government, in collaboration with Heart of Florida United Way and FDOH, created the Central Florida HIV Planning Council (CFHPC), a combined entity that incorporates the four EMA Counties (Lake, Orange, Osceola, and Seminole) along with Area 7 counties (Brevard, Orange, Osceola, and Seminole) to oversee planning activities for HIV prevention and patient care in Central Florida.

F. Collaboration with RWHAP-Funded Parts- SCSN Requirement

The RWHAP Part A Recipient and CFHPC have yet to review the latest iteration of the FDOH statewide Integrated HIV Plan. It is hoped that, despite not being able to review the FDOH document, that the aims and goals are similar in fashion in addressing gaps and maximizing funding.

G. Engagement of people with HIV- SCSN Requirement

PWH were instrumental in the development of this document through their participation in the Integrated Plan Ad Hoc Committee and on the Planning Council as well as through the townhalls and focus groups.

H. Priorities

Key priorities are summarized in Section IV.

I. Updates to Other Strategic Plans Used to Meet Requirements

Not applicable.

SECTION III. CONTRIBUTING DATA SETS AND ASSESSMENTS

This section summarizes the findings from the available data to identify services that OSA residents need to access and maintain HIV prevention, care, and treatment services and barriers encountered by clients accessing those services; and gaps in the HIV prevention and care service delivery system.

This section fulfills several legislative requirements including: (1) Statewide Coordinated Statement of Need (SCSN), (2) Part A and B planning requirements including those necessitating feedback from PWH and other key stakeholders, and (3) CDC planning requirements.

A. Data Sharing and Use

Data sharing agreements (DSAs) were executed between RWHAP Parts A, B, C, and D recipients and subrecipients for participation in Provide Enterprise (PE), a client and provider-level relational database. PE modules include client demographics, HIV epidemiologic, financial, and health insurance enrollment data. PE uses unique client identifiers to link client-level data with detailed client assessments, service utilization data, lab orders and results, and expenditures, and other programmatic information. Groupware Technologies, Inc. (GTI), the PE developer, has DSA with Transunion, a third-party data vendor that queries Florida Medicaid enrollment files to complete HIPAA 270/270 transactions. GTI also has a DSA with Florida ADAP. In turn, Florida ADAP has DSAs with each RWHAP Part A recipient, including the Orlando EMA.

Similarly, DSAs were established between the FDOH and RWHAP Part B subrecipients for use of CAREWare, a client-level database. Similarly, FDOH ADAP and the health insurance premium and cost sharing program have DSAs with RWHAP Part B subrecipients and FDOH local health departments.

B. Epidemiologic Snapshot

Data presented in this snapshot were obtained for the period through Calendar Year (CY) 2024, the most recent year of available data.

Incidence: The FDOH Bureau of Communicable Diseases reports that there were 669 new (incident) HIV cases in the OSA in 2024- a decrease by 17 cases from 686 cases in 2023. Over the past five years, the number of new AIDS cases decreased by 32 for a total of 263 cases in 2024. The decline in HIV testing during the COVID pandemic likely contributed to the decline in new HIV and AIDS case reporting.

The number of people with HIV increased by 1,343 to 17,590 people with HIV between 2020 and 2024. In all three groups, the Black non-Hispanic (BNH) population was overrepresented in the percent of new HIV cases and new AIDS cases. BNHs accounting for 43.5% and 43.0%, respectively. The Hispanic/Latinx population accounted for 36.9% of new HIV cases and 31.1% of new AIDS cases. The BNH population increased to 38.6% of people WITH HIV while consistently representing around 15.8% of the OSA population.

Males were disproportionately represented among new AIDS cases, ranging from 73.7% of new AIDS cases to 72.8% of new HIV cases in the last five years. The ratio of females to males residing in the OSA was the same between 2020 and 2024: 51:49, respectively. Youth ages 13-24 years accounted for 12.3% of new HIV cases, 5.7% of new AIDS cases, and 2.3% of people with HIV.

Adults 50 years of age or older accounted for 17.8% of new HIV cases, 29.3% of new AIDS cases, and 50.6% of people with HIV. The Male-to-Male Sexual Contact (MMSC) exposure category accounted for 50.2%, down from 81.5% in 2020 of all new male HIV cases. MMSC exposure accounted for 45.6% of new male AIDS cases and 75.4% of male people with HIV. Heterosexual contact was reported as the mode of exposure for 96.2% of new female HIV cases, 88.4% of new female AIDS cases, and 87.7% of female people with HIV. Perinatal exposure accounted for the sole new HIV case for children ages 0-12 years in 2024.

Trends in New Incident HIV Cases: The number of people with HIV receiving a new diagnosis of HIV increased by 16.9% from 572 cases to 669 cases between 2020-2024. Among racial and ethnic groups, 18.5% identified as White Non-Hispanic (WNH), 43.5% as Black Non-Hispanic (BNH), and 36.9% as Hispanic. Both BNHs and Hispanics were overrepresented when compared to the racial/ethnic distribution in the OSA population.

Over the past five years, the percentage of Hispanics with a new diagnosis of HIV increased from 32.9% in 2020 to 36.9% in 2024. Males were also overrepresented. accounting for 72.8% of new HIV cases.

Among age groups, the greatest increases in the last five years were noted among people with HIV between 45-49 years of age and people with HIV 35-39 years of age. The number of new HIV cases increased 54.3% and 34.6%, respectively. MMSC exposure accounted for 50.2% of new HIV cases in 2024.

Trends in HIV exposure categories over the last five years were identified. MMSC/IDU decreased from 10 to 7 people and people with HIV exposed via IDU decreased from 17 to 11. Heterosexual contact increased by 104% between 2020 and 2024 among men and increased by 64% among women. New HIV cases among Black Heterosexuals increased by 84.6% between 2020 and 2024. New HIV cases increased by 74% among Black women between 2020 and 2024 and increase 80% among Black heterosexual women. New HIV cases nearly doubled for Black women of childbearing potential (WCBP) and increased from 16 to 20 for Hispanic/Latina WCBP (defined as woman between 15-44 years of age). New cases among Hispanic/Latino men increased by 28% over the last five years. Newly diagnosed people with AIDS increased 13.8% from 231 cases in 2020 to 263 cases in 2024.

Racial and ethnic diversity was found in the OSA general population, with 17.0% identifying as WNH, 49.0% as BNH, and 31.0% as Hispanic. BNHs were overrepresented when compared to the OSA population, with only 15.8% of OSA residents identifying as BNH. Over the last five years, new AIDS cases among WNHs increased 21.1%, BNHs increased 4.6%, and Hispanics decreased 22.4%. Among Asian/Native Hawaiian/Pacific Islanders, the number of new AIDS cases decreased from four cases in 2020 to one case in 2024. Men were overrepresented, accounting for 72.8% of all new HIV cases in 2024. New AIDS cases increased among adults ages 35-49 and 55-59 years of age. Among people with new AIDS cases between 13-24 years, there was an increase from 12 to 15 people from 2020 to 2024. MMSC exposure accounted for 45.6% of all new AIDS cases among men, a decrease from the 2022-2026 plan data (74.1%). Heterosexual contact as an exposure category increased 22.4% between 2020 and 2024.

Prevalence: Living people with HIV increased from 16,247 in 2020 to 17,590 in 2024- an 8.3% increase. Racial/ethnic gaps exist, as BNHs accounted for 15.8% of the OSA population but 39% of people with HIV. The percentage of Hispanic people with HIV were similar to the OSA population- 29.9% versus 31.0%, respectively. Asian/ Pacific Islander, American Indian/Alaska Native, and Others accounted for 2.3% of people with HIV.

Men were overrepresented among people with HIV (75%) versus women (25%). Increases over the last five years were noted among people with HIV 60 years of age or older (42.9%),

people with HIV 45-49years (4%), and 40-44 years (19.8%). people with HIV ages 0-12 decreased by 16.3%, while youth 13-24 decreased by 18% from 2020-2024. MMSC accounted for 79.4% of all men people with HIV, an increase of 9% over the past five years. Men with IDU exposure decreased 8.5% from 2020-2024. Heterosexual contact accounted for 87.7% of women people with HIV and 14.1% of men people with HIV. People with HIV increased among Hispanic MMSC exposure by 26%

Mortality: FDOH reports the deaths among people with HIV. In 2024, there were 65 deaths of people with HIV in the OSA, down from 95 deaths in 2020. Deaths decreased from 19 to 5 in Brevard County over the past five years. Deaths decreased in Orange County from 52 to 37 in the same time span and increased from 4 to 6 people in Osceola County. Lake County saw an increase from 8 people to 9 people between 2020 and 2024 and dropped from 12 people to 3 people in Seminole County.

HIV and Comorbid Conditions: FDOH provided population-adjusted rates of co-morbid conditions per 100,000 population. People at disproportionate risk for HIV infections included those diagnosed with infectious syphilis, chlamydia, and gonorrhea. The BNH population had higher rates of Hepatitis B compared to their WNH and Hispanic counterparts. WNH had higher rates of Hepatitis C.

Population-adjusted rates of infectious syphilis in 2024 stood at 31.1, down from 34.8 in 2020 for Lake, Orange, Osceola, and Seminole Counties. It decreased from 29.0 to 26.2 in Brevard County during the same timeframe. The number among Hispanic men with syphilis increased 10.4% between 2020 and 2024 although the rate was generally flat overall. In Orange County, the rate among BNH males in 2024 was 21.7 compared to 6.7 among WNH. BNH in Lake County had a rate of 18.6, more than four times the rate of 4.3 among WNH. The rate among BNH was 50.8 compared to 7.3 for WNH in Brevard County, and in Osceola County the rate for BNH was 31.8 compared to 1.6 for WNH. No disparities were identified among Hispanics compared to non-Hispanics throughout each of the five counties.

Rates of gonorrhea for NHB in Osceola County was 144.8 compared to 28.7 for WNH as of 2024. In Lake the rate stood at 301.3 compared to 28.9 for WNH. Brevard, Orange, and Seminole Counties saw similarly discrepant rates between NHB and WNH in 2024. Gonorrhea rates in Brevard County for Hispanics stood at 57.5, lower than rates for WNH and NHB. Gonorrhea rates for Hispanics in Lake, Orange, Osceola, and Seminole were lower than that for NHB and WNH. Trends across the board for all counties and racial/ethnic groups were on the decline over the past five years.

Data from FDOH revealed chronic HBV rates in Lake, Orange, Osceola, and Seminole Counties increased from 21.1 in 2020 to 24.2 in 2024. Brevard County saw a decrease in the HBV rate, down from 16.1 to 13.3. The rate for BNH in Lake, Orange, Osceola, and Seminole jumped from 24.7 to 44.5 between 2020 and 2024. Rate increases were noted among people between 30-44 years of age as well as individuals 60 years of age and older in Lake, Orange, Osceola, and Seminole Counties.

Rates for chronic hepatitis C virus (HCV) decreased across the board between 2020 and 2024. The rate decreased overall from 145.8 in 2020 to 99 in 2024- or a 32.1% decrease. While there were some fluctuations for BNH and Hispanics in Brevard their overall rates decreased from 77.5 to 49.8.

The FDOH Division of Disease Control and Prevention, Tuberculosis (TB), reported that TB rates were generally low, seeing increases in Orange (at 4.7 compared to 2.9 for Florida) and Osceola (4.8). A total of four people were diagnosed with TB in 2024 in Brevard, eight people in Lake County, and three in Seminole.

An analysis of FDOH data revealed increases in new HIV cases among Black Heterosexual

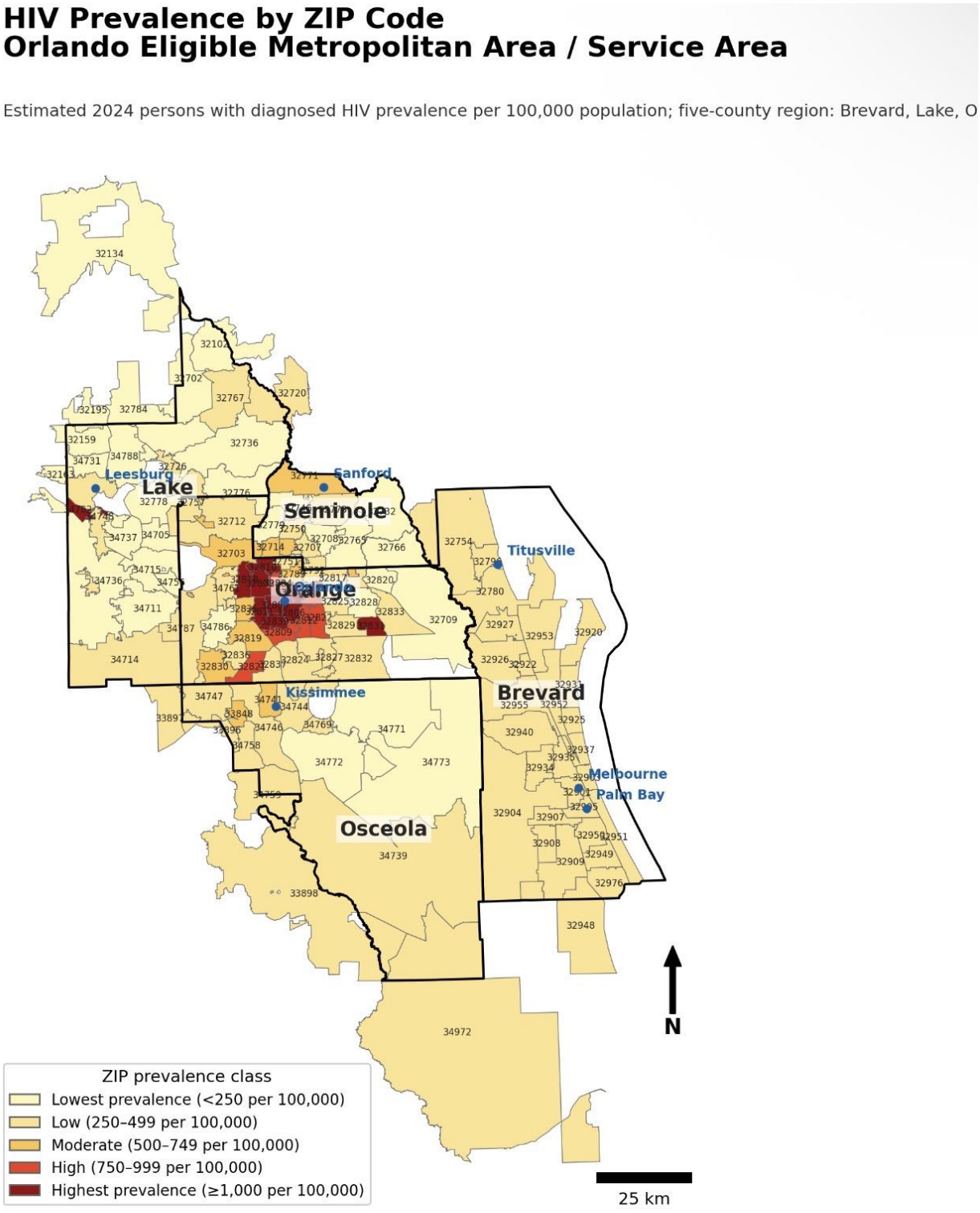
and Black women, primarily through heterosexual contact as the mode of transmission. Among BNH Heterosexuals, cases increased 84% between 2020 and 2024. Among BNH women new HIV cases increased 77.3% in the past five years. Among all women of childbearing potential there was a 50% increase in new HIV cases. There was a nearly nine percent decrease in the number of new HIV cases among WNH during this timeframe. Among all women there was a 49.2% increase in new HIV cases.

Figure 8 provides a breakout of the top ten prevalence areas by zip-code by county. **Figure 9** on the next page illustrates the strong association between HIV prevalence and residential location among people with HIV.

Figure 8. Top Ten Prevalence Areas by Zip-Code by County

Brevard County	Lake County	Orange County	Osceola County	Seminole County
32901	34748	32808	34741	32771
32922	34711	32839	34744	32714
32907	34714	32805	34746	32773
32935	32726	32811	34743	32707
32905	32757	32818	34758	32701
32909	34736	32822	34747	32708
32780	32778	32801	34769	32765
32955	34715	32810	34772	32746
32926	34788	32703	34771	32750
32927	32159	32806	34773	32779

Figure 9. People with HIV by ZIP Code for Orlando Service Area, Year-End 2024 (N = 17,590)



Sources: Florida Department of Health FLHealthCHARTS, Persons With HIV (PWH), 2024 county controls; AIDSVu Orlando ZIP prevalence, 2023; Census Reporter /
Method: ZIP estimates calibrated to 2024 county PWH totals. ZIPs without public ZIP-rate data use county-rate fallback; see methodology notes.

C. Needs Assessment

This section summarizes needs assessment activities and data to inform the goals and objections of the OSA Integrated HIV Plan. Based on the needs assessment data collected via the focus groups, town halls, and survey data, this is a summary of the services that:

- People need to obtain HIV testing.
- People engaging in activities to remain HIV negative.
- People need help linking to HIV medical care and treatment quickly after receiving an HIV positive diagnosis

Figure 10: Barriers to HIV Prevention – Service Gaps

Barriers to Prevention	Social and Structural	Legislative	Health Depts	Program	Provider	Client
Inadequate funding		X	X	X		
Federal guidelines restricting bridging of programs	X	X	X	X		
Federal, State, and local policies not aligned with community needs	X	X	X	X	X	
Agency turnover and lack of staff continuity			X	X	X	
Varied needs among residents in the OSA counties	X	X	X	X		
Weak or nonexistent partnership and/or communication between agencies	X		X	X	X	
Community members unaware of available programs	X				X	X
Lack of community education leading to HIV stigma	X	X	X	X	X	
Inability to educate the public due to local and state policies	X	X	X	X		
Lack of staff training to understand and address cultural barriers and norms			X	X	X	
Inadequate public transportation	X	X				

Note: 1.) Social and Structural service gaps refer to barriers people face trying to access health services, perhaps due to lack of awareness of services, systemic issues, 2.) Legislative service gaps refer to barriers people face due to policies at the local, county, state, or federal level, 3.) Health Departments service gaps refer to issues health departments face that result in people being unable to access health care services, 4) Program service gaps refer to the resource-related issues experienced by programs that result in people being unable to access services, 5.) Provider service gaps refer to agencies experiencing a multitude of issues, including staffing, location, hours, and/or funding that impacts people's abilities to obtain services, and 6.) Client service gaps refer to people not being able to obtain care due to not knowing where to go for care or not having the resources to obtain care.

Figure 11: Barriers to HIV Care and Treatment

Barriers to Care	Social and Structural	Legislative	Health Department	Program	Service Provider	Client
Policy implementation (e.g., Medicaid expansion, SSPs, abstinence-based curriculum, etc.)	X	X	X	X	X	X
Federal, State, and County contracting and procurement processes		X	X	X	X	X
Inadequate coordination between FDOH and Medicaid managed care program and MCOs	X	X				
Insufficient health insurer payments	X	X		X	X	
Delay in FDOH epidemiologic data impeding unmet need and planning process		X	X	X	X	X
Insufficient communication between prevention and care providers	X	X	X	X	X	
Inadequate local public transportation	X	X		X		
Insufficient dental providers	X			X		
Insufficient primary and specialty care providers	X	X				X
Insufficient staff to client ratios					X	
Lack of community partnerships and linkages	X	X	X	X	X	X
Lack of affordable housing	X	X		X		X
Lack of knowledge of the RWHAP-funded services	X	X	X	X	X	X
Lack of affordable health insurance	X	X				
Linguistic and cultural barriers	X	X			X	X

Note: 1.) Social and Structural service gaps refer to barriers people face trying to access health services, perhaps due to lack of awareness of services, systemic issues, 2.) Legislative service gaps refer to barriers people face due to policies at the local, county, state, or federal level, 3.) Health Departments service gaps refer to issues health departments face that result in people being unable to access health care services, 4) Program service gaps refer to the resource-related issues experienced by programs that result in people being unable to access services, 5.) Provider service gaps refer to agencies experiencing a multitude of issues, including staffing, location, hours, and/or funding that impacts people's abilities to obtain services, and 6.) Client service gaps refer to people not being able to obtain care due to not knowing where to go for care or not having the resources to obtain care.

D. Priorities

Figure 12 summaries key priorities arising from the needs assessment.

Figure 12. Key Priorities Arising From OSA Needs Assessment

Priority 1. Prevent New Infections
Increase number of organizations offering PrEP
Expand availability and accessibility of PrEP outside of traditional methods
Increase the number of people retained on PrEP
Increase the number of people tested for HIV
Priority 2: Improve HIV-Related Health Outcomes Among people with HIV
Increase the number of medical providers to include HIV treatment
Increase medical provider capacity to ensure treatment begins at diagnosis or most recent encounter within seven days
Increase number of people with HIV who are out of care re-engaged in care
Priority 3: Ensure More People Know Their HIV Status
Increase the number of prioritized HIV tests
Increase the number of routine HIV testing
Increase the number of healthcare providers who offer comprehensive sexual health screening and counseling
Priority 4: Cluster Detection and Response (CDR) Program
Develop a CDR program that can be executed by 2028
Collaborate with FDOH epidemiologists to detect clusters
Re-establish and expand data sharing agreements for cluster detection with each county of the OSA
Implement and provide HIV testing and outreach events to locations based on identified clusters

E. Actions Taken

Not applicable.

F. Approach

Not applicable.

G. Financial and Human Resources Inventory

Figure 13 summarizes the inventory of financial and human resources for the five counties in the OSA.

- Organizations and agencies providing HIV care and prevention services in the jurisdiction.
- HRSA and CDC funding sources.
- Leveraged public and private funding sources including the HRSA's Community Health Center Program, HUD HOPWA Program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration (SAMHSA) programs, and foundation funding.

It is noteworthy that expenditure data were unavailable to the OSA RWHAP Part A Recipient for key funders including Florida AHCA (Medicaid), Medicare, Department of Veteran's Affairs, FDOH ADAP for OSA residents, and FDOH Health Insurance Premiums and Cost Sharing.

Figure 13. CY 2025 OSA HIV Funding Sources by Recipient, County, Funding Source, and Available Funds ($)

Funding Source	Recipient	Brevard	Lake	Orange	Osceola	Seminole	Available $
RWHAP Part A	Orange County HSD		X	X	X	X	$10,184,123
RWHAP Part A- MAI	Orange County HSD		X	X	X	X	$889,686
RWHAP Part B	FDOH HFUW	X		X	X	X	$1,714,310
RWHAP Part B	FDOH Area 7	X		X	X	X	$185,804
RWHAP Part C	FDOH – Orange		X	X	X		$1,063,777
RWHAP Part C	Unconditional Love	X					$212,796
RWHAP Part D	FDOH – Orange	X	X	X	X	X	$827,940
FDOH EHECDC	FDOH - Orange			X			$672,658
RWHAP EHE	Orange County HSD			X			$2,440,669
RWHAP FDOH ADAP	FDOH – Orange			X			$532,820
CHD GR	FDOH - Brevard						$108,044
CHD GR	FDOH – Lake		X				$100,000
CHD GR	FDOH - Orange			X			$350,000
CHD GR	FDOH - Osceola				X		$100,000
CHD GR	FDOH - Seminole					X	$184,500
CHD GR/Surveillance and Prevention	FDOH – Orange			X			$192,213
PCN GR	Tri-County HFUW	X					$615,195
FDOH HIP	Project Response and Unconditional Love	X					$430,000
FDOH EBI	FDOH - Orange			X			$500,000
FDOH EBI	FDOH – Orange			X	X		$500,000
FDOH EBI	FDOH - Seminole					X	$75,000
FDOH EBI	FDOH – Brevard	X					$125,000
FDOH Prevention	DOH Orange	X		X	X	X	$824,071
FDOH Surveillance	DOH- Orange			X	X	X	$269,421
FDOH HOPWA	HFUW	X					$523,131
FDOH TOPWA	Miracle of Love			X			$155,000
SAMHSA SA and HIV Prevention Navigator	26 Health, Inc.	X					$199,774
SAMHSA SA and HIV Prevention Navigator	Aspire Health Partners, Inc.			X			$500,000
FL AHCA Medicaid Program	OSA-Wide						Unavailable
Department of Veteran's Affairs	OSA-Wide						Unavailable
CMS (Medicare)	OSA-Wide						Unavailable
TOTAL $							$24,475,932

Acronym Key: ADAP (AIDS Drug Assistance Program), AHCA (Agency for Health Care Administration), BPHC (Bureau of Primary Health Care), CHD (County Health Department), CMS (Centers for Medicare and Medicaid Services), DASH (Division of Adolescent School Health), EBI (Evidence-Based Intervention), EMA (Eligible Metropolitan Area) FDOH (FL Department of Health, HCH (Healthcare Center for the Homeless), GR (General Revenue), HSD (Health Service Department), HOPWA (Housing Opportunities for Persons with AIDS), MAT (Medication-Assisted Treatment), MAI (Minority AIDS Initiative), MOE (Maintenance of Effort), OBFH (Orange Blossom Family Health), TCE HIV (Targeted Capacity Expansion HIV Program), TOPWA (Targeted Outreach for Pregnant Women Act), UW (United Way)

Figure 14: OSA HIV Care Continuum, CY 2024

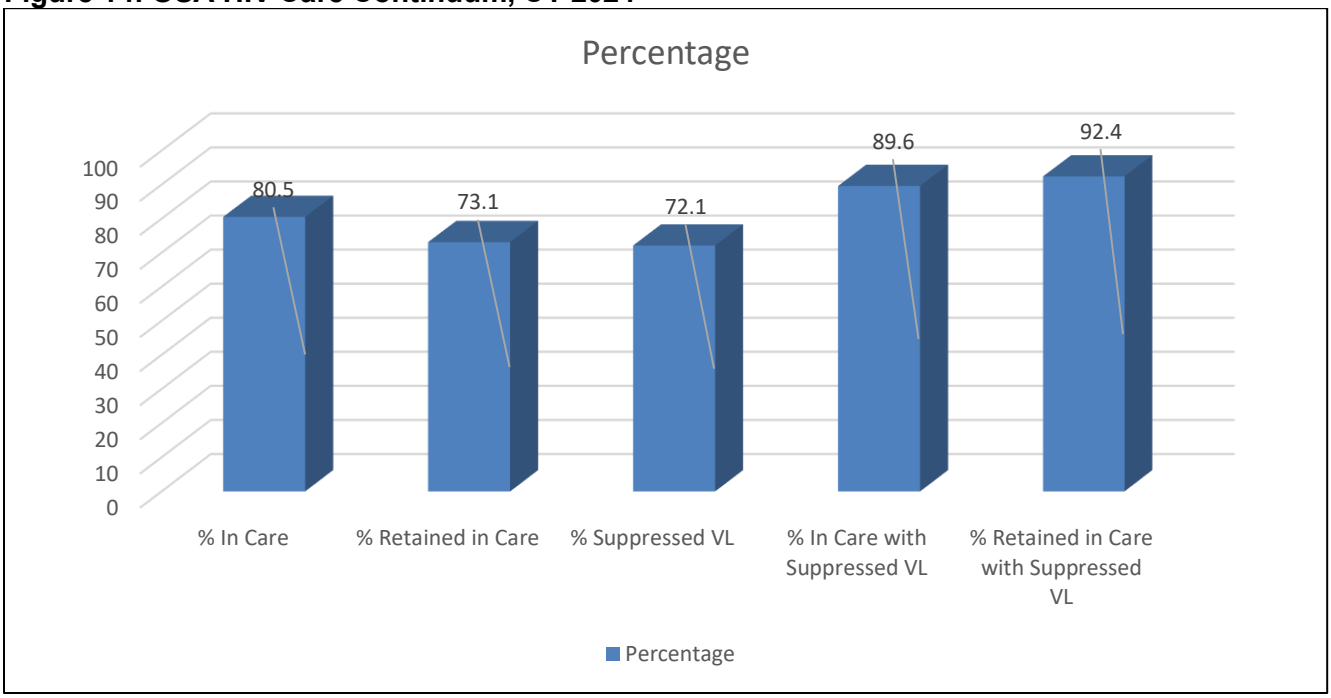


Figure 15. Variability of Steps in the OSA HIV Care Continuum, By County, CY 2024

OSA Counties	% In Care	% Retained in Care	% Suppressed VL	% In Care with Suppressed VL	% Retained in Care with Suppressed VL
Brevard.	85.9%	80.1%	79.2%	92.2%	94.4%
Lake.	86.9%	76.7%	77.3%	89.0%	92.8%
Orange	78.7%	71.7%	70.1%	89.1%	91.7%
Osceola	79.6%	71.3%	71.1%	89.3%	92.6%
Seminole	81.1%	73.2%	73.2%	90.4%	93.7%
OSA	**80.5%**	**73.1%**	**72.1%**	**89.6%**	**92.4%**

H. Analytic Specifications Used by FDOH to Calculate the HIV Care Continuum of Counties in the OSA

- The OSA includes Brevard, Lake, Orange, Osceola, and Seminole Counties
- People with HIV is defined as the number of people living with an HIV diagnosis in this area at the end of each respective calendar year, as of 6/30/2025.
- HIV diagnoses include persons whose HIV diagnosis occurred in the period specified, data as of 6/30/2025.
- In Care: people with HIV with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2024 through 3/31/2025, data as of 6/30/2025.
- Out of Care: people with HIV with no documented VL or CD4 lab, medical visit, or prescription from 1/1/2024 through 3/31/2025, data as of 6/30/2025.
- Retained in Care: people with HIV with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2024 through 6/30/2025, data as of 6/30/2025.
- Suppressed VL: people with HIV with a suppressed VL (<200 copies/mL) on the last VL

from 1/1/2024 through 3/31/2025, data as of 6/30/2025.

- In Care with Suppressed VL: people with HIV with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2024 through 3/31/2025 that also has a suppressed VL (<200 copies/mL) on the last VL from 1/1/2024 through 3/31/2025, data as of 6/30/2025.
- Retained in Care with Suppressed VL: people with HIV with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2024 through 6/30/2025 that also has a suppressed VL (<200 copies/mL) on the last VL from 1/1/2024 through 3/31/2025, data as of 6/30/2025.
- No VL: No documented VL lab from 1/1/2024 through 3/31/2025, data as of 6/30/2025.
- Late Diagnosis: AIDS diagnosis within three months of HIV diagnosis.

SECTION IV. SITUATIONAL ANALYSIS

A. Summary of the Situational Analysis

This Section offers an overview of the strengths, challenges, and needs for HIV prevention and care services in the OSA. This Section synthesizes information gathered from the Community Engagement and Planning Process (Section II) and Contributing Data Sets and Assessments (Section III). The situational analysis addresses the four EHE pillars:

- **Pillar 1: Diagnose** all people with HIV as early as possible;
- **Pillar 2: Treat** people with HIV rapidly and effectively to reach sustained viral suppression;
- **Pillar 3: Prevent** new HIV transmissions by using proven interventions (e.g., PrEP and SSPs);
- **Pillar 4: Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

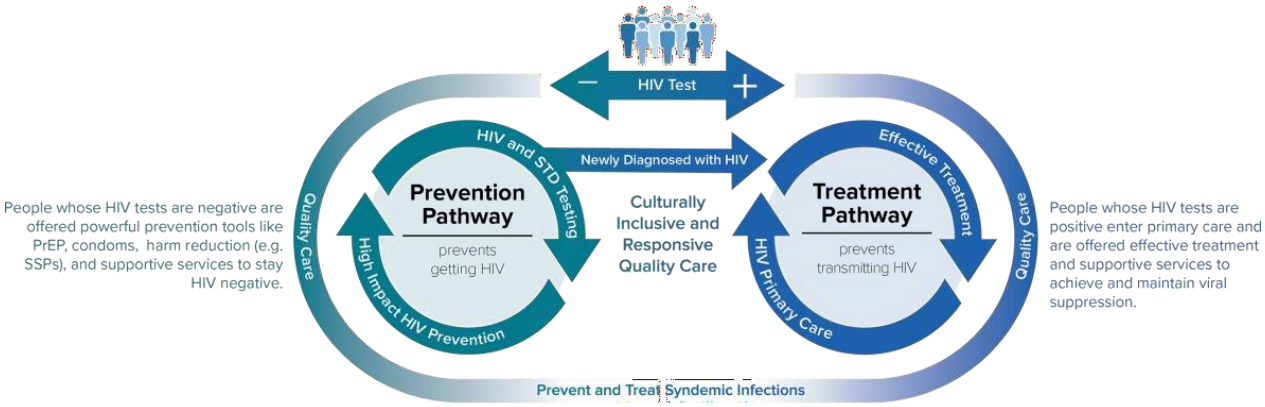
We have focused the summary of our analysis on one key topic per goal.

This section also identifies OSA's priority populations whose prevention and care needs will be addressed.

B. Application of Status-Neutral Approach to HIV Prevention and Care

The CDC recommends high-impact initiatives that apply a status-neutral approach to HIV prevention and care. This approach involves initial HIV testing services as the entry point to HIV prevention and/or care services, regardless of the result. **Figure 16** illustrates the approach.

Figure 16: Status-Neutral Approach to HIV Prevention and Care



Source: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf

The OSA will apply the status neutral model to HIV prevention and care services proposed in the Integrated HIV Plan. The OSA proposes initiatives and strategies that align with the EHE pillars described below. We highlight strengths, challenges, and identified needs of the HIV prevention and care delivery system.

Goal 1: Ensure more people know their HIV status as soon as possible

A great deal of discussion in the town halls, focus groups, and the Integrated Plan Ad Hoc committee zeroed in on the need to ensure all people know their HIV status. To that end, increasing routine testing, prioritized testing, as well as expanding the numbers of medical providers who offer comprehensive sexual health screenings and counseling services lead the way for addressing this goal. While fear and stigma play a critical role in people not getting tested, it is also necessary to expand where people are tested to better use limited testing resources to increase the number of people who know their status. It's important to expand beyond traditional HIV testing locations that may be perceived as stigmatizing.

One approach to address testing is to expand both the number of prioritized and routine HIV testing to areas that have not seen as much testing despite epidemiology data indicating the need for more. It is not uncommon for ASOs to test and re-test in familiar areas, so it has been determined that expanding to other locales, particularly ERs, acute care settings, urgent care, internal/primary care providers, OBGYNs, and other non-traditional testing sites are key to increasing the number of people who know their HIV status. The ultimate goal is to achieve routine testing for HIV in all medical facilities.

GOAL 1: Ensure more people know their HIV status as soon as possible

Pillar: DIAGNOSE

To increase the number of prioritized HIV tests conducted by 20% within the jurisdiction by 2031.

To increase the number of routine HIV tests conducted by 20% within the jurisdiction by 2031.

To increase the number of healthcare providers who provide comprehensive sexual health screening and counseling by 20% within the jurisdiction by 2031.

The data gathered through the Ad Hoc committee and TAI revealed a need to also expand the number of medical providers that offer comprehensive sexual health screenings and counseling. There continues to be hesitation to discuss sexual health in many medical settings, perhaps due to shame, fear, judgement, and/or stigma. Collaborating with local partners to educate healthcare providers on syndemics and incorporate HIV into primary care and internal medicine practices serves to address this shortcoming in the healthcare system.

Goal 2: Provide medical treatment to people diagnosed with HIV within 7 days

Discussions held with the Integrated Plan Ad Hoc committee, based on data gathered from the town halls and focus groups, indicated a continued need to expand the number of medical providers that offer basic HIV treatment. While the OSA boasts a solid lineup of HIV medical providers in Orange County, the rest of the OSA is still in need of trained medical professionals who can offer HIV care beyond diagnosis and medication.

Goal 2: Provide medical treatment to people diagnosed with HIV within seven days.

Pillar: TREAT

To increase the number of medical providers to include HIV medical treatment by 20% by 2031.

To increase capacity by 20% for medical providers to ensure treatment begins at diagnosis or most recent encounter within 7 days (Rapid Start).

To increase the number of people with HIV who are out of care that are re-engaged in medical care by 20% by 2031.

The array of locales in need of HIV capacity training includes ERs, acute care settings, urgent care, internal/primary care providers, OBGYNs, etc., who do not have HIV medical care available to begin providing that service. This is particularly true in Brevard, Lake, Osceola, and Seminole Counties, as was shared during the data collection portion of this process. Wider expansion of the service delivery system will impact linkage, prescription of ARV, retention in medical care, and viral load suppression.

Rapid Start programs will be key to understanding the current infrastructure to determine the

best steps forward. This will include identifying and addressing barriers to care, particularly for people with HIV who are not in care and in need of being re-engaged into care. Expanding Rapid Start throughout the OSA will assist in bringing people back into care.

Goal 3: Prevent New HIV Transmissions

Treatment as prevention, PrEP is an effective tool in decreasing new transmissions. Despite its efficacy, the uptake for PrEP has been limited to date. When taken as prescribed it is over 99% effective at preventing HIV transmission. The OSA identified the need to recruit and establish clinics and community-based organizations to initiate PrEP services. This effort includes training providers as needed to educate them on PrEP and how to make appropriate referrals to CBOs when indicated.

Goal 3. Prevent New Infections

EHE Pillar: PREVENT

To increase the number of organizations that provide PrEP services by 30% by 2031.

To expand the availability and accessibility of PrEP outside of traditional methods to priority populations by 20% by 2031.

To increase the number of people from priority populations retained on PrEP by 20% by 2031.

To increase the number of people tested for HIV by 20% by 2031.

To expand the availability of PrEP throughout the OSA, education services must be expanded that includes discussions on cost-effectiveness and identifying sustainable service expansion. Barriers will need to be identified as well as the need to identify and train facilitators to ensure successful PrEP persistence and adherence. Populations of focus will serve as a focal point for encouraging the implementation of non-traditional activities. Disparities in the uptake of PrEP and nPEP still exist among the populations of focus.

HIV testing will continue to be a cornerstone of prevention efforts. Populations of focus will serve as a focal part of this effort, with the intent of increasing the number of prioritized or rapid HIV testing to them. In addition, the OSA will work to educate medical providers on the importance of routine screenings completed in conjunction with regular blood work. Blood work in most medical settings do not include HIV or STI tests; an ancillary effort here will focus on training medical providers and medical providers in training about the importance of complete and thorough bloodwork panels.

Finally, it is noted here again of the importance of increasing the number of HIV tests provided in non-traditional settings. FDOH will work with CBOs and ASOs to identify new venues for testing to reach more people.

Goal 4: Cluster Detection and Response (CDR) Plan

To be well positioned to respond aggressively to flare-ups in HIV incidence, a more unified effort across all HIV partners must be re-established and supported. The OSA will require data as close to real-time as possible to implement strategies to mitigate the spread of HIV clusters. To that end, one of the first steps in responding to outbreaks is identifying best practices through the convening of existing communities of practice. This, in conjunction with using data to identify gaps, will be key in developing plans of action. A proper CDR plan will require data, data sharing agreements, best practices, promising

Goal 4: Cluster Detection and Response Plan

Pillar: RESPOND

To develop a Cluster and Outbreak Detection and Response (CDR) Plan that can be executed effectively by 2028.

To collaborate with the Florida Department of Health (FDOH) epidemiologists to detect clusters in the Orlando Service Area.

Re-establish and expand a data sharing agreements for cluster detection with each county of the Orlando Service Area.

Implement and provide HIV testing and outreach events to locations based on identified clusters.

practices, and all hands-on deck to quickly address issues as they emerge in a time of ever dwindling resources.

The Recipient, FDOH, Planning Council, Lead Agency, people with HIV, and subrecipients, will identify and engage all key collaborators in the plan development process, including people with lived experience and those with certain risk factors for acquiring HIV.

One area raised during the development of the plan was data sharing agreements between FDOH and the Recipient as well as representatives from each of OSA's service counties. Those data sharing agreements must be re-established and maintained so that information can flow freely to each of the counties to best address outbreaks. The OSA will collaborate with FDOH to create a reciprocal client informed consent form and release of information to acknowledge that data may be shared to improve service provision, linkage, and retention services.

Once these data sharing agreements are up and running, the OSA intends to work closely with High Impact Prevention (HIP) providers and other community partners to be dispatched to identify clusters.

C. Priority Populations

The priority populations identified in the OSA Integrated HIV Plan for 2027-2031 were selected by the CFHPC and reflect the results of the extensive community engagement process as well as the analytic results of qualitative and quantitative assessment processes.

Selection of those priority populations reflects the results of the Community Engagement and Planning Process described earlier in Section II, as well as Contributing Data Sets and Assessments reviewed and summarized in Section III.

It is noteworthy that the same populations of focus were included in the two previous iterations of the Integrated HIV Plan. Their selection in the three planning periods speaks to the continued issues facing these groups during the course of the history of the HIV epidemic in the Orlando Service Area.

SECTION V. 2027-2031 GOALS AND OBJECTIVES

A. Goals and Objectives Description

In this section, we identify goals and objectives for how the OSA will diagnose, treat, prevent, and respond to HIV. **Figure 17** describes OSA's goals and related NHAS pillars, objectives, and strategies for 2027-2031. Activities, responsible parties, and data indicators are included for each proposed strategy. The timeframe for all goals is the five-year period of 2027-2031. We propose that 2026 be used as the baseline for determination of achievement of the Plan's goals, objectives, and strategies. We further propose that at the beginning of 2027, an annual workplan will be developed to assess accomplishments, identify newly emerging barriers and facilitators, and recognize newly established policies, clinical guidelines, and availability of funds. The annual workplans will be adjusted for newly identified objectives and strategies as the HIV prevention and care delivery system contributes to ending the OSA HIV epidemic.

In conducting 2027 OSA planning efforts, local stakeholders agree to support the goals and objectives of the FDOH statewide Integrated HIV Plan. Broad population-wide efforts to improve Floridian's awareness of HIV status are best addressed at the state-level. Similarly, efforts to support statutory changes and raise State General Revenue for HIV prevention and care services are also best accomplished at the state level.

With these factors in mind, the OSA Integrated HIV Plan focuses on improving the HIV prevention and care delivery system in the five-county area. The OSA Integrated HIV Plan is envisioned to be implemented largely by and for OSA residents. It is recognized, however, that some goals and objectives of the OSA Integrated HIV Plan will be heavily dependent on federal supplemental and competitive grant funding. In turn, FDOH funding priorities may not be aligned with those of the OSA. Other service areas may be higher priorities for funds and FDOH personnel.

B. Updates to Other Strategic Plans Used to Meet Requirements

No other strategic plans were used to meet the requirements of the guidance.

Figure 17. OSA integrated HIV Plan Goals and Related NHAS Pillars, Objectives, and Strategies for 2027-2031

Goal 1. Ensure more people know their HIV status as early as possible.		
EHE Pillar: DIAGNOSE		
Objectives	**Activity/Performance Measure**	**Responsible Party(ies)**
To increase the number of prioritized HIV tests conducted by 20% within the jurisdiction by 2031.	Increase the number of rapid HIV testing sites in under-tested (?) areas based on need identified in epidemiology data.	FDOH Part B, HIP Providers, CTL Providers
To increase the number of routine HIV tests conducted by 20% within the jurisdiction by 2031.	Increase capacity of health care delivery systems to offer routine testing in ERs, acute care settings, urgent care, internal/primary care providers, OBGYNs, etc.	FDOH Part B, HIP Providers, CTL Providers, Advent Health, Orlando Health
To increase the number of healthcare providers who provide comprehensive sexual health screening and counseling by 20% within the jurisdiction by 2031.	Collaborate with local partners to educate healthcare providers on syndemics and incorporate HIV into primary care and internal medicine practices.	HIP Providers, FDOH, HIP Providers

Goal 2: Provide medical treatment to people diagnosed with HIV within seven days.

EHE Pillar: TREAT

Objectives	Activity/Performance Measure	Responsible Party(ies)
To increase the number of medical providers to include HIV medical treatment by 20% by 2031.	Increase capacity of healthcare delivery systems such as ERs, acute care settings, urgent care, internal/primary care providers, OBGYNs, etc., who do not have HIV medical care available to begin providing that service.	Part A, CTL Providers, Provider Detailers
To increase capacity by 20% for medical providers to ensure treatment begins at diagnosis or most recent encounter within 7 days (Rapid Start).	Assess current infrastructure to determine how to incorporate Rapid Start	Part A, CTL Providers, Provider Detailers, Part B
To increase the number of people with HIV who are out of care that are re-engaged in medical care by 20% by 2031.	1) Identify and re-engage people with HIV who are out of care 2) Create and implement interventions to identify people with HIV who are out of care 3)To assess clinical infrastructure to determine what barriers are contributing to reengagement to care	Part A, CTL Providers, Provider Detailers, Part B, EHE

GOAL 3: Prevent new HIV transmissions.

EHE Pillar: PREVENT

Objectives	Activity/Performance Measure	Responsible Party(ies)
To increase the number of organizations that provide PrEP services by 30% by 2031.	Recruit and establish clinics and community-based organizations to initiate PrEP services, which include clinical prescribers and referrals.	FDOH HIP Providers, CTL Providers, Provider Detailers
To expand the availability and accessibility of PrEP outside of traditional methods to populations of focus by 20% by 2031.	1) Educate providers on cost-effectiveness and sustainable service expansion. 2) Encourage implementation of nontraditional activities with an emphasis on populations of focus.	FDOH HIP Providers, CTL Providers, Provider Detailers
To increase the number of people from populations of focus retained on PrEP by 20% by 2031.	1) Identify barriers and facilitators to successful PrEP persistence. 2) Implement strategies to reduce barriers and increase facilitators. 3) Implement treatment adherence services.	FDOH HIP Providers, CTL Providers, Provider Detailers
To increase the number of people tested for HIV by 20% by 2031.	1) Increase the number of prioritized or rapid HIV testing to populations of focus. 2) Increase the number of routine screenings completed in conjunction with regular blood work. 3) Increase the number of HIV tests provided in nontraditional settings.	FDOH HIP Providers, CTL Providers, Provider Detailers, EHE, Advent Health, Orlando Health, Part C

Goal 4: Develop and implement a Cluster Detection and Response (CDR) Plan.

Pillar: RESPOND

Objective	Activity/Performance measure	Responsible Party(ies)
To develop a Cluster and Outbreak Detection and Response (CDR) Plan that can be executed effectively by 2028.	Convene existing communities of practice to share outbreak best response practices and known gaps to guide development and key strategies in the plan	FDOH, CTL Providers, OAHS, Advent Health, Orlando Health, Provider Detailers, HIP Providers
To collaborate with the Florida Department of Health (FDOH) epidemiologists to detect clusters in the Orlando Service Area.	Identity and engage all key collaborators in the plan development process, including people with lived experience and those with certain risk factors for acquiring HIV	FDOH, CTL Providers, OAHS, Advent Health, Orlando Health, Provider Detailers, HIP Providers
Re-establish and expand data sharing agreements for cluster detection with each county of the Orlando Service Area.	Collaborate with FDOH to create a reciprocal client informed consent form and release of information to acknowledge that data may be shared to improve service provision, linkage, and retention services.	FDOH, Area 12, Area 5/6/14, Area 7, Area 3/13
Implement and provide HIV testing and outreach events to locations based on identified clusters.	To utilize HIP providers and other community partners to be dispatched to identified clusters.	FDOH, CTL Providers, OAHS, Advent Health, Orlando Health, Provider Detailers, HIP Providers

SECTION VI. 2027-2031 INTEGRATED HIV PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP

In this section we describe the infrastructure, procedures, systems, and tools to support the key phases of integrated HIV planning to accomplish the OSA Integrated HIV Plan's goals and objectives. The key phases include: (1) implementation, (2) monitoring, (3) evaluation, (4) improvement, and (5) reporting and dissemination.

A. 2027-2031 Integrated HIV Planning Implementation Approach

The CFHPC will continue to lead OSA-wide integrated HIV planning and implementation activities. In this role and in collaboration with the RWHAP Part A and B Recipients, it will spearhead efforts to accomplish the five integrated HIV planning phases. The Planning Council will collaborate with people with HIV, CDC and RWHAP recipients, FDOH prevention and care subrecipients, RWHAP Part B Lead Agencies in Areas 7 and 3/13, community stakeholders, and others to:

- **Implement** the OSA Integrated HIV Plan by expanding the capacity of the HIV prevention and care delivery system; addressing unmet need; undertaking innovative and evidence-based interventions; and addressing emerging barriers as they emerge.
- **Monitor** OSA participating entities' service delivery, expenditures, billing to insurers and other payers as required by the RWHAP, performance assessment, process measures, and key outcomes. A Continuous Quality Improvement (CQI) framework is used to identify and address opportunities for service provider, organizational, and systemwide improvement.
- **Evaluate** performance and quality to determine fidelity with service models, funder requirements, performance indicators, process measures, client and provider satisfaction, and impact on OSA residents generally, as well priority populations specifically. A goal attainment model will be used to measure the extent to which the OSA Integrated HIV Plan's goals, strategies, and objectives achieve the desired impact on the OSA population, HIV prevention and care system, and people with HIV clinical outcomes.
- **Report** accomplishments achieved by OSA Integrated HIV Plan implementation, efforts to expand community engagement, and results of provider and agency performance and outcomes. CDC and HRSA also require reporting of programmatic metrics, performance measures, and outcomes. Local reporting contributes to awareness of national EHE efforts and their impact on the HIV epidemic.
- **Disseminate** results of monitoring, improvement, and evaluation activities to the CFHPC and their committees, Ryan White Community Meetings, townhall meetings, provider groups, funders, and other audiences. Dissemination efforts will also be designed to contribute to FDOH and the FCPN as they undertake the statewide Integrated HIV Plan.

i. Implementation

The Orlando RWHAP Part A Recipient is designated by HRSA and CDC policy as the Lead Agency for OSA integrated HIV planning. The chief elected official in the largest jurisdiction in the EMA selected the Orange County Services Health Department (OCHSD) to design and implement plans for the periods of 2022-2026 and 2027-2031. The RWHAP Part A Program is uniquely positioned for this role as they are also responsible for implementing Part A planning and services delivery, as well as MAI, EIIHA, and EHE planning and implementation. The

OCHSD is the fiscal agent for Orange County's HOPWA Program.
OCHSD has considerable resources to manage federal, state, and local funds; undertake community engagement and planning, monitor subrecipient performance, evaluate services, and undertake QI. The RWHAP Part A Program also supports the CFHPC in fulfilling its RWHAP Part A statutory role in community engagement, coordinated and collaborative planning, PSRA, recipient oversight, and other responsibilities.

Procurement, Contracting, and Programmatic and Fiscal Monitoring: The RWHAP Part A Recipient will collaborate with CDC and HRSA recipients to implement the OSA Integrated HIV Plan's objectives, strategies, and activities related to launching new services and expanding existing ones. Based on collaborating recipients and subrecipients' roles, they may focus on RWHAP or CDC-funded programs or other activities identified in **Figure 17**. These activities will be undertaken using existing organizational procurement, contracting, monitoring, and reporting processes.

Outreach and Collaborative Efforts: Identifying and establishing collaborative efforts with agencies outside of the federal and state-funded sectors will be an important responsibility of the RWHAP Part A Recipient. In these roles, the RWHAP Part A Recipient will collaborate with members of the Service Systems, and Quality, and the Needs Assessment Committees to expand and strengthen the HIV prevention and care delivery system to include HRSA BPHC, FQHCs and look-alike CHCs, acute care inpatient hospitals and their EDs and labor and delivery units, urgent care centers, VA medical centers and outpatient clinics throughout the OSA, medical societies, and community-based medical practices.

Collaborative efforts with CBOs will be conducted to expand HIV awareness, prevention, and support services. Similarly, collaboration with the faith-based community will be initiated to organize health fairs, concerts, and other community events throughout the OSA.

The RWHAP Part A Recipient collaborates with FDOH in outreach to the Florida AHCA, the state's program responsible for healthcare regulation and Medicaid financing, other publicly financed insurance programs, and Medicaid managed care plans.

Based on the OSA Integrated HIV Plan's five-year goals and objectives, the RWHAP Part A Recipient may also identify other key sectors for targeted outreach, collaboration, and coordination. Such efforts are important in achieving goals such as increasing awareness of HIV status and expanded primary and secondary HIV prevention services.

Outreach by FDOH, with assistance from the RWHAP Part A Recipient, to healthcare professional education and training programs is also critical. As described in this document, lack of collaboration between OSA HIV prevention and care and funders and training programs must be addressed. Expanding the OSA "pipeline" of health professionals and allied health workers is critical to incorporating HIV care into primary care practices. Collaborative efforts to create practicums, residencies, and fellowships in HIV clinics, FDOH Local Health Departments, and CBOs is likely to promote interest in careers in these sectors. Ideally, funds used to recruit and train replacement personnel can be invested instead in increased salaries and benefits.

Implementation Oversight and Community Engagement

The CFHPC serves as the statutorily required RWHAP Part A Planning Council for the Orlando EMA. In that role, the CFHPC provides implementation oversight for RWHAP Part A, MAI, EIIHA, EHE, and related programs. The CFHPC oversaw implementation of the *2022-2026 Integrated HIV Prevention and Care Plan*. They continued in this role in 2026 while awaiting the CDC and HRSA Guidance for the 2027-2031 Integrated Plan. The CFHPC will continue in its oversight role in implementing the 2027-2031 Integrated HIV Plan. It is also proposed that CFHPC expand its efforts to guide the Part A Recipient in community engagement and solicitation of

supplemental funds.

The RWHAP Part A Recipient will continue to make quarterly presentations to the CFHPC on implementation of the OSA Integrated HIV Plan. In June 2026, the Recipient will provide the CFHPC with an overview of the 2027-2031 Integrated HIV Prevention and Care Plan, goals, objectives, and strategies. The Recipient will discuss the proposed roles of the CFHPC and its committees. In subsequent reports to the CFHPC, the Part A Recipient will discuss accomplishments made to undertake Plan strategies, barriers and facilitators for accomplishing the Plan, upcoming community engagement and organizational outreach activities, and funding opportunities.

In addition to its oversight role, it is proposed that CFHPC committees continue to collaborate with the RWHAP Part A Recipient on implementation activities. **Figure 18** summarizes those activities.

Figure 18. Roles of CFHPC Committees in Supporting OSA Integrated HIV Plan Implementation, 2027-2031

Membership and Engagement Committee
Develop marketing and recruitment strategies to expand community engagement efforts related to implementing the Integrated HIV Plan Workplan for 2027-2031.
Develop marketing materials related to HIV awareness, testing, PrEP, PEP, linkage to care, and retention in care.
Develop content and post Plan-related content on the CFHPC social media platforms and website
Advise the RWHAP Part A Recipient on effective methods for disseminating public information and education related to prevention and care services.
Coordinate community events and activities related to the Plan.
Advise the RWHAP Part A Recipient in designing compelling requests for additional funds to support OSA HIV prevention, care, and treatment services
Service Systems and Quality Committee
Recommend strategies for using Provide Enterprise data to strengthen multi-agency care management and referral systems to improve retention in care and outcomes.
Review Plan-related quantitative and qualitative data summaries, identify methods for assessing the impact of the Plan on priority populations, and manage Plan-related data presentations to the CFHPC and key stakeholders.
Update Standards of Care relevant to process measures and clinical outcomes, monitor performance of CQM activities related to the Plan.
Needs Assessment and Planning Committee
Provide feedback and recommendations on the Plan's goals, objectives, and strategies.
Track the Plan's progress through a monitoring and evaluation tool and make updates as necessary.
Provide feedback and recommendations for the design and implementation of Plan-related needs assessments, special studies, evaluations, and questions to be addressed by attendees in town hall meetings, surveys, listening sessions, and other community engagement efforts.

ii. Monitor

Monitoring implementation of the OSA Integrated HIV Plan will be undertaken at several levels:

- Monitoring and oversight in implementing the Integrated HIV Plan will be provided by the CFHPC and its committees, as described in the Implementation section above and

Programmatic and financial monitoring consistent with CDC and HRSA grant monitoring requirements. With this approach, participating recipients will monitor their subrecipients using methods and reporting requirements that may vary by federal, state, and/or county-level funders.

Collaborating recipients will conduct subrecipient program monitoring by measuring the extent to which the data indicators are fully, moderately, or inadequately achieved in each Plan implementation year (2027-2031). 2026 will serve as the baseline year to measure improvement**.** Programmatic monitoring will be achieved through virtual monitoring site visits by recipients to assess various aspects of programmatic performance as required by the funder. The recipients will also assess the fidelity of the services provided to Service Standards, DHHS clinical guidelines, United States Prevention Services Task Force (USPSTF) recommendation, and other standards.

Financial monitoring will be conducted by Recipients using the methods specified in grant awards and federal and state fiscal monitoring policies. Desk audits may be conducted, for example, to confirm that subrecipients applied federal accounting regulations in their management of federal funds.

Based on the results of programmatic and financial monitoring, the recipient may request that a subrecipient conduct a Corrective Action Plan (CAP). CAPs are required by recipients from subrecipients whose performance did not meet established targets or did not conduct required programmatic or fiscal activities. The recipient will conduct a follow-up session with the subrecipient to monitor implementation and anticipated improvement.

Specific activities conducted by subrecipients will be monitored to determine the extent to which data indicators reflect achievement of objectives. The application of the data indicators will measure progress being made toward addressing the overall objectives. These indicators will be assessed through data reported by subrecipients. Specific numerators and denominators for each indicator will be developed, and training will be undertaken to ensure consistency in methods used. Performance data will be obtained from Provide Enterprise, CAREWare, attendance rosters, lab tests conducted, etc. as reported by subrecipients. Aggregate data will be summarized in reports to recipients or directly to the funder (e.g., CDC directly funded grants). Quarterly aggregated data reports will be submitted to the CFHPC, subrecipients, and other stakeholders. Such reports will apply plain language methods, apply graphic presentations, and other strategies to ensure that they can be understood by a variety of audiences.

iii. Evaluation

Our evaluation strategy is similar to that described in the Monitoring discussion above. Additionally, formal and ad hoc evaluations will be conducted by recipient staff on topics aligned with the goals and objectives of the OSA Integrated HIV Plan. Evaluation methods used will be based on the nature of the services provided. For example, population or population of focus groups may be invited to participate in surveys conducted through convenience sampling to obtain respondents' awareness of HIV prevention services, such as availability of HIV harm minimization services in a county. Focus groups, key informant interviews, and other qualitative evaluative methods may be used to assess availability, accessibility, and satisfaction with HIV prevention and care services.

Quantitative methods will be applied to client, provider, and agency-level evaluations. This approach is often used in identifying the association between interventions (e.g., disease case management) and retention in care, HIV treatment adherence, and clinical outcomes. Causality commonly cannot be proven in these types of evaluations as the evaluation subjects may experience multiple interventions simultaneously.

Client, provider, and agency-level evaluation methods are greatly strengthened by use of Provide Enterprise by prevention and care recipients and subrecipients. Longitudinal evaluations and

trend analyses, for example, allow assessment of the impact of evolving programmatic changes on healthcare utilization and expenditure before, during, and following quarantine and HIV clinic closures in the event of a pandemic. Factors associated with uptake of new services can also be evaluated, such as telehealth visit modalities to conduct virtual medical visits and counseling sessions.

Selection of evaluation topics will be guided in 2027-2031 by recommendations of CDC and HRSA staff and CFHPC, as well as people with HIV and provider surveys. As in other implementation activities, evaluation topics will also be guided by the goals, objectives, and strategies of the OSA Integrated HIV Plan.

iv. Improvement

The mission of the OSA Clinical Quality Management (CQM) program is to provide high quality medical and support services to people with HIV to achieve optimal clinical outcomes. RWHAP Recipient and Lead Agency CQM programs seek to develop and expand systems of care to meet the needs of people with HIV. Each recipient and subrecipient may provide different services, staffing mix, policies, and procedures. Their CQM programs reflect these differences, as well as priorities for improvement based on baseline clinical performance and outcomes. Collectively, the vision of these OSA CQM programs is to maximize the benefit of staff collaboration to increase efficiency and apply innovative strategies to improve health outcomes.

In implementing the OSA Integrated HIV Plan, the overall responsibility for CQM activities rests with the RWHAP Part A Recipient's CQM team. The team ensures that care is provided in accordance with FDOH and DHHS care and treatment guidelines and OSA Service Standards. The aim of these efforts is to reduce the number of people who acquire HIV, increase access to care and treatment, reduce secondary HIV infections through achievement of sustained undetectable HIV, optimize health outcomes, and reduce health disparities.

The CQM Team facilitates implementation of quality workplans and relevant activities. The CQM Team develops and undertakes systemwide quality initiatives including rapid cycle quality improvement projects (QIPs) that focus on specific high priority areas of improvement. For example, earlier QIPs improved rates of tuberculosis (TB) screening and treatment, ARV adherence, and retention in care. Subrecipients selected individualized approaches to improved clinical processes, conducted Plan-Do-Study-Act (PDSAs), and refined their processes until they achieved significant improvement over baseline. Subrecipient methods and results were compared to provide benchmarks and share improvement techniques among agencies.

The RWHAP Part A Recipient Administrator is the chairperson of the CQM Steering Committee, an advisory board overseeing implementation, monitoring, and evaluation of the CQM Program and the development of the multi-year QM Plan. The QM Steering Committee meets quarterly. The Recipient Administrator authorizes the QM Steering Committee to oversee the development of data driven QIPs and measures before implementing performance improvement strategies throughout the provider network. The Recipient Administrator reports to the CFHPC CQM findings, summary utilization reports, special studies, evaluation of outcomes and indicators from all service categories, emerging issues, and progress.

v. Reporting and Dissemination

Throughout this section, we have summarized processes used to report about implementation of the 2027-2031 integrated HIV Plan. In summary, reporting will continue by the RWHAP Part A Recipient to the appropriate CFHPC committees, the monthly Ryan White HIV Meetings, and the CFHPC. Reports are also made to the CFHPC by the RWHAP Parts B and General Revenue recipients, HOPWA, and other key programs. RWHAP Part B reports are made to CFHPC by the Area 7 HAPC. Part B reporting by HAPCs is conducted for Areas 7 and 3/13 to FDOH. Similarly, FDOH prevention program reporting is also conducted by the HAPCs and local

prevention programs to the FDOH. FQHCs and other directly funded recipients of CDC and HRSA funds submit reports and aggregate data to their granting programs.

Reporting is also conducted by CDC and HRSA recipients and subrecipients based on grant program requirements such as quarterly and annual EHE reports. Client and subrecipient-level reporting is conducted annually to meet RWHAP requirements for submission of Ryan White HIV/AIDS Program Services Report (RSR) data. Those data are aggregated by HAB at the national level and disseminated to Congress, key stakeholders, recipients, and the public.

The OSA Integrated HIV Plan for 2027-2031 identifies improved and increased dissemination efforts by the RWHAP Part A Recipient, CFHPC, and its committees. Dissemination strategies will be collaboratively designed by the RWHAP Part A Recipient, RWHAP Part B Lead Agency, the NAP and the SSQ Committees to expand awareness of the Plan and its various strategies. Dissemination will focus on attainment of the Plans goals and related objectives and strategies. Information about new services and programs will be disseminated through the CFHPC website, online newsletter, and its social media accounts. Planned community engagement events will be promoted, and the results of community and agency engagement activities will also be provided.

The results of evaluations, special studies, and other evaluation-related products will be produced for dissemination. These materials will be designed to be easily read and understood, including easy-to-understand infographics, focus on topical areas of interest to a wide audience. Once again, the guidance of the CFHPC Membership, and Engagement Committee will be sought to ensure uptake of the disseminated materials.

Dissemination strategies will be adopted to ensure that all OSA counties are the focus of reports and materials of relevance to their residents generally as well as people with HIV specifically. Advice from people with HIV residents of those counties will be sought to identify topics of interest through focus groups and key informant interviews to be conducted by RWHAP Part A Recipient staff.

vi. Updates to Other Strategic Plans to Meet Requirements

Not applicable, the jurisdiction did not use portions of another local strategic plan to satisfy this requirement.

SECTION VII. LETTER OF CONCURRENCE