2022-2026

State of Florida

Integrated HIV Prevention and Care

Monitoring and Evaluation Plan

Contents

Introduction

Florida's Integrated HIV Prevention and Care (IPC) Plan encompasses the state's entire system of HIV prevention and care. The IPC Plan was reviewed by members of Florida's integrated HIV prevention and care planning body, FCPN, during the Fall 2022 meeting held in Lutz, Florida, October 18–19, 2022. During the two-day meeting, FCPN members and other stakeholders in attendance supplied feedback and suggestions on the draft plan. Concurrence for the plan was gained on October 19, 2022, through a vote of FCPN members. The Department of Health (Department) presented Florida's IPC Plan, which is intended to re-energize and strengthen a whole-of-society response to the epidemic while supporting PWH (persons with HIV) in Florida and reducing HIV-associated morbidity and mortality.

The Integrated HIV Prevention and Care Plan Evaluation has been created to support the 2022-2026 State of Florida Integrated HIV Prevention and Care Plan in response to Section 6 of the plan.

The current Integrated HIV Prevention and Care Plan is readily available below on the Florida Department of Health's website at the following link: https://www.floridahealth.gov/diseases-and-conditions/aids/administration/integrated-plan.html

Evaluation Goal

The goal of this evaluation plan is to check both operational performance and progress on goals, strategies, and activities in the strategic plan. These data will then be used to make program decisions and direct efforts to ensure the state achieves the intended results and to help find additional operational and process improvement opportunities.

Evaluation Team

The team primarily responsible for monitoring both operational performance and progress on goals, strategies, and activities in the strategic plan are as follows:

Table 1: Roles and Responsibilities of the Evaluation Team Members		
Individual/Agency	Role	Responsibilities
Florida Department of Health	• Ensuring that the Integrated HIV Plan's activities are aligned with goals and objectives, and that ongoing reviews lead to informed modifications for optimal outcomes. • Ensures the responsible and ethical release of data to support transparency and informed decision-making.~~TBD~~	• ~~TBD~~To ensure successful implementation of the Integrated HIV Plan (IHP), it is recommended to conduct a thorough review of the community engagement and jurisdiction planning process, data sets and assessments, situational analysis, and goals and objectives at least twice a year. Based on the findings, necessary modifications should be implemented to further improve IHP activities and optimize outcomes. • Utilize data-driven insights to determine the effectiveness of IHP activities and identify any discrepancies or gaps in implementation. • Engage with key stakeholders, including community organizations, healthcare providers, and internal teams, to gather input and insights related to the implementation processes. • Communicate assessment findings, modifications, and progress updates to relevant internal and external stakeholders • Approve the release of any data. • Ensure the accuracy and reliability of data used for assessments and reviews.
The AIDS Institute	• Contracted Partner to assist FL DOH in developing and implementing a monitoring and evaluation plan for assessing, monitoring, and evaluating 2022-2026 Integrated HIV Prevention and Care plan.	• Develop draft monitoring and evaluation plan for assessing implementation of Post-Submittal Coordination, Monitoring, and Evaluation of 2022-2026 Integrated HIV Prevention and Care plan. • Assist in implementation of

		monitoring and evaluation plan. • Assist in assessing implementation of the Post-Submittal Coordination, Monitoring, and Evaluation of 2022-2026 Integrated HIV Prevention and Care plan.
Coordination of Efforts Subcommittee of the Florida Community Planning Network (FCPN)	TBD Establish mechanisms and time frames the state will use to monitor, evaluate, and update the IPC Plan, as necessary	• TBD The Coordination of Efforts Committee for the FCPN will select the most suitable mechanism for monitoring, evaluating, and updating the plan as needed. This committee ensures that data indicators for plan activities are tracked, and progress is reported to the appropriate programs and partners to achieve plan goals. • Data on performance indicators will be collected and disseminated through a status report to statewide partners. Regular FCPN meetings are the principal mechanism for updating planning bodies and stakeholders on the plan implementation progress and soliciting and using stakeholder feedback for ongoing plan improvements.

Stakeholder Assessment

There were countless stakeholders involved with the creation of the Integrated HIV Prevention and Care Plan. Also, many stakeholders have a personal stake in the success of the plan, measured through this evaluation plan. Table 2 below outlines the various stakeholder groups, their interest or perspective, role in the evaluation plan, and additionally includes how and when to engage.

Table 2: Stakeholder Assessment and Engagement Plan

Stakeholder Category	Interest or Perspective	Role in the Evaluation	How and When to Engage
Members of the Florida Comprehensive Planning Network and associated advisory groups	• TBD Members of FCPN include PWH and representatives across the state representing patient care and prevention groups, local planning bodies, CBOs, academic institutions, local and regional clinics, city and county governments, RWHA Program recipients, the transgender community, advocacy groups, substance use and social service providers, and behavioral science groups.	TBD	TBD
Ryan White HIV/AIDS Program Partners	TBD	TBD	TBD
Florida Department of Health, County Health Department Staff	TBD	TBD	TBD
Members of the community	TBD	TBD	TBD

planning partnerships (past and present)			
Members of the local area consortia (past and present)	TBD	TBD	TBD
AIDS Service Organizations and Community-Based Organization Staff and Volunteers throughout the state	TBD	TBD	TBD
The AIDS Institute	Contracted Partner & Vested community stakeholder organization	Assist FL DOH in leading monitoring and evaluation efforts	Creation, implementation, and assessment of plan.
State Agency and Association Partners	TBD	TBD	TBD
Private Sector Partners	TBD	TBD	TBD
Florida Department of Heath | Bureau of Communicable Diseases Staff	TBD	TBD	TBD
Citizens of Florida	TBD	TBD	TBD
Federal Stakeholders	TBD	TBD	TBD

Background and Description of the HIV Prevention and Care Program

Need

The United States (U.S.) has taken on a bold plan to end the HIV epidemic by the year 2030. To reach national goals of reducing new HIV infections by 75% by 2025 and by 90% by 2030, the country must take aggressive actions by scaling up key HIV prevention and treatment strategies. The presentation of Florida's HIV Integrated Prevention and Care (IPC) Plan, 2022–2026 is the culmination of several local (rapid HIV antiretroviral start programs), state (Data to Care programs), and federal initiatives including:

- National HIV/AIDS Strategy, 2022–2025 (NHAS)
- Ending the HIV Epidemic (EHE) in the United States (2019)
- National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021–2025

These plans work in unison to achieve national goals. The 2022-2026 plan builds upon the previous work in Florida's Statewide Integrated HIV Prevention and Care Plan, 2017–2021 and Florida's Unified Ending the HIV Epidemic (EHE) Plan, 2020.

The impact of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in Florida is far reaching with 120,502 persons with HIV (PWH) living in the state as of 2021, which is only 86% of PWH—the rest of whom are unaware of their status (approximately 14%).

People in Florida should have the right to:

- Know their HIV status.
- Access Pre-Exposure Prophylaxis (PrEP) if they are negative but at risk for developing the disease.
- Receive services needed to achieve or maintain a high quality of life if they have tested positive.
- Obtain health care, free of stigma.
- Be a voice in their local communities to effect positive change.

According to the Centers for Disease Control and Prevention (CDC), in 2020 (the most recent data available), Florida was ranked third highest (15.7 per 100,000 population) for new HIV diagnosis rates in the United States (including the District of Columbia). In 2021, 4,708 persons received an HIV diagnosis in Florida, a 37% increase from the 3,441 HIV diagnoses in 2020. In 2021, 83% of those newly diagnosed were linked to HIV-related care within 30 days of

diagnosis. The number of AIDS cases diagnosed in 2012 in Florida was 2,846, and in 2021 case numbers dropped to 1,860. The current estimate of 14% of PWH in Florida not knowing their status, along with the substantial decrease in AIDS cases over a 10-year period, together underscore the importance of HIV prevention and care service delivery in Florida.

The seven Florida EHE counties make up approximately 11% of the total national HIV burden as outlined in the EHE plan and represent 72% of the total persons with an HIV diagnosis in Florida. Five of the EHE counties, Pinellas (77%), Hillsborough (71%), Orange (72%), Broward (70%), and Duval (69%) had a viral suppression rate equivalent to or greater than the state rate of 69%, while Palm Beach (65%) and Miami-Dade (63%) had lower viral suppression rates than the state at the end of 2021.

Context

Florida is a large and diverse state. It has both rural and metropolitan areas, an extensive mix of cultures, and an oscillating population due to seasonal residents, tourists, and itinerant workers. These factors can challenge the planning processes of disease control. The IPC Plan is designed to show coordinated HIV prevention and care activities by assessing resources and service delivery needs across HIV prevention and care systems to ensure the allocation of resources based on data.

Florida receives funding for and implements a wide range of programs and services for persons with and those at increased risk for HIV, including: the AIDS Drug Assistance Program (ADAP), Ryan White HIV/AIDS Program (RWHAP) patient care programs, prevention (HIV testing, PrEP, linkage), housing, substance use disorder and mental health, and other programs.

Core medical and support services are provided by the federal RWHAP to low-income Floridians living with HIV or AIDS who have inadequate or no health insurance and are ineligible for Medicaid, Medicare, or any other public insurance programs through different entities. Services such as medical care, pharmaceuticals, dental services, payment of health insurance premiums, laboratory services, counseling and treatment for substance use disorder, and medical case management are provided through the various parts of the RWHAP. Each part has separate eligibility criteria that clients must meet.

Ending HIV requires partnership and collaboration. The IPC Plan was developed through collaborative efforts that span the continuum of HIV prevention and care, and with representatives from the Florida Comprehensive Planning Network (FCPN) and associated advisory groups, local HIV planning bodies, Department of Health staff, and communities living with and affected by HIV/AIDS. The IPC Plan also aligns with the previously sent Florida EHE Plan (2020), Florida's 4 Key Component Plan (2016), and the NHAS goals and strategies.

Florida's IPC Plan encompasses the state's entire system of HIV prevention and care. The IPC Plan was reviewed with members of Florida's integrated HIV prevention and care planning body, FCPN, during the Fall 2022 meeting held in Lutz, Florida, October 18–19, 2022. During the

two-day meeting, FCPN members and other stakeholders in attendance supplied feedback and suggestions on the draft plan. Concurrence for the plan was gained on October 19, 2022, through a vote of FCPN members. Florida's IPC Plan is intended to re-energize and strengthen a whole-of-society response to the epidemic while supporting PWH in Florida and reducing HIV-associated morbidity and mortality.

Priority Populations

Priority Populations for Primary HIV Prevention.

Priority populations for primary HIV prevention are derived from the average proportion of each race and mode of exposure groups diagnosed with HIV in the last three years (2019–2021). This information is used to address those at the highest risk of acquiring HIV and with the greatest need for primary prevention services (i.e., services directed toward people who have a negative or unknown HIV status). As shown in Figure 27 of the State of Florida Integrated Prevention and Care Plan, 2022-2026, the top five priority populations are:

- Hispanic/Latino MSM (28% of new diagnoses over the past three years)
- Black heterosexuals (20%)
- Black MSM (18%)
- White MSM (15%)
- Hispanic/Latino heterosexuals (8%)

Priority Populations for Secondary Prevention.

Priority populations for secondary prevention for PWH represent the proportion of each race and mode of exposure groups to the total PWH. Secondary HIV prevention activities are directed toward people with HIV, with the intention of preventing transmission to those who are HIV negative. This information is used to prevent HIV transmission through services provided to PWH in these affected demographic groups. As shown in Figure 28 of the State of Florida Integrated Prevention and Care Plan, 2022-2026, for 2021, the top priority groups include:

- Black heterosexuals (25%)
- White MSM (22%)
- Hispanic/Latino MSM (18%)
- Black MSM (15%)
- Hispanic/Latino heterosexuals (6%)

Added efforts exist to reduce the transmission of HIV including improving viral suppression among Black males and females and among WCBA (aged 15 to 44).

There were 120,502 persons with an HIV diagnosis living in Florida through 2021 which is estimated to be only 86% of persons with HIV—the remainder of whom are unaware of their status (approximately 14%, based on the current CDC methodology used to calculate

percentage unaware). Persons living with HIV but unaware of their status also need to be prioritized and underscore the importance of implementing a status-neutral approach to HIV prevention and care. Routine screening is needed to diagnose persons with HIV who are unaware of their status and rapidly link them to care and treatment to achieve viral suppression.

More information on the Epidemiological Profile for HIV in Florida, 2021, can be found in the State of Florida Integrated Prevention and Care Plan, 2022-2026.

Goals and Objectives

In January 2021, HHS released the HIV National Strategic Plan: A Roadmap to End the Epidemic 2021–2025 which creates a collective vision for HIV service delivery across the nation. IPC Plans created for every jurisdiction address four goals:

- Prevent new HIV infections.
- Improve HIV-related health outcomes for people with HIV.
- Reduce HIV-related disparities.
- Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders.

Objectives have been named for each of the four goals and included in Table 3. The table outlines the goals and objectives for how Florida will address the strategies to diagnose, treat, prevent, and respond to HIV; the goals and objectives align with the NHAS. Actionable activities have been named to address each of the goals and objectives, along with other pertinent information to inform a plan of action.

Table 3: Goals and Objectives		
Goal	Objective	Objective Description
Goal 1 Prevent New HIV Infections	Objective 1.1	Increase awareness of HIV.
	Objective 1.2	Increase knowledge of HIV status.
	Objective 1.3	Expand and improve implementation of effective prevention Interventions.
	Objective 1.4	Increase capacity of health care delivery systems, public health, and health workforce to prevent and diagnose HIV.

Goal	Objective	Objective Description
Goal 2 Improve HIV-Related Health Outcome of PWH	Objective 2.1	Link people to care rapidly after diagnosis and provide low-barrier access to HIV treatment.
	Objective 2.2	Identify, engage, or reengage people with HIV who are not in care or not virally suppressed.
	Objective 2.3	Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.
	Objective 2.4	Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV.
	Objective 2.5	Expand capacity to provide whole-person care to older adults with HIV and long-term survivors.
	Objective 2.6	Advance the development of next-generation HIV therapies and accelerate research for HIV cure.
Goal 3 Reduce HIV-related Disparities	Objective 3.1	Reduce HIV-related stigma and discrimination.
	Objective 3.2	Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum.
	Objective 3.3	Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV.
	Objective 3.4	Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities.
	Objective 3.5	Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations.
	Objective 3.6	Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust.

Goal	Objective	Objective Description
Goal 4 Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Interested Parties	Objective 4.1	Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and institutional factors including stigma, discrimination, and violence.
	Objective 4.2	Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and CBOs, the private sector, academic partners, and the community.
	Objective 4.3	Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data.
	Objective 4.4	Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.

Program Development

The Department will continue to coordinate and collaborate with internal and external partners and stakeholders to meet the objectives of the IPC Plan. The Department's RWHAP Part B; RWHAP Part A, C, D, and F programs; PWH; and other members of the FCPN-associated committees, workgroups, and advisory groups (e.g., FL Men's Health Workgroup, Community HIV Advisory Group, Florida Black Leaders Group, CQM Committee); EHE-funded jurisdictions and directly-funded providers; HIV prevention and care providers; state and local agency administrators; and persons at increased risk for HIV will be included in each step of the IPC Plan implementation, monitoring and evaluation. Through this coordinated implementation approach, the Department and partners can explore opportunities to better leverage funding streams supporting Florida's HIV prevention, care, and treatment services (e.g., CDC and HRSA funding to state and local entities). Implementation progress of the IPC Plan will also be used to find where more resources (e.g., funding, staffing) may be needed to ensure IPC Plan objectives are met.

Focus of the Evaluation

In alignment with the goals of the IPC plan, the following are the core evaluation questions:

1. Have the strategies employed in the IPC prevented new HIV infections?
2. Have the HIV-related health outcomes for people with HIV been improved because of the strategies employed in the IPC?
3. Have HIV-related disparities been reduced because of the strategies employed in the IPC?
4. Have partners and stakeholders referenced within the IPC achieved integrated, coordinated efforts to address the HIV Epidemic?

Gathering Credible Evidence: Data Collection

Indicators

Through routine (biannual) monitoring and communication of progress in achieving the goals and objectives outlined in the IPC Plan, the state will identify areas in need of improvement and make necessary adjustments to the IPC Plan. Revisions will be made on an annual basis and items for proposed revision will be reviewed with RWHAP Part A jurisdictions, members of the FCPN and associated workgroups and advisory bodies, and other key stakeholders, voted on, and implemented. The collaborative approach—structured and arranged to interweave state and community partnerships with shared discretion and responsibilities—will help to achieve the IPC Plan objectives more effectively than each program could on its own. This approach will align, support, and advance the goals of the NHAS, the Department, as well as meet CDC and HRSA requirements, to ensure improvement in the access to and quality of HIV prevention and care services throughout Florida.

Table 4: Activities and Program Benchmark for Evaluation Questions		
Activities	Process and Outcome Indicators	Program Benchmark
Strategy 1.1.1 Develop and implement campaigns and resources to provide education about comprehensive sexual health; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.	• Number of campaigns developed • Number of publicly funded HIV tests • Number of areas engaging with law enforcement • Stigma measure to be developed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.1.2 Increase awareness of HIV among people, communities, and the health workforce in geographically disproportionately affected areas.	• Number of publicly funded HIV tests • Number of BRTA/FRTA partnerships • Number of outreach and education efforts to specific priority populations • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.1.3 Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the syndemic, such as STIs, viral hepatitis, and substance use and mental health disorders.	• Number of campaigns with integrated messaging addressing syndemics • Number of new or non-traditional partnerships established to deliver education around syndemics • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.2.1 Test all people for HIV according to the most current USPSTF recommendations and CDC guidelines.	• Number of new HIV diagnoses • Number of publicly funded HIV tests • Number of HIV self-test kits distributed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.2.2 Develop new and expand implementation of effective, evidence-based or evidence informed models for HIV testing that improve convenience and access.	• Number of new HIV diagnoses • Number of publicly funded HIV tests • Number of HIV self-test kits distributed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.2.3 Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative and immediate linkage to HIV care and treatment for those who test positive.	• Number of new HIV diagnoses • Number of publicly funded HIV tests • Number of HIV self-test kits distributed • Number of people receiving prescriptions for PrEP • Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis • Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis • Additional specific, quantifiable measures for each activity (TBD)	TBD

Activities	Process and Outcome Indicators	Program Benchmark
Strategy 1.2.4 Provide partner services to people diagnosed with HIV or other STIs and sexual or needle sharing partners.	• Number of people receiving HIV partner services interviews • Number of people receiving prescriptions for PrEP • Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis • Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.3.1 Engage people at risk for HIV in traditional public health and health care delivery systems, as well as in nontraditional community settings.	• Number of publicly funded HIV tests • Number of HIV self-test kits distributed • Number of people receiving prescriptions for PrEP • Number of primary care visits (AHCA report) • Number of FQHC visits for priority populations • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.3.2 Scale-up treatment as prevention/U=U by diagnosing all people with HIV, as early as possible and engaging them in care and treatment to achieve and maintain viral suppression.	• Number of publicly funded HIV tests • Number of people receiving prescriptions for PrEP • Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis • Percent of PWH retained in care • Percent of PWH who are virally suppressed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.3.3 Make HIV prevention, including condoms, PrEP, PEP, SSPs easier to access and support continued use.	• Number of condoms distributed statewide • Number of people receiving prescriptions for PrEP • Number of people receiving PEP • Number of operational SSPs • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.3.4 Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.	• Number of cultural humility trainings performed • Number of engagement activities with local and state civic, community and spiritual leaders • Additional specific, quantifiable measures for each activity (TBD)	TBD

Activities	Process and Outcome Indicators	Program Benchmark
Strategy 1.3.5 Support research into the development and evaluation of new HIV prevention modalities and interventions for preventing HIV transmissions in priority populations.	• Number of partnerships with HIV-related research entities • Number of HIV research sharing events and opportunities • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.3.6 Expand implementation research to successfully adapt EBIs to local environments to maximize potential for uptake and sustainability.	• Number of partnerships with HIV-related research entities • Number of HIV research sharing events and opportunities • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.4.1 Provide resources, incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible HIV testing, prevention, and supportive services especially in areas with shortages that are geographic, population, or facility based.	• Number of partnerships with HIV-related research entities • Number of HIV research sharing events and opportunities • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.4.2 Increase the diversity of the workforce of providers who deliver HIV prevention, testing, and supportive services.	• Number of partnerships with HIV-related research entities • Number of HIV research sharing events and opportunities • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.4.3 Increase inclusion of paraprofessionals and SMEs on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.	• Number of partnerships with private entities • Assessment of ART barriers conducted • Number of peer navigators or near-peers • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 1.4.4 Increase the diversity and capacity of health care delivery systems, community health, public health, and the health workforce to prevent and diagnose HIV.	• Number of academic institutions receiving education and outreach • Number of local providers, peer navigators and near-peers that reflect priority populations • Additional specific, quantifiable measures for each activity (TBD)	TBD

Activities	Process and Outcome Indicators	Program Benchmark
Strategy 2.1.1 Increase linkage to HIV medical care in 30-days of diagnosis, as early as the same day.	• Number of new HIV diagnoses • Number of PWH engaged in care through T&T • Number of PWH engaged in care through telehealth • Number of PWH linked to same-day treatment (rapid ART) • Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.1.2 Provide same-day initiation or rapid start (within 7 days) of ART for those who are able to take it.	• Number of new HIV diagnoses • Number of PWH engaged in care through T&T • Number of PWH engaged in care through telehealth • Number of PWH linked to same-day treatment (rapid ART) • Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.2.1 Expand uptake of data-to-care models using data sharing agreements, integration and use of surveillance, clinical services, pharmacy, and social/support services data to identify and engage people not in care or not virally suppressed.	• Number of new HIV diagnoses • Number of PWH linked to same-day treatment (rapid ART) • Number of PWH reengaged through D2C • Number of PWH engaged in care through telehealth • Percent of PWH retained in care • Percent of PWH who are virally suppressed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.2.2 Identify and address barriers for people who have never engaged in care or who have fallen out of care.	• Number of new HIV diagnoses • Number of PWH linked to same-day treatment (rapid ART) • Number of PWH reengaged through D2C • Number of PWH engaged in care through telehealth • Percent of PWH retained in care • Percent of PWH who are virally suppressed • Additional specific, quantifiable measures for each activity (TBD)	TBD

Activities	Process and Outcome Indicators	Program Benchmark
Strategy 2.3.1 Support the transition of health care systems, organizations, and clients to become more health literate in the provision of HIV prevention, care, and treatment services.	• Number of in-person and virtual learning opportunities for staff providing prevention, care, and treatment services • Number of plain language processes and materials developed to assist clients who are newly diagnosed or returning to care • Number of peers and near-peers providing linkage, reengagement, or retention efforts • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.3.2 Develop and implement effective, evidence based or evidence-informed interventions and supportive services that improve retention in care.	• Number of peers, near-peers, and/or CHWs providing retention support • Number of peer programs implemented • Number of provider educational opportunities around syndemics • PWH reengaged through D2C • Percent of PWH retained in care • Percent of PWH who are virally suppressed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.3.3 Develop and implement effective, evidence-based, or evidence-informed interventions such as HIV telemedicine, accessible pharmacy services, CHWs and peer navigators, and others, that improve convenience and access, facilitate adherence, and increase achievement and maintenance of viral suppression.	• Number of PWH linked to same-day treatment (rapid ART) • Number of PWH reengaged through D2C • Number of PWH engaged in care through telehealth • Number of peers, near-peers, and CHWs providing linkage and retention support • PWH reengaged through D2C • Percent of PWH retained in care • Percent of PWH who are virally suppressed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.3.4 Support ongoing clinical, behavioral, and other research to support retention in care, medication adherence and durable viral suppression.	• Number of collaborations with academic institutions engaged in HIV research • Number of updates to providers on ongoing or recruiting efforts on clinical trials • Number of FQHCs and other community health settings engaged in research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark

Strategy 2.4.1 Provide resources, value-based and other incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent and linguistically appropriate care, treatment, and supportive services especially in areas with shortages that are geographic, population, or facility based.	• Number of collaborations with academic institutions engaged in HIV research • Number of updates to providers on ongoing or recruiting efforts on clinical trials • Number of FQHCs and other community health settings engaged in research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.4.2 Increase the diversity of the workforce of providers who deliver HIV and supporting services.	• Number of collaborations with academic institutions engaged in HIV research • Number of updates to providers on ongoing or recruiting efforts on clinical trials • Number of FQHCs and other community health settings engaged in research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.4.3 Increase inclusion of paraprofessionals on teams by advancing training, certification, supervision, reimbursement, and team functioning to assist with screening/management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.	• Number of collaborations with academic institutions engaged in HIV research • Number of updates to providers on ongoing or recruiting efforts on clinical trials • Number of FQHCs and other community health settings engaged in research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.5.1 Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services.	• Number of partnerships with organizations that serve PWH aged 50+ • Assessment of barriers to care for PWH aged 50+ • Number of educational opportunities for PWH aged 50+ • Number of collaborations with service providers that specialize in services for the aging population • Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities) • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark

Strategy 2.5.2 Identify and implement best practices related to addressing psychosocial and behavioral health needs of older people with HIV and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation.	• Number of partnerships with organizations which address psychosocial and behavioral health for PWH aged 50+ and long-term survivors • Number of educational opportunities on substance use and mental health for PWH aged 50+ • Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities) • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.5.3 Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services.	• Number of partnerships with organizations which address psychosocial and behavioral health for PWH aged 50+ and long-term survivors • Number of educational opportunities on substance use and mental health for PWH aged 50+ • Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities) • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.5.4 Promote research, cross-agency collaborations, and sharing of research discoveries that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.	• Number of collaborations with service providers that specialize in services for the aging population • Number of educational opportunities on substance use and mental health for PWH aged 50+ • Number of educational opportunities provided by HIV long-term survivor groups • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.5.5 Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing people living with HIV at various life stages to support healthy aging with HIV.	• Number RWHAP programs offering geriatric case management services • Number of collaborations with service providers that specialize in services for the aging population • Number of educational opportunities on substance use and mental health for PWH aged 50+ • Number of educational opportunities provided by HIV long-term survivor groups • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark

Strategy 2.6.1 Promote research and encourage public-private partnerships to accelerate new therapies to achieve sustained viral suppression and to address drug toxicity, viral resistance, adherence, and retention in care and stigma associated with ART use.	• Number RWHAP programs offering geriatric case management services • Number of collaborations with service providers that specialize in services for the aging population • Number of collaborations with academic institutions focusing on HIV therapies and HIV cure research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 2.6.2 Increase investment in innovative basic and clinical research to inform and accelerate a research agenda to discover how to sustain viral suppression, achieve ARV-free remission, reduce, and eliminate viral reservoirs, and achieve HIV cure.	• Percent of ADAP clients using injectable ART • Number of collaborations with academic institutions focusing on HIV therapies and HIV cure research • Number of collaborations with academic institutions engaged in clinical research and ART clinical trials • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.1.1 Strengthen enforcement of civil rights laws (including language access services and disability rights), reform state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, and sexism.	• Number of educational and skills building opportunities for PWH • Stigma indicator to be developed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.1.2 Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV.	• Number of continuing education opportunities and trainings for health care professionals and front-line staff • Number of HIV stigma materials developed and/or disseminated • Stigma indicator to be developed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.1.3 Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.	• Number of outreach and education opportunities to recruit peers • Number of community and faith-based leaders engaged in trainings that address HIV stigma and misconceptions • Stigma indicator to be developed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark

Strategy 3.1.4 Ensure resources are focused on the communities and populations where the need is greatest, especially Black, Latino, and American Indian/Alaska Native and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.	• Number of new diagnoses in communities and priority populations at increased risk for HIV • Number of mobile medical units providing services to priority populations • Number of ongoing and new initiatives for priority populations • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.1.5 Create funding opportunities that specifically address social determinants of health (SDOH) as they relate to Black, Latino, and American Indian/Alaska Native and other people of color.	• Number of funding opportunities which support programs that address SDOH in Black, Hispanic and other racial/ethnic communities • Number of educational opportunities which address SDOH • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.2.1 Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.	• Number of materials developed and disseminated which highlight HIV-related disparities • Number of HIV data dashboards available • Number of educational opportunities and listening sessions for impacted communities • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.2.2 Develop new and scale up effective, evidence-based, or evidence-informed interventions to improve health outcomes among priority populations and other populations or geographic areas experiencing disparities.	• Number of collaborations with academic institutions and other partners (outside of HIV) • Number of funding opportunities which focus on improving health outcomes in priority populations • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.3.1 Create and promote public leadership opportunities for people with or at risk for HIV.	• Number of people with or at risk for HIV on planning bodies and other advisory groups • Establishment of peer navigator certification program • Number of training and mentorship opportunities for PWH to build leadership and advocacy skills • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark

Strategy 3.3.2 Work with communities to reframe HIV services and HIV-related messaging so they do not stigmatize people or behaviors.	• Number of HIV-related materials reviewed by the state's educational material review panel • Number of engagement activities conducted with priority populations and local leaders to develop HIV-related messaging • Stigma indicator to be developed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.4.1 Develop whole-person systems of care that address co-occurring conditions for people with HIV or at risk for HIV.	• Number of syphilis diagnoses in communities and priority populations at risk for STIs • Number of HCV diagnoses in communities and priority populations at increased risk for HCV, including PWID • STI, HCV, and TB co-infection rates among persons diagnosed with HIV • Number of new diagnoses in communities and priority populations at increased risk for HIV • Viral suppression percentages in communities and priority populations at increased risk for HIV • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.4.2 Adopt policies that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV.	• Number of HIV service providers offering after hours and weekend services for HIV clients • Number of training and cross-training opportunities for medical case managers, RWHAP Part B, HOPWA, and CBOs • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.4.3 Improve screening and linkage to services for people with or at risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.	• Number of educational opportunities for providers specializing in co-occurring conditions • Number of partnerships with agencies implementing routine screening and linkage services • Number of mobile units offering HIV/STI screening, treatment, and prevention services during non-traditional hours • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark

Strategy 3.4.4 Develop and implement effective, evidence-based- or evidence-informed interventions that address social determinants of health among people with or at risk for HIV including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.	• Number of mobile units providing outreach services to priority populations • Number of educational materials identified and disseminated on client rights and health literacy • Stigma indicator to be developed • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.4.5 Develop new and scale up effective, evidence-based/informed interventions to improve health outcomes and QOL for people across lifespan including youth and people over 50 w/ or at risk for HIV, and long-term survivors.	• Establishment of telehealth provider network • Number of cultural humility trainings for providers • Number of non-traditional HIV/STI testing and treatment sites • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.4.6 Develop new and scale up effective, evidence-based/informed interventions that address intersecting factors of HIV, trauma and violence, and gender especially among cis- and transgender women and gay and bisexual men.	• Number of trainings identified and disseminated on TIC • Number of training opportunities for evidence-based interventions addressing mental health • Number of training opportunities to educate the HIV, STD, hepatitis/substance use, and mental health workforce on intersecting issues • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.5.1 Promote the expansion of existing programs and initiatives designed to increase the numbers of racial/ethnic minority research and health professionals.	• Number of trainings for HBCUs around HIV prevention, care, and treatment • Number of partnerships established with HBCUs • Development of inventory of SPNS projects and opportunities for replication • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.5.2 Increase support for the implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.	• Number of organizations identified that have mentorship programs • Number of training opportunities identified for PWH to build leadership and advocacy skills • Number of professional groups and associations engaged • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark
Strategy 3.5.3	• Number of opportunities to	TBD

Encourage the implementation of effective recruitment of community partners through community-based participatory research and social networking approaches.	collaborate with the Florida Center for HIV/AIDS Research • Number of research study opportunities shared with community partners and planning bodies • Additional specific, quantifiable measures for each activity (TBD)	
Strategy 3.6.1 Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.	• Number of educational and community sharing opportunities to share information and address misinformation • Number of anti-stigma campaigns and materials developed to dispel HIV myths • Assessment of common myths and misconceptions held in and among priority populations • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.6.2 Increase diversity and cultural competence in health communication research, training, and policy.	• Number of collaborations with HBCU medical colleges and other schools of health • Number and type of training opportunities for cultural humility in health communication research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.6.3 Expand community engagement in health communication initiatives and research.	• Number and type of engagements with CBOs, social service agencies and community resource centers • Assessment of populations that may not be receiving accurate health information • Number of collaborations with academic institutions to solicit feedback on health communication initiatives and research • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 3.6.4 Include critical analysis and health communication skills in HIV programs to provide participants with the tools to seek and identify accurate health information and to advocate for themselves and their communities.	• Number and type of needs assessments conducted • Number of educational opportunities for providers, peers, and staff on health literacy identified and disseminated • Number and type of health literacy resources identified and developed for clients • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark
Strategy 3.6.5	• Number of local leaders, influencers,	TBD

Expand effective communication strategies between providers and clients to build trust, optimize collaborative decision-making, and promote success of evidence-based prevention and treatment strategies.	and gatekeepers recruited to assist with communication initiatives • Number of CHWs and peers • Number of education and training opportunities on leading with empathy, active listening, patient experience, and on TIC • Additional specific, quantifiable measures for each activity (TBD)	
Strategy 4.1.1 Integrate HIV awareness and services into outreach and services for issues that intersect with HIV such as intimate partner violence, homelessness/housing instability, STIs, viral hepatitis, and substance abuse/mental health disorders.	• Development of community of practice to share expertise and collaborate on focus areas • Number of trainings identified and disseminated related to human trafficking, domestic violence, and sexual assault • Number of partnerships with mobile providers • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.1.2 Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, and substance use and mental health disorders across programs.	• Number of reciprocal agreements established with local community partners • Number of HIV service providers using a no-wrong-door approach to screening and linkage services • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.1.3 Identify and address funding, policy, data, workforce capacity, and programmatic barriers to effectively address the syndemic.	• Number of local information sessions conducted with stakeholders to identify barriers to service delivery • Analysis of data from the state's HIV/AIDS hotline • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.1.4 Coordinate and align strategic planning efforts on HIV, STIs, viral hepatitis, substance use disorders, and mental health care across national, state, and local partners.	• Development of collaborative forum to share and learn about OD2A programs • Number of local health care facilities participating in local community health needs assessments • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.1.5 Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs.	• Number of opportunities to education state and local legislators on harm-reduction practices • Number of local planning bodies supporting or participating in opioid initiatives • Number and type of naloxone access points • Number of naloxone training courses identified and disseminated • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark
Strategy 4.2.1	• Development of interactive locator for	TBD

Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.	mobile service providers • Number of public-private partnerships established at local levels • Additional specific, quantifiable measures for each activity (TBD)	
Strategy 4.2.2 Enhance collaboration among local, state, tribal, territorial, national, and federal partners, and the community to address policy barriers that contribute to persistent HIV-related disparities and implement policies that foster improved health outcomes.	• Development of centralized information platform to collect integrated HIV planning information • Number of and type of materials developed and disseminated in three languages (i.e., English, Spanish and Haitian-Creole) • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.2.3 Coordinate across partners to quickly detect and respond to HIV outbreaks.	• Number and geographic location of HIV transmission clusters identified • Number of intersectional teams developed at local levels for outbreak response • Number of mobile units using HIV transmission cluster data to direct positioning • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.2.4 Support collaborations between CBOs, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.	• Inventory of multi-agency collaborations at local levels • Number of partnerships with non-traditional sites to provide HIV awareness, prevention, or linkage services • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.3.1 Promote the collection, electronic sharing, and use of HIV risk, prevention, and care and treatment data using interoperable data standards, including data from electronic health records, in accordance with applicable law.	• Development of centralized dashboard to share aggregate HIV-related data • Number of data sharing agreements developed with RWHAP partners • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark
Strategy 4.3.2	• Evaluation of digital resources and	TBD

Use interoperable health information technology, including application programming interfaces (APIs), clinical decision support tools, electronic health records and health IT products certified by the Office of the National Coordinator's Health IT Certification Program, and health information exchange networks, to improve HIV prevention efforts and care outcomes.	clinical decision support tools • Development of reciprocal client-informed consent and release of information • Number of local areas with electronic referral systems • Additional specific, quantifiable measures for each activity (TBD)	
Strategy 4.3.3 Encourage and support patient access to and use of their individual health information, including use of their patient-generated health information and use of consumer health technologies in a secure and privacy supportive manner.	• Development of client-centered training module around public health data collection and uses of patient information for public health • Development of reciprocal client-informed consent and release of information • Number and type of information shared around use of patient portals to facilitate client access to medical information • Assessment of information sharing methods best suited for rural communities and other areas with limited internet access • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.4.1 Adopt approaches that incentivize the scale up of effective interventions among academic centers, health departments, CBOs, allied health professionals, people with HIV and their advocates, the private sector, and other partners.	• Number and type of public-private partnerships established and maintained • Development of statewide conference on HIV • Number of non-traditional partners participating in local HIV awareness events • Number of HIV prevention and treatment sites using ARV starter packs • Additional specific, quantifiable measures for each activity (TBD)	TBD
Strategy 4.4.2 Expand opportunities and mechanisms for information sharing and peer technical assistance in and across jurisdictions to move effective interventions into practice more swiftly.	• Development of centralized information repository on best practices programs and interventions for addressing the HIV epidemic • Number and type of information sharing mechanisms used in local areas • Number of multi-agency collaboratives supporting data and information sharing • Additional specific, quantifiable measures for each activity (TBD)	TBD
Activities	Process and Outcome Indicators	Program Benchmark
Strategy 4.4.3	• Development of centralized	TBD

Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.	information repository on best practices programs and interventions for addressing the HIV epidemic • Number and type of information sharing mechanisms used in local areas • Number of multi-agency collaboratives supporting data and information sharing • Additional specific, quantifiable measures for each activity (TBD)	

Data Collection

Table 5 below provides all the data indicators included within the IPC and the sources from where they are expected to be pulled. Additionally, data indicators have been crossmatched to the relevant strategies for which they apply when the same data indicator is used to assess multiple strategies.

Table 5: Indicator Data and Strategy Crossmatch

Indicator #	Relevant Strategies	Indicator	Source(s)
1	Strategy 4.1.3	Analysis of data from the state's HIV/AIDS hotline	TBD
2	Strategy 1.4.3	Assessment of ART barriers conducted	TBD
3	Strategy 2.5.1	Assessment of barriers to care for PWH aged 50+	TBD
4	Strategy 3.6.1	Assessment of common myths and misconceptions held in and among priority populations	TBD
5	Strategy 4.3.3	Assessment of information sharing methods best suited for rural communities and other areas with limited internet access	TBD
6	Strategy 3.6.3	Assessment of populations that may not be receiving accurate health information	TBD
7	Strategy 4.3.1	Development of centralized dashboard to share aggregate HIV-related data	TBD
8	Strategy 4.2.2	Development of centralized information platform to collect integrated HIV planning information	TBD
9	Strategy 4.4.2 Strategy 4.4.3	Development of centralized information repository on best practices programs and interventions for addressing the HIV epidemic	TBD
10	Strategy 4.3.3	Development of client-centered training module around public health data collection and uses of patient information for public health	TBD
11	Strategy 4.1.4	Development of collaborative forum to share and learn about OD2A programs	TBD
12	Strategy 4.1.1	Development of community of practice to share expertise and collaborate on focus areas	TBD
13	Strategy 4.2.1	Development of interactive locator for mobile service providers	TBD
14	Strategy 3.5.1	Development of inventory of SPNS projects and opportunities for replication	TBD
15	Strategy 4.3.2 Strategy 4.3.3	Development of reciprocal client-informed consent and release of information	TBD
16	Strategy 4.4.1	Development of statewide conference on HIV	TBD
17	Strategy 3.3.1	Establishment of peer navigator certification program	TBD
18	Strategy 3.4.5	Establishment of telehealth provider network	TBD
19	Strategy 4.3.2	Evaluation of digital resources and clinical decision support tools	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
20	Strategy 4.2.4	Inventory of multi-agency collaborations at local levels	TBD
21	Strategy 4.2.3	Number and geographic location of HIV transmission clusters identified	TBD
22	Strategy 3.6.3	Number and type of engagements with CBOs, social service agencies and community resource centers	TBD
23	Strategy 3.6.4	Number and type of health literacy resources identified and developed for clients	TBD
24	Strategy 4.3.3	Number and type of information shared around use of patient portals to facilitate client access to medical information	TBD
25	Strategy 4.4.2 Strategy 4.4.3	Number and type of information sharing mechanisms used in local areas	TBD
26	Strategy 4.1.5	Number and type of naloxone access points	TBD
27	Strategy 3.6.4	Number and type of needs assessments conducted	TBD
28	Strategy 4.4.1	Number and type of public-private partnerships established and maintained	TBD
29	Strategy 3.6.2	Number and type of training opportunities for cultural humility in health communication research	TBD
30	Strategy 1.4.4	Number of academic institutions receiving education and outreach	TBD
31	Strategy 4.2.2	Number of and type of materials developed and disseminated in three languages (i.e., English, Spanish and Haitian-Creole)	TBD
32	Strategy 3.6.1	Number of anti-stigma campaigns and materials developed to dispel HIV myths	TBD
33	Strategy 1.1.1	Number of areas engaging with law enforcement	TBD
34	Strategy 1.1.2	Number of BRTA/FRTA partnerships	TBD
35	Strategy 1.1.1	Number of campaigns developed	TBD
36	Strategy 1.1.3	Number of campaigns with integrated messaging addressing syndemics	TBD
37	Strategy 3.6.5	Number of CHWs and peers	TBD
38	Strategy 3.2.2	Number of collaborations with academic institutions and other partners (outside of HIV)	TBD
39	Strategy 2.6.2	Number of collaborations with academic institutions engaged in clinical research and ART clinical trials	TBD
40	Strategy 2.3.4 Strategy 2.4.1 Strategy 2.4.2 Strategy 2.4.3	Number of collaborations with academic institutions engaged in HIV research	TBD
41	Strategy 2.6.1 Strategy 2.6.2	Number of collaborations with academic institutions focusing on HIV therapies and HIV cure research	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
42	Strategy 3.6.3	Number of collaborations with academic institutions to solicit feedback on health communication initiatives and research	TBD
43	Strategy 3.6.2	Number of collaborations with HBCU medical colleges and other schools of health	TBD
44	Strategy 2.5.1 Strategy 2.5.4 Strategy 2.5.5 Strategy 2.6.1	Number of collaborations with service providers that specialize in services for the aging population	TBD
45	Strategy 3.1.3	Number of community and faith-based leaders engaged in trainings that address HIV stigma and misconceptions	TBD
46	Strategy 1.3.3	Number of condoms distributed statewide	TBD
47	Strategy 3.1.2	Number of continuing education opportunities and trainings for health care professionals and front-line staff	TBD
48	Strategy 3.4.5	Number of cultural humility trainings for providers	TBD
49	Strategy 1.3.4	Number of cultural humility trainings performed	TBD
50	Strategy 4.3.1	Number of data sharing agreements developed with RWHAP partners	TBD
51	Strategy 3.6.5	Number of education and training opportunities on leading with empathy, active listening, patient experience, and on TIC	TBD
52	Strategy 3.6.1	Number of educational and community sharing opportunities to share information and address misinformation	TBD
53	Strategy 3.1.1	Number of educational and skills building opportunities for PWH	TBD
54	Strategy 3.4.4	Number of educational materials identified and disseminated on client rights and health literacy	TBD
55	Strategy 3.2.1	Number of educational opportunities and listening sessions for impacted communities	TBD
56	Strategy 3.4.3	Number of educational opportunities for providers specializing in co-occurring conditions	TBD
57	Strategy 3.6.4	Number of educational opportunities for providers, peers, and staff on health literacy identified and disseminated	TBD
58	Strategy 2.5.1	Number of educational opportunities for PWH aged 50+	TBD
59	Strategy 2.5.1 Strategy 2.5.2 Strategy 2.5.3	Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities)	TBD
60	Strategy 2.5.2 Strategy 2.5.3 Strategy 2.5.4 Strategy 2.5.5	Number of educational opportunities on substance use and mental health for PWH aged 50+	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
61	Strategy 2.5.4 Strategy 2.5.5	Number of educational opportunities provided by HIV long-term survivor groups	TBD
62	Strategy 3.1.5	Number of educational opportunities which address SDOH	TBD
63	Strategy 3.3.2	Number of engagement activities conducted with priority populations and local leaders to develop HIV-related messaging	TBD
64	Strategy 1.3.4	Number of engagement activities with local and state civic, community and spiritual leaders	TBD
65	Strategy 1.3.1	Number of FQHC visits for priority populations	TBD
66	Strategy 2.3.4 Strategy 2.4.1 Strategy 2.4.2 Strategy 2.4.3	Number of FQHCs and other community health settings engaged in research	TBD
67	Strategy 3.2.2	Number of funding opportunities which focus on improving health outcomes in priority populations	TBD
68	Strategy 3.1.5	Number of funding opportunities which support programs that address SDOH in Black, Hispanic and other racial/ethnic communities	TBD
69	Strategy 3.4.1	Number of HCV diagnoses in communities and priority populations at increased risk for HCV, including PWID	TBD
70	Strategy 3.2.1	Number of HIV data dashboards available	TBD
71	Strategy 4.4.1	Number of HIV prevention and treatment sites using ARV starter packs	TBD
72	Strategy 1.3.5 Strategy 1.3.6 Strategy 1.4.1 Strategy 1.4.2	Number of HIV research sharing events and opportunities	TBD
73	Strategy 1.2.1 Strategy 1.2.2 Strategy 1.2.3	Number of HIV self-test kits distributed	TBD
74	Strategy 1.3.1	Number of HIV self-test kits distributed	TBD
75	Strategy 3.4.2	Number of HIV service providers offering after hours and weekend services for HIV clients	TBD
76	Strategy 4.1.2	Number of HIV service providers using a no-wrong-door approach to screening and linkage services	TBD
77	Strategy 3.1.2	Number of HIV stigma materials developed and/or disseminated	TBD
78	Strategy 3.3.2	Number of HIV-related materials reviewed by the state's educational material review panel	TBD
79	Strategy 2.3.1	Number of in-person and virtual learning opportunities for staff providing prevention, care, and treatment services	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
80	Strategy 4.2.3	Number of intersectional teams developed at local levels for outbreak response	TBD
81	Strategy 4.3.2	Number of local areas with electronic referral systems	TBD
82	Strategy 4.1.4	Number of local health care facilities participating in local community health needs assessments	TBD
83	Strategy 4.1.3	Number of local information sessions conducted with stakeholders to identify barriers to service delivery	TBD
84	Strategy 3.6.5	Number of local leaders, influencers, and gatekeepers recruited to assist with communication initiatives	TBD
85	Strategy 4.1.5	Number of local planning bodies supporting or participating in opioid initiatives	TBD
86	Strategy 1.4.4	Number of local providers, peer navigators and near-peers that reflect priority populations	TBD
87	Strategy 3.2.1	Number of materials developed and disseminated which highlight HIV-related disparities	TBD
88	Strategy 3.1.4	Number of mobile medical units providing services to priority populations	TBD
89	Strategy 3.4.3	Number of mobile units offering HIV/STI screening, treatment, and prevention services during non-traditional hours	TBD
90	Strategy 3.4.4	Number of mobile units providing outreach services to priority populations	TBD
91	Strategy 4.2.3	Number of mobile units using HIV transmission cluster data to direct positioning	TBD
92	Strategy 4.4.2 Strategy 4.4.3	Number of multi-agency collaboratives supporting data and information sharing	TBD
93	Strategy 4.1.5	Number of naloxone training courses identified and disseminated	TBD
94	Strategy 3.1.4 Strategy 3.4.1	Number of new diagnoses in communities and priority populations at increased risk for HIV	TBD
95	Strategy 1.2.1 Strategy 1.2.2 Strategy 1.2.3 Strategy 2.1.1 Strategy 2.1.2 Strategy 2.2.1 Strategy 2.2.2	Number of new HIV diagnoses	TBD
96	Strategy 1.1.3	Number of new or non-traditional partnerships established to deliver education around syndemics	TBD
97	Strategy 3.4.5	Number of non-traditional HIV/STI testing and treatment sites	TBD
98	Strategy 4.4.1	Number of non-traditional partners participating in local HIV awareness events	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
99	Strategy 3.1.4	Number of ongoing and new initiatives for priority populations	TBD
100	Strategy 1.3.3	Number of operational SSPs	TBD
101	Strategy 3.5.3	Number of opportunities to collaborate with the Florida Center for HIV/AIDS Research	TBD
102	Strategy 4.1.5	Number of opportunities to education state and local legislators on harm-reduction practices	TBD
103	Strategy 3.5.2	Number of organizations identified that have mentorship programs	TBD
104	Strategy 1.1.2	Number of outreach and education efforts to specific priority populations	TBD
105	Strategy 3.1.3	Number of outreach and education opportunities to recruit peers	TBD
106	Strategy 3.5.1	Number of partnerships established with HBCUs	TBD
107	Strategy 3.4.3	Number of partnerships with agencies implementing routine screening and linkage services	TBD
108	Strategy 1.3.5 Strategy 1.3.6 Strategy 1.4.1 Strategy 1.4.2	Number of partnerships with HIV-related research entities	TBD
109	Strategy 4.1.1	Number of partnerships with mobile providers	TBD
110	Strategy 4.2.4	Number of partnerships with non-traditional sites to provide HIV awareness, prevention, or linkage services	TBD
111	Strategy 2.5.1	Number of partnerships with organizations that serve PWH aged 50+	TBD
112	Strategy 2.5.2 Strategy 2.5.3	Number of partnerships with organizations which address psychosocial and behavioral health for PWH aged 50+ and long-term survivors	TBD
113	Strategy 1.4.3	Number of partnerships with private entities	TBD
114	Strategy 1.4.3	Number of peer navigators or near-peers	TBD
115	Strategy 2.3.2	Number of peer programs implemented	TBD
116	Strategy 2.3.1	Number of peers and near-peers providing linkage, reengagement, or retention efforts	TBD
117	Strategy 2.3.3	Number of peers, near-peers, and CHWs providing linkage and retention support	TBD
118	Strategy 2.3.2	Number of peers, near-peers, and/or CHWs providing retention support	TBD
119	Strategy 1.2.4	Number of people receiving HIV partner services interviews	TBD
120	Strategy 1.3.3	Number of people receiving PEP	TBD
121	Strategy 1.2.3 Strategy 1.2.4 Strategy 1.3.1 Strategy 1.3.2 Strategy 1.3.3	Number of people receiving prescriptions for PrEP	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
122	Strategy 3.3.1	Number of people with or at risk for HIV on planning bodies and other advisory groups	TBD
123	Strategy 2.3.1	Number of plain language processes and materials developed to assist clients who are newly diagnosed or returning to care	TBD
124	Strategy 1.3.1	Number of primary care visits (AHCA report)	TBD
125	Strategy 3.5.2	Number of professional groups and associations engaged	TBD
126	Strategy 2.3.2	Number of provider educational opportunities around syndemics	TBD
127	Strategy 1.1.1 Strategy 1.1.2 Strategy 1.2.1 Strategy 1.2.2 Strategy 1.2.3 Strategy 1.3.1 Strategy 1.3.2	Number of publicly funded HIV tests	TBD
128	Strategy 4.2.1	Number of public-private partnerships established at local levels	TBD
129	Strategy 2.1.1 Strategy 2.1.2	Number of PWH engaged in care through T&T	TBD
130	Strategy 2.1.1 Strategy 2.1.2 Strategy 2.2.1 Strategy 2.2.2 Strategy 2.3.3	Number of PWH engaged in care through telehealth	TBD
131	Strategy 2.1.1 Strategy 2.1.2 Strategy 2.2.1 Strategy 2.2.2 Strategy 2.3.3	Number of PWH linked to same-day treatment (rapid ART)	TBD
132	Strategy 2.2.1 Strategy 2.2.2 Strategy 2.3.3	Number of PWH reengaged through D2C	TBD
133	Strategy 4.1.2	Number of reciprocal agreements established with local community partners	TBD
134	Strategy 3.5.3	Number of research study opportunities shared with community partners and planning bodies	TBD
135	Strategy 3.4.1	Number of syphilis diagnoses in communities and priority populations at risk for STIs	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
136	Strategy 3.4.2	Number of training and cross-training opportunities for medical case managers, RWHAP Part B, HOPWA, and CBOs	TBD
137	Strategy 3.3.1	Number of training and mentorship opportunities for PWH to build leadership and advocacy skills	TBD
138	Strategy 3.4.6	Number of training opportunities for evidence-based interventions addressing mental health	TBD
139	Strategy 3.5.2	Number of training opportunities identified for PWH to build leadership and advocacy skills	TBD
140	Strategy 3.4.6	Number of training opportunities to educate the HIV, STD, hepatitis/substance use, and mental health workforce on intersecting issues	TBD
141	Strategy 3.5.1	Number of trainings for HBCUs around HIV prevention, care, and treatment	TBD
142	Strategy 3.4.6	Number of trainings identified and disseminated on TIC	TBD
143	Strategy 4.1.1	Number of trainings identified and disseminated related to human trafficking, domestic violence, and sexual assault	TBD
144	Strategy 2.3.4 Strategy 2.4.1 Strategy 2.4.2 Strategy 2.4.3	Number of updates to providers on ongoing or recruiting efforts on clinical trials	TBD
145	Strategy 2.5.5 Strategy 2.6.1	Number RWHAP programs offering geriatric case management services	TBD
146	Strategy 2.6.2	Percent of ADAP clients using injectable ART	TBD
147	Strategy 1.2.3 Strategy 1.2.4 Strategy 2.1.1	Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis	TBD
148	Strategy 1.2.3 Strategy 1.2.4 Strategy 1.3.2 Strategy 2.1.2	Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis	TBD
149	Strategy 1.3.2 Strategy 2.2.1 Strategy 2.2.2 Strategy 2.3.2 Strategy 2.3.3	Percent of PWH retained in care	TBD
150	Strategy 1.3.2 Strategy 2.2.1 Strategy 2.2.2 Strategy 2.3.2 Strategy 2.3.3	Percent of PWH who are virally suppressed	TBD

Indicator #	Relevant Strategies	Indicator	Source(s)
151	Strategy 2.3.2 Strategy 2.3.3	PWH reengaged through D2C	TBD
152	Strategy 3.4.1	STI, HCV, and TB co-infection rates among persons diagnosed with HIV	TBD
153	Strategy 3.1.1 Strategy 3.1.2 Strategy 3.1.3 Strategy 3.3.2 Strategy 3.4.4	Stigma indicator to be developed	TBD
154	Strategy 1.1.1	Stigma measure to be developed	TBD
155	Strategy 3.4.1	Viral suppression percentages in communities and priority populations at increased risk for HIV	TBD

The following strategies are expected to have added specific, quantifiable measures to be developed for each activity:

Strategy 1.1.2	Strategy 2.2.1	Strategy 3.1.3	Strategy 3.6.3
Strategy 1.1.3	Strategy 2.2.2	Strategy 3.1.4	Strategy 3.6.4
Strategy 1.2.1	Strategy 2.3.1	Strategy 3.1.5	Strategy 3.6.5
Strategy 1.2.2	Strategy 2.3.2	Strategy 3.2.1	Strategy 4.1.1
Strategy 1.2.3	Strategy 2.3.3	Strategy 3.2.2	Strategy 4.1.2
Strategy 1.2.4	Strategy 2.3.4	Strategy 3.3.1	Strategy 4.1.3
Strategy 1.3.1	Strategy 2.4.1	Strategy 3.3.2	Strategy 4.1.4
Strategy 1.3.2	Strategy 2.4.2	Strategy 3.4.1	Strategy 4.1.5
Strategy 1.3.3	Strategy 2.4.3	Strategy 3.4.2	Strategy 4.2.1
Strategy 1.3.4	Strategy 2.5.1	Strategy 3.4.3	Strategy 4.2.2
Strategy 1.3.5	Strategy 2.5.2	Strategy 3.4.4	Strategy 4.2.3
Strategy 1.3.6	Strategy 2.5.3	Strategy 3.4.5	Strategy 4.2.4
Strategy 1.4.1	Strategy 2.5.4	Strategy 3.4.6	Strategy 4.3.1
Strategy 1.4.2	Strategy 2.5.5	Strategy 3.5.1	Strategy 4.3.2
Strategy 1.4.3	Strategy 2.6.1	Strategy 3.5.2	Strategy 4.3.3
Strategy 1.4.4	Strategy 2.6.2	Strategy 3.5.3	Strategy 4.4.1
Strategy 2.1.1	Strategy 3.1.1	Strategy 3.6.1	Strategy 4.4.2
Strategy 2.1.2	Strategy 3.1.2	Strategy 3.6.2	Strategy 4.4.3

Plan Timeline

Monitoring and evaluation activities will occur throughout the year on an ongoing basis. Activities include entry of data into centralized data entry system, generating relevant reports to assess progress, update progress status in IPPC plan, and then to prepare and report om progress of plan, including highlighting any areas of strengths or areas requiring improvement.

Table 6: Illustrative Timeline for Evaluation Activities

Evaluation Activities	Timing of Activities for each year, 2022 - 2026			
Quarters	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Months	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Data Entry	X	X	X	X
Reports Generated	X	X	X	X
Reports Assessed	X	X	X	X
Progress updated	X	X	X	X
Status Report Prepared		X		X
Report disseminated		X		X
Ad hoc activities, as needed	X	X	X	X

Justifying Conclusions: Analysis and Interpretation

Analysis

Meaningful measures and indicators will be used to monitor both operational performance and progress on objectives, strategies, and activities in the strategic plan. Data are used to make program decisions and direct efforts to ensure the state achieves the intended results and to help identify additional operational and process improvement opportunities.

The IPC Plan will receive a detailed annual review by HIV/AIDS Section leadership after Florida's legislative session and the Department's budget planning process. As part of the annual review, the section will use surveillance and program data to assess health outcomes along the HIV Care Continuum which impacts the quality of the HIV service delivery system. This will allow for adjustments in response to changing conditions, and information from the review will be provided for input and feedback to the FCPN.

Strategic planning, the process generating the statewide IPC Plan, helps focus resources on vital objectives chosen to move the Patient Care and Prevention programs toward fulfillment of the NHAS goals. The IPC Plan identifies key objectives that Florida will pursue in the next five years, along with strategies and activities that will guide and facilitate the necessary actions required to achieve the desired outcomes. Plan objectives each have a corresponding measure for ongoing monitoring. Using meaningful measures and data indicators will ensure Department HIV/AIDS Section leadership, RWHAP Part A partners and the FCPN planning body members are able to manage and track efforts toward the intended results, while identifying improvement opportunities over the course of the five-year period.

Table 7: Analysis Plan

Data Analysis Technique	Responsible Person
Monitoring and Evaluation of IPC Plan	The AIDS Institute
Care Continuum Data Chart	FL DOH

Interpretation

Evaluation ensures the strategies and activities are making changes that positively affect outcomes of the IPC Plan objectives. Evaluation that focuses on project outputs, provides accountability for public resources relating to specific actions. It establishes the empirical basis needed for the ongoing cycle of collaborative planning and the actions that need to be accomplished. The evaluation component is an extension of the integrated Plan, Do, Study, Act cycle which is a continuous process. The IPC Plan must be flexible to allow for adjustments as there are changes to external or internal conditions; yet a meaningful evaluation must be integrated in the planning process and include a review and analysis of the intended outcome. The HIV/AIDS Section, with the engagement of stakeholders, will review the strategic plan using meaningful performance measures and indicators to analyze, assess and evaluate outcomes

and determine whether modifications to the IPC Plan are necessary. Through participatory evaluation and diverse range of perspectives, knowledge, values, needs, and abilities of stakeholders will be applied to the planning and evaluation process.

Ensuring Use and Sharing Lessons Learned: Report and Dissemination

Dissemination

Summarized annual data are uploaded to the Department's HIV/AIDS Section web page (http://floridaaids.org/) and are also available on an internal SharePoint site for internal use at the state and CHD level. Annual data releases include a comprehensive epidemiological profile for the state and for each partnership area, a state slide set presented annually to FCPN and RWHAP partners, and other annual data products. The epidemiological (epi) profiles are an expanded Excel workbook with multiple tabs containing 5-year trend analyses of HIV (demographics, diagnosis, AIDS, deaths, and continuum of care), STIs, HBV, HCV, and TB. Various factsheets are generated to portray epidemiology and disease highlights for a demographic population. These fact sheets highlight summary data for priority population groups and are updated annually, shared with community stakeholders, and uploaded to the Department's external web and internal SharePoint sites. Integrated slide sets and epidemiological profile tables are generated to support stakeholder engagement and planning. The Department's HIV/AIDS Section has generated compressive slides sets and epi profiles specifically for each of the 14 partnership areas each year since the 1990s. These slide sets and epi profiles are shared with the RWHAP Part A entities, community stakeholders, field surveillance staff, and others who may request these data. These data are frequently used as tools for program planning and evaluation.

Data Sharing and Use

De-identified HIV, viral hepatitis, STD, and TB data are routinely shared via ad-hoc requests to surveillance programs with outside entities including, but not limited to, academic institutions, community partners, RWHAP Parts, internal agency partners and collaborators, and the public.

Each of these programs provide annual data which are uploaded into FLHealth CHARTS (https://www.flhealthcharts.gov/charts/CommunicableDiseases/default.aspx). In addition, FL Health CHARTS is updating the FLHealth CHARTS website (a web-based platform that provides easy access to health indicator data at the community and statewide level for the state of Florida from a multitude of sources) with a new dashboard (at the county level) that will incorporate a multitude of HIV/AIDS indicators including, but not limited to, demographic and socio-economic indicators, partner services data, testing and treatment facilities, PrEP, and other data not previously included on FL Health CHARTS. By ensuring all these data and information are made readily accessible and user friendly, the new dashboard will help local and state planning bodies develop more effective and efficient programs and corresponding activities and monitor progress of IPC strategies and activities.

Along with HIV data, the Department also summarizes data from MMP and NHBS surveillance along with the Department's PrEP, Test and Treat, and HIV counseling and testing data. Data from the needs assessments are also shared in reports sent out to FCPN membership.

Table 8: Dissemination Plan		
Yes ✓	Dissemination Medium	Organization/Person Responsible
	Department's HIV/AIDS Section web page	FL DOH | HIV Section
	FCPN and related listservs	The AIDS Institute

Use

The goal of the monitoring and evaluation plan is to assess successful implementation of the unified IPC Plan as measured by:

- Completion of stated strategies and activities.
- Annual progress toward the target measurements of stated goals, objectives, and benchmarks.

Data are used to direct efforts to ensure the program achieves the intended results and to help identify additional operational and process improvement opportunities.

Through biannual meetings and monthly committee calls, the Department's HIV/AIDS Section and the FCPN will actively participate in regular monitoring of strategies and activities set forth in the unified IPC Plan. The Department, in collaboration with the FCPN Coordination of Efforts Committee, will establish mechanisms and times the state will use to monitor, evaluate, and update the IPC Plan, as necessary. This committee leads efforts to ensure data indicators for plan activities are being tracked and that progress is communicated with appropriate programs and partners to meet plan objectives. Data on performance indicators will be collected and disseminated through a status report to statewide partners. Local planning body feedback will also be collected and shared by FCPN representatives for each respective area. The Department currently uses an electronic dashboard tool to collect EHE-related activity information and consideration is being given to using this tool to collect activity-related information for the IPC Plan. Regular FCPN meetings are the principal mechanism for updating planning bodies and stakeholders on the progress of plan implementation as well as soliciting and using feedback from stakeholders for ongoing plan improvements. A standing agenda item to review IPC activity progress will be added to the state's FCPN meetings. After each FCPN meeting, a summary report is provided to all attendees and shared with community partners; this mechanism will be used to share information on the IPC Plan's progress toward completing activities and achieving objectives.

The IPC Plan will receive a detailed annual review by the Department HIV/AIDS Section leadership. As part of the annual review, the section will use surveillance and program data to assess health outcomes along the HIV Care Continuum that impact the quality of the HIV service delivery system. This will allow for adjustments to be made in response to changing conditions, and information from the review will be provided to FCPN for feedback.

The Department's HIV/AIDS Section, with the engagement of stakeholders, will review the strategic plan using identified measures and indicators to analyze, assess, and evaluate outcomes and determine whether modifications to the IPC Plan are necessary. The diverse range of perspectives—knowledge, values, needs, and abilities—of stakeholders will be applied through a participatory planning and evaluation process. The collaborative approach, structured and arranged to interweave state and local community partnerships with shared discretion and responsibilities, will help to achieve the IPC Plan objectives more effectively than each program could on its own. This approach will align with, support, and advance the goals of the IPC initiative, the NHAS, and the Department, as well as meet CDC and HRSA requirements.

As the state of Florida moves forward in ending the epidemic, regularly scheduled events to inform all stakeholders and researchers of relevant data and evidence for improving or, more precisely, monitoring and evaluating the implementation and impact of the IPC Plan is essential. These opportunities will ensure that plan implementers are working with the best available evidence to work toward ending the epidemic.