Puerto Rico Enhanced Comprehensive HIV Prevention

San Juan-Caguas-Guaynabo Metropolitan Statistical Area

Revised as of April 14th, 2011

Estudios Técnicos Inc.

DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO

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EXECUTIVE SUMMARY

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BACKGROUND

During the past months, the Puerto Rico Department of Health (PRDOH) has been engaged in the preparation of an Enhanced Comprehensive HIV Prevention Plan (ECHPP) for the San Juan -

Caguas-Guaynabo Metropolitan Statistical Area (SJMSA). This is a demo project[1] created by the Centers for Disease Control and Prevention (CDC) that provides funds to facilitate the development and implementation of such plans in the twelve Metropolitan Statistical Areas most affected by the HIV epidemic. It responds to the goals of the National HIV/AIDS Strategy of: 1) reducing the number of people infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

The Project is organized in two phases. This document presents the most significant findings of the first two steps of the first phase: a Situational Analysis, and the process of Goals and Objectives Setting.

The PRECHPP is the result of an intensive planning process, which involved the participation of over fifty (50) stakeholders from the public sector, the private sector (particularly CBOs) and the affected community. Decisions regarding strategies and objectives were based on the results of the situational analysis. Interventions were prioritized using a participatory deliberation model based on three main criteria: Timing, Balanced Inclusion of Prevention and Treatment Interventions and Feasibility (Resources & Previous Experience). A total of sixteen (16) interventions were addressed in the analysis and the Plan: fourteen (14) required interventions and two (2) recommended interventions.

SITUATIONAL ANALYSIS

Puerto Rico, like many other jurisdictions in the United States, has been greatly affected by HIV/AIDS/STD/TB infections. As of 2009, the HIV/AIDS Surveillance System indicates that a total of 33,277 cumulative cases of AIDS have been diagnosed and reported since the first individuals were diagnosed in the early 1980's[2]. As of February of 2011, a total of 14,271 cases of HIV/AIDS have been diagnosed in the SJ- SJMSA. The SJMSA comprises forty one (41) municipalities and has the highest HIV/AIDS incidence, prevalence and mortality rates in Puerto Rico.

[1] Funding Opportunity Number: CDC-RFA-PS10-10181, authorized under Sections 317(k)(2) and 318 of the Public Health Service Act (42 U.S.C. Sections 247b(k)(2) and 247c), as amended, and Section 4002 of the Patient Protection and Affordable Care Act (PL 111-148).

[2] http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table20.pdf.

Data as of 2009, shows - as would be expected - that the overwhelming majority of people diagnosed with HIV/AIDS in the SJ-Caguas-Guaynabo MSA are Hispanic, with only a few exceptions that make up less than 1% of the number of cases. Hispanics, including Puerto Ricans, comprise a significant fraction of the total number of HIV/AIDS diagnoses in the United States, representing 17% of the cumulative number of cases[3], trailing African Americans and Caucasians.

The main transmission category for adult males in the SJMSA was injection drug use, followed by male-to-male sexual contact (42% and 27% of male cases, respectively); with 6% of overlap between the two categories. This trend differs from that exhibited in the United States in general, where 60% of AIDS diagnoses in adult males resulted from male-to-male sexual contact and 21% from injection drug use; with 9% resulting from both male-to-male contact and injection drug use[4].

Nineteen percent (19%) of males diagnosed with HIV/AIDS contracted the disease through heterosexual contact, compared to 8% nationally. For women in the San Juan-Caguas-Guaynabo MSA, heterosexual contact, followed by injection drug use were the two main methods of transmission (67% and 26% of female cases, respectively). This follows the national transmission trend for HIV/AIDS cases of female adults or adolescents.

The Puerto Rico Department of Health (PRDOH) is the agency responsible for the epidemiological control of HIV and for developing and implementing public policy regarding this subject[5].

Other governmental, federal, state, and municipal entities that provide direct and preventive epidemiology-related services collaborate with the PRDOH. Similarly, a network of nonprofit and community based organizations (CBOs) that also provide these services has emerged throughout the years. The number of entities that provide social services in different areas of need[6] in the Island is estimated to surpass 6,000, the majority of which are located in the SJMSA[7].

[3] http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table2a.pdf.
[4] 2009 CDC estimates for cumulative HIV/AIDS diagnoses http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table2a.pdf)
[5] Puerto Rico Department of Health (2008), OCASET, Transition Report.
[6] These services include, in general, services related to education, health, and community development, among others.
[7] Estudios Técnicos, Inc. (2007). Study on nonprofit organizations. Retrieved from the Web at www.estudiostecnicos.com.

In the PRDOH, the "Secretariat of Family Health and Integrated Services and Health Promotion", houses the clinical health programs that comprise the preventive strategy to improve special communities and populations.

Prevalence and epidemiologic data for Puerto Rico, as well as other sources of information fully support the need to focus the interventions that will be implemented as part of the PRECHPP on UDIs and MSMs, along with other special subgroups, such as women at high risk. Likewise, available data points out to the need of strengthening areas such as:

- Testing in clinical and non-clinical settings;
- Education and knowledge (of the community as well as service providers);
- Condom distribution; and
- Communication and alliances among agencies and service providers to facilitate linkage to care.

Also, an examination of the current institutional and regulatory framework reveals the importance of working with public policy changes that would help make viable the proposed strategies.

INTERVENTIONS:	PLANS FOR IMPLEMENTATION		
	Begin	Scale-Up	Continue
Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"		●	
Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"		●	
Required Intervention #3: "Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection"		●	
Required Intervention #4: "Provision of Post-Exposure Prophylaxis to populations at greatest risk"			●
Required Intervention #5: "Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment"	●		
Required Intervention #6: "Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care"	●		
Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"			●
Required Intervention #8: "Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons"			●
Required Intervention #9: "Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons"		●	
Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"			●
Required Intervention #11: "Implement prevention of perinatal transmission for HIV-positive persons"			●
Required Intervention #12: "Implement ongoing partner services for HIV-positive persons"		●	
Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"		●	
Required Intervention #14: "Implement linkage to other medical and social services for HIV-positive persons"		●	
Recommended Intervention # 15: "Condom distribution for the general population"		●	
Recommended Intervention #16: "HIV and sexual health communication or social marketing campaigns targeted to relevant audiences"	●		

THE PLAN

The portfolio of interventions that will be implemented in Puerto Rico is aligned with the goals of (1)Reducing the number of people with HIV infection; (2)increasing access to care for HIV+ people; Improve health outcomes for HIV+ people; and (3)Reducing HIV related health disparities. Interventions proposed and their corresponding goals include the following.

Goals, Objectives and Strategies
Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"
Goal 1: Increase the number of persons who get tested for HIV through the Opt-out methodology in a clinical context.
Strategy 1: Promote and educate persons using health care facilities on the importance of routine, opt-out screening for HIV.
Objetive 1.1: Hire at least one trained HIV Health Educator that will offer orientation to persons utilizing different health care facilities highlighting the importance of routine, opt-out screening for HIV.
Objetive 1.2: the Health Educator will conduct visits to at least 20 health care facilities in the SJMSA.
Strategy 2: Negotiate with health insurance providers to cover the cost of HIV screening and confirmation test.
Objective 2.1: A meeting will be arranged with the state Medicaid Health System and the *Administración de Servicios de Salud de PR* (ASES) to negotiate coverage of at least one annual rapid HIV test per person.
Objective 2.2: OCASET will coordinate a meeting with the Private Insurance Commissioner to negotiate coverage of at least one annual HIV test per person by private insurance companies.
Strategy 3: Diversify the scenarios in which opt-out tests are provided in clinical settings.
Objective 3:1 Conduct rapid HIV testing on at least 60% of the persons who use emergency rooms in the Diagnostic and Treatment Centers located in 3 high incidence areas (Cataño, Loiza and Canóvanas) in the SJMSA.
Objective 3.2: The Correctional Health System will provide HIV tests to at least 75% of inmates who receive clinical services in their institutions.
Goal 2: Increase the number of providers that offer HIV testing through the Opt-out methodology in a clinical context
Strategy 1: Conduct a survey to identify the type of health providers that do not offer HIV testing in their clinics in the SJMSA
Objetive 1.1: ECHPP team will use the data obtained from the survey to identify the profile of health care providers that do not offer HIV testing in their clinics, to be able to design specific strategies targeted to these groups.
Objetive 1.2: hire at least one trained HIV Health Educator that will offer presentations highlighting the importance of routine opt-out screening for HIV in annual medical conferences.
Strategy 2: Establish alliances with medical organizations to promote opt-out testing among health providers.
Objective 2.1: By June 2012, The ECHPP PI and or Coordinator will have met with medical organizations' chairs to establish collaborative agreements on promoting routine opt-out screening for HIV among their members.
Strategy 3: Provide rapid HIV tests in emergency rooms.
Objective 3.1: By January 2012, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms located in Bayamón, Carolina and San Juan Hospitals.
Objective 3.2: By January 2013, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms in CDTs located in Cataño, Canóvanas and Loíza.
Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"
Goal 1: Increase the number of persons who get tested for HIV in non-clinical settings.
Strategy 1: Identify CBOs that provide support services to high risk groups (MSM, IDU, HRH) in high incidence areas of the SJMSA.
Objective 1.1 By June 2011, create an inventory of CBOs by high risk groups in high incidence areas of the SJMSA.
Strategy 2: Promote collaboration among the CBOs that provide support services to high risk groups in high incidence areas of the SJMSA to establish a referral system to maximize HIV testing opportunities and ensure greater access.
Objetivo 2.1 By January 2013, establish collaborative agreements between CBOs so they can refer persons to others CBOs that provide HIV testing in non-clinical settings.
Strategy 3: Evaluate the implementation of a web based recruitment and referral system between CBOs and PRDOH (no partner services).
Objective 3.1: By June 2012, provide web access for at least two PRDOH HIV Prevention Outreach Technicians so they can recruit high-risk persons via web to provide them with referrals for HIV testing sites.
Goal 2: INCREASE THE NUMBER OF OUTREACH ACTIVITIES WHERE TESTING IS CONDUCTED
Strategy 1: Increase the number of community based organizations that administer HIV tests in the SJMSA.
Objective 1:1 By January 2013 assure that 50% of the organizations that provide preventive services, offer testing.
Strategy 2: Identify new funding sources for these organizations.
Objective 2:1 By January 2013, coordinate at least two meetings with legislators who deal with health-related issues to identify new sources of funding to be used for HIV testing services.

Required Intervention #3: "Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection"
Goal 1: Implement condom distribution in clinical facilities that provide services to HIV positive persons.
Strategy 1: Create a survey to identify the clinical facilities that provide services to persons living with HIV in the SJMSA.
Objective 1.1 By June 2011, based on the data obtained from the survey, create an inventory of clinical facilities where condoms can be distributed.
Objective 1.2: By August 2011, establish liaisons with the identified clinical facilities to promote condom distribution to persons living with HIV.
Strategy 2: Develop an evaluation plan to measure condom distribution and usage in organizations that receive condoms for persons with HIV and those at high-risk.
Objective 2.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.
Goal 2: Increase condom distribution in CBO's not funded by the PRDOH that provide services to high risk groups in high incidence areas in the SJMSA.
Strategy 1: Identify municipalities with the highest HIV incidence rates in the SJMSA
Objective 1.1: By June 2011, the Puerto Rico Surveillance Program will provide incidence data by municipalities and risk groups in the SJMSA.
Strategy 2: Identify the CBOs that provides services to populations at high risk within the municipalities with the highest rates of HIV in the SJMSA
Objective2.1: By July 2011, create an inventory of CBOs that provide services in municipalities with the highest risk incidence.
Strategy 3: Establish collaborative agreements with these CBOs not funded by the PRDOH for condom distribution.
Objetive 3.1: By December 2011, establish at least five collaborative agreements to provide condoms to CBOs that provide services in municipalities with the highest risk incidence.
Strategy 4: Develop an evaluation plan to measure condom distribution and usage in CBOs not funded by the PRDOH.
Objective 4.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.
Required Intervention #4: "Provision of Post-Exposure Prophylaxis to populations at greatest risk"
Goal 1: Decrease the probability of acquiring HIV in a risky event, by the provision of Post-Exposure Prophylaxis.
Strategy 1: Update post-exposure protocol in cases of physical/sexual abuse or occupational/non-occupational accidents.
Objective 1.1: By June 2011, the PRDOH will update and standardize post-exposure protocols.
Strategy 2: Standardize post-exposure procedures in case of physical/sexual abuse or occupational/non-occupational accidents.
Objective 2.1: By June 2011, the PRDOH will ensure that 100% of accredited continuing health education programs; will provide health professionals with the topic of post HIV exposure protocol as part of the "Exposure to Blood Pathogens" course.
Strategy 3: Disseminate and implement post-exposure protocols in cases of physical/sexual abuse or occupational/non-occupational accidents.
Objective 3.1: By December 2011, the PRDOH will implement and disseminate post-exposure protocols in the areas contained in the MSA.
Required Intervention #5: "Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment"
Goal 1: Identify and conduct activities to change those structures, rules, and regulations which may constitute barriers to the creation of an optimal environment for the prevention, care, and treatment of HIV.
Strategy 1: Amend regulations of the College of Medical Technologists so that any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical setting can do so.
Objective 1.1: By December 2011, the Secretary of the PRDOH will sign an administrative order to amend the College of Medical Technologists' rules and regulations, enabling any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical settings.
Strategy 2: Provide education to physicians on comprehensive HIV disease treatment and care.
Objective 2.1: By December 2012, the PRDOH will collaborate with the AIDS Education and Training Center (AETC) to provide updated training in the treatment and management of the HIV disease to members of the HIV-Care Providers Association and the Physician and Surgeons College in Puerto Rico in their annual conferences.

Strategy 3: Establish an HIV disease care protocol for physicians in the SJMSA that includes integral medical services required for persons with HIV.
Objective 3.1: By June 2011, the PRDOH will distribute the protocol for the management of care of HIV patients to 100% of clinics and physicians working with HIV patients in the SJMSA.
Strategy 4: Create a network of specialized physicians to provide services to persons with HIV.
Objective 4.1: By March 2012, PRECHPP will compile a directory of physicians with different specialties related to persons living with HIV.
Objective 4.2: By December 2012, OCASET and the AETC will offer basic HIV disease care training to other medical specialists to broaden the HIV care providers network.
Strategy 5: Issue an administrative order to recommend HIV testing as part of routine medical care.
Objective 5.1: By March 2012, the *Coalición Alcance Juvenil* will begin a process to propose legislation to include HIV testing as part of routine medical care for persons 13 years of age and older.
Strategy 6: Facilitate access to needles for injection drug users.
Objective 6.1: By July 2011, OCASET will educate the Municipal Police Departments in the SJMSA regarding Law 73 for needle exchange and other related policies in PR.
Objective 6.2: By December 2011, the OCASET will counsel the *Pharmacists Association on the dispositions of law 73* of 2007, regarding the sale of needles/syringes in drug stores without a prescription.
Objective 6.3: By June 2013, ECHHP will increase the number of syringe vending machines accessible to IDUs within the SJMSA
Objective 6.4: By July 2013, initiate a process of analysis in order to promote the beginning of negotiations between PRDOH and the Legislature regarding additional funding to increase syringe exchange programs within the SJMSA.
Objective 6.5: By December 2013, Propose amendments to Law 73 to allow access to paraphernalia for the purpose of improving needle exchange programs.
Strategy 7: Create a Committee for the development and promotion of public policy regarding HIV, that can help in making viable and providing continuity to the proposed changes.
Objective 7.1: By May 2011, identify the members for the public policy committee, one of whom will be a coordinator from ECHPP team.
Objetive 7.2: By May 2011, Develop the structure of the committee, including procedures and norms related to its functioning.
Strategy 8: Promote public policy changes within the Department of Education (DOE) and the Department of Correction (DOC) to include condom distribution.
Objective 8.1: By January 2012, coordinate at least two meetings with the Department of Education and Department of Correction Secretaries concerning the distribution of condoms in their policies and operating procedures.
Strategy 9: Collaborate with the DOE in revising the health education curriculum, assessing the impact of current HIV and STD prevention strategies, and identifying ways of strengthening it.
Objective 9.1: By January 2012, coordinate and create a revision panel to evaluate and submit recommendations to the Secretary of DOE, specifically in the area of HIV and STD prevention and care.

Required Intervention #6: "Implement linkages to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care"
Goal 1: Implement a referral network between the PRDOH and the DOC in order to link persons with HIV who have served time in a correctional facility, with care providers.
Strategy 1: Establish a liaison between the staff of Correctional Health Facilities and Ryan Part B-Planning Body.
Objective 1.1: By December 2011, the Correctional Health Facilities and Ryan Part B-Planning Body will develop a collaborative agreement to link HIV positive ex-inmates to care providers.
Strategy 2: Provide CAREWare system to the Correctional Health Facilities.
Objective 2.1: By December 2012, PRECHPP will provide the structure for the CAREWare system in the Correctional Health Facilities.
Goal 2: Implement CDC's guidelines for Partner Services for the AIDS Surveillance Program and the STD Surveillance Program to be able to share HIV results.
Strategy 1: Establish a collaboration between the HIV Surveillance Program and the STD Surveillance Program
Objective 1.1: By October 2011, Coordinate a meeting to create an internal protocol to share positive HIV results between the HIV Surveillance Program and the STD Surveillance Program
Objective 1.2: By November 2011, Coordinate one training session with the HIV Surveillance Program to discuss the STD Surveillance program procedures.
Objetive 1.3: By November 2011, Coordinate one training session with the STD Surveillance Program to discuss the HIV Surveillance program procedures.
Goal 2: Implement linkages to care, treatment and prevention services for those testing HIV positive in the STD clinics.
Strategy 1: Establish a standard procedure protocol between STD clinics (Clets, Caguas and Bayamón)
Objective 1.1: By December 2011, The HIV/STD Prevention Program will complete the standardize procedure protocol for linkage to care, treatment and prevention services for those testing HIV positive in STD clinics and not in care.
Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"
Goal 1: Provide health care along the continuum of the HIV disease for persons living with HIV.
Strategy 1: Develop activities that promote the continuum of care for persons living with HIV
Objective 1.1: By January 2012, establish a periodical process to identify persons living with HIV who have being out of care for the last twelve months in the SJMSA.
Objective 1.2: By December 2012, the Ryan White Part B will identify at least 6 barriers that impede person living with HIV from receiving care, with the purpose of reintegrating these patients into health care services.
Strategy 2: Provide counseling to persons living with HIV on the importance of receiving continuous medical care
Objective 2.1: By January 2012, have 100% of new patients fill out a questionnaire during their first medical appointment to determine if they have been offered counseling regarding the importance of receiving continuous care.
Strategy 3: Create the mechanisms to overcome barriers and facilitate access to care for care persons living with HIV
Objective 3.1: By August 2013, identify resources to overcome 50% of the barriers identified in Objective 1.2.
Required Intervention #8: "Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons"
Goal 1: Develop policies and procedures that facilitate implementation of the most updated guidelines on the use of Anti Retroviral Therapy in both public and private settings.
Strategy1: Provide training to medical professionals in the CPTETs of the SJMSA.
Objective 1:1 By January 2012, conduct training on PHS guidelines to 100% of recently recruited clinical personnel in the CPTETs of the SJMSA before they provide direct medical services to patients.
Objective 1:2 By January 2012, ensure that clinic directors coordinate at least one training session for 100% of clinical personnel within 30 days after PHS and CDC guidelines have been updated.
Strategy2: Offer continued education to medical professionals
Objective 2:1 By January 2013, ensure that the PRDOH establishes as public policy that every health professional receives training in PHS and CDC guidelines prior to renewing a license.
Objective 2:2 Starting in January 2013, establish as PRDOH public policy that public insurance (Puerto Rico Health Insurance or PRHI) providers must disseminate all updates of PHS and CDC guidelines to the service providers network as a precondition to renewing contracts.
Strategy3: Strengthen the information gathering system that allows for measuring compliance with treatment guidelines.
Objective 3.1 By May 2012, increase by 50% compliance with indicators related to the use of antiretroviral treatment in municipalities that comprise the SJMSA.

Required Intervention #9: "Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons"
Goal 1: Increase adherence to antiretroviral treatment for persons with HIV
Strategy 1: Develop adherence protocols that include interventions for MSM, illegal immigrants, and injecting drug users.
Objective 1:1 By June 2011, develop management guidelines for special populations identified in the SJMSA (MSM, UDI, transgender persons and illegal immigrants) as supplements to the existing adherence protocol through the Ryan White Part B Planning Body.
Objective 1:2 By March 2012, 90% of clinical personnel will participate in at least one annual training session regarding the protocol for special populations.
Objective 1.3 By March 2013, reduce by 5% the number of patients in special populations that do not adhere to treatment.
Strategy 2: Strengthen the non-adherent patient identification system by means of recruiting personnel.
Objective 2:1 By September 2012, complete recruiting Records Abstractors (persons who identify adherence information in medical records) and Case Managers funded by Ryan White B Funds.
Objective 2:2 Starting in January 2012, increase by 5% the quantity of persons that receive a case management evaluation and adherence evaluation every six months.
Strategy 3: Strengthen the non-adherent patient search system by employing organizations that offer search services.
Objective 3:1 By April, 2011, complete contract procedures of eight organizations subsidized by Ryan White Part B to search for non-adherent patients.
Objective 3:2 By September 2012, increase by 10% the number of non-adherent patients who are contacted by the search system to resume treatment.
Strategy 4: Promote patient and collateral education among identified populations through videos, pamphlets, among others.
Objective 4:1 By May 2012, the Ryan White Part B Planning Body will develop a training program and the corresponding instructional materials to train health education staff and other groups regarding the promotion of adherence to treatment.
Objective 4:2 By September 2012, the Ryan White Part B Planning Body will train Prevention Division health education staff in promoting adherence to treatment, subsidized by the Ryan White Part F AIDS ETC.
Objective 4:3 By September 2012, conduct at least two monthly educational sessions on the importance of adhering to treatment in each of the five CPTETs located within the MSA (on the use of existing services and resources, etc.).
Strategy5: Foster medical treatment (methadone and buprenorphine) in IDU, HIV-positive patients.
Objective 5:1 By January 2012, increase the number of IDU HIV-positive patients that receive methadone or buprenorphine clinical treatment by 5%.
Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"
Goal 1: Promote early detection and treatment of sexually transmitted diseases (STDs).
Strategy1: Train clinical personnel on the updated 2011 CDC SDT treatment guidelines.
Objective 1.1: By June 2011, OCASET will finalize training on new guidelines for STD treatments to personnel offering services in the CPTET.
Strategy 2 Promote public information iniatives regarding STD prevention.
Objective 2.1: By May 2012, develop an educational campaign targeted to high-risk populations.
Strategy3: Provide access to STD (syphilis, chlamydia, gonorrhea), TB, and Hepatitis C tests in a non-clinical setting to at-risk persons.
Objective 3.1: By May 2012, reduce by 10% new STD contagion among HIV-positive persons that receive treatment in the five CPTET within the San Juan MSA.
Objective 3.2: By May 2012, at least 10 community based organizations will provide STD screening services to priority population groups within the SJMSA.
Strategy4: Expansion of the Ryan White Quality Improvement Initiative mentorship program.
Objective 4.1: By September 2011, establish a central quality committee in OCASET to develop an inter-program quality pilot plan.
Objective 4.2: By May 2012, expand the Ryan White Quality Improvement Initiative mentorship program to increase the STD/HIV prevention services in the five CPTET in the SJ MSA.
Objective 4.3: By September 2013, extend the treatment and prevention mentorship project to at least 20% of community organizations subsidized with funds for prevention and treatment, to measure the quality of services provided.

Required Intervention #11: "Implement prevention of prenatal transmission for HIV-positive persons"
Goal 1: Maintain the perinatal transmission rate below the established standard.
Strategy 1: Expand or strengthen existing monitoring programs in delivery rooms.
Objective 1.1: By September 2012, conduct monitoring activities in at least 50% of San Juan MSA's delivery rooms to assure compliance with rules and guidelines regarding prevention of prenatal transmission for HIV-positive persons.
Strategy 2: Require insurance companies' compliance with PHS guidelines.
Objective 2:1 By May 2012, require that PRHI Administration's (ASES) contracts with insurance providers ensure that all prenatal care providers conduct HIV testing and anti-retroviral treatment for pregnant women who are HIV-positive according to CDC guidelines.
Strategy 3: Inform clinical personnel (obstetricians, gynecologists, nurses, midwives…) of the importance of testing and detection during the first to third trimester of pregnancy.
Objective 3:1 By September 2011, train clinical personnel that provide services to pregnant women with HIV in order to comply with established deadlines.
Strategy 4: Promote adherence to antiretroviral treatment in pregnant women who are HIV-positive.
Objective 4:1 By September 2011, at least 85% of pregnant women with HIV in the SJMSA, will maintain adherence to antiretroviral treatment.
Required Intervention #12: "Implement ongoing partner services for HIV-positive persons"
Goal 1: Early identification of individuals who are at high risk of becoming infected and decreasing this risk.
Strategy1: Establish a uniform partner services monitoring and referral system.
Objective 1.1: By September 2011, HIV STD Prevention will establish a unique referral system for "partner services" in at least 50% of the organizations that provide HIV screening services.
Objective 1.2 By January 2012, HIV STD Prevention will train at least 50% of the organizations that carry out HIV testing so that they may refer following established procedures.
Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"
Goal 1: Decrease the number of HIV-positive persons at risk of transmitting HIV.
Strategy 1: Bolster risk reduction in HIV-positive patients.
Objective 1:1 By September 2013, prepare an intervention in the effective behavioral interventions (EBI) inventory and increase by 20% the number of people who receive services through risk reduction interventions offered through CBOs and CPTETs.
Strategy 2: Incorporate EBIs offered by direct services personnel in community-based organizations and CPTETs.
Objective 2:1 By May 2012, train at least 20% of CPTET direct services personnel in EBIs
Objective 2.2: By May 2012, train at least 20% of community-based organizations' direct services personnel in the RESPECT intervention
Objective 3:1 By September 2012, design an evaluation plan to determine the level of efficacy with the EBIs in the CPTET.
Required Intervention #14: "Implement linkages to other medical and social services for HIV-positive persons"
Goal 1: Support persons with HIV in accessing other social and health services that result in improved health and wellness.
Strategy 1: Expand access to treatment with FDA approved drugs and according to the guidelines established by the "National Quality Forum" to treat opiate dependency for IDU in HIV treatment centers and other services sectors.
Objective 1.1: By September 2011, two (2) CPTET of the SJMSA will have a buprenorphine certified physician who will refer persons with HIV to buprenorphine treatment.
Objective 1:2 By September 2012, increase to 100 the number of HIV-positive, opium-addicted inmates with less than two years remaining of their sentences who receive buprenorphine/methadone treatment and transition them to receive services in the community.
Strategy 2: Promote coordination of referrals through case management
Objective 2:1 By May 2012, increase by 20% the number of referrals of HIV-positive patients to clinical social and support services following an assessment of their needs.

Strategy 3: Formalize working relationships with organizations that provide psycho-social services and medical treatment for opiate dependence and HIV patients.
Objective 3:1 By September 2011, identify at least one liaison in each center that provides referrals for supportive services.
Objective 3.2 By March 2012, train CPTET personnel on HIV medical and social services available in the SJMSA for persons living with HIV.
Objective 3.3 By December 2012, implement a continuous educational campaign about available services that encompass the affected population, health services providers, and employees of public agencies that provide support to the HIV-positive population.
Objective 3.4. By December 2011, increase by 50% referrals of patients that meet clinical criteria for buprenorphine treatment for persons with HIV and opiate dependency who have public (Mi Salud) or private health insurance.
Strategy 4: Create and update an inventory of support and preventive resources and of medical treatments for opiate dependency.
Objective 4:1 By December 2011, update and disseminate a virtual or traditional directory of organizations that provide support
Recommended Intervention # 15: "Condom distribution for the general population"
Goal 1: Extend the distribution and access to condoms in high pedestrian circulation zones in the SJMSA
Strategy 1 Establish collaboration with CBO's that provides HIV prevention services for the distribution of condoms in places of high flow of people in the SJMSA.
Objective 1.1: By April 2011, identify at least five (5) CBOs that will participate in collaborative agreements for condom distribution activities.
Objective 1.2: By September 2011, identify 100% of high HIV prevalence areas in the SJMSA.
Objective 1.3: By April 2011, identify at least five (5) high pedestrian circulation places (such as train stations, bus stations, etc.) in the SJMSA to be impacted by the CBO's with the distribution of at least 500 condoms per place impacted.
Objective 1.4: By September 2011, define a process for condom distribution that includes specific places and dates to conduct the intervention.
Objective 1.5: By September 2011, have established agreements with the agencies and organizations that can provide access to the areas identified for condom distribution.
Strategy 2: Establish collaboration with CBOs that provide HIV prevention services for the distribution of condoms in mass activities in the SJMSA.
Objective 2.1: By April 2011, identify at least five (5) CBOs willing to engage in a collaborative agreement for condom distribution activities.
Objective 2.2: By April 2011, identify at least five (5) mass activities in the SJMSA region to be impacted by the CBOs with the distribution of 1,000 condoms per activity.
Objective 2.3: By September, 2011, implement the process for condom distribution in specific places and dates (as defined in the process designed as part of Objective 1.4).
Objective 2.4: By September, establish communication with relevant government agencies defining the locations and activities to be carried out, to ensure their collaboration in the implementation of the intervention.
Strategy 3: Integrate coordination agencies hired by the program Ryan White Part B.
Objective 3.1: By May 2011, identify at least two (2) collaborative agencies of the Ryan White Program, Part B, to participate in the distribution of at least 2,000 condoms.
Recommended Intervention #16: "HIV and sexual health communication or social marketing campaigns targeted to relevant audiences"
Goal 1: Promote HIV educational messages directed towards changing high risk behavior in women.
Strategy 1: Establish collaborative agreements with the HIV Prevention Division of the PRDOH to disseminate preventive measures directed towards changing high risk behavior in women.
Objective 1.1: By September 2011, validate the campaign design for changes in high risk behavior in women between the ages of 13 and 60.
Objective 1.2: By October 2011, determine at least two (2) mass media channels to disseminate the campaign for behavioral changes in women between 13 and 16 years of age with high risk behavior.
Objective 1.3: By December 2011, begin the dissemination of mass media campaign that seeks to change behavior in women between 13 and 16 years of age with high risk behavior.

Lastly, as part of the implementation of the PRECHPP, a dissemination campaign has been designed, which includes continuous meetings with government, public and private agencies, media tours, and the use of alternative channels, such as the Internet. The Puerto Rico team has also developed a strong evaluation plan based on a formative approach that will allow for changes and improvements during the process of implementation of the Plan.

Workbook 1: Situational Analysis

DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO

BACKGROUND

During the past months, the Puerto Rico Department of Health (PRDOH) has been engaged in the preparation of an Enhanced Comprehensive HIV Prevention Plan (ECHPP). This is a demo project[8] created by the Centers for Disease Control and Prevention (CDC) that provides funds to facilitate the development and implementation of such plans in the twelve Metropolitan Statistical Areas most affected by the HIV epidemic. The Project responds to the goals of the National HIV/AIDS Strategy of: 1) reducing the number of people infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

The project will be conducted in two phases: (1) Phase I, during which grantees will develop focused ECHPPs for the targeted MSAs and begin the implementation of those plans; and (2) Phase II, in which a subset of the jurisdictions funded under Phase I will be selected, through a competitive process, to further implement their Enhanced Comprehensive HIV Prevention Plans over a two year project period. Each ECHPP should include a mixture of interventions and public health strategies selected by the jurisdiction from three categories: a) required (14 in total); b) recommended for consideration (10 in total); and c) innovative local activities.

The Phase I of the project is organized in three steps (a Situational Analysis, Goal Setting and the construction of SMART objectives), and its results are compiled in two workbooks designed by the CDC. This Workbook presents the most significant findings of the first two steps: the Situational Analysis conducted by Puerto Rico, and the process of Goal Setting. A total of sixteen (16) interventions were addressed in the analysis: the fourteen (14) required and two (2) optional.

As a preamble to the discussion of the findings related to each intervention, a profile of the San Juan Metropolitan Statistical Area is included. The profile presents information on the epidemiological profile of the area, demographic profile, institutional and regulatory framework

[8] Funding Opportunity Number: CDC-RFA-PS10-10181, authorized under Sections 317(k)(2) and 318 of the Public Health Service Act (42 U.S.C. Sections 247b(k)(2) and 247c), as amended, and Section 4002 of the Patient Protection and Affordable Care Act (PL 111-148).

and general description of the characteristics and risk behaviors of the population regarding HIV transmission.

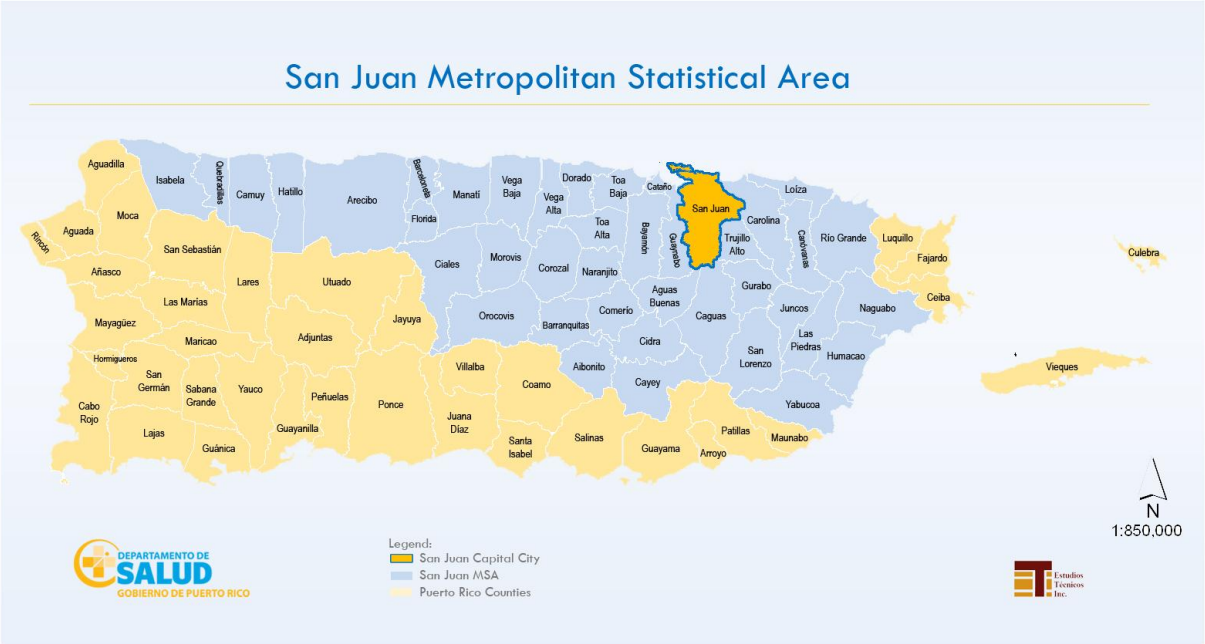
EPIDEMIOLOGICAL PROFILE

Puerto Rico, like many other jurisdictions in the United States, has been greatly affected by HIV/AIDS/STD/TB infections. Epidemiological data serves as the basis for identifying the population groups, age, gender, and behavioral risk factors associated with these infectious diseases. In the Metropolitan Statistical Areas (MSAs) and the Metropolitan Division, the Puerto Rico Department of Health (PRDOH) collects such data through the HIV/AIDS Surveillance System, STD Surveillance Office, and the Tuberculosis Control Program.

As of 2009, the HIV/AIDS Surveillance System indicates that a total of 33,277 cumulative cases of AIDS have been diagnosed and reported since the first persons were diagnosed in the early 1980s[9]. From 1980 through 1993 the number of cases steadily increased, and the expansion of the AIDS case definition resulted in additional cases. These programmatic changes, and the introduction of HAART in 1996, decreased the number of cases each year from 1993 through 2007. The PRDOH, through Administrative Order # 177, implemented the name-based HIV not-AIDS case registry in 2003. Additionally, it ordered all tests which could lead to an HIV diagnosis to be reported to the HIV/AIDS Surveillance Program, including Viral Load and CD4's tests. Since then, 6,834 cases have been reported. Consequently, more people will need expanded HIV prevention interventions that take into account the linkage of a high quality medical care component as well as behavioral interventions to further reduce the number of new infections.

As of February of 2011, a total of 14,271 cases of HIV/AIDS had been diagnosed in the SJ-Caguas-Guaynabo Metropolitan Statistical Area (SJMSA). The SJMSA is located in the Commonwealth of Puerto Rico, an incorporated territory of the United State of America with a territory of approximately 4,000 square miles and a population of 3,725,789 as of 2010[10].

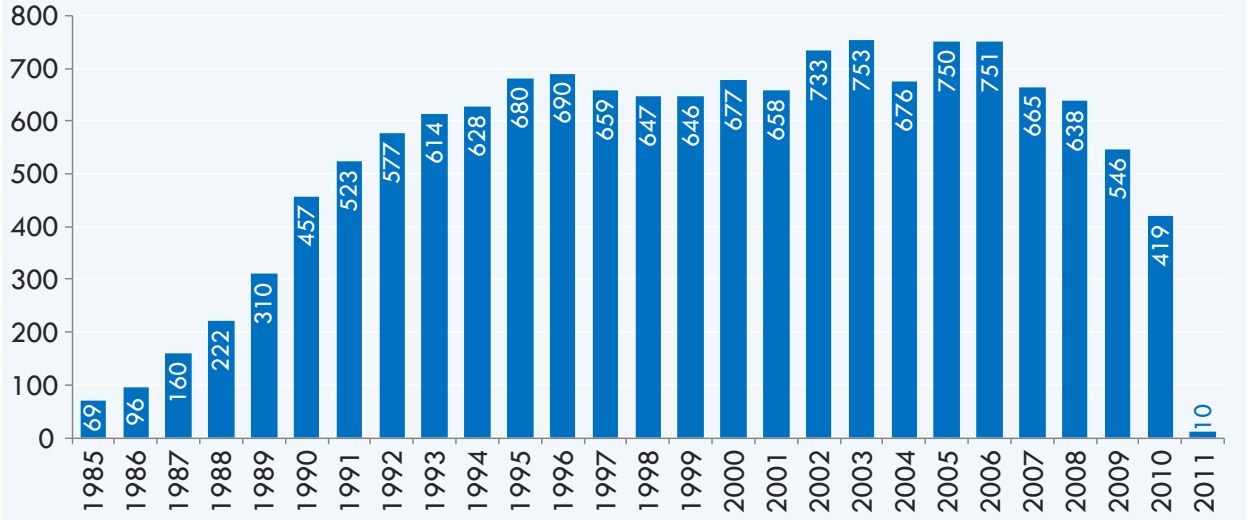
[9] http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table20.pdf.
[10] US Census Bureau, Census of Population and Housing, 2010.



People living with HIV/AIDS by diagnostic status and age category (cummulative as of 2009)						
Diagnostic status	Adults or adolescents		Children (<13 yrs)		Total	
	No.	%	No.	%	No.	%
HIV infection (not AIDS)	5582	40	85	39	5667	40
AIDS - Immunologic	4604	33	30	14	4634	32
AIDS - All others	3867	28	103	47	3970	28
Total	**14053**	**100**	**218**	**100**	**14271**	**100**

The SJMSA comprises forty one (41) municipalities and has the highest HIV/AIDS incidence, prevalence and mortality rates in Puerto Rico. The yearly number of cases remained relatively constant throughout the second half of the 1990s, and has been decreasing since 2006.

Table 1: Cumulative HIV/AIDS cases diagnosed as of February 28, 2011



Of this total, 5,667 have been cases of HIV infection (not AIDS), and 218 have been cases of HIV/AIDS diagnosed in children younger than 13. Of the total number of cases, 69% (9,835) were males and 31% (4,436) were females. For both males and females, the age group with the highest incidence of cases was 25 to 34 years old (36% and 34%, respectively).

Number of cases by age at diagnosis and sex[b]

Age at diagnosis (yrs)	Male		Female		Total	
	No.	%	No.	%	No.	%
<13	118	1	100	2	218	2
13-14	9	0	9	0	18	0
15-24	1087	11	677	15	1764	12
25-34	3520	36	1505	34	5025	35
35-44	3122	32	1238	28	4360	31
45-54	1398	14	656	15	2054	14
55-64	424	4	199	4	623	4
>=65	157	2	52	1	209	1
Total	**9835**	**100**	**4436**	**100**	**14271**	**100**

b Data exclude (0) persons with missing or unknown sex.

As would be expected, the overwhelming majority of people diagnosed with HIV/AIDS in the SJ-Caguas-Guaynabo MSA are Hispanic, with only a few exceptions that make up less than 1% of the number of cases. Hispanics, including Puerto Ricans, comprise a significant fraction of the total

number of HIV/AIDS diagnoses in the United States, representing 17% of the cumulative number of cases[11], trailing African Americans and Caucasians.

The main transmission category for adult males in the SJMSA was injection drug use, followed by male-to-male sexual contact (42% and 27% of male cases, respectively); with 6% of overlap between the two categories. This trend differs from that exhibited in the United States in general, where 60% of AIDS diagnoses in adult males resulted from male-to-male sexual contact and 21% from injection drug use; with 9% resulting from both male-to-male contact and injection drug use[12].

Nineteen percent (19%) of males diagnosed with HIV/AIDS contracted the disease through hetero-sexual contact, compared to 8% nationally. For women in the San Juan-Caguas-Guaynabo MSA, heterosexual contact, followed by injection drug use were the two main methods of transmission (67% and 26% of female cases, respectively). This follows the national transmission trend for HIV/AIDS cases of female adults or adolescents.

Number of cases among adults or adolescents by transmission category and sex[d]

Transmission category	Male		Female		Total	
	No.	%	No.	%	No.	%
Male-to-male sexual contact	2589	27	0	0	2589	18
Injection drug use	4089	42	1129	26	5218	37
Male-to-male sexual contact and injection drug use	593	6	0	0	593	4
Hemophilia/coagulation disorder	7	0	1	0	8	0
Heterosexual contact	1802	19	2894	67	4696	33
Receipt of blood, components, or tissue	7	0	4	0	11	0
Perinatal exposure, HIV diagnosed >= 13 years old	5	0	3	0	8	0
Other risk factor reported	0	0	0	0	0	0
No identified risk factor (NIR)[f]	235	2	101	2	336	2
No risk factor reported (NRR)[g]	390	4	203	5	593	4
Total	9717	100	4335	100	14052	100

d Data exclude (0) adults or adolescents with unknown or missing sex.

Note. Data include cases with a diagnosis of HIV infection, a diagnosis of HIV infection and a later AIDS diagnosis, and concurrent diagnoses of HIV infection and AIDS.
Note. Data exclude cases missing age at diagnosis.

Therefore injection drug use has been the main overall transmission category for adults in the SJMSA, representing 37% of cases since the disease was first diagnosed in the 1980s, compared

[11] http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table2a.pdf.

[12] 2009 CDC estimates for cumulative HIV/AIDS diagnoses http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table2a.pdf)

to 25% of cases nationally. The Injection Drug Use (IDU) and Men who have Sex with Men (MSM) populations present the greatest challenge for HIV prevention efforts, since they are often discriminated against and alienated from society.

The majority (74%) of children diagnosed with HIV/AIDS in the SJMSA have been children whose mothers had the disease or were at risk of becoming infected. The remainder did not identify or report a risk factor, with two exceptions in which the patients became infected through the receipt of blood, components, or tissue. This is also consistent with national trends.

In 2009, 587 cases of HIV/AIDS were diagnosed, of which the majority (66%) were HIV infection (not AIDS) and none were children.

Number of cases by diagnostic status and age category, 2009

Diagnostic status	Adults or		Children (<13 yrs)				Total	
	No.	%	No.	%	Deaths	%	No.	%
HIV infection (not AIDS)	389	66	0	0	0	0	389	66
AIDS - Immunologic	130	22	0	0	0	0	130	22
AIDS - All others	68	12	0	0	0	0	68	12
Total	**587**	**100**	**0**	**100**	**0**	**0**	**587**	**100**

Thirty percent of male cases were in the age group of 25-34 years of age, making it the age group with the highest incidence for males.

Number of cases by age at diagnosis and sex[b]

Age at diagnosis (yrs)	Male		Female		Total	
	No.	%	No.	%	No.	%
<13	0	0	0	0	0	0
13-14	0	0	0	0	0	0
15-24	43	10	20	12	63	11
25-34	124	30	39	23	163	28
35-44	117	28	52	30	169	29
45-54	85	20	45	26	130	22
55-64	34	8	12	7	46	8
>=65	13	3	3	2	16	3
Total	416	100	171	100	587	100

[b] Data exclude (0) persons with missing or unknown sex.

For females, the group with the highest incidence was 35-44 (30%), which also had the highest incidence overall (29% of total cases fell in this age group). The age group of 25-34 closely

followed in terms of overall incidence, with 28% of all cases falling in this category. No one younger than 15 years of age was diagnosed in this period.

The main means of transmission, for both males and females, during this period was heterosexual contact (34%). Nonetheless, for males the main transmission categories were MSM contact (38%) and IDU (25%). Most females who became infected during this period did so through heterosexual contact (71%), with 10% contracting the disease through injection drug use and 19% not identifying or reporting a risk factor.

Number of cases among adults or adolescents by transmission category and sex[d]

Transmission category	Male		Female		Total	
	No.	%	No.	%	No.	%
Male-to-male sexual contact	159	38	0	0	159	27
Injection drug use	104	25	17	10	121	21
Male-to-male sexual contact and injection drug use	10	2	0	0	10	2
Hemophilia/coagulation disorder	0	0	0	0	0	0
Heterosexual contact	79	19	122	71	201	34
Receipt of blood, components, or tissue	0	0	0	0	0	0
Perinatal exposure, HIV diagnosed >= 13 years old	0	0	0	0	0	0
Other risk factor reported	0	0	0	0	0	0
No identified risk factor (NIR)[f]	47	11	24	14	71	12
No risk factor reported (NRR)[g]	17	4	8	5	25	4
Total	**416**	**100**	**171**	**100**	**587**	**100**

[d]Data exclude (0) adults or adolescents with unknown or missing sex.

[e]Data exclude (0) children <13 years with unknown or missing sex.

[f]NIR: After one year, or after investigation, no risk factor identified.

[g]NRR: No risk factor reported at the time of initial report.

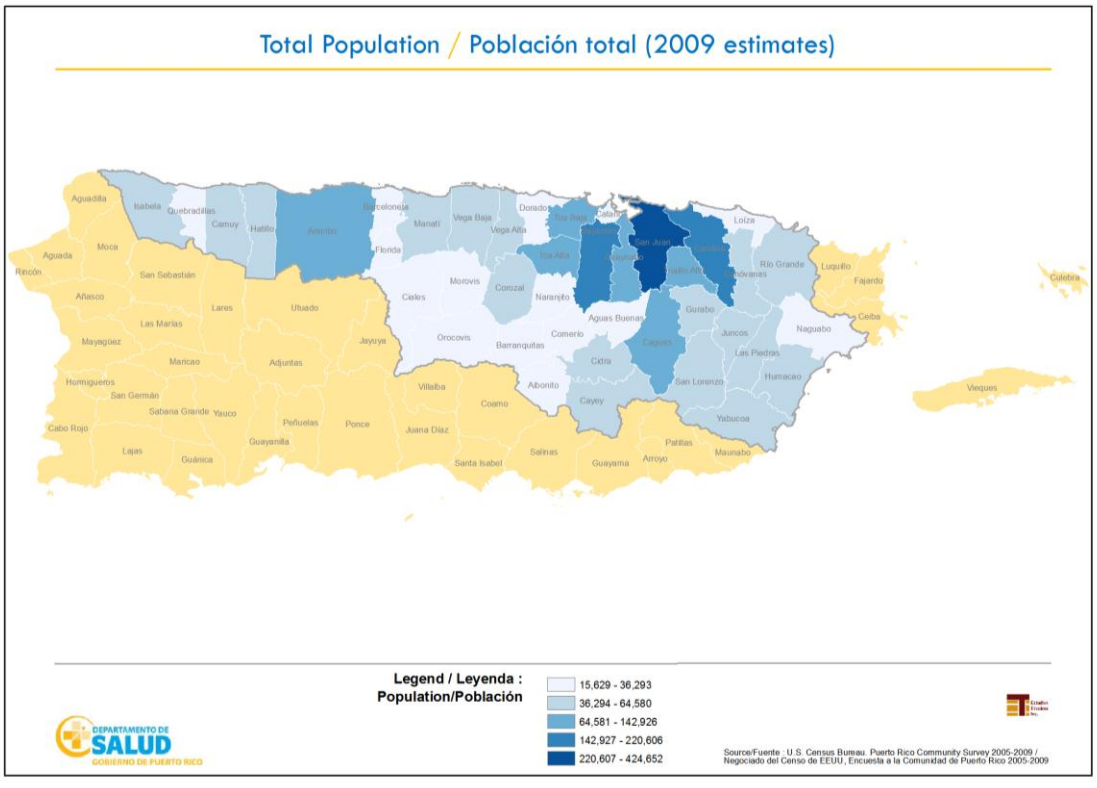
All 587 people diagnosed during this period were Hispanic.

Number of cases by race/ethnicity[c] and age category						
Race/ethnicity	Adults or adolescents		Children (<13 yrs)		Total	
	No.	%	No.	%	No.	%
Hispanic, All races	586	100	0	0	586	100
Not Hispanic, American Indian/Alaska Native	0	0	0	0	0	0
Not Hispanic, Asian	0	0	0	0	0	0
Not Hispanic, Black or African American	0	0	0	0	0	0
Not Hispanic, Native Hawaiian/Pacific Islander	0	0	0	0	0	0
Not Hispanic, White	1	0	0	0	1	0
Not Hispanic, Legacy Asian/Pacific Islander	0	0	0	0	0	0
Not Hispanic, Multi-race	0	0	0	0	0	0
Unknown	0	0	0	0	0	0
Total	**587**	**100**	**0**	**0**	**587**	**100**

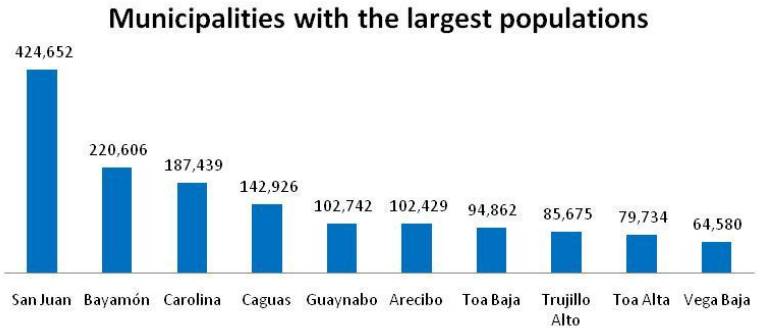
[c]Data exclude (0) adults or adolescents and (0) children <13 years missing race/ethnicity.

SOCIODEMOGRAPHIC PROFILE

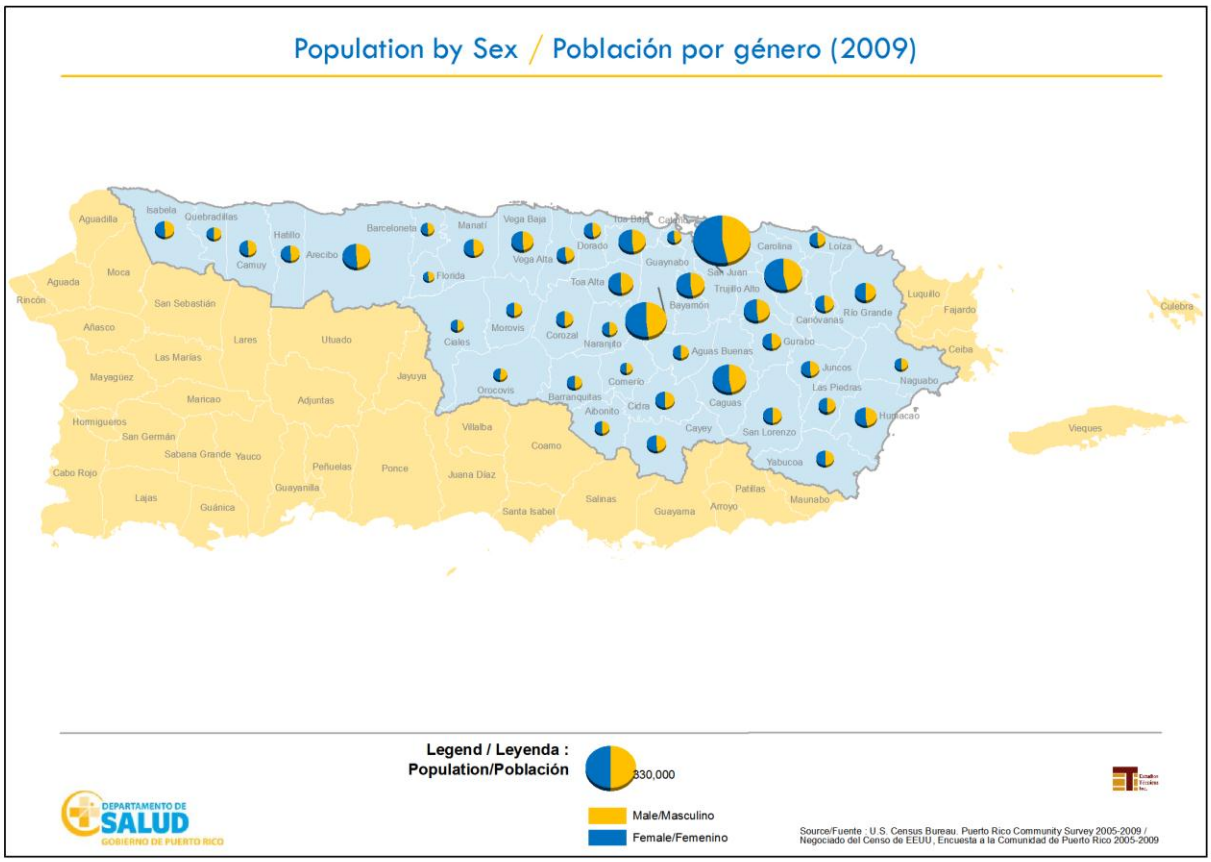
The SJMSA has 2,634,026 people, representing 66.9% of the Island's total population.



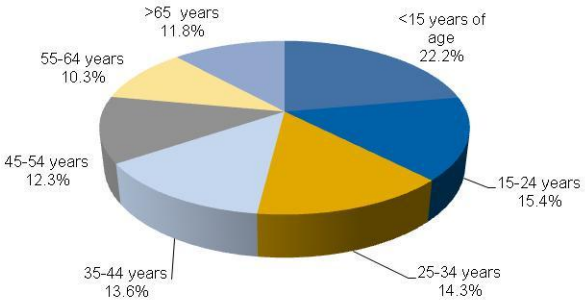
Of the municipalities that make up the SJMSA, San Juan has the largest population (424,652, or 16.1% of the regional population). In terms of population, San Juan is followed by Bayamón and Carolina, with 8.4% and 7.1% of the regional population, respectively. Florida, Comerío, and Ciales have the smallest populations in the region, each with 0.6%, 0.7%, and 0.8% of the regional population.



In the San Juan MSA, 22% of the male population and 19.4% of the female population is younger than 15 years of age, making this the largest age group (proportionally) in the region. Only 10.3% of the male population and 11.4% of the female population is between the ages of 55 and 64, making this the smallest age group in the region. Sixty six percent of the total population is between 15 and 64 years of age.

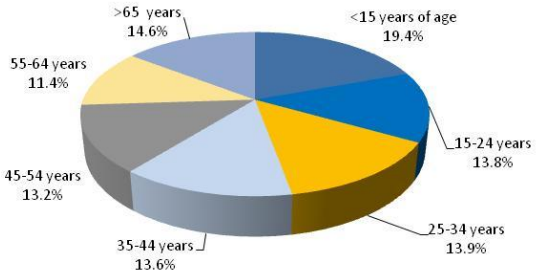


Male population by age



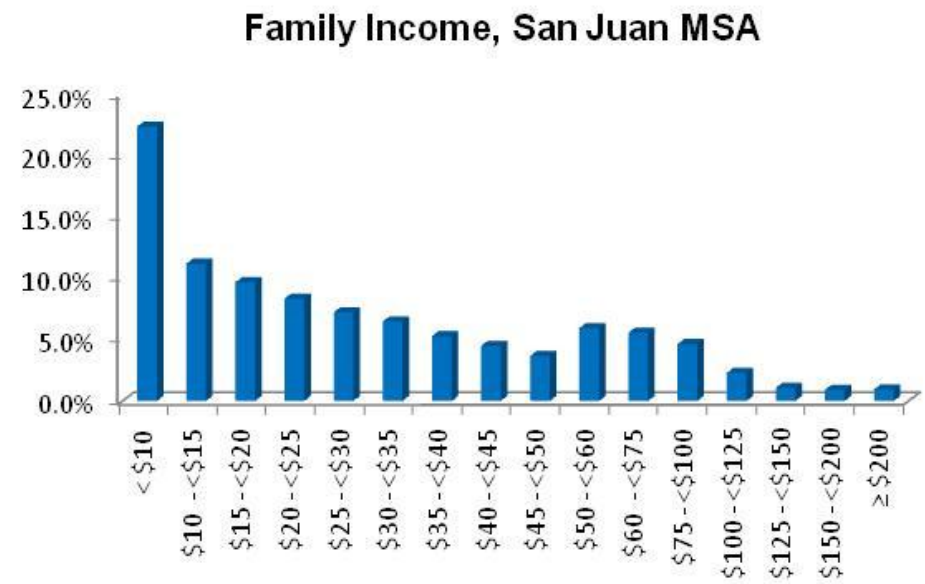
Source: U.S. Census Bureau. *Puerto Rico Community Survey 2005-2009.*

Female population by age



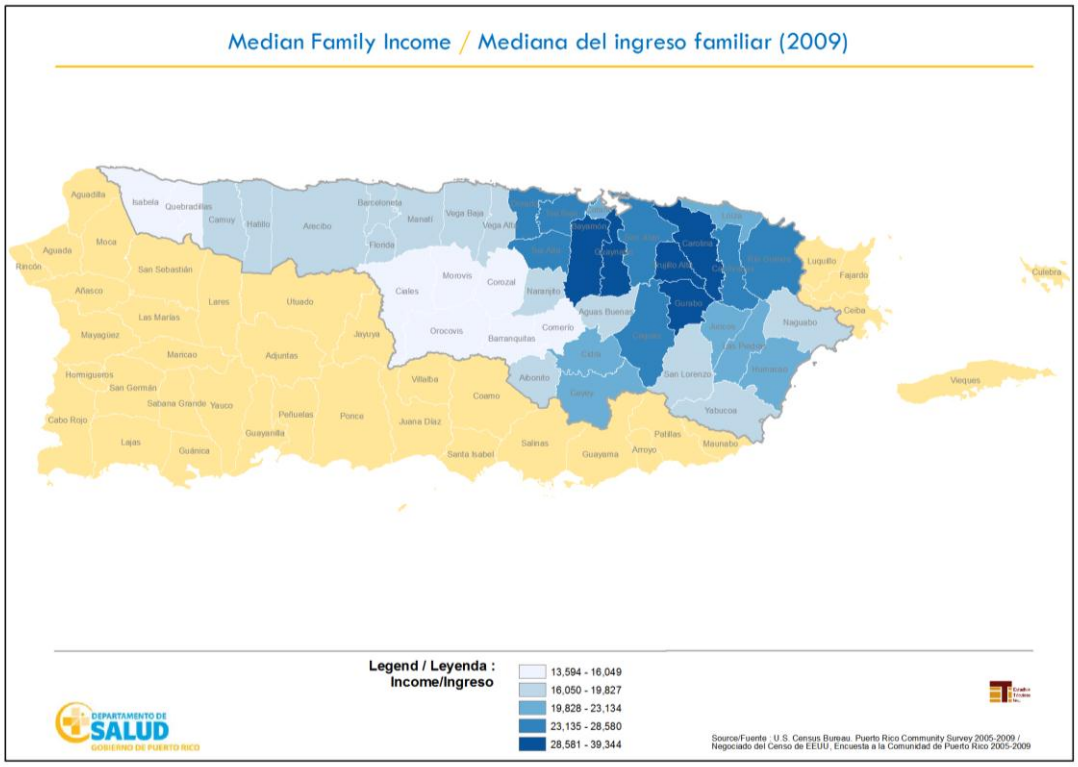
Source: U.S. Census Bureau. *Puerto Rico Community Survey 2005-2009.*

The region has a total of 613,909 families. Around twenty two percent (137,119) of families have incomes of less than $10,000. Of all families in the region, 65.2% (400,390 families) have incomes lower than $35,000; and only 60,479 families (9.9%) have incomes above $75,000.

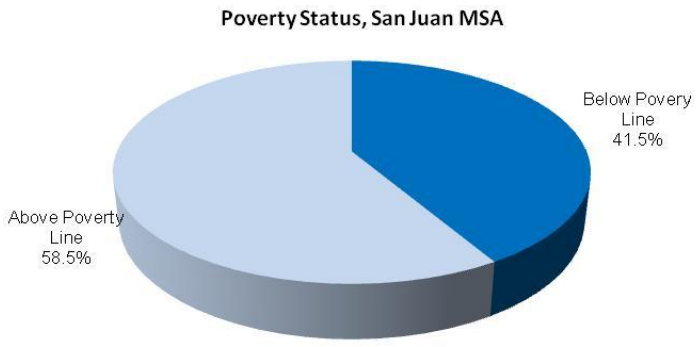


Source: U.S. Census Bureau. *Puerto Rico Community Survey 2005-2009*

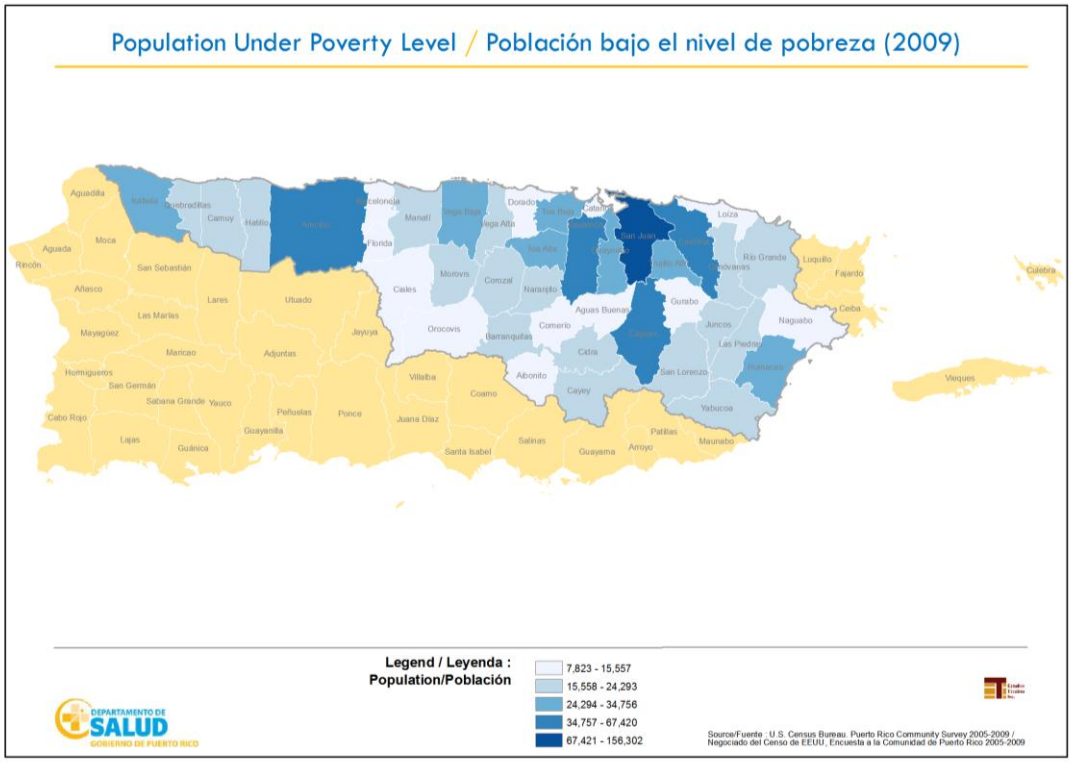
In all municipalities, the majority of families have incomes ranging from $10,000 to $34,999. Comerío has the largest proportion of families with incomes of less than $10,000 (40% of all families in Comerío). Guaynabo, Dorado, Trujillo Alto, and San Juan have the highest proportions of families with incomes of $75,000 or more (27.3%, 17.3%, 16.8%, and 16.4%, respectively). Guaynabo, San Juan, and Dorado also have the largest proportions of families with incomes over $200,000 (4.6%, 2.5%, and 2.3%).



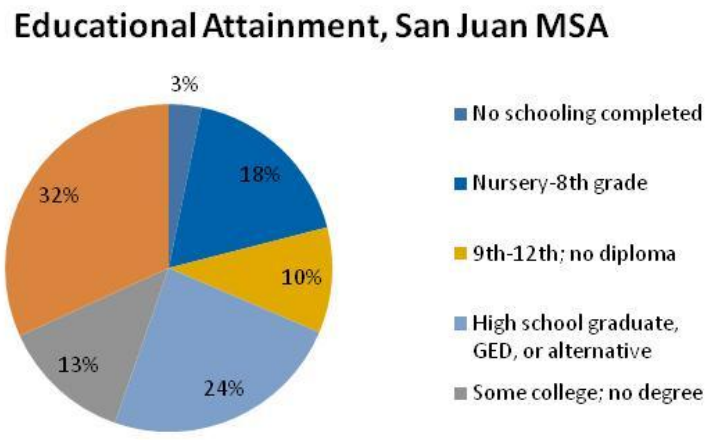
Of the total regional population, 41.5% have incomes below the poverty line. The municipalities with the highest proportion of their populations living under the poverty line are Orocovis and Morovis (62.6% and 62%, respectively). Guaynabo (27.3%), Carolina (29.2%), and Trujillo Alto (29.7%) have the smallest percentages of population below the poverty line.



Source: U.S. Census Bureau. *Puerto Rico Community Survey 2005-2009*

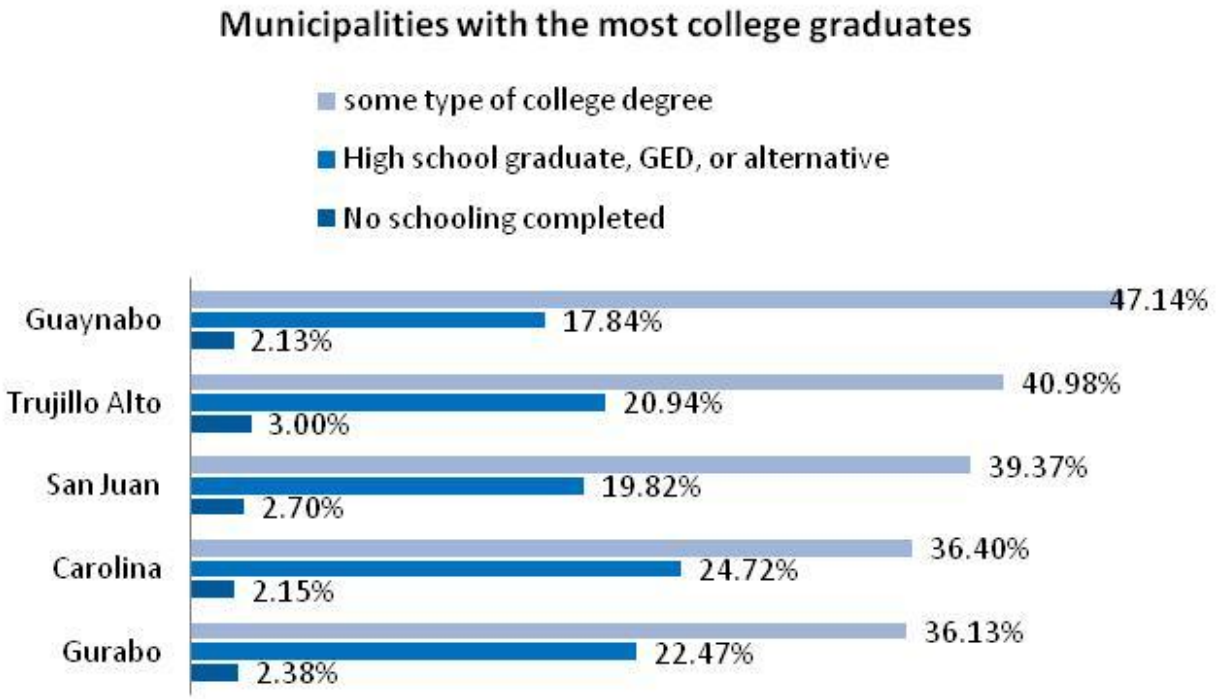


In terms of educational attainment, over 31% of the population 25 years of age and older has not received a high school diploma. Of the population 25 years of age and older, 23.9% has a high school diploma and 12.9% has completed some years in college without obtaining a degree. Almost 32% of the population has some college or professional degree.

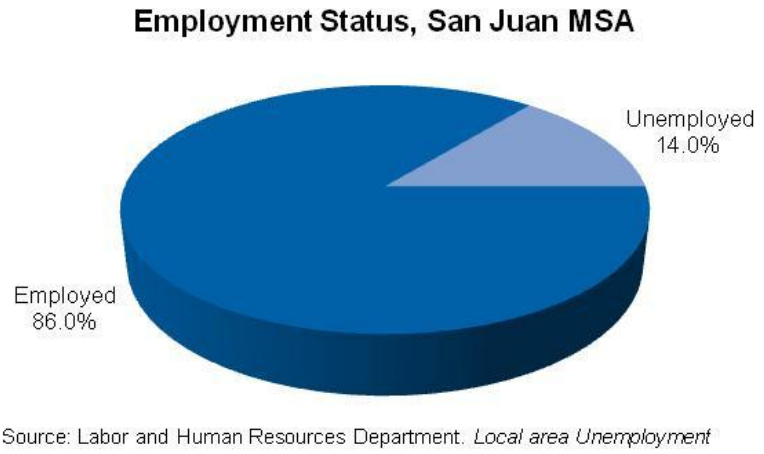


Isabela, Orocovis, and Florida have the highest proportions of their respective populations over the age of 25 who have not completed any level of schooling (5.97%, 5.73%, and 5.65%, respectively). In Loíza, Cidra, and Humacao, over 30% of the population has a High School Diploma or GED.

Guaynabo has the highest proportion of population in the age group that has attained some type of college degree (47.14%), while Orocovis has the smallest proportion of the population with a post-secondary degree (18.55%).

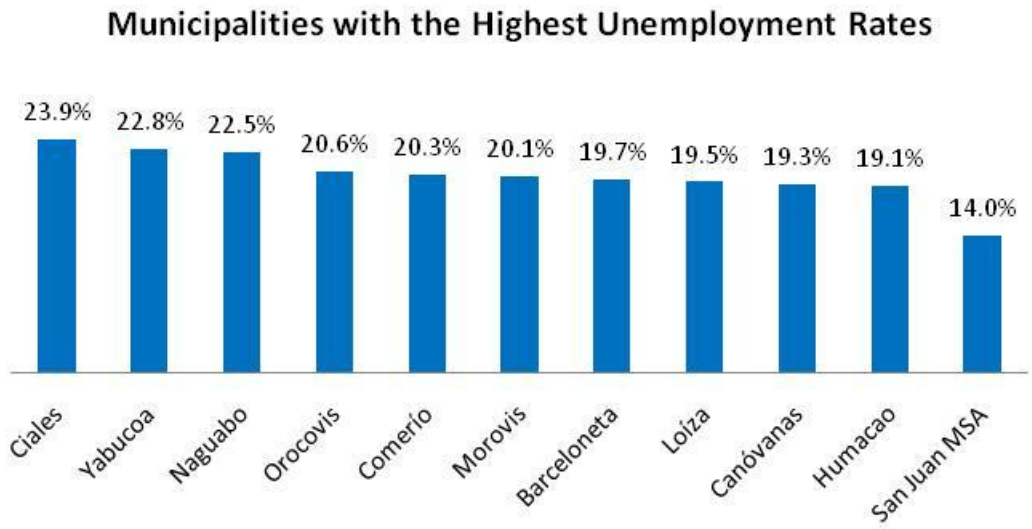


Only 34.2% of the total population of the region is in the labor force. Of those in the labor force, 14.0% are unemployed. Eighty six percent of the regional labor force is currently employed. Only 29.4% of the total population of the region is employed because of a low labor force participation rate.



Source: Labor and Human Resources Department. *Local area Unemployment*

The average of the municipal unemployment rates is 16.6%. Ciales has the highest unemployment rate, 23.9%, whereas Guaynabo has the lowest (9.4%). Most municipalities have unemployment rates which are higher than the regional rate, with only 8 municipalities presenting unemployment rates below 14%.



RISK BEHAVIORS IN THE SJMSA

As part of the Comprehensive HIV Prevention Plan developed by the Community Planning Group (CPG)[13] and the PRDOH, a series of studies have been conducted in order to identify STD/HIV/AIDS prevention needs.

One of these studies conducted in 2008[14] revealed differences concerning behavioral patterns of the different groups in high risk of being affected by HIV. These groups include: UDIs, MSMs, persons living with HIV/AIDS, adult heterosexuals and young heterosexuals. UDIs, were found to be the group with the highest number of persons who incurred in high risk behaviors, while the majority of heterosexuals (youngsters and adults), does not perceive the risk of acquiring HIV and does not use condoms with the same frequency as the other groups (MSM and HIV/AIDS affected). In fact, a recent update of this study in twelve municipalities of the Island[15] revealed that only 50% of the population that comprises these high risk groups, use a condom during sexual relationships. Condom usage is lower particularly among heterosexuals. The main reason for not using condoms deals with trusting their sexual partners and enjoying more the sexual relationship. Also, these two studies illustrate how heterosexuals in general (adults and youngsters), are the two main groups with the lower rate of testing positive for HIV/AIDS. This fact points out the importance of expanding testing in clinical and non-clinical settings.

[13] The Community Planning Group for HIV Prevention is comprised of representatives of the community, community-based organizations that provide services to underserved and high risk population, and governmental agencies . The CPG for HIV Prevention through an active, continuous and collaborative process, serve as an advisory body to all matters related to the development of the HIV epidemic in the Island and its prevention efforts.

[14] Departamento de Salud & Grupo de Planificación Comunitaria (2008), Estudio de Necesidades de Prevención de VIH y ETS, 2008.

[15] Departamento de Salud & Grupo de Planificación Comunitaria (2010), Actualización del Estudio de Necesidades de Prevención de VIH y ETS, 2010.

A series of focus groups conducted in 2009, also confirmed these patterns and behaviors[16], and revealed other important facts such as the following:

- Using the Internet with the intent of finding a sexual partner, is more common among men, especially in the group of men who have sex with men.

- Use of alcohol and/or drugs is more common in men (including men who have sex with men).

- There is a difference in risk perception between men and women. While men feel that they are at risk of acquiring a disease or getting a woman pregnant, women do not feel at risk. This, in conjunction with a recent tendency of an increase in women affected by HIV, establishes the importance of designing educational campaigns targeted to women.

The discussions during the focus groups also revealed the desire of these groups for the integration of innovative ideas in educational campaigns; Especially using more images, techniques and information both positive and negative, where they can acquire knowledge and skills to help them have better sexual health.

Finally, an update of the Needs Assessment conducted in 2009[17], focused in the MSM population, provided a demographic profile of this group and a more in depth idea of their sexual behavioral patterns.

[16] Department of Health (2009), 2009 HIV/STD Prevention Needs Assessment.
[17] Department of Health (2009), HIV risk conduct research and the context of that risk in a sample of the men sex with men (MSM) population in Puerto Rico, 2009.

MSM have an average age of 42 years, most live in the Metropolitan Area, seven out of every ten are single, six out of every ten are employed, their median educational level is a bachelor's degree and 42.7% earn $1,500 or more per month.

In terms of their sexual behavior, the younger the men the more probability of performing unsafe practices such as never using condoms, use of injection and/or not injection drugs and practicing anal sex. On the other hand, results regarding knowledge about HIV and STDs were mixed. For most of the practices (receptive anal sex, insertive anal sex or both) having more education or knowledge meant less probability of performing them, but for two practices (anonymous sex and sex with multiple partners) it meant more probability of performing them.

Almost thirty two percent of persons interviewed for this study, (31.6%) were HIV positive. Of these, 38% were diagnosed with other STD besides HIV. More than one fourth (28.7%) had sex under the influence of drugs or alcohol; while 80% reported to have performed anal sex, 57.3% receptive anal sex, 62% insertive anal sex and 80.7% oral sex. One of every five, (21.3%) practiced anonymous sex, and a same proportion (22%) had multiple sex partners.

The type of information to prevent STD/HIV/AIDS that the sample reported they would like to receive include: Healthy life styles (59.3%); How can they protect the partner or couple (56.7%); treatments or a cure (56%); basic aspects of STD/HIV/AIDS (55.3%); and available services and where to apply or request them (55.3%).

Persons with whom the sample reported they would feel more comfortable, secure or receptive in receiving preventive services were peers or equals (32.7%) and men (30%).

The data indicated that although the majority of the sample knew about STD and HIV/AIDS preventive methods, they often incurred in unsafe or high risk practices. The main reason reported for these conducts is trust in their sexual partners.

PROFILE OF PERSONS WHO RECEIVED SERVICES IN THE CPTETS AND IN CBOS THROUGH RYAN WHITE, PART B FUNDS

During the last year, a total of 6,661 persons received services in the CPTETs and in CBOs that receive funds from Ryan White, Part B. Six out of every ten persons that received services are men (61.39%); 38.34% are women; and 0.27% are transgender. Median age of persons who received services is between 45 to 64 years old. Primary treatment services received by this population include: Ambulatory Services (4,487 persons[18]), Case Management (3,380 persons); and Nutritional Therapy (1,027 persons). In the case of support services the main were: Case Management (2,414 persons), Case search (1,152 persons), Psychosocial support (745 persons), Emergency help (636 persons), and Transportation (508 cases).

Lastly as of March 31st, 2010, a total of 4,524 persons were admitted to the AIDS Drugs Assistance Program (ADAP) under Ryan White; 61.65% men and 38.35% women. Median age of these beneficiaries is 45-64 years old. In terms of the treatment regimen 233 persons are in one (1) or two (2) retrovirals; 3,979 are in three (3) to four (4), and 162 are in more than four (4).

[18] These are provided in combination with Local Funds.

REGULATORY FRAMEWORK

Local laws and regulations, as well as Federal statutes and policies comprise the Puerto Rican law system. The primary law is the Constitution of the Commonwealth of Puerto Rico. The United States Constitution is also applicable. Regarding HIV Programs, there are numerous laws and regulations, both federal and local that governs issues related to the implementation of the public policy for the epidemiological control of HIV.

First of all, there is the Enabling Act of the Puerto Rico Department of Health (PRDOH)[19], which establishes that the Secretary of the PRDOH will be the head of the agency and is responsible for all matters delegated by law relating to sanitary issues, health and public welfare. The PRDOH was elevated to Constitutional rank by Article IV, Section 6 of the Constitution of Puerto Rico in 1952. Also, there are regulations and administrative orders enacted by the PRDOH according to the Uniform Administrative Procedures Act.[20]

Regulation 87 was enacted to implement the Law for the Prevention of Sexually Transmitted Diseases.[21] This regulation establishes definitions, doctors' and laboratories' duties and the procedures for investigation and test of sexual partners of HIV positive individuals. Regulation 87-A22, about Sexually Transmitted Diseases (STD), amends number 87, defines STDs and requires obligatory and confidential reports and laboratory tests results. This regulation also deals with other issues related to patients infected with VIH, including the notification of sexual partners, epidemiology technician responsibilities and penalties for noncompliance. Also, Regulation 87-B23 deals with the confidentiality and anonymous laboratory reports and doctor's reports through the use of laboratory codes regarding STDs.

The PRDOH also adopts administrative orders to regulate VIH treatment and control. Administrative Order 3924 created The "Central Office for AIDS affairs and Transmissible Disease" (OCASET). For its part, Administrative Order 25925 amends the list of diseases and

[19] Law 81 of May 14, 1912, as amended.
[20] Law 170 of August 12, 1988, as amended.
[21] Law 81 of June 4, 1983, as amended.
[22] August 14, 1997.
[23] Regulation 5829 August 12, 1998
[24] May 21, 1990.
[25] Amends Administrative Order 217.

health conditions to be reported to the Health Department and establishes the procedure to be followed to validate positive results. Finally, Administrative Order 22826 establishes the administrative procedures to be followed with respect to the Ryan White Program.

In Puerto Rico, there are special laws that also apply to HIV control and prevention. The Law for the Prevention and Treatment of Sexually Transmitted Diseases[27] establishes the public policy related to the prevention of STDs in Puerto Rico and institutes the requirements of notification to patients' sexual and syringes exchange partners, including minors and the mentally disabled. Meanwhile, the HIV/AIDS Carriers and Patients' Bill of Rights,[28] establishes the rights of persons with HIV and AIDS, and protects them against discrimination and prejudice.

Pertaining to federal laws, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act[29] was enacted on August 18, 1990 and creates the major federally funded program in the United States for people living with HIV/AIDS. The act sought funding to improve availability of care for low income, uninsured and under-insured victims of the disease and their families. The CARE Act provides funds to states and eligible US territories to improve the quality, availability and organization of HIV healthcare and support services. In addition to other programs, the CARE Act finances the US AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. In 2009, Congress passed, and the President signed, the Ryan White HIV/AIDS Treatment Extension Act. This law is the second extension to the CARE act benefits and extends them for four additional years.

In Puerto Rico the program developed under Ryan White, is divided in four main components[30]: *BASE*; Treatment and Support Services Coordination; AIDS Drugs Assistance Program; and evaluation planning and quality. The goals of the Program are to assure equal access to treatment services; provide psychosocial and support services for persons living with HIV/AIDS through contracts with agencies Island-wide; improve the quality of services for persons living with

[26] February 28, 2008.
[27] Law 81 of June 4, 1983, as amended.
[28] Law 349 of September 2, 2000.
[29] Pub. L. 101-381.
[30] These are explained in more detail in the next sections.

HIV/AIDS; and increase the number of persons with HIV/AIDS that receive treatment and support services.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) attempts to address some of the barriers to healthcare coverage and related job mobility impediments facing people with HIV as well as other vulnerable populations. HIPAA has three main goals:

1. Provides persons with group coverage new protections from discriminatory treatment.
2. Enables small groups (such as businesses with a small number of employees) to obtain and keep health insurance coverage more easily.
3. Gives persons losing/leaving group coverage new options for obtaining individual coverage.

There are other Federal laws that protect HIV patients' rights. In the workplace arena, the Americans with Disability Act (ADA), Occupational Safety and Health Act (OSHA), Family Medical Leave Act (FMLA) and Consolidated Omnibus Budget Reconciliation Act (COBRA) are applicable. Related to drugs available for treatment, there is the Federal Food, Drug and Cosmetic Act[31] and the Public Health Service Act[32], assuring that drugs and biologics are safe and effective for their intended uses, and are properly labeled. Both of these regulations are enforced by the Food and Drug Administration (FDA). FDA responsibilities regarding HIV/AIDS-related issues include the review and oversight function in areas related to drugs, biologics and medical devices for the prevention and treatment of HIV/AIDS, and AIDS-related conditions. Also, Federal law[33] has established procedures and requirements governing the use of investigational new drugs, including procedures and requirements for the submission to, and review by, the FDA of investigational new drug applications (IND's).

In July 2010, President Obama announced the National HIV/AIDS Strategy (NHAS) and the Implementation Plan, which establish mandates for various federal agencies responsible for the NHAS implementation, while the White House Office of National AIDS Policy (ONAP) will provide oversight. A Memorandum was also distributed to the heads of executive departments and

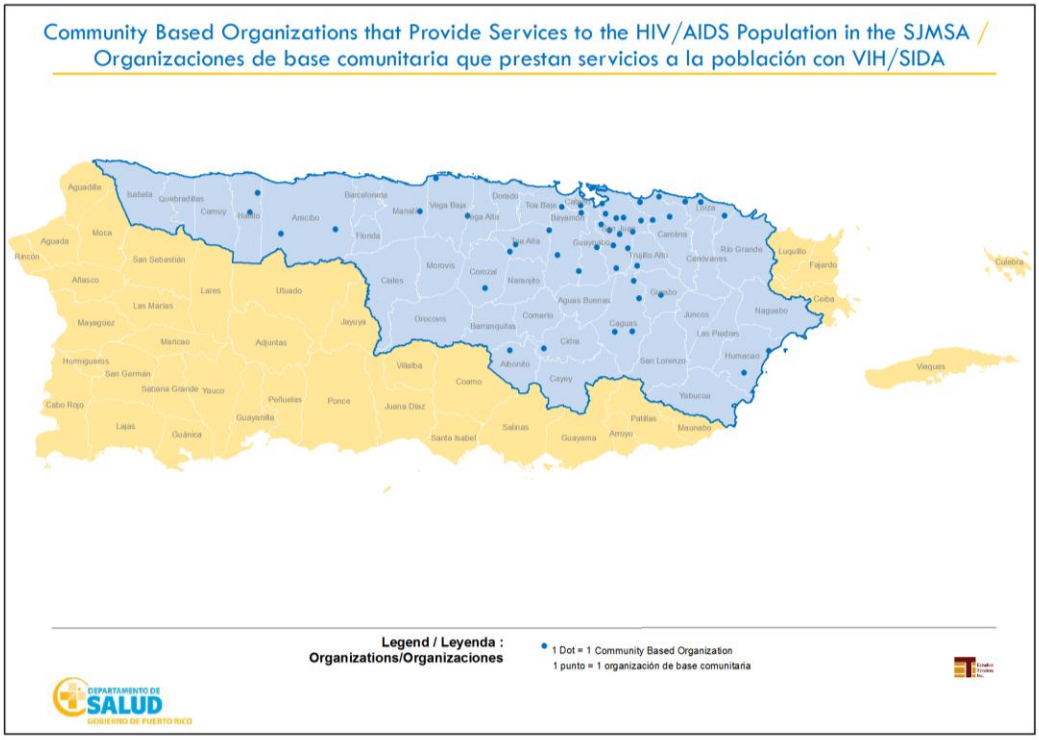
[31] 21 U.S.C. § 301
[32] 42 U.S.C. §201
[33] 21 CFR 312

Federal agencies that identifies the responsibilities of individual agencies in outlining a strategy to meet the goals of the NHAS.

INSTITUTIONAL FRAMEWORK

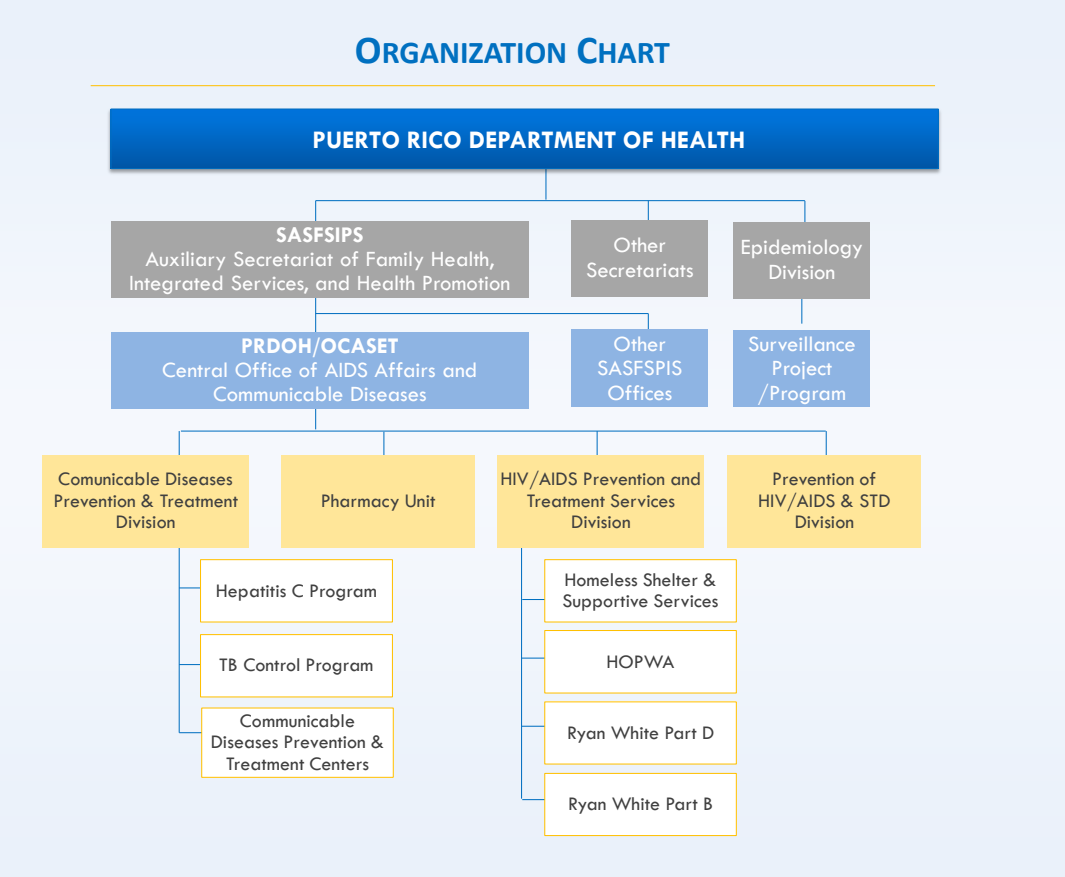
Within this regulatory framework, the Puerto Rico Department of Health (PRDOH) is the agency responsible for monitoring the HIV epidemic and for developing and implementing public policy regarding this subject[34].

Other governmental, federal, state, and municipal entities that provide direct and preventive epidemiology-related services collaborate with the PRDOH. Similarly, a network of nonprofit and community based organizations (CBOs) that also provide these services has emerged throughout the years. The number of entities that provide social services in different areas of need[35] in the Island is estimated to surpass 6,000, the majority of which are located in the SJMSA[36].



[34] Puerto Rico Department of Health (2008), OCASET, Transition Report.
[35] These services include, in general, services related to education, health, and community development, among others.
[36] Estudios Técnicos, Inc. (2007). Study on nonprofit organizations. Retrieved from the Web at www.estudiostecnicos.com.

In the PRDOH, the "Secretariat of Family Health and Integrated Services and Health Promotion", houses the clinical health programs that comprise the preventive strategy to improve special communities and populations.



The "Central Office for AIDS Affairs and Transmissible Disease" (OCASET, from its Spanish acronym) is responsible for managing HIV-related programs, and serves as an intermediary between the Department, the community, and other service providers which include CBOs.

At the beginning of the 1990s, OCASET organized its services in a continuous care system (SCC), which is structured into three subsystems: (1) Prevention and early identification of infected persons and people at risk of being infected; (2) medical treatment; and (3) support services.

OCASET is in turn divided into four operational areas, which include:

1) Division for the Prevention and Treatment of Sexually Transmitted Diseases, which is made up of eight (8) Centers for Prevention and Treatment of Sexually Transmitted

Diseases also known as Immunology clinics (CEPTET's, from its Spanish acronym). These clinics are distributed among the different health regions, a satellite clinic in the municipality of Humacao, and the Hepatitis C and Tuberculosis Control programs. The San Juan Metropolitan Statistical Area (SJMSA), which is the object of this study, includes six of these clinics.

2) Pharmacy Unit that includes the Medicine Distribution Center of the Department of Health and the institutional pharmacies of the CEPTET's.

3) HIV/AIDS Services division is divided into three operational sections: Housing for Persons with HIV/AIDS Section (HOPWA), Comprehensive Health Services to Families with HIV/AIDS Section (Ryan White Title D) and the Ryan White Part B Services.

4) Division for the Prevention of HIV/AIDS and Sexually Transmitted Diseases (STD), is responsible for operating the STD/HIV/AIDS Prevention Program.

   The STD/HIV/AIDS Prevention Division aims to promote, through safe sex practices, the prevention and early detection of HIV/AIDS and other sexually transmitted diseases among the population of Puerto Rico. The divisions' goals are: Promoting educational and preventive services that lead to a decrease in the number of HIV/AIDS cases in the Puerto Rican population by emphasizing risky behavior; Providing clinical services to treat all cases of sexually transmitted diseases, including HIV/AIDS, in order to prevent the spread of such diseases; and to provide educational and preventive services that lead to a decrease in the incidence of other sexually transmitted diseases.

   The STD/HIV/AIDS Prevention Program under this Division is the agency's primary services provider in terms of identification and prevention services. It is mostly funded by the Center for Diseases Control and Prevention in Atlanta (CDC) and state funds.

   Besides, PRDOH has several advisory committees: two Community Planning Groups (CPG) and TB Elimination Advisory Committee. The Community Planning Group for

HIV Prevention is comprised of representatives of the community, community-based organizations that provide services to underserved and high risk population, and governmental agencies (including mental health and substance abuse services, correctional health services, and municipal representatives). The CPG for HIV Prevention through an active, continuous and collaborative process, serves as an advisory body to all matters related to the development of the HIV epidemic in the Island and its prevention efforts.

The CPG for RW-Part B serves as advisory body in the planning of clinical services to improve delivery, quality, and treatment services for persons affected or living with HIV. The CPG of RW Part B is composed of representatives of the community affected or infected with HIV, CBO's, governmental agencies, researchers, academic professionals, and professional health providers. Community sectors are represented by persons living with HIV/ADIS or affected by the disease in all health regions. Among the governmental sector representatives are: San Juan EMA, Caguas and Ponce TGAs, PRDOH employees from PRDOH/OCASET, and representatives of ASSMCA. The providers sector for HIV/AIDS includes consortiums and coordinating agencies, representatives of Ryan White Part C, D, F, Ponce Medicine School, and the external pharmacy network for the AIDS Drug Assistance Program (ADAP).

REQUIRED INTERVENTION #1: "ROUTINE, OPT-OUT SCREENING FOR HIV IN CLINICAL SETTINGS"

A: SITUATIONAL ANALYSIS

TESTING IN PUERTO RICO

In Puerto Rico, a total of 22,574 people were tested for HIV in 2009 using the conventional testing method[37], out of which 135 were confirmed positive (0.6%). Of the people identified as HIV positive, 115 received test results. Forty nine of those who tested positive were referred to Partner Counseling and Referral Services (PCRS) , and 46 accessed medical care and treatment. The majority (around 56%) of conventional HIV tests were carried out in PRDOH STD Clinics. These clinics also had the highest positive result rate for this kind of testing, along with Community Based Organizations (CBOs only carried out 7% of conventional tests, but both had a 0.68% positivity rate).

CTR 2009 Conventional Testing						
A. Types of Funded providers	B. Number of Clients tested	C. Number of newly identified, confirmed HIV positive	D. Overall Seropositivity rate for each setting	E. Number of newly identified HIV positives receiving a test result	F. Of E, Number of newly identified HIV positives referred for care and treatment, # that accessed care	G. Of E, Number of newly identified HIV positives referred to PCRS
Health department STD Clinics	12,596	86	0.68	81	37 / 34	37
Department of Corrections	21	0	0	0	0	0
Drug Treatment Facilities	2,031	12	0.59	8	2 / 3	5
Family Planning Programs	10	0	0	0	0	0
Universities/ Colleges	494	0	0	0	0	0
CBO's	1,472	10	0.68	7	1 / 1	1
Local Health Department MSJ	3,291	14	0.43	9	5 / 5	1
Hospitals	446	2	0.45	2	0	1
Community Settings (including PRDOH)	2,213	11	0.50	8	3 / 3	4
Total	**22,574**	**135**	**0.60**	**115**	**48 / 46**	**49**

On the other hand, a total of 3,663 people were tested using a rapid testing method, of which 29 tested positive (0.79%). Of the 29 people identified as HIV positive, 26 received test results; and 6 people were referred for medical treatment of which only 3 accessed care. Around half of these tests were carried out in Community Settings

[37] Venues supported with funds from PA 04012 dollars for CTR in 2009.

(including PRDOH), and 29% of tests were carried out by CBOs. Community Based Organizations identified 14 HIV positive persons through this method of testing, for a 1.3% positive rate of testing. Local Health Department MSJ carried out less than 1% of tests but had the highest positive rate, around 6.5%.

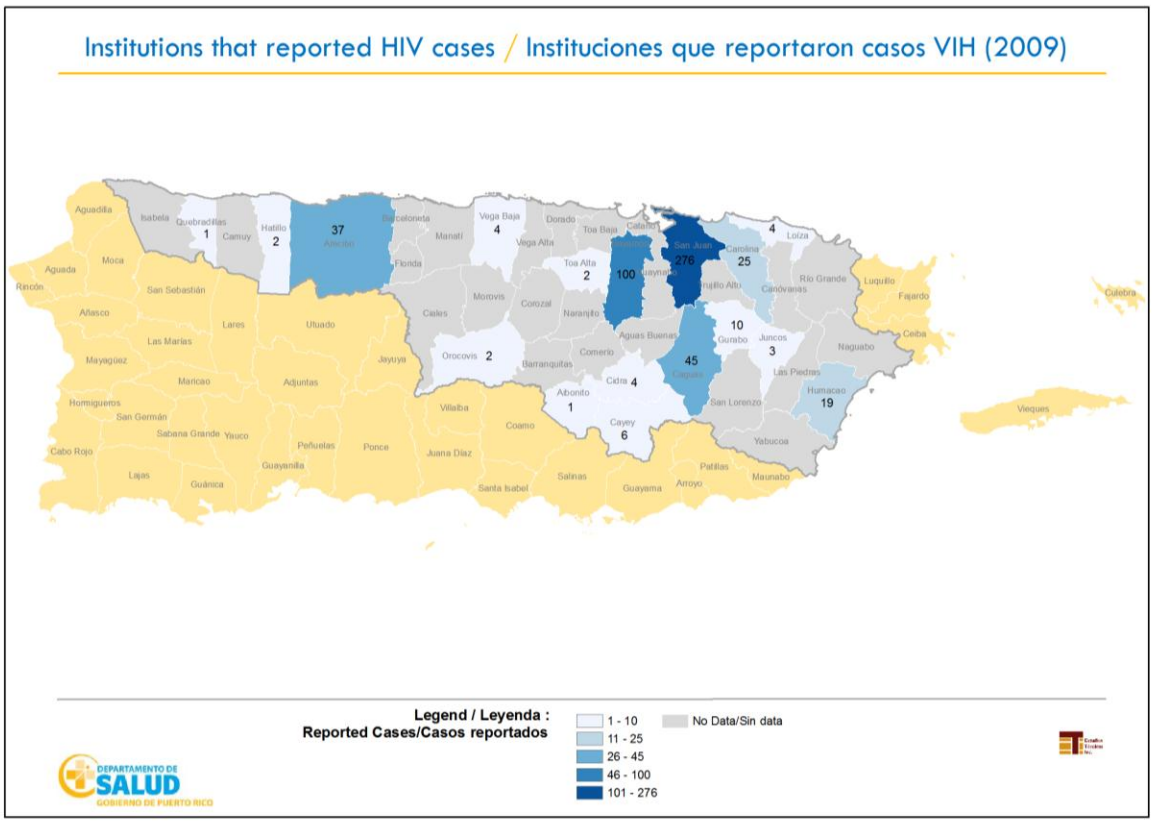
CTR 2009 Rapid Testing						
A. Types of Funded providers	B. Number of Clients tested for each setting	C. Number of newly identified, confirmed HIV positive	D. Overall Seropositivity rate for each setting	E. Number of newly identified HIV positives receiving a test result	F. Of E, the number of newly identified HIV positives referred that accessed care	G. Of E, Number of newly identified HIV positives referred to PCRS
Health Department STD Clinics	455	1	0.22	1	0 / 0	0
Drug Treatment Facilities	107	0	0	0	0	0
Universities/Colleges	122	0	0	0	0	0
CBOs	1,066	14	1.31	12	1 / 0	3
Local Health Department MSJ	31	2	6.45	2	1 / 0	0
Community Settings (including PRDOH)	1,882	12	0.64	11	4 / 3	4
Total	**3,663**	**29**	**0.79**	**26**	**6 / 3**	**7**

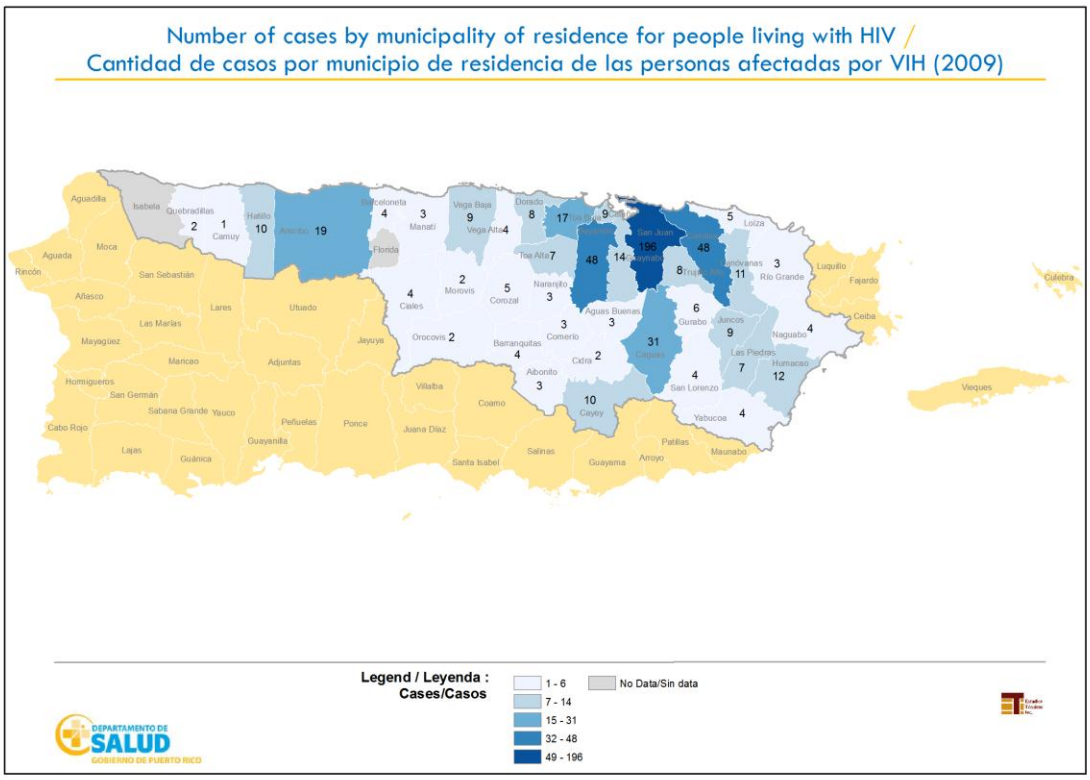
Only the HIV Specialty Clinic of the Centro Epidemiología de Bayamón carried out HIV testing using other methods. Of the 978 clients tested, 9 were confirmed positive (0.92%). Six of the 9 people identified as HIV positive received their test results; and 5 of the 6 people referred for treatment accessed care.

REPORTING FACILITIES IN THE SJMSA

A total of 65 facilities located in 19 municipalities of the SJSMA reported new HIV diagnoses in 2009[38]. Most facilities reported between 1 and 10 cases, but 11 facilities reported 15 or more cases. The average number of cases reported per facility was 8. The facilities that reported the highest number of cases were CLETS (Río Piedras), Bayamón Penitentiary, HIV Bayamón, Programa (San Juan), and HIV Caguas, all reporting 30 or more cases. Of all facilities, CLETS in Río Piedras reported the highest number of cases (96). CLETS in Río Piedras reported 60 more cases than the facility with the second highest number of cases, Bayamón Penitentiary, which reported 36.

[38] These includes Venues supported with funds from PA 04012 dollars for CTR in 2009, as well as other sources of funding.


Institutions that reported HIV cases / Instituciones que reportaron casos VIH (2009)
Aguadilla
Isabela
Quebradillas
1
Camuy
Hatillo
2
37
Arecibo
Barceloneta
Manatí
Vega Baja
4
Vega Alta
Dorado
Toa Baja
Catano
San Juan
276
Carolina
25
4
Loiza
Aguada
Moca
Rincón
San Sebastián
Añasco
Lares
Utuado
Las Marías
Mayagüez
Maricao
Adjuntas
Jayuya
Hormigueros
San Germán
Sabana Grande
Yauco
Cabo Rojo
Lajas
Guánica
Peñuelas
Ponce
Guayanilla
Juana Díaz
Villalba
Coamo
Orocovis
2
Barranquitas
Comerío
Corozal
Naranjito
Morovis
Ciales
Toa Alta
2
100
Guaynabo
Aguas Buenas
Cidra
4
Aibonito
1
Cayey
6
Caguas
45
Gurabo
10
Juncos
3
Naguabo
Las Piedras
Humacao
19
San Lorenzo
Yabucoa
Maunabo
Patillas
Arroyo
Guayama
Salinas
Santa Isabel
Río Grande
Canóvanas
Luquillo
Fajardo
Culebra
Ceiba
Vieques
Legend / Leyenda :
Reported Cases/Casos reportados
1 - 10
11 - 25
26 - 45
46 - 100
101 - 276
No Data/Sin data
DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO



A total of 543 cases were diagnosed among all facilities in the municipalities in 2009. Most municipalities reported between 1 and 10 cases, yet 5 municipalities had more than 30 new cases. Río Piedras and San Juan had the most facilities that reported cases (16 and 12, respectively). Río Piedras, Bayamón, and San Juan had the highest number of cases, reporting a total of 182, 100, and 94 cases respectively among all facilities in each municipality. Caguas, the municipality with the fourth highest number of reported diagnoses, had less than half the number of cases reported in San Juan (45 among all facilities in Caguas). (Source: Puerto Rico HIV/AIDS Surveillance Program).

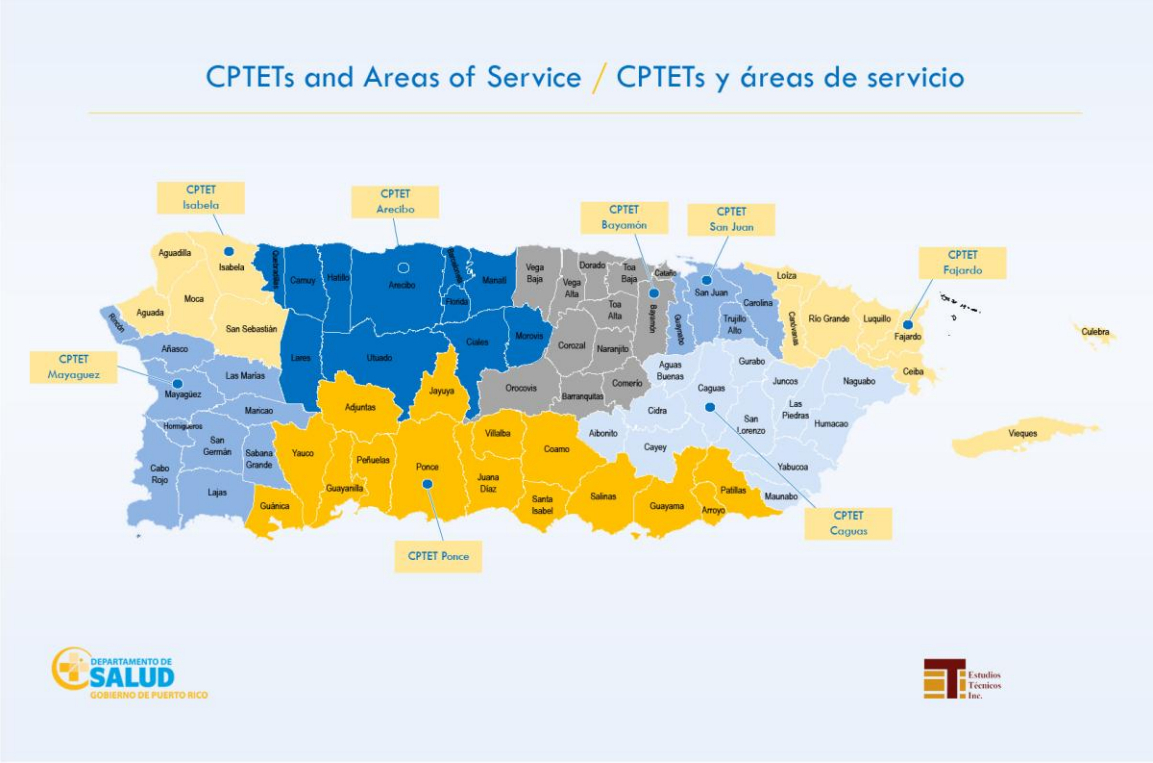
THE INTERVENTION IN THE SJMSA AND SOURCES OF FUNDING

Although the PRDOH has in recent years carried out activities related to this first intervention, currently there is no general public policy that establishes its use in public and private clinical settings.

Activities which the Program has implemented in recent years include a project designed to carry out rapid testing in delivery rooms. The Department acquires the tests and distributes them among 43 delivery rooms in Puerto Rico. In 2009, the Department invested $188,656.00 in this initiative in the SJMSA, ($38,656.00 in CDC funds and $150,000.00 state funds) and a total of 1,522 tests were administered. Total number of infants, who were perinatally infected was 0, for 2009.

Additionally, last year the Department was granted $1,781,457.00 in CDC funds to implement an HIV rapid testing project in Emergency Rooms. The project will begin operations in three selected emergency rooms located in the San Juan MSA.

On the other hand, the Department of Health's Department of Immunology clinics offer Preventive Counseling, Testing, and CTR Referral services. These services are provided by Epidemiology Technicians, Health Educators, Nurses, Preventive Case Managers, and community outreach workers that belong to the STD/HIV/AIDS Prevention Division of the Department of Health, as well as by other clinic personnel such as properly trained and certified Nurses and Clinical Case Managers.



Beyond the context of the PRDOH, several community based organizations also provided these services during 2009. The PRECHPP team conducted a short survey to 53 CBOs in the area, to identify if they provide this intervention, the type of technology they use and funding. This information was also combined with secondary data regarding "Offices Setting Clinics 330: Primary Health Centers[39]".

In terms of CBOs, a total of five organizations were identified as providing this intervention. These are, Puerto Rico CONCRA, COAÍ, COSSMA, Pro-familia and Casa Joven del Caribe. The types of tests used by these organizations include conventional testing and rapid tests (Ora Quick, Ora Sure and Uni Gold). Three of these organizations are directly funded by the CDC. Other sources of funding include HRSA, and local funds from the PRDOH.

Information regarding the number of tests conducted was obtained only from PR CONCRA, Coaí and Casa Joven de Caribe, PR CONCRA provides HIV rapid testing services in a clinical context, from 8:00am to 4:00pm Monday through Thursday. During 2009, PR CONCRA conducted 1,042 tests, out of which 16 were positives. This service is funded by HRSA and CDC funds, private donations, and other state funds which the organization has access to. Casa Joven del Caribe, on the other hand, conducted 465 tests during 2009. Coaí, conducted 191 tests during 2009-2010 out of which 7 turned out to be positive.

As mentioned, Offices Setting Clinics 330: Primary Health Centers also provide testing services. These organizations receive funds from Ryan White, Part C and from Section 330 of the Public Health Service Act (PHSA). Currently there are 14 centers that operate in Puerto Rico, nine of these are sponsored by Ryan White Funds.

According to several opinion leaders consulted for the Plan, the implementation and efficacy of an intervention such as this one, requires an increase in the number of clinics. This implies developing a clear public policy which defines both public and private clinical settings and establishes whether this is aimed at prioritized groups or the general population, within the parameters established by the Federal Government in 2006.

[39] These are non-profit organizations that serve disadvantage communities and persons with limited access to health services.

Moreover, it implies the training of clinical personnel and assessing the limitations of current regulations regarding the type of personnel that may administer tests in Puerto Rico in these contexts.

B: GOAL SETTING

GOAL 1: Increase the provision of routine opt-out screening in hospital admissions located in areas of high HIV prevalence.

Goal 2: Increase the number of providers that offer HIV testing through the Opt-out methodology in a clinical context

Stakeholders consider that increasing the provision of routine opt-out screening in clinical settings, is crucial in achieving two of the national objectives: 1) reducing the number of people who become infected with HIV; and 2) increasing access to care and improving health outcomes for people living with HIV. By making testing a habitual practice, as getting a blood test, regardless of whether or not people suspect having the condition, the number of persons diagnosed increases. This will help preventing others from acquiring the condition, and represents the first step in introducing a person to treatment.

Also, the experience gained by the PRDOH in the implementation of HIV rapid tests in delivery rooms, has helped in the development of a structure that makes feasible the implementation of this intervention in other clinical settings, which at the same time, adds value to other interventions.

REQUIRED INTERVENTION #2: "HIV TESTING IN NON-CLINICAL SETTINGS TO IDENTIFY UNDIAGNOSED HIV INFECTION"

A: SITUATIONAL ANALYSIS

THE INTERVENTION IN THE SJMSA

Within the Public Health System, this intervention is carried out mainly through the STD/HIV/AIDS Prevention Program and specifically through the work of personnel from Alcance Comunitario. Services are available to the entire population, although they especially target population groups

deemed to be at higher risk of contracting diseases, such as injection drug users and men who have sex with men, and women.

The service is provided in the community, in areas of high morbidity and/or frequented by individuals who practice behaviors that place them at high risk of acquiring HIV. These individuals have been previously identified and remain unaware of their HIV-positive status, or are HIV-negative but have not been tested within the previous six (6) months. The aim is to refer them to Counseling and Testing Referral (CTR) and to do further screening for other sexually transmitted diseases (STDs)

Service is provided to clients on a convenient schedule through clinical-educational activities in their communities. Prior to this, an assessment of the area and of the community's profile is done. Additionally, community leaders are contacted and the activity is coordinated and promoted in order to provide services that adapt to the needs of the population.

The setting varies depending on the targeted population. The settings may include, but are not limited to: entertainment places, places where sexual encounters take place, educational centers, streets, and places where drugs are sold. The agency designed the "Community Outreach Protocol" to provide guidelines for such interventions.

SOURCES OF FUNDING AND ORGANIZATIONS BEING FUNDED

In terms of resources, during 2009 the HIV Prevention Program was assigned $559,893.00 in CDC federal funds. Meanwhile, in the last Fiscal Year (2008-2009), the program employed $1,511,500.00 in state funds to conduct this intervention. Within the Public Health System; this intervention is provided mainly through the STD/HIV/AIDS Prevention Program and specifically through the work of the Trabajador de Alcance Comunitario (TAC)(Outreacher)

With the amount of funding available (State and, in 2009 the Agency sponsored nine (9) organizations and facilities that provide services in the SJMA, which are responsible for carrying out twelve projects. Funding assigned to these entities amounts to $2,071,393.00. Efforts carried out during 2009 impacted 2,982 persons.

Organizations/Projects	Funding	
Municipio de San Juan	$	196,084.00
Amor que Sana, Inc.	$	156,236.00
Casa Joven del Caribe	$	156,236.00
Casa del Peregrino	$	156,236.00
CIIPAP	$	125,002.00
COAI, INC.	$	125,002.00
Iniciativa Comunitaria de Investigacion	$	125,002.00
Iniciativa Comunitaria de Investigacion	$	156,236.00
Iniciativa Comunitaria de Investigacion	$	125,002.00
Lucha Contra El SIDA (MSM)	$	105,310.00
Lucha Contra El SIDA	$	156,236.00
Pro-Familia	$	125,002.00

The Division of Comprehensive Services for Families with Children, under the OCASET, also carries out activities related to this intervention. Services are provided in communities to children, youths, and pregnant women through to counselors who receive administrative support. Tests are administered in collaboration with OCASET.

This intervention has proved effective, but has been under revision during the last year since currently the proportion of new cases is not very high. As illustrated in a table from the previous section, in 2009, a total of 2,213 conventional HIV tests were conducted in community settings including the PRDOH, for a seropositivity of 0.50, while 1,882 HIV rapid tests were conducted in this setting for a seropositivity of 0.64.

The consulted interest groups identified the lack of economic resources as the main limitation to the successful implementation of this intervention, as well as the need to tie it to educational elements which are sometimes not permitted in some places that offer this method of intervention.

Consulted parties also agreed on the advisability of particularly promoting HIV rapid testing in non-clinical settings. This speeds up processes and promotes immediate action in providing treatment and services. They also indicated that these measures must be combined with communication and other strategies in order to attract patients to get further testing and to get involved in a continuous care process.

On the other hand, some consulted parties pointed to aspects of public policy which may affect the implementation of this type of intervention, such as restrictions concerning who can get tested.

Some also identified the schedules of staff members working on this intervention as an aspect that adversely affects its implementation. The reason being that this schedule does not coincide with the hours when some members of at-risk population groups frequent such settings.

Similarly emphasized was the need to coordinate this intervention with other agencies and groups in order to prevent some limitations that have arose in the past, as for instance duplication of services.

B: GOAL SETTING

GOAL 1: Increase the number of persons who get tested for HIV in non-clinical settings.
GOAL 2: increase the number of outreach activities where testing is conducted

The rational for considering expanding this intervention was the same as for intervention Number 1. However, other aspects were taken in consideration.

Stakeholders agree that increasing the provision of tests in non-clinical settings, is crucial in achieving two of the national objectives: 1) reducing the number of people who become infected with HIV; and 2) increasing access to care and improving health outcomes for people living with HIV, and represents the first step towards integrating the person into treatment.

CBOs play a very important role in this intervention, because they are one of the main points of contact within the populations at risks. However, there are limitations concerning the amount of organizations that offer services to IDUs and MSMs and that provide HIV testing. This presents an obstacle, since, for example, individuals receive drug addiction treatment (either for injection drug use or to receive psychological assistance, etc.) in a specific center and then must go to another place to get their HIV test, they then become "lost" because HIV testing is not offered in the same place. Because the vulnerable population visits centers that do not all provide testing, provision of these services are not connected. This happens frequently in HIV prevention centers, where some patients may never get tested unless they can get tested in the same place. Thus, the

identification of sources of funding and other resources for the provision of these services in non-clinical settings is essential.

REQUIRED INTERVENTION #3: "CONDOM DISTRIBUTION PRIORITIZED TO TARGET HIV-POSITIVE PERSONS AND PERSONS AT HIGHEST RISK OF ACQUIRING HIV INFECTION"

A: SITUATIONAL ANALYSIS

Although this is one of the main prevention activities, it is not carried out in a structured manner and lacks mechanisms to assess its efficacy. Currently, one of the main obstacles identified is the lack of a process or system to keep track of distributed materials and the subsequent use of such materials.

Condoms are distributed in the DOH clinics and in community outreach activities. Although they are provided to all persons that request them, emphasis is placed on HIV-positive persons and those in high risk groups.

Some consulted parties identified a separate barrier to providing this intervention, namely the lack of financial resources and policies that hinder distribution. For example, some consider condoms distribution in schools as an important element, but public policy prevents this.

IMPACT AND SOURCES OF FUNDING

According to data gathered in meetings, about one million condoms are annually distributed Island-wide, out of these 145,000 approximately are distributed in the SJMSA. Within the PRDOH, community outreach personnel provide this service. There is no specific data available regarding the profile of persons who are impacted through this intervention.

State and CDC funds finance this intervention. The HIV/STD Prevention Program possesses around $100,000 in CDC funds for the chosen region.

CBOs constitute an important ally in this process. These organizations focus on distributing condoms in community activities and workshops and focus primarily on IDU's, HIV-positive heterosexual youths, and MSM. Participating entities identified obstacles regarding the PRDOH funded activities, noting that payments are sometimes late or that they sometimes do not have timely access to incentives.

Following Federal Government guidelines, the PRDOH recently established the VOICES Program. This program consists of a group intervention which gathers eight to twelve patients in a private setting to learn about HIV infection risks and proper condom use. The screening of a culturally sensitive video facilitates group discussion; and participants are also exposed to a poster presenting a variety of condom types with brief explanations of the characteristics of each type. This intervention emphasizes condom usage skills presented in the video, followed by role play and practice among participants. Approximately 45 minutes are allotted at the end for an open discussion on the subject, and participants are provided with sample condoms. The intervention contains certain essential elements that support its purpose. In 2009, a total of 196 interventions were conducted in the PRDOH Immunology clinics.

B: GOAL SETTING

GOAL 1: Implement condom distribution in clinical facilities that provide services to HIV positive persons.

GOAL 2: Increase condom distribution in CBOs not funded by the PRDOH that provide services to high risk groups in high incidence areas in the SJMSA.

When establishing the goal and strategies for this intervention, stakeholders considered how the use of condoms plays a significant role in HIV prevention. However, they also considered how its efficiency depends in the degree in which it is positioned within a comprehensive combination of HIV interventions. In order to structure this intervention in an adequate manner, complementary measuring systems have to be developed. This will allow measuring the impact of the intervention, seeing if it has been effective and re-focusing, if necessary.

REQUIRED INTERVENTION #4: "PROVISION OF POST-EXPOSURE PROPHYLAXIS TO POPULATIONS AT GREATEST RISK"

A: SITUATIONAL ANALYSIS

Currently, the jurisdiction does not have a formal public policy regarding the provision of Post-Exposure Prophylaxis to Populations at Greatest Risk. The few efforts that have been implemented by the State are focused in the occupational context and in situations where the

victim has been raped. Institutions such as the University of Puerto Rico, Medical Sciences Campus, and private hospitals also provide this intervention. The Updated U.S. Public Health Service Guidelines, for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis of 2005, are used in the occupational context.

However, there is concern on the provision of Protocols of Post-Exposure Prophylaxis both within the occupational and non-occupational environments. And stakeholders agree that post-exposure procedures in cases of physical/sexual abuse or occupational/non-occupational accidents should be standardized and disseminated.

According to some consulted parties, clinical settings lack equipped medicine kits to offer this intervention, which presents a barrier to offering prophylaxis on time. Moreover, they consider this a high-cost intervention, although according to the Guidelines for the Identification, Treatment, and Follow up of Patients Infected with HIV, if a test is administered within two hours of the accident and the results are negative, there is no need to provide drugs for 28 days- which increases the cost of the intervention

In cases concerning the general population, such as rape, services may be provided through the PRDOH clinics, six of which are located in the SJMSA. In such cases, Federal Government-recommended guidelines and protocols are followed, with the aim of beginning treatment within 72 hours of risk exposure. The multidisciplinary personnel in the clinics also provide counseling and follow up to those who receive services.

In the case of CBOs surveyed, only one indicated having a Post-Exposure Prophylaxis provision protocol for its employees who are at a high risk of being infected with HIV through cuts, etc. Some exposed personnel include: nurses, technicians, and dentists. This service is handled by the SIFC.

This service should be available not only to those persons within the organizations who work in healthcare fields with a high risk of HIV infection, but also to those persons exposed to HIV outside of their job setting. Nonetheless, this service entails high costs, which is why a protocol needs to be established to determine who will provide the services and who will bear its costs.

B: GOAL SETTING

GOAL 1: Decrease the probability of acquiring HIV in a risky event, by the provision of Post-Exposure Prophylaxis.

Stakeholders discussed how this intervention is complementary to other interventions. For example, while interventions 1 and 2 serve to promote early identification of the infection in general, this intervention aims to prevent infection after being at risk of contracting it whether by an occupational or physical/sexual accident. The intervention is essential for reduction of HIV cases. It is also essential for increasing the number of persons with rapid access to health treatment.

REQUIRED INTERVENTION #5: "EFFORTS TO CHANGE EXISTING STRUCTURES, POLICIES, AND REGULATIONS THAT ARE BARRIERS TO CREATING AN ENVIRONMENT FOR OPTIMAL HIV PREVENTION, CARE, AND TREATMENT"

A: SITUATIONAL ANALYSIS

EFFORTS TO CHANGE EXISTING STRUCTURES, POLICIES, AND REGULATIONS

Generally, as part of their ministerial duties, the PRDOH's divisions promote changes in public policy and regulations. In such cases, different divisions collaborate with each other such as, the Office of Legal Affairs and the HIV Surveillance Program. These divisions also collaborate with nonprofit community-based entities.

The HIV Prevention Program as well as the Ryan White, Part B Program provide concrete examples of cases in which these strategies have been employed to seek change in public policy and in applicable regulations and procedures.

During 2008, and previous years, the HIV Prevention Program carried out efforts to promote the approval of public policy that would enable the administration of HIV rapid tests in delivery rooms in Puerto Rico. The division collaborated in various amendment proposals for laws that limited this activity. This process lasted about two years and was ultimately successful. The process resulted in a change in public policy and in the establishment of protocols for administering these tests in emergency rooms.

Additionally, the Ryan White, Part B Program has implemented a series of strategies and initiatives, such as community forums, which provide counsel to the Program through the Quality Committee, the Planning Group, the ADAP Advisory Committee, and the "Comités Interpartes". These committees enable the development of guides and documents concerning existing structures and procedures. To this end, $432,955 in HRSA: Ryan White Part B funds were used in 2009. The Planning Group met on twelve occasions, resulting in the development of fifteen procedural handbooks and work plans.

CBOs were also involved in efforts to change existing policies and regulations during the year 2009. Activities concerning these efforts included: participating in multi-sector committees or work groups, legislative hearings, and administrative proceedings.

CURRENT PUBLIC POLICY BARRIERS

By consulting several stakeholders groups, public policy barriers were identified which at times hinder the effective implementation of the various interventions. Some of these limitations are related to the following topics:

- Regulations concerning the type of personnel that can administer HIV rapid tests.
- HIV testing as part of routine medical care.
- Access to needles for injection drug users.
- Development of written public policy regarding condom distribution in contexts such as schools and correctional institutions.

The PRECHPP team will focus part of its efforts in promoting changes in public policy regarding these matters.

B: GOAL SETTING

Identify and conduct activities to change those structures, rules, and regulations which may constitute barriers to the creation of an optimal environment for the prevention, care, and treatment of HIV.

Changes in public policies, procedures and regulations may require extensive effort and time; however stakeholders understand that it is a key issue to assure the implementation of other interventions. Examples of the influence of this intervention are the efforts conducted for the implementation of the HIV rapid testing in delivery rooms project. The same changes should occur in order to implement condom distribution intervention in settings such as correctional institutions and schools.

This intervention is considered by stakeholders as essential for attaining the three national objectives, due to its close relationship with the other thirteen strategies.

REQUIRED INTERVENTION #6: "IMPLEMENT LINKAGE TO HIV CARE, TREATMENT, AND PREVENTION SERVICES FOR THOSE TESTING HIV POSITIVE AND NOT CURRENTLY IN CARE"

A: SITUATIONAL ANALYSIS

TRENDS

The state uses the Puerto Rico HIV/AIDS Epidemiologic Profile, developed by the PRDOH Epidemiology Division HIV/AIDS Surveillance Program as its main data source on the HIV epidemic in terms of people, time, and place. This Program is funded by the Center for Disease Control, and is part of the National HIV Surveillance System. The state also employs other important data to plan and implement preventive services and to treat this population.

Law 81 of June 4th, 1983, Article 4, establishes that all physicians who diagnose a sexually transmitted disease (STD) must inform the STD Surveillance Program within 5 days of making the diagnosis, while AIDS cases will be reported to the HIV Surveillance Program. Administrative Order #177, which came into effect on January 1st of 2003, enabled confidential named based HIV reporting to the HIV Surveillance System. HIV cases reports are Category 1 reportable disease, which establishes mandatory reporting to the PRDOH within 5 business days. Nonetheless, some groups noted that some of these reports do not have complete risk behavior data, especially when completed by private setting medical staff.

Other data sources that the Surveillance Program uses to keep track of persons with HIV- and to determine who does not receive services include: data from the Health Insurance Administration of Puerto Rico, in charge of administering the Public Health Care Plan (Mi Salud), and Health

Resources and Services Administration (HRSA) data. In addition, other supplementary sources include: National HIV Behavioral Surveillance, Medical Monitoring Project and Enhanced Perinatal HIV Surveillance.

Similarly, the Community Planning Group, Ryan White Part B programs and the HIV Prevention Program carry out research to establish priorities and determine a course of action to effectively engage the HIV-positive population that currently does not receive services.

Furthermore, the Ryan White Program has the responsibility of carrying out a study using data from HIV/AIDS Surveillance to calculate the number of HIV positive people in the jurisdiction and the proportion not registered for treatment or care, or unmet need. This is funded by HRSA. According to the most recent available data (2007)[40], of the 18,678 people with HIV/AIDS in Puerto Rico, 71.15% (13,289) received primary medical care during a determined period. Of the 7,849 people living with HIV (not AIDS) in 2007, 79.50% (5,452 people) received the corresponding treatment.

Some variation becomes evident upon closer analysis of this data, despite the fact that there are no significant differences. For example, a higher proportion of men with HIV (not AIDS) receives treatment (70.58 %,) when compared to men living with AIDS (67.98% do not receive treatment).

A little over half of all people living with HIV/AIDS (51.44%) who do not receive treatment are injection drug users. Regarding men who have sex with men, the percentage of people that do not receive treatment totals 13.04%. The proportion is smaller in cases of HIV without AIDS (10.25% versus 15.39% in cases of HIV with AIDS).

In the case of the SJMSA, 59.01% of cases are reportedly not being treated. This data presents issues, since some undocumented (not legal citizen) patients have access to primary treatment covered by private healthcare plans, among other shortcomings in gathering the information.

EFFORTS TO PROMOTE LINKAGE TO CARE

As previously mentioned, throughout the years, the PRDOH has developed a series of programs and services to treat people with HIV. The HIV Prevention Division has carried out a series of

[40] Puerto Rico Unmet Need Study 2009.

interventions sponsored by the CDC in Atlanta, which has been carried out according to guidelines developed by the Federal Government. Nonetheless, unawareness of the places where people can receive services may be posing an obstacle to the implementation of this intervention.

The services provided by the CEPTET (PRDOH Immunology clinics), six of which are located in the SJMSA are among these programs.

Moreover, the Ryan White Part B Program is responsible for providing health and support services to people with HIV and their families who live in Puerto Rico. In addition, the Program seeks to effectively distribute medication to eligible HIV patients in the Island. It must be noted that during program year 2009-2010, no activities related to this intervention were carried out. Nonetheless, activities were established during program year 2010-2011 that are currently being implemented. Currently Ryan White provides services related to several interventions through four agencies,

1. Fundación Acción Social Refugio Eterno, San Juan
2. Fundación Acción Social Refugio Eterno, Bayamón
3. Asociación Puertorriqueña de Servicios y Ayuda al Paciente con SIDA (APSAPS, Caguas)
4. Instituto Pre-Vocacional e Industrial de Puerto Rico, Programa Capernaum, Arecibo

Additionally, the Program is in the process of signing contracts for fiscal year 2011-2012 with two organizations: SIVIF en Gurabo and "Corporación SANOS" in Caguas.

Moreover, the Program recently established an agreement with the HIV Prevention Program to refer HIV-positive cases from prevention to treatment. A consent-based process was established by means of which a person is offered counseling at the time of getting tested, and in the event that he/she tests positive and has consented to the services, he/she may be contacted by Ryan White personnel.

In the case of the Division of Comprehensive Services to Families with Children, the service is offered throughout the Island in cooperation with CBOs and other projects such as CEMI (Centro

Estudios Materno Infantil) funded by NIH and NIWH. CEMI is a clinic that is supported by this Division, and provides services to children, adolescents, and pregnant women.

Regarding CBOs; a network of referrals has been created to assist those organizations that do not have access to these services. Some of the organizations to which referrals are submitted with or without collaborative agreements include: Health Council in Loíza, Profamilia, Department of Health, PR CONCRA, COSSMA drug stores and health clinics.

Other nonprofit institutions that provide services include the 330 Primary Health Center. As it was mentioned earlier, these entities receive funding from Ryan White Part C, and Section 330. Their main focus is in disadvantaged communities and persons with limited access to health services. In 2009, the centers provided services to 362,025 persons in Puerto Rico. These include persons that received HIV related services as well as other primary health services.

Finally, although no concrete data is available regarding the agencies that recruited the higher number of persons at risk, according to participants the entity which has been most successful in recruiting and retaining a high number of people in their clinical interventions is *Iniciativa Comunitaria*.

Some obstacles to this intervention include delay in offering some services, the perception of being identified in the facilities (stigma), services being offered in distant places, and in the case of some population groups, the mistaken belief that no services are offered to them.

SPECIAL AREAS OF INTEREST

Lastly, one area that should be reinforced in terms of linkage to care is the provision of services to ex-inmates.

Data from the HIV Surveillance System shows that from 1981 to 2009, a total of 3,235 HIV cases have been reported in the correctional institutions Island-Wide. In 2009, a total of 63 cases were reported. Although a system was developed to provide services to this population while in the correctional institution, the main concern is treatment once they are released from the institutions.

Total HIV cases in Puerto Rico in correctional institutions (1981 – 2009)				
hf_name1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
CAMP FORT ALLEN	27	0.83	27	0.83
CAMP GUAVATE	3	0.09	30	0.93
CAMP LA PICA	13	0.4	43	1.33
CAMP PUNTA LIMA	31	0.96	74	2.29
CAMP ZARZAL	87	2.69	161	4.98
PEN AGUADILLA	83	2.57	244	7.54
PEN BAYAMON	923	28.53	1167	36.07
PEN ESTATAL	765	23.65	1932	59.72
PEN FEDERAL	18	0.56	1950	60.28
PEN FLORIDA	1	0.03	1951	60.31
PEN GUAYAMA	246	7.6	2197	67.91
PEN HUMACAO	6	0.19	2203	68.1
PEN MAYAGUEZ	21	0.65	2224	68.75
PEN MUJ V A	302	9.34	2526	78.08
PEN NINAS PONCE	1	0.03	2527	78.11
PEN PARADA 8	2	0.06	2529	78.18
PEN PON ADUL	582	17.99	3111	96.17
PEN PON MUJ	20	0.62	3131	96.79
PEN PSIQ FORENSE	26	0.8	3157	97.59
PEN PSIQ PONCE	39	1.21	3196	98.79
PEN SABANA HOYOS ARECIBO	39	1.21	3235	100

Cases reported in correctional institutions in 2009				
hf_name1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
PEN AGUADILLA	3	4.76	3	4.76
PEN BAYAMON	36	57.14	39	61.9
PEN ESTATAL	1	1.59	40	63.49
PEN MUJ V A	8	12.7	48	76.19
PEN PON ADUL	12	19.05	60	95.24
PEN SABANA HOYOS ARECIBO	3	4.76	63	100

B: GOAL SETTING

GOAL 1: Implement a referral network between the PRDOH and the DOC in order to link persons with HIV who have served time in a correctional facility, with care providers.

GOAL 2: Implement CDC's guidelines for Partner Services for the AIDS Surveillance Program and the STD Surveillance Program to be able to share HIV results.

GOAL 3: Implement linkages to care, treatment and prevention services for those testing HIV positive in the STD clinics.

When establishing this goal, stakeholders discussed how persons "get lost", in the system due to poor communication between the different agencies and organizations, and the importance of strengthening channels of communication among entities in order to link HIV persons to services. This is crucial to attain national goals related to the reduction of HIV, as well as increasing access to care and improving health outcomes for people living with HIV. "Engagement in medical care after a diagnosis of human immunodeficiency virus (HIV) infection is essential to initiate lifesaving antiretroviral therapy and facilitate the delivery of important prevention messages for reducing HIV transmission. Failure to engage and be retained in HIV care can be associated with negative outcomes for both the individual and the community."[41].

REQUIRED INTERVENTION #7: "IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING RETENTION IN OR RE-ENGAGEMENT IN CARE FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS

The Ryan White Program, Part B, has developed a series of initiatives related to this intervention, including the Case Search Committees through the PRDOH's Immunology clinics and the organizations hired by Part B. The Program also provides training to clinical personnel, case managers, and case searchers.

[41] Kenneth Hugh Mayer, Introduction: Linkage, Engagement, and Retention in HIV Care: Essential for Optimal Individual- and Community-Level Outcomes in the Era of Highly Active Antiretroviral Therapy. Oxford Journals, Volume52, Issuesuppl 2.

The entities contracted by Part B include those within the Program Base Component and those subsidized by one of the projects, as Minority AIDS Initiative (MAI) Project. There are a total of seven organizations. In the case of MAI, two community agencies that provide services to Caguas and Bayamón are currently being subsidized. They specialize in searching for HIV-positive persons who are not receiving treatment, so they can begin to receive clinical and support services as part of continuous care. The initiative seeks to: (1) ensure continuous medical care through collaborative agreements with different entities that provide clinical and support services, primary HIV prevention interventions, centers for treatment of substance abuse, and any other services; (2) offer counseling regarding treatment adherence to persons living with HIV/AIDS who are not receiving treatment; (3) refer all persons with HIV/AIDS to seek the services of the AIDS Drugs Assistance Program (ADAP); (4) reconnect with health services those persons living with HIV/AIDS who have missed two or more appointments in six months.

Funding to subsidize these activities comes primarily from HRSA Ryan White Parte B (BASE y MAI) and is a total $1,120,449 for the year 2009[42].

Search Committees held five meetings, carried out 555 search interventions, and identified a total of 525 persons with HIV to restart treatment.

This intervention is carried out according to the guidelines established in the Program's Clinical Case Management Guide.

In the case of Comprehensive Services to Families with Children, services are offered throughout Puerto Rico in collaboration with CBOs and research projects such as CEMI which is also funded by NIH and NIWH.

Epidemiology technicians also manage the intervention in the community. On the other hand, among the weaknesses identified is the change in contact information by the population.

In relation to this, a pilot Project called "Healthy Relationships" is currently being carried out in clinics by five physicians and one coordinator, as well as two additional projects targeting MSM.

[42] Total funds from Ryan White assigned to Puerto Rico for the period of April 2009 to March 2010 add up to $34,195,229: $20,854,678 assigned to ADAP; $3,153,659 for Supplementary ADAP; $10,023,481 for Program BASE; and $163,411 for Program MAI.

Finally, the CBOs that were consulted noted that they had been forced to develop up to date strategies to attract the population's attention and to ensure that these recently diagnosed cases receive services. Strategies include: using text messaging, social networking sites, email, coordinating activities such as hotel stays, organizing activities in the clinics, phone calling, among others.

B: GOAL SETTING

GOAL 1: Provide health care along the continuum of the HIV disease for persons living with HIV.

When discussing this goal, closely related to the second goal and the National Initiative of increasing access to care and improving health outcomes for people living with HIV; and, reducing HIV-related health disparities, a conclusion was reached that the intervention should focus on convincing patients not to abandon treatment, and on simplifying the process to encourage them to continue or start treatment.

REQUIRED INTERVENTION #8: "IMPLEMENT POLICIES AND PROCEDURES THAT WILL LEAD TO THE PROVISION OF ANTIRETROVIRAL TREATMENT IN ACCORDANCE WITH CURRENT TREATMENT GUIDELINES FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS

SERVICES AND ORGANIZATIONS

The AIDS Drugs Assistance Program (ADAP) receives federal funding to provide FDA-approved medication to treat HIV in Puerto Rican residents who do not have access to physicians and have no or limited insurance coverage for medication. Depending on eligibility, people with HIV may gain access to ADAP medications in 45 participating Centers or private clinics throughout the Island. These include the CEPTETS; and an external network consisting of the following entities:

- Centro de Salud de Lares (16 centers)
- Centro de Epidemiología de Bayamón
- Casa Joven del Caribe de Toa Alta

- Gurabo Community Health Center
- Hospital Ryder Memorial / Proyecto CIS Humacao
- Centro de Salud de Migrantes,
- Prog. SSIMA
- Iniciativa Comunitaria San Juan
- Concilio de Salud Integral de Loíza
- Programa más Salud: SIDA con Salud, San Juan
- Nuevo Puerto Rico CoNCRA San Juan
- Centro de Salud Familiar Dr. Julio Palmieri Arroyo
- Consejo de Salud de la Comunidad
- CDT Ponce
- Clínica Especial de la Salud de Juana Díaz
- Centro Deambulantes Cristo Pobre, Inc. Ponce
- Centro Ararat, Ponce
- Amor que Sana, Inc. Ponce

During 2009-2010, this program cleared 4,796 HIV-positive people for treatment, offering 110,825 drugs to 4,716 people.

Indicators corresponding to the Treatment Guidelines published by PHS are measured through the Ryan White Quality Committee and the ADAP Assessment Committee, which offer advice on the list of medications available through the Program.

RESOURCES AND ADDITIONAL EFFORTS

In 2009, $348,387 HRSA: Ryan White Part B funds were used to finance this project. The Program estimates that the monthly expense of a patient that is in a 3 to 4 antiretroviral treatment is about $1,225.00.

Through the Quality Initiative, the Ryan White Program distributes treatment guides to all staff members of the Immunology clinics. When treatment guidelines are updated or revised, they are given to clinical directors and to quality controllers of the PRDOH clinics.

In 2009, the ADAP Assessment Committee met on five occasions, and PHS Treatment Guidelines were distributed to 50 people. These included: Guidelines for Prevention and Treatment, Guidelines for the Use of Antiretroviral Agents in Pediatrics, Prenatal Guidelines, and Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents.

The CBOs consulted consider this a highly important intervention. Nonetheless, these organizations recognize the high costs of treatments and the fact that not all have access to them. Furthermore, they note that medical insurance plans limit the time of coverage for these drugs.

B: GOAL SETTING

GOAL 1: Develop policies and procedures that facilitate implementation of the most updated guidelines on the use of Anti-Retroviral Therapy in both public and private settings.

According to stakeholders, this is an important goal considering that, in order to offer uniform treatment according to the guidelines for treating persons with HIV, all staff in charge of treating this population must be adequately trained in all changes and updates to these guidelines. It was also discussed that to reach national objectives and maximize the effect of the ECHPP, a data gathering system must be put in place to measure the use of and adherence to these guidelines.

REQUIRED INTERVENTION #9: "IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING ADHERENCE TO ANTIRETROVIRAL MEDICATIONS FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS

The Ryan White Part B Program has implemented various initiatives directed at improving adherence to treatment among persons with HIV receiving services at the PRDOH's CEPTETs. The Program, through its Minority Health Initiative funding disseminates educational material to persons with HIV when they arrive for treatment for the first time at the CEPTET. In addition, they also request authorization to locate patients who miss their medical appointments. The Part B Program also has under contract the Ponce School of Medicine's Health Psychology Program specializing in HIV-related services. Clinical psychologists who are part of this program conduct direct adherence promotion interventions as well as provide training to case managers, outreachers and other clinical personnel on the topic. During 2009 the Part B Program assigned funding for these interventions but services were limited due to the difference in Ryan White Fiscal Year and the calendar year periods. Activities related to these interventions began in the last quarter of program year 2009-2010, so the greatest impact will be determined based on 2010 data.

These activities are part of the treatment protocol for HIV positive persons, and are incorporated in the procedural guidelines of case managers and all health professionals that work in the centers. They are also part of the educational plans that are implemented throughout the network. In addition a system to gather client-level information is available to gauge the progress achieved in complying with quality indicators based on treatment guidelines. Through the Quality Initiative, this information is gathered and worked on with the quality committees and the staff in the clinics.

The amount of funds used in 2009 related to this intervention was $340,035. Educational material was distributed to 706 persons and two Psychology of Health interventions were completed. These services were provided in CLETS and four CPETs in the SJMSA.

The intervention was also made in the Centro de Estudios Materno Infantil (CEMI) in the Medical Sciences Campus and it operates with NIH and NIWH funds. The intervention is provided in CBOs; that include: Taller Salud, Iniciativa Comunitaria, and others; and with other programs in the

University Hospital in the University of Puerto Rico, Medical School Campus such as Project GAMMA.

The CBOs consulted, consider this intervention important since the persons being treated should be maintained in the assigned treatment protocol, since this will permit evaluating whether it is correct or not. They also perceive that treatment will make the person healthier. However some of the limitations that make it difficult to keep persons in treatment process are: access to clinics that offer medications, their cost and limits in the coverage by the health plans.

Some of the groups consulted indicated that one barrier for this intervention is that medications are offered by different entities, such as Ryan White and Mi Salud, and that each one use different dates to refill prescriptions and thus forces patients to undergo a large number of transactions.

B: GOAL SETTING

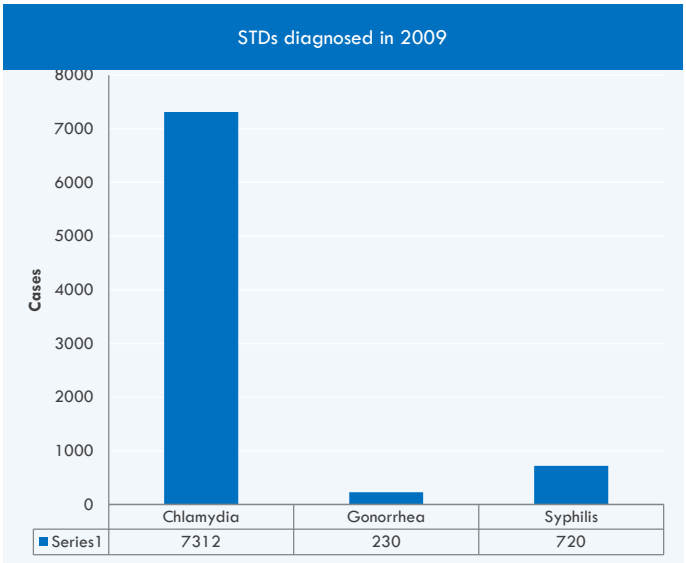
GOAL 1: Increase adherence to antiretroviral treatment for persons with HIV

According to stakeholders, this intervention is important within a national plan that aims to promote adherence to anti-retroviral treatment among persons with HIV. Another goal is to reduce the disparities among different population groups with high numbers of HIV persons (illegal immigrants/inmates /IDUs/sex workers/transgenders/ MSM) who have "particular needs" or are treated differently at the time of receiving services.

Thus, in order to be effective and to integrate this with other interventions it is important to develop innovative strategies to effectively reach those persons with HIV who, out of fear, prejudice, lack of resources, or stigma, decide not to seek services; provide specific training related to the intervention in populations targeted in this plan, and maintain collaboration with other services organizations.

REQUIRED INTERVENTION #10: "IMPLEMENT STD SCREENING ACCORDING TO CURRENT GUIDELINES FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS



The screening of sexually transmitted diseases in persons that are HIV Positive and that is at high risk, is carried out according to the 2006 STD guidelines, and is carried out in the PRDOH's CEPTETs and in community activities. In 2009, the Prevention Program used $373,281.00 from the CDC.

The Centers for the Prevention and Treatment of Transmissible Disease (CEPTET, from its Spanish acronym), previously known as Regional Immunology Clinics, were established in August 1990. The CEPTET's mission is to integrate prevention, treatment and services related to HIV/AIDS, STD, TB and Hepatitis C.

Entry into the system of health services offered by the Center is on a voluntary basis. The persons that seek services from the CEPTET are referred by public and private institutions or come on their own.

In the case of community based organizations, Iniciativa Comunitaria is the only one that receives funding directly from the CDC ($173,267.00). Among its programs there are some that are educational and have as their objective the prevention of sexually transmitted diseases. "Kamaria" is one of these projects, directed at users of injection drugs and women who are sex workers. A similar program exists in Caguas.

Another community organization that provides this kind of service is Casa Joven del Caribe, which also focuses on those that use drugs that are injected, but receives funding from undisclosed private source.

B: GOAL SETTING

GOAL 1: Promote early detection and treatment of sexually transmitted diseases (STDs).

According to stakeholders, testing is essential in order to identify, treat, and educate people who practice risky behaviors. The promotion of early detention and treatment of sexually transmitted diseases is closely related to the second objective of the national strategy of increasing access to care and improving health outcomes for people living with HIV, and also with objective one, because sexual risky behaviors are identified in the process.

Stakeholders consider important for staff be trained on the 2011 updates for STD treatment guidelines (staff currently follows 2006 guidelines). Necessary materials to administer tests in non-clinical settings must also be provided, and the staff must be trained to administer such tests. A network of preventive services providers and health educators should also be made available in order to integrate this to other interventions.

REQUIRED INTERVENTION #11: "IMPLEMENT PREVENTION OF PERINATAL TRANSMISSION FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS

PREVENTION OF PERINATAL TRANSMISSION PROJECT

The HIV Prevention Division has a supplementary proposal for prevention of perinatal transmission. In addition, it offers case management services to HIV positive pregnant women in CEMI and Groupedic, HIV tests to heterosexual women in reproductive ages, public information and educational campaigns. A Project protocol of perinatal HIV prevention was created to guide the interventions.

Services related to this intervention, were offered in all delivery rooms through a coordinator. The service is provided to pregnant women and infants. Around six persons are involved in providing the service. It is done in collaboration with medical personal dealing with births, gynecologists and obstetricians. The Program has been very effective. However, one obstacle was convincing gynecologists and obstetricians, to test the women during the third quarter, particularly in those cases that had a negative result during the first quarter.

The Project works with CDC funds, which in 2009 totaled $330,243.00. The transmission rate was "0" in 2009. Tests were done on 1,874 women, and case management was provided to 52 HIV positive women.

OTHER EFFORTS

On the other hand, under the Ryan White Program, medications are provided to HIV positive pregnant women, under HRSA: Ryan White Part B, ADAP Program. In 2009, $404,177 was used for this purpose. Services were provided to 66 pregnant women.

The treatment Guidelines used for this intervention were: Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States and the 2009 Public Policy that calls for rapid HIV testing in maternity rooms to women who have not previously been tested.

B: GOAL SETTING

GOAL 1: Maintain the perinatal transmission rate below the established standard.

When discussing this goal, stakeholders emphasized in the importance of this experience for the implementation of other similar interventions, such as Intervention 1. The goal is closely related to National Initiative 1, of reducing the number of people who become infected with HIV; as well as increasing access to care and improving health outcomes for people living with HIV.

REQUIRED INTERVENTION #12: "IMPLEMENT ONGOING PARTNER SERVICES FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS

Based on information from HIV/AIDS Surveillance not knowing the HIV status of your partner and incurring in high risk activities increased the possibility of becoming HIV positive and transmitting the condition. Approximately 62% of men with at least one sex partner in the last 12 months other than his principal partner did not know the HIV status of that sex partner.

STRATEGY IMPLEMENTATION

Services provided to couples is a strategy aimed at persons who have had a possible exposure to HIV and do not suspect that they have been at risk. These services play an important role in early detection in high risk individuals by early referral to medical and prevention services. Likewise, it permits early detection of the transmission chain and its curtailment.

The specific purpose of this service of notifying partners is to help those HIV positive persons to inform their sex Partners and/or those with whom they exchange needles over the potential HIV risk. It also helps couples to access counseling services, tests, medical evaluations, treatment and prevention services.

This service is offered when the person receives a HIV positive result, confirmed by a serology test, and is voluntary and with an explicit acceptance expressed.

In Puerto Rico, partner notification is conducted by the PRDOH through an Epidemiology Technician who has the preparation, experience, knowledge, staff and the protection against any legal action rising from this action. Law 81, approved on June 4, 1983, and amended in June 1994, makes it possible for the PRDOH to obtain positive results of sexually transmitted diseases from public and private laboratories and health services providers.

The Epidemiology Technician, is the only health professional authorized by law to offer this service, to meet, counsel, investigate and interview persons that are suspected to have or already have a sexually transmitted disease, including minors, persons with mental retardation or other mental deficiencies.

Other providers can offer assistance to their HIV positive clients so that they voluntarily notify their partners with or without the presence of the agency staff. Nevertheless, if the client does not do it or is not contacted by the agency, the case is referred to the Department of Health for this service.

PROTOCOLS

To provide guidance for this service, the PRDOH developed the Service Protocol for Partners Notification, which complies with Federal Government recommendations of 2008. In addition, Law 81 and its regulations were amended, to incorporate the specific functions of the Epidemiology Technician.

RESOURCES AND IMPACT

The funds for this intervention in 2009, were provided by the CDC and were $531,608.

As a result of this intervention, the service is offered in clinics to couples that are HIV positive. At the moment there are nine persons assigned to offer this service. Based on the Law, this activity is performed by PRDOH staff. The Epidemiology Technicians work jointly with the Partner Services Program and data for 2009, establishes that the service was offered to a total of 409 persons, of these 376 accepted the services, 277 were tested and 49 were confirmed as positive.

Among the major obstacles confronted are the following: that the HIV positive couples or those with some STD refuse to participate, no interventions with private patients, Internet contacts, lack of knowledge regarding the legal aspects of the service and coordinating with other government agencies when legal resources are needed. In private cases the training of the case manager and of other service staff is fundamental in order to make the appropriate referral to the PRDOH.

With respect to Internet contacts a Project has been started, but only three cases have been contacted.

CBOs consulted understand this is a fundamental intervention but that it requires caution in its implementation. Organizations that carry out HIV tests and detect a positive are required to report to the PRDOH. The organizations must make it clear to the patient that informing the PRDOH is part of the protocol. In addition the person is advised to inform any sexual partner so that they can have the necessary tests done. The participating organizations indicated that the PRDOH identifies the person that had a sexual contact with a person with HIV and contacts them in order to test them. However, these persons never know the identity of the person responsible for putting them at risk or infecting them.

B: GOAL SETTING

GOAL 1: Early identification of individuals who are at high risk of becoming infected and decreasing this risk.

REQUIRED INTERVENTION #13: "BEHAVIORAL RISK SCREENING FOLLOWED BY RISK REDUCTION INTERVENTIONS FOR HIV-POSITIVE PERSONS (INCLUDING THOSE FOR HIV-DISCORDANT COUPLES) AT RISK OF TRANSMITTING HIV"

A: SITUATIONAL ANALYSIS

This type of intervention are done in the PRDOH's CEPTETs by health educators, and in collaboration with the HIV Prevention Epidemiology Technicians and the health psychology service. Clinics that provide this intervention are: Bayamón, Arecibo, Ponce, Caguas, Humacao and Carolina.

In 2009, a total of six meetings with sixty health professionals were given and two trainings on the trans-theorical model to for 33 persons.

In the past Comprehensive Risk Reduction Counseling Services were also offered, including "risk screening" of persons to determine their eligibility to participate in the program. In 2008, three trans-theorical model of behavioral change activities were carried out, with the participation of 28 health professionals, in 2009, two trans-theorical model of behavioral change model was offered to 33 health care providers.

The service is provided to HIV positive persons as well as those at risk of contracting sexually transmitted diseases. Funds for this program come from the CDC. One of the major obstacles according to those consulted was the medical flow chart and the architecture of the clinics.

Individual Prevention Intervention for Persons living with HIV given in 2009 at the CEPTET's and CLETs were the following:

- 34 interventions to Heterosexual men living with HIV who practice unprotected sex, between the ages of 25 and 44.

- 44 interventions to Heterosexual women living with HIV who practice unprotected sex, between the ages of 25 and 44.
- 29 interventions to MSM living with HIV who practice unprotected sex, between the ages of 25 and 44.
- 28 interventions of IDU living with HIV who practice paraphernalia sharing, between the ages of 25 and 44.

The HIV Surveillance System, provides support for this intervention through information gathering. The annual Budget for this task is $30,000 and the information is sent directly to the CDC. Some problems were identified with the data gathering process due mainly to changes in the system used to gather the information.

Additionally, in some cases private physicians, frequently do not adequately complete information about risky behavior. Moreover, according to some consulted parties, the use of different systems made it difficult to consolidate databases.

CBOs mentioned the importance of this intervention and the need for developing an Intervention Plan for reducing risk and also includes the identification of practices that augment the risk of contracting HIV or some other sexually transmitted disease.

In addition to various community based organizations that provide services related to this intervention (Projects GAMMA, CONCRA, COSSMA and Lucha contra el SIDA), a program for drug users was identified in ASMMCA. It is funded with federal government funds.

B: GOAL SETTING

GOAL 1: Decrease the number of HIV-positive persons at risk of transmitting HIV.

This intervention is essential in reaching the National Objective 1 of reducing the number of people who become infected with HIV. Efforts in this direction are important to reduce the risk of getting the infection, as well as to optimize the output of medical treatment. The intervention is also important to maximize the results of interventions such as interventions six and ten.

REQUIRED INTERVENTION #14: "IMPLEMENT LINKAGE TO OTHER MEDICAL AND SOCIAL SERVICES FOR HIV-POSITIVE PERSONS"

A: SITUATIONAL ANALYSIS

Through the Ryan White Program, Part B case management services are provided to coordinate psychosocial and medical services for HIV positive persons. In 2009, funds from HRSA were used, totaling $1,295,035. For purposes of the intervention financial support was offered to seven community organizations located in or providing services to various regions: (Fundación Acción Social Refugio Eterno, Bayamón; Fundación Acción Social Refugio Eterno, San Juan; Instituto PreVocacional e Industrial, Mayagüez; Instituto PreVocacional e Industrial, Arecibo; Bill´s Kitchen, Fajardo; APSAPS, Caguas; Consorcio Región Sur de Puerto Rico, Ponce). The amount allocated in 2009 for these purposes was $970,685.00.

The "Guía de Manejo de Casos Clínicos" (Guidelines for Managing Clinical Cases) was used to guide the intervention. The number of persons dealt with in 2009, was 5,504. The CAREWare system was implemented in 2009 to electronically gather information from all CEPTET's, offering services to 3,317 non-duplicate patients

Community organizations and the Prevention Program also coordinate services with other entities. Collaborative agreements have been reached, not necessarily in written form, to provide the service.

Among the obstacles that have been confronted on occasions in providing these services are the scarcity of human resources and lack of adequate training.

The CBOs consulted for the purpose of developing the Plan were very receptive to the idea of engaging other entities to guarantee an adequate provision of services to patients that will make it possible for them to have a good quality of life. However, there is some uncertainty in regards to integrating persons to a network not well defined.

In the particular case of priority populations for the purposes of the Plan, according to data in PR NHBS-IDU2, Secondary Data Review Report, in San Juan there are approximately 156 facilities that deal with drug use. Most of them are either run by government or managed by non-profit organizations. In addition to drug addiction related services, services are provided that have to

do with mental health and health in general. Among the services offered: ambulatory or external services, (daily treatment, partial hospitalization, methadone and buprenorphine, among others); residential (short and long term) and hospitalization (detoxification and rehabilitation).

There is also a large number of organizations that provide prevention services and direct services to this population including: "Iniciativa Comunitaria" (IC), "Lucha Contra el SIDA", "SIDA de San Juan", "Casa Joven del Caribe", "Hogar Crea" "Asociación Puertorriqueña de Servicios y Ayuda al Paciente con SIDA-Caguas", Instituto Pre-vocacional e Industrial de Puerto Rico", "Bill's Kitchen", y "La Perla del Gran Precio". The services provided by these organizations are related to the provision of shelter, satisfying basic needs (for example, nutrition), training workshops, case management, psychological services, education for couples, emergency shelter, control of STDs and community outreach. Between 2006 and 2009, 4,130 referrals were granted for different services, impacting 3,202 non-duplicated persons.

The Municipality of San Juan, has the service known as "SIDA con SALUD", that provides services to HIV positive persons, including injection drug users. Services provided include: prevention, community activities, ambulatory services, nursing services, social work, medical services and those related to health issues, case management and detoxification.

In the case of the male with male population, in the SJMSA there are two CBOs that provide services to this population. These are COAI and Puerto Rico CONCRA. COAI, provides services related to education, orientation, counseling, emotional support, outreach and referrals. The entity receives $582,345.00 in federal funds annually. In addition, it has access to local funds from the government and private foundations.

Puerto Rico CONCRA, on the other hand, provides services related to early intervention, case management and referrals, primary health services, protocol development, dental services, nutrition, services related to mental health, those related to social work and partner projects, among others. It receives funding from the CDC in Atlanta, and has access to Ryan White funds, distributed locally. Annually, CONCRA receives approximately $318,465 in federal funds.

Finally, persons with HIV and their families can have access to other programs sponsored by the Federal Government, among them HOPWA. This program operates with Federal Housing and Urban Development Department funds.

B: GOAL SETTING

GOAL: Support persons with HIV in accessing other social and health services that result in improved health and wellness.

The goal of supporting persons with HIV in accessing other social and health services is seen as essential for improving the quality of life of the person living with HIV and their families, and to reach the National Initiative of increasing access to care and improving health outcomes for people living with HIV. Also, access to social and psychological services is a key aspect to other interventions that pursue the integration of persons into medical treatment.

RECOMMENDED INTERVENTION #15: "CONDOM DISTRIBUTION FOR THE GENERAL POPULATION"

A: SITUATIONAL ANALYSIS

As mentioned in the required intervention #3, condom distribution is one of the main prevention activities conducted in the Island. However, it is not carried out in a structured manner and lacks mechanisms to assess its efficacy.

Condoms are distributed in the PRDOH's clinics and in community outreach activities. Although they are provided to all persons that request them, emphasis is placed on persons with HIV and those in high risk groups. Some areas outside the PRDOH's facilities may include gay bars, pre-identified by the HIV Prevention Division. In the case of the general population, condoms are distributed in activities such as the International AIDS Day.

Outside of these activities and places outreached by the PRDOH, condom distribution is done by CBOs, such as COSSMA, Lucha contra el SIDA, and PR-CONCRA among others, in community activities and in their facilities. Activities conducted by the PRDOH are funded by the CDC. Activities conducted by the CBOs are funded by the CDC through a subcontract with the PRDOH and other state funds.

As it was mentioned earlier, about one million condoms are annually distributed Island-wide, out of these 145,000 approximately are distributed in the SJMSA.

B: GOAL SETTING

GOAL: Extend the distribution and accessibility of condoms in high pedestrian circulation in the SJMSA

The extension of condom distribution is considered by stakeholders as an important step in order to broaden the population already served. This strategy can help reduce new HIV cases, by reaching people at risk who do not visit high risk environments, such as gay bars, in order to avoid being identified. This type of action, according to the stakeholders, can also increase the level of awareness in the population.

Stakeholders consider that its effectiveness may be measured by including questions on the use of condoms in the Behavioral Risk Factor Surveillance System (BRFSS).

RECOMMENDED INTERVENTION #16: "HIV AND SEXUAL HEALTH COMMUNICATION OR SOCIAL MARKETING CAMPAIGNS TARGETED TO RELEVANT AUDIENCES"

A: SITUATIONAL ANALYSIS

Currently, there is no comprehensive campaign focused in communicating health information related to HIV and sexual behavior. The reason for this lack of effort in conducting health communication or social marketing for HIV and sexual behaviors is the lack of funds available for this purpose. Therefore, the educational element for the population is included in outreach activities. Interventions in clinical settings also include an educational element, but it is not a massive event.

The PRDOH HIV Prevention Division has conducted some research on the information needs of the population, and one of their findings was the lack of knowledge on basic HIV transmission information. Within the general population, a target should be men who have sex with men. As it was mentioned in a previous section, MSM have an average age of 42 years, most live in the Metropolitan Area, seven out of every ten are single, six out of every ten are employed, their median educational attainment is a bachelor's degree and 42.7% earn $1,500 or more per month.

In terms of their sexual behavior, the younger the men the more probability of performing unsafe practices such as never using condoms, use injection and/or not injection drugs and practice anal sex. On the other hand, results regarding knowledge about HIV and STDs were mix. For most of the practices (receptive anal sex, insertive anal sex or both) having more education or knowledge meant less probability of performing them, but for two practices (anonymous sex and sex with multiple partners) it meant more probability of performing them.

This group also expressed they would like to receive information regarding: Healthy life styles (59.3%); How they can protect their partner or couple (56.7%); treatments or a cure (56%); basic aspects of STD/HIV/AIDS (55.3%); available services and where to apply or request them (55.3%).

In order to meet this need of information a small scale social marketing campaign has been planned. Most of the research directed towards the type of message and vocabulary, and which communication channel can be more effective has been done. This project has not been implemented due to lack of funds.

B: GOAL SETTING

GOAL: Promote HIV educational messages directed towards changing high risk behavior in women.

According to almost all stakeholders this is the most important intervention in order to achieve the National Strategy, because of its influence in other interventions. The importance of the media in the attitude and behavior of individuals has been proven. Moreover, knowledge is one of the first steps to change behavioral patterns. Thus, if we want to be effective in the implementation of other interventions, a complementary strategy, such as this one, has to be incorporated. This will assure that people can access information that provides them some knowledge on HIV or where to access basic information.

PROCESS INFORMATION

In order to conduct the situational analysis several tasks were conducted and organized in two main phases. The first of these phases consisted of one on one interviews and focus groups with internal and external stakeholders. Internal stakeholders included representatives of the different divisions and programs of the Secretariat of Family Health and Integrated Services and Health Promotion (see Appendix 1- A). External stakeholders included leaders and personnel from other Governmental Agencies, Municipalities, and Community Based Organizations of the San Juan SMA. Fifty six persons participated in these meetings and focus groups.

Interviews and focus groups provided qualitative information about activities that are taking place in the locality, who is conducting them, where they are occurring, who is reached, and the resources involved in supporting them. It also, was a first step to determine areas of priority regarding possible interventions.

As part of this phase, a matrix was developed to gather data on activities or services budget, organizations sponsored by the state and impact indicators. This information was analyzed in combination with secondary sources of data, which included, among others: Comprehensive plans from Prevention Program and Ryan White, local epidemiological data, and other internal assessments and statistics (See Appendix 1-A, for a complete list).

As a second phase, an Internet link was developed so people could continue providing input through the process, and have access to the documents that were being used in the situational analysis (www.estudiostecnicos.com). Lastly, in order to validate findings from the situational analysis, and decide upon goals and create smart objectives, a three day workshop was conducted for the 14 required interventions and a one day workshop for two recommended interventions.

During the process, a series of limitations were encountered concerning the availability of data or the format in which certain data was available. For example, some indicators were not available as of 2009. In other cases, information could not be segregated by intervention or for the SJMSA. Additionally specific data concerning condom distribution, and adherence to medications, started to be collected six months ago.

Step 2: In the list below, please describe the process that occurred to complete the evidence-based goal setting in Step 2 that is documented in this workbook. Please address the list of considerations below.

- In making decisions about which goals to set, what were the most useful sources of data? What other resources were the most useful?
- What additional resources would have been helpful to support goal setting (e.g., data sets, planning tools, staff, other)?
- How did you make decisions about the combined effects of required activities to optimize HIV prevention efforts?
- How did you reach a final decision about which activities to change and include in the enhanced plan (e.g., consensus of key staff, voting, other)?

The Ryan White Part B, Comprehensive Plan; the HIV Prevention Comprehensive Plan, Epidemiological Data and information derived from the interviews conducted were some of the most useful sources of data used when making decisions among goals. Also the interaction between different stakeholders in the workshops brought different perspectives to the discussion. On the other hand, data as the one mentioned in the previous section (specific indicators for SJMSA), would had been useful in the process.

The workshop was the most important tool for decisions about the combined effects of required interventions. Participants of the workshops represented internal and external stakeholders (See Appendix 1- B). They were organized in two main groups that discussed interventions individually, and then shared the results of their discussions, with the entire group in order to reach a consensus. Consensus was reached through a guided discussion and a final vote to establish priorities. When reaching a consensus and voting, decisions were made based on the feasibility of the proposed strategies, which considered aspects such as: time to implement, internal resources (funds, personnel, service infrastructure), external resources (sources of funding), capacity to combine efforts with other sectors and possible impact.

Workbook 2: Goals, Strategies and Objectives

DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO

INTRODUCTION

This Workbook includes the results of the Second Step of the development of the **Puerto Rico Enhanced Comprehensive HIV Prevention Plan** (PRECHPP). The goals, strategies and objectives included are the result of an intensive planning process, which involved the participation of over fifty (50) stakeholders from the public sector, the private sector (particularly CBOs) and the affected community. Decisions regarding strategies and objectives were based on the results of the situational analysis. Interventions were prioritized using a participatory deliberation model based on three main criteria: Timing, Balanced Inclusion of Prevention and Treatment Interventions and Feasibility (Resources & Previous Experience).

The planned impact of the portfolio of interventions is aligned with the goals of:

- reducing the number of people with HIV infection
- Increasing access to care for HIV+ people
- Improve health outcomes for HIV+ people
- Reduce HIV related health disparities

Prevalence and epidemiologic data for Puerto Rico, as well as other sources of information fully support the need to focus the interventions that will be implemented as part of the PRECHPP on UDIs and MSMs, as well as other special subgroups, such as women at high risk. Also, available data points out to the need of strengthening areas such as:

- Testing in clinical and non-clinical settings;
- Education and knowledge (of the community as well as service providers);
- Condom distribution; and
- Communication and alliances among agencies and service providers to facilitate linkage to care.

Also, an examination of the current institutional and regulatory framework revealed the importance of working with public policy changes that would help make viable the proposed strategies.

INTERVENTIONS:	PLANS FOR IMPLEMENTATION		
	Begin	Scale-Up	Continue
Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"		●	
Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"		●	
Required Intervention #3: "Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection"		●	
Required Intervention #4: "Provision of Post-Exposure Prophylaxis to populations at greatest risk"			●
Required Intervention #5: "Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment"	●		
Required Intervention #6: "Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care"	●		
Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"			●
Required Intervention #8: "Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons"			●
Required Intervention #9: "Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons"		●	
Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"			●
Required Intervention #11: "Implement prevention of perinatal transmission for HIV-positive persons"			●
Required Intervention #12: "Implement ongoing partner services for HIV-positive persons"		●	
Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"		●	
Required Intervention #14: "Implement linkage to other medical and social services for HIV-positive persons"		●	
Recommended Intervention # 15: "Condom distribution for the general population"		●	
Recommended Intervention #16: "HIV and sexual health communication or social marketing campaigns targeted to relevant audiences"	●		

Lastly, goals, strategies and objectives were structured over a period of three years.

TIME TABLE	2011												2012												2013											
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"																																		
Goal 1: Increase the number of persons who get tested for HIV through the Opt-out methodology in a clinical context.																																		
Strategy 1: Promote and educate persons using health care facilities on the importance of routine, opt-out screening for HIV.																																		
Objetive 1.1: Hire at least one trained HIV Health Educator that will offer orientation to persons utilizing different health care facilities highlighting the importance of routine, opt-out screening for HIV.																																		
Objetive 1.2: the Health Educator will conduct visits to at least 20 health care facilities in the SJMSA.																																		
Strategy 2: Negotiate with health insurance providers to cover the cost of HIV screening and confirmation test.																																		
Objective 2.1: A meeting will be arranged with the state Medicaid Health System and the *Administración de Servicios de Salud de PR* (ASES) to negotiate coverage of at least one annual rapid HIV test per person.																																		
Objective 2.2: OCASET will coordinate a meeting with the Private Insurance Commissioner to negotiate coverage of at least one annual HIV test per person by private insurance companies.																																		
Strategy 3: Diversify the scenarios in which opt-out tests are provided in clinical settings.																																		
Objective 3:1 Conduct rapid HIV testing on at least 60% of the persons who use emergency rooms in the Diagnostic and Treatment Centers located in 3 high incidence areas (Cataño, Loiza and Canóvanas) in the SJMSA.																																		
Objective 3.2: The Correctional Health System will provide HIV tests to at least 75% of inmates who receive clinical services in their institutions.																																		
Goal 2: Increase the number of providers that offer HIV testing through the Opt-out methodology in a clinical context																																		
Strategy 1: Conduct a survey to identify the type of health providers that do not offer HIV testing in their clinics in the SJMSA																																		
Objetive 1.1: ECHPP team will use the data obtained from the survey to identify the profile of health care providers that do not offer HIV testing in their clinics, to be able to design specific strategies targeted to these groups.																																		
Objetive 1.2: hire at least one trained HIV Health Educator that will offer presentations highlighting the importance of routine opt-out screening for HIV in annual medical conferences.																																		
Strategy 2: Establish alliances with medical organizations to promote opt-out testing among health providers.																																		
Objective 2.1: By June 2012, The ECHPP PI and or Coordinator will have met with medical organizations' chairs to establish collaborative agreements on promoting routine opt-out screening for HIV among their members.																																		
Strategy 3: Provide rapid HIV tests in emergency rooms.																																		
Objective 3.1: By January 2012, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms located in Bayamón, Carolina and San Juan Hospitals.																																		
Objective 3.2: By January 2013, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms in CDTs located in Cataño, Canóvanas and Loíza.																																		
Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"																																		
Goal 1: Increase the number of persons who get tested for HIV in non-clinical settings.																																		
Strategy 1: Identify CBOs that provide support services to high risk groups (MSM, IDU, HRH) in high incidence areas of the SJMSA.																																		
Objective 1.1 By June 2011, create an inventory of CBOs by high risk groups in high incidence areas of the SJMSA.																																		
Strategy 2: Promote collaboration among the CBOs that provide support services to high risk groups in high incidence areas of the SJMSA to establish a referral system to maximize HIV testing opportunities and ensure greater access.																																		
Objetivo 2.1 By January 2013, establish collaborative agreements between CBOs so they can refer persons to others CBOs that provide HIV testing in non-clinical settings.																																		
Strategy 3: Evaluate the implementation of a web based recruitment and referral system between CBOs and PRDOH (no partner services).																																		
Objective 3.1: By June 2012, provide web access for at least two PRDOH HIV Prevention Outreach Technicians so they can recruit high-risk persons via web to provide them with referrals for HIV testing sites.																																		
Goal 2: INCREASE THE NUMBER OF OUTREACH ACTIVITIES WHERE TESTING IS CONDUCTED																																		
Strategy 1: Increase the number of community based organizations that administer HIV tests in the SJMSA.																																		
Objective 1:1 By January 2013 assure that 50% of the organizations that provide preventive services, offer testing.																																		
Strategy 2: Identify new funding sources for these organizations.																																		
Objective 2:1 By January 2013, coordinate at least two meetings with legislators who deal with health-related issues to identify new sources of funding to be used for HIV testing services.																																		

TIME TABLE

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	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Required Intervention #3: "Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection"																																		
Goal 1: Implement condom distribution in clinical facilities that provide services to HIV positive persons.																																		
Strategy 1: Create a survey to identify the clinical facilities that provide services to persons living with HIV in the SJMSA.																																		
Objective 1.1 By June 2011, based on the data obtained from the survey, create an inventory of clinical facilities where condoms can be distributed.																																		
Objective 1.2: By August 2011, establish liaisons with the identified clinical facilities to promote condom distribution to persons living with HIV.																																		
Strategy 2: Develop an evaluation plan to measure condom distribution and usage in organizations that receive condoms for persons with HIV and those at high-risk.																																		
Objective 2.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.																																		
Goal 2: Increase condom distribution in CBO's not funded by the PRDOH that provide services to high risk groups in high incidence areas in the SJMSA.																																		
Strategy 1: Identify municipalities with the highest HIV incidence rates in the SJMSA																																		
Objective 1.1: By June 2011, the Puerto Rico Surveillance Program will provide incidence data by municipalities and risk groups in the SJMSA.																																		
Strategy 2: Identify the CBOs that provides services to populations at high risk within the municipalities with the highest rates of HIV in the SJMSA																																		
Objective2.1: By July 2011, create an inventory of CBOs that provide services in municipalities with the highest risk incidence.																																		
Strategy 3: Establish collaborative agreements with these CBOs not funded by the PRDOH for condom distribution.																																		
Objetive 3.1: By December 2011, establish at least five collaborative agreements to provide condoms to CBOs that provide services in municipalities with the highest risk incidence.																																		
Strategy 4: Develop an evaluation plan to measure condom distribution and usage in CBOs not funded by the PRDOH.																																		
Objective 4.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.																																		
Required Intervention #4: "Provision of Post-Exposure Prophylaxis to populations at greatest risk"																																		
Goal 1: Decrease the probability of acquiring HIV in a risky event, by the provision of Post-Exposure Prophylaxis.																																		
Strategy 1: Update post-exposure protocol in cases of physical/sexual abuse or occupational/non-occupational accidents.																																		
Objective 1.1: By June 2011, the PRDOH will update and standardize post-exposure protocols.																																		
Strategy 2: Standardize post-exposure procedures in case of physical/sexual abuse or occupational/non-occupational accidents.																																		
Objective 2.1: By June 2011, the PRDOH will ensure that 100% of accredited continuing health education programs; will provide health professionals with the topic of post HIV exposure protocol as part of the "Exposure to Blood Pathogens" course.																																		
Strategy 3: Disseminate and implement post-exposure protocols in cases of physical/sexual abuse or occupational/non-occupational accidents.																																		
Objective 3.1: By December 2011, the PRDOH will implement and disseminate post-exposure protocols in the areas contained in the MSA.																																		
Required Intervention #5: "Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment"																																		
Goal 1: Identify and conduct activities to change those structures, rules, and regulations which may constitute barriers to the creation of an optimal environment for the prevention, care, and treatment of HIV.																																		
Strategy 1: Amend regulations of the College of Medical Technologists so that any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical setting can do so.																																		
Objective 1.1: By December 2011, the Secretary of the PRDOH will sign an administrative order to amend the College of Medical Technologists' rules and regulations, enabling any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical settings.																																		
Strategy 2: Provide education to physicians on comprehensive HIV disease treatment and care.																																		
Objective 2.1: By December 2012, the PRDOH will collaborate with the AIDS Education and Training Center (AETC) to provide updated training in the treatment and management of the HIV disease to members of the HIV-Care Providers Association and the Physician and Surgeons College in Puerto Rico in their annual conferences.																																		

	TIME TABLE																																			
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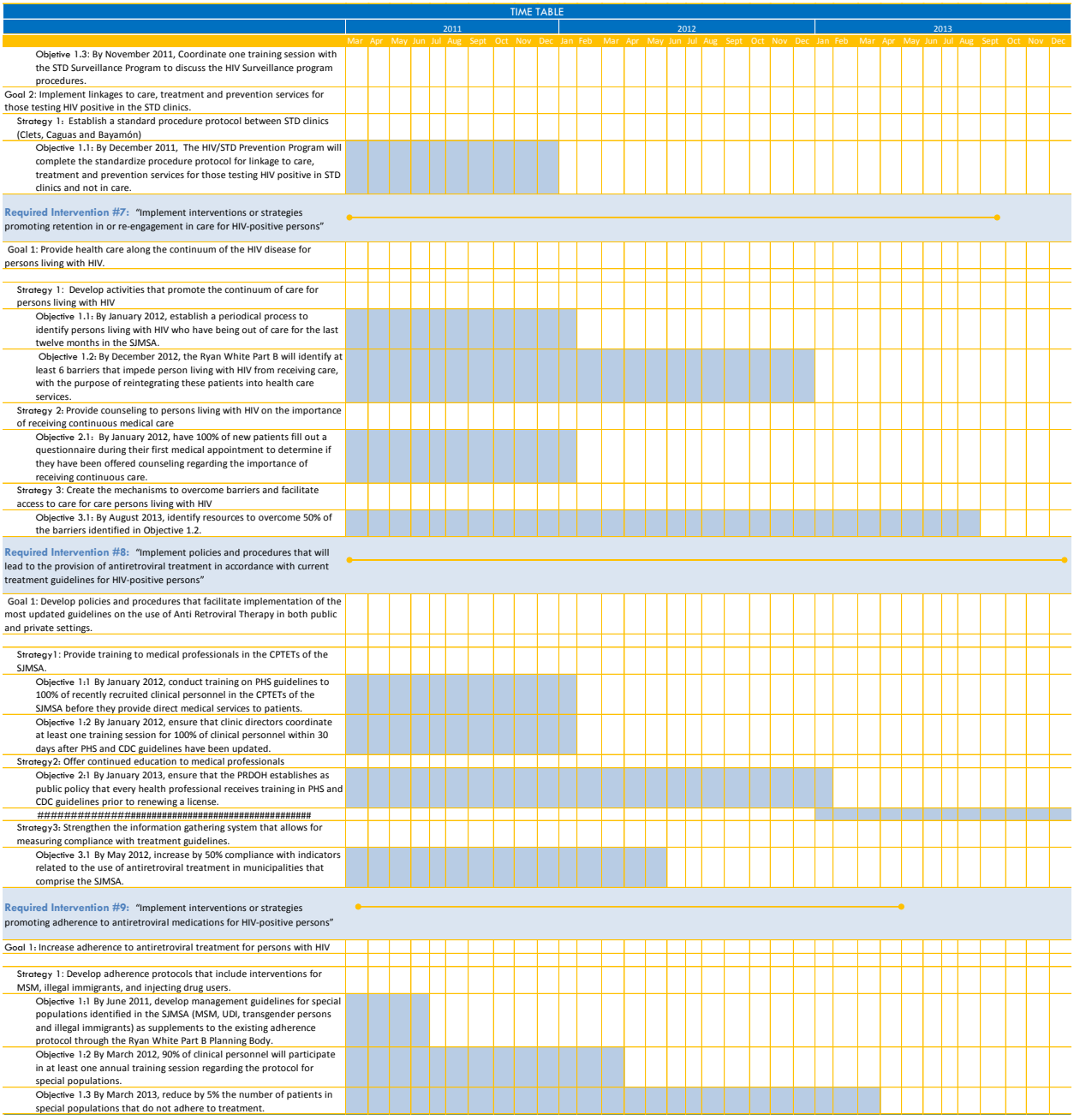
Strategy 3: Establish an HIV disease care protocol for physicians in the SJMSA that includes integral medical services required for persons with HIV.																																				
Objective 3.1: By June 2011, the PRDOH will distribute the protocol for the management of care of HIV patients to 100% of clinics and physicians working with HIV patients in the SJMSA.																																				
Strategy 4: Create a network of specialized physicians to provide services to persons with HIV.																																				
Objective 4.1: By March 2012, PRECHPP will compile a directory of physicians with different specialties related to persons living with HIV.																																				
Objective 4.2: By December 2012, OCASET and the AETC will offer basic HIV disease care training to other medical specialists to broaden the HIV care providers network.																																				
Strategy 5: Issue an administrative order to recommend HIV testing as part of routine medical care.																																				
Objective 5.1: By March 2012, the *Coalición Alcance Juvenil* will begin a process to propose legislation to include HIV testing as part of routine medical care for persons 13 years of age and older.																																				
Strategy 6: Facilitate access to needles for injection drug users.																																				
Objective 6.1: By July 2011, OCASET will educate the Municipal Police Departments in the SJMSA regarding Law 73 for needle exchange and other related policies in PR.																																				
Objective 6.2: By December 2011, the OCASET will counsel the *Pharmacists Association on the dispositions of law 73* of 2007, regarding the sale of needles/syringes in drug stores without a prescription.																																				
Objective 6.3: By June 2013, ECHHP will increase the number of syringe vending machines accessible to IDUs within the SJMSA																																				
Objective 6.4: By July 2013, initiate a process of analysis in order to promote the beginning of negotiations between PRDOH and the Legislature regarding additional funding to increase syringe exchange programs within the SJMSA.																																				
Objective 6.5: By December 2013, Propose amendments to Law 73 to allow access to paraphernalia for the purpose of improving needle exchange programs.																																				
Strategy 7: Create a Committee for the development and promotion of public policy regarding HIV, that can help in making viable and providing continuity to the proposed changes.																																				
Objective 7.1: By May 2011, identify the members for the public policy committee, one of whom will be a coordinator from ECHPP team.																																				
Objective 7.2: By May 2011, Develop the structure of the committee, including procedures and norms related to its functioning.																																				
Strategy 8: Promote public policy changes within the Department of Education (DOE) and the Department of Correction (DOC) to include condom distribution.																																				
Objective 8.1: By January 2012, coordinate at least two meetings with the Department of Education and Department of Correction Secretaries concerning the distribution of condoms in their policies and operating procedures.																																				
Strategy 9: Collaborate with the DOE in revising the health education curriculum, assessing the impact of current HIV and STD prevention strategies, and identifying ways of strengthening it.																																				
Objective 9.1: By January 2012, coordinate and create a revision panel to evaluate and submit recommendations to the Secretary of DOE, specifically in the area of HIV and STD prevention and care.																																				
Required Intervention #6: "Implement linkages to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care"																																				
Goal 1: Implement a referral network between the PRDOH and the DOC in order to link persons with HIV who have served time in a correctional facility, with care providers.																																				
Strategy 1: Establish a liaison between the staff of Correctional Health Facilities and Ryan Part B-Planning Body.																																				
Objective 1.1: By December 2011, the Correctional Health Facilities and Ryan Part B-Planning Body will develop a collaborative agreement to link HIV positive ex-inmates to care providers.																																				
Strategy 2: Provide CAREWare system to the Correctional Health Facilities.																																				
Objective 2.1: By December 2012, PRECHPP will provide the structure for the CAREWare system in the Correctional Health Facilities.																																				
Goal 2: Implement CDC's guidelines for Partner Services for the AIDS Surveillance Program and the STD Surveillance Program to be able to share HIV results.																																				
Strategy 1: Establish a collaboration between the HIV Surveillance Program and the STD Surveillance Program																																				
Objective 1.1: By October 2011, Coordinate a meeting to create an internal protocol to share positive HIV results between the HIV Surveillance Program and the STD Surveillance Program																																				
Objective 1.2: By November 2011, Coordinate one training session with the HIV Surveillance Program to discuss the STD Surveillance program procedures.																																				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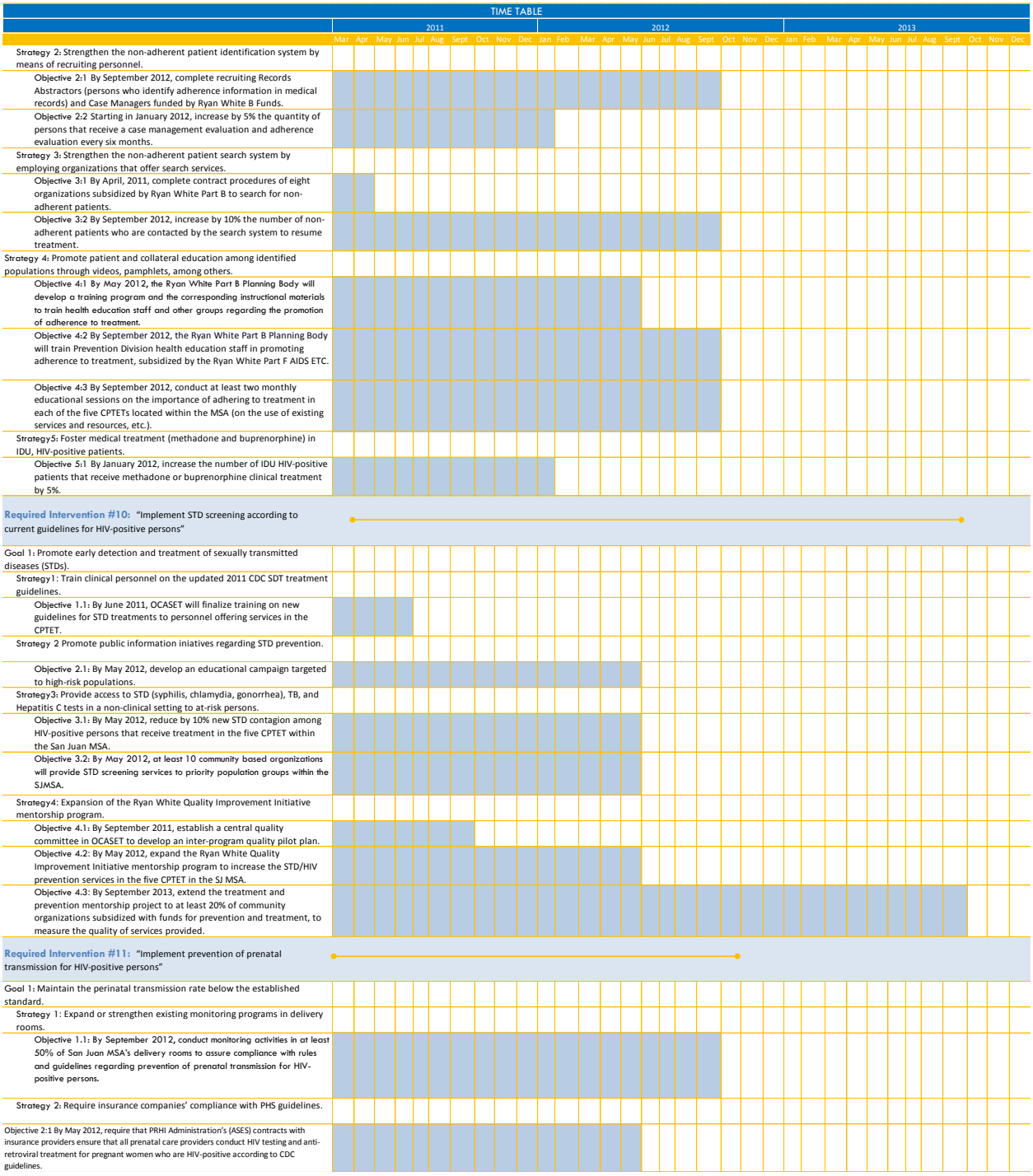
Objetive 1.3: By November 2011, Coordinate one training session with the STD Surveillance Program to discuss the HIV Surveillance program procedures.
Goal 2: Implement linkages to care, treatment and prevention services for those testing HIV positive in the STD clinics.
Strategy 1: Establish a standard procedure protocol between STD clinics (Clets, Caguas and Bayamón)
Objective 1.1: By December 2011, The HIV/STD Prevention Program will complete the standardize procedure protocol for linkage to care, treatment and prevention services for those testing HIV positive in STD clinics and not in care.
Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"
Goal 1: Provide health care along the continuum of the HIV disease for persons living with HIV.
Strategy 1: Develop activities that promote the continuum of care for persons living with HIV
Objective 1.1: By January 2012, establish a periodical process to identify persons living with HIV who have being out of care for the last twelve months in the SJMSA.
Objective 1.2: By December 2012, the Ryan White Part B will identify at least 6 barriers that impede person living with HIV from receiving care, with the purpose of reintegrating these patients into health care services.
Strategy 2: Provide counseling to persons living with HIV on the importance of receiving continuous medical care
Objective 2.1: By January 2012, have 100% of new patients fill out a questionnaire during their first medical appointment to determine if they have been offered counseling regarding the importance of receiving continuous care.
Strategy 3: Create the mechanisms to overcome barriers and facilitate access to care for care persons living with HIV
Objective 3.1: By August 2013, identify resources to overcome 50% of the barriers identified in Objective 1.2.
Required Intervention #8: "Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons"
Goal 1: Develop policies and procedures that facilitate implementation of the most updated guidelines on the use of Anti Retroviral Therapy in both public and private settings.
Strategy1: Provide training to medical professionals in the CPTETs of the SJMSA.
Objective 1:1 By January 2012, conduct training on PHS guidelines to 100% of recently recruited clinical personnel in the CPTETs of the SJMSA before they provide direct medical services to patients.
Objective 1:2 By January 2012, ensure that clinic directors coordinate at least one training session for 100% of clinical personnel within 30 days after PHS and CDC guidelines have been updated.
Strategy2: Offer continued education to medical professionals
Objective 2:1 By January 2013, ensure that the PRDOH establishes as public policy that every health professional receives training in PHS and CDC guidelines prior to renewing a license.
##########
Strategy3: Strengthen the information gathering system that allows for measuring compliance with treatment guidelines.
Objective 3.1 By May 2012, increase by 50% compliance with indicators related to the use of antiretroviral treatment in municipalities that comprise the SJMSA.
Required Intervention #9: "Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons"
Goal 1: Increase adherence to antiretroviral treatment for persons with HIV
Strategy 1: Develop adherence protocols that include interventions for MSM, illegal immigrants, and injecting drug users.
Objective 1:1 By June 2011, develop management guidelines for special populations identified in the SJMSA (MSM, UDI, transgender persons and illegal immigrants) as supplements to the existing adherence protocol through the Ryan White Part B Planning Body.
Objective 1:2 By March 2012, 90% of clinical personnel will participate in at least one annual training session regarding the protocol for special populations.
Objective 1.3 By March 2013, reduce by 5% the number of patients in special populations that do not adhere to treatment.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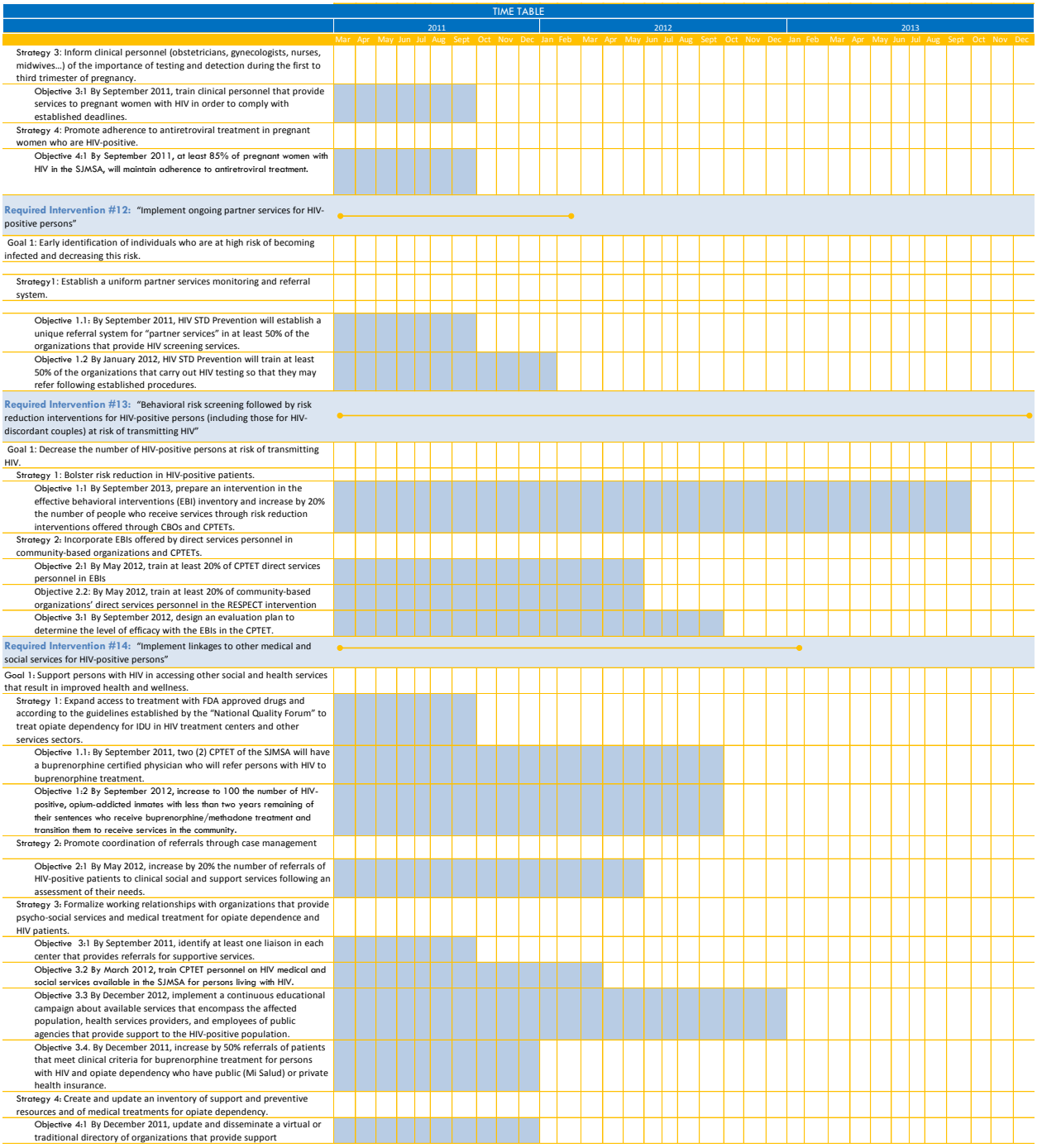
Strategy 2: Strengthen the non-adherent patient identification system by means of recruiting personnel.
Objective 2:1 By September 2012, complete recruiting Records Abstractors (persons who identify adherence information in medical records) and Case Managers funded by Ryan White B Funds.
Objective 2:2 Starting in January 2012, increase by 5% the quantity of persons that receive a case management evaluation and adherence evaluation every six months.
Strategy 3: Strengthen the non-adherent patient search system by employing organizations that offer search services.
Objective 3:1 By April, 2011, complete contract procedures of eight organizations subsidized by Ryan White Part B to search for non-adherent patients.
Objective 3:2 By September 2012, increase by 10% the number of non-adherent patients who are contacted by the search system to resume treatment.
Strategy 4: Promote patient and collateral education among identified populations through videos, pamphlets, among others.
Objective 4:1 By May 2012, the Ryan White Part B Planning Body will develop a training program and the corresponding instructional materials to train health education staff and other groups regarding the promotion of adherence to treatment.
Objective 4:2 By September 2012, the Ryan White Part B Planning Body will train Prevention Division health education staff in promoting adherence to treatment, subsidized by the Ryan White Part F AIDS ETC.
Objective 4:3 By September 2012, conduct at least two monthly educational sessions on the importance of adhering to treatment in each of the five CPTETs located within the MSA (on the use of existing services and resources, etc.).
Strategy5: Foster medical treatment (methadone and buprenorphine) in IDU, HIV-positive patients.
Objective 5:1 By January 2012, increase the number of IDU HIV-positive patients that receive methadone or buprenorphine clinical treatment by 5%.
Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"
Goal 1: Promote early detection and treatment of sexually transmitted diseases (STDs).
Strategy1: Train clinical personnel on the updated 2011 CDC SDT treatment guidelines.
Objective 1.1: By June 2011, OCASET will finalize training on new guidelines for STD treatments to personnel offering services in the CPTET.
Strategy 2 Promote public information iniatives regarding STD prevention.
Objective 2.1: By May 2012, develop an educational campaign targeted to high-risk populations.
Strategy3: Provide access to STD (syphilis, chlamydia, gonorrhea), TB, and Hepatitis C tests in a non-clinical setting to at-risk persons.
Objective 3.1: By May 2012, reduce by 10% new STD contagion among HIV-positive persons that receive treatment in the five CPTET within the San Juan MSA.
Objective 3.2: By May 2012, at least 10 community based organizations will provide STD screening services to priority population groups within the SJMSA.
Strategy4: Expansion of the Ryan White Quality Improvement Initiative mentorship program.
Objective 4.1: By September 2011, establish a central quality committee in OCASET to develop an inter-program quality pilot plan.
Objective 4.2: By May 2012, expand the Ryan White Quality Improvement Initiative mentorship program to increase the STD/HIV prevention services in the five CPTET in the SJ MSA.
Objective 4.3: By September 2013, extend the treatment and prevention mentorship project to at least 20% of community organizations subsidized with funds for prevention and treatment, to measure the quality of services provided.
Required Intervention #11: "Implement prevention of prenatal transmission for HIV-positive persons"
Goal 1: Maintain the perinatal transmission rate below the established standard.
Strategy 1: Expand or strengthen existing monitoring programs in delivery rooms.
Objective 1.1: By September 2012, conduct monitoring activities in at least 50% of San Juan MSA's delivery rooms to assure compliance with rules and guidelines regarding prevention of prenatal transmission for HIV-positive persons.
Strategy 2: Require insurance companies' compliance with PHS guidelines.
Objective 2:1 By May 2012, require that PRHI Administration's (ASES) contracts with insurance providers ensure that all prenatal care providers conduct HIV testing and anti-retroviral treatment for pregnant women who are HIV-positive according to CDC guidelines.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Strategy 3: Inform clinical personnel (obstetricians, gynecologists, nurses, midwives…) of the importance of testing and detection during the first to third trimester of pregnancy.
Objective 3:1 By September 2011, train clinical personnel that provide services to pregnant women with HIV in order to comply with established deadlines.
Strategy 4: Promote adherence to antiretroviral treatment in pregnant women who are HIV-positive.
Objective 4:1 By September 2011, at least 85% of pregnant women with HIV in the SJMSA, will maintain adherence to antiretroviral treatment.
Required Intervention #12: "Implement ongoing partner services for HIV-positive persons"
Goal 1: Early identification of individuals who are at high risk of becoming infected and decreasing this risk.
Strategy1: Establish a uniform partner services monitoring and referral system.
Objective 1.1: By September 2011, HIV STD Prevention will establish a unique referral system for "partner services" in at least 50% of the organizations that provide HIV screening services.
Objective 1.2 By January 2012, HIV STD Prevention will train at least 50% of the organizations that carry out HIV testing so that they may refer following established procedures.
Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"
Goal 1: Decrease the number of HIV-positive persons at risk of transmitting HIV.
Strategy 1: Bolster risk reduction in HIV-positive patients.
Objective 1:1 By September 2013, prepare an intervention in the effective behavioral interventions (EBI) inventory and increase by 20% the number of people who receive services through risk reduction interventions offered through CBOs and CPTETs.
Strategy 2: Incorporate EBIs offered by direct services personnel in community-based organizations and CPTETs.
Objective 2:1 By May 2012, train at least 20% of CPTET direct services personnel in EBIs
Objective 2.2: By May 2012, train at least 20% of community-based organizations' direct services personnel in the RESPECT intervention
Objective 3:1 By September 2012, design an evaluation plan to determine the level of efficacy with the EBIs in the CPTET.
Required Intervention #14: "Implement linkages to other medical and social services for HIV-positive persons"
Goal 1: Support persons with HIV in accessing other social and health services that result in improved health and wellness.
Strategy 1: Expand access to treatment with FDA approved drugs and according to the guidelines established by the "National Quality Forum" to treat opiate dependency for IDU in HIV treatment centers and other services sectors.
Objective 1.1: By September 2011, two (2) CPTET of the SJMSA will have a buprenorphine certified physician who will refer persons with HIV to buprenorphine treatment.
Objective 1:2 By September 2012, increase to 100 the number of HIV-positive, opium-addicted inmates with less than two years remaining of their sentences who receive buprenorphine/methadone treatment and transition them to receive services in the community.
Strategy 2: Promote coordination of referrals through case management
Objective 2:1 By May 2012, increase by 20% the number of referrals of HIV-positive patients to clinical social and support services following an assessment of their needs.
Strategy 3: Formalize working relationships with organizations that provide psycho-social services and medical treatment for opiate dependence and HIV patients.
Objective 3:1 By September 2011, identify at least one liaison in each center that provides referrals for supportive services.
Objective 3.2 By March 2012, train CPTET personnel on HIV medical and social services available in the SJMSA for persons living with HIV.
Objective 3.3 By December 2012, implement a continuous educational campaign about available services that encompass the affected population, health services providers, and employees of public agencies that provide support to the HIV-positive population.
Objective 3.4. By December 2011, increase by 50% referrals of patients that meet clinical criteria for buprenorphine treatment for persons with HIV and opiate dependency who have public (Mi Salud) or private health insurance.
Strategy 4: Create and update an inventory of support and preventive resources and of medical treatments for opiate dependency.
Objective 4:1 By December 2011, update and disseminate a virtual or traditional directory of organizations that provide support

TIME TABLE	2011										2012										2013									
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Recommended Intervention # 15: "Condom distribution for the general population"																																		
Goal 1: Extend the distribution and access to condoms in high pedestrian circulation zones in the SJMSA																																		
Strategy 1 Establish collaboration with CBO's that provides HIV prevention services for the distribution of condoms in places of high flow of people in the SJMSA.																																		
Objective 1.1: By April 2011, identify at least five (5) CBOs that will participate in collaborative agreements for condom distribution activities.																																		
Objective 1.2: By September 2011, identify 100% of high HIV prevalence areas in the SJMSA.																																		
Objective 1.3: By April 2011, identify at least five (5) high pedestrian circulation places (such as train stations, bus stations, etc.) in the SJMSA to be impacted by the CBO's with the distribution of at least 500 condoms per place impacted.																																		
Objective 1.4: By September 2011, define a process for condom distribution that includes specific places and dates to conduct the intervention.																																		
Objective 1.5: By September 2011, have established agreements with the agencies and organizations that can provide access to the areas identified for condom distribution.																																		
Strategy 2: Establish collaboration with CBOs that provide HIV prevention services for the distribution of condoms in mass activities in the SJMSA.																																		
Objective 2.1: By April 2011, identify at least five (5) CBOs willing to engage in a collaborative agreement for condom distribution activities.																																		
Objective 2.2: By April 2011, identify at least five (5) mass activities in the SJMSA region to be impacted by the CBOs with the distribution of 1,000 condoms per activity.																																		
Objective 2.3: By September, 2011, implement the process for condom distribution in specific places and dates (as defined in the process designed as part of Objective 1.4).																																		
Objective 2.4: By September, establish communication with relevant government agencies defining the locations and activities to be carried out, to ensure their collaboration in the implementation of the intervention.																																		
Strategy 3: Integrate coordination agencies hired by the program Ryan White Part B.																																		
Objective 3.1: By May 2011, identify at least two (2) collaborative agencies of the Ryan White Program, Part B, to participate in the distribution of at least 2,000 condoms.																																		
Recommended Intervention #16: "HIV and sexual health communication or social marketing campaigns targeted to relevant audiences"																																		
Goal 1: Promote HIV educational messages directed towards changing high risk behavior in women.																																		
Strategy 1: Establish collaborative agreements with the HIV Prevention Division of the PRDOH to disseminate preventive measures directed towards changing high risk behavior in women.																																		
Objective 1.1: By September 2011, validate the campaign design for changes in high risk behavior in women between the ages of 13 and 60.																																		
Objective 1.2: By October 2011, determine at least two (2) mass media channels to disseminate the campaign for behavioral changes in women between 13 and 16 years of age with high risk behavior.																																		
Objective 1.3: By December 2011, begin the dissemination of mass media campaign that seeks to change behavior in women between 13 and 16 years of age with high risk behavior.																																		

WORKBOOK #2: GOALS, STRATEGIES, AND OBJECTIVES

REQUIRED INTERVENTION #1: "ROUTINE, OPT-OUT SCREENING FOR HIV IN CLINICAL SETTINGS"

Goal 1: Increase the number of persons who get tested for HIV through the Opt-out methodology in a clinical context.	Funding sources: CDC, Puerto Rico Department of Health (PROHD) State funds (Mi Salud),
Strategy 1: Promote and educate persons using health care facilities on the importance of routine, opt-out screening for HIV. Strategy 2: Negotiate with health insurance providers to cover the cost of HIV screening and confirmation test. Strategy 3: Diversify the scenarios in which opt-out tests are provided in clinical settings.	
Objective 1.1: By December 2011, hire at least one trained HIV Health Educator that will offer orientation to persons utilizing different health care facilities highlighting the importance of routine, opt-out screening for HIV. Objective 1.2: From January 2011 to December 2011, the Health Educator will conduct visits to at least 20 health care facilities in the SJMSA. Objective 2.1: By September 2011, a meeting will be arranged with the state Medicaid Health System and the *Administración de Servicios de Salud de PR* (ASES) to negotiate coverage of at least one annual rapid HIV test per person. Objective 2.2: By January 2012, OCASET will coordinate a meeting with the Private Insurance Commissioner to negotiate coverage of at least one annual HIV test per person by private insurance companies. Objective 3:1 By January 2013, conduct rapid HIV testing on at least 60% of the persons who use emergency rooms in the Diagnostic and Treatment Centers located in 3 high incidence areas (Cataño, Loiza and Canóvanas) in the SJMSA. Objective 3.2: By January 2012, The Correctional Health System will provide HIV tests to at least 75% of inmates who receive clinical services in their institutions.	Data sources: Hospitals, Department of Health, Correctional Institutions, Medical Associations, Insurance Commissioner, ASES, OCASET

Goal 2: Increase the number of providers that offer HIV testing through the Opt-out methodology in a clinical context	Funding sources: CDC, Puerto Rico Department of Health (PROHD) State funds (Mi Salud),
Strategy 1: Conduct a survey to identify the type of health providers that do not offer HIV testing in their clinics in the SJMSA Strategy 2: Establish alliances with medical organizations to promote opt-out testing among health providers. Strategy 3: Provide rapid HIV tests in emergency rooms.	
Objective 1.1: By October 2011, ECHPP team will use the data obtained from the survey to identify the profile of health care providers that do not offer HIV testing in their clinics, to be able to design specific strategies targeted to these groups. Objective 1.2: By December 2011, hire at least one trained HIV Health Educator that will offer presentations highlighting the importance of routine opt-out screening for HIV in annual medical conferences. Objective 2.1: By June 2012, The ECHPP PI and or Coordinator will have met with medical organizations' chairs to establish collaborative agreements on promoting routine opt-out screening for HIV among their members. Objective 3.1: By January 2012, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms located in Bayamón, Carolina and San Juan Hospitals. Objective 3.2: By January 2013, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms in CDTs located in Cataño, Canóvanas and Loíza.	Data Source: Evaluation Measure Report, PRDOH, OCASET, ECHPP

REQUIRED INTERVENTION #2: "HIV TESTING IN NON-CLINICAL SETTINGS TO IDENTIFY UNDIAGNOSED HIV INFECTION"

<table>
<tr><td>Goal 1: Increase the number of persons who get tested for HIV in non-clinical settings.</td><td>Funding sources:

CDC, State funding (Mi Salud/Puerto Rico Health Insurance), Legislative donations, Pharmaceuticals, municipalities</td></tr>
<tr><td colspan="2">Strategy 1: Identify CBOs that provide support services to high risk groups (MSM, IDU, HRH) in high incidence areas of the SJMSA.

Strategy 2: Promote collaboration among the CBOs that provide support services to high risk groups in high incidence areas of the SJMSA to establish a referral system to maximize HIV testing opportunities and ensure greater access.

Strategy 3: Evaluate the implementation of a web based recruitment and referral system between CBOs and PRDOH (no partner services).</td></tr>
<tr><td>Objective 1.1 By June 2011, create an inventory of CBOs by high risk groups in high incidence areas of the SJMSA.

Objective 2.1 By January 2013, establish collaborative agreements between CBOs so they can refer persons to others CBOs that provide HIV testing in non-clinical settings.

Objective 3.1: By June 2012, provide web access for at least two PRDOH HIV Prevention Outreach Technicians so they can recruit high-risk persons via web to provide them with referrals for HIV testing sites.</td><td>Data sources:

PRDOH, Community Based Organizations, Municipalities (Municipios), Legislature, CDC</td></tr>
<tr><td>Goal 2.1: Increase the number of outreach activities where testing is conducted.</td><td>CDC, PRHI, Legislative donations, Municipalities</td></tr>
<tr><td colspan="2">Strategy 1: Increase the number of community based organizations that administer HIV tests in the SJMSA.

Strategy 2: Identify new funding sources for these organizations.</td></tr>
</table>

Objective 1:1 By January 2013 assure that 50% of the organizations that provide preventive services, offer testing. Objective 2:1 By January 2013, coordinate at least two meetings with legislators who deal with health-related issues to identify new sources of funding to be used for HIV testing services.	CBO's Narratives, PRDOH, Municipalities Narratives, Proposals, CDC

REQUIRED INTERVENTION #3: "CONDOM DISTRIBUTION PRIORITIZED TO TARGET HIV-POSITIVE PERSONS AND PERSONS AT HIGHEST RISK OF ACQUIRING HIV INFECTION"

Goal 1: Implement condom distribution in clinical facilities that provide services to HIV positive persons.	Funding sources: CDC, Foundations, Department of Health
Strategy 1: Create a survey to identify the clinical facilities that provide services to persons living with HIV in the SJMSA. Strategy 2: Develop an evaluation plan to measure condom distribution and usage in organizations that receive condoms for persons with HIV and those at high-risk.	
Objective 1.1 By June 2011, based on the data obtained from the survey, create an inventory of clinical facilities where condoms can be distributed. Objective 1.2: By August 2011, establish liaisons with the identified clinical facilities to promote condom distribution to persons living with HIV. Objective 2.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.	Data sources: Community based organizations, PRDOH,
Goal 2: Increase condom distribution in CBO's not funded by the PRDOH that provide services to high risk groups in high incidence areas in the SJMSA.	Funding sources: CDC, Foundations, Department of Health
Strategy 1: Identify municipalities with the highest HIV incidence rates in the SJMSA Strategy 2: Identify the CBOs that provides services to populations at high risk within the municipalities with the highest rates of HIV in the SJMSA Strategy 3: Establish collaborative agreements with these CBOs not funded by the PRDOH for	

condom distribution. Strategy 4: Develop an evaluation plan to measure condom distribution and usage in CBOs not funded by the PRDOH.
Objective 1.1: By June 2011, the Puerto Rico Surveillance Program will provide incidence data by municipalities and risk groups in the SJMSA. Objective2.1: By July 2011, create an inventory of CBOs that provide services in municipalities with the highest risk incidence. Objective 3.1: By December 2011, establish at least five collaborative agreements to provide condoms to CBOs that provide services in municipalities with the highest risk incidence. Objective 5.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.

REQUIRED INTERVENTION #4: "PROVISION OF POST-EXPOSURE PROPHYLAXIS TO POPULATIONS AT GREATEST RISK"

Goal 1: Decrease the probability of acquiring HIV in a risky event, by the provision of Post-Exposure Prophylaxis.	Funding sources: Legislature, Insurance Plans, Insurance Providers, CFSE, Executive, Department of Justice, Department of Health
Strategy 1: Update post-exposure protocol in cases of physical/sexual abuse or occupational/non-occupational accidents. Strategy 2: Standardize post-exposure procedures in case of physical/sexual abuse or occupational/non-occupational accidents. Strategy 3: Disseminate and implement post-exposure protocols in cases of physical/sexual abuse or occupational/non-occupational accidents.	

Objective 1.1: By June 2011, the PRDOH will update and standardize post-exposure protocols. Objective 2.1: By June 2011, the PRDOH will ensure that 100% of accredited continuing health education programs; will provide health professionals with the topic of post HIV exposure protocol as part of the "Exposure to Blood Pathogens" course. Objective 3.1: By December 2011, the PRDOH will implement and disseminate post-exposure protocols in the areas contained in the MSA.	Data Source: Record File, Internal Protocols of Emergency Rooms, Narratives

Goal 1: Identify and conduct activities to change those structures, rules, and regulations which may constitute barriers to the creation of an optimal environment for the prevention, care, and treatment of HIV.	Funding sources: Department of Health
Strategy 1: Amend regulations of the College of Medical Technologists so that any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical setting can do so. Strategy 2: Provide education to physicians on comprehensive HIV disease treatment and care. Strategy 3: Establish an HIV disease care protocol for physicians in the SJMSA that includes integral medical services required for persons with HIV. Strategy 4: Create a network of specialized physicians to provide services to persons with HIV. Strategy 5: Issue an administrative order to recommend HIV testing as part of a routine medical care. Strategy 6: Facilitate access to needles for injection drug users. Strategy 7: Create a Committee for the development and promotion of public policy regarding HIV, to help make viable these initiatives and give continuity to the proposed changes. Strategy 8: Promote public policy changes within the Department of Education (DOE) and the Department of Correction (DOC) to include condom distribution. Strategy 9: Collaborate with the DOE in revising the health education curriculum, assessing the impact of current HIV and STD prevention strategies, and identifying ways of strengthening it.	

Objective 1.1: By December 2011, the Secretary of the PRDOH will sign an administrative order to amend the College of Medical Technologists' rules and regulations, enabling any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical settings. Objective 2.1: By December 2012, the PRDOH will collaborate with the AIDS Education and Training Center (AETC) to provide updated training in the treatment and management of the HIV disease to members of the HIV-Care Providers Association and the Physician and Surgeons College in Puerto Rico in their annual conferences. Objective 3.1: By June 2011, the PRDOH will distribute the protocol for the management of care of HIV patients to 100% of clinics and physicians working with HIV patients in the SJMSA. Objective 4.1: By March 2012, PRECHPP will compile a directory of physicians with different specialties related to persons living with HIV. Objective 4.2: By December 2012, OCASET and the AETC will offer basic HIV disease care training to other medical specialists to broaden the HIV care providers' network. Objective 5.1: By March 2012, the *Coalición Alcance Juvenil* will begin a process to propose legislation to include HIV testing as part of routine medical care for persons 13 years of age and older. Objective 6.1: By July 2011, OCASET will educate the Municipal Police Department in the SJMSA regarding Law 73 for needle exchange and other related policies in PR. Objective 6.2: By December 2011, the OCASET will counsel the *Pharmacists Association on the dispositions of law 73* of 2007, regarding the sale of needles/syringes in drug stores without a prescription. Objective 6.3: By June 2013, PRECHHP will increase the number of syringe vending machines accessible to IDUs within the SJMSA Objective 6.4: By July 2013, initiate a process of analysis in order to promote the beginning of negotiations between PRDOH and the Legislature regarding additional funding to increase syringe exchange programs within the SJMSA. Objective 6.5: By December 2013, Propose amendments to Law 73 to allow access to paraphernalia for the purpose of improving needle exchange programs. Objective 7.1: By June 2011, identify the members for the public policy	Data sources: Legislature, Department of Health, College of Medical Technicians, CDC, ASES, Part A, Part B, R.W.C.A., AETC.

committee, one of whom will be a coordinator from ECHPP team. Objective 7.2: By June 2011, Develop the structure of the committee, including procedures and norms related to its functioning. Objective 8.1: By January 2012, coordinate at least two meetings with the Department of Education and Department of Correction Secretaries concerning the distribution of condoms in their policies and operating procedures. Objective 9.1: By January 2012, coordinate and create a revision panel to evaluate and submit recommendations to the Secretary of DOE, specifically in the area of HIV and STD prevention and care.	

REQUIRED INTERVENTION #6: "IMPLEMENT LINKAGES TO HIV CARE, TREATMENT, AND PREVENTION SERVICES FOR THOSE TESTING HIV POSITIVE AND NOT CURRENTLY IN CARE"

Goal 1: Implement a referral network between the PRDOH and the DOC in order to link persons with HIV who have served time in a correctional facility, with care providers.	Funding sources: Department of Health, Correctional Administration, MAI, HRSA, CDC
Strategy 1: Establish a liaison between the staff of Correctional Health Facilities and Ryan White Part B-Planning Body. Strategy 2: Provide CAREWare system to the Correctional Health Facilities.	
Objective 1.1: By December 2011, the Correctional Health Facilities and Ryan White Part B-Planning Body will develop a collaborative agreement to link HIV positive ex-inmates to care providers. Objective 2.1: By December 2012, PRECHPP will provide the structure for the CAREWare system in the Correctional Health Facilities.	Data Source: Assistance Sheet, Narratives, CAREWare, Receipts
Goal 2: Implement CDC's guidelines for Partner Services for the AIDS Surveillance Program and the STD Surveillance Program to be able to share HIV results.	Funding Source: CDC

Strategy 1: Establish a collaboration between the HIV Surveillance Program and the STD Surveillance Program	
Objective 1.1: By October 2011, Coordinate a meeting to create an internal protocol to share positive HIV results between the HIV Surveillance Program and the STD Surveillance Program Objective 1.2: By November 2011, Coordinate one training session with the HIV Surveillance Program to discuss the STD Surveillance program procedures. Objective 1.3: By November 2011, Coordinate one training session with the STD Surveillance Program to discuss the HIV Surveillance program procedures.	Data Source: Assistance Sheet, Minutes, Agreements, Information reach
Goal 3: Implement linkages to care, treatment and prevention services for those testing HIV positive in the STD clinics.	Funding Source: CDC
Strategy 1: Establish a standard procedure protocol between STD clinics (Clets, Caguas and Bayamón)	
Objective 1.1: By December 2011, The HIV/STD Prevention Program will complete the standardize procedure protocol for linkage to care, treatment and prevention services for those testing HIV positive in STD clinics and not in care.	Data sources: Department of Health, Correctional System, Ryan White Part B-CAREWare, Prevention

REQUIRED INTERVENTION #7: "IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING RETENTION IN OR RE-ENGAGEMENT IN CARE FOR HIV-POSITIVE PERSONS"

Goal 1: Provide health care along the continuum of the HIV disease for persons living with HIV.	Funding sources: MAI, HRSA, Department of Health.
Strategy 1: Develop activities that promote the continuum of care for persons living with HIV. Strategy 2: Provide counseling to persons living with HIV on the importance of receiving continuous medical care. Strategy 3: Create the mechanisms to overcome barriers and facilitate access to care for persons living with HIV.	
Objective 1.1: By January 2012, establish a periodical process to identify persons living with HIV who have been out of care for the last twelve months in the SJMSA. Objective 1.2: By December 2012, the Ryan White Part B will identify at least 6 barriers that impede persons living with HIV from receiving care, with the purpose of reintegrating these patients into health care services. Objective 2.1: By January 2012, have 100% of new patients fill out a questionnaire during their first medical appointment to determine if they have been offered counseling regarding the importance of receiving continuous care. Objective 3.1: By August 2013, identify resources to overcome 50% of the barriers identified in Objective 1.2.	Data sources: Department of Health, Correctional System, HRSA Ryan White Part A and Part B.

REQUIRED INTERVENTION #8: "IMPLEMENT POLICIES AND PROCEDURES THAT WILL LEAD TO THE PROVISION OF ANTIRETROVIRAL TREATMENT IN ACCORDANCE WITH CURRENT TREATMENT GUIDELINES FOR HIV-POSITIVE PERSONS"

Goal 1: Develop policies and procedures that facilitate implementation of the most updated guidelines on the use of Anti-Retroviral Therapy in both public and private settings.	Funding sources: HRSA; State funds
Strategy1: Provide training to medical professionals in the CPTETs of the SJMSA. Strategy2: Offer continued education to medical professionals. Strategy3: Strengthen the information gathering system that allows for measuring compliance	

with treatment guidelines.	
Objective 1:1 By January 2012, conduct training on PHS guidelines to 100% of recently recruited clinical personnel in the CPTETs of the SJMSA before they provide direct medical services to patients. Objective 1:2 By January 2012, ensure that clinic directors coordinate at least one training session for 100% of clinical personnel within 30 days after PHS and CDC guidelines have been updated. Objective 2:1 By January 2013, ensure that the PRDOH establishes a public policy that every health professional receives training in PHS and CDC guidelines prior to renewing a license. Objective 2:2 Starting in January 2013, establish a PRDOH public policy that public insurance (Puerto Rico Health Insurance or PRHI) providers must disseminate all updates of PHS and CDC guidelines to the service providers network as a precondition to renewing contracts. Objective 3.1 By May 2012, increase by 50% compliance with indicators related to the use of antiretroviral treatment in municipalities that comprise the SJMSA.	Data sources: Written certification of training Examination Boards Contracts with insurance providers

REQUIRED INTERVENTION #9: "IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING ADHERENCE TO ANTIRETROVIRAL MEDICATIONS FOR HIV-POSITIVE PERSONS"

Goal 1: Increase adherence to antiretroviral treatment for persons with HIV.	Funding sources: HRSA, Americ Corp, RWJF,Community Foundation
Strategy 1: Develop adherence protocols that include interventions for MSM, and injecting drug users. Strategy 2: Strengthen the non-adherent patient identification system by means of recruiting personnel. Strategy 3: Strengthen the non-adherent patient search system by employing organizations that offer search services. Strategy 4: Promote patient and collateral education among identified populations through videos, pamphlets, among others. Strategy 5: Foster medical treatment (methadone and buprenorphine) in IDU, HIV-positive patients.	
Objective 1:1 By June 2011, develop management guidelines for special populations (MSM, UDI, and transgender persons) identified in the SJMSA as supplements to the existing adherence protocol through the Ryan White Part B Planning Body. Objective 1:2 By March 2012, 90% of clinical personnel will participate in at least one annual training session regarding the protocol for special populations. Objective 1.3 By March 2013, reduce by 5% the number of patients in special populations that do not adhere to treatment. Objective 2:1 By September 2012, complete recruiting Records Abstractors (persons who identify adherence information in medical records) and Case Managers funded by Ryan White Part B Funds. Objective 2:3 Starting in January 2012, increase by 5% the quantity of persons that receive a case management evaluation and adherence evaluation every six months. Objective 3:1 By April, 2011, complete contract procedures of eight	Data sources: Assistance sheet, Progress sheet, Advertising, CareWare Reports Number of signed contracts, Clinical case management evaluations

organizations subsidized by Ryan White Part B to search for non-adherent patients. Objective 3:2 By September 2012, increase by 10% the number of non-adherent patients who are contacted by the search system to resume treatment. Objective 4:1 By May 2012, the Ryan White Part B Planning Body will develop a training program and the corresponding instructional materials to train health education staff and other groups regarding the promotion of adherence to treatment. Objective 4:2 By September 2012, the Ryan White Part B Planning Body will train Prevention Division Health Education Staff in promoting adherence to treatment, subsidized by the Ryan White Part F AIDS ETC. Objective 4:3 By September 2012, conduct at least two monthly educational sessions on the importance of adhering to treatment in each of the five CPTETs located within the MSA (on the use of existing services and resources, etc.). Objective 5.1: By January 2012, increase by 5% the number of IDU HIV-positive patients that receive methadone or buprenorphine clinical treatment.	

REQUIRED INTERVENTION #10: "IMPLEMENT STD SCREENING ACCORDING TO CURRENT GUIDELINES FOR HIV-POSITIVE PERSONS"

Goal 1: Promote early detection and treatment of sexually transmitted diseases (STDs).	Funding sources: Ryan white HRSA State/Municipal Funds
Strategy1: Train clinical personnel on the updated 2011 CDC STD treatment guidelines. Strategy2 Promote public information initiatives regarding STD prevention. Strategy3: Provide access to STD (syphilis, chlamydia, and gonorrhea) TB, and Hepatitis C tests	

in a non-clinical setting to at-risk persons. Strategy4: Expansion of the Ryan White Part B Quality Improvement Initiative mentorship program.	
Objective 1.1: By June 2011, OCASET will finalize training on new guidelines for STD treatments to personnel offering services in the CPTET. Objective 2.1: By May 2012, OCASET will develop an educational campaign targeted to high-risk populations through public service availability. Objective 3.1: By May 2012, reduce by 10% new STD contagion among HIV-positive persons that receive treatment in the five CPTET within the San Juan MSA. Objective 3.2: By May 2012, at least 10 community based organizations will provide STD screening services to priority population groups within the SJMSA. Objective 4.1: By September 2011, establish a central quality committee in OCASET to develop an inter-program quality pilot plan. Objective 4.2: By May 2012, implement the Ryan White Part B Quality Improvement Initiative mentorship program to increase the STD/HIV prevention services in the five CPTET in the SJ MSA. Objective 4.3: By September 2013, extend the treatment and prevention mentorship project to at least 20% of community organizations subsidized with funds for prevention and treatment, to measure the quality of services provided.	Data sources: Ryan White, Tests processed with CDC funds through HIV Prevention

REQUIRED INTERVENTION #11: "IMPLEMENT PREVENTION OF PRENATAL TRANSMISSION FOR HIV-POSITIVE PERSONS"

Goal 1: Maintain the perinatal transmission rate below the established standard.	Funding sources: State, CDC
Strategy1: Expand or strengthen existing monitoring programs in delivery rooms. Strategy2: Require insurance companies' compliance with PHS guidelines. Strategy3: Inform clinical personnel (obstetricians, gynecologists, nurses, midwives…) of the importance of testing and detection during the first to third trimester of pregnancy. Strategy 4: Promote adherence to antiretroviral treatment in pregnant women who are HIV-positive.	
Objective 1.1: By September 2012, conduct monitoring activities in at least 50% of San Juan MSA's delivery rooms to assure compliance with rules and guidelines regarding prevention of perinatal transmission for HIV-positive persons. Objective 2:1 By May 2012, require that PRHI Administration's (ASES) contracts with insurance providers ensure that all perinatal care providers conduct HIV testing and anti-retroviral treatment for pregnant women who are HIV-positive according to CDC guidelines. Objective 3:1 By September 2011, train clinical personnel that provide services to pregnant women with HIV in order to comply with established deadlines. Objective 4:1 By September 2011, at least 85% of pregnant women with HIV in the SJMSA, will maintain adherence to antiretroviral treatment.	Data sources: Clinical records, HIV Surveillance program, VIH, R.W.C.A.

REQUIRED INTERVENTION #12: "IMPLEMENT ONGOING PARTNER SERVICES FOR HIV-POSITIVE PERSONS"

Goal 1: Early identification of individuals who are at high risk of becoming infected and decreasing this risk.	Funding sources: Federal and State
Strategy1: Establish a uniform partner services monitoring and referral system.	
Objective 1.1: By September 2011, HIV STD Prevention will establish a unique referral system for "partner services" in at least 50% of the organizations that provide HIV screening services. Objective 1.2 By January 2011, HIV/STD Prevention will train at least 50% of the organizations that carry out HIV testing so that they may refer following established procedures.	Data sources: Department of Health, Quantity of monthly referrals, Partner Services Interviews, OIAT

REQUIRED INTERVENTION #13: "BEHAVIORAL RISK SCREENING FOLLOWED BY RISK REDUCTION INTERVENTIONS FOR HIV-POSITIVE PERSONS (INCLUDING THOSE FOR HIV-DISCORDANT COUPLES) AT RISK OF TRANSMITTING HIV"

Goal 1: Decrease the number of HIV-positive persons at risk of transmitting HIV.	Funding sources: CDC/
Strategy1: Bolster risk reduction in HIV-positive patients. Strategy2: Incorporate EBIs offered by direct services personnel in community-based organizations and CPTETs.	
Objective 1: By September 2013, prepare an intervention in the effective behavioral interventions (EBI) inventory, increasing by 20% the number of people who receive services through risk reduction interventions offered through CBOs and CPTETs. Objective 2:1 By May 2012, train at least 20% of CPTET direct services personnel in EBIs	Data sources: CAREWare Prevention Evaluation Report

Objective 2.2: By May 2012, train at least 20% of community-based organizations' direct services personnel in the RESPECT intervention. Objective 3: By September 2012, design a survey to determine the level of efficacy with the EBIs in the CPTET.	

REQUIRED INTERVENTION #14: "IMPLEMENT LINKAGES TO OTHER MEDICAL AND SOCIAL SERVICES FOR HIV-POSITIVE PERSONS"

Goal 1: Support persons with HIV in accessing other social and health services that result in improved health and wellness.	Funding sources: Legislative Funds State/Federal CDC HUD/HOPWA
Strategy 1: Expand access to treatment with FDA approved drugs and according to the guidelines established by the "National Quality Forum" (to treat opiate dependency for IDU in HIV treatment centers and other services sectors). Strategy 2: Promote coordination of referrals through case management. Strategy 3: Formalize working relationships with organizations that provide psycho-social services and medical treatment for opiate dependence and HIV patients. Strategy 4: Create and update an inventory of support and preventive resources and medical treatments for opiate dependency.	
Objective 1.1: By September 2011, two (2) CPTET of the SJMSA will have a buprenorphine certified physician who will refer persons with HIV to buprenorphine treatment. Objective 1:2 By September 2012, increase to 100 the number of HIV-positive, opium-addicted inmates with less than two years remaining of their sentences who receive buprenorphine/methadone treatment and transition them to receive services in the community. Objective 2:1 By May 2012, increase by 20% the number of referrals of HIV-positive patients to clinical social and support services following an assessment of their needs. Objective 3.1 By September 2011, identify at least one liaison in each center	Data sources: -Care ware -Identify key person in agencies and resource bank organizations -SAMHSA CDC NQF

that provides referrals for supportive services. Objective 3.2 By March 2012, train CPTET personnel on HIV medical and social services available in the SJMSA for persons living with HIV. Objective 3.3 By December 2012, implement a continuous educational campaign about available services that encompass the affected population, health services providers, and employees of public agencies that provide support to the HIV-positive population. Objective 3.4. By December 2011, increase by 50% referrals of patients that meet clinical criteria for buprenorphine treatment for persons with HIV and opiate dependency who have public (Mi Salud) or private health insurance. Objective 4: By December 2011, update and disseminate a public virtual or traditional directory of organizations that provide support to persons living with HIV.	

RECOMMENDED INTERVENTION # 15: "CONDOM DISTRIBUTION FOR THE GENERAL POPULATION"

Goal 1: Extend the distribution and access to condoms in high pedestrian circulation zones in the SJMSA	Funding sources: Puerto Rico Department of Health, ECHPP
Strategy 1 Establish collaboration with CBO's that provides HIV prevention services for the distribution of condoms in places of high flow of people in the SJMSA. Strategy 2: Establish collaboration with CBOs that provide HIV prevention services for the distribution of condoms in mass activities in the SJMSA. Strategy 3: Integrate the Ryan White Part B Coordination Agencies.	
Objective 1.1: By April 2011, identify at least five (5) CBOs that will participate in collaborative agreements for condom distribution activities. Objective 1.2: By September 2011, identify 100% of high HIV prevalence areas in the SJMSA. Objective 1.3: By September 2011, identify at least five (5) high pedestrian circulation places (such as train stations, bus stations, etc.) in the SJMSA to be impacted by the CBO's with the distribution of at least 500 condoms per	Data sources: Prevention resource inventory, List of organization of the Planning Division, HIV/AIDS

place impacted. Objective 1.4: By September 2011, define a process for condom distribution that includes specific places and dates to conduct the intervention. Objective 1.5: By September 2011, have established agreements with the agencies and organizations that can provide access to the areas identified for condom distribution. Objective 2.1: By April 2011, identify at least five (5) CBOs willing to engage in a collaborative agreement for condom distribution activities. Objective 2.2: By April 2011, identify at least five (5) mass activities in the SJMSA region to be impacted by the CBOs with the distribution of 1,000 condoms per activity. Objective 2.3: By September 2011, implement the process for condom distribution in specific places and dates (as defined in the process designed as part of Objective 1.4). Objective 2.4: By September, 2011, establish communication with relevant government agencies defining the locations and activities to be carried out, to ensure their collaboration in the implementation of the intervention. Objective 3.1: By May 2011, identify at least two (2) collaborative agencies of the Ryan White Program, Part B, to participate in the distribution of at least 2,000 condoms.	Surveillance Program and NHBS, Municipalities, Institute of Culture, Ryan White Parte B

RECOMMENDED INTERVENTION #16: "HIV AND SEXUAL HEALTH COMMUNICATION OR SOCIAL MARKETING CAMPAIGNS TARGETED TO RELEVANT AUDIENCES"

Goal 1: Promote HIV educational messages directed towards changing high risk behavior in Men who have Sex with Men (MSM)	Funding sources: ECHPP
Strategy 1: Establish collaborative agreements with the HIV Prevention Division of the PRDOH to disseminate preventive measures directed towards changing high risk behavior in MSM.	
Objective 1.1: By September 2011, develop a media campaign designed to promote changes in high risk behavior of MSM in the SJMSA. Objective 1.2: By October 2011, determine at least two (2) mass media channels to disseminate the campaign for behavioral changes in MSM with	Data sources: Population to be impacted focus groups, HIV Prevention

high risk behavior. Objective 1.3: By December 2011, begin the dissemination of mass media campaign that seeks to change behavior in MSM with high risk behavior.	Division of the Puerto Rico Department of Health

NATIONAL STRATEGIC GOALS TOOL

REDUCING NEW HIV INFECTIONS

1. REDUCE THE ANNUAL NUMBER OF NEW HIV INFECTIONS BY 25% AND REDUCE THE HIV TRANSMISSION RATE BY 30%

Puerto Rico will contribute to reducing the annual number of new HIV infections by 25% through a combination of interventions, including interventions #3, #4 and #5. Some of the actions that will be taken as part of these interventions, include the distribution of condoms in areas with the highest incidence of HIV in the SJMSA, dissemination of information among the general population regarding the availability of post-exposure treatment as a result of physical/sexual abuse or occupational/non-occupational accidents, increasing the number of needle vending machines accessible to IDU population within the SJMSA and increasing the number of needle exchange programs within the area. Previous experiences regarding, for example, needle exchange programs in the SJMSA, provide a basis for the expansion of this strategy. At the same time, community based organizations represent an important ally in leveraging government resources.

Based on the limitations that have been faced in certain contexts, however, efforts will be made to produce changes in public policy in order to have access, for example, to schools and correctional institutions to distribute condoms and to facilitate access to needles. In order to maximize resources and have a greater impact, these efforts will be coordinated in collaboration with other governmental agencies and leaders of the nonprofit sector, for example the Pharmacists Association and community based organizations.

On the other hand, the combination of interventions #11, #12 and #13 will be particularly important in reaching the objective of reducing the HIV transmission rate by 30%. Strategies

that will be implemented as part of these interventions include the promotion of adherence to antiretroviral treatment in pregnant women who are HIV-positive, establishing a requirement that PRHI Administration's (ASES) contracts with insurance providers ensure that all prenatal care providers conduct HIV testing and provide anti-retroviral treatment to pregnant women who are HIV-positive, establishing uniform partner services monitoring system, and bolstering risk reduction in HIV-positive patients, among others.

These actions, as well as the ones that will be described in the next sections, were designed taking into consideration limitations in the jurisdiction regarding the infrastructure to provide services; limitations related to public policy, statutes, norms and procedures; and available resources. Also, decisions were based on an examination of current sources of funding and the opportunity to combine federal and state funds, as well as resources from other sectors such as municipal governments and CBOs.

2. INCREASE THE PERCENTAGE OF PEOPLE LIVING WITH HIV WHO KNOW THEIR SEROSTATUS TO 90%

To increase the percentage of people living with HIV who know their serostatus to 90%, Puerto Rico developed a series of strategies related to interventions #1, #2, and #12. In clinical settings testing, although there is no formal public policy that establishes its use, the PRDOH has implemented activities in recent years related to this intervention that provide useful experiences to take into account when implementing the proposed strategy.

The provision of rapid HIV tests in emergency rooms, negotiations with health insurance providers to cover the cost of HIV tests, and the promotion of HIV clinic services, are some of the actions that will be taken to promote testing in clinical settings. Also, actions will be taken to increase the number of community based organizations that administer HIV tests in the SJMSA, promote HIV testing in non-clinical settings, and to establish a uniform partner services monitoring system. These strategies and actions were conceptualized thinking not only of making available the service, but also of minimizing limitations as for example the number of persons that, after being tested, don't return for the results. Thus, a greater emphasis was given to rapid testing and to strategies focused in educating the general population about the subject.

3. INCREASE THE PERCENTAGE OF PEOPLE NEWLY DIAGNOSED WITH HIV INFECTION THAT HAVE A CD4 COUNT OF 200 CELLS/µL OR HIGHER BY 25%

For increasing the percentage of people newly diagnosed with HIV infection that have a CD4 count of 200 cells/µl or higher by 25%, the PRDOH will focus efforts on intervention #1, #2, #4, #5, #6, #7, #8 and #9.

Strategies for these interventions are directed to identifying new cases and referring them to service and care as soon as they are diagnosed. Interventions 1 and 2 serve to promote early identification of the HIV infection in general. Intervention #4 aims to prevent infection after being at risk of contracting it whether by an occupational or physical/sexual accident. Considered were: revision and up-date of post-exposure protocol in cases of physical/sexual abuse or occupational/non-occupational accidents; the standardization of post-exposure procedures in case of physical/sexual abuse or occupational/non-occupational accidents; dissemination and implementation of post-exposure protocols in cases of physical/sexual abuse or occupational/non-occupational accidents; and dissemination of information to the public on the availability to receive post-exposure treatment as a result of physical/sexual abuse or occupational/non-occupational accidents. Intervention #5 should become the basis for having HIV testing accessible to the population and facilitate taking HIV tests in different settings. Interventions # 6, 7, 8 and 9 include strategies to ensure that every person HIV positive is provided with services that will promote adequate treatment adherence and services. If the goals are achieved this allows newly diagnosed cases to return for care and monitor their HIV disease, and as a result maintain their CD4 levels higher.

4. REDUCE THE PROPORTION OF MSM WHO REPORTED UNPROTECTED ANAL INTERCOURSE DURING THEIR LAST SEXUAL ENCOUNTER WITH A PARTNER OF DISCORDANT OR UNKNOWN HIV STATUS BY 25%

Puerto Rico will contribute to the reduction of the proportion of MSM who reported unprotected anal intercourse during their last sexual encounter with a partner of discordant or unknown HIV status by 25% through intervention #3, which includes conducting efforts for promoting condom distributions at schools and correctional facilities, as well as to the population that is at high risk

of being infected and intervention #13, which is focused in conducting behavioral risk screening followed by risk reduction interventions. Regarding this intervention, efforts will be coordinated between CBOs and the PRDOH Clinics. It is expected that the number of people who receive services in these two settings will increase by 20%. For this, initial steps will be taken, taking into account current limitations in the provision of services. These include training in behavioral interventions.

5. REDUCE THE PROPORTION OF IDU AT RISK FOR TRANSMISSION/ACQUISITION OF HIV BY XX% [INDICATOR TBD PENDING DHAP STRATEGIC PLAN]

For reducing the proportion of IDU at risk for transmission/acquisition of HIV by XX%, Puerto Rico will facilitate access to needles for injection drug users through increasing the number of needle vending machines accessible to them within the SJMSA and increasing the number of needle exchange programs within the mentioned area. These actions require changes in current public policy. Because of the large amount of time it may take for these changes to actually be in effect, initial steps will be taken, such as for example providing counseling to San Juan MSA's Police Departments concerning needle exchange programs, to educate and prevent police interventions with IDU that receive paraphernalia and clean needles. The capability of CBO's that implement this kind of intervention will be a very important factor in reaching Puerto Rico's objectives. Finally, a long term objective will be to amend Law 73 to allow access to paraphernalia for the purpose of needle exchange programs, among other strategies.

6. DECREASE THE NUMBER OF PERINATALLY ACQUIRED PEDIATRIC HIV CASES BY 25%

Puerto Rico has been successful in the prevention of perinatal transmission, reducing transmission rates during the past years to 0. Capitalizing in the service infrastructure that has been developed as part of that experience, Puerto Rico will contribute to this national objective by expanding or strengthening existing monitoring programs in delivery rooms; requiring insurance companies' compliance with PHS guidelines; informing clinical personnel of the importance of testing and detection during the first quarter of pregnancy; and promoting adherence to antiretroviral treatment in pregnant women who are HIV-positive. This will be conducted in coordination with several divisions of the PRDOH, including Ryan White Part B and Part D

programs, and other private and nonprofit organizations including CEMI and Groupedic. The combination of State and CDC funds will be fundamental for the continuation and strengthening of this intervention.

INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV

7. REDUCE AIDS DIAGNOSES BY 25%

The reduction of AIDS diagnoses by 25% will be achieved through interventions #6, #7 and #9. As part of these interventions, Puerto Rico will implement a referral network between the PRDOH and the DOC in order to link HIV positive persons who have served time in a correctional facility to care providers. Puerto Rico will develop activities to promote the continuous care of HIV positive persons. IT will provide counseling to HIV-positive patients regarding the importance of receiving continuous medical care and the adherence to treatment, and will develop adherence protocols. Educational activities directed towards adherence to treatment will be carried out through videos, pamphlets, among other educational materials. These activities, as well as the ones that will be described in items 8 and 9, are also closely related to other interventions aimed at the early identification of persons with HIV. As has been described previously, multi-sectorial coordination is essential to maximize resources and have a greater impact in the community. Successful implementation of these strategies will also imply a close coordination among governmental agencies such as the Department of Health and the Correctional Administration. Local and federal funding sources will be combined in order to provide the related services.

8. INCREASE THE PERCENTAGE OF PERSONS DIAGNOSED WITH HIV WHO ARE LINKED TO CLINICAL CARE AS EVIDENCED BY HAVING A CD4 COUNT OR VIRAL LOAD MEASURE WITHIN 3 MONTHS OF HIV DIAGNOSIS TO 85%

Puerto Rico will contribute to increasing the percentage of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count on viral load measure within 3 months of HIV diagnosis to 85% through interventions #6, #7, #9 and #14. These interventions

include the implementation of a referral network between the PRDOH and the DOC in order to link to care providers persons with HIV who have served time in a correctional facility, and the adoption of an administrative order by the PRDOH requiring health providers to report all positive HIV results to PRDOH service providers of a person that has not received his/her positive result so that the HIV Prevention Epidemiology Technicians may strive to deliver the results and any corresponding referrals.

Puerto Rico will develop activities that promote the continuous care of persons with HIV, will provide counseling to HIV-positive patients regarding the importance of receiving continuous medical care, and will create the mechanisms to overcome barriers and facilitate access to patients. In addition, Puerto Rico will educate patients and collaterals about the importance of adherence to treatment through videos and pamphlets, will foster medical treatment in IDU, HIV positive patients, and will expand access to treatment with FDA approved drugs and according to the guidelines established by the "National Quality Forum" to treat opiate dependency for IDU in HIV treatment centers and other services sectors.

9. INCREASE BY 10% THE PERCENTAGE OF HIV-DIAGNOSED PERSONS IN CARE WHOSE MOST RECENT VIRAL LOAD TEST IN THE PAST 12 MONTHS WAS UNDETECTABLE

Puerto Rico will contribute to increasing by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable through interventions #6, #7, #9 and #14. These interventions include the implementation of a referral network between the PRDOH and the DOC in order to link to care persons with HIV who have served time in a correctional facility, and the creation of an administrative order by the PRDOH requiring health providers to report all positive HIV results to PRDOH service providers of a person that has not received his/her positive result so that epidemiology technicians may strive to deliver the results and any corresponding referrals.

Also, Puerto Rico will develop activities that promote the continuous care of HIV-positive patients, will provide counseling to HIV-positive patients regarding the importance of receiving continuous medical care, and will create the mechanisms to overcome barriers and facilitate access to patients. In addition, Puerto Rico will educate patients and collaterals about the importance of adherence to treatment through videos and pamphlets, will foster medical treatment in IDU, HIV

positive patients, and will expand access to treatment with FDA approved drugs and according to the guidelines established by the "National Quality Forum" to treat opiate dependency for IDU in HIV treatment centers and other services sectors.

10. REDUCE THE PERCENTAGE OF HIV-DIAGNOSED PERSONS IN CARE WHO REPORT UNPROTECTED ANAL OR VAGINAL INTERCOURSE DURING THE LAST 12 MONTHS WITH PARTNERS OF DISCORDANT OR UNKNOWN HIV STATUS BY 33%

For reducing the percentage of HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the last 12 months with partners of discordant or unknown HIV status by 33%, Puerto Rico will implement a series of actions regarding intervention #3 and #13. This intervention, as was described in item 4 includes conducting efforts for promoting condom distributions at schools and correctional facilities, as well as to the population at high risk of being infected, and to organizations that serve HIV-positive persons. In addition, as part of intervention #13 Puerto Rico will bolster risk reduction in HIV-positive patients.

11. BY 2015, INCREASE THE PROPORTION OF RYAN WHITE HIV/AIDS PROGRAM CLIENTS WHO ARE IN CONTINUOUS CARE (AT LEAST TWO VISITS FOR ROUTINE HIV MEDICAL CARE IN 12 MONTHS AT LEAST 3 MONTHS APART) FROM 73% TO 80%

Puerto Rico will contribute to increasing the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80% by 2015 through interventions #6, #7, #9, #12 and #14. These interventions include the implementation of a referral network between the PRDOH and the DOC in order to link to care persons with HIV who have served time in a correctional facility, and the creation of an administrative order by the PRDOH requiring health providers to report all positive HIV results to PRDOH service providers of a person that has not received his/her positive result so that epidemiology technicians may strive to deliver the results and any corresponding referrals. Also, Puerto Rico will develop activities that promote the continuous of care of HIV-positive patients, will provide counseling to HIV-positive patients regarding the importance of receiving continuous medical care, and will create the mechanisms to overcome barriers and facilitate access to patients. In addition, Puerto Rico

will educate patients and collaterals about the importance of adherence to treatment through videos, pamphlets, among others, will foster medical treatment in IDU, HIV positive patients, will establish a uniform partner services monitoring and referral system and will improve the coordination of referrals through case management.

12. BY 2015, INCREASE THE NUMBER OF RYAN WHITE CLIENTS WITH PERMANENT HOUSING FROM 82% TO 86%.

For increasing the number of Ryan White clients with permanent housing from 82% to 86% by 2015, a close coordination with other social services is required. Puerto Rico will create the mechanism to overcome barriers and facilitate access to patients, will improve the coordination of referrals to other social services through case management, and will formalize working relationships with organizations that provide psycho-social services and medical treatment for opiate dependence and HIV patients. State funds, as well as federal funds will be combined for these purposes.

REDUCING HIV-RELATED DISPARITIES

13. INCREASE THE PERCENTAGE OF HIV-DIAGNOSED GAY AND BISEXUAL MEN WITH UNDETECTABLE VIRAL LOAD BY 20%

For increasing the percentage of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%, Puerto Rico will recommend physicians to offer and provide HIV tests as part of routine medical care, provide rapid HIV tests in emergency rooms, negotiate with health insurance providers to cover the cost of HIV tests, promote and advertise public and private HIV clinic services, increase the number of community based organizations that administer HIV tests in the SJMSA, promote HIV testing in non-clinical settings, and establish a uniform partner services monitoring system. All of these methods are contained in interventions #1, #2 and #12. When deciding upon these actions, stakeholders took into account the social and cultural barriers that exist in Puerto Rico in the provision of services to these populations, and the factors that may impede them from accessing services. Thus, one of the main focuses was to concentrate efforts in

non-clinical settings and in the channels of communication that already exist among these populations and CBOs.

14. INCREASE THE PERCENTAGE OF HIV-DIAGNOSED BLACKS WITH UNDETECTABLE VIRAL LOAD BY 20%

Puerto Rico's HIV disease is 100% Hispanics, so no major strategy will be conducted for Blacks in our jurisdiction.

15. INCREASE THE PERCENTAGE OF HIV-DIAGNOSED LATINOS WITH UNDETECTABLE VIRAL LOAD BY 20%

To increase the percentage of HIV-diagnosed Latinos with undetectable viral load by 20%, Puerto Rico will recommend physicians to offer and provide HIV tests as part of routine medical care, provide rapid HIV tests in emergency rooms, negotiate with health insurance providers to cover the cost of HIV tests, promote and advertise public and private HIV clinic services, increase the number of community based organizations that administer HIV tests in the SJMSA, promote HIV testing in non-clinical settings, and to establish a uniform partner services monitoring system. All of these methods are contained in interventions #1, #2 and #12.

16. REDUCE THE DISPARITY IN HIV INCIDENCE FOR BLACKS VERSUS WHITES (BLACK: WHITE RATIO OF NEW INFECTIONS) BY 25%; BY 2015, REDUCE THE DISPARITY IN HIV INCIDENCE FOR HISPANICS VERSUS WHITES (HISPANIC: WHITE RATIO OF NEW INFECTIONS) BY 25%

Puerto Rico's HIV disease is 100% Hispanics, so no mayor strategy will be conducted for Blacks in our jurisdiction. Our overall goals will contribute to the proportion of Hispanics/White in the National HIV Surveillance dataset.

17. REDUCE THE DISPARITY IN HIV INCIDENCE FOR MSM VERSUS OTHER ADULTS IN THE UNITED STATES BY 25%

Puerto Rico will contribute to the reduction of the disparity in HIV incidence for MSM versus other adults in the United States by 25% through actions related to interventions #1, #2, #12 and #13, as mentioned in previous items. Once again, some of the main barriers in reaching this population are related to cultural and social issues. Thus, particular attention was paid to the identification of proper channels of communication and impact. Non clinical settings, particularly CBOs, represent and important point of contact with this population.

18. ENSURE THE PERCENTAGE OF PERSONS DIAGNOSED WITH HIV WHO HAVE A CD4 COUNT WITHIN 3 MONTHS OF HIV DIAGNOSIS IS 75% OR GREATER FOR ALL RACIAL/ETHNIC GROUPS

To ensure the percentage of persons diagnosed with HIV who have a CD4 count within 3 months of HIV diagnosis is 75% or greater for all racial/ethnic groups, Puerto Rico will contribute through in #6 and #7. As part of these interventions, Puerto Rico will implement a referral network between the PRDOH and the DOC in order to link persons with HIV who have served time in a correctional facility to care providers. Also, Puerto Rico will develop activities that promote the continuous of care of HIV-positive patients, will provide counseling to HIV-positive patients regarding the importance of receiving continuous medical care, and will create the mechanisms to overcome barriers and facilitate access to patients. These actions, as previously mentioned, depend on other interventions focused in the early identification of HIV positive persons and those at high risk of acquiring the condition.

Appendixes

DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO

APPENDIX 1-A: LIST OF STAKEHOLDERS CONTACTED DURING THE PROCESS

Name	Program or organization
Dra. Irma Febo	Programa GAMMA
Sr. Juan A. Figueroa Morales	Christian Community Center
Sra. Gisel Guemares - con Flor Dalissa y Ulises Santiago Adorno	Fundación Acción Social Refugio Eterno
Sr. Carlos Ortega	Grupedic
Sr. Ángel Jiménez	Hogar Crea
Dra. Felicita de Jesús	Metadona Caguas
Sra.Maria de los A. Lendor	Centro centro metadora SJ 2do ofic 70
Sra. Aida Enid Vélez	Lucha contra el SIDA Caguas
Sra. Cecilia La Luz	Comunidad Hombre sexo con Hombre
Sra. Lizbeth Rivera	ASPIRA Inc. de Puerto Rico
Sra. Sandra Torres	Bill's Kitchen
Sra. Nilsa Cintron	Asociación Puertorriqueña de Servicios
Sr. Jeffrey Gómez	Asociación Laica Misionera
Sra. Elsie Solano	Albergue el Paraíso

PUERTO RICO ECHPP

Name	Program or organization
Sra. Noemí Colon	Municipio de Caguas
Hna. Carmen Delia Rosado	Voluntarios y Acompañantes Comprometidos con el SIDA
Dr. Luis Martinez	Municipio de San Juan
Lcda. Sonia Collazo de Jesús	Municipio de San Juan
Sra. Deborah Medina	Municipio de Bayamón
Sra. Carmen Rivera***(ya no es la directora de Profamilia)	Asociación Puertorriqueña Pro Bienestar de la Fam.
Dr. José A. Vargas / Glenda Dávila	Iniciativa Comunitaria de Investigación (ICI)
Sra. Irish Figueroa	La Fondita de Jesús
Sra. Wanda Liz Roman	Fundesco
Sra. María Ramos Andino	Hogar de Ayuda el Refugio
Sra. Gladys Colon Vázquez	Hogar Posada la Victoria
Rvda. Lissette Alonso	La Perla de Gran Precio
Sr.Ramfis J. Pérez (sustituye a Sustituye Edwin Otero Cuevas)	Lucha Contra El SIDA
Sra. Limaris Rodríguez	Centro de Amor el Elion
Sra. María Felicier Escalera	Proyecto Oasis de Amor

Sra. Rosaura López Fontanez	Puerto Rico CONCRA
Sra. Alana Feldman	Taller Salud Inc.
Sra. Isolina Miranda	Corporacion de Servicios de Salud y Medicina Avanzada
Dr. Iván Andújar	Director
Dr. Milton Garland	Director Servicios Médicos / entrevistar manana - 1:00pm
Dra. Ada S. Martínez	Consultora - van a verificar cuándo tiene disponible para reunirse
Dra. Norma Delgado	Directora
Dra. Odette García - Sherly Ramos	Director Servicios Medicos
Dra. Trinidad García	Directora
Eileen Pérez García	Supervisora - comparte con Ryan White Parte D y Prevención (a través de Pedro García)
Johanny Velázquez	Supervisora Sección de Evaluación, Investigación y Control de Calidad
Lcda. Amparo Yunque	Directora
Lcda. Maritza López	Directora - teléfono nuevo
Lcdo. Manuel González	Director

María de los A. Amaro	Coordinadora
Sr. Carlos Rivera	Coordinador Orientacion de Pruebas Rapidas y Referidos (CTR) - partnership for health
Sr. Manuel Rodríguez	Director - cmu, capacitación - desarrollo de materiales educativos
Sr. Miguel Fernández	Supervisor de Epidemiologia - cambio de teléfono llamar
Sr. Miguel Gelabert	Coordinador
Sr. Pedro J. García	Coordinador de Pruebas Rapidas
Sra. Ángeles Vázquez	Supervisora - teléfono nuevo. Llamar
Sra. Cynthia Payton	Supervisora Técnico de Epidemiologia
Sra. Enid Quiles	Co - Chair GPC
Sra. Evelyn Colon	Supervisora Regional Técnico de Epidemiologia
Sra. Isa Chinea	Asesora Federal
Sra. Janelli Rivera	Supervisora
Sra. Juanita Gómez	Enfermera III Pediatría
Sra. Luz Gelabert	Supervisora Alcance Comunitario
Sra. Maribel Ríos	Supervisora Técnico de Epidemiologia

Sra. Maritza Cruz	Vigilancia SIDA
Sra. Sylvia Pérez	Supervisora Técnico de Epidemiologia
Jorge Santana (Director ACTU)	
Doctor José Cordero	Ciencias Médicas
Dra. Carmen Zorilla, Directora CEMI	
Dra. Irmaris Cruz	Lucha contra el SIDA
Margarita Parilla	
Aracelis	
José Joaquín Mulinelli	
Julius Álvarez	
Dra. Rafaela Robles	
Luis Segundo (Co-Chair CPG Prevención)	
Sr. Carlos (Co-Chair ACTU)	
Nilda Santos	COSSMA
Dra. Rosa Rivera	Municipio de Caguas
Peter Shepard	COAI

Rosita Rivera	
Carmen Albizu	
Lcda. Margaret Wolf	
Secretario de Salud	
Carmen Barbosa	

APPENDIX 1-B: STAKEHOLDERS THAT PARTICIPATED IN THE WORKSHOPS

Name	Program or Organization
1. Dra. Norma Delgado	Programa Ryan White parte B
2. Dra. Trinidad Garcia	Programa Prevención VIH
3. Sra. Maritza Cruz	Programa Vigilancia SIDA
4. Sr. Julius Alvarez	Epidemiologia/Prevención VIH
5. Sa. Isa Chinea	Prevención VIH
6. Sra. Johanny Velázquez	Investigación y control de Calidad
7. Dr. Javier Parga	Grupo Planificación Ryan White
8. Dr. Hermes García	OCASET
9. Lcda. Margaret Wolfe	Sec Auxiliar de Salud Familiar,Servicios Integrados y Promoción de la Salud
10. Sra. Sandra Miranda	Vigilancia SIDA/ Proyecto ECHPP
11. Sra. Enid Quiles	Programa Prevención
12. Dr. Luis Segundo	GPC - Prevención VIH
13. Sra. Ursula Torres	Proyecto ECHPP
14. Sr. Carlos Velez	Proyecto ACTU/Grupo Planificación Ryan White

15. Sr. Peter Shepard	COAI, INC
16. Sr. Jose Joaquin Mulinelli	COAI, INC
17. Sra. Carmen Rivera	Proyecto GAMMA
18. Sr. Wilfredo Santiago	Consultor
19. Dr. Angel Gonzalez	Recinto de Ciencias Médicas
20. Sra. Carmen Barbosa	Ayudante Especial Secretaria Familiar
21. Sra. Nancy Berrios	ECHPP
22. Sr. Wilson Valentin	PRO Familia
23. Dr. Ramón Ramirez Ronda	Clínica Inmunología Mayagüez
24. Sra. Bernardita	Programa Vigilancia SIDA
25. Sr. Jaime Santana	Coordinador del Programa
26. Sra. Mirta Santos	Grupo Planificación Comunitaria Prevención de VIH
27. Dra. Ada Martinez	Asesora de Secretario de Salud/ Programa TB
28. Sra. Maria Elena Collazo	COSSMA Inc
29. Sra. Rosita Rivera	Salud Correccional
30. Sra. Ivette Gonzalez	Grupo Planificación Ryan White

31. Sr. Anselmo Fonseca	Pacientes Pro Política Sana
32. Sra. Samira Sanchez	Secretaria Auxiliar de Planificación
33. Sa. Caroline Maldonado	ECHPP
34. Sra. Yomaris Reyes	Programa Ryan White
35. Sr. Adalid Castro	Programa Prevención VIH
36. Sra. Glenda Dávila	Iniciativa Comunitaria
37. Sra. Ivelisse Cruz	Programa SIDA SJ
38. Sr. Lexter Rosario	Programa SIDA SJ
39. Sra. Gladys L. Rodríguez	Programa Servicios Comprensivos a Fam VIH/SIDA
40. Sra. Carmen Albizu	UPR EGSP

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APPENDIX 3: EVALUATION PLAN FIRST DRAFT

Intervenciones Requeridas	**1. "Routine Opt – Out screening" para VIH en contextos clínicos."**
Metas	Aumentar el número de personas que se realizan la prueba de VIH a través de la metodología Opt-out en un contexto clínico.
Estrategias	**Estrategia 1**: Recomendación a la clase médica para realizar prueba de VIH. **Estrategia 2:** Realizar pruebas rápidas de VIH en salas de emergencia. **Estrategia 3:** Crear alianzas con organismos médicos. **Estrategia 4:** Negociar que se cubra el costo de la prueba a través de las aseguradoras. **Estrategia 5:** Promocionar los servicios de las clínicas (públicas y privadas). **Estrategia 6**: Ampliar los escenarios en los cuales se realizan las pruebas opt-out en un contexto clínico.

Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Ob[illegible]ve 1: [illegible]ara ene[illegible] de [illegible]012 ad[illegible] a [illegible]100 mé[illegible] de la [illegible]gión AM[illegible] de San [illegible]uan en [illegible] tema [illegible] lo ori[illegible]ación de[illegible] [illegible]IH.	[illegible] D[illegible]inar [illegible] específic[illegible] tr[illegible]ba[illegible]. [illegible] D[illegible]ollo de[illegible] currículo pre[illegible]ar y p[illegible]sentador/[illegible] del te[illegible]a. [illegible] S[illegible]nar o[illegible] [illegible]vitar a mé[illegible] al[illegible]ar. **1.4** Seleccionar lugares y fechas para la presentación de la actividad. **1.5** Desarrollo de presentación. **1.6** Evaluación del tema de VIH presentado.	[illegible]# [illegible]e mé[illegible] l[illegible]zado[illegible] [illegible] Plan [illegible]a[illegible]o [illegible]ef[illegible]do. - Adiestramiento finalizado. - Área del AME impactada. - Resultados de la evaluación	-D[illegible]sión Ed[illegible]ación Ed[illegible]ón ó [illegible] de [illegible]revenci[illegible] Pre[illegible]upación qu[illegible] h[illegible] presentación

Objetivo 2.1: Para enero del 2012, el Departamento de Salud, implementará proyecto de prueba rápida en tres salas de emergencia localizadas en AME de San Juan.	**2.1** Analizar requisitos para el establecimiento del proyecto de prueba rápida. **2.2** Determinar las salas de emergencias a utilizarse. **2.3** Desarrollo de criterios para adquisición de las pruebas. **2.4** Compras de pruebas. **2.5** Desarrollo de protocolo para la realización de las pruebas rápidas. **2.5** Evaluación del proceso de desarrollo del proyecto.	- Salas determinadas para el Proyecto. - Proyecto de Pruebas rápida finalizado y documentado. - Protocolo de Pruebas rápidas.	-División de Prevención VIH.
Objetivo 2.2: Para enero de 2012, lograr que el 60% de las personas que lleguen a estas salas de emergencia se realicen la prueba.	**2.2.1** Definir proceso para la realización de la prueba entre personas que lleguen a las salas de emergencia. **2.2.2** Selección de personal a realizar las pruebas. **2.2.3** Determinar participantes a alcanzar. **2.2.4** Utilizar el protocolo definido. **2.2.5** Evaluar la intervención efectuada. **2.2.6** Determinar por ciento alcanzado.	- Cantidad y (%) de pruebas realizadas. - Resultados de las pruebas.	-División de Prevención VIH
Objetivo 3: Para enero de 2012, participar en al menos un congreso médico anual, para orientar sobre la importancia de incluir la prueba VIH en el cuidado médico rutinario.	**3.1** Determinar plan de acción relacionado a la orientación de la prueba de VIH. **3.2** Hacer contactos con las organizaciones médicas. **3.3** Presentar a la Junta de Directores de Médicos la idea sobre la importancia de incluir la prueba de VIH en cuidado rutinario. **3.4** Seleccionar congreso anual a	- Evaluación del Congreso. - Cantidad y (%) de médicos impactados. - Congreso establecido.	-División de Prevención VIH. - Junta de Directores de Organización Médica. - Secretario de Salud.

	impactar. **3.5** Determinar cantidad de médicos impactados. **3.6** Desarrollo de evaluación de la actividad.		
Objetivo 4: Para enero de 2012, coordinar una reunión con el Comisionado de Seguros de los planes privados para lograr que se cubra la prueba rápida de VIH una vez al año.	**4.1** Determinar plan de acción relacionado a la necesidad de cubrir las pruebas rápidas entre las personas claves en los planes privados. **4.2** Hacer contactos con personas claves en los planes privados. **4.3** Presentar a la Junta de Directores de la Comisión de Seguros la importancia de incluir la prueba de VIH en cuidado rutinario. **4.4** Seleccionar fecha de reunión. **4.5** Determinar agenda de reunión. **4.6** Determinar acuerdos con el Comisionado de Seguros.	- Evaluación del Congreso. - Cubierta para realización de la prueba. - Coordinación de reunión.	- Junta de Directores de la Comisión de Seguros de Salud. - Secretario de Salud.
Objetivo 5: Para enero de 2012, Coordinar una reunión con ASES para lograr que se cubra la prueba rápida de VIH una vez al año.	**5.1** Determinar plan de acción relacionado a la necesidad de cubrir las pruebas rápidas una vez al año por los planes de salud. **5.2** Hacer contactos con personas claves en los planes de salud en PR para negociación de cubierta. **5.3** Presentar a la Junta de Directores de ASES la importancia de incluir la prueba de VIH en cuidado rutinario. **5.4** Seleccionar fecha de reunión. **5.5** Determinar agenda de reunión. **5.6** Determinar acuerdos con ASES.	- Acuerdos establecidos en la reunión. - Cubierta para realización de la prueba. - Coordinación de reunión.	- División de Prevención. - Secretario de Salud.

Objetivo 6: Para enero de 2012, lograr que el 60% de las personas en las instituciones penales que reciben servicios clínicos, se hagan la prueba.	**6.1** Definir proceso para la realización de la prueba dentro de la Institución Penal. **6.2** Realizar acuerdos entre el personal responsable de hacer las pruebas y personal administrativo en las instituciones penales. **6.2** Selección de personal a realizar las pruebas. **6.3** Determinar participantes a alcanzar. **6.4** Definir un protocolo de servicios. **6.5** Evaluar la intervención efectuada. **6.6** Determinar por ciento alcanzado.	- Cantidad y (%) de pruebas realizadas entre las personas en instituciones penales. - Protocolo de servicios. - Acuerdos definidos para las Instituciones Penales.	- Instituciones penales.

Intervenciones Requeridas	2. **"Pruebas de VIH en entornos para identificar la infección con este virus aun sin diagnosticar."**
Metas	Aumentar el número de personas que se realizan la prueba de VIH en contextos no clínicos.
Estrategias	Estrategia 1: Aumentar el número de organizaciones (OBC) que trabajan con prevención realicen la prueba de VIH. Estrategia 2: Promover que se realicen las pruebas rápidas en escenarios no clínicos. Estrategia 3: Crear alianzas entre las organizaciones para maximizar los esfuerzos de prueba, para asegurar un mayor acceso. Estrategia 4: Identificar de nuevas fuentes de fondos. Estrategia 5: Ampliar los escenarios en los cuales se realizan las pruebas de VIH en los contextos no clínicos. Estrategia 6: Brindar acceso de data e internet a proveedores para reclutamiento y referido (no partner services).

Objetivos	Objetivo de Proceso (Actividades)	Indicador	Persona o División Responsable
Objet 3:	Determi área ia incid	- ad	Divisi

enero del 2012, distribuir condones y ofrecer orientación sobre el uso del mismo en aquellas áreas de alta incidencia en el 60% de los municipios comprendidos en el AME San Juan.	**1.2** Desarrollar documentación a presentar para orientar a participantes **1.3** Definir un plan de trabajo para la distribución de condones en las áreas. **1.4** Evaluar la intervención efectuada. **1.5** Determinar por ciento alcanzado.	(%) de participantes alcanzados. - Cantidad de condones distribuidos. - Documentos desarrollados para la orientación. - Orientación desarrollada.	Prevención. -OBC determinadas.
Objetivo 2; 5: Para enero de 2012, que el 50% de los proveedores de servicios que ofrecen servicios de prevención ofrezcan la prueba de VIH.	**2.1** Determinar la cantidad de proveedores de servicios de prevención. **2.2** Definir proceso para la inclusión del ofrecimiento de la prueba de VIH entre los proveedores. **2.3** Determinar áreas a impactar. **2.4** Definir un plan de trabajo para la ofrecer la prueba de VIH. **2.5** Evaluar la intervención efectuada. **2.6** Determinar por ciento alcanzado.	- Cantidad y (%) de proveedores que realizan la prueba. - Áreas impactadas. - Cantidad y (%) de pruebas de VIH realizadas.	-División de Prevención VIH. - Proveedores de Servicios de Prevención.
Objetivo 4: Para enero de 2012, coordinar al menos dos reuniones con legisladores que atiendan asuntos de salud para la identificación de fondos dirigidos a hacer pruebas de VIH.	**4.1** Conocer los procedimientos para realizar acercamientos a la legislatura. **4.2** Determinar comisiones de servicios de salud. **4.3** Definir procesos y personal para la solicitud de fondos. **4.4** Establecer las dos reuniones con la Comisión de Salud para solicitar los fondos. **4.5** Finalizar el proceso de solicitud de fondos.	- Fondos determinados. - Agenda y minuta de reuniones. - Solicitud de fondos. - Reuniones coordinadas y ofrecidas.	-División de Prevención VIH. - Comisión de Salud en la Legislatura. - Secretario de Salud.
Objetivo 6: Para junio 2012, ampliar el acceso de Internet	**6.1** Revisar los criterios específicos para establecer servicios de Internet.	- Nombres de los TAC. - Cantidad y	- División de Prevención. - Supervisora/o

del Departamento de Salud de al menos 2 TAC para el reclutamiento de personas en alto riesgo a través de la Web.	**6.2** Determinar proceso para ampliar los servicios de Internet. **6.3** Desarrollar adiestramiento para lograr el reclutamiento de personas en alto riesgo. **6.4** Seleccionar dos (2) TAC para el reclutamiento a través de Web. **6.5** Evaluar el proceso final de reclutamiento.	(%) de personas reclutadas por los dos TAC. - Acceso de Internet.	de TAC.

Intervenciones Requeridas	3. "Distribución de condones dirigidos a poblaciones con el mayor riesgo de adquirir VIH."
Metas	Disminuir el número de personas en alto riesgo de adquirir o transmitir el VIH mediante el uso del condón.
Estrategias	Estrategia 1: Identificar los lugares donde se ofrecen servicios y lugares de encuentro de personas VIH positivas y en alto riesgo. Estrategia 2: Promover cambios en política pública dentro del sistema del departamento de educación y corrección para que se incluya la distribución de condones. Estrategia 3: Incluir el tema de la promoción y prevención del VIH y ETS en el currículo de salud escolar. Estrategia 4: Establecer alianzas entre agencias y organizaciones para proveer condones a entidades que atienden a personas positivas. Estrategia 5: Desarrollar mecanismos para medir la utilización del condón entre personas positivas y en alto riesgo.

Objetivos	Objetivo de Proceso (Actividades)	Indicador	Persona o División Responsable
Objetivo 1: enero del 2012 distribuir condones y establecer prioridades sobre su uso mismo a áreas de alta incidencia en el 50% de los municipios comprendidos en el AME San Juan.	**1.1** Determinar áreas de incidencia de VIH en el AME. **1.2** Desarrollar documentación de participantes para orientación de participantes. **1.3** Establecer un plan de trabajo para la distribución de condones en las áreas. **1.4** Evaluar la intervención efectuada. **1.5** Determinar por ciento alcanzado.	Cantidad (%) de participantes alcanzados. Cantidad de condones distribuidos. - Documentos desarrollados para la orientación.	Director de Prevención.
Objetivo 2/3: Para enero del 2012, coordinar al menos	**2.1** Conocer los procedimientos para realizar acercamientos a la	- Políticas públicas desarrolladas	-Secretario de Corrección.

dos reuniones con los Secretarios de Educación y Corrección para incluir en las políticas públicas de ambas agencias el uso y distribución de condones en ambos escenarios.	Secretaría de Educación y la Secretaría de Corrección. **2.2** Determinar procesos para el desarrollo de política pública para ambas agencias. **2.3** Establecer las reuniones en las diferentes secretarías. **2.4** Finalizar el proceso de desarrollo de la política pública para las agencias.	y establecidas para las agencias. - Agenda y minuta de reuniones.	-Secretario de Educación. -División de Prevención.
Objetivo 3: Para enero de 2012, asegurar que el 100% de las organizaciones que ofrecen servicios de prevención tengan disponible una partida para la compra y distribución de condones.	**3.1** Determinar la cantidad de organizaciones de servicios de prevención. **3.2** Definir proceso para incluir la compra y distribución y compra de condones. **3.3** Desarrollo oficial entre las organizaciones la inclusión de la partida para la compra y distribución de condones. **3.4** Determinar por ciento alcanzado.	- Cantidad de organizaciones que ofrecen los servicios. - Modificaciones en los contratos. - Compras de condones realizadas.	-División de Prevención.
Objetivo 4: Para enero de 2012, lograr al menos cinco alianzas con entidades que ofrecen servicios a personas VIH positivas para proveer condones.	**4.1** Determinar cantidad de entidades que ofrecen servicios a personas VIH positivas. **4.2** Desarrollo de proceso para distribuir condones. **4.3** Conocer procesos administrativos para el establecimiento de alianzas. **4.4** Determinar las cinco entidades para el establecimiento de las alianzas. **4.5** Administrativamente hacer las [illegible] entidades	- Alianzas definidas. - Evaluación de la provisión de condones. - Entidades alcanzadas.	-División de Prevención.

Objetivo 5: Para enero de 2012, llevar a cabo un estudio sobre el uso del condón en la población VIH positiva y en alto riesgo en el AME San Juan.	**5.1** Determinar población VIH + a servir. **5.2** Desarrollo de hipótesis (propósito e interés) para el estudio. **5.3** Establecer variables a medir. **5.4** Determinar muestra del estudio. **5.5** Realización del estudio. **5.6** Presentar conclusiones del estudio.	- Estudio finalizado. - Resultados del estudio.	- División de Prevención.

Intervenciones Requeridas	**4. "Suministro de Profilaxix Post-Exposición a poblaciones de alto riesgo."**		
Metas	Disminuir el riesgo de adquirir el VIH post-exposición en un evento de riesgo.		
Estrategias	**Estrategia 1**: Revisar y actualizar el protocolo post-exposición en casos de una agresión física/sexual o accidentes ocupacionales/no-ocupacionales.		
	Estrategia 2: Estandarizar el protocolo post-exposición en casos de una agresión física/sexual o accidentes ocupacionales/no-ocupacionales.		
	Estrategia 3: Diseminar e implementar el protocolo post-exposición en casos de una agresión física/sexual o accidentes ocupacionales/no-ocupacionales.		
	Estrategia 4: Difundir entre la población sus derechos a solicitar tratamiento post-exposición como resultado de agresión física/sexual o accidentes ocupacionales/no-ocupacionales.		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetive 1: Para 2 1, lud be izar lariz otocolo posición	**1.1** Revisión de última versión del p otocolo post-exposición **1.2** mir isitos p esarrollo un nuevo ro olo exposición. **1.3** Se ionar ersonas r por able el sarro del prot plo **1.4** ecer criterios	-Protocolo post- expos n.	Divisió de re

	exposición. **1.5** Desarrollo de protocolo.		
Objetivo 2: Para diciembre 2011, el Departamento de Salud debe implementar y diseminar el protocolo post-exposición en las áreas correspondientes al AME.	**2.1** Conocer estrategias de manejo para pacientes post-exposición al virus. **2.2** Desarrollo de manual de estrategias para implementación del protocolo post-exposición. **2.3** Realizar plan de diseminación en las áreas del AME. **2.4** Desarrollo del material (fotocopias) para entrega en las áreas.	-Plan de distribución. - Áreas del AME impactadas.	-División de Prevención.
Objetivo 3: Para junio 2011, el Departamento de Salud se asegurará que el 100% de las agencias acreditadoras de educación continua a profesionales de la salud incluyan el tema de protocolo post-exposición al VIH dentro del curso "Exposición a Patógenos en Sangre".	**3.1** Realizar revisión de documentación para la inclusión de temas para las agencias acreditadoras. **3.2** Determinar proceso específico para la inclusión de temas en las diferentes agencias acreditadoras. **3.3** Seleccionar personas responsables del desarrollo del tema. **3.4** Desarrollo del tema. **3.5** Establecer un currículo oficial del tema.	- Tema desarrollado "Exposición a Patógenos en Sangre". - (%) de Agencias acreditadoras impactadas. - Currículo final.	- Departamento de Salud. -AETC.
Objetivo 4: Para mayo 2012, el Departamento de Salud desarrollará una campaña educativa para difundir entre la población sus derechos a solicitar tratamiento post-exposición como resultado de agresión física/sexual o accidentes ocupacionales/no-ocupacionales.	**4.1** Determinar los derechos para la población para el tratamiento post-exposición. **4.2** Especificar procesos para la solicitud de los servicios para el tratamiento post-exposición. **4.3** Escoger y determinar la información a presentar en la campaña educativa. **4.4** Desarrollo del proceso de selección de la agencia a contratar para la campaña. **4.5** Selección de medios a utilizar. **4.6** Evaluación del proceso de selección.	- Campaña desarrollada. - Medios seleccionados. - Evaluación de la campaña.	-Departamento de Salud. -Agencia de promoción.

Intervenciones Requeridas	5. **"Esfuerzos para cambiar políticas, estructuras existentes y reglamentos que son barreras para crear un ambiente optimo para la prevención, atención y tratamiento del VIH."**
Metas	Identificar y llevar a cabo esfuerzos para cambiar aquellas estructuras, normas y reglamentos que puedan ser barreras para crear un ambiente óptimo para la prevención, cuidado y tratamiento de VIH
Estrategias	**Estrategia 1**: Enmendar el reglamento del Colegio de los Tecnólogos Médicos a los fines de que cualquier persona certificada por el Departamento de Salud pueda administrar una prueba rápida de VIH en cualquier escenario, ya sea clínico o no clínico.
	Estrategia 2: Educar a los médicos sobre el cuidado integral de la condición y sus tratamientos a pacientes con VIH.
	Estrategia 3: Establecer un protocolo de cuidado de salud para los pacientes VIH que considere las necesidades y servicios médicos integrales de los pacientes.
	Estrategia 4: Crear una red de médicos especialistas que brinden atención a personas con VIH.
	Estrategia 5: Crear una orden administrativa para que se recomiende la consejería y prueba de VIH como parte del cuidado prenatal.
	Estrategia 6: Facilitar el acceso a jeringuillas/agujas a usuario/as de drogas inyectables.

Objetivos	Objetivo de Proceso (Actividades)	Indicador	Persona o División Responsable
Objetive 1: Para diciembre 2011, se desarrollará e implementará una orden administrativa a través del Secretario de Salud para enmendar el reglamento del Colegio de Tecnólogos Médicos a los fines de que cualquier persona certificada por el Departamento de Salud pueda administrar cualquier metodología de	**1.1** Determinar los procesos para la realización de enmiendas a reglamentos. **1.2** Revisión del reglamento del Colegio de Tecnólogos Médicos. **1.3** Determinar y conocer los procesos para la administración de las diferentes metodologías para la realización de pruebas rápidas de VIH. **1.4** Hacer contactos con personas claves que aporten al proceso de desarrollo de una orden administrativa. **1.5** Hacer contactos y reuniones con el Colegio de Tecnólogos Médicos.	- Orden administrativa finalizada. - Minutas de reuniones. - Metodología de pruebas rápidas determinadas.	-Colegio de Tecnólogos Médicos. - División de Prevención.

prueba rápida de VIH en cualquier escenario, ya sea clínico o no clínico.	**1.6** Escoger y determinar áreas a modificar en la orden administrativa. **1.7** Evaluación del proceso de modificación. **1.8** Desarrollo de la orden administrativa.		
Objetivo 2: Para junio 2012, el Departamento de Salud, en colaboración con AETC, ofrecerá un adiestramiento a los miembros de la Asociación de Médicos Tratantes de VIH y al Colegio de Médicos y Cirujanos de Puerto Rico sobre actualización de manejo y tratamiento de la condición de VIH.	**2.1** Conocer y determinar información para la actualización del manejo y tratamiento de la condición de VIH. **2.2** Determinar procesos específicos para el ofrecimiento de adiestramientos tanto en la Asociación de Médicos Tratantes de VIH, Colegio de Médicos y Cirujanos de Puerto Rico. **2.3** Desarrollar documentación a presentar para el adiestramiento. **2.4** Desarrollo del adiestramiento a presentar. **2.5** Determinar fecha del adiestramiento.	- Adiestramiento finalizado. - Minutas de reuniones.	-División de Prevención. - AETC.
Objetivo 3: Para junio 2011, el Departamento de Salud distribuirá al 100% de las clínicas y médicos que manejan pacientes con VIH y que están situadas en el AME, el protocolo del cuidado de salud para los pacientes VIH.	**3.1** Revisión de última versión del protocolo del cuidado de salud para los pacientes VIH. **3.2** Determinar cantidad específica de clínicas y médicos que manejan pacientes VIH en el AME. **3.3** Establecer proceso de distribución y reproducción del documento. **3.4** Conocer por ciento alcanzado.	- Protocolo de Cuidado de salud para los pacientes VIH. - Lista de lugares en donde se distribuyó el protocolo. - Por ciento alcanzado.	- Clínicas y médicos que manejan pacientes con VIH. - División de Prevención.
Objetivo 4.1: Para marzo 2012, el Departamento de Salud desarrollará un directorio de médicos de diferentes especialidades que atiendan personas con VIH.	**4.1.1** Conocer y determinar entidades y médicos que atienden personas VIH. **4.1.2** Determinar las especialidades de atención médica para pacientes VIH. **4.1.3** Determinar procesos necesarios para el desarrollo de un directorio médico. **4.1.4** Establecer proceso de distribución y reproducción del	- Directorio finalizado.	- Departamento de Salud.

	documento (directorio).		
Objetivo 4.2: Para junio 2012, el Departamento de Salud, en colaboración con AETC, ofrecerá un adiestramiento a médicos de diversas especialidades con el fin de reclutarlos para que se integren a la red de servicios a pacientes con VIH.	**4.2.1** Conocer procesos de reclutamiento a la red de servicios a pacientes con VIH. **4.2.2** Realizar y efectuar contactos de trabajo para el desarrollo de talleres con el AETC. **4.2.3** Determinar procesos de invitación a médicos para formar parte de la red. **4.2.4** Desarrollo del adiestramiento. **4.2.5** Coordinar el ofrecimiento del adiestramiento. **4.2.6** Desarrollo del adiestramiento a presentar.	- Adiestramiento coordinado y ofrecido. - Cantidad y (%) de médicos alcanzados. - Cantidad y (%) de médicos que formarán parte de la red de servicios a pacientes con VIH.	- AETC. - Departamento de Salud.
Objetivo 5: Para diciembre 2012, el equipo de trabajo de la Coalición Alcance Juvenil desarrollará un proyecto de ley a los fines de establecer la prueba de VIH de forma rutinaria como parte del cuidado médico para personas de 13 años en adelante.	**5.1** Conocer y determinar información sobre la Coalición Alcance Juvenil. **5.2** Determinar capacidades para el desarrollo de un proyecto de ley. **5.3** Determinar procesos para establecer la prueba de VIH de forma rutinaria como proyecto de ley. **5.4** Conocer procesos rutinarios e importantes de la coalición **5.5** Asignar personas responsables para el desarrollo del proyecto de ley. **5.6** Desarrollo del proyecto de ley. **5.7** Aprobación del proyecto de ley.	- Proyecto de Ley para la prueba de VIH rutinaria en personas de 13 años en adelante. - Minutas de reuniones entre la Coalición y el personal de prevención VIH.	- Coalición Alcance Juvenil. - División Prevención.
Objetivo 6.1: Para	**6.1.1** Conocer todos los aspectos	- Acuerdos	- Colegio de

diciembre 2011, el Departamento de Salud orientará al Colegio de Farmacéuticos sobre la ley #73 de venta de jeringuillas/agujas en las farmacias, sin receta médica.	relacionados al desarrollo de presentación sobre la Ley#73. **6.1.2** Hacer contactos con el Colegio de Farmacéuticos. **6.1.3** Determinar reunión y personas claves para presentar la importancia de que conozcan la ley sobre la venta de jeringuillas/agujas en farmacias. **6.1.4** Establecer un día específico para la presentación formal de la ley #73 al Colegio de Farmacéuticos. **6.1.5** Determinar acuerdos entre el Colegio de Farmacéuticos y el Departamento de Salud para el cumplimiento adecuado de la Ley.	establecidos. -Presentación formal de la Ley #73. -Redacción de la orientación.	Farmaceuticos. - Departamento de Salud.
Objetivo 6.2: Para junio 2013, añadir 1 máquina expendedora de jeringuillas (vending machine) en uno de los programas de intercambio de jeringuillas existente que este situado en uno de los municipios de mayor prevalencia de VIH dentro del AME.	**6.2.1** Conocer los procesos para la adquisición de la máquina expendedora de jeringuilla. **6.2.2** Determinar por medio de prevalencia de casos el municipio en el que se debe establecer la máquina. **6.2.3** Selección de compra de la máquina. **6.2.4** Desarrollo del proceso de compra de la máquina. **6.2.4** Culminar el proceso de compra.	- Compra de la máquina. - Programa de intercambio de jeringuilla establecido.	- Área administrativa del Municipio seleccionado. - Departamento de Salud.
Objetivo 6.3: Para julio 2013, aumentar en 1 la cantidad de programas de intercambio de jeringuillas.	**6.3.1** Conocer detalles específicos para el establecimiento de un programa de intercambio de jeringuillas. **6.3.2** Determinar fondos para el establecimiento del programa.	- Programa de Intercambio de jeringuilla.	- Departamento de Salud.

	6.3.3 Iniciar proceso de desarrollo del programa y solicitud de fondos. **6.3.4** Presentar la necesidad del establecimiento del programa. **6.3.5** Establecer lugar, materiales y el municipio para llevar a cabo el programa.		
Objetivo 6.4: Para julio 2011, establecer acuerdos de colaboración entre el Departamento de Salud y la Comandancia de la Policía Estatal y Municipal de los municipios en los que se lleva a cabo programas de intercambio de jeringuillas para educarles y asegurar que no se interviene con UDI que reciben parafernalia y jeringuillas limpias.	**6.4.1** Conocer procesos que efectúa la Comandancia de la Policía Estatal y Municipal para el manejo de aquellos UDI que reciben parafernalia y jeringuillas limpias. **6.4.2** Determinar la política establecida por prevención para el manejo de los UDI con parafernalia y jeringuillas. **6.4.3** Determinar procesos de educación permitidos para la Policía Estatal y Municipal. **6.4.4** Desarrollo de educación y presentación apropiada para el manejo adecuado de los UDI con parafernalia. **6.4.5** Efectuar contacto con personas claves para el desarrollo de acuerdos de colaboración con el fin de desarrollar un manejo adecuado parafernalia y jeringuillas limpas.	- Acuerdos de colaboración establecidos. - Cantidad de Comandancias de la Policía Estatal y Municipal en el acuerdo.	- Administración de Comandancias de la Policía Estatal y Municipal. - Departamento de Salud.
Objetivo 6.5: Para diciembre 2013, hacer esfuerzos para modificar/flexibilizar la ley #73 de 2007 "Ley de sustancias controladas" (Enmienda de parafernalia).	**6.5.1** Analizar la Ley de sustancias controladas. **6.5.2** Determinar los cambios a realizar a la ley. **6.5.3** Legalmente conocer los procesos de cambios de leyes. **6.5.4** Hacer presentaciones ante las	- Ley #73 de 2007 "Ley de sustancias controladas" modificada. - Minutas de reuniones efectuadas.	- Secretaría de Justicia. - Departamento de Salud.

	entidades administrativas para la solicitud de cambio de ley. **6.5.5** Establecer acuerdos finales.		

Intervenciones Requeridas	**6. "Llevar a cabo enlaces para los servicios de atención, tratamiento y prevención de VIH, para aquello con resultado positivo y que actualmente no reciben atención."**
Metas	Enlazar a cuidado, tratamiento y servicios preventivos a aquellos que son VIH positivos y que no se encuentran actualmente recibiendo servicios.
Estrategias	**Estrategia 1**: Implementar una red de referidos entre el Departamento de Salud y el Sistema de Corrección a los fines de enlazar a cuidados a las personas VIH positivas que salen del sistema correccional.
	Estrategia 2: Establecer una orden administrativa para que el proveedor de servicios de salud que tenga conocimiento de un paciente que no haya recibido sus resultados positivos, notifique al Departamento de Salud para que los técnicos en epidemiología hagan un esfuerzo de entrega de los mismos y de los referidos correspondientes.
	Estrategia 3: Desarrollar un protocolo a los efectos de que la oficina de Vigilancia de VIH/Sida comparta los resultados VIH positivos con Vigilancia de ETS para seguimiento de los técnicos en epidemiología.
	Estrategia 4: Crear un procedimiento donde se intercambie o se refiera información de pacientes VIH positivos entre las clínicas de VIH y el personal de ETS.

Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetive 1: Para junio 2011, desarrollar un acuerdo colaborativo entre el Departamento de Salud y la Administración de Corrección para	**1.1** Conocer los procesos de salidas de confinados VIH positivos. **1.2** Determinar áreas a mejorar para la continuidad de los servicios. **1.3** Presentar las áreas a mejorar a la Administración de Corrección. **1.4** Presentar un plan de mejoras del plan que asegure los servicios a	- Acuerdo colaborativo. - Ex confinados referidos. -Clínicas que forman parte del acuerdo.	- Departamento de Salud - Administración de Corrección. - Clínicas del acuerdo.

referir a los ex confinados que son VIH positivos a las clínicas de proveedores de servicios de VIH.	estos pacientes. **1.5** Ofrecer alternativas para el desarrollo del acuerdo colaborativo para los referidos de los ex confinados. **1.6** Hacer contactos y acuerdos con las clínicas de proveedores de VIH para recibir pacientes y obtener los servicios de salud. **1.7** Finalizar el acuerdo colaborativo.		
Objetivo 2: Para junio 2012, emitir una orden administrativa estableciendo que el proveedor de servicios de salud que tenga conocimiento de un paciente que no haya recibido sus resultados, notifique al Departamento de Salud para que los técnicos en epidemiología hagan un esfuerzo de entrega de los mismos y de los referidos correspondientes.	**2.1** Conocer los procesos que realizan los proveedores de servicios con los pacientes que no reciben su diagnóstico. **2.2** Definir proceso estándar para efectuar contacto con los pacientes que no reciben su diagnóstico. **2.3** Determinar con los técnicos de epidemiología el proceso estandarizado para la entrega de resultados. **2.4** Ofrecer alternativas para el desarrollo de la orden administrativa. **2.5** Hacer contactos y acuerdos con los técnicos en epidemiología de forma que se proteja la confidencialidad del proceso. **2.6** Hacer acuerdo final que asegure la continuidad de servicios para los pacientes que no han recibido su diagnóstico.	- Orden administrativa establecida. - Acuerdos con los Técnicos de Epidemiología. - Contactos realizados por los técnicos en epidemiología para localizar a la persona VIH+.	- Departamento de Salud. -Proveedores de servicios.
Objetivo 3: Para noviembre 2011, compartir el protocolo con todo el personal de Vigilancia VIH/SIDA, Vigilancia ETS, buscadores de casos de R.W. y los técnicos en epidemiología para su implantación.	**3.1** Conocer personas claves de Vigilancia VIH/SIDA, Vigilancia ETS, buscadores de casos de R.W. y los técnicos en epidemiología. **3.2** Determinar fechas para presentación del protocolo ya desarrollado. **3.3** Efectuar las reuniones para presentar a las diferentes áreas el	- Reuniones de presentación en las áreas. - Resultados de evaluación del proceso. - Protocolo desarrollado para compartir	- Personal clave en Vigilancia VIH/SIDA, Vigilancia ETS, buscadores de casos de R.W. y técnicos en epidemiología. - División Prevención.

	protocolo. **3.4** Evaluar el proceso de implantación del protocolo.	resultados VIH+.	
Objetivo 4: Para septiembre 2011, establecer un protocolo en las áreas que cubre el AME que asegure que el 70% de los pacientes que salen con resultados positivos de VIH en los CPTET sean conectados al cuidado de salud correspondiente a esta condición.	**4.1** Conocer los procesos que actualmente realizan los pacientes positivos al momento de su diagnóstico en los CPTET que forman parte del AME. **4.2** Definir proceso estándar para asegurar el contacto a servicios. **4.3** Determinar áreas con menor por ciento de personas conectadas a servicios una vez diagnosticados. **4.4** Determinar procesos específicos para estas áreas de menor por ciento de contacto. **4.5** Definir un flujograma que defina los pasos que se realizan en los CPTET para estos participantes y detectar áreas a mejorar. **4.6** Definir documentación y temas importantes para incluir en el protocolo. **4.7** Redacción y distribución del protocolo. **4.8** Determinar por ciento de participantes alcanzados.	- Protocolo finalizado. - Cantidad y (%) de pacientes + alcanzados. - Cantidad de CPTET que utilizan el protocolo desarrollado. - Áreas en el AME impactadas.	- CPTET en al AME.

Intervenciones Requeridas	**7. "Ejecutar intervenciones y estrategias para promover la retención o el re-envolvimiento en la atención de personas VHI positivas"**		
Metas	Mantener y retener a los pacientes VIH positivos en cuidado continuo de salud.		
Estrategias	**Estrategia 1**: Desarrollar actividades/intervenciones que promuevan que los pacientes VIH positivos se mantengan recibiendo servicios o se-reintegren a los mismos.		
	Estrategia 2: Orientar a los pacientes VIH positivos sobre la importancia de mantenerse en los servicios de salud.		
	Estrategia 3: Crear los mecanismos para superar las barreras y facilitar el acceso a los pacientes.		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetive 1: Para marzo 2012, identificar los pacientes VIH que abandonaron su tratamiento durante los últimos doce meses en los municipios comprendidos en el AME.	**1.1** Identificar pacientes que han abandonado su tratamiento. **1.2** Determinar proceso de referido a utilizar, sea los procesos del MAI o algún otro. **1.3** Hacer identificación de personas por pueblos. **1.4** Hacer lista oficial de pacientes sin servicio por el tiempo determinado. **1.5** Realizar un plan de trabajo parra con esos pacientes.	- Pacientes sin servicio. - Municipios alcanzados. - Identificar tiempo entre estos participates.	- Departamento de Salud - Programa Ryan White, MAI.
Objetivo 1.2: Para diciembre 2012, el Departamento de Salud identificará al menos 6 barreras que inciden en que los pacientes VIH positivos no reciban sus cuidados de salud con la intención de re-integrar a los pacientes a los mismos.	**1.2.1** Realizar revisión documentada de razones presentadas por los pacientes VIH+ del por qué no reciben servicios. **1.2.2** Establecer equipo de trabajo para determinar razones para no recibir servicios. **1.2.3** Priorizar las razones presentadas. **1.2.4** Desarrollo de opciones para el re-integro a los servicios para las	- Cantidad y (%) de personas re-integradas a servicios. - Barreras identificadas.	- Departamento de Salud.

	primeras 6 barreras. **1.2.5** Contactar personas identificadas y efectuar acercamiento para su re-integro.		
Objetivo 2: Para enero 2012, documentar mediante un formulario firmado por el paciente que el 100% de los pacientes que van a su primera cita sean orientados sobre la importancia de mantenerse activos en los servicios de cuidado de salud.	**2.1** Realizar lista de nuevos pacientes. **2.2** Determinar las prioridades de estos participantes en su visita. **2.3** Realizar formularios a completar. **2.4** Desarrollo de documento oficial de orientación sobre la importancia de mantenerse activos en los servicios de cuidado de salud. **2.5** Distribución al 100% de los participantes el documento.	- Formulario desarrollado. - Cantidad y (%) de participantes. - Formularios firmados. - Orientaciones ofrecidas.	- CPTET's. - Directores Clínicos de los CPTET's.
Objetivo 3: Para agosto 2013, identificar los recursos para superar el 50% de las barreras identificadas en el objetivo 1.2	**3.1** Realizar revisión documentada previamente de razones presentadas por los pacientes VIH+ del por qué no reciben servicios. **3.2** Mediante la priorización realizada (1.2.3) dar continuidad identificando recursos que puedan mejorar las barreras. **3.3** Contactar personas identificadas y efectuar acercamiento para su re-integro a servicios a por lo menos el 50% de personas que identifica esas barreras.	-	-

Intervenciones Requeridas	8. "Ejecutar políticas y procedimientos que lleven al suministro de tratamientos antirretrovirales, en acorde con las guías actuales de tratamiento para personas VIH positivas"		
Metas	Desarrollar e implementar aquellas políticas y procedimientos que faciliten la implementación de las guías más recientes para el uso de ART, en contextos públicos y privados.		
Estrategias	**Estrategia 1**: Capacitación a profesionales médicos de los CPTET del AME SJ.		
	Estrategia 2: Educación continuada a profesionales de la salud.		
	Estrategia 3: Estrategia3: Fortalecer el sistema de recogido de información que permita medir el cumplimiento con la utilización de las guías de **tratamiento**.		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetive 1: Para enero de 2012, ofrecer capacitación acerca de las guías de PHS al 90% del personal clínico de recién reclutamiento en los CPTET del AME SJ antes de la intervención con pacientes.	**1.1** Determinar personal clínico de nuevo ingreso. **1.2** Realizar un plan/programa de capacitación acerca de las guías de PHS. **1.3** Determinar personas responsables para el ofrecimiento de la capacitación. **1.4** Conocer cantidad de participantes a con necesidad de la capacitación. **1.5** Explorar forma de alcanzar el 90% de ese personal. **1.6** Ofrecer el taller de capacitación.	- Taller de capacitación finalizado y programado. - Evaluación del taller de capacitación. - Cantidad y (%) del personal clínico en el taller/es. -CPTET's participantes.	- Directores Médicos de los CPTET's en el AME. - OCASET
Objetivo 1:2 Para enero 2012, asegurar que los directores de las clínicas coordinen al menos un adiestramiento en o antes de 30 días a partir de la actualización de las guías de PHS y CDC para	**1.2.1** Determinar personal responsable para recibir información de la actualización de las guías. **1.2.2** Hacer contactos tanto con PHS como con CDC. **1.2.3** Coordinar el o los adiestramientos sobre la actualización de las guías. **1.2.4** Realizar invitaciones al personal. **1.2.5** Determinar % del personal	-Cantidad y (%) del personal clínico alcanzado. - Documentación y material desarrollad para el adiestramiento. - Evaluación del adiestramiento.	- Directores clínicos del AME. - CDC y PHS.

el 90% del personal clínico.	alcanzado. **1.2.6** Desarrollo de evaluación del adiestramiento.		
Objetivo 2:1 Para enero 2013, asegurar que el Departamento de Salud establezca como política pública que todo profesional de la salud reciba capacitación sobre las guías de PHS y CDC para la renovación de licencia.	**2.1** Repasar y revisar los procedimientos para el establecimiento de política pública. **2.2** Determinar pasos para la inclusión de todo profesional de la salud al alcance de la política pública sobre la capacitación. **2.3** Finalizar el proceso de desarrollo de la política pública. **2.4** Establecer de forma oficial que toda licencia del campo de salud requiera la capacitación.	- Cantidad y (%) del personal capacitado. - Documentación y material desarrollad para la capacitación. - Cantidad de licencias renovadas. -Política pública establecida	- Departamento de Salud. - CDC y PHS
Objetivo 2:2 A partir de enero 2013, establecer como política pública que el Departamento de Salud y que las aseguradoras públicas divulguen a la red de los proveedores de servicios todas las actualizaciones de las guías PHS y CDC, sujeto a la renovación de contratos. [monitorear y fiscalizar]	**2.2.1** Repasar y revisar los procedimientos para el establecimiento de política pública. **2.2.2** Determinar pasos para que DS y las aseguradoras públicas divulguen toda información a la red. **2.2.3** Establecer de forma oficial el requerimiento sobre la divulgación de las actualizaciones de las guías. **2.2.3** Evaluar el proceso de cumplimiento para otorgación de licencias o renovación de contratos. **2.2.4** Finalizar el proceso de desarrollo de la política pública.	- Política pública establecida. - Actualizaciones de las guías PHS y CDC. - Renovaciones otorgadas. - Proveedores de servicios alcanzados.	- Departamento de Salud. - Aseguradoras públicas. - Paneles médicos

Objetivo 3.1 A mayo 2012, aumentar en un 50% el cumplimiento de los indicadores relacionados a la utilización del tratamiento antirretroviral en los municipios que comprende el AME del SJ.	**3.1** Determinar proceso de evaluación de la utilización de tratamiento antirretroviral. **3.2** Determinar municipios específicos a evaluar. **3.3** Conocer criterios específicos para medir los indicadores de utilización. **3.4** Determinar personas en tratamiento. **3.5** Definir la evaluación de los indicadores. **3.6** Establecer % de cumplimiento.	-Indicadores definidos. -Cantidad y por ciento de tratamiento antirretroviral ofrecido. - % de cumplimiento con los indicadores determinado. -Municipios alcanzados.	- AME

Intervenciones Requeridas	**9. "Ejecutar intervenciones o estrategias que promuevan la adhesión a medicamentos antirretrovirales para personas VIH positivas"**
Metas	Aumentar el porciento de adherencia a personas con VIH en tratamiento antirretrovirales.
Estrategias	**Estrategia 1**: Desarrollar protocolos de promoción de adherencia que incluya intervenciones para HSH, inmigrantes (indocumentados) y usuarios de drogas inyectables.
	Estrategia 2: Fortalecer el sistema de identificación de pacientes no adherentes mediante el reclutamiento personal.
	Estrategia 3: Estrategia3: Fortalecer el sistema búsqueda de pacientes no adherentes mediante la contratación de las organizaciones que ofrecen el servicio de búsqueda.
	Estrategia 4: Educación a pacientes, colaterales en poblaciones identificadas y cuidadores a través de videos, panfletos, entre otros.
	Estrategia 5: Fomentar el tratamiento con medicamentos (metadona y buprenorfina) en UDI, VIH positivo.

Objetivos	Objetivo de Proceso (Actividades)	Indicador	Persona o División Responsable
Objetivo 1:1 Para el 30 de noviembre de 2011, desarrollar guías de manejo para poblaciones especiales identificadas (HSH, UDI, transgéneros e inmigrantes) dentro del protocolo de promoción de adherencia a través de un comité multisectorial.	**1.1** Conocer particularidades de las poblaciones a impactar. **1.2** Identificar guías de manejo ya existentes por población. **1.3** Evaluar áreas a modificar. **1.4** Desarrollo de guías específicas para estas poblaciones. **1.5** Establecer prioridades en información a incluir en el protocolo. **1.6** Establecer formato para el desarrollo de este protocolo. **1.7** Desarrollo del protocolo. **1.8** Diseminación del protocolo.	- Protocolo desarrollado. - Guías de manejo por población. - Notas efectuadas por el comité.	- Programa Ryan White - División de Prevención.
Objetivo 1:2 Para marzo 2012, el 90% del personal clínico recibirá al menos un adiestramiento anual acerca del protocolo a poblaciones especiales.	**1.2.1** Revisar el protocolo a poblaciones especiales. **1.2.2** Determinar información a proveer en el adiestramiento. **1.2.3** Determinar personal clínico a alcanzar. **1.2.4** Desarrollo del adiestramiento. **1.2.5** Desarrollo de evaluación del adiestramiento. **1.2.6** Determinación del porciento alcanzado.	- Cantidad y (%) de personal en adiestramiento. -Evaluación del adiestramiento. - Adiestramiento finalizado.	- Programa Ryan White - División de Prevención.
Objetivo 1.3 Para marzo 2013, reducir en un 5% los	**1.3.1** Conocer por ciento de participantes no adherentes. **1.3.2** Determinar procesos adecuados	- Cantidad y (%) de participantes alcanzados. - Por ciento que representa la	- Programa Ryan White - División de Prevención.

pacientes no adherentes a tratamiento en poblaciones especiales.	para el regreso a tratamiento de la población no adherente. **1.3.3** Evaluar proceso para reducción de los pacientes no adherentes. **1.3.4** Determinar por ciento de pacientes en las poblaciones especiales alcanzados.	reducción.	
Objetivo 2.1 Para el 30 de septiembre de 2012, completar el reclutamiento de 'records abstractor' (personas que abstraen de los expedientes médicos información de adherencia) y manejadores de caso clínico subvencionado con fondos Ryan White B.	2.1.1 Conocer el proceso completo de los 'records abstractor'. 2.1.2 Determinar proceso de reclutamiento.	- Records abstractors definidos. - Expedientes médicos alcanzados.	- Programa Ryan White.
Objetivo 2.2 Para mayo de 2013, establecer un comité multisectorial para la coordinación de búsqueda de casos en los 41 municipios del AME.	**2.2.1** Definir procesos de búsqueda de casos. **2.2.2** Definir propósito de la búsqueda de casos. **2.2.3** Seleccionar personas participantes para el comité. **2.2.4** Establecer criterios específicos para el comité. **2.2.5** Establecer pasos a seguir para coordinar la búsqueda. **2.2.6** Definir un plan de trabajo.	- Comité multisectorial establecido. - Cantidad y (%) de casos alcanzados. - Resultados de la coordinación. - Municipios alcanzados. - Definir propósitos del comité.	- Coordinación de casos.
Objetivo 2:3 A partir de enero 2012, aumentar un 5% de	**2.3.1** Conocer proceso de evaluación de manejo de caso. **2.3.2** Desarrollo de plan de trabajo para el alcance a pacientes.	- % de pacientes con evaluación. - Termino (periodo de meses) de evaluaciones determinado.	- Programa Ryan White Parte B.

pacientes que reciben una evaluación de manejo de caso con evaluación de adherencia cada seis meses.	**2.3.3** Determinar personal a cargo de la evaluación. **2.3.4** Definir criterios de evaluación. **2.3.5** Conocer % de pacientes alcanzados.		
Objetivo 3:1 Para el 30 de abril de 2011, completar la contratación de ocho organizaciones subvencionadas por Ryan White Parte B para que lleven a cabo búsqueda de pacientes no adherentes.	**3.1.1** Definir procesos de búsqueda de casos llevado a cabo por organizaciones. **3.1.2** Definir propósito para la contratación de organizaciones. **3.1.3** Seleccionar organizaciones. **3.1.4** Establecer criterios específicos para la contratación. **3.1.5** Definir un plan de trabajo para la búsqueda de casos.	- Organizaciones contratadas. - Cantidad y (%) de pacientes adherentes. - Planes de trabajo definidos.	- Programa Ryan White Parte B.
Objetivo 3:2 Para septiembre 2012/13, aumentará en un 10% los pacientes no adherentes contactados por el sistema de búsqueda regresen a tratamiento.	**3.2.1** Definir procesos de búsqueda de casos no adherentes. **3.2.2** Establecer criterios específicos para la el regreso a tratamiento. **3.2.3** Definir un plan de trabajo para la el regreso a tratamiento. **3.2.4** Determinar % en aumento de pacientes alcanzados.	-% de pacientes no adherentes alcanzados. - Cantidad y (%) de pacientes que regresan a tratamiento.	- Programa Ryan White Parte B.
Objetivo 4:1 Para mayo 2012, desarrollará un programa de pares a través del Departamento	**4.1.1** Conocer proceso de capacitación desarrollada en adherencia. **4.1.2** Definir procesos de ofrecimiento de talleres para adquirir destrezas en la adherencia a tratamiento. **4.1.3** Realizar un plan/programa de pares para la capacitación de adherencia.	- Taller de capacitación a pares. - Personal que conforman los pares alcanzados. - Programa de pares.	- Departamento de Salud.

de Salud para ofrecer capacitación en adherencia a tratamiento.	**4.1.4** Determinar personas responsables para el ofrecimiento de la capacitación. **4.1.5** Determinar personas responsables para el desarrollo del programa de pares. **4.1.6** Conocer cantidad de participantes a con necesidad de la capacitación. **4.1.7** Ofrecer el taller de capacitación.		
Objetivo 4.2 Para septiembre 2011, subvencionar a través del Programa Ryan White Parte F un adiestramiento al personal de educación en salud de la División de Prevención sobre la promoción de adherencia al tratamiento.	**4.2.1** Determinar tema específico a trabajar. **4.2.2** Desarrollo de un currículo a presentar y presentador/a del tema. **4.2.3** Seleccionar personal de educación en salud a impactar. **4.2.4** Seleccionar lugares y fechas para el adiestramiento. **4.2.5** Desarrollo de la evaluación del adiestramiento. **4.2.6** Evaluación del adiestramiento.	- Adiestramiento finalizado. - Personal de educación en salud adiestrado. -Resultados de la evaluación.	- División de Prevención
Objetivo 4.3 Para septiembre 2012, ofrecer al menos dos sesiones al mes en los cinco CPTET localizados en el AME sesiones educativas en la sala de espera sobre la importancia de la adherencia a tratamiento. (Utilización de	**4.3.1** Desarrollo de las sesiones a ofrecer. **4.3.2** Desarrollo de un currículo a presentar en las sesiones. **4.3.3** Selección de adiestradores y presentador/a de los temas. **4.3.4** Preparación de áreas en los CPTET para los adiestramientos. **4.3.5** Desarrollo de la evaluación de los adiestramientos. **4.3.6** Evaluaciones de los adiestramientos.	- Sesiones ofrecidas. - Salas de esperas impactadas. -Resultados de las evaluaciones.	- Administración de los CPTET. - Directores médicos. - Personal de educación en salud.

servicios existentes, materiales etc.)			
Objetivo 4.4 Para enero 2012, se iniciará programa educación de pares a través del Departamento. De Salud.	**4.1.1** Definir proceso de educación de pares. **4.1.2** Realizar un plan/programa de trabajo para la educación de pares. **4.1.3** Determinar personas responsables para el ofrecimiento de la educación y el programa. **4.1.4** Determinar plan de trabajo.	-Programa finalizado.	- Departamento. De Salud
Objetivo 5: Para Enero 2012, aumentar en 5% los pacientes UDI VIH positivos que reciben tratamiento de metadona o buprenorfina en escenarios clínicos.	**5.1** Definir procesos para el ofrecimiento de metadona o buprenorfina. **5.2** Identificar participantes del programa. **5.3** Establecer criterios específicos para el ofrecimiento. **5.4** Definir un plan de trabajo y autorizaciones para ofrecimiento en escenarios clínicos. **5.5** Determinar % y cantidad de pacientes en tratamiento.	- Desarrollo de evaluación del proceso. -% de UDI en tratamiento. -Escenarios clínicos definidos para este proceso.	- OBC's.

Intervenciones Requeridas	10. "Implementación de "STD Screening" de acuerdo a las directrices actuales para personas VIH positivas"		
Metas	Promover la detención e intervención temprana de enfermedades sexualmente transmisible con el objetivo de disminuir la posibilidad de transmisión o infección de personas de alto riesgo.		
Estrategias	**Estrategia 1**: Habilitar al personal clínico en las nuevas guías de tratamiento de ETS del CDC de 2011.		
	Estrategia 2: Promover información pública.		
	Estrategia 3: Habilitar acceso a pruebas de ETS (Sífilis, clamidia, gonorrea), TB y Hepatitis C a personas en alto riesgo en escenarios no clínico.		
	Estrategia 4: Expansión del programa mentores comité mejoramiento en calidad.		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetivo 1: Para marzo 2011, completar el adiestramiento sobre las nuevas guías de tratamiento de ETS a personal clínico que ofrece servicios en los CPTET.	**1.1** Revisar información sobre las nuevas guías de tratamiento de ETS. **1.2** Desarrollo de documentación a presentar en el adiestramiento. **1.3** Seleccionar personal a impactar. **1.4** Seleccionar formato de presentación de este adiestramiento. **1.5** Desarrollo de la evaluación del adiestramiento. **1.6** Evaluación del adiestramiento.	- Adiestramiento desarrollado. - Guías de tratamiento finales. - Cantidad y (%) de personal clínico alcanzado.	- División de Prevención, Sección Vigilancia ETS.
Objetivo 2: Para mayo 2012, desarrollar una campaña informativa sensible a las poblaciones prioritarias en alto riesgo	**2.1** Determinar equipo de trabajo. **2.2** Determinar puntos a considerar para las poblaciones prioritarias en la campaña. **2.3** Especificar procesos para la selección de los medios alternos. **2.4** Escoger y determinar la información a presentar en la campaña educativa.	- Campaña desarrollada. - Poblaciones prioritarias. - Medios alternos seleccionados.	- División de Prevención - ECHPP.

mediante medios alternos de comunicación.	**2.5** Desarrollo del proceso de selección de la agencia a contratar para la campaña. **2.6** Solicitar desarrollo de la campaña. **2.7** Evaluación del proceso de desarrollo de la campaña.		
Objetivo 3.1: Para mayo 2012, reducir en 10% los nuevos contagios con ETS entre personas con VIH que reciben servicios en cinco CPTET.	**3.1.1** Hacer contacto con los directores clínicos de los 5 CPTET a alcanzar. **3.1.2** Identificar personal de trabajo. **3.1.3** Determinar plan de trabajo dirigido a la reducción de contagio. **3.1.4** Establecer criterios específicos para la determinación de casos. **3.1.5** Desarrollo de orientación a participantes dirigido la reducción de contagio. **3.1.6** Determinar % y cantidad de pacientes que representan la reducción.	- Cantidad y (%) de pacientes que representan la reducción. - Estadísticas de personas con VIH en los CPTET.	- CPTET
Objetivo 3.2: Para mayo de 2012, capacitar al menos 10 organizaciones comunitarias que llevan a cabo pruebas de anticuerpos al VIH y PARA administrar pruebas de cernimiento de ETS a las poblaciones prioritarias.	**3.2.1** Determinar organizaciones que serán impactadas. **3.2.2** Presentar plan de trabajo para el impacto a las poblaciones. **3.2.3** Determinar proceso de compra y distribución de pruebas. **3.2.4** Determinar proceso de selección de las 10 organizaciones. **3.2.5** Evaluación del proceso.	- Organizaciones seleccionadas. - Cantidad y (%) de pruebas realizadas. - Resultados de las pruebas.	- OBC. - Departamento de Salud.
Objetivo 4.1: Para septiembre 2011, establecer un comité central	**4.1.1** Determinar equipo de trabajo. **4.1.2** Determinar puntos a considerar para el desarrollo del plan de trabajo. **4.1.3** Especificar criterios para la	- Comité establecido. - Deberes y responsabilidades del comité establecidas.	- OCASET.

en OCASET para desarrollar un plan piloto de calidad inter-programas.	selección del comité. **4.1.4** Escoger y determinar información a considerar sobre la calidad inter-agencia y sus deberes y responsabilidades. **4.1.5** Desarrollo del proceso de selección del comité. **4.1.6** Evaluación del proceso.		
Objetivo 4.2: Para mayo 2012, ampliar el programa de mentores a las intervenciones y servicios de prevención de ETS/VIH en los cinco CPTET en el AME de San Juan.	**4.2.1** Conocer proceso de desarrollo de programa de mentores. **4.2.2** Definir procesos en el programa **4.2.3** Realizar un plan/programa de trabajo. **4.2.4** Determinar personas responsables para el ofrecimiento de este programa. **4.2.5** Conocer cantidad de participantes que necesitan el programa. **4.2.6** Definir intervenciones para el ofrecimiento de servicios de ETS/VIH en los cinco CPTET .	- Programa de mentores. - Cinco CPTET seleccionados. -Intervenciones desarrolladas.	- OCASET.
Objetivo 4.3: Para septiembre 2013, extender el proyecto de mentores en tratamiento y prevención a por lo menos 20% de las organizaciones comunitarias subvencionadas con fondos de prevención y tratamiento.	**4.3.1** Definir procesos de extensión del programa **4.3.2** Realizar un plan/programa de trabajo. **4.3.3** Determinar personas responsables para el ofrecimiento de este programa y la extensión. **4.2.5** Conocer cantidad de participantes que necesitan el programa. **4.2.6** Determinar el % de organizaciones comunitarias subvencionadas.	- Programa de mentores. - % de organizaciones subvencionadas.	- OCASET.

Intervenciones Requeridas	11. "Promover la prevención de la transmisión perinatal del VIH positivo"		
Metas	Continuar brindando servicio de modo que las tasa de transmisión continúe baja.		
Estrategias	**Estrategia 1:** Expandir o fortalecer programas ya existentes de monitoria en sala de parto.		
	Estrategia 2: Requerir cumplimiento de las aseguradoras con las guías de PHS.		
	Estrategia 3: Orientar e informar al personal clínico (obstetra, ginecólogo, enfermeras parteras…) de la importancia de la prueba, detección temprana en el primer y tercer trimestre del embarazo.		
	Estrategia 4: Promover la adherencia a tratamiento antirretroviral en mujeres embarazadas con VIH		
Objetivos	**Objetivo de Proceso (Actividades)**	**Indicador**	**Persona o División Responsable**
Objetivo 1: Para septiembre 2012 llevar a cabo monitorias en por lo menos 50% de las salas de parto en el AME de San Juan.	1.1 Desarrollo de selección de un proceso de monitoria. 1.2 Determinar criterios a observar y medir. 1.3 Selección de profesionales a efectuar monitorias. 1.4 Preparación de formato para efectuar monitorias. 1.5 Desarrollo de itinerario de monitorias.	- Cantidad de salas de parto monitoreadas.	- Administración de hospitales.
Objetivo 2: Para mayo 2012 establecer en los contratos de ASES con los asegurados que todo proveedor de servicios de	**2.1** Definir proceso para modificación de los contratos. **2.2** Establecer criterios específicos para estos contratos y de pruebas de cernimiento. **2.3** Revisión de procesos en las guías de CDC. **2.4** Hacer contactos para el	- Guías del CDC. - Contratos modificados. -Mujeres alcanzadas.	- Departamento de Salud. - ASES.

cuidado pre-natal cumpla con el cernimiento de pruebas y terapia anti-retroviral en mujeres embarazadas con VIH según las guías de CDC.	desarrollo de estos contratos con ASES. **2.5** Determinar junto al personal de ASES método de información para los proveedores.		
Objetivo 3: Para septiembre 2011, capacitar al personal clínico que ofrece servicios a mujeres embarazadas con VIH para cumplir con las guías establecidas. **No medible**	**3.1** Determinar organizaciones de las cuales su personal clínico será impactado. **3.2** Presentar plan de trabajo para la capacitación. **3.3** Determinar personal clínico que ofrece servicios a mujeres a embarazadas. **3.4** Definir estructura y plan de la capacitación. **3.5** Evaluación del proceso.	- Capacitación estructurada. - Personal impactado. -Mujeres alcanzadas.	- CPTET - Ryan White Parte B.
Objetivo 4: Para septiembre 2011, mantener en por lo menos 85% la adherencia a medicamento antirretrovirales en las mujeres embarazadas con VIH.	**4.1** Conocer proceso de adherencia para mujeres embarazadas. **4.2** Definir procesos para compartir información con las participantes. **4.3** Realizar un plan/programa de adherencia a mujeres embarazadas. **4.4** Determinar % de mujeres alcanzadas	- Cantidad y (%) de mujeres alcanzadas. - Por ciento que define cumplimiento con la adherencia a tratamiento.	- Ryan White Parte B. - CPTET.

Intervenciones Requeridas	12. "Implementar 'partner services' para personas con VIH positivo"		
Metas	Disminuir el riesgo e identificar de manera temprana individuos en alto riesgo, de contraer la infección.		
Estrategias	**Estrategia 1:** Estrategia1: Establecer un sistema uniforme de referidos y monitoreo de 'partner services'.		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetivo 1.1: Para septiembre 2011, establecer un sistema de referido para "partner services" único en al menos 50% de las organizaciones que ofrecen el servicio de cernimiento de VIH.	**1.1.1** Determinar organizaciones que ofrecen servicios de cernimiento de VIH. **1.1.2** Conocer procesos de 'partner services'. **1.1.3** Incluir el proceso de referido. **1.1.4** Consultas para establecer un sistema único. **1.1.5** Conocer participantes en el proceso. **1.1.6** Determinar % de organizaciones alcanzadas.	- Sistema único de referido para "partner services" definido. -Cantidad y (%) de participantes alcanzados. -Cantidad y (%) de cernimientos realizados.	- Departamento de Salud, División de Prevención.
Objetivo 1.2: Para enero 2012, capacitar y diseminar a por lo menos 50% de las organizaciones que hacen pruebas VIH para refieran según los protocolos establecidos.	**1.2.1** Determinar organizaciones que realizan la prueba. **1.2.2** Presentar plan de trabajo para la capacitación y la diseminación de la información. **1.2.3** Establecer proceso de referidos según protocolo. **1.2.4** Definir plan para la capacitación. **1.2.5** Evaluación del proceso.	-Organizaciones impactadas. -% de organizaciones que hacen la prueba y que cumplen con el objetivo. -Protocolo establecido.	- Organizaciones.

Intervenciones Requeridas	**13. "Evaluación de comportamientos riesgoso seguida por las intervenciones de reducción de riesgos para las personas VIH positivas (Incluidos los de parejas VIH discordante) en situación de riesgo de transmisión del VIH"**		
Metas	Disminuir el número de personas en alto riesgo de adquirir o transmitir el VIH.		
Estrategias	**Estrategia 1:** Reforzar reducción de riesgo en pacientes VIH positivo **Estrategia2:** Incorporar EBI'S que ofrece el personal de servicio directo en organizaciones de base comunitaria y CPTET. **Estrategia3:** Evaluar efectividad de los programas intercambio jeringuillas.		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetivo 1: Para septiembre 2013, preparar un inventario de las intervenciones, (EBI's) aumentar en un 20% el número de personas que reciben servicios mediante intervenciones de reducción de riesgo (EBI's) que se ofrecen a través de las OBC y CPTET.	**1.1** Determinar personas que reciben servicios mediante las intervenciones de reducción de riesgo. **1.2** Mantener contactos con las OBC's y CPTET. **1.3** Definir proceso de ofrecimiento de los servicios de RR. **1.4** Establecer % de participantes impactados.	- Servicios de intervenciones establecidos. - Cantidad y (%) de personas que reciben los servicios.	- CPTET.
Objetivo 2: Para mayo 2012, adiestrar a por lo menos el 20% del personal de los CPTET's en las	**2.1** Determinar intervenciones efectivas. **2.2** Desarrollo de proceso de adiestramiento. **2.3** Selección de personal a alcanzar. **2.4** Efectuar proceso de adiestramiento.	-Intervenciones definidas. -Cantidad y (%) de personal adiestrado.	- CPTET

intervenciones efectivas de cambio (EBIS's). **Cambié redacción**	**2.5** Evaluar el proceso.		
Objetivo 2.1: Para mayo 2012, adiestrar en la intervención RESPECT al menos 20% del personal de servicio directo en las organizaciones de base comunitaria.	**2.1.1** Definir y conocer la intervención RESPECT. **2.1.2** Desarrollo de proceso de adiestramiento. **2.1.3** Selección de personal a alcanzar. **2.1.4** Efectuar proceso de adiestramiento. **2.1.5** Evaluar el proceso.	- Intervención definida. - Cantidad y (%) de participantes alcanzados.	- OBC
Objetivo 3: Para septiembre 2012, desarrollar y diseñar un plan de evaluación para determinar el cumplimiento con los elementos del protocolo de intercambio de jeringuillas en un 50% en los OBC's.	**3.1** Conocer los elementos del protocolo de intercambio de jeringuillas. **3.2** Conocer parámetros para el cumplimiento con los elementos. **3.3** Establecer personal responsable para el desarrollo del plan de evaluación. **3.4** Conocer los requisitos para el desarrollo del plan de evaluación. **3.5** Determinar % de OBC's a alcanzar.	- Plan de evaluación. -% de OBC con el Protocolo definido.	- OBC

Intervenciones Requeridas	**14. "Implementar enlaces a otros servicios médicos y sociales para las personas VIH positivas"**		
Metas	Proveer apoyo a las personas con VIH para que puedan acceder otros servicios sociales que repercutan en su salud y bienestar.		
Estrategias	**Estrategia 1**: Expandir acceso a tratamiento con medicamento aprobado por el FDA y según las guía del 'National Quality Forum 'para tratar dependencia a opiáceos para UDI en centros de tratamiento VIH y en otros sectores de servicios.		
	Estrategia 2: Coordinación de los referidos mediante manejo de casos (enlace).		
	Estrategia 3: Formalizar enlace con organizaciones q pueden ofrecen servicios sico-sociales, tratamiento con medicamentos para la dependencia a opiáceos y a pacientes VIH		
	Estrategia 4: Crear y mantener actualizado un inventario de recursos de apoyo, servicios de prevención, de tratamiento asistido por medicamentos para dependencia a opiáceos		
Objetivos	**Objetivo de Proceso** **(Actividades)**	**Indicador**	**Persona o División Responsable**
Objetivo 1: Para septiembre 2011 los cinco CPTET del AME de San Juan contarán con al menos un médico certificado para proveer tratamiento con buprenorfina.	**1.1** Establecer criterios para la selección de personal médico especializado en buprenorfina. **1.2** Desarrollo del proceso de selección. **1.3** Desarrollo de responsabilidades de este personal en los CPTET. **1.4** Evaluar personal médico a seleccionar por CPTET. **1.5** Desarrollo de proceso de provisión de buprenorfina.	- Selección de médicos por CPTET. - Desarrollo de proceso de tratamiento.	- Departamento de Salud, CPTET.
Objetivo 2: Para mayo 2012, aumentar por	**2.1** Conocer número de personas con VIH. **2.2** Conocer resultados de la evaluación	- Cantidad y (%) de referidos realizados. - Evaluación de necesidades.	- CPTET. - Ryan White. - HRSA - HUD/HOPWA

20% el número de referidos de personas con VIH a servicios sociales, comunitarios clínico y de apoyo según la evaluación de sus necesidades.	de las necesidades. **2.3** Selección de proceso de referidos. **2.4** Efectuar proceso de referido **2.5** Determinar % alcanzado. **2.6** Evaluar el proceso.		
Objetivo 3. Para septiembre de 2011, identificar por lo menos una persona de enlace en los centros que proveen la red de servicios de referido para servicios de apoyo	**3.1** Identificar centros que proveen referidos para servicios de apoyo. **3.2** Conocer servicios de apoyo para los referidos. **3.3** Selección de proceso de servicios de apoyo de interés. **3.4** Conocer y evaluar personal de los centros. **3.5** Establecer criterios para selección de persona de enlace. **3.6** Selección de persona de enlace.	- Servicios de referido definido. - Selección de la persona enlace. - Servicios de apoyo seleccionados.	- CPTET. - Ryan White.
Objetivo 3:1 Para diciembre de 2011 actualizar y diseminar directorio virtual y/o tradicional de organizaciones que ofrecen servicios.	**3.1.1** Conocer procesos para el desarrollo de directorios virtuales y/o tradicionales. **3.1.2** Determinar información importante a incluir en el directorio. **3.1.3** Establecer estructura del directorio. **3.1.4** Desarrollo del plan de actualización y diseminación. **3.1.5** Desarrollo del material (fotocopias) para entrega en	- Directorio virtual y/o tradicional desarrollado. - Organizaciones alcanzadas.	- OBC - Ryan White - Prevención.

	las organizaciones.		
Objetivo 3.2 Para marzo 2012 diseminar al personal de los CPTET y organizaciones subvencionadas… capacitar al personal de las clínicas de CPTET sobre los servicios disponibles para personas con VIH. **Objetivo con mezcla de objetivos.**		-	-
Objetivo 3.2: Para marzo 2012, adiestrar al personal de los CPTET sobre los servicios disponibles para personas VIH+. **No medible**	**3.2.1** Determinar tema/s específico/s a trabajar relacionado a los servicios disponibles. **3.2.2** Desarrollo de un currículo a presentar y presentador/a de los temas. **3.2.3** Seleccionar o invitar a personal para presentar los servicios disponibles. **3.2.4** Seleccionar CPTET a alcanzar. **3.2.5** Evaluación del tema de VIH presentado.	- Personal alcanzado. - Evaluación de los servicios.	- CPTET's.
Objetivo 3.3 Para diciembre 2011, realizar una campaña de educación sobre servicios disponibles que abarque a la población afectada, a	**3.3.1** Determinar los servicios a presentar a la población afectada. **3.3.2** Escoger y determinar la información a presentar en la campaña educativa. **3.3.3** Desarrollo del proceso de selección de la agencia a contratar para la campaña. **3.3.4** Selección de medios a utilizar.	- Campaña educativa desarrollada. - Itinerario de presentación de los anuncios/mensajes.	- ECHPP - División de Prevención.

proveedores de salud y a los empleados de agencias públicas que proveen apoyo a la población con VIH.	**3.3.5** Evaluación del proceso de selección y desarrollo de la campaña educativa.		
Objetivo 3.4. Para diciembre 2011 aumentar por 50% los referidos a servicios de tratamiento con buprenorfina para personas con VIH y dependencia a opiáceos que poseen seguro de salud público (Mi salud) o privado.	3.4.1 Definir procesos para el ofrecimiento de metadona o buprenorfina. **3.4.2** Identificar participantes del programa que poseen seguro de salud público o privado. **3.4.3** Establecer criterios específicos para que los clientes sean referidos. **3.4.4** Definir un plan de trabajo y autorizaciones para el tratamiento. **3.4.5** Determinar % y cantidad de pacientes en tratamiento alcanzados.	- Servicios de tratamiento ofrecidos. -Cantidad y (%) de clientes que demuestran el aumento de servicios.	- Ryan White. - División de Prevención.

APPENDIX 4: EVALUATION PLAN SECOND DRAFT

REQUIRED INTERVENTION	**15. "Routine Opt – Out screening" para VIH en contextos clínicos."**
Goal 1	Increase the number of persons who get tested for HIV through the Opt-out methodology in a clinical context.
Strategies	**Strategy 1:** Promote and educate persons using health care facilities on the importance of routine, opt-out screening for HIV.
	Strategy 2: Negotiate with health insurance providers to cover the cost of HIV screening and confirmation test.
	Strategy 3: Diversify the scenarios in which opt-out tests are provided in clinical settings.

Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By December 2011, hire at least one trained HIV Health Educator that will offer orientation to persons utilizing different health care facilities highlighting the importance of routine, opt-out screening for HIV.	**15.1.1** Define criteria for health educators selection. **15.1.2** Define the selection process and staff responsible for this selection. **15.1.3** Define duties and responsibilities of the post. **15.1.4** Application of candidates (promotion of the position). **15.1.5** Selection of potential candidates. **15.1.6** Establish specific criteria for the recruitment. **15.1.7** Final recruitment.	- Signed contract. - Health Educator selected. - Evaluation criteria defined. - Duties and responsibilities.	-PRECHPP.	- Individual.	December 2011.
Objective 1.2: From January 2011 to December 2011, the Health Educator will conduct	**1.2.1** Identify and define the process of the visits. **1.2.2** Development of criteria for presentation during	- Process defined and formalized visits. - Quantity of health care	- PRECHHP. - Health educator.	- Individual	- January 2011 to December 201

visits to at least 20 health care facilities in the SJMSA.	the visits. **1.2.3** Selection of facilities to visit. **1.2.4** Realization of the official process for visits.	facilities reached. -Findings on visits. - Dating determined by means of visits. - Information obtained as a result of the visits.			1 – Monthly report
Objective 2.1: By will be arranged with the state Medicaid Health System and the "*Administración de Servicios de Salud de PR* (ASES)" to negotiate coverage of at least one annual rapid HIV test per person.	**2.1.1** Determine action plan for negotiations related to the need to cover at least an annual rapid test. **2.2.2** Make contacts with key people in Medicaid Health System and ASES. **2.2.3** Present the importance of including HIV testing in routine care. **2.2.4** Select meeting date. **2.2.5** Determine meeting agenda. **2.2.6** Enter specific criteria for coverage of this test. **2.2.6** Final arrangements for coverage.	- Evaluation of the meeting. - Definition of coverage for the annual test. - Agenda of the coordinated Meeting.	- Medicaid Health System and the ASES Boards. - Secretary of Health. - PRECHPP.	- Public agencies.	- September 2011 – monthly repots.
Objective 2.2: By January 2012, OCASET will coordinate a meeting with	**2.2.1** Determine action plan related to the need to meet the rapid tests once a year for health	- Final action plan. - Evaluation of the meeting. - Definition of	- Medicaid Health System and the ASES Boards.	- Public agencies.	- January 2012-monthly

the Private Insurance Commissioner to negotiate coverage of at least one annual HIV test per person by private insurance companies.	plans. **2.2.2** Make contacts with key people in the Private Insurance Commission to include specific coverage for an annual HIV test. **2.2.3** Presented to the Board of Directors of the Private Insurance Commission the importance of including HIV testing in routine care **2.2.4** Select meeting date. **2.2.5** Coordinate a meeting day. **2.2.6** Determine the meeting agenda. **2.2.7** Final agreement with the Private Insurance Companies.	coverage for the annual test. - Meeting coordination. - Private Insurance Commission agreements.	- Secretary of Health.		report s.
Objective 3.1: By January 2013, conduct rapid HIV testing on at least 60% of the persons who use emergency rooms in the Diagnostic and Treatment Centers located in 3 high incidence areas (Cataño, Loiza and Canóvanas) in the SJMSA.	**3.1.1** Define process for conducting the test among people who come to emergency rooms. **3.1.2** Selection of personnel responsible to make HIV testing's. **3.1.3** Determine participants to be reached. **3.1.4** Create a protocol for rapid testing's procedures.	- Number and (%) of tests. - Tests results.	- Administrative Division of Cataño, Loiza and Canóvanas Health Centers. - PRECHPP.	- Public agencies .	- Until January 2013 – quarterl y reports.

	3.1.5 Protocol evaluation. **3.1.6** Determine percent reached.				
Objective 3.2: By January 2012, The Correctional Health System will provide HIV tests to at least 75% of inmates who receive clinical services in their institutions.	**3.2.1** Define process for conducting the test within the institution. **3.2.2** Make arrangements between staff responsible for making the tests and administrative staff in penal institutions. **3.2.3** Selection of staff to conduct the tests. **3.2.4** Determine participants achieve. **3.2.5** Define a service protocol. **3.2.6** Evaluate the interventions procedure. **3.2.7** Determine reached percent.	- Number and (%) of tests conducted among people in penal institutions. - Protocol services. - Defined agreements with penal institutions.	- Administrative area of Correctional facilities. - PRDOH.	- Public agencies.	- Until January 2012 - Quarterly reports.
Goal 2	Increase the number of providers that offer HIV testing through the Opt-out methodology in a clinical context.				
Strategies	**Strategy 1**: Conduct a survey to identify the type of health providers that do not offer HIV testing in their clinics in the SJMSA.				
	Strategy 2: Establish alliances with medical organizations to promote opt-out testing among health providers.				
	Strategy 3: Provide rapid HIV tests in emergency rooms.				

Objectives	Process Objective	Indicator	Responsible Person or Division	Data Type	Reporting Schedule
Objective 1.1: By October 2011, ECHPP team will use the data obtained from the survey to identify the profile of health care providers that do not offer HIV testing in their clinics, to be able to design specific strategies targeted to these groups. Definir area	**1.1.1** Establish objectives to interview HIV test providers. **1.1.2** Determine the amount of HIV health care providers. **1.1.3** Determine providers who offer HIV testing. **1.1.4** Analysis by means of mapping from suppliers that do not offer HIV services. **1.1.5** Define process to include strategies to impact these groups. **1.1.6** Define a work plan to present the process of inclusion of providers that do not offer HIV testing.	- Number and (%) of providers who perform the test. - Areas impacted. - Number and (%) of HIV testing done.	- HIV Prevention. Division. - Prevention Services Providers.	- Clinics reports.	October 2011
Objective 1.2: By December 2011, hire at least one trained HIV Health Educator that will offer presentations highlighting the importance of routine opt-out screening for HIV in annual medical conferences. Porq la impr	**1.2.1** Define criteria for health educators' selection. **1.2.2** Application for presentation of the theme developed by these health educators. **1.2.3** Define personnel responsible of health educators' selection. **1.2.4** Selection of potential candidates.	- # of doctors reached on the annual medical conference. - Work plan defined. - Training completed. - AME Area impacted. - Evaluation	- Supervisor of Education-Division or Director of OCASET.	- Program report.	December 2011 -Annual activity report.

de la contratación	**1.2.5** Determine annual conference. **1.2.6** Evaluation of presentation.	results.			
Objective 2.1: By June 2012, The ECHPP PI and or Coordinator will have met with medical organizations' chairs to establish collaborative agreements on promoting routine opt-out screening for HIV among their members.	**2.1.1** Make contacts with key informers in medical organizations. **2.1.2** Determine action plan related to the need of opt-out HIV screening among members of medical organizations. **2.1.3** Submit to the Medical Organizations Board of Directors the importance of establish collaborative agreements for the routine opt-out screening among members. **2.1.4** Select meeting dates. **2.1.5** Determine meeting agendas **2.1.6** Determine collaborative arrangements.	- Evaluation meeting or meetings. - Final Collaborative agreement. - Meeting coordination process.	- Medical organization Chairs. - PRECHPP PI and or Coordinator.	- Private agencies.	- June 2012 – Annual progress.
Objective 3.1: By January 2012, the PRDOH will	**3.1.1** Analyze requirements for the establishment of the	- Emergency rooms identified.	- HIV Prevention. Division.	- Program	- Until January 2012

have implemented a rapid HIV testing program in three emergency rooms located in Bayamón, Carolina and San Juan Hospitals.	proposed rapid test. **3.1.2** Determine emergency rooms to be used. **3.1.3** Development of criteria for the acquisition of HIV tests. **3.1.4** Purchases of HIV tests. **3.1.5** Development of protocol for the implementation of rapid tests. **3.1.6** Assessment of the project development process.	- Rapid Testing Project completed and documented. - Rapid tests Protocol.	- Emergency rooms coordinator.	reports.	- Quarterly reports.
Objective 3.2: By January 2013, the PRDOH will have implemented a rapid HIV testing program in three emergency rooms in CDTs located in Cataño, Canóvanas and Loíza.	**3.2.1** Analyze requirements for the establishment of the proposed rapid test. **3.1.2** Determine CDTs personnel to present the rapid test program. **3.1.3** Development of criteria for the acquisition of HIV tests. **3.1.4** Purchases of HIV tests. **3.1.5** Development of protocol for the implementation of rapid tests. **3.1.6** Assessment of the project development	- Emergency rooms identified. - Rapid Testing Project completed and documented. - Rapid tests Protocol.	- HIV Prevention. Division. - CDT coordinator.	- Program reports.	- Until January 2013 - Quarterly reports.

	process.				

REQUIRED INTERVENTION	**16.** ""HIV TESTING IN NON-CLINICAL SETTINGS TO IDENTIFY UNDIAGNOSED HIV INFECTION"				
Goal 1	Increase the number of persons who get tested for HIV in non-clinical settings.				
Strategies	**Strategy 1**: Identify CBOs that provide support services to high risk groups (MSM, IDU, HRH) in high incidence areas of the SJMSA.				
	Strategy 2: Promote collaboration among the CBOs that provide support services to high risk groups in high incidence areas of the SJMSA to establish a referral system to maximize HIV testing opportunities and ensure greater acces.				
	Strategy 3: Evaluate the implementation of a web based recruitment and referral system between CBOs and PRDOH (no partner services).				
Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By June 2011, create an inventory of CBOs by high risk groups in high incidence areas of the SJMSA	**1.1.1** Make contacts with the DOH Prevention Division and CBOs. **1.1.2** Development of documentation (contact sheet) to request information. **1.1.3** Determine the amount of prevention service providers in areas of high HIV incidence. **1.1.4** Set format for the inventory. **1.1.5** Determine information of CBOs to be included in inventory.	- Number and (%) of CBOs in high incidence areas. - Final Inventory.	-PRECHPP.	- Community.	Annually.

Objective 2.1: By January 2013, establish collaborative agreements between CBOs so they can refer persons to others CBOs that provide HIV testing in non-clinical settings.	**2.1.1** Make contacts with key people in CBOs that provide HIV testing in non-clinical settings. **2.1.2** Determine CBOs without HIV testing services. **2.1.3** Define action plan to present the importance to develop a referral service plan within CBOs without testing services. **2.1.4** Determine collaborative agreements to be made.	- Final Collaborative agreement. - Meeting coordination process.	- PRECHPP. - Executive Directors of CBOs.	- Private and Public agencies.	- January 2013– Quarterly reports.
Objective 3.1: By June 2012, provide web access for at least two PRDOH HIV Prevention Outreach Technicians so they can recruit high-risk persons via web to provide them	**3.1.1** Review the specific criteria to establish Web services. **3.1.2** Determine process to expand web services. **3.1.3** Develop training to achieve the recruitment of	- Names of the PRDOH HIV Prevention Outreach Technicians. - Number and (%) of people recruited by the two PRDOH HIV Prevention Outreach Technician. - Internet	- Prevention Division Supervisor. - DOH Communication area.	Program agency.	Until June 2012 – Quarterly reports.

with referrals for HIV testing sites.	high-risk individuals through the web. **3.1.4** Select two PRDOH HIV Prevention Outreach Technicians for recruitment across the Web. **3.1.5** Evaluate the final process of recruitment.	Access.			
Goal 2.1	Increase the number of outreach activities where testing is conducted.				
Strategies	**Strategy 1**: Increase the number of community based organizations that administer HIV tests in the SJMSA.				
	Strategy 2: Identify new funding sources for these organizations.				
Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By January 2013 assure that 50% of the organizations that provide preventive services offer testing.	**1.1.1** Determine the number of providers of prevention services. **1.1.2** Define process for the inclusion of offering HIV testing among providers. **1.1.3** Determine impact areas. **1.1.4** Define a work plan to provide HIV testing	- Number and (%) of providers who perform the test. - Impacted Areas. - Number and (%) of HIV testing.	- HIV Prevention Division. - Prevention Services Providers.	- Public agency.	Until 2013 - Quarterly reports.

	services. **1.1.5** Evaluate the intervention. **1.1.6** Determine final percent.				
Objective 2.1: By January 2013, coordinate at least two meetings with legislators who deal with health-related issues to identify new sources of funding to be used for HIV testing services.	**16.1.1** Know the procedures for approaches to the legislature. **16.1.2** Determine commission's health services. **16.1.3** Define processes and personnel to apply for legislation. **16.1.4** Establish the two meetings with the Health Commission to request funds. **16.1.5** Identify new sources of funds. **16.1.6** Completing the funding application process.	- Funds determined. - Agenda and minutes of meetings. - Request for funds. - Coordinated meetings and offered.	- HIV Prevention Division. - Legislature Health Committee. - Secretary of Health.	- Public.	- Annual report.

REQUIRED INTERVENTION	**17. ""CONDOM DISTRIBUTION PRIORITIZED TO TARGET HIV-POSITIVE PERSONS AND PERSONS AT HIGHEST RISK OF ACQUIRING HIV INFECTION"**				
Goal 1	Implement condom distribution in clinical facilities that provide services to HIV positive persons.				
Strategies	**Strategy 1**: Create a survey to identify the clinical facilities that provide services to persons living with HIV in the SJMSA.				
	Strategy 2: Develop an evaluation plan to measure condom distribution and usage in organizations that receive condoms for persons with HIV and those at high-risk.				
Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By June 2011, based on the data obtained from the survey, create an inventory of clinical facilities where condoms can be distributed.	**1.1.1** Make contacts with clinical facilities with the adequate disposition for condom distribution. **1.1.2** Development of documentation (contact sheet) to request information. **1.1.3** Determine the amount of clinics where condoms can be distributed. **1.1.4** Set format for the inventory. **1.1.5** Determine information of clinical facilities to be included in inventory.	- Number and (%) of facilities. - Final Inventory.	- PRECHPP. - Prevention clinics.	- Community.	Annually.
Objective 1.2: By August 2011, establish liaisons with the identified clinical facilities to promote condom distribution to persons living with HIV.	**1.2.1** Review the inventory of medical facilities. **1.2.2** Determine process for the distribution of condoms. **1.2.3** Development of documents required for the promotion of	- Agreements finalized. - Promotion and distribution of condoms defined.	- CPTETs.	- Public and Private agencies.	August 2011.

	condom distribution. **1.2.4** Define peer agencies to develop agreements for the promotion and condom distribution. **1.2.5** Define and establish arrangements for promotion and condom distribution.				
Objective 2.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.	**2.1.1** Determine HIV + population to serve. **2.1.2** Development of hypotheses (purpose and interest) for the study. **2.1.3** Establish variables measured. **2.1.4** Determine the study sample. **2.1.5** Conduct of the study. **2.1.6** Present findings of the study.	- Study completed. - Study Results.	- HIV Prevention Division.	- Public and Private agencies.	- Until January 2012 – Quarterly reports.
Goal 2:					
Strategies					
	Increase condom distribution in CBO's not funded by the PRDOH that provide services to high risk groups in high incidence areas in the SJMSA.				
	Strategy 1: Identify municipalities with the highest HIV incidence rates in the SJMSA.				
	Strategy 4: Develop an evaluation plan to measure condom distribution and usage in CBOs not funded by the PRDOH.				
Objective 1.1: By June 2011, the Puerto Rico Surveillance	**1.1.1** Make direct contact with the Surveillance Program. **1.1.2** Determine format for requesting	- Incidence data. - Risk groups determined.	- Puerto Rico Surveillance Progr	- Public.	- Monthly report.

Program will provide incidence data by municipalities and risk groups in the SJMSA.	information related to HIV incidence by municipalities. **1.1.3** Identify personnel responsible for the activity. **1.1.4** Collect and organize information from the municipalities of SJMSA.		am. - PRECH PP.		
Objective2.1: By July 2011, create an inventory of CBOs that provide services in municipalities with the highest risk incidence.	**2.1.1** Make contacts with the CBOs. **2.1.2** Development of documentation (contact sheet) to request information. **2.1.3** Determine the amount of CBOs that provide services in high risk incidence area. **2.1.4** Set format for the inventory. **2.1.5** Determine information of CBOs to be included in inventory.	- Number and (%) of CBOs in high incidence areas. - Final Inventory.	- PRECH PP. - CBOs in the high incidence area.	- Community.	Annually.
Objective 3.1: By December 2011, establish at least five collaborative agreements to provide condoms to CBOs that provide services in municipalities with the highest risk incidence.	**17.1.1** Determine number of entities that provide services to people with HIV. **17.1.2** Development process for distributing condoms. **17.1.3** Knowledge management processes for the establishment of partnerships. **17.1.4** Identify the five entities for the establishment of partnerships. **17.1.5** Administratively make alliances between entities.	- Alliances defined. - Evaluation of the provision of condoms. - Entities achieved.	- HIV Prevention Division.	- Public and Private agencies.	- Monthly report.

Objective 5.1: By January 2012, PRDOH will implement a study to analyze the use of condoms among persons with HIV and persons at high-risk within the SJMSA.	**5.1.1** Determine HIV + population to serve. **5.1.2** Development of hypotheses (purpose and interest) for the study. **5.1.3** Establish variables measured. **5.1.4** Determine the study sample. **5.1.5** Conduct of the study. **5.1.6** Present final findings of the study.	- Study completed. - Study Results.	- HIV Prevention Division	- Public and Private agencies.	- Monthly report.
REQUIRED INTERVENTION	**18.** "PROVISION OF POST-EXPOSURE PROPHYLAXIS TO POPULATIONS AT GREATEST RISK"				
Goal 1	Decrease the probability of acquiring HIV in a risky event, by the provision of Post-Exposure Prophylaxis.				
Strategies	**Strategy 1**: Update post-exposure protocol in cases of physical/sexual abuse or occupational/non-occupational accidents.				
	Strategy 2: Standardize post-exposure procedures in case of physical/sexual abuse or occupational/non-occupational accidents.				
	Strategy 3: Disseminate and implement post-exposure protocols in cases of physical/sexual abuse or occupational/non-occupational accidents.				
Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By June 2011, the PRDOH will update and	**1.1.1** Review the latest post-exposure protocol. **1.1.2** Determine	- Final post-exposure protocol.	- HIV Prevention	- Public agencies.	Until June 2011 – Quarterly reports.

standardize post-exposure protocols.	requirements for the development of a new post-exposure protocol. **1.1.3** Identify Key staffs that are developing the protocols. **1.1.4** Establish the criteria for post-exposure. **1.1.5** Protocol development.		Division. - CPTET.		
Objective 2.1: By June 2011, the PRDOH will ensure that 100% of accredited continuing health education programs; will provide health professionals with the topic of post HIV exposure protocol as part of the "Exposure to Blood Pathogens" course.	**2.1.1** Conduct a review of information provided by health education programs. **2.1.2** Identify specific process for the inclusion of items in the various programs. **2.1.3** Select people who are developing the topic or topics of interest. **2.1.4** Development of the theme or themes. **2.1.5** Establish a formal curriculum.	- Theme of "Exposure to Pathogens in Blood developed. " - (%) of accrediting agencies impacted. - Final Curriculum.	- PRDOH. - AETC.	- Public agencies.	Until June 2011 – Quarterly reports.
Objective 3.1: By December 2011, the PRDOH will implement and disseminate post-	**3.1.1** Define post-exposure strategies for HIV patients.	- Distribution Plan. - Impacted areas.	- PREC HPP.	- Public agencies.	Until December 2011 – Quarterly reports.

exposure protocols in the areas contained in the MSA.	**3.1.2** Development of implementation protocol manual to accomplish post-exposure strategies. **3.1.3** Deliver dissemination plan in the areas of MSA. **3.1.4** Development of material (photocopies or CDs) for the SJMSA areas.				

REQUIRED INTERVENTION	5. "EFFORTS TO CHANGE EXISTING STRUCTURES, POLICIES, AND REGULATIONS THAT ARE BARRIERS TO CREATING AN ENVIRONMENT FOR OPTIMAL HIV PREVENTION, CARE, AND TREATMENT"
Goal 1	Identify and conduct activities to change those structures, rules, and regulations which may constitute barriers to the creation of an optimal environment for the prevention, care, and treatment of HIV.
Strategies	**Strategy 1:** Amend regulations of the College of Medical Technologists so that any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical setting can do so.
	Strategy 2: Provide education to physicians on comprehensive HIV disease treatment and care.
	Strategy 3: Establish an HIV disease care protocol for physicians in the SJMSA that includes integral medical services required for persons with HIV.

	Strategy 4: Create a network of specialized physicians to provide services to persons with HIV				
	Strategy 5: Issue an administrative order to recommend HIV testing as part of routine medical care.				
	Strategy 6: Facilitate access to needles for injection drug users.				
	Strategy 7: Create a Committee for the development and promotion of public policy regarding HIV, that can help in making viable and providing continuity to the proposed changes.				
	Strategy 8: Promote public policy changes within the Department of Education (DOE) and the Department of Correction (DOC) to include condom distribution.				
	Strategy 9: Collaborate with the DOE in revising the health education curriculum, assessing the impact of current HIV and STD prevention strategies, and identifying ways of strengthening it.				
Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By December 2011, the Secretary of the PRDOH will sign an administrative order to amend the College of Medical Technologists' rules and regulations, enabling any person certified by the PRDOH to administer a rapid HIV test in clinical and non-clinical settings.	**1.1.1** Determine the processes for the implementation of regulations ammendements. **1.1.2** Review the College of Medical Technologists'. **1.1.3** Identify and know the processes for managing the different	- Administrative Order completed. - Minutes of meetings. - Determined rapid tests methodology.	- College of Technologists Medical. - PRDOH Prevention Division.	- Public agencies.	- By December 2011 – Bimonthly report.

	methodologies for conducting rapid HIV testing. **1.1.4** Make contact with key people who contribute to the development process of an administrative order. **1.1.5** Make contacts and meetings with the College of Medical Technologists'. **1.1.6** Select and identify areas to be changed in the administrative order. **1.1.7** Assessment of the modification process. **1.1.8** Development of the				

	administrative order.				
Objective 2.1: By December 2012, the PRDOH will collaborate with the AIDS Education and Training Center (AETC) to provide updated training in the treatment and management of the HIV disease to members of the HIV-Care Providers Association and the Physician and Surgeons College in Puerto Rico in their annual conferences.	**2.1.1** Identify information for updating the management and treatment of HIV status. **2.1.2** Determine specific processes to offer training to the members of the HIV-Care Providers Association and the Physician and Surgeons College in Puerto Rico. **2.1.3** Develop documentation to be submitted for training. **2.1.4** Develop of training for providers. **2.1.5** Determine training date.	- Training completed. - Minutes of meetings.	- HIV Prevention Division. - AETC.	- Public agencies.	- By December 2012 – Bimonthly report.

Objective 3.1: By June 2011, the PRDOH will distribute the protocol for the HIV Care Management of Protocol to 100% of clinics and physicians working with HIV patients in the SJMSA.	**3.1.1** Review of latest's health care protocol for HIV patients. **3.1.2** Identify specific number of clinics and physicians who manage patients with HIV in the MSA. **3.1.3** Establish process for distribution and reproductio n of the document. **3.1.4** Identify p reached.	- HIV Care Management of Protocol. - List of places where the protocol was distributed. - Percent of distributed.	- Clinics and doctors who manage patients with HIV. - HIV Prevention Division.	- Public agencies.	- By June 2011 - Bimonth ly report.
Objective 4.1: By March 2012, PRECHPP will compile a directory of physicians with different specialties	**4.1.1** Understand and identify providers and physician caring for HIV.	- Directory completed.	- PRDOH. - PRECHPP.	- Public and Private agencies.	- By March 2012 – Quarter ly report.

related to persons living with HIV.	**4.1.2** Determine the specialties of medical care for HIV patients. **4.1.3** Determine the processes needed for development of a medical directory. **4.1.4** Establish process for distribution and reproduction of the document (directory).				
Objective 4.2: By December 2012, OCASET and the AETC will offer basic HIV disease care training to other medical specialists to broaden the HIV care providers' network.	**4.2.1** Understanding recruitment processes to the network of services for patients with HIV. **4.2.2** Develop and make job contacts for the development of workshops	- Training offered coordinated. - Number and (%) of doctors reached. - Number and (%) of physicians who will be part of the network of services for patients with HIV.	- AETC. - PRDOH.	- Public agencies.	- By December 2012 – Bimonthly reports.

	with the AETC. **4.2.3** Determining medical processes invitation to join the network. **4.2.4** Developme nt of training. **4.2.5** Coordinate the offer of training. **4.2.6** Developme nt of training to occur.				
Objective 5.1: By March 2012, the *Coalición Alcance Juvenil* will begin a process to propose legislation to include HIV testing as part of routine medical care for persons 13	**18.1.1** Investigat e and determine information about the *Coalición Alcance Juvenil*. **18.1.2** Determin e capacities for the developmen t of a draft law. **18.1.3** Determin	- Legislation for routine HIV testing in people 13 and older. - Minutes of meetings between the Coalition and the HIV Prevention staff.	- *Coalición Alcance Juvenil*. - PRECHPP.	- Public and private agencies.	- By March 2012 – Bimonthly reports.

years of age and older.	e processes to establish HIV testing routinely as legislation. **18.1.4** Investigate and important routine processes of coalition. **18.1.5** Assign persons responsible for the development of legislation. **18.1.6** Development of the legislation. **18.1.7** Approval of legislation.				
Objective 6.1: By July 2011, OCASET will educate the Municipal Police Departments in the SJMSA regarding Law 73 for needle exchange and other related policies in PR.	**6.1.1** Investigate processes that made the administrative offices' of the State Police and municipal management of those IDUs receiving drug paraphernalia and syringes.	- Partnerships established. - Number of Municipal Polices' in the state and municipal agreements.	- Municipal Police Departments. - OCASET.	- Public agencies.	- By July 2011 – Bimonthly reports.

	6.1.2 Determine the policy for syringe exchange and other related policies. **6.1.3** Determining educational processes allowed in the Municipal Police. **6.1.4** Education Developme nt and presentatio n on the Law No. 73. **6.1.5** Making contact with key people to develop partnerships in order to develop appropriat e managemen t of parapherna lia and syringes.				
Objective 6.2: By December 2011, the OCASET will counsel the *Pharmacists Association on the dispositions*	**6.2.1** Understand all aspects of Law No. 73 of 2007. **6.2.2** Make	- Acuerdos establecidos. -Presentación formal de la Ley #73. -Redacción	- Pharmacists Association. - PRDOH.	- Private and Public agencies.	- By Decembe r 2013 - Bimonthly reports.

of law 73 of 2007, regarding the sale of needles/syringes in drug stores without a prescription.	initial contact with the College of Pharmacists. **6.2.3** Identify key staff to who they will present the importance of law on the sale of syringes / needles at pharmacies. **6.2.4** Establish a specific day for discussion of the law dispositions. **6.2.5** Determine an agreement between the College of Pharmacists and the DOH for the assure compliance to the law.	acuerdos.			
Objective 6.3: By June 2013, ECHHP will increase the number of syringe vending	**6.2.1** Determine the processes for the acquisition of syringe vending	- Vending machines purchased. - Syringe Exchange Program	- Municipalities Administrative Area. - PRDOH.	- Public agencies.	- By June 2013 - Bimonthly reports.

machines accessible to IDUs within the SJMSA.	machine. **6.2.2** Use the HIV prevalence to determine the municipalities in which the machine will be set. **6.2.3** Selection of machines to be purchased. **6.2.4** Development of the process of buying the machines. **6.2.5** Complete the checkout process.	established.			
Objective 6.4: By July 2013, initiate a process of analysis in order to promote the beginning of negotiations between PRDOH and the Legislature regarding additional funding to increase syringe exchange	**6.4.1** Determine negotiations between the PRDOH and the legislature to determine funding for needle exchange programs. **6.4.2** Submit the need to establish the programs to the	- Syringe Exchange Program. - Minutes of negotiations. - Agreements between PRDOH and the Legislature.	- PRDOH. - Legislature, Commission of Health.	- Public and Governmental agencies.	- By July 2013 – Quarterly reports.

programs within the SJMSA.	Legislature and to determine additional funds. **6.4.3** Determine Municipality, location, supplies and materials to enhance syringe exchange programs. **6.4.4** Process analysis. **6.4.5** Presentation of results for proper negotiation.				
Objective 6.5: By December 2013, Propose amendments to Law 73 to allow access to IDU paraphernalia to improve the needle exchange programs.	**6.5.1** Analyze Law #73. **6.5.2** Determine what changes will be made to the law. **6.5.3** Determine the legal processes of changes in laws. **6.5.4** Do	- Law No. 73 of 2007 amended. - Minutes of meetings held.	- PRDOH. - Legislature, Commission of Health.	- Public and Government agencies.	- By December 2013 – Quarterly reports.

	presentations to the administrative bodies to apply for change of law. **6.5.5** Establish final agreements.				
Objective 7.1: By March 2011, create a Committee for the development and promotion of public policy regarding HIV, that can help in making viable and providing continuity to the proposed changes	**7.1.1** Define recruitment processes for the development of public policy. **7.1.2** Develop and make job contacts for the formation of the committee. **7.1.3** Determine processes invitation to join the committee. **7.1.4** Determine process for developing public policy. **7.1.5** Establish the committee.	- Members identified. - Public Policy defined.	- PRECHPP.	- Public agencies	- March 2011

Objective 7.2: By May 2011, develop the structure of the committee, including procedures and regulations that will guide them.	**7.1.1** Determine the adequate structure for this committee. **7.1.2** Develop and define procedures and and regulations. **7.1.3** Establish the structure of the committee.	- Defined Committee and regulations norms defined.	- PRECHPP.	- Public agencies	- By May 2011 – Bimonthly report.
Objective 8.1: By January 2012, coordinate at least two meetings with the Department of Education and Department of Correction Secretaries concerning the distribution of condoms in their policies and operating procedures.	**8.1.1** Determine process to establish meeting with the Department of Education and the Department of Correction. **8.1.2** Determine the policies and procedures for the distribution of condoms. **8.1.3** Development of agendas for the discussion of condom distribution.	- Agreements established for the distribution of condoms. - Agendas of the meetings.	- Department of Education - Department of Correction	- Public agencies.	- By January 2012 - Bimonthly report.

	6.4.5 Making contact with key staff to determine the days of meeting with the two Secretaries.				
Objective 9.1: By January 2012, coordinate and create a revision panel to evaluate and submit recommendations to the Secretary of DOE, specifically in the area of HIV and STD prevention and care.	**9.1.1** Determine process to establish a revision panel **9.1.2** Determine the policies and procedures for the revision panel. **9.1.3** Development of recommendations related to HIV and STD prevention care. **9.1.4** Establish the committee, its purpose and the revision panel.	- Committee Agreements. - Recommendations made.	- Department of Education	- Public agencies.	- By January 2012 - Bimonthly report.

REQUIRED INTERVENTION	6. "IMPLEMENT LINKAGES TO HIV CARE, TREATMENT, AND PREVENTION SERVICES FOR THOSE TESTING HIV POSITIVE AND NOT CURRENTLY IN CARE"				
Goal 1	Implement a referral network between the PRDOH and the DOC in order to link persons with HIV who have served time in a correctional facility, with care providers.				
Strategies	**Strategy 1:** Establish a liaison between the staff of Correctional Health Facilities and Ryan Part B-Planning Body.				
	Strategy 2: Provide CAREWare system to the Correctional Health Facilities.				
Objectives	**Process Objective**	**Indicator**	**Responsible Person or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By December 2011, the Correctional Health Facilities and Ryan Part B-Planning Body will develop a collaborative agreement to link HIV positive ex-inmates to care providers.	**1.1.1** Know areas (a mejorar) processes of inmates with HIV. **1.1.2** Determine areas for improvement for continuity of services. **1.1.3** Shows the areas to improve the administration of Correction. **1.1.4** Shows an improvement plan of arrangement to ensure	- Collaborative Agreement. - Ex confined referrals. - Clinics that are part of the agreement.	- PRDOH. - Correctional Health Facilities. - Ryan Part B-Planning Body.	- Public agencies.	- By December 2011 – Quarterly report.

	services to these patients. **1.1.5** Offers alternatives for the developme nt of collaborativ e agreement for referrals from former inmates. **1.1.6** Make contacts and agreements with providers of HIV clinics to receive patients and to obtain health services. **1.1.7** Establish the collaborativ e agreement.				
Objective 2.1: By December 2012, PRECHPP will provide the structure for the CAREWare system in the Correctional Health Facilities.	**2.1.1** Identify processes for the acquisition of CAREWare. **2.1.2** Make contacts with key people in correctional facilities.	- System set. - Final agreement.	- PRECHPP.	Data	- By Decemb er 2012 – Quarter ly report.

	2.1.3 Develop a work plan for the structure of the CAREWare in Corrections. **2.1.4** Establish the arrangements for the provision of the system.				
Goal 2	Implement CDC's guidelines for Partner Services for the AIDS Surveillance Program and the STD Surveillance Program to be able to share HIV results.				
Strategies	**Strategy 1:** Establish collaboration between the HIV Surveillance Program and the STD Surveillance Program.				
Objective 1.1: By October 2011, coordinate a meeting to create an internal protocol to share positive HIV results between the HIV Surveillance Program and the STD Surveillance Program.	**1.1.1** Monitoring key people from HIV Surveillance Program and the STD Surveillance Program. **1.1.2** Define the protocol agreements for development of positive participants. **1.1.3** Identify personnel responsible for protocol development. **1.1.4** Conduct	- Meetings of the areas. - Evaluation of the process. - Final protocol.	- Key personnel from HIV Surveillance Program and the STD Surveillance Program. - Minutes from meetings.	- Public agencies.	- By October 2011 – Quarterly report.

	meetings to discuss program responsibilities. **1.1.5** Evaluate the implementation process of the protocol. **1.1.6** Final development of the protocol.				
Objective 1.2: By November 2011, coordinate one training session with the HIV Surveillance Program to discuss the STD Surveillance program procedures.	**1.2.1** Know the procedures for training sessions. **1.2.2** Determine needs from personnel of HIV Surveillance Program. **1.2.3** Define training session. **1.2.4** Select personnel to be trained. **1.2.5** Define agenda for the trainning.	- Training needs and objectives. - Agenda and minutes of training. - Training session.	- PRECHPP. - STD Surveillance program personnel.	- Public agencies.	- By November 2011 – Bimonthly reports.
Objective 1.3: By November 2011, coordinate one training session with the STD Surveillance Program to	**1.2.6** Know the procedures for training sessions. **1.2.7** Determine needs from personnel of STD Surveillance Program.	- Training needs and objectives. - Agenda and minutes of training. - Training session.	- PRECHPP. - HIV Surveillance program personnel.	- Public agencies.	- By November 2011 – Bimonthly reports.

discuss the HIV Surveillance program procedures.	**1.2.8** Define training session. **1.2.9** Select personnel to be trained. **1.2.10** Define agenda for the training.				
Goal 3:	Implement linkages to care, treatment and prevention services for those testing HIV positive in the STD clinics.				
Strategies	Strategy 1: Establish a standard procedure protocol between STD clinics (Clets, Caguas and Bayamón)				
Objective 1.1: By December 2011, The HIV/STD Prevention Program will complete the standardize procedure protocol for linkage to care, treatment and prevention services for those testing HIV positive in STD clinics and not in care.	1.1.1 Identify the processes currently carried out for positive patients in the STD clinics. 1.1.2 Define the standard process to ensure contact with services. 1.1.3 Determine areas with the lowest percent of people connected to services once diagnosed. 1.1.4 Identify specific processes for these areas of lower percent of contact.	- Final Protocol. - Number and (%) of positive patients achieved. - Number of clinics using the protocol. - Impacted Areas of the MSA.	- Clinics on MSA.	- Public agencies.	- By December 2011 – Bimonthly reports.

	1.1.5 Define a flow chart defining the steps for linkage to care. 1.1.6 Define documentation and issues important to include in the protocol. 1.1.7 Preparation and distribution of the protocol.				
			-	-	-
REQUIRED INTERVENTION	7"IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING RETENTION IN OR RE-ENGAGEMENT IN CARE FOR HIV-POSITIVE PERSONS"				
Goal 1	Provide health care along the continuum of the HIV disease for persons living with HIV.				
Strategies	**Strategy 1:** Develop activities that promote the continuum of care for persons living with HIV.				
	Strategy 2: Provide counseling to persons living with HIV on the importance of receiving continuous medical care.				
	Strategy 3: Create the mechanisms to overcome barriers and facilitate access to care for care persons living with HIV				
Objectives	**Process Objective**	**Indicator**	**Person Responsible or Division**	**Data Type**	**Reporting Schedule**
Objective 1.1: By January	**1.1.1** Identify patients	- Patients out of care.	- PRDOH. - Ryan White	- Program data.	- By January

2012, establish a periodical process to identify persons living with HIV who have being out of care for the last twelve months in the SJMSA.	who have left treatment. **1.1.2** Determine referral process to use. **1.1.3** Make identification of people by MSA areas. **1.1.4** Make official list of patients without service for determine time. **1.1.5** Define a work plan for these patients.	- Participating Municipalities - List of persons who have not received services in the last twelve months.	Program, Minority AIDS Initiative.		2011 – Bimonthly reports.
Objective 1.2: By December 2012, the Ryan White Part B will identify at least 6 barriers that impede person living with HIV from receiving care, with the purpose of reintegrating these patients into health care services.	**1.2.1** Perform documented review of reasons presented by HIV + patients on why they do not receive services. **1.2.2** Establish task force to determine reasons for not receiving services. **1.2.3** Prioritize the reasons given.	- Number and (%) of people re-integrated in services. - Barriers identified.	- Ryan White Part B.	- Program data.	- By December 2011 – Bimonthly reports.

	1.2.4 Development of options for re-integrate services for the first 6 barriers. **1.2.5** Contact persons identified and make approach for re-integrated.				
Objective 2.1: By January 2012, have 100% of new patients fill out a questionnaire during their first medical appointment to determine if they have been offered counseling regarding the importance of receiving continuous care.	**2.1.1** Create list of new patients. **2.1.2** Determine participant priorities during their appointments. **2.1.3** Create forms to be completed by participant. **2.1.4** Development of an official document as guidance on the importance of staying active in health care. **2.1.5** Determine objectives to develop the questionnaire.	- Final questionnaire developed. - Number and (%) of participants that completed the questionnaire. - Counseling regarding the importance of receiving continuous care offered	- HIV Clinics. - Clinical Directors.	-	-

	2.1.6 Distribute document to 100% of participants. **2.1.7** Analyze questionnaires answers and present results.				

APPENDIX 5: WORKSHOP EVALUATION (SPANISH)

Introducción

Para el 13 de julio de 2010 el Presidente de los Estados Unidos, Sr. Barack Obama, presentó datos que afirman que cada año más de 56,000 personas en Estados Unidos se contagian con el VIH. Los datos también señalan que existen más de 1.1 millones de estadounidenses que tienen el VIH. Trae a nuestra atención que esta epidemia nacional exige actualmente que nos volvamos a comprometer a combatirla y se le dedique más atención pública y liderazgo. Ante esta situación, la Oficina de Política Nacional sobre el SIDA (Office of National AIDS Policy) que formulara una Estrategia Nacional contra el VIH/SIDA con tres objetivos primordiales:

1. Reducir el número de casos nuevos de personas infectadas con el VIH;
2. Aumentar el acceso a la atención médica y optimizar los resultados de salud para personas con el VIH, y
3. Reducir las disparidades en salud relacionadas con el VIH.

Ante esta realidad, se efectuó un llamado a intensificar y reorientar los esfuerzos a fin de producir mejores resultados para bien del pueblo estadounidense.

A tales efectos, Puerto Rico fue una de las doce (12) jurisdicciones seleccionadas para la realización de un proyecto piloto que busca desarrollar el "*Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS*", es decir, una Estrategia Nacional contra el VIH/SIDA. El propósito de este proyecto es facilitar el desarrollo e implementación de un plan que recoja las estrategias para las áreas más afectadas por el VIH, de modo que se pueda reducir el riesgo y la incidencia en las áreas.

Justificación

Para el desarrollo del Plan, se busca revisar la distribución actual de los recursos destinados para la prevención y tratamiento del VIH y atender posibles vacíos en la cobertura o realinear los recursos para reducir la incidencia del VIH en la Isla. Como parte de esta elaboración, en Puerto Rico se desarrolló el retiro/taller titulado "*Puerto Rico Enhanced*

Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS" los días 26 al 28 de enero de 2011. Durante estos días se presentó el proceso de elaboración del mismo, en el cual; se presentó un análisis situacional como primer paso, el establecimiento de metas como paso 2 y el trabajo directo para el desarrollo de los objetivos "*SMART*" como paso final.

Como proceso de evaluación de estos talleres, estos días fueron evaluados a través de una hoja de evaluación. Los resultados de esta evaluación se presentarán a continuación.

Resultados

Un total de sesenta y cuatro (64) participantes completaron la hoja de evaluación de los talleres. Esta hoja constaba de cinco (5) premisas, que a través de una escala Likert el/la participante definía su opinión sobre la aseveración de la premisa como totalmente de acuerdo (valor 4), de acuerdo (valor 3), en desacuerdo (valor 2) y como último; totalmente en desacuerdo como (valor 1). Además, la hoja incluyó tres (3) preguntas abiertas, que auscultaban: 1) los más que le gustó del taller, 2) las sugerencias para el mejoramiento de los mismos y 3) comentarios adicionales. Importante mencionar que esta hoja fue utilizada para evaluar los talleres diariamente. El total de participantes que completó la hoja de evaluación fue de 116, lo que representa un 55% de respuesta.

En cuanto a los días de realización de los talleres), el día 28 de enero de 2011 refleja un mayor por ciento de participantes que completó la hoja de evaluación, es decir, un 35.9% (n=23), seguido por el día 27 de enero de 2011 con un 34.4% (n=22) y el día 19 de enero reflejó un por ciento de personas que completó la evaluación como un 29.7% (n=19)(ver Tabla 1).

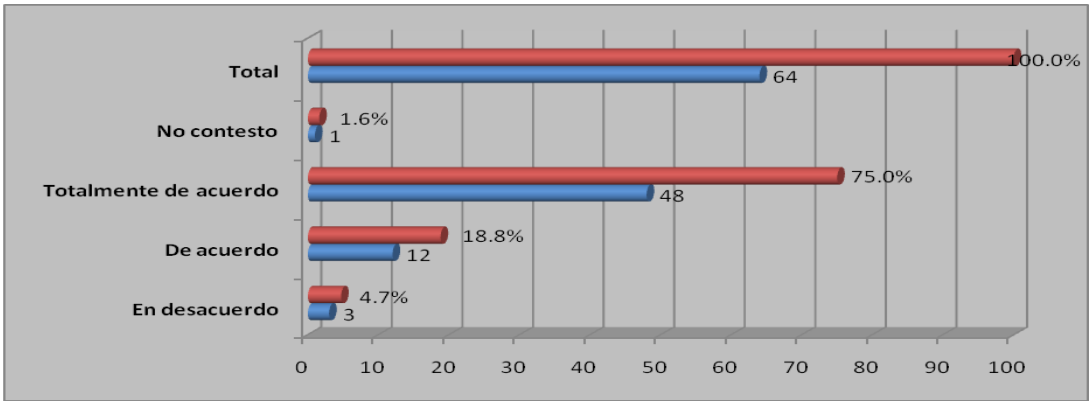
Tabla 1. Distribución de frecuencia y por ciento de participación diaria en los talleres.

Días	Frecuencia	Por Ciento
26.01.2011	19	29.7%
27.01.2011	22	34.4%
28.01.2011	23	35.9%

Total	**64**	**100.0%**

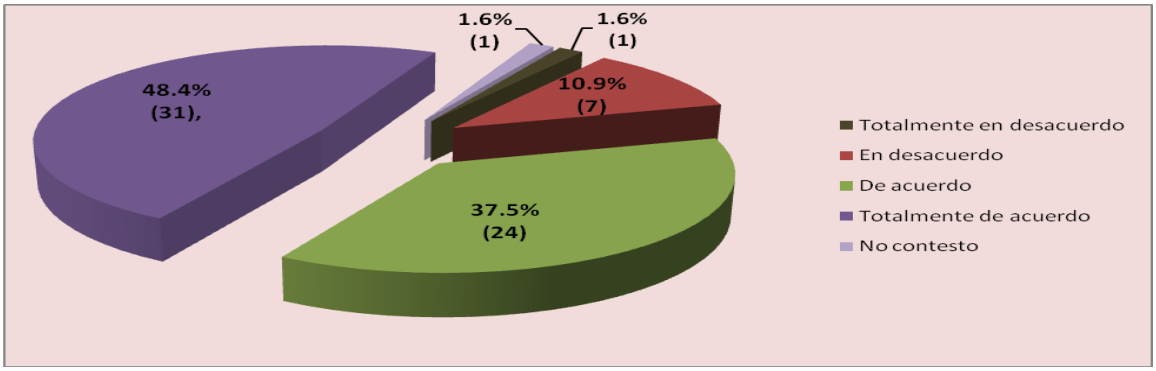
La evaluación consideró una valoración relacionada a los recursos, la cual se dirigía a conocer si las personas a cargo de presentar la información del taller lo hicieron de forma clara, encontrando que un 75.0% (n=48) señaló estar totalmente de acuerdo con la aseveración. Un 4.7% (n=3) respondió estar en desacuerdo con que los recursos hayan presentado la información de manera clara (ver Gráfica #1).

Gráfica 1. Distribución porcentual y frecuencia sobre forma en que los recursos presentaron la información en los talleres.



Los participantes presentaron su opinión sobre el tiempo utilizado para el desarrollo de la actividad. Los resultados reflejan que un 48.4% (n=31) opina estar totalmente de acuerdo con la aseveración, mientras que 10.9% (7) contestó estar en desacuerdo (ver Gráfica #2) .

Gráfica 2. Distribución porcentual y frecuencia de la opinión de los participantes sobre el tiempo utilizado para el desarrollo de los talleres.



Relacionado a la opinión de estos participantes dirigido a conocer la adecuacidad de las facilidades

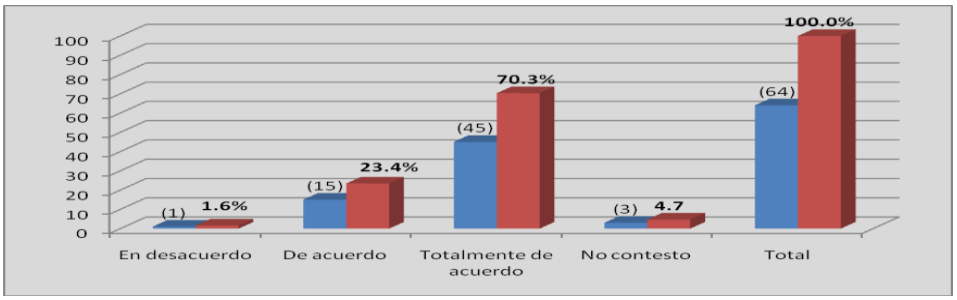
para el desarrollo de los trabajos, un 90.6% (n=58) determinó estar totalmente de acuerdo. Considerando estos resultados, es notable que no se dieran respuestas que dirijan estas opiniones en una dirección contraria; es decir, las respuestas son a favor de estar totalmente de acuerdo y de acuerdo.

Tabla 2. Distribución de frecuencia y por ciento sobre la adecuacidad de las facilidades para los talleres.

Aseveraciones	Frecuencia	Por Ciento
Totalmente de acuerdo	90.6	58
De acuerdo	7.8	5
No contestó	1.6	1
Total	**64**	**100.0%**

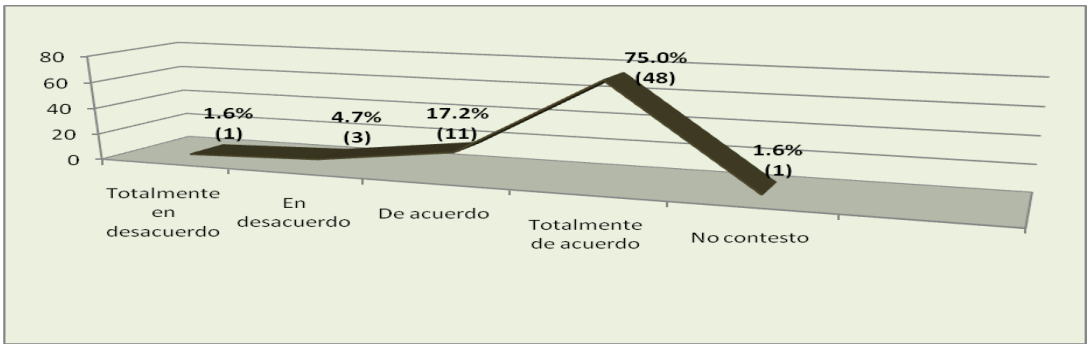
En cuanto al propósito del taller, representando la mayoría de los participantes que completaron la evaluación, un 70.3% (n=45) opinó estar totalmente de acuerdo con la premisa que define que el propósito de los talleres fue alcanzado. La evaluación resalta también que un 1.6% (n=1) contestó estar en desacuerdo. Además, un 4.7% (n=3) no contestó esa premisa (ver Gráfica 3).

Gráfica 3. Distribución porcentual de la opinión que define el logro (propósito) de la realización de los talleres.



Fue considerada también la opinión de los/as participantes sobre la adecuacidad que los facilitadores tuvieron para el uso de la de la información provista los/as participantes. La premisa reveló que un 75.0% (n=48) entiende que el uso fue totalmente adecuado. Por otro lado, un 1.6% (n=1) señaló estar totalmente en desacuerdo relacionado a esta premisa (ver Gráfica #4).

Gráfica 4. Distribución porcentual de la opinión sobre la adecuacidad que los facilitadores tuvieron para con la información provista.



Preguntas abiertas

A continuación se presentan de forma resumida respuestas presentadas con mayor frecuencia o relevancia.

¿Qué fue lo que más le gustó del taller?

- Dinámica.
- Propósito del esfuerzo.
- Discusión de grupos.
- Disposición de los participantes a integrar ideas.
- Diversidad de opiniones y se cumplieron las metas.
- Diversidad de participantes que aportaran para el cumplimiento de las tareas.
- El proceso creativo
- El profesionalismo del personal de Estudios Técnicos y el compromiso de trabajo de los invitados.
- El trabajo en equipo de líderes (profesionales y consumidores) para el desarrollo de ideas y acciones.
- Escuchar sobre las nuevas iniciativas que surgieron en la discusión acerca de la prevención.
- Integración de los sectores.

- Interacción de programas. Conocer debilidades y fortalezas del sector Salud y OBCs.
- La discusión de estrategias entre los equipos.
- La discusión en pleno enriqueció aún más los trabajos en los subgrupos.
- Aprovechar el tiempo para sacar un resultado concreto.
- La discusión objetiva de las intervenciones presentadas.
- La interacción de los dos sectores; prevención y servicios.
- La motivación en todo el grupo.
- La oportunidad de poder compartir con expertos en diversas áreas.
- La oportunidad de compartir ideas y colaborar con el desarrollo del Plan.
- La organización y trato en las facilidades.
- Presentación final.
- Propósito y resultado.
- Que el grupo está inmerso en lograr la realización del trabajo.

¿Qué sugerencias presentaría para el mejoramiento del taller?

- Contar con las estadísticas que respalden las intervenciones requeridas.
- Disponibilidad de algunos datos estadísticos básicos para determinar el impacto actual y la posible proyección para mejorar.
- Disponibilidad de datos para facilitar la toma de decisiones.
- Incluir más personas de las poblaciones identificadas.
- Grupos más pequeños para facilitar y expertos para desarrollar objetivos.
- Invitar personas del sector comunidad y otras agencias de servicios como lo son servicios a migrantes y servicios a UDI.
- Más integración de otros sectores.
- Más representación demográfica.
- Mayor tiempo de información.
- Notificar con más tiempo para coordinar asistencia
- Se necesita mayor información (datos) para la toma de decisiones y diseño del plan de trabajo (objetivos y viabilidad).

Comentarios adicionales.

- !Excelente!
- !Fue productivo!
- Al finalizar los trabajos se debe enviar los resultados finales de lo trabajado a las diferentes organizaciones para conocer el trabajo final.
- De alguna forma hacer llegar copia del producto final y de lo que iniciará finalmente.
- Mayor participación de pacientes.

- Excelentes facilidades y servicios de parte del Hotel. Valiosa aportación de mujer VIH+. Todo muy organizado, excelentes facilidades.
- Facilidades fueron adecuadas, organización excelente del trabajo. Excelente comida y muy bien coordinado.
- Felicito a los organizadores y coordinadores de esta actividad. A Wilfredo muchas felicitaciones. Las facilidades físicas y la comida, EXCELENTE.
- Gracias por estos tres días de comida y meriendas, riquísimas.
- La comida excelente, muy rica. El servicio excelente, las facilidades cómodas y adecuadas. La coordinación de Wilfredo Santiago, excelente.
- La coordinación de la actividad, fue excelente. Felicito al Sr. Wilfredo Santiago, fue excelente coordinando. El servicio del hotel, fue excelente.
- La organización ha sido excelente.
- Se debe hacer esta práctica anual para el mejoramiento de los procesos para que redunde en la población VIH, mejorar su calidad de vida.
- Todo lo relacionado a las atenciones del Hotel en cuanto a alimentos ha sido excelente. La atención absoluta de Wilfredo Santiago, es excelente.

Conclusiones

Con el propósito del desarrollo de la estrategia para Puerto Rico se llevó a cabo el "*Puerto Rico Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS*". Para la realización del mismo fueron invitados personas claves e instituciones/organizaciones que han sido eje para el servicio a las comunidades que incluyen educación y prevención del VIH. Cumpliendo con dicho propósito, fueron considerados el análisis y trasfondo de prevención y tratamiento para la condición del VIH, las intervenciones propuestas para el posterior desarrollo de la metodología y las intervenciones guías de este proyecto.

Un total de 14 intervenciones fueron presentadas a los/as participantes en este retiro, quienes cumpliendo con un interés genuino aportaron al desarrollo final del proyecto para esta jurisdicción. Para conocer la efectividad de este retiro se llevó a cabo una evaluación de proceso la cual a través de unas 5 preguntas cerradas y 3 preguntas abiertas nos permitió conocer la efectividad del mismo.

Sesenta y cuatro (64) participantes completaron la hoja de evaluación de los talleres. El tercer día del retiro fue el que presentó un mayor número de participantes con un 35.9% (23). Entre los datos importantes resaltan:

- un 75.0% (n=48) señaló estar totalmente de acuerdo en que la información fue presentada claramente por los recursos de la actividad,
- un 48.4% (n=31) consideró estar totalmente de acuerdo con el tiempo utilizado para el desarrollo de la actividad,
- un 75.0% (n=48) entendió que el uso de la información provista por los/as participantes fue totalmente adecuado por parte de los/as facilitadores,
- un 70.3% (n=45) opinó estar totalmente de acuerdo con la premisa que define que el propósito de los talleres fue alcanzado; y,
- un 90.6% (n=58) señaló estar totalmente de acuerdo a que las facilidades utilizadas para el retiro fueron adecuadas.

Entre las preguntas abiertas se resalta en la pregunta relacionada a lo más que les gustó de los talleres, el dinamismo generado y presentado en los grupos, la discusión entre los grupos, el propósito alcanzado en la actividad, la disposición de los/as participantes y el profesionalismo del personal de Estudios Técnicos.

Como sugerencia para el mejoramiento del taller se presentó el que se considere la utilización de estadísticas para respaldar las intervenciones presentadas y para la toma de decisiones. Como resultados óptimos, algunos comentarios fueron determinantes para definir la actividad, entre estos;

- !Excelente!
- !Fue productivo!
- Excelentes facilidades y servicios de parte del Hotel. Valiosa aportación de mujer VIH+. Todo muy organizado, excelentes facilidades.
- Felicito a los organizadores y coordinadores de esta actividad. A Wilfredo muchas felicitaciones. Las facilidades físicas y la comida, EXCELENTE.
- La coordinación de la actividad, fue excelente. Felicito al Sr. Wilfredo Santiago, fue excelente coordinando. El servicio del hotel, fue excelente.
- Todo lo relacionado a las atenciones del Hotel en cuanto a alimentos ha sido excelente. La atención absoluta de Wilfredo Santiago, es excelente.

Atando toda esta información los resultados permiten relacionar la efectividad que se presenta en el proyecto. El inicio ha alcanzado un compromiso de todos y de todas, lo que permite la continuidad de desarrollo para un resultado positivo en el proyecto.