Interagency Coordinating Council for HIV and Hepatitis

September 2010

Report to the Legislature

Texas Department of State Health Services

TEXAS
Department of
State Health Services

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Executive Summary

In accordance with the Health and Safety Code §81.010, the 2010 Annual Report on the Interagency Coordinating Council for HIV and Hepatitis (the Council) is presented to the Texas Legislature and Governor. The report describes policy recommendations developed and prioritized by the Council and describes activities conducted this year to address those recommendations.

In 2008, an estimated 63,019[1] Texans were living with HIV/AIDS and 400,000[2] had chronic viral hepatitis. These preventable infections will cost Texans millions of dollars in treatment costs and thousands of years in productive life lost. The Council was created to improve coordination between Texas state agencies in providing prevention for populations at risk and care and treatment for individuals living with these diseases[3]. The Council is also charged with producing an annual report for the Legislature and Governor on these issues by September 1 of each year.

This report highlights ten policy recommendations developed and prioritized by the Council, and includes activities conducted this year to address each recommendation.

Additionally, in the appendix, the Council provides an epidemiological description of HIV, AIDS and hepatitis in Texas (Appendix A and B), and available information on federal and state resources for prevention and health services for AIDS, HIV and hepatitis in Texas (Appendix C and D).

[1] Texas Department of State Health Services. (2009). *Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention and Services Planning*. Austin, Texas

[2] Melville S K, Heseltine G, Delamater E, Gilani Z, Hendricks K, Suarez L. (2006) Hepatitis C Virus Seroprevalence: Selected Health Care Settings In Texas. *Journal of Texas Medicine*, 102, (3): 56–61.

[3] The Council is described in Section 81.010 of the Texas Health and Safety Code.

Background

Legislation passed in 2007 and codified as Health and Safety Code §81.010 re-created the Council. The Texas Health and Human Services Commission (HHSC) provides administrative support to the Council, and its Council representative serves as chairperson (Appendix E). Agencies represented on the Council include:

- Health and Human Services Commission (HHSC);
- Department of State Health Services (DSHS);
- Department of Aging and Disability Services (DADS);
- Department of Assistive and Rehabilitative Services (DARS);
- Department of Family and Protective Services (DFPS);
- Texas Youth Commission (TYC);
- Texas Department of Criminal Justice (TDCJ);
- Texas Juvenile Probation System;
- Texas Education Agency (TEA);
- Texas Medical Board;
- Board of Nurse Examiners;
- State Board of Dental Examiners;
- Texas Workforce Commission (TWC); and
- Texas Higher Education Coordinating Board

The Council is required to assist with communication and coordination among the member agencies concerning the agencies' programs for prevention and services related to HIV, AIDS and hepatitis. Further, the Council is required to:

- Identify statewide plans related to HIV, AIDS and hepatitis;
- Identify all federal, state, and local funds spent on HIV and hepatitis prevention and care services in Texas, including Medicaid and Medicare (Appendices C and D);
- Identify areas in which state agencies interact on HIV and hepatitis issues and the policy issues that arise from this interaction;
- Assess gaps in prevention and health care services for HIV and hepatitis and develop strategies to address gaps through service coordination;
- Identify barriers to prevention services and health care services for HIV, AIDS and hepatitis faced by populations disproportionately affected by these illnesses;
- Identify the health care and service needs of persons living with HIV, AIDS or hepatitis and evaluate the level of service and quality of health care for these Texans compared to national standards; and
- Identify emerging issues related to HIV and hepatitis and their impact on delivering prevention and health care services.

Update on Prioritized Policy Recommendations

Among the agencies on the Council, DSHS is the state public health entity that works to identify, report and control HIV and hepatitis in Texas. Therefore, DSHS conducted most of the activities addressing the ten prioritized policy recommendations (Appendix F).

The ten policy recommendations are listed in prioritized order below, with activities that have occurred during the past fiscal reporting year (09/9/09 – 6/30/10).

1) Increase earlier diagnosis of HIV infection by promoting routine testing for HIV in a variety of acute care settings in high prevalence areas of Texas with high HIV prevalence

Beginning in late 2008, DSHS began routine HIV testing in select acute care sites in response to the Centers for Disease Control and Prevention (CDC) *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings (2006).* These recommendations state that HIV testing should be a part of routine care delivered in acute health care settings to persons aged 15 – 64. The selected sites include correctional facilities, hospital emergency departments, community health centers, substance abuse treatment centers, and family planning centers. Selected local health department STD clinics, which have conducted routine HIV testing for many years, began expansion of rapid HIV testing.

Routine HIV testing is being established in acute care settings in Austin, Dallas, El Paso, Fort Worth, Houston, Longview, and San Antonio. The bulk of these tests are being done in emergency departments and large primary care clinics. As of November 2010, 39 sites in these cities have been funded to provide routine HIV testing. They have performed 204,611 HIV tests and found 2,151 positives for a 1.05% positivity rate. In 2011, the plan is to continue promoting diffusion to more emergency departments and increasing focus on primary care providers, community health centers, substance abuse treatment centers, and local correctional settings. Routine HIV testing in these settings is still considered a novel practice by most providers and implementation requires both fiscal support for testing and extensive technical assistance during the adoption process. DSHS will provide both as resources permit. DSHS will work with stakeholder groups in the medical and public health communities to advocate adoption of routine HIV testing, and will explore policy and educational avenues to address barriers to adoption of the CDC recommendations.

2) Increase access to hepatitis B immunization to avoid vaccine preventable infections for children and at-risk adults

In 2009, DSHS formed the Viral Hepatitis Integration Workgroup. The workgroup created the Texas Viral Hepatitis Integration Plan. One goal in the plan is to increase immunization rates for hepatitis A and B among high-risk populations by accomplishing the following two objectives by the end of 2010:

- Increase the number of sites that are enrolled in the Adult Hepatitis B Immunization Initiative by 5%.
- Develop a policy that recommends that STD clinics in Texas have a procedure in place that ensures clients receive a health assessment including a hepatitis A and B vaccination.

The workgroup is determining programmatic baseline data for hepatitis A and B vaccinations. As of May 2010, 457 sites were enrolled in the Adult Hepatitis B Immunization Initiative and 42,134 doses of hepatitis B and A/B doses were shipped to providers. Most of the enrolled sites are local health departments and STD clinics (284). Ongoing recruitment efforts will target HIV counseling and testing sites, methadone clinics and correctional facilities to increase enrollment in the program. The need for additional vaccinations has become more critical since universal hepatitis B vaccination of incoming offenders has been eliminated at the TDCJ, in response to budget cuts.

STD program operating procedures were updated in November 2009. They include a requirement that all STD clinics provide routine hepatitis A and B immunizations to all unimmunized patients, regardless of risk factors, unless the patient opts out. STD clinics must have a system in place to refer patients for subsequent injections if they do not want to return to the STD clinic for their second or third dose.

3) Increase early diagnosis of and intervention in HIV/AIDS and hepatitis through coordination among state agencies and expansion of current programs

In 2009, the Council developed strategies to encourage HIV and hepatitis C testing. Discussion focused on the two groups that Council agencies had access to: 1) their respective client populations; and 2) agency employees.

DSHS staff met with representatives from the Texas Commission on Jail Standards to review its role in providing hepatitis and HIV prevention and care services. DSHS also met with DFPS to review its policies on HIV and hepatitis care for their clients.

The Council worked with DSHS to develop an informational sheet promoting HIV awareness called "HIV – Talk About It". This information was electronically distributed to employees in the health and human service agencies overseen by the HHSC and to Council members on World AIDS Day (December 1, 2009). The one-page fact sheet encouraged recipients to re-start the conversation about HIV prevention with colleagues, clients and their families.

4) Continue to invest in core public health activities such as public health follow up and partner services to prevent further transmission of HIV

Partner services provided by DSHS and local health departments create opportunities to provide testing and education to persons at highest risk of acquiring HIV and other STDs (e.g., individuals who have had sexual contact with and/or shared intravenous drug needles with infected persons). In the past year, DSHS and local health departments have continued to improve efficiency and effectiveness of traditional partner services. One example is the expanded use of Internet and social networking sites to locate and notify partners.

Since reducing untreated STDs reduces HIV acquisition, DSHS has prioritized work to expand access to STD treatment services. DSHS requested, and the Texas Medical Board agreed, to amend its rules so that all Texas clinicians can provide treatment for sex partners of patients diagnosed with uncomplicated chlamydia or gonorrhea without requiring an examination of the

partner. Expedited treatment of sex partners reduces the rates of persistent or recurring gonorrhea or chlamydial infection[4].

5) Address the fragmented nature of viral hepatitis prevention and treatment services

The lack of dedicated resources continues to provide a challenge to initiating and maintaining a robust and comprehensive public health response to address hepatitis prevention and treatment needs in Texas. Hepatitis program activities at DSHS - including limited surveillance, perinatal hepatitis B prevention, hepatitis A and B vaccination and adult viral hepatitis prevention – are conducted by programs that are located in different areas of the department. There are no specific state programs for providing hepatitis care. Individuals without health insurance frequently cannot obtain treatment.

In 2009, DSHS hired an Adult Viral Hepatitis Prevention Coordinator (AVHPC) with funding received from the CDC. The AVHPC works with other state programs, local health departments, advocacy organizations, and healthcare providers to improve viral hepatitis awareness and to integrate hepatitis prevention and treatment into appropriate program activities at the state. The purpose of this program coordination is to organize and blend inter-related health issues so that new and established linkages between programs can incorporate the delivery of hepatitis prevention and care services.

Since the addition of the AVHPC, there has been an increase in hepatitis C virus (HCV) testing, education and awareness activities, and collaboration with community stakeholders to identify issues and develop strategies for addressing viral hepatitis. Many of these achievements were realized at low or no cost through programmatic synthesis and the use of web-based technology.

6) Develop new prevention and treatment strategies that address the health disparities associated with HIV/AIDS and hepatitis infection, and increase access to existing prevention and treatment programs

Blacks bear a disproportionate share of HIV and STD cases in Texas, and Hispanics are more likely than Whites or Blacks to receive a late diagnosis of HIV. The HIV/STD Program will continue to:

- Launch targeted social marketing campaigns for populations disproportionately affected, as funding allows;
- Convene local round table discussions for stakeholders to examine HIV/STD-related issues disproportionately affecting minority populations, particularly Black women, Black men who have sex with men (MSM), and Latino MSM;
- Fund HIV prevention evidence-based interventions specifically for Blacks and Latinos;
- Launch the "Stomp Out Syphilis" social marketing campaign and associated outbreak response activities in areas of Texas with high syphilis prevalence, as funding allows; syphilis resurgence is primarily among Black Texans;
- Offer HIV medication and support services through the federal Minority AIDS Initiative project; and

[4] Matthew R. Golden, M.D., M.P.H., William L.H. Whittington, A. B., H. Hunter Handsfiled, M.D., James P. Hughes, Ph.D, Walter E. Stamm, M.D., Mathew Hogben, Ph.D., Agnes Clark, B.S., Cheryl Malinski, B.S., Jennifer R. L. Helmers, B.S., Katherine K. Thomas, M.S., and King K. Holmes, M.D., Ph.D., (February 17, 2005) "Effect of Expedited Treatment of Sex Partners on Recurrent or Persistent Gonorrhea or Chlamydial Infection," in *The New England Journal of Medicine,* p.p. 676-685.

- Provide scientifically accurate, culturally appropriate HIV/STD informational materials in English and Spanish.

7) Expand implementation of behavioral interventions with demonstrated evidence of effectiveness in reducing risk for HIV and hepatitis

Wider accessibility to behavioral interventions with demonstrated effectiveness in reducing risk for HIV and hepatitis is critical in preventing new infections. As of September 1, 2010 the HIV/STD program at DSHS funds 36 sites to administer behavioral interventions.

Examples of evidence-based interventions currently implemented in Texas are Brother-to-Brother, Community Promise, and Healthy Relationships. Brother-to-Brother is a three session behavioral intervention aimed at reducing HIV infection among African American gay and bisexual men. The sessions are designed to foster positive self-identity development, educate participants about HIV/AIDS risks, teach assertiveness, and encourage the sharing of commitments and strategies for risk reduction among group members. Community Promise begins with a community assessment and then peer advocates are recruited and trained from the target population. Role model stories are written from interviews with the target populations and these stories are distributed, along with other risk reduction materials, to target audiences to help people move toward safer sex or risk reduction practices. Healthy Relationships is a five session, small group intervention for men and women living with HIV/AIDS.

While the scale and scope of these interventions is bounded by availability of funds, DSHS is working with providers to institute innovative recruitment and retention approaches for participants in community-based programs.

8) Improve viral hepatitis surveillance

General state revenue for HCV activities was largely eliminated in the 78th Legislative Session. Reductions in resources meant that DSHS was no longer able to support adequate HCV reporting and surveillance. In 2007, disease reporting rules were amended to eliminate chronic hepatitis C from the reportable disease list. Acute hepatitis A, B and C infections remain on the list of reportable diseases and conditions. Reactive (positive) tests for perinatal hepatitis B are reported to local and state health departments.

Establishing a statewide surveillance system for reporting chronic hepatitis B and C would be resource-intensive. Instead, DSHS is examining other methods for gathering data on hepatitis prevalence, such as creating sentinel surveillance sites and conducting serosurveillance studies. However, these activities will depend on the availability of additional funds.

9) Explore structural interventions that address underlying vulnerabilities among risk groups for HIV and viral hepatitis caused by substance abuse and mental health needs

Structural interventions focus on programs and policies designed to change the environment in which risk behaviors occur to reduce the transmission of HIV and HCV.

Beginning with examination of policy and practices this past year, DSHS began work on integrating HIV and hepatitis testing and immunization into substance abuse and mental health programming. For example, in September 2010, five DSHS-funded opioid substitution clinics

began offering comprehensive testing for HIV, HBV, HCV, TB and syphilis, as well as hepatitis A and B vaccinations.

Currently, research and clinical trials are underway on new prevention technologies. Though these technologies may not be widely available, it is important that conversations, education and policy initiatives begin on these new prevention innovations. These technologies address the underlying limitations of many traditional prevention approaches used with HIV and viral hepatitis. They may be especially useful among vulnerable populations including individuals with substance abuse and mental health needs.

10) Commit to continued investigation of issues identified as needing further study

Council members will continue to examine the prioritized policy recommendations and will report any activities or progress to address the prioritized recommendations.

Not all HIV and hepatitis prevention and treatment activities conducted by state agencies can be categorized into one of the ten recommendations. For this reason, the TDCJ and TYC activities are listed separately.

HIV/AIDS and Hepatitis Prevention, Care and Treatment Efforts in State Correctional Facilities

Texas Department of Criminal Justice (TDCJ)

The TDCJ follows Administrative Directive 6.60 and Correctional Managed Health Care (CMHC) Infection Control Manual Policy B-14.11 to govern the management of offenders infected with HIV. These policies address testing and counseling, infection control, treatment, housing, job assignment, confidentiality and pre-release discharge planning. They are modeled after DSHS guidelines. In addition, the TDCJ Bloodborne Pathogen Exposure Control Plan, Correctional Managed Health Care Infection Control Manual Policy B-14.27, addresses the risk for and prevention of exposure to these pathogens for employees. Correctional Managed Health Care Infection Control Manual Policy B-14.31 addresses the use and availability of personal protective equipment and spill kits for all staff.

Direct medical care for offenders is provided, as per Chapter 501, Subchapter E, Texas Government Code, by university providers (ie, University of Texas Medical Branch at Galveston [UTMB] and Texas Tech University Health Sciences Center) under the supervision of the Correctional Managed Healthcare Committee.

Table 1. PLWHA in TDCJ, 2009

	number	percent
Total	2,419	100.0%
Sex		
Male	2,183	90.2%
Female	236	9.8%
Race/Ethnicity		
White	598	24.7%
Black	1,497	61.9%
Hispanic	322	13.3%
Other	2	0.02%
Age Group		
<20	4	0.2%
20-29	250	10.3%
30-39	652	27.0%
40-49	1,033	42.7%
50+	480	19.8%
Mode of Exposure		
MSM	116	4.8%
IDU	965	39.9%
MSM or IDU	578	23.9%
Other	760	31.4%

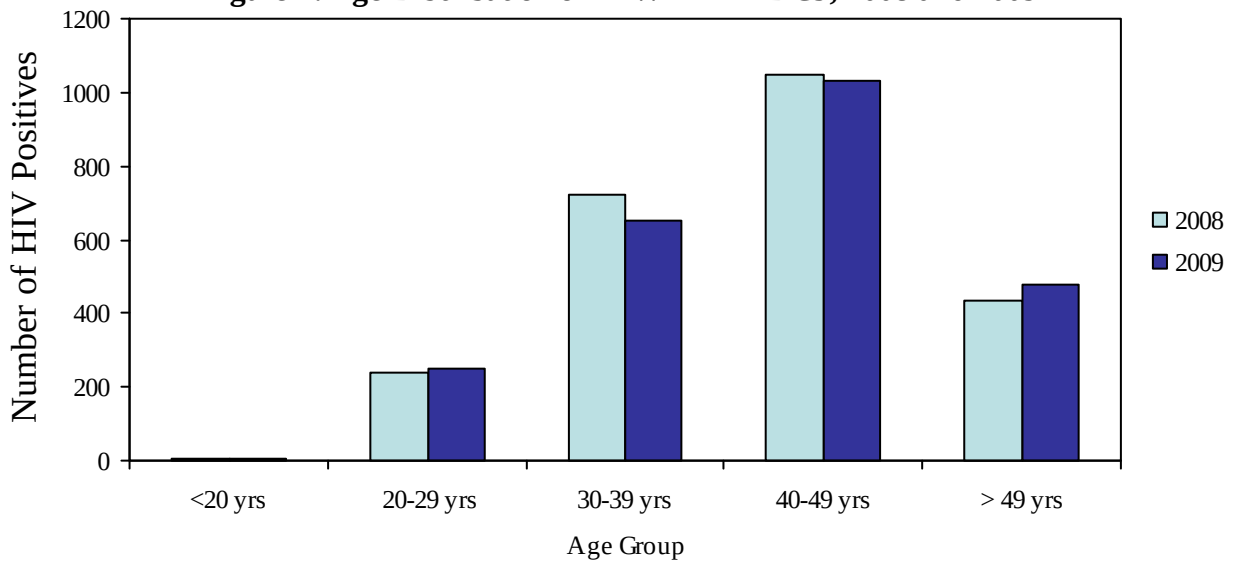
HIV/AIDS in TDCJ

The statewide surveillance system for HIV/AIDS that is carried out by DSHS collects the location of each case based on the county of the patient's residence at the time of diagnosis. After diagnosis, changes in residence are difficult to track. The TDCJ population is particularly transitory. For that reason, reports from TDCJ are a more accurate reflection of the infected population in TDCJ facilities. As of December 31, 2009, 2,419 persons living with HIV/AIDS (PLWHA) were incarcerated in TDCJ. PLWHA in TDCJ are overwhelmingly male and predominantly Black (Table 1). Risk factors included injection drug use (IDU) for 40% of cases; MSM, for 5%; both IDU and homosexuality/bisexuality for 24%, and "other" for 31%. The age distribution of PLWHA in TDCJ varied little from 2008 to 2009 (Figure 1).

Offender Education

UTMB develops educational pamphlets that address the symptoms, treatment, and prevention of HIV and hepatitis. They are available in both English and Spanish. The pamphlets are actively distributed in a variety of ways. For instance, many units include the pamphlet in the orientation package that is provided to newly arriving offenders. The pamphlets are also posted in common areas such as dayrooms; this makes the information available to most offenders on a daily basis. Approximately 70,000 offenders have been provided these materials this fiscal year (FY2010).

Figure 1. Age Distribution of PLWHA in TDCJ, 2008 and 2009



TDCJ in cooperation with DSHS and in partnership with AIDS Foundation Houston, AIDS Arms of Dallas and other community based organizations, offers an offender peer education program called "Wall Talk" to teach offenders about prevention of HIV, hepatitis, and other communicable diseases. Peer educators are offenders who have been trained in education techniques and in the disease about which they teach. The program started in 1999 in five prison units. It has since grown to include 108 units as of December 31, 2009. In 2009, 76,261 offenders attended peer education classes and received HIV and hepatitis prevention education. The peer education curriculum is modular so that each course can be tailored to the needs and interests of the class. Modules include HIV, hepatitis, sexually transmitted infections, tuberculosis, diabetes, staphylococcal infections and how to access health care after being released. Each course addresses the core curriculum topics of HIV and hepatitis. Females use a curriculum called "Women to Women" that incorporates the information in "Wall Talk" but also includes topics such as the female reproductive system, making health choices, and emotional and mental well-being. A typical peer education course lasts six to eight hours and materials may be presented over the course of several days or weeks. The HIV portion of the course addresses the stages of HIV infection, modes of transmission, prevention methods, attitudes about persons with HIV infection (stigma), whether to be tested for HIV, communicating with partners, and treatment. The hepatitis portion uses several HIV topics because of the similarity in modes of

transmission. It also includes information about transmission, treatment, and prevention of hepatitis.

Pre- Release HIV Testing

TDCJ initiated pre-release HIV testing during the 2006-2007 biennium, as required by Section 501.054(1) of the Texas Government Code. From September 1, 2006 through August 31, 2008, 120 positive pre-release tests were reported to the DSHS for surveillance and partner notification purposes. During the same time frame, another 2,640 HIV-positive offenders were released from TDCJ. From September 1, 2008 through August 31, 2009, 28 offenders with positive pre-release tests were reported to DSHS. During the same time frame, a total of 1,393 HIV-positive offenders were released. The overwhelming majority of HIV-positive offenders who are released are identified through mandatory intake, offender-requested, and physician-requested HIV testing.

Mandatory Intake HIV Testing

TDCJ also implemented mandatory intake HIV screening starting in July, 2007, as required by Chapter 501.054 of the Texas Government Code. During 2009, mandatory intake and both offender, and provider, requested HIV tests all fell under the larger rubric of "routine" HIV tests. In 2009, 84,397 offenders had a routine test, and 574 of the routine tests were HIV positive. Since January 2010, all HIV tests have been coded as "mandatory intake," "offender-requested," "provider-requested," or "mandatory pre-release" tests. From January through May of 2010, mandatory intake tests have accounted for more than 95% of the positive "routine" (i.e., intake, offender-requested, and provider-requested tests. Because the distribution of positive tests by category for 2009 data is unlikely to differ from the distribution of positives for the 2010 data, mandatory intake tests may have accounted for most of the 574 positive routine tests for 2009.

In both pre-release HIV testing and intake testing, few of these cases are newly identified infections.

Hepatitis Screening

Rates of hepatitis B, hepatitis C and HIV are two to ten times higher among offenders than they are among members of the general population.[5] Carriers of either type of hepatitis are at increased risk of hepatocellular carcinoma (HCC) and carriers of both are at an extremely increased risk.[6] A recent meta-analysis revealed that:

- hepatitis B carriers were 22 times more likely than noncarriers to get HCC;
- hepatitis C carriers were 17 times more likely than noncarriers to get HCC; and

[5] Weinbaum CM. Sabin KM, and Santibanez SS. Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention. *AIDS*. 2005. Suppl 3: S41-46

[6] Kew MC. Interaction between hepatitis B and C viruses in hepatocellular carcinogenesis. *J Viral Hepat.* 2006 Mar;13(3):145-149.

- hepatitis B *and* C carriers were 165 times more likely than noncarriers of either to get HCC.[7]

Both the CDC and the Advisory Committee on Immunization Practices (ACIP) currently recommend universal hepatitis B vaccination of all adults in correctional facilities who have not completed the vaccine series.[8] Vaccinating offenders may not appear to be cost-beneficial to prisons, however, there is a cost benefit once offenders have left the system. According to a moderately recent study:[9]

- For each 1,000 offenders vaccinated, 200 hepatitis B infections are averted. The costs for one-third of these would accrue inside the prison system; the cost for the remaining two-thirds would accrue outside; and
- For each 1,000 offenders vaccinated, the prison system would pay $27,000, but the overall medical system would save $118,000.

During 2009, a universal hepatitis B screening and immunization strategy was in effect in TDCJ. Newly arriving offenders and already-incarcerated offenders (on their date-of-incarceration annual review) had laboratory tests performed to determine whether they were immune or susceptible to hepatitis B. Those who were susceptible were offered the vaccine. Although universal hepatitis B screening and vaccination was discontinued in the spring of 2010 due to budgetary constraints, all offenders have been, and still are, questioned about risk factors for hepatitis B during the intake medical evaluation process. Those with risk factors are tested unless documentation of previous infection or vaccination can be verified. High-risk offenders who remain susceptible to hepatitis B are offered vaccine. Vulnerable populations such as hemodialysis patients, pregnant offenders, those with acute hepatitis infections, and those who are HIV-positive are also screened by blood test for susceptibility and offered vaccine if indicated.

Screening for the hepatitis A virus (HAV) antibodies must be performed on offenders who are newly diagnosed with HIV as well as on those with chronic hepatitis B or hepatitis C. These offenders are offered HAV vaccine if they are susceptible.

Offenders are also questioned about risk factors for hepatitis C and for signs and symptoms of liver disease during the intake medical evaluation. If risk factors or signs or symptoms are present, offenders are offered hepatitis C screening with an anti-HCV antibody test. Testing may be repeated every 12 months at the offender's request or as medically indicated.

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[7] Donato F, Boffetta P, Puoti M. A meta-analysis of epidemiological studies on the combined effect of hepatitis B and C virus infections in causing hepatocellular carcinoma. *Int J Cancer.* 1998 Jan 30;75(3):347-354.

[8] MMWR 55(RR16);1-25. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. 2006. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5516a1.htm, Accessed April 6, 2010. *MMWR* 59 (01);1-4. Recommended Adult Immunization Schedule – United States, 2010. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5901a5.htm, Accessed April 6, 2010.

[9] Pisu M, Meltzer MI, Lyerla R. Cost-effectiveness of hepatitis B vaccination of prison inmates. *Vaccine.* 2002; 21:312-321.

Discharge Planning

The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) plays the major role in "continuity of care" discharge planning for HIV-positive offenders who are being released. TCOOMMI Human Service Specialists meet with eligible offenders either by phone or in person within ten days of their release. During this meeting, offenders receive information about community services and assistance in making plans for continuing care after release. Offenders are also enrolled in services such as Social Security if they are eligible.

In addition to the activities of TCOOMMI continuity-of-care workers, TDCJ Field Services staff meet with HIV-positive offenders just prior to release. The released inmates are provided with a 10-day supply of their medication, written information about services they can access in their community and a review of their post-release plan for continuing care. State jail offenders also receive the 10-day supply of medication prior to release.

HIV-positive offenders receive instructions on how they can have an additional 30-day supply of medication filled through a pharmacy of their choice after release. This allows them more time for accessing care in the community.

TDCJ also cooperates with community organizations to coordinate discharge planning. These organizations include AIDS Arms of Dallas, the Montrose Counseling Center, and AIDS Foundation Houston. There are active inreach programs at Stiles, Henley, Keegan, Plane State Jail, Gatesville, and Dawson State Jail. When they are available from the community agencies, CMHC staff distribute information pamphlets and postage-paid return mailers to HIV-positive offenders. This is done so that they can request pre-release services from these organizations even if they are not on one of the units where the organizations have a physical presence.

The University of Texas Correctional Managed Health Care Infectious Disease Clinic, which sees nearly all HIV-positive offenders in TDCJ, has a grant-funded position that helps offenders who are nearing release to make plans for continuing care after their release.

Texas Youth Commission

TYC has youth offenders with HIV, AIDS, and/or hepatitis in its facilities. UTMB provides medical care to TYC youth offenders. The cost of care specifically related to HIV and hepatitis within TYC is unknown.

TYC maintains General Administrative Policies that address HIV and AIDS to "provide for a safe and healthful environment for youth in facilities as it relates to HIV and AIDS." The policies address testing, confidentiality, reporting, housing, treatment, access to services and education.[10]

TYC's Personnel Policy and Procedure Manual address occupational exposure and reportable diseases. These include AIDS, HIV, HBV and/or HCV infections. The manual covers TYC's

[10] Texas Youth Commission. (2006) *General Administrative Policy Manual*. GAP.91.97. Retrieved July 1, 2008 from http://austin.tyc.state.tx.us/Cfinternet/gap/91/gap9197.htm

commitment to employees, volunteers and youth in its care. The agency has an Exposure Control Plan to comply with Chapter 81, Subchapter H of the Texas Health and Safety Code.[11] TYC's policies recognize that employees with life-threatening or contagious disease – including HIV, HBV and HCV – may wish to continue to work as long as physically and mentally able. The policy outlines TYC's commitment to fair and equal treatment of employees and youth and requires ongoing training for staff, youth, contractors and subcontractors on HIV infection and prevention.[12]

The rates for those that tested positive for HIV in TYC (.08%) are similar to the rates of diagnoses of HIV infection among adolescents (13-19 years of age), in Texas (0.089%) and the United States (0.091%). There is no state or national hepatitis B or C surveillance data to compare with the TYC rates.

Table 2. Percent of TYC population who have had an HIV and/or Hepatitis B and C diagnosis, either at TYC or prior to coming to TYC.

Rate (%) of HIV and Hepatitis B and C
FY2008 - FY2010 (ytd)*

Condition	FY2008	FY2009	FY2010(ytd)*
HIV	0.10%	0.05%	0.08%
Hep B	0.04%	0.08%	0.08%
Hep C	0.22%	0.13%	0.08%

*September 2009 - February 2010

Conclusion

During the next planning year, members will examine the purpose of the Council and its activities in order to ensure that the forum is being used to accomplish the intent of the legislation. The Council will continue to revisit the prioritized policy recommendations to determine their respective roles in addressing each recommendation.

[11] Texas Youth Commission. (2001). Personnel *Policy and Procedure Manual*, Chapter23: Employee Injury/Illness. Retrieved July 1, 2008 from http://austin.tyc.state.tx.us/Cfinternet/prs/prs23/prs2305.html
[12] Texas Youth Commission. (2004) Personnel Policy and Procedure Manual, Chapter 01: Conditions of Employment. Retrieved July 1, 2008 from http://austin.tyc.state.tx.us/Cfinternet/prs/prs01/prs0119.html

Appendix A. Epidemiology of HIV/AIDS in Texas

HIV is the virus that causes acquired immune deficiency syndrome (AIDS). HIV (human immunodeficiency virus) can be transmitted from person to person through sexual contact and sharing syringes and needles used to inject drugs. The virus can be passed to a baby during pregnancy or delivery or while breast feeding, if the mother is HIV-infected. Blood and blood products used in medical care were a source of transmission early in the epidemic, but routine screening methods have ensured the safety of blood products for many years. Most people with HIV infection have no symptoms for many years. AIDS is diagnosed when the immune system becomes so weak that diseases and infections begin to attack the body. Although there is no cure for HIV infection or for AIDS, there is good news regarding treatment. Increased understanding of HIV disease progression, availability of sophisticated testing, ability to prevent or reduce the impact of opportunistic infections, and potent treatment therapies have made HIV an increasingly manageable chronic disease.

This summary presents an overview of information on known HIV/AIDS cases in Texas for 2008. The full HIV/AIDS Epidemiologic Profile, including details on HIV/AIDS in selected geographic areas within Texas, is available at http://www.dshs.state.tx.us/hivstd/planning/EpiProfile.pdf. These data are drawn from routine disease surveillance efforts. They have been adjusted for reporting delay and redistribution of cases for which mode of transmission was not known at the time of this analysis. This data is updated periodically.

Increases in Living Cases of HIV/AIDS, but Steady Numbers of New Diagnoses and Deaths

Since 2002, the number of PLWHA in Texas has increased steadily, about 6% each year. The number of PLWHA in 2008 was about 42% higher than in 2002 (Figure 2.1). New diagnoses and deaths have been relatively stable over the past seven years. The number of new HIV/AIDS cases diagnosed each year increased the total PLWHA but is partially offset by deaths among those infected (Figure 2.2). The increase in PLWHA over the past seven years reflects continued

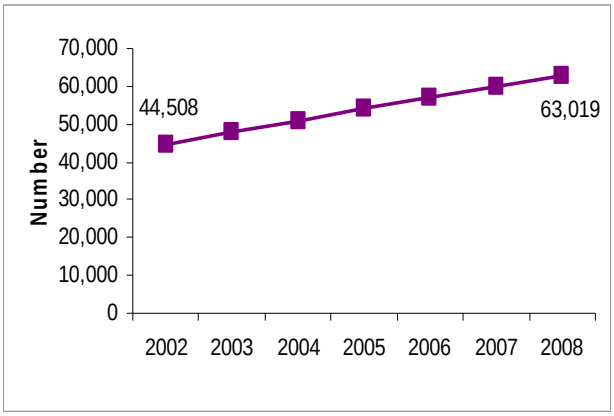


Figure 2.1. Living Cases of HIV/AIDS

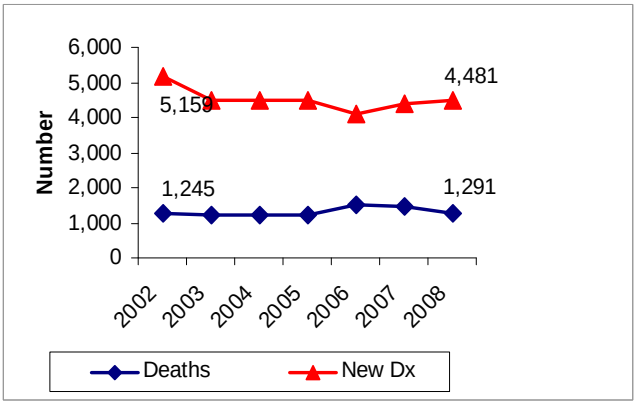


Figure 2.2. New Diagnoses and Deaths among PLWHA, Texas 2008

survival due to better treatment, not an increase in new diagnoses. In an environment of increasing numbers of PLWHA, the fact that new diagnoses remained level speaks to successful prevention efforts, but more must be done in order to reduce new diagnoses.

Men make up the greatest numbers of PLWHA in Texas.

The numbers and rates of PLWHA increased substantially for both sexes, across all races/ethnicities and across all age groups except for those less than 13 years old. The distribution of cases between sexes remained the same from 2002 to 2008, with over three quarters of living cases among males.

For every one woman living with HIV/AIDS in Texas, there are about three men. From 2003 to 2007, the number of new diagnoses of HIV/AIDS remained fairly stable for both sexes: around 3,500 diagnoses per year among men and about 1,000 diagnoses each year for women.

Blacks are disproportionately affected by HIV/AIDS in Texas.

Blacks account for about 11% of the population in Texas. In 2008, Blacks accounted for the largest proportion of PLWHA (38.0% compared to 36.2% White and 24.8% Hispanic). When rates are compared, the rate of Black PLWHA (850 per 100,000) was over four times the rate in Whites (197 per 100,000) and about five times the rate in Hispanics (174 per 100,000). Numbers and rates of PLWA can be found in Figure 3.

New diagnoses of HIV also show disproportionate impact on the Black population. Black persons had the highest number and rate of new infections. The 2008 rate of new cases in Black persons (76 per 100,000) was about five and seven times higher than the rates for Hispanics (16 per 100,000) and Whites (11 per 100,000).

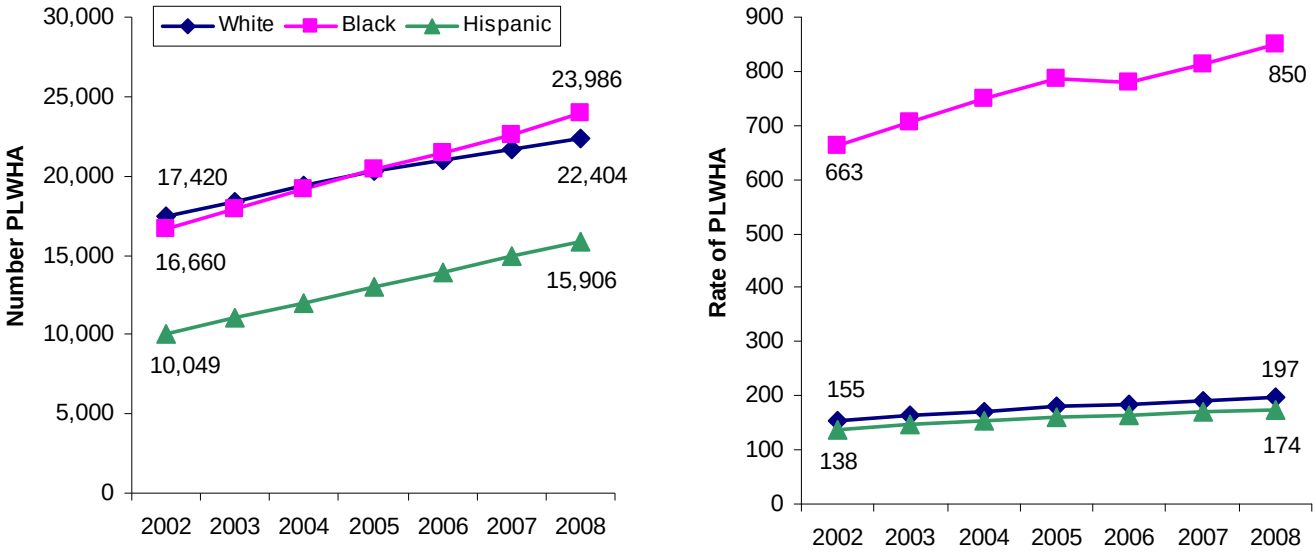
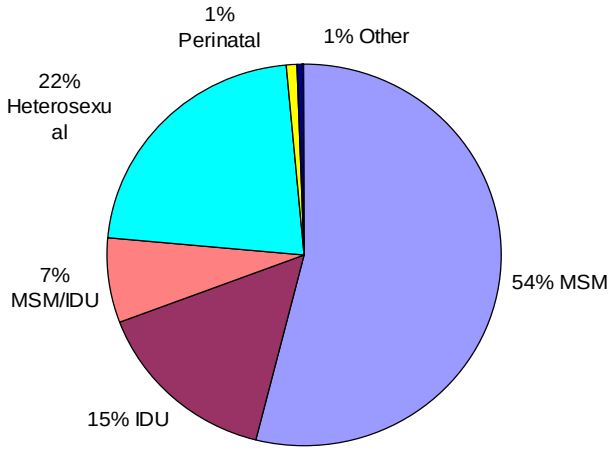


Figure 3. Numbers and Rates (per 100,000) of Living HIV/AIDS Cases by Race/Ethnicity, Texas 2008

Figure 4. Persons Living With HIV/AIDS by Mode of Exposure, Texas



The mode of exposure is the most likely way that someone became infected with HIV based on the risks found for the case. Estimates of population sizes for exposure groups are being developed, but are not ready for use at this time. Therefore, case rates were not examined. Instead, the proportion of cases due to each mode of exposure was examined. The most common exposure groups were MSM (54%), IDU (15%), and heterosexuals (22%) (Figure 4). MSM/IDU refers to cases among men who report both sex with men and injection drug use. In Texas, a small proportion of cases were due to other causes such as transfusions and perinatal (mother-to-child) transmissions (1%). While the number of PLWHA increased over the past five years in all major exposure categories, the relative proportions of living cases for each mode of exposure did not change substantially. In 2008, MSM accounted for half of the people living with HIV/AIDS. The proportion of PLWHA that were exposed through heterosexual sex increased from 20% in 2002 to 22% in 2008; the proportion of IDU and MSM/IDU cases each dropped about one percentage point, respectively.

Over half of people living with HIV/AIDS were in the Dallas and Houston areas.

The profiles of PLWHA in geographic areas of Texas are shown in Table 3. Within these geographic areas, some groups show extreme burdens of HIV/AIDS. More than one in 100 Black persons in Houston are living with HIV/AIDS. When subpopulations are considered, even more profound impacts can be seen. For example, one out of 27 Black men aged 35 – 44 in Houston and one out of 32 black men in Dallas were living with HIV/AIDS in 2007. More details on subpopulations with greater than 1% prevalence can be found in the Table 3.

Many Texans first learn their HIV+ status years after the infection occurs.

Once infected with HIV, people typically have five to ten years without symptoms before they progress to AIDS. Early HIV/AIDS diagnosis allows HIV infected people to benefit from life-saving medication and treatment. Additionally, early testing is critical in preventing the further spread of HIV/AIDS. Those unaware of their status are more likely to transmit the disease to others, resulting in missed opportunities for the prevention of new HIV infections. Diagnosis of AIDS within a short time period from HIV diagnosis (concurrent diagnosis) is associated with poorer prognosis and decreased long-term survival. From 2003 through 2007, over one third of all new diagnoses in Texas received an AIDS diagnosis within one year of their HIV diagnosis (Figure 2.8). A larger proportion of males than females received HIV and AIDS diagnosis within one year of each other. The Hispanic population had a larger proportion of concurrent diagnosis (43%) than the White (32%) of Black (33%) populations. After the age of 12, the percent of concurrent diagnosis increases steadily from 20% among 13-24 year olds to 52% among those 55 years or older. These numbers demonstrate that a substantial proportion of current PLWHA were not diagnosed until late in the progression of the HIV disease.

Table 3. Select Characteristics of Persons Living with HIV/AIDS in Texas by Area, 2008

	Statewide		Austin EMA		Dallas EMA		Fort Worth EMA		Houston EMA		San Antonio EMA		East Texas		U.S.-Mexico Border	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Total	63,019	258.4	4,268	264.9	15,309	357.2	3,950	191.6	19,777	391.4	4,372	234.7	3,772	147.3	3,453	136.8
Status																
HIV	26,827	110.0	1,692	105.0	6,692	156.2	1,734	84.1	8,375	165.7	1,648	88.5	1,551	60.6	1,352	53.6
AIDS	36,191	148.4	2,576	159.9	8,618	201.1	2,216	107.5	11,402	225.6	2,724	146.3	2,221	86.7	2,100	83.2
Sex																
Male	49,224	402.8	3,602	434.9	12,452	576.9	2,996	289.4	14,554	573.3	3,684	403.3	2,546	197.1	2,855	230.5
Female	13,795	113.4	666	85.1	2,857	134.3	954	92.9	5,223	207.7	688	72.5	1,225	96.5	598	46.5
Race/Ethnicity																
White	22,405	196.8	2,119	236.5	6,754	307.7	1,798	154.1	5,645	291.3	1,302	196.8	1,596	97.3	359	133.4
Black	23,986	850.4	1,011	798.0	5,775	937.4	1,495	621.0	9,654	1113.6	638	477.9	1,787	397.3	111	386.6
Hispanic	15,906	174.2	1,086	212.8	2,561	209.0	597	111.5	4,225	224.6	2,383	235.6	364	87.6	2,969	135.2
Other^	722	68.9	51	65.5	219	88.0	60	50.6	253	68.8	50	89.2	25	44.7	14	46.1
Age Group																
under 2	24	3.0	1	2.1	3	2.2	3	4.6	6	3.6	1	1.7	3	4.2	.	
2-12	242	6.2	12	5.1	37	5.4	29	8.9	97	11.8	15	5.1	21	5.7	18	3.7
13 - 24	2,787	64.5	161	58.0	645	92.3	184	50.9	952	108.5	191	56.1	207	46.4	157	31.3
25 - 34	11,172	301.2	697	246.6	2,615	391.4	635	198.6	3,695	450.9	734	265.1	754	223.1	642	176.6
35 - 44	20,788	575.9	1,462	530.6	5,197	675.0	1,251	389.9	6,382	794.2	1,427	556.2	1,115	345.6	1,169	358.6
45 - 54	19,845	593.9	1,416	610.7	4,937	800.7	1,295	445.1	5,925	834.6	1,424	559.3	1,148	312.5	1,030	361.6
55+	8,162	173.0	520	198.2	1,875	264.3	553	146.8	2,719	317.2	580	152.8	523	81.1	436	97.0
Mode of Exposure*	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
MSM	33,914	53.8	2,704	63.4	10,367	67.7	1,977	50.1	9,921	50.2	2,863	65.5	1,555	41.2	2,035	58.9
IDU	9,631	15.3	525	12.3	1,294	8.5	756	18.8	2,490	12.6	524	12.0	637	16.9	401	11.6
MSM/IDU	4,516	7.2	364	8.5	742	4.8	298	7.4	1,164	5.9	224	5.1	291	7.7	170	4.9
Heterosexual	14,066	22.3	630	14.8	2,752	18.0	828	20.6	5,888	29.8	711	16.3	1,206	32.0	786	22.8
Perinatal	530	0.8	33	0.8	102	0.7	61	1.5	255	1.3	29	0.7	54	1.4	39	1.1
Other	363	0.6	12	0.3	52	0.3	30	0.7	59	0.3	20	0.5	29	0.8	22	0.6

Note: All rates are calculated based on the number of cases per 100,000 in the population.

* Small numbers of unknown race/ethnicity and age have been excluded. Category totals will not match.

^Rates are not calculated because there are no good estimates of population sizes for behavioral risk groups. Proportions are shown instead.

EMA/TGA are major metropolitan areas (multi-county) that meet certain thresholds of reported AIDS cases defined by the U.S. Health Resources and Services Administration.

2008 Estimates of Unmet Need for HIV-Related Medical Care in Texas

In order to prevent progression to AIDS and death, and to reduce the chances of transmission to an uninfected partner, persons with HIV require access to medical care and treatment. This includes monitoring of their body's immunological response to the infections (e.g., viral load and CD4 t-lymphocite level testing) and uninterrupted access to appropriate, maximimally-suppressive therapy. Each year, DSHS is required to estimate the numbers and proportions of PLWH with unmet need for HIV-related care. CD4 counts, viral load tests, and antiretroviral therapy are standard tests and treatments typically administered to HIV/AIDS patients. If there was evidence of one of these three things, the person was considered to have had their medical needs met. If there was no evidence of access to any of these services, it is unlikely that the person was consistently involved in a system of medical care that adheres to current care standards.

Estimates of unmet need included in this report do not include HIV-related care provided by the Veteran's Administration, Medicare, TDCJ, and all private providers. In addition, matches conducted between some data sources were based on a unique identifier or limited data elements rather than client name, which may underestimate the true number of clients with met need from these data sources. Additionally, the number of living cases reported in this section will not exactly match figures for cases given in the epidemiologic profile earlier in this report. This is because unmet need figures were not adjusted for reporting delay and exclude cases diagnosed in TDCJ. While the reporting delay adjustments give a more exact estimate and profile of living cases, the data needed to create unmet need estimates required use of unadjusted data.

Overview of Unmet Need in Texas, 2008

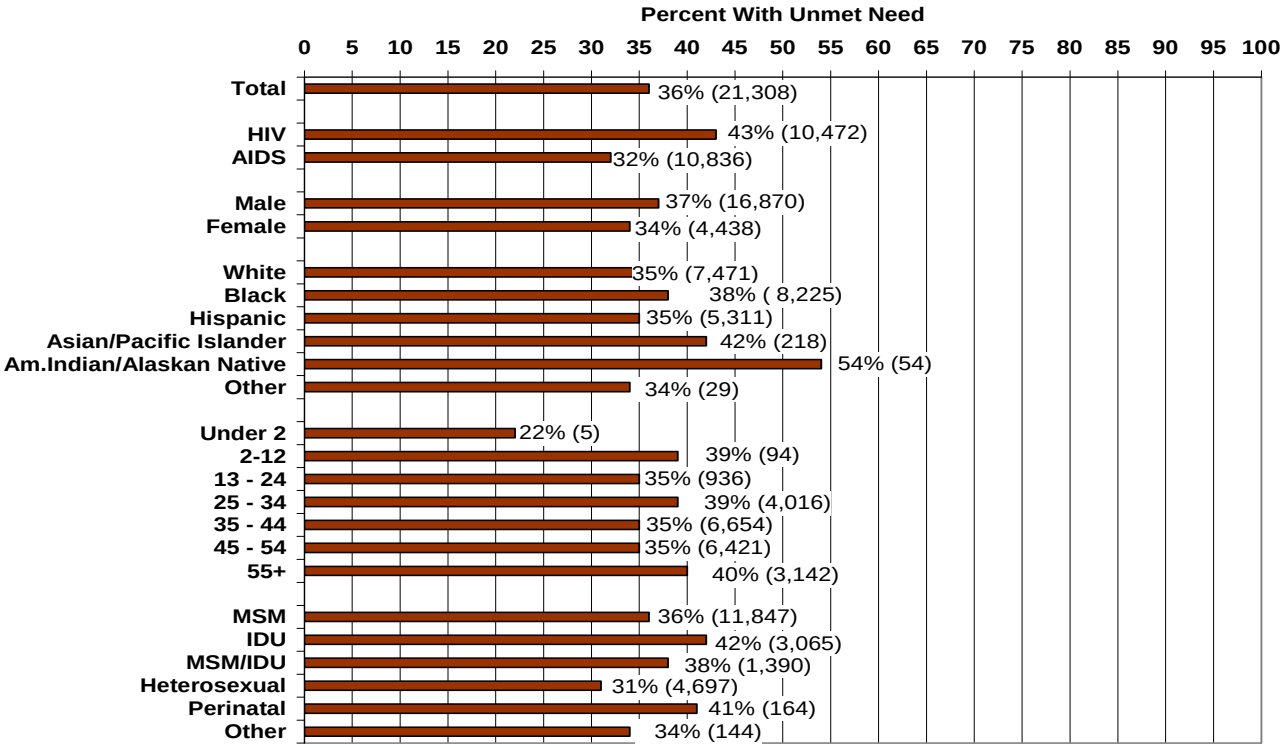
This section includes a discussion of both the number and proportion of each group with unmet need for medical care. ***In 2008, 36% (21,308) of PLWHA had no evidence of medical care.*** Overall, the patterns of unmet need are very similar to those observed in the past. Table 3 shows the number and proportion of persons living with HIV/AIDS who were out of care by disease, demographic and mode of exposure characteristics.

Although there is a small difference in unmet need between men and women (37% and 34%, respectively), men encompassed 79% of individuals out of care. A greater number of men were out of care when compared to women (16,870 males compared to 4,438 females).

Thirty-eight percent of Blacks were out of care compared to Whites (35%) and Hispanics (35%). Although a greater proportion of Asian/Pacific Islanders and American Indian/Alaskan Natives exhibited unmet need for medical care, it is important to consider that they represent less than two percent of PLWHA out of care. Persons between the ages of 35 and 54 made of 62% of those with unmet need although those in younger and older age groups showed greater proportions out of care.

In terms of mode of exposure, MSM made up the majority of persons with unmet need, although injection drug users show greater proportions out of care.

Table 4. Number and Proportion of PLWHA with Unmet Need for Medical Care, 2008



Overall, the patterns of unmet need are very similar to those observed in the past. Each area of Texas has developed community based plans to address barriers to care and to promote participation in HIV-related medical care and adherence to medications. However, the systems and providers who serve persons with HIV infection have been challenged by the increases in: numbers of Texans living with HIV, enrollment in public programs due to unemployment, cost of treatment, and relatively flat or declining availability of funding. As demand and need for these programs rises, we are likely to see future increases in unmet need for treatment despite the best efforts of the programs to enhance access to care.

Appendix B. Epidemiology of Viral Hepatitis

Cases of infection with hepatitis A virus (HAV) in Texas have drastically declined since the availability of vaccine in 1995. The incidence of HAV has dropped from 12.6 cases per 100,000 population in 1990 to 0.7 cases per 100,000 population in 2009.

Acute HBV incidence has declined 82% nationwide, from 8.5 cases per 100,000 population in 1990 to 1.5 cases per 100,000 population in 2007, the lowest rate recorded in the United States. Declines occurred among all age groups but were greatest among children under 15 years. Texas has also experienced a decline in acute HBV from a high of 23.3 cases per 100,000 population in 1997 to 1.7 cases per 100,000 population in 2009.

Universal vaccination of children against HBV, beginning in 1991, has reduced disease incidence substantially among younger age groups. Higher rates of acute HBV continue among adults, particularly among males aged 30–44 years, reflecting the need to vaccinate adults at risk for HBV infection.

In 2006, DSHS estimated that chronic viral hepatitis affects 409,400 Texans.

Approximately 800,000–1.4 million U.S. residents are living with chronic HBV infection. It is the underlying cause of an estimated 3,000 deaths each year in the United States. Approximately 800 to 1,200 infants are born to HBV surface antigen (HBsAg) positive women in Texas annually, based on estimates provided from the National Health and Examination Survey (NHANES). Of the estimated cases, 523 were reported in 2008 and those cases resulted in eight infants becoming infected with HBV.

In the US, the estimated prevalence of chronic HCV is between 0.87 and 1.3 cases per 100,000 population (2.7 million -3.9 million)[13]. In Texas this represents 217,500-325,000 cases. There are three times as many people infected with HCV as with HIV, making it the most common blood-borne pathogen in the United States.

[13] Institute of Medicine, *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C* (Washington, DC: The National Academies Press, 2010), p. 24.

Appendix C. HIV Prevention and Treatment Resources in Texas

Introduction to the Resource Information on HIV, AIDS and Hepatitis

Pursuant to House Bill 1370 of the 80th Texas Legislative Session, the Council must compile a complete inventory of all federal, state and local money spent in Texas on HIV infection, AIDS, and hepatitis prevention and healthcare services. This includes services provided through or covered under Medicaid and Medicare. Conducting a comprehensive account of resources presents many issues in achieving a complete and accurate account of monies directed toward HIV, AIDS and hepatitis efforts. Even though the Council strives to report the most recent information, the budget tables are a "snapshot" of reported resources. Additionally, the information below only contains budget and activities reported to the Council by other state programs and agencies.

Federal, State and Local Funds Spent on HIV Prevention and Care

This section contains a compilation of federal, state and local money spent on HIV prevention and care services reported to the Council. Members of the Council were asked for their expenditures associated with HIV in the previous year. Within DSHS, the Council focused on major funding streams that provided support for HIV prevention and treatment. It should be understood that while general health, women's health, and family planning programs provide access to HIV prevention services, these are not easily separated from their integrated services. The complete list of local funds is unavailable for this report and will require more thorough canvassing of local health departments. Medicare, Veterans Administration expenditures and non-Medicaid indigent care efforts are not captured here. Finally, this summary does not include state and federal resources associated with inpatient hospitalizations. Sources of data on inpatient billings were not segregated by source of payment. Absence of inpatient charges deflates treatment and care figures, however, studies of costs of care attribute less than 10% of the lifetime cost of care for a HIV-infected person to inpatient hospitalization. The following tables provide summaries of the estimated federal, local and state funds currently appropriated, awarded and/or spent on HIV prevention and care services in Texas.

Table 5. Summary of HIV/AIDS Prevention and Treatment Resources

Type of Funds	Service Description	Amount
HIV/AIDS Treatment and Care Services	This amount includes federal and state funding for outpatient medical and support services including Medicaid. It does not reflect local funds devoted to indigent care, inpatient care, care paid for by Veterans' Administration or Medicare, or care delivered in correctional settings.	**$287,691,532**
HIV/AIDS Prevention	This amount includes federal and state funding through a variety of delivery mechanisms at the state and local level. (An additional $3.6 million supporting integrated substance abuse, HIV, and hepatitis prevention efforts are included in the hepatitis prevention summary.)	**$48,355,789**
Total		**$336,047,321**

Funding Resources for HIV/AIDS Care and Treatment Services in Texas

Table 6 summarizes major federal and state funding streams for HIV care and treatment. All figures represent 12 month periods, but the actual months covered vary from source to source as detailed in the footnotes. Table 6 also shows the source of funds, a description of services provided by the funds, and reported annualized amounts. Immediately following the table are full descriptions of the different programs providing HIV/AIDS care and treatment services in Texas.

Table 6. Funding Resources for HIV/AIDS Care and Treatment in Texas

Type of Funds	Service Description	Amount
Ryan White Program (Part A through F) (Federal[14])	Provides medical and supportive services for persons with HIV including the AIDS Drug Assistance Program (ADAP); also includes program administrative figures.	$150,165,202
Medicaid (Federal and State) [15]	Provides outpatient medical services and HIV-related drugs from Medicaid programs.	$63,714,798
State Appropriated Funds (State) [16]	Provides direct medical and supportive services for persons with HIV; includes funds for drugs purchased through the ADAP.	$51,565,521
Housing Opportunities for People with AIDS (HOPWA) (Federal) [17]	Provides tenant-based and emergency housing assistance for persons living with HIV/AIDS and their families. These funds are federal and come both to the state and directly to local communities.	$17,896,011
Substance Abuse and Mental Health Service Agency (SAMHSA) (Federal) [18]	Direct to community based organizations. Provides case management services for HIV-positive individuals. Some portion of these funds is also spent on testing	$4,350,000
Total		**$287,691,532**

Ryan White Program

The Ryan White Program (authorized by the HIV/AIDS Treatment Modernization Act of 2006) provides funding for medical and supportive services to PLWHA. The majority of these monies require that at least 75% of funds be spent on core medical services. Part A

[8]Source of data: Federal Fiscal Year 2010 data was the most current information available from the HRSA website for total Ryan White funding. http://granteefind.hrsa.gov/searchbystate.aspx?select=TX&index=51&year=2010 Retrieved May 5, 2010

[15] Source of data: Outpatient Medicaid data compiled for unmet need and Women Infant Children & Youth (WICY) reports for Federal Fiscal Year 2009 (10/1/08-9/30/09).

[16] Source of data: DSHS general revenue estimated expenditures for State Fiscal Year 2010 (9/1/09-8/31/10).

[17] Source of Data: Housing and Urban Development (HUD) website reported data of Housing Opportunities for People with AIDS (HOPWA) funds allocated as for Federal Fiscal Year 2010. (http://www.hud.gov/offices/cpd/about/budget/budget09/index.cfm)

[18] Source of Data: Substance Abuse and Mental Health Services Administration (SAMSHA) website reported the most current data available from funds allocated in state fiscal year 2009. (http://www.samhsa.gov/Statesummaries/detail/2009/TX.aspx)

funds go to metropolitan areas that meet certain thresholds of reported AIDS cases. Part B funds go to the state (through DSHS) to provide medical and support services for person living with or affected by HIV and AIDS. Part B also provides funds for the AIDS Drugs Assistance Program, which provides HIV medications to low income Texans with no or inadequate insurance. Part C grants go directly to clinics and support HIV clinical early intervention services. Part D grants go directly to local communities to provide family-centered treatment and support services for women, infants, children and youth. Part F grants fund Special Projects of National Significance, AIDS Education Training Centers, dental programs and the Minority AIDS Initiative (MAI).

Medicaid

Medicaid is the state and federal cooperative venture that provides medical coverage to eligible needy persons. Medicaid serves primarily low income families, non-disabled children, related caretakers or dependent children, pregnant women, elderly and people with disabilities.

State Revenue for Direct Client HIV Care and Treatment Services

State Revenue funds are distributed through DSHS to local communities for medical care and services such as transportation, case management, food and housing. These funds also purchase medications through ADAP to provide HIV medications to low income Texans with inadequate or no insurance.

Housing Opportunity for Persons with AIDS (HOPWA)

The HOPWA program provides housing assistance and supportive services to income-eligible PLWHA and their families. The purpose of this program is to establish or better maintain a stable living environment in decent, safe and sanitary housing, to reduce the risk of homelessness and to improve access to healthcare and support services.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA provides Texas with funding to provide case management services for PLWHA at substance abuse treatment facilities.

Funding Resources for HIV Prevention in Texas

The following table summarizes the major state and federal funding streams for HIV prevention. All figures represent 12 month periods, but the actual months covered vary from source to source, as detailed in the footnotes. This does not reflect local expenditures on prevention. The table shows the source of funds, types of services provided by the funds and the reported annualized amounts.

Table 7. Funding Resources for HIV Prevention in Texas

Type of Funds	Service Description	Amount
Centers for Disease Control and Prevention (CDC) Cooperative Agreements (Federal)[19]	Provides counseling, testing and referral, partner services, and evidence-based risk reduction interventions primarily for those at high risk. Supports limited routine HIV testing in medical care settings. [20] Funding comes through DSHS and City of Houston and directly to local agencies.	$24,621,391
CDC (portion of Comprehensive STD Prevention Systems)[21]	Provides public health follow up for the purpose of rapidly locating and referring high-risk individuals to medical examination, treatment (treatment), counseling and risk reduction.	$6,876,148
State Appropriated Funds [22]	Provides counseling, testing and referral, partner services and evidence-based risk reduction interventions primarily for those at high risk. Supports limited routine HIV testing in medical care settings. Funding comes through DSHS HIV/TB/STD and MHSA.	$4,800,125
SAMHSA funds (Federal) [23]	Provides counseling, testing and referral, outreach and education, integrated substance abuse, HIV and hepatitis prevention efforts. Funding comes from SAMHSA directly to local agencies.	$3,682,996
SAMHSA (State) pass through funds[24]	Provides counseling, testing and referral, education and case management. Funding comes through DSHS and directly to local agencies.	$6,799,375
Title X Integration Project for HIV (Federal) [25]	Provides for integration of HIV testing for adults, adolescents and pregnant women in family planning clinics. Funding comes through DSHS.	$1,118,000
Title XX HIV Testing (Federal) [26]	Provides HIV testing for adults, adolescents and pregnant women in family planning clinics. Funding comes through DSHS.	$457,754
Total		**$48,355,789**

HIV prevention in Texas is primarily focused on testing, brief individual counseling and behavioral interventions with evidence of effectiveness in reducing HIV risk behaviors. These behavioral interventions are delivered to individuals, in groups or communities.

[19] Source of Data: Federal fiscal year 2010 grant awards to DSHS for Texas HIV Prevention Services. (CDC direct funded monies, HIV Prevention Projects; the Expanded Testing Grant, HIV Prevention Training Centers and the Funding Summary for Houston Department of Health and Human Services Bureau of HIV/STD.

[20] Rider 82, 2010-11 General Appropriations Act (Senate Bill 1, 81st Legislature, Regular Session, 2009) mandated that DSHS use $4.4 million from appropriated funds (federal and GR) for routine HIV testing. No new GR were funds appropriated. Both GR and federal funds are used to meet requirements.

[21] Source of Data: DSHS federal grant awards for federal fiscal year 2010 for HIV prevention services (STD Prevention Program Fund, STD/HIV Prevention Training Fund, and the HIV Training Fund)

[22] Source of data: DSHS HIV prevention expenditures estimated for state fiscal year 2010.

[23] Source of data: SAMSHA Report of federal funds dedicated to HIV prevention for state fiscal year 2009.

[24] Source of data: DSHS federal funds from SAMSHA Block Grant reports based on the state fiscal year 2009 and used for HIV prevention services.

[25] Source of data: Title X HIV Integration Spreadsheet itemizing federal funds expended on HIV prevention services for the federal fiscal year 2009 (9/1/08 – 8/31/09).

[26] Source of data: Title XX Federal Block Grant for federal fiscal year 2009 (which runs congruent to the state fiscal year 2008) with HIV testing expenditures isolated (9/1/08 – 8/31/09).

The interventions are designed to modify knowledge, attitudes, beliefs, self-efficacy and emotional well being while reducing risk-taking behaviors.[27]

Partner Services

Partner services are essential public health activities. They are recognized by CDC as one of the Eleven Elements of Successful Prevention Programs. Based on statewide guidelines, the highest priority for partner services is for early syphilis cases and newly identified HIV-positive cases. Next in priority are HIV positives with continued high-risk behavior and latent syphilis cases of unknown duration. The lowest priority is given to gonorrhea and chlamydia prevention.

Partner services begin when the disease intervention specialist (DIS) receives a report of an infected client through the public health surveillance system. The DIS locates and notifies the infected individuals of their health status. The DIS then conducts partner elicitation, refers the patient to additional medical and social services, provides counseling on methods to reduce the risk of acquiring or transmitting STDs and HIV in the future and conducts partner notification. Through field investigation, the DIS locates and refers named partners for examination, treatment and/or counseling. This cycle continues with identification of each infected partner.

DSHS funds disease intervention activities through its regional programs and through contracts with local health departments. In FY 2010, eight city and county health departments received funds to carry out these duties in Texas. Those departments are Austin/Travis County Health and Human Services Department, Corpus Christi-Nueces County Public Health District, City of El Paso Department of Public Health, Tarrant County Public Health, Galveston County Health District, San Antonio Metropolitan Health District, Houston Department of Health and Human Services and Dallas County Department of Health and Human Services (Table 8[28]).

Table 8. Local Health Departments funded to conduct Partner Services

Name of Contractor	FY 2010 Contract Total
Dallas County	$2,094,088
Houston	$1,644,701
Tarrant County	$575,240
Austin/Travis County	$373,259
San Antonio Metro	$540,176
Corpus Christi	$52,187
El Paso	$172,836
Galveston	$196,249
TOTAL	**$5,648,736**

[27] Texas Department of State Health Services. (2006) *HIV/STD Program Annual Report 2006.* Austin, Texas

[28] Source of data: Base funding amount awarded to these local health departments in FY 2010 contracts.

Appendix D. Funding Resources for Hepatitis Prevention and Treatment Services

Table 9 below provides a summary of estimated federal, local and state funds currently appropriated, awarded and/or spent on hepatitis prevention and care services in Texas. It does not include Medicare or Veterans Administration expenditures, nor does it include full accounting for local funds for outpatient care. It does not include expenditures made in correctional facilities, as these were not possible to disaggregate from all healthcare expenditures made in these facilities.

Table 9. Summary of Hepatitis Prevention and Treatment Resources in Texas

Type of Funds	Service Description	Amount
Hepatitis Treatment and Care Services	Hepatitis Medicaid expenditures for outpatient care and outpatient hospital expenditures.	**$24,567,367**
Hepatitis Prevention	CDC funding for viral hepatitis coordination given to DSHS and the City of Houston. Local funds from the City of Houston. SAMHSA funding for hepatitis prevention services The majority of these funds (over $3 million) are not dedicated solely to hepatitis prevention; they support integrated substance abuse, HIV and hepatitis prevention efforts. They are included here rather than in HIV funding because they are almost the only funding with a grant focus that includes hepatitis prevention. CDC funding for hepatitis A and B immunizations.	**$4,893,100**
Total		**$29,460,467**

Funding Resources for Hepatitis Care and Treatment Services

There is fragmented information on how individuals receive their care for chronic hepatitis unless they are Medicaid recipients. The true extent of caring for those individuals with acute or chronic viral hepatitis is an area that needs further study.

Table 10. Funding Resources for Hepatitis Related Care and Treatment in Texas

Type of Funds	Service Description	Amount

Medicaid (Federal and State)	Provides outpatient medical services and hepatitis-related drugs from Medicaid programs.	**$24,567,367**[29]

Most people infected as adults recover fully from hepatitis B, even if their signs and symptoms are severe. Hepatitis B infected persons should be evaluated by a physician for liver disease. Treatment of chronic hepatitis includes use of antiviral medication including interferon, lamivudine, entecavir, telbivudine and Adefovir dipivoxil. Liver transplant is also an option if liver damage is severe.[30] Further study is needed of the health service delivery systems throughout Texas to understand how services are provided to individuals living with chronic viral hepatitis.

Funding Resources for Hepatitis Prevention

Table 11. Funding Resources for Hepatitis Prevention in Texas

Type of Funds	Service Description	Amount
CDC (Federal)	Funds support viral hepatitis coordination activities at state and local level. Funds go to DSHS.	$90,529 [31]
	Funds support viral hepatitis coordination activities at state and local level. Funds go to the City of Houston.	$87,485 [32]
City of Houston (Local)	Funds support testing, counseling, and referral services as well as outreach and educational activities.	$100,000 [33]
SAMHSA (Federal)	These funds are not dedicated solely to hepatitis prevention; they support integrated substance abuse, HIV and hepatitis prevention efforts. They are included here rather than in HIV funding because they are almost the only funding with a grant focus that includes hepatitis prevention. Funds support outreach and educational activities and testing, counseling, and referral services. Funds go directly to local communities.	$2,543,220[34]
CDC (Federal)	These funds include adult hepatitis B and hepatitis A/B vaccine administered through DSHS immunization sites.	$2,071,866 [35]
Total		**$4,893,100**

Prevention Efforts for HAV

[29] For FY 2009 (10/1/08-9/30/09), the Medicaid products that are included in this number are: STAR+PLUS, STAR, FFS-PCCM, Vendor Drug and CHIP.
[30] Texas Department of State Health Services. *The ABC's of Viral Hepatitis.* Retrieved July 1, 2008 from http://www.dshs.state.tx.us/idcu/disease/hepatitis/resources/hepabc.pdf
[31] NGA from the CDC for 2010 (11/1/09 – 10/31/10). Issue date 10/26/09
[32] Reported by the City of Houston Health and Human Resources for FY 2009 (11/1/09 – 10/31/10).
[33] Reported by the City of Houston Health and Human Resources for FY 2010 (7/1/10 – 6/30/11).
[34] SAMSHA Report of federal funds dedicated to HIV prevention for state fiscal year 2009 (9/1/09 – 8/31/10). http://www.samhsa.gov/Statesummaries/detail/2009/TX.aspx Retrieved 4/22/10
[35] Reported from DSHS Immunization Program for FY 2009 (1/1/09 – 12/31/09), 6/11/10.

Texas students in pre-kindergarten and child care facilities are required to have Hepatitis A immunizations in all counties. In 40 Texas counties, kindergarten through third grade, students are required to have the HAV vaccine for school entry. DSHS provides the HAV vaccine for adults through DSHS Health Service Regions, local health departments, Texas Youth Commission State School and other providers. DSHS' effort to provide HAV vaccine through regional health departments, local health departments and other agencies is part of a safety net of vaccines for adults at high risk, uninsured or underinsured.[36]

HBV Vaccination of Children

The best method of preventing infection from hepatitis B is vaccination. DSHS operates the Texas Vaccines for Children (TVFC) Program through participation in the Federal Vaccines for Children Program (VFC) initiated through the Omnibus Reconciliation Act of 1993. Currently, there are over 6000 providers enrolled in the program. Vaccine is provided to enrolled TVFC providers at no cost. The provider may not charge for the vaccine itself but is permitted to charge a reasonable administration fee. HBV is a required immunization for a student prior to entry, attendance, or transfer to a child-care facility or public, or private elementary or secondary school in Texas. The three-dose vaccination series for HBV is recommended at birth, one month and after six months. If the mother has HBV, HBV immune globulin (HBIG) is also administered with the vaccine.[37]

According to the 2007 National Immunization Survey, a random telephone survey conducted by the CDC, 91.7% of Texas children have received three doses of HBV vaccine by 35 months of age. The Healthy People 2010 goal is 90%[38].

Adult HBV Vaccination

Hepatitis B can be spread through having unprotected sex, sharing needles and syringes, having contact with blood or open sores, sharing razors, toothbrushes and washcloths, and using unsterilized needles in body piercing/tattoos. Although school-age children are required to be vaccinated, adults are not unless they are in health-related courses with direct patient contact in institutions of higher education. The highest rate of disease occurs in those 20-49 years old. The Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilitates providing drug abuse treatment and prevention services; healthcare settings targeting services to IDUs or MSM; correction facilities; end-stage renal disease

[36] Texas Department of State Health Services. (2008). *Adult and Adolescent Immunization Information*. Retrieved July 1, 2008 from http://www.dshs.state.tx.us/immunize/adult.shtm

[37] Texas Department of State Health Services. (2007) Texas Vaccines for Children Fact Sheet. Retrieved July 1, 2008 from http://www.dshs.state.tx.us/immunize/tvfc/default.shtm .

[38] U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000, Chapter 14. Immunizations and Infectious Diseases, p. 14-37

programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilitates for persons with developmental disabilities.[39]

Some students enrolled in higher education are required to either complete a three-dose series of Hepatitis B vaccine or show evidence of immunity prior to the start of direct patient care. This applies to all medical interns, residents, fellows, nursing students, and others who are being trained in medical schools, hospitals, and health science centers and students attending two-year and four-year colleges whose course work involves direct patient contact regardless of the number of courses taken, number of hours taken and student classification. Vaccination must occur prior to any direct patient contact that may be part of the course of study. Also, students enrolled in schools of veterinary medicine whose coursework involves direct contact with animals or animal remains must receive a complete series of HBV vaccine prior to contact. HBV vaccine is available through local health departments as part of a safety net for students who are uninsured or underinsured.

Effective August 27, 2007, public clinics in Texas provide HBV vaccine as part of the adult safety net for uninsured and underinsured adults. The LHD is also responsible for planning and implementing efforts to increase awareness of adult immunization recommendations. LHDs collaborate with DSHS health service regional staff and provide information and education on adult vaccination and vaccine preventable diseases to healthcare providers and the general public. They act as health subject matter experts for providers regarding vaccination schedules, high-risk groups, recommendations and disease prevention. Additionally, the LHDs often collaborate with community organizations, healthcare facilities, local employers and others to identify populations and individuals who need immunizations.

The DSHS Refugee Health Screening Program (RHSP) operates primarily with funds from the Office of Refugee and Resettlement in the U.S. Department of Health and Human Services Administration for Children and Families. The program supports local health departments in principal refugee resettlement areas with resources to provide health assessments to newly arrived official refugees. The program encourages screening and treatment for tuberculosis, immunization status, intestinal parasites, HBV, as well as identification, education and referral for other health problems. Three major settlement areas are Houston, Dallas and Fort Worth. Combined, these areas receive about 85% of all refugee arrivals to Texas. Smaller numbers of refugees also settle and are served in local programs in areas such as Amarillo, Austin, Abilene and San Antonio.

Perinatal HBV

Texas law requires that providers and hospitals screen all pregnant women for HBsAG at their first prenatal visit and at delivery. Perinatal HBV infections and all positive HBsAg mothers must be reported to DSHS (Texas Administrative Code Title 25, Part 1 Chapter 97, subchapter A, § 97.135 and 97.3)

[39] Centers for Disease Control and Prevention. (2007) *Hepatitis B: Fact Sheet.* Retrieved July 1, 2008 from http://www.cdc.gov/ncidod/diseases/Hepatitis/b/fact.htm

CDC estimates that there are up to 1,200 children born to HBsAg-positive women every year in Texas. The goal of DSHS' Perinatal Hepatitis B Prevention Program (PHBPP) is to identify these women so that the newborn can be treated at the time of birth. The program ensures that infants of any HBsAg-positive pregnant women receive HBV immune globulin (HBIG) and the HBV vaccine at birth and subsequently complete the HBV vaccine services and serological testing. Ninety percent of babies born to a positive mother will become chronic carriers of the disease if they do not receive this treatment at birth. Finally, the program identifies the mother's contacts and household members to provide immunization, serological testing and education services as needed.

Prevention Efforts for HCV

There is no vaccine to prevent against HCV infection. Prevention efforts rely on risk assessment, HCV testing, referrals to treatment for those with HCV and health education. Persons at risk for HCV may also participate in HIV prevention programming designed to reduce health risks associated with injection drug use. Grants provided through SAMHSA directly to communities throughout Texas focus on prevention of blood-borne diseases such as hepatitis and HIV. These grants support a wide variety of prevention services which range from health education or outreach services to prevention skills building in substance abuse treatment facilities. SAMHSA funds prevention services through block grants received by the DSHS Community Mental Health and Substance Abuse Program. These funds promote prevention of HIV and other communicable disease with particular focus on hepatitis and especially HCV.

DSHS supports a limited and highly targeted HCV testing through 11 HIV testing contractors. Programs are selected based on the number of injection drug users identified through their HIV testing efforts. These programs use a counseling protocol that includes assessment of HCV risk. When warranted, HCV testing is offered. Each program must establish referral networks for HCV assessment and treatment, HBV and HAV immunization, drug and alcohol treatment and substance use counseling. Availability of treatment varies and is often dependent on the local indigent healthcare system. Those who are not eligible for indigent care or who have no access to such care may go without treatment for chronic HCV. However, even if care is problematic, individuals with HCV can benefit from health education. Benefits include factors that can aggravate the effects of HCV infection and increase the chances of developing liver disease, and counseling to support adoption of behaviors that reduce the risk of transmitting hepatitis to others.

Appendix E. Council Members and Participating Agency Profiles

On September 1, 2007 House Bill 1370 took effect, re-creating the Interagency Coordinating Council for HIV and Hepatitis (Council). The legislation outlines the required representation and leadership of the Council, the opportunity for public input, and levels of expected participation. HHSC is charged with providing administrative support to the Council and its representative on the Council serves as chairperson. Each agency included in HB 1370 is represented on the Council by an appointee named by the executive director or commissioner of the agency. The agencies and representatives are listed as follows:

Agency Name	Agency Contact
Texas Health and Human Services Commission	Tom Valentine, Chair
Board of Dental Examiners	Lisa Hoyt
Texas Board of Nursing	Denise Benbow
Department of Aging and Disability Services	Don Henderson
Department of Assistive and Rehabilitative Services	Jan Skinner
Department of Family and Protective Services	Dr. James Rogers
Texas Department of State Health Services	Ann Robbins
Texas Department of Criminal Justice	Dr. Kate Hendricks
Texas Education Agency	Onnalita Sutton
Texas Higher Education Coordinating Board	Donna Carlin
Texas Juvenile Probation Commission	Steve Spencer
Texas Medical Board	Leigh Hopper
Texas Workforce Commission	Catherine L. Bingle
Texas Youth Commission	Rajendra C. Parikh

The Council is required to facilitate communication and coordination among the member agencies concerning the agencies' programs for prevention and services related to HIV, AIDS and hepatitis. Further, the Council is required to:

- Identify statewide plans related to HIV, AIDS and hepatitis;
- Compile all federal, state, and local money spent on HIV and hepatitis prevention and care services in Texas, including Medicaid and Medicare;
- Identify areas in which state agencies interact on HIV and hepatitis issues and the policy issues that arise from this interaction;
- Assess gaps in prevention and health care services for HIV and hepatitis and develop strategies to address gaps through service coordination;

- Identify barriers to prevention services and health care services for HIV, AIDS and hepatitis faced by populations disproportionately affected by these illnesses;
- Identify the health care and service needs of persons living with HIV, AIDS or hepatitis and evaluate the level of service and quality of health care for these Texans compared to national standards; and
- Identify emerging issues related to HIV and hepatitis and their impact on the delivery of prevention and health care services.

By September 1 of each year, DSHS must file a report with the Legislature and the Governor. This report contains policy recommendations based on the information reported to the Council related to prevention of HIV and hepatitis and the delivery of health services to individuals living with HIV and hepatitis.

Agency Profiles

Each agency represented on the Council was surveyed regarding statistics and plans related to HIV/AIDS and hepatitis. Of the 14 agencies, only TDCJ, TYC and DSHS reported polices and programs that specifically address prevention and services for persons at risk for or living with HIV/AIDS or hepatitis.

Texas Health and Human Services (HHSC)

Originally created in 1991, HHSC oversees operations of the entire health and human services system in Texas; this system is composed of five agencies:

- Health and Human Service Commission (HHSC);
- Department of Aging and Disability Services (DADS);
- Department of State Health Services (DSHS);
- Department of Assistive and Rehabilitative Services (DARS); and
- Department of Family and Protective Services (DFPS).

HHSC provides administrative oversight of Texas health and human services programs, and direct administration of some programs, to include: Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families, Food Stamps and Nutritional Programs, Family Violence Services, Refugee Services, Disaster Assistance, Early Childhood Coordination, and Ombudsman Services. Expenditures of the Medicaid and CHIP programs are highlighted in this report. Though the direct services of HHSC are not targeted to individuals living with HIV/AIDS and hepatitis, HHSC services are available to these individuals who are otherwise eligible. HHSC oversees the activities of the DSHS, which does provide services directly targeted to populations at risk for HIV and hepatitis and PLWHA.

Texas Board of Dental Examiners

The mission of the Texas Board of Dental Examiners is to safeguard the dental health of Texans. This is done by developing and maintaining programs to ensure that only

qualified persons are licensed to provide dental care and ensure that violators of laws and rules regulating dentistry are sanctioned as appropriate. The Texas State Board of Dental Examiners does not target services to individuals at risk for or living with HIV/AIDS and hepatitis.

Texas Board of Nursing

The mission of the Texas Board of Nursing is to protect and promote the welfare of the people of Texas by ensuring that each person holding a license as a nurse in the State of Texas is competent to practice safely. This agency does not target services to individuals at risk for or living with HIV/AIDS and hepatitis.

Department of Aging and Disability (DADS)

The mission of DADS is to provide a comprehensive array of aging and disability services, support and opportunities that are easily accessed in local communities. DADS provides and contracts for long-term care and services and support to eligible older Texans and to children and adults with cognitive and physical disabilities. DADS regulates facilities and agencies and credentials staff working in these facilities and agencies. DADS does not target services to individuals at risk for or living with HIV/AIDS and hepatitis.

Department of Assistive and Rehabilitative Services (DARS)

The mission of DARS is to work in partnership with Texans with disabilities and families with children who have developmental delays to improve the quality of their lives and enable their full participation in society. Although the services of DARS are not specifically targeted to individuals at risk of or living with HIV/AIDS and hepatitis, DARS assists individuals with AIDS and chronic hepatitis who have been deemed severely disabled and are applying for Social Security Disability Insurance and/or Supplemental Security Income. Individuals experiencing significant functional limitations related to HIV/AIDS or hepatitis may also be eligible for DARS programs that provide assistance with achieving vocational and independent living goals.

Department of Family and Protective Services (DFPS)

The mission of DFPS is to protect children, and adults who are elderly or have a disability from abuse, neglect, and exploitation by working with clients, family and communities. The agency is charged with managing community based programs that prevent delinquency, abuse, neglect, and exploitation of Texas children, as well as elderly and disabled adults. The services of DFPS are not specifically targeted to individuals at risk for or living with HIV/AIDS and hepatitis.

Department of State Health Services (DSHS)

The mission of DSHS is to improve health and well-being in Texas. Especially relevant to the Council are DSHS responsibilities for HIV/AIDS and hepatitis. This includes surveillance and epidemiology, public education, vaccine distribution for prevention of HAV and HBV, coordination and funding of local DIS activities, hepatitis prevention and services associated with treatment and care for PLWHA, including the AIDS Drug Assistance Program (ADAP). Prevention and care services have both a physical and mental health emphasis, and acknowledge the role that substance abuse plays in disease transmission and acquisition and adherence to treatment. DSHS provides targeted services to people who are at risk for and those living with HIV/AIDS and hepatitis.

Texas Department of Criminal Justice (TDCJ)

The mission of the TDCJ is to provide public safety, promote positive change in offender behavior, reintegrate offenders into society and assist victims of crime. TDCJ manages offenders in state prisons, state jails and private correctional facilities that contract with TDCJ. The agency also provides funding and certain oversight of community supervision (previously known as adult probation) and is responsible for the supervision of offenders released from prison on parole or mandatory supervision. TDCJ provides medical care and prevention to people who are at risk for and living with HIV/AIDS and hepatitis within their context of the correctional facilities.

Texas Education Agency (TEA)

Establishing policy and providing leadership for the Texas public school system are the responsibilities of the State Board of Education (Board). Composed of 15 members elected from districts, the Board adopts rules and establishes policies that govern a wide range of educational programs and services provided by Texas public schools. The commissioner of education serves as chief executive officer of the Board and supervises the administration of Board rules through TEA. Together the Board, the commissioner, and TEA facilitate the operation of a vast public school system. TEA does not target services to individuals living with HIV/ AIDS and hepatitis. However, it does develop, with community input, the Texas Essential Knowledge and Skills for Health Education for grades K-12. Included in these curricula are guidelines for health information, health behaviors, personal and interpersonal skills. Also included are disease knowledge, health risks, health promotion and disease prevention.

Texas Higher Education Coordinating Board

The Texas Higher Education Coordinating Board provides leadership and coordination for the higher education system to achieve excellence in college education of Texas students. The services of the Higher Education Coordinating Board are not targeted to individuals at risk for or living with HIV/AIDS and hepatitis.

Texas Juvenile Probation Commission

The Texas Juvenile Probation Commission (Commission) works in partnership with local juvenile boards and juvenile probation departments. They support and enhance juvenile probation services throughout the state by providing funding, technical assistance, and training; establishing and enforcing standards; collecting, analyzing and disseminating information; and facilitating communications between state and local entities. The services of the Commission are not targeted to individuals at risk for or living with HIV/AIDS and hepatitis.

Texas Medical Board

The Texas Medical Board is a regulatory agency that serves and protects the public's welfare by ensuring licensed healthcare professionals are competent and provide quality patient health care, and by educating consumers regarding their rights in seeking quality health care. The Texas Medical Board does not target services to individuals at risk for or living with HIV/AIDS and hepatitis.

Texas Workforce Commission (TWC)

TWC is the state government agency charged with overseeing and providing workforce development services to the employers and job seekers of Texas. For employers, TWC offers recruiting, retention, training and retraining, and outplacement services, as well as information on labor and unemployment tax law, tax saving programs, and labor market planning. For job seekers, TWC offers career development information, job search resources, training programs, and administers the unemployment benefits program. Although the services of TWC are not targeted to individuals living with HIV/AIDS and hepatitis, these services are available for otherwise eligible individuals.

Texas Youth Commission (TYC)

TYC is the state's juvenile corrections agency. They operate juvenile correctional facilities and partner with communities to provide a safe and secure environment for youth. Youth in the agency's care receive individualized education, treatment, life skills and employment training and positive role models to facilitate successful community reintegration. TYC is responsible for the care, custody, rehabilitation, and reestablishment in society of Texas' most chronically delinquent or serious juvenile offenders. TYC administers servcies to people who are at risk for or living with HIV/ AIDS and hepatitis within the context of the correctional facilities.

Appendix F. Discussion of Prioritized Policy Recommendations

Ten policy recommendations were included in the initial 2008 Report to the Legislature. Below is a discussion of these Council recommendations.

Improve viral hepatitis surveillance.

Surveillance of disease is a core public health activity and provides needed information vital to reducing disease impact. Information gathered through disease surveillance is critical to identify successful public health interventions. Unfortunately, local and regional health departments lack the capacity to systematically investigate and establish cases as reportable acute infections. If systemic case-based surveillance cannot be established in Texas, then other sampling-based approaches hold some promise, but further study and discussion are needed. However, even these alternatives may require additional funding.

Address the fragmented nature of viral hepatitis prevention and treatment services.

The lack of core testing systems, prevention and care for viral hepatitis is a central and persistent concern of communities attempting to respond to viral hepatitis. Funding is often piecemeal or short-term, especially for treatment. DSHS provides HCV testing on a limited basis through identified HIV counseling and testing sites. Few federal resources are specifically dedicated to viral hepatitis prevention. Treatment resources, particularly for HCV, are rare. However, those patients are still faced with the prospect of large expenditures for physician care, specialty care, diagnostic testing and routine, ongoing laboratory work. Pharmaceutical companies have made hepatitis C medication available for free to some HIV patients with HCV. Individuals living with viral hepatitis who lack insurance coverage or the means to pay for care must piece together disjointed health services with a particular reliance on the local indigent care system. Many individuals who are unable to pay for costly treatment and either do not have indigent services available or do not qualify for those services, go without medical care for their chronic hepatitis.

Develop new prevention and treatment strategies that address the health disparities associated with HIV/AIDS and hepatitis infection, and increase access to existing prevention and treatment programs.

HIV and HCV have a disproportionate impact on racial/ethnic and sexual minorities. This vulnerability is often complicated by poverty and co-occurring conditions of mental

illness and substance abuse. The African American community has been particularly hard hit by HIV. A new and proven strategy to address health disparities associated with HIV/AIDS and viral hepatitis is needed to ensure prevention and treatment services are accessible and relevant to affected communities. Together with the Office of Elimination of Health Disparities at HHSC, agencies and programs represented on the Council can assist in research, education, policy change and community partnerships to reduce health disparity. Council agencies must explore ways to coordinate efforts to engage communities and constituencies. The effort to address health disparities requires scaling up prevention and treatment. This involves broad community participation and awareness, in conjunction with efforts to address other diseases with disparate impact and structures to promote early diagnosis and more participation in prevention and treatment for these groups.

Factors contributing to these health disparities are numerous and have been better established for HIV. Logically, the same factors contribute to disparities in disease burden for viral hepatitis. Only a few of these factors will be highlighted here. The U.S.-Mexico border presents unique challenges for promoting prevention and treatment services. Because communicable diseases can be spread across geographic borders, robust public health efforts in areas of Texas along the Mexico border help protect the health of Texans. Border populations cite the same service needs and barriers to care as for PLWHA in other areas of the state. Additionally language, poverty and fear about immigration status may act as barriers to seeking care. Higher poverty rates along the Texas-Mexico border create the need for increased social and supportive services for PLWHA. Immigrant populations, especially the undocumented, are unable to navigate the service system and have misperceptions of requirements such as paperwork, eligibility determination and identification. The impact of viral hepatitis along the Texas-Mexico border is unknown. Continued investigation is needed to the extent of which border populations are able to address prevention and health service needs.

Health literacy continues to be a challenge for populations such as the homeless, low educational attainment and those with substance abuse and mental health issues. These conditions may compromise their ability to understand and manage treatment adherence requirements. Also, if patients not fluent in English receive health information at medical visits translated by non-medical personnel, it may result in inaccurate or misleading information. In addition, some service providers may not have the capacity to translate technical language used to describe medical issues into culturally appropriate, understandable language, or provide health education to non-English speaking clients.

Stigma is a barrier to care for many PLWHA. It reduces awareness and use of prevention services by those at risk for infection. HIV service providers have noted client concerns of privacy when accessing services and fear of being identified as HIV positive. Other stigma related barriers are cited along the Texas-Mexico border. A fear of being reported to authorities for active drug use, fear of having children removed from the home, general distrust of the federal government and fear of deportation for having HIV or HCV creates a reluctance to seek testing and treatment.

Increase Hepatitis B immunization to avoid vaccine preventable infections for children and at-risk adults.

In Texas every child must be immunized for HBV unless a parent or guardian obtains an exemption. The need for HBV immunization among adults is not as well understood. Healthcare providers and others who work with populations who could benefit from greater access to HBV vaccinations for adults are often unsure of the local resources for this service. Students enrolled in health science programs at institutions of higher education providing direct patient care are also required to have received a three-shot series of the hepatitis B vaccination prior to providing patient care. Council agencies, decision makers and providers who serve vulnerable populations require a better understanding of how HBV immunization among adults might benefit their clients, communities, and current resources available. Further focus is needed on efforts to work together in order to expand access to HBV vaccination.

Increase earlier diagnosis of HIV infection by promoting routine testing for HIV in a variety of acute care settings in areas of Texas with high prevalence.

A substantial number of PLWHA in Texas are diagnosed late in the progression of HIV. Almost one quarter of all recent diagnoses in Texas received an AIDS diagnosis within one month of their HIV diagnosis, indicating that they have had undiagnosed HIV infection for a lengthy time. Late diagnosis is a particular concern in the Hispanic community. Nearly one third of Hispanics with HIV/AIDS had both diagnoses within one month compared to 22% of White and Black PLWHA. Research has shown that earlier diagnosis produces better health outcomes, reduces care costs and results in behavior changes that prevent further disease spread. For these reasons, the CDC recommends routine HIV testing in a variety of acute care settings.[40] Implementing these recommendations across a variety of healthcare providers, including community health centers and hospitals in higher morbidity areas, requires joint promotion of this issue as a priority. This will also include promoting the efforts of peer champions for this practice among healthcare providers, and coordinated efforts to address reimbursement issues across payers.

Explore structural interventions that address underlying vulnerabilities among risk groups for HIV and viral hepatitis caused by substance abuse and mental health needs.

It is not uncommon for those living with HIV to have a "triple diagnosis" of HIV infection, substance abuse and mental illness. Research has indicated the key role that substance use and abuse and mental illness, especially depression, play in acquiring HIV and viral hepatitis. These same issues interfere with participation in treatment.[41]

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[40] Centers for Disease Control and Prevention. (2006) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR*, September 22, 2006 15, 1 – 17. Retrieved December 3, 2007 from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

[41] Health Resources Service Administration. (2004) *Guide to Primary Care for People with HIV/AIDS*, (2004 Edition). Retrieved August 1, 2008 from http://hab.hrsa.gov/tools/primarycareguide/PCGchap14.htm#PCGchap14a

Assessments within Texas have indicated that HIV clients cite substance abuse as one of the top reasons for dropping out of care. This is especially true for those aged 13 – 24, and it is the top reason for youth entering care late.

Continue to invest in core public health activities such as public health follow up and partner services.

Disease intervention and partner services are core public health activities. The goal of partner services is to notify partners of infected persons and other individuals at high-risk for HIV/STD of a possible exposure and to offer them testing and linkage to treatment (if infected). Investment in public health follow-up and partner services protects communities by intervening in disease spread, promoting knowledge of status, entry into care and opportunities to lower risk. These activities require coordination of state, regional and local resources. They are particularly reliant on personnel resources at the local and regional level. DSHS is currently pursuing possible ribonucleic acid (RNA) testing to identify recently acquired HIV infection. Paired with robust partner services, this approach increases the potential of intervening before the disease is spread. It should be noted that currently, partner services for HBV and HCV are not systemically supported or enacted.

Expand implementation of behavioral interventions with demonstrated evidence of effectiveness in reducing risk for HIV and hepatitis.

Because there is no cure for HIV and hepatitis C, prevention efforts are crucial. DSHS has funded behavioral interventions through contracts with local health departments and community based organizations. The scale and scope of these interventions is limited by resources available for such efforts. DSHS and other Council agencies can work together to address their consumers' needs by expanding the behavioral interventions available to Texans at risk for HIV and hepatitis.

Increase early diagnosis and intervention of HIV/AIDS and hepatitis through coordination among state agencies and expansion of current programs.

Close and frequent communication among service organizations is crucial to opening access to individuals newly diagnosed with HIV/AIDS and hepatitis. A broad array of service providers is needed to provide a continuum of care. Most importantly, a wide variety of services need to be available at the client level. Greater awareness among Council agencies' employees, their consumers, contracting partners and communities they serve will foster greater local efforts to provide care. Council agencies can build on existing relationships to further mutual goals and objectives. Existing efforts between DSHS and criminal justice/corrections agencies to link the recently released to care represents a prime opportunity to ensure that more releasees continue with life saving medications and receive support services.

Commit to continued investigation of issues identified as needing further study.

Throughout this report issues have been identified which need additional information. The Council is committed to continued study on these issues to determine the impact on prevention and treatment services for HIV/AIDS and hepatitis. Although many lingering questions persist, the following are issues set for study and discussion in upcoming reports.

- Further discussion is needed on immunization requirements for healthcare students. Students enrolling for health-related courses involving direct patient contact are required to either complete a three-dose series of hepatitis B vaccine or show evidence of immunity. This must occur prior to any direct patient contact that may be part of the course of study. This vaccine is available through local health departments as part of the safety net for students who are uninsured or underinsured.

- Further efforts are needed to understand local resources addressing HIV and hepatitis. Local funds are not captured in the current assessment of resources. Canvassing local health departments will be an extensive undertaking. Further efforts are also needed to assess use of federal and state funds expended for inpatient care. This will more fully reflect expenditures at all levels of care within corrections and for immunization efforts, and to understand expenditures with Medicare and the Veterans' Administration system.