

Texas

AIDS Rate per 100,000

12.8*

State Funds for HIV Early Intervention Services

State Expenditures	
Required Base	SFY 2008 Expenditures Maintenance
\$60,500	\$3,797,184
SAPT EXPENDITURES	
FY 2006 HIV Set-Aside	FY 2009 Planned
\$6,774,380	\$6,799,375

FY 2010 SAPT Reports

Set-aside funds are made available through a network of HIV early intervention services providers in nine of the 11 regions of the State. This network ensures a service system to target substance abusers at risk for or infected with HIV. Early intervention services include pre/posttest counseling.

HIV Early Intervention Services Provided							
Rapid Testing	Funding Rapid Testing	Regular HIV Testing	Pre-Test and Post-Test Counseling	Referral Services	Risk Assessment	HIV/AIDS Education	Outreach
√	√	√	√		√	√	√

State Narrative Summary

In FY 2006, block grant funds were used to maintain a network of HIV early intervention service providers in nine of the 11 regions in the State. These programs targeted active users at highest risk of infection, and performed the first line of intervention for promoting behavior change using various behavior change methods. In FY 2006, more than 107,000 adults and youth at risk for HIV and other communicable diseases were contacted through outreach programs. A new RFP solicitation process was put in place for FY 2008 with the intention of focusing HIV early intervention services on those regions of the State with growing numbers of HIV/AIDS cases, increased risk, and/or drug use. There were 32 SAMHSA-funded programs offering case management services that serve an average of 900 to 1300 HIV infected people. In FY 2009, the State planned to work with SAMHSA and the Centers for Disease Control and Prevention to keep up-to-date on the latest information and research about false-positive tests, and to develop a monitoring system that will report false positives directly to the State. New contracts awarded during this period will require additional monitoring, training, and technical assistance follow-up.

*THE MOST RECENT DATA PUBLISHED PRIOR TO OCTOBER 1, 2008 BY THE CDC IS TABLE 14, REPORTED AIDS CASES AND ANNUAL RATES (PER 100,000 POPULATION), BY AREA OF RESIDENCE AND AGE CATEGORY, CUMULATIVE THROUGH 2006-UNITED STATES, HIV/AIDS SURVEILLANCE REPORT 2005 VOL. 17, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HIV, STD, AND TB PREVENTION, DIVISION OF HIV/AIDS, PREVENTION, SURVEILLANCE, AND EPIDEMIOLOGY. SINGLE COPIES OF THE REPORT ARE AVAILABLE THROUGH THE CDC NATIONAL PREVENTION INFORMATION NETWORK, 1-800-458-5231 OR 301-562-1098 OR [HTTP://WWW.CDC.GOV/HIV/TOPICS/SURVEILLANCE/RESOURCES/REPORTS/2005REPORT/TABLE14.HTM](http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/table14.htm).

Full State Narrative

FY 2006 (COMPLIANCE)

In FY 2006, a network of HIV early intervention services was maintained with block grant funds to ensure a service system that would target substance abusers at risk for and infected with HIV, and would promote communicable diseases education and training for those at risk, their families and significant others. The HIV program network was comprised of 31 HIV prevention and intervention programs, including testing, risk reduction, and case management programs; one training program the HIV training services (HTS) which promotes communicable disease education and training; and one HIV residential treatment program, which is not funded with set-aside funds. HIV programs funded with HIV set aside funds were in nine of the 11 regions of the state, and provided critical services in sub-state planning areas that were most in need of HIV early intervention services, which included regions 1, 3, 4, 5, 6, 7, 8, 10 and 11.

HIV intervention and risk reduction programs were responsible for targeting active users at highest risk of infection and performing the first line of intervention for promoting behavior change, using Motivational Interviewing techniques and the Transtheoretical Model, Prochaska- DiClemente Stages of Change. They also performed the largest portion of the HIV counseling and testing effort, locating and identifying HIV-infected, chemically-dependent persons (as well as those identified at risk) encouraging them to enroll in HIV early intervention case management and substance abuse treatment services. In FY 2006, HIV Outreach programs contacted 107,566 (adults and youth) at risk for HIV and other communicable diseases. HIV early intervention programs performed case management for an ongoing caseload of HIV infected, chemically-dependent individuals. The program's purpose was to ensure that adequate resources were dedicated to services related to HIV disease management and to address substance abuse treatment and recovery simultaneously.

HIV early intervention case management programs also reduced barriers to treatment access by serving as the gate for admission to Homeward Bound, the HIV residential treatment program, providing treatment services to HIV-infected persons in need of and ready for substance abuse treatment. (NOTE: The treatment program portion of the network was funded separately and was not considered a part of the HIV set-aside). HIV intervention, risk reduction and early intervention programs provided the largest portion of interim services for all the treatment providers in their region. Block grant funds also supported education and training through the HTS contractor to ensure that all HIV contract staff and all funded treatment and prevention programs were kept current on the latest HIV clinical information and trained on the National Institute on Drug Abuse's Community-based Outreach Model, Motivational Interviewing and the Transtheoretical Model of Change/Prochaska-DiClemente's Stages of Change.

FY 2006 also marked the first full year of rapid testing throughout the Texas SAMHSA funded HIV programs. The SAMHSA Rapid Testing Initiative of 2005 continued to be useful in providing additional resources to contractors throughout the state. Many of our contractors began a "marketing" campaign in their communities to increase testing of at-risk populations through rapid testing. Twenty new cases were identified by one of the Houston area (Region 6) contractors during this time. All tests were confirmed using the OraQuick processes and were reported using the state data collection system. The positivity rate for rapid testing services continued to mirror the national average.

HIV programmatic and fiscal activities were monitored by comparing monthly and quarterly reports against performance measure projections submitted by providers and by using matrices built by DSHS staff specific to each program type. These tools were used to monitor ability to provide interim services to IVDU clients waiting for treatment, performance measure documentation, service agreements that link provider resources, etc.

This was the last year of contract renewals and DSHS followed a new solicitation process of procurement for all its HIV intervention programs and SA prevention programs under SAMHSA's block grant. The new RFP solicitation process was designed to focus HIV early intervention services in the regions of the state that have growing numbers of HIV/AIDS cases, increased risk, and/or drug use. Nine of eleven regions in the state were eligible to apply for these five year (annual renewal) grants. Applicants were asked to respond to the RFP which targeted the following: (1) Persons at risk of being infected with HIV as a result of practicing behaviors related to a substance abuse lifestyle (2) Persons who are HIV infected and identified as having a problem with substance abuse (3) Significant others and/or family members of those described in #1 and #2.

Currently there are 32 SAMHSA HIV funded block grant programs. HIV early intervention case management programs currently serve an average of 900-1300 HIV-infected, chemically dependent individuals on the caseloads. That number has been relatively constant for the past five years. HIV testing, intervention and risk reduction activities account for approximately 85,000 contacts for the year based on numbers reported during the first, second and third quarters of FY 08.

The State of Texas HIV program effort has suffered a slight decrease in funding from CDC (prevention) and HRSA/Ryan White (HIV clinical services). Both DSHS HIV/STD and DSHS HIV/SA divisions continue to actively collaborate and examine how to best leverage services to the target population.

While this year marked a transition in program coordination at the DSHS staff level, there was a strong plan in place to provide programmatic continuity. Key Performance Measures continue to be reviewed in order to capture clear numbers and information that would allow for improved program evaluation and quality improvements. We continue to monitor these measures quarterly and provide technical assistance to all contractors in how to best report their accomplishments and the changing trends/needs of our target populations across the state.

While the SAMHSA Rapid Test Initiative ended and all the kits were distributed, DSHS HIV programs continued to rely on the Rapid Test as the primary tool for counseling and testing highrisk populations. Counseling and testing (not screening) continued to be the strategy for performing HIV testing within SAMHSA/DSHS HIV programs. All HIV testing contractors were required to use Rapid Test devices for at least 40% of all HIV testing performed.

Contractors continued to be convinced of its usefulness, most used Rapid Tests 90% of the time, holding to blood draws only when requested or when working with less transient populations. The latest information on "false positives" released by the New York City Health Dept. and the CDC was received and a review by this office and our HIV testing providers, began in order to determine what changes may be needed in our rapid testing protocols. Currently, all providers are reporting their false positive tests/numbers to this office by telephone calls to the HIV Coordinator and are following procedures for confirmatory testing DSHS was also successful in initiating a plan to increase unit costs for HIV residential treatment and thereby improve quality of service. The approved rate went from a \$69.00 unit cost for an HIV substance abuse treatment bed to \$108.00 this year.

HIV early intervention program services continue to be monitored through a matrix developed by the Program Implementation and Quality Management units of MHS. This matrix is used during site visits to determine that all documentation related to required services associated with HIV early intervention program activity is accurate and timely. In addition, HIV early intervention programs continue to report quarterly through BHIPS on level of access to services associated with case management. For example, one key measure evaluates how many clients in the HIV case management caseload are engaged in substance abuse services. Note: A client receiving these case management services may participate in program activities regardless of whether he/she is also in substance abuse treatment. Since the program strives to address HIV clinical issues and

recovery simultaneously, this measure is used as an indicator for success in persuasion and engagement techniques used for meeting that goal, how the program employs best practice skills such as those associated with motivational interviewing, and other client centered counseling strategies.

FY 2009 (INTENDED USE)

HIV programs will continue to rely on the Rapid Test as the primary tool for counseling and testing high-risk populations. DSHS will continue to work with SAMHSA funded contractors to monitor and obtain the latest research and information available through the CDC and SAMHSA regarding false positivity rates with Rapid Testing. DSHS will work with contractors to develop a monitoring system so that contractors will report any false positives on an ongoing basis directly to DSHS in addition to following other established reporting protocols. In addition, we will work closely with contractors to follow all CDC and SAMHSA recommendations and possible changes in protocols. Counseling and testing (not screening) will continue to be the strategy for performing HIV testing within SAMHSA/DSHS HIV programs. If funding continues as expected, the HIV program network will continue with all program types as described, with expectations of incorporating new strategies to influence pharmacotherapy populations.

New contract awards for this new cycle will require additional monitoring, training (through the HIV Training Services (HTS) contract) and technical assistance follow-up. Progress with Performance Measures will be monitored monthly through BHIPS and through quarterly reports from the contractors. Over this next year DSHS will work closely with contractors to determine to best and clearest Key Performance Measures that provide the most accurate and useful information for program design and monitoring. HIV early intervention case management services will be new to two providers (Region 6 and Region 11) this year and one provider (Region 4) has been contracted to provide additional HIV early intervention services which include testing, risk reduction and intervention beginning this year. A total of 28 SAMHSA HIV early intervention programs will be serving Texans this year.

The Ryan White AIDS Drug Assistance Program (ADAP) program funding with DSHS is expected to meet the demands of projected eligible cases. Since all HIV clients receiving case management meet the eligibility requirements for receiving those medications there should be no gaps related to securing HIV antiretroviral treatment.

New joint collaboration planning meetings between the DSHS HIV/STD division and the DSHS HIV/MHSA division will begin this year for the purpose of determining the feasibility of testing and actively supporting both Hepatitis and HIV testing in all treatment facilities/programs for all clients. This is both a public health and substance abuse treatment issue which will require a strong integrated approach with clear protocols and clear communication with clients. In addition, we anticipate a stronger collaboration will assist in developing a higher level of resource mapping (HIV) for the state and a more timely approach to dealing with changing drug use patterns and new HIV cases.

DSHS will also continue to closely monitor changes in drug use patterns across the state, especially in the Texas-Mexico Border regions. Working closely with SAMHSA and the Gulf Coast Addiction Technology Transfer Center researchers will allow us to further monitor the use of injection and non injection drugs which are increasingly impacting high risk sexual activity and risk for HIV/AIDS.

All DSHS HIV program services will continue to be monitored onsite using the program matrix developed by Program Implementation and Quality Management units. In-house desk reviews will be performed by DSHS staff, using monthly and quarterly reviews as submitted quarterly in BHIPS.

HIV Early Intervention Services

In FY 2006, a network of HIV early intervention services was maintained through block grant funds to ensure a service system that would target substance abusers at risk for and infected with HIV. The HIV program network was comprised of 31 HIV risk reduction, community based interventions and early intervention case management programs); one training program (HIV training services or HTS), which promotes communicable disease education and training; and one HIV residential treatment program. A total of \$6,774,380.00 was expended in block grant funds on early intervention services for HIV, consistent with the 5% set-aside requirement established in the summer of 2002. An additional amount of \$403,503.00 was expended in state general revenue funds, consistent with the mandatory five percent cap. A combination of block grant set-aside funds and state general revenue supported all the programs within the HIV network with the exception of the HIV residential treatment program which is funded with block grant treatment funds.

In FY 2006, early intervention programming comprised a number of strategies designed to intervene with persons actively involved in risk behaviors associated with HIV and other communicable diseases. HIV early intervention programs were located in nine of the 11 Health and Human Service Commission regions of Texas with multiple programs installed in all major metropolitan areas with high rates of HIV/AIDS, (Houston, Dallas, Ft. Worth, San Antonio, Austin) including high risk areas such as, South Texas (Laredo, McAllen, Brownsville, and Harlingen), and other risk areas such as Galveston and Beaumont. One training program, HTS, continued as the primary capacity building agent in the network. They offered over 10 different curricula to contractors in order to build motivational interviewing skills, counseling skills and support behavior change efforts and procedures [using the model established by the National Institute on Drug Abuse (NIDA)], ensuring that all HIV community based programs operate in a safe manner. In FY 2006, the HTS facilitated education about HIV, TB, hepatitis and other communicable diseases for all block grant funded treatment, intervention and prevention programs, Over 700 participants were trained through their HIV/AIDS Update and TB courses.

FY 2006 marked the first full fiscal year of the HIV Rapid Test Initiative which began in June 2005 in Texas. All program staff that performed counseling and testing through this initiative was thoroughly trained in laboratory procedures, interpreting preliminary test results and reporting outcomes. Participants who were identified and confirmed as positive were offered immediate intervention services including case management, access to an HIV-knowledgeable primary care physician and opportunities to enter substance abuse treatment and recovery.

HIV Early Intervention Programs Receiving Funds				
Program	Status	Address	Phone	Funds
Montrose Counseling Center	A	401 Branard Street, 2nd Floor, Houston, TX 77006	713-529-0037	\$1,071,385
Alliance Work Programs, Workers Assistance Program	N/A	2525 Wallingwood Drive, Building 5, Austin, TX 78746	N/A	\$531,408
The South East Texas Regional Planning Commission	A	3501 Turtle Creek Drive, Suite 108, Port Arthur, TX 77642	409-727-2384	\$159,010
Community Clinic Inc.	N/A	203 W Olmos, Suite 300, San Antonio, TX 78212	N/A	\$255,406
Greater Dallas Council on Alcohol & Drug Abuse	N/A	4525 Lemmon Avenue, Suite 300, Dallas, TX 75219	N/A	\$761,117

East Dallas Counseling Center	N/A	4144 North Central Expressway, Suite 530, Dallas, TX 75204	N/A	\$416,487
Coastal Bend AIDS Foundation	N/A	400 Mann Street, Suite 800, Corpus Christi, TX 78401	N/A	\$223,493
Valley AIDS Council	N/A	418 E Tyler, Suite B, Harlingen, TX 78550	N/A	\$255,277
Amarillo Council on Alcoholism and Drug Abuse	N/A	803 S Rusk, Amarillo, TX 79108	N/A	\$201,754
The Association for the Advancement of Mexican Americans, Barrios Unidos	A	204 Clifton Street, Houston, TX 77011	713-926-9491	\$415,013
Families Under Urban & Social Attack	N/A	P.O Box 88107, Houston, TX 77288	N/A	\$79,519
South Texas Council on Alcohol and Drug Abuse	A	2359 East Saunders Street, Laredo, TX 78041	956-791-6131	\$58,673
Special Health Resources for Texas	N/A	P.O Box 2709, Longview, TX 75606	N/A	\$149,986
The AIDS Resource Center of Texoma	N/A	222 W Brockett, Sherman, TX 75090	N/A	\$51,698

Status Key: [A] Active, [I] Inactive, [n/a] Not available, [P] Facility physically closed, [S] No substance abuse services provided, [U] Closed as duplicate of another facility.