Program Collaboration, Service Integration

Texas PCSI Plan
September 15, 2011

Texas Department of State Health Services
Program Collaboration, Service Integration (PCSI)
Texas Plan

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Executive Summary

The Texas Department of State Health Services (DSHS) has a long history of program collaboration, beginning in 1994 when the HIV and STD programs began working together toward one unified vision. Service integration initiatives soon followed this organizational merging; since the late 1990's, routine HIV testing has occurred at all STD clinics, providers of targeted HIV testing programs have implemented syphilis testing, and disease intervention specialists have routinely interviewed both priority STD and HIV cases. This record of collaboration and integration has brought about a unique view of program collaboration and service integration (PCSI). It is not a project, it is a way of doing business, a philosophy, and a key value in the way public health is delivered in Texas.

Service integration initiatives emerge through analyzing co-morbidity data with a focus toward priority populations. Service integration leans heavily on the practice level, zeroing in on where, how and what services a client receives. Program collaboration initiatives, when viewed from a starting point, are identified through assessments and look to the macro-level, working with the organization or environment to bring about system-wide change. While service integration can be an outcome of program collaboration, the other products of program collaboration include mutual planning; alignment of resources, policy, guidelines, standards and recommendations; joint evaluation; and cross-training. It is from these two perspectives spring the four critical paths of the Texas plan for enhanced integration and collaboration for TB, HIV, STD, and viral hepatitis.

Population Focus

There is a good deal of rational justification for integration of various combinations of HIV, STD, TB, and viral hepatitis services. Some groups are more vulnerable to certain conditions by virtue of risk behaviors, such as risk of Hepatitis C and HIV infections due to injection drug use. Some populations have heightened risk for STD and HIV due to geography and the overlap in social-sexual networks – as are observed in Blacks in Houston, Dallas and East Texas, or because of heightened opportunity for exposure as is observed for TB along the US-Mexico border. A clear path to identifying opportunities for integration that could have a meaningful effect on containment of multiple conditions is creation of an enriched data environment that eases management and analysis burdens across these conditions.

Texas' plan for an enriched data environment will deepen our insight into co-morbidities and the patterns of co-occurring conditions. In addition, it will shed light on which populations could be targeted for service integration or other initiatives, and provide clues to what interventions would best benefit these at-risk groups. This refined understanding will not just inform the PCSI project; the enriched data will stimulate thoughtfulness and work in other areas of the TB/HIV/STD and Viral Hepatitis Unit. Three critical paths are connected to this strategy: data integration and analysis, physical integration of data management systems, and increased data sharing.

This process highlights an identified data gap: information on viral hepatitis. Although acute infections with HAV, HBV, and HCV are reportable in Texas, chronic infections with HBV and HCV are not. While we acknowledge this shortcoming, overcoming this issue is not within the current scope of this project. Rather, this project focuses on integration of TB, STD, and HIV data at the levels of data collection, management and analysis.

The blueprint for analytic data integration ultimately creates a so-called master patient list across TB, STD, and HIV that will allow for full cross matching across these conditions. It will also allow for full analysis of co-morbidities, using each condition in turn as the core condition, and examining the characteristics of groups with shared diagnoses for each of the companion conditions. This task has been partially accomplished in the first year using prevalent HIV infections as a core, identifying the characteristics of persons with HIV also diagnosed with new STD and with TB.

While this allows some potential intervention in terms of new program design for populations with high levels of joint diagnoses, it does not make individual-level data available for intervention in the field. Physical integration will provide a more permanent home for the matched data and allow the ongoing addition of new information. In this way, previously matched data will not have to be re-matched whenever a new question or new information arises. But it will also allow public health workers conducting public health follow up and case management of new infections timely access to data that could enhance appropriate intervention and treatment, such as knowledge of current HIV infection in intervention decision making for persons with newly diagnosed TB.

Increasing data sharing with the Mental Health and Substance Abuse division (MHSA) will align process data collection for Substance Abuse Mental Health Services Administration (SAMHSA) funded HIV, STD, TB and viral hepatitis activities, create a strategy for the sharing of this data, and fill in important details on the HIV, STD, TB and viral hepatitis epidemics within the substance abuse population. It will also meet goals in the National HIV/AIDS Strategy, namely, enhanced reporting of infectious disease activities across all funding streams.

All of this matched and shared information will flow into the population-focused service integration committee. Texas already has a large and diverse PCSI committee; however the group's expertise lies outside of HIV, STD, TB and viral hepatitis. A leaner group specifically centered on the core functions of HIV, STD, TB and viral hepatitis will be better able to analyze data, accurately identify syndemically involved populations, and pinpoint appropriate service integration initiatives. This more focused group will also be able to provide the required oversight to PCSI grant activities.

Systems Focus

State health departments have a unique role in providing leadership, promoting policy development, setting standards, and carrying out state and national mandates. This position to influence larger systems cannot be filled by city health departments or local community agencies. While program collaboration can emerge from the implementation needs of a client-level service integration initiative, it can also originate from a systems assessment and analysis. This macro-level perspective is a vital PCSI informant.

Two critical paths are connected with the system-focused strategy: integration of physical and behavioral health and exploring areas of program collaboration. System assessments point to major gaps in HIV, STD, TB and viral hepatitis activities in the behavioral health system in Texas. The Opioid Therapy clinic project was identified as an avenue to bridge the gap between physical and behavioral health, and to provide a platform for further integration in policy and practice. In order to continue to explore areas of program collaboration with larger systems and leverage public health concerns in the environment, the current PCSI committee will concentrate on systems issues.

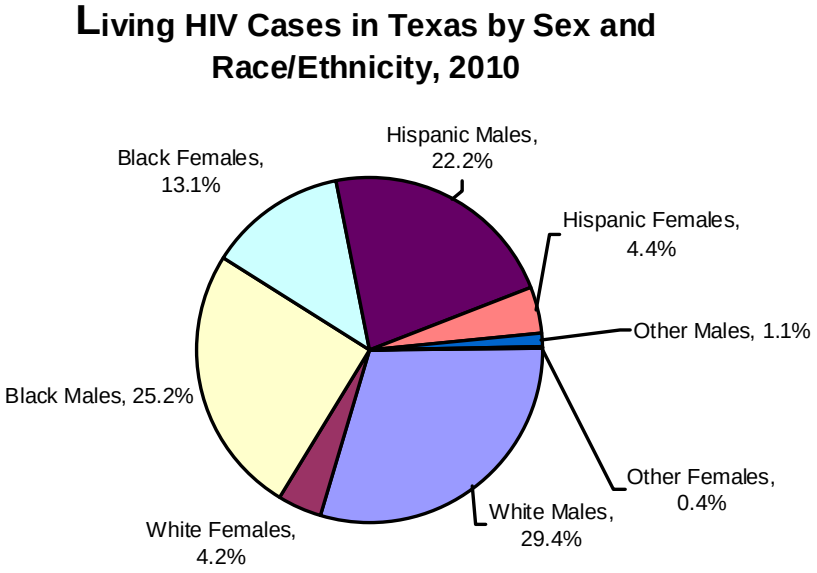
Texas PCSI Plan

Description of Texas Syndemics

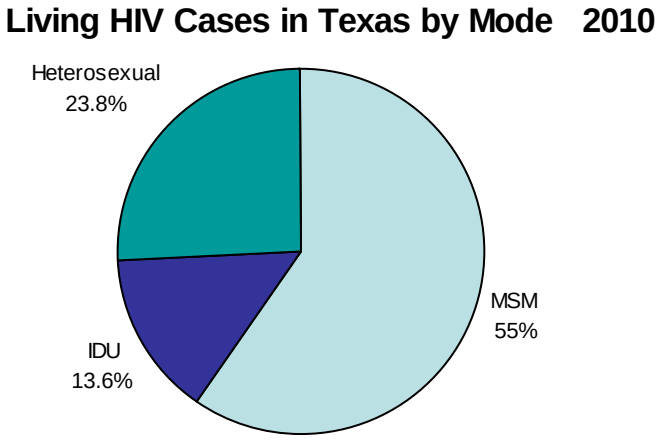
This section begins with brief examinations of the profiles of persons living with and newly diagnosed with HIV, Chlamydia, gonorrhea, primary and secondary syphilis, and TB. We have not included data on viral hepatitis, as only acute infections are reportable, and the data are more limited in their completeness.

HIV

As of end of 2010, 65,077 persons in Texas were known to be living with HIV. Whites made up above a third of the living cases, Blacks over 38%, and Hispanics about 27%.

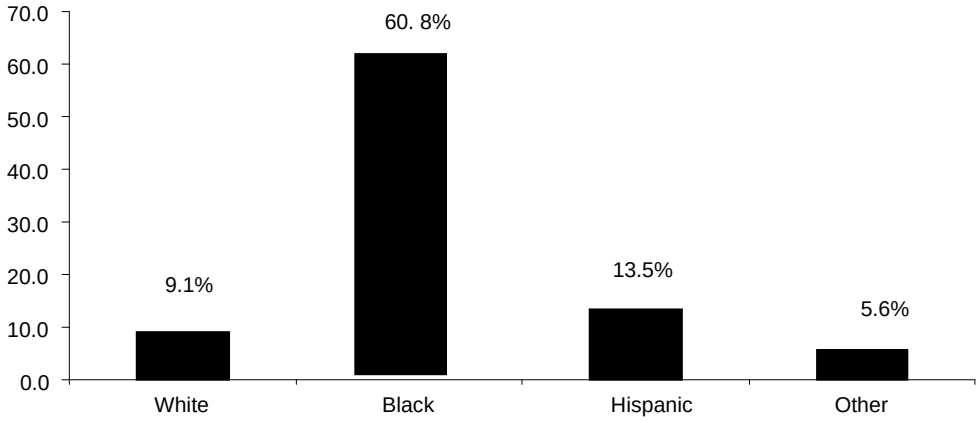


Over 55% of the living cases are among men who have sex with men (MSM); about 24% among heterosexuals, and 13.5% attributed to injection drug use.



The number of newly diagnosed cases has remained steady over the past several years-- around 4,200 per year. However, the data has shown the disproportionate impact of HIV on Blacks. In 2010, Blacks had crude rates of infection that were over 4 times greater than Hispanics and over 7 times greater than Whites.

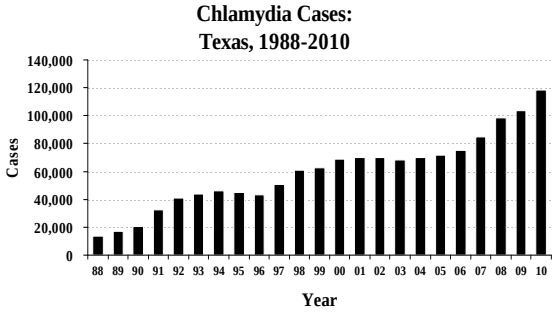
Newly Diagnosed HIV Infections in Texas by Race/Ethnicity, 2010



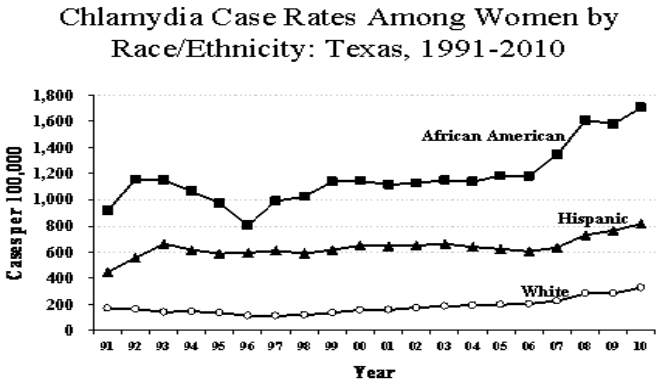
MSM continue to account for over half of the newly diagnosed cases in Texas, with over 2,000 cases reported among this population in 2010. Geographically, nearly 60% of those cases are living in either Dallas or Houston.

Chlamydia

Case numbers for Chlamydia in Texas have been increasing in the past decade. Reports of Chlamydia in 2010 totaled 118,577 cases, up 14% from 2009. The increase in the number of Chlamydia cases seen in the previous four years could be the result of a combination of factors including increased screening, more frequent use of amplified testing technologies, improvements and expansion of electronic lab reporting and possibly a true rise in morbidity.



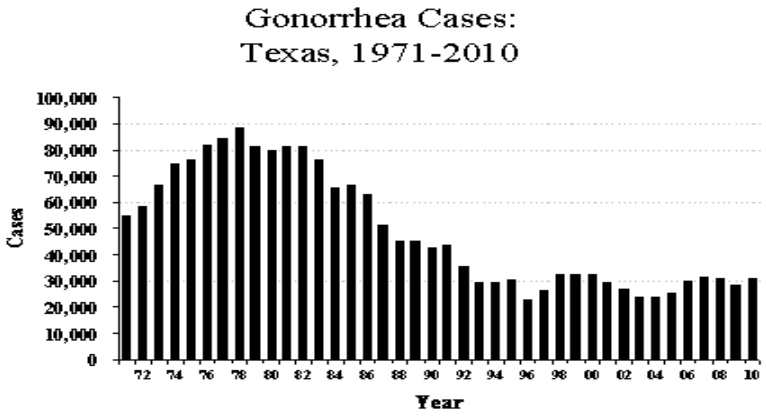
Of the Chlamydia cases reported in 2010, the number of cases in Blacks was 5 times that of Whites and twice that of Hispanics. About 78% of the cases were among women. Black women had the highest case rate at 1,701, followed by Hispanic and White women (814 and 328, respectively). Approximately 71% of all reported Chlamydia patients in 2009 and 2010 were women aged 15-24. The case rate among this age group was 3,759 in 2010. In particular, a very high case rate was found among Black women in this age group over 7,900 cases per 100,000.



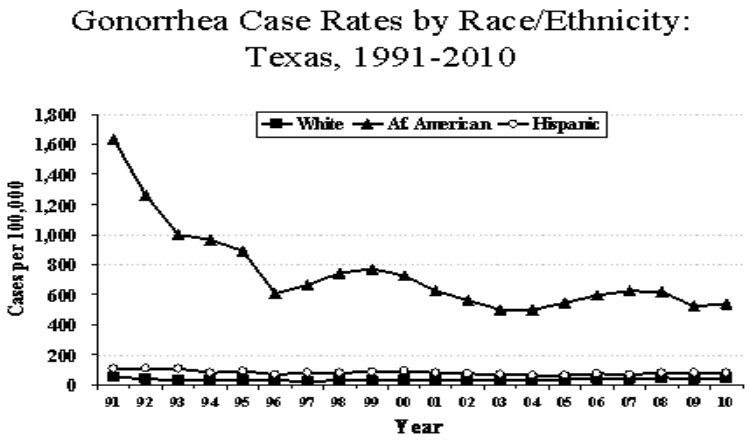
Geographically, Chlamydia is widely spread throughout Texas, with high rates not limited to highly populated counties.

Gonorrhea

The number of cases of gonorrhea has been fairly steady in the last 5 years. There were 31,453 cases reported in 2010, a slight increase from 28,782 in 2009. The case rate was 124 per 100,000, up from 116 in 2009.



Similar to Chlamydia, Blacks had the highest rate of infection with gonorrhea. This group also reported larger numbers of absolute cases (15,730 vs. 7,953 Hispanics or 5,335 Whites). In relative terms, Blacks had 11 times the case rate of gonorrhea than among Whites, and over 6 times the rate among Hispanics. Regarding age groups, similar with Chlamydia, the highest case rates of gonorrhea were among women aged 15-24. This group of young women comprised 73% of all female cases, with a case rate of 553 per 100,000. The same age group (15-24) of young men accounted for 56% of all male gonorrhea cases.

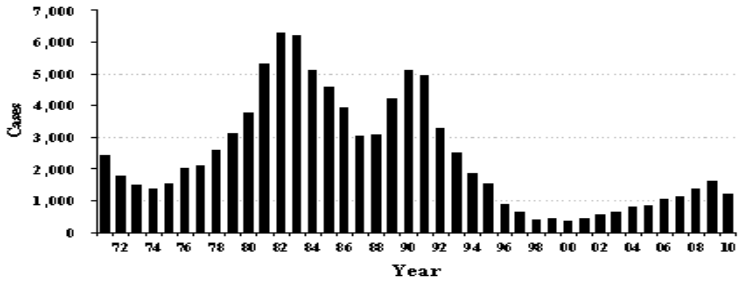


Gonorrhea is spread throughout all regions of Texas. Counties with higher rates in 2010 tended to be slightly more concentrated in eastern Texas, which also has a higher proportion of Blacks than in many other regions of the state.

Syphilis

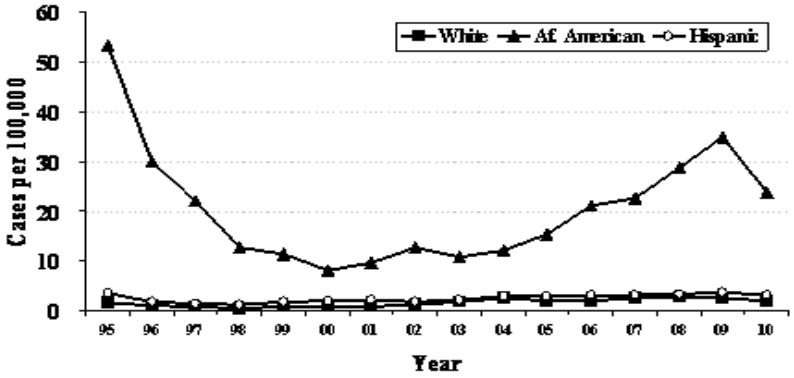
Texas reported 1,231 cases of primary and secondary (P&S) syphilis in 2010, a 25% decrease from the 1,644 cases reported in 2009. This was the first drop in case numbers in 10 years. The overall state case rate for P&S syphilis was 4.9/100K, down from 6.6 a year before.

Primary and Secondary Syphilis Cases: Texas, 1971-2010

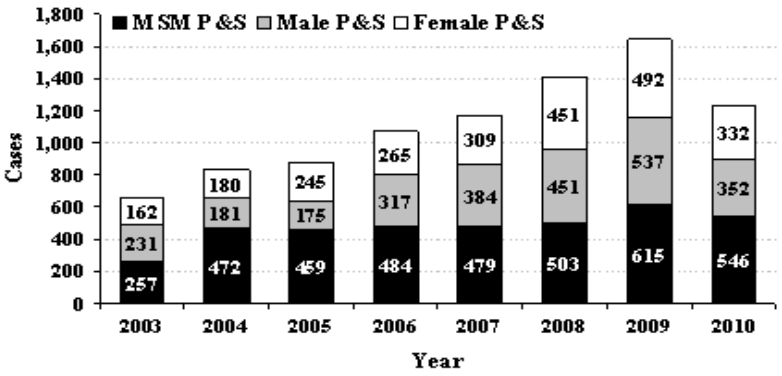


The case rate of P&S syphilis among Blacks in 2010 was 23.8 per 100,000, which was nearly 8 times the rate for Hispanics (3.0 per 100,000) and over 12 times the rate for Whites (1.9 per 100,000). In 2010, the highest P&S case rates were among those aged 15-24 (13.3 per 100,000) followed by those age 25- 34 (10.3 per 100,000).

P&S Syphilis Case Rates by Race/Ethnicity: Texas, 1995-2010



P&S Syphilis Cases by Sex and MSM: Texas, 2003-2010



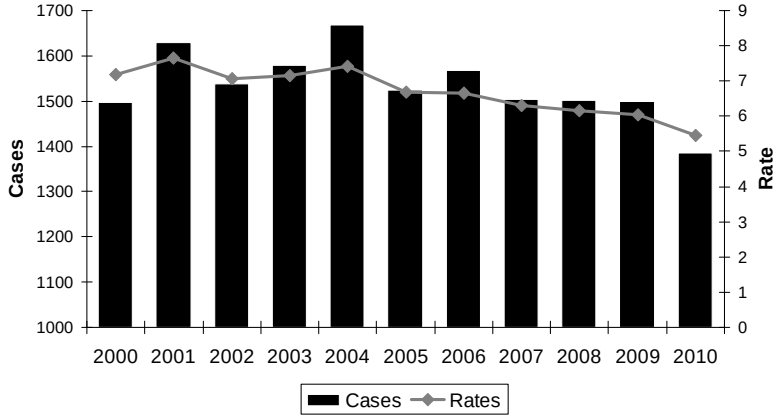
The P&S case rate among males was 7.0 per 100,000 compared to 2.6 per 100,000 among females: an indication that syphilis transmission among men who have sex with men (MSM) is a factor. Although the share of cases made up by MSM declined from 2009 to 2010,

P&S syphilis cases found in 2010 were concentrated in 75 of 254 countries in Texas, which tended to be the largest urban counties and the surrounding areas or mid-sized counties with sustained population increases.

TB

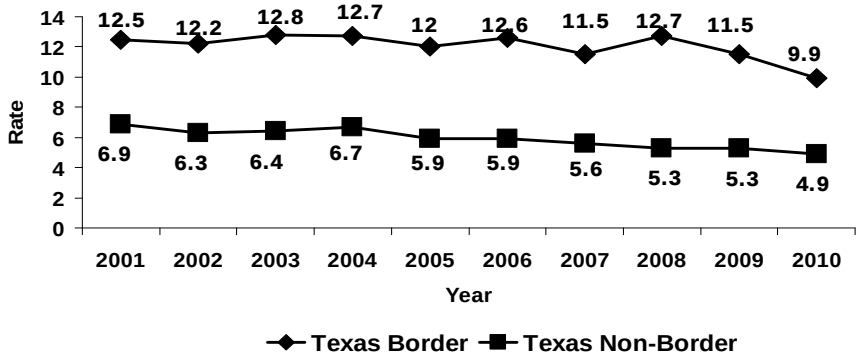
The number of reported TB cases in Texas declined 7% from 2000 to 2010. New cases of infections have been consistent over the last few years. However, Texas still carries a higher rate of the disease than the U.S. as a whole. There were 1,385 cases of TB in Texas, with a case rate of 5.5 per 100,000, versus 3.6 per 100,000 for the nation as a whole.

TB Cases and Incidence Rates
Texas, 2000-2010

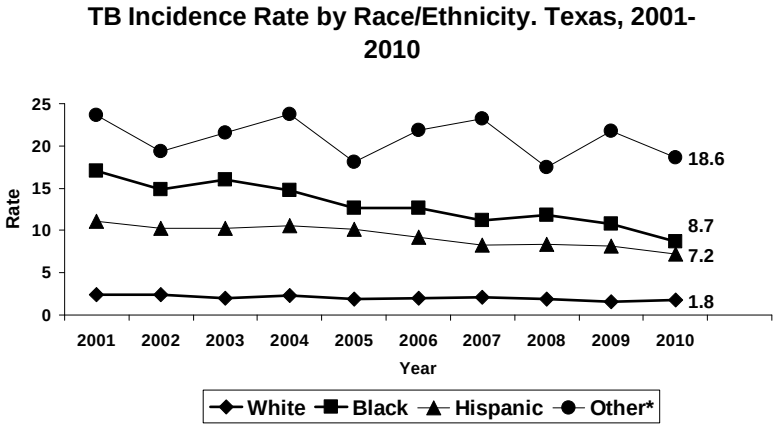


Most reported TB cases are concentrated in the large metropolitan areas and the border counties in Texas. Ten counties reported the greatest number of cases in 2010, representing approximately 75% of all cases reported in the state. In addition, the incidence rate in these counties (except Bexar) also exceeded the statewide rate. The rate of 9.9 among the border region is over 3 times higher than the non-border, non-metro counties in Texas.

TB Incidence Rate: Border vs. Non-Border. Texas, 2001-2010



The highest rate of TB infection in Texas is among the Asian population. In 2010, 58% of TB cases in those aged 18 and over were foreign born. The case rate among Asians was 18.6. Although Hispanics only make up a bit more than a third of the population of the state, they account for more than half of all reported TB cases. Blacks have almost a fifth of all reported cases of TB. The rates among these two groups were 6 and 4 times greater than that of Whites.



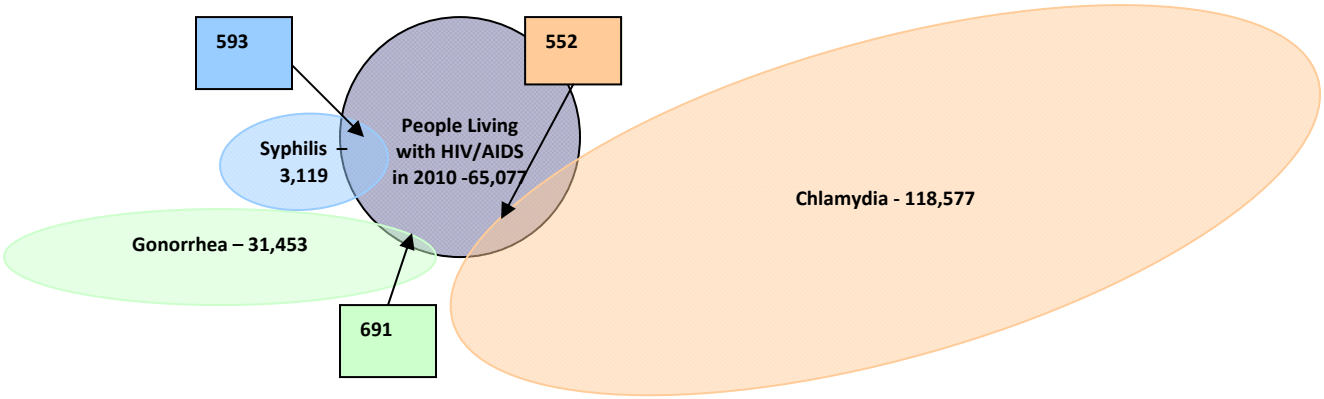
Co-morbidity: HIV and Other STD

Compared to the general Texas population, people with HIV have higher rates of sexually transmitted infections. In 2010, 0.4% of the general population was diagnosed with Chlamydia, but among people living with HIV (PLWH), more than 0.8% was diagnosed with Chlamydia, twice the rate. Gonorrhea was more than 10 times higher among PLWH than the general population, 0.1% vs. 0.01%. Early syphilis was similar: in 2010, there were only 1,231 P&S syphilis cases, but 48% of those, or 593 cases, were among PLWH –despite PLWH making up only 0.2% of the population in the state. Furthermore, the cases of co-morbidity are disproportionately distributed by race and risk behavior. With only 11.5% of the statewide population 2010, Blacks made up 42-56% of those with HIV- STD co-morbidities. There were over twice the number of cases of HIV and Chlamydia and HIV-gonorrhea among Blacks than that of either Whites or Hispanics. Blacks saw 40% more HIV-early syphilis cases than Hispanics and 70% more cases than Whites.

In terms of sex, data reveals that men accounted for the overwhelming majority of persons living with HIV and STD co-morbidity in Texas in 2010. The ratio of men to women with HIV-early syphilis cases is roughly 23 : 1; HIV-gonorrhea 6.3 : 1; HIV-Chlamydia 1.9 : 1. Blacks accounted over 50% of the cases, with Hispanic and White accounting for 25% and 24%, respectively. It is important to note that case matching for HIV co-morbidities was based on the HIV population, which is also overwhelmingly male and predominately Black and a majority are MSM. This probably accounts for some of the disparities seen by gender, race and mode of transmission.

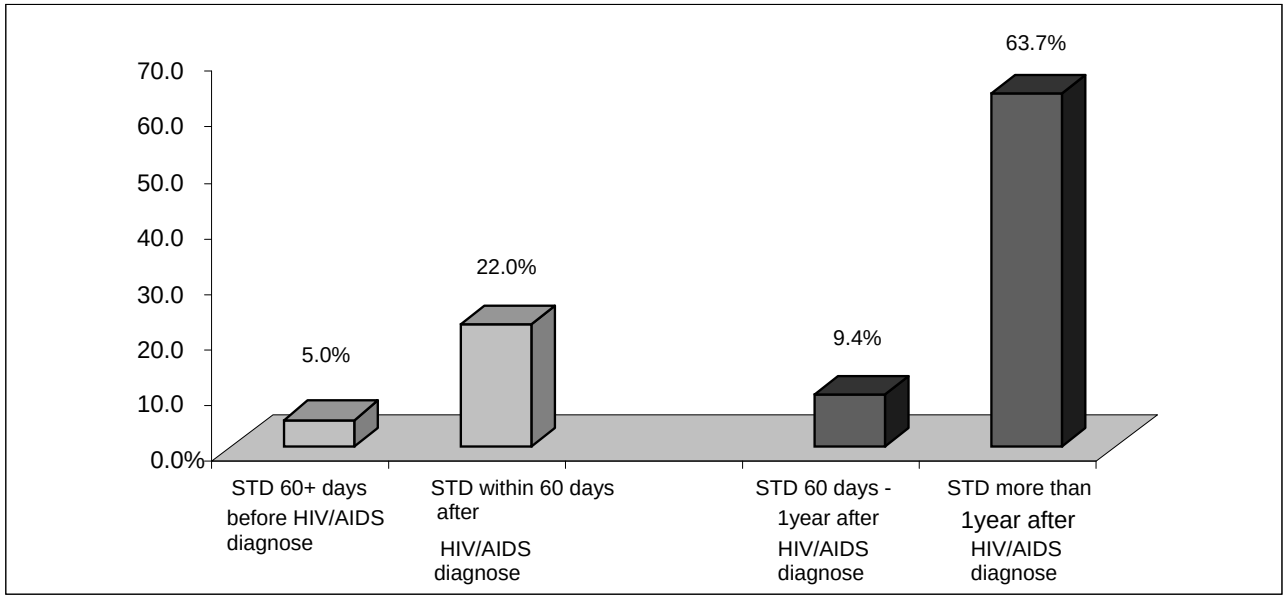
In 2010, 72% of persons with HIV and STD co-infections were MSM, compared to 17% Heterosexuals. One in two people with a reported case of HIV-Chlamydia identified as MSM, while three out of four people with HIV-gonorrhea and six out of seven people with HIV-early syphilis were MSM. Among MSM living with HIV/AIDS, 3.7% were co-infected with a selected STD in 2010..

Diagram of STD Co-Morbidities among People with HIV in 2010



Among the 1,617 HIV and selected STD co-infected cases in 2010, 63.7% were diagnosed with an STD after 1 year of being diagnosed with HIV, 9.4% were diagnosed with an STD 60 days to 1 year after their HIV diagnosis. Twenty-two percent were diagnosed with an STD within 60 days of their HIV diagnosis, and 5% were diagnosed 60 or more days before their HIV diagnosis. The amount of time between diagnoses could indicate opportunities for further behavioral interventions for these cases as well as an opportunity to ensure these cases are linked to HIV care.

Time Interval Between HIV and STD Diagnoses for Persons Living with HIV and Selected STDs, 2010 N = 1617

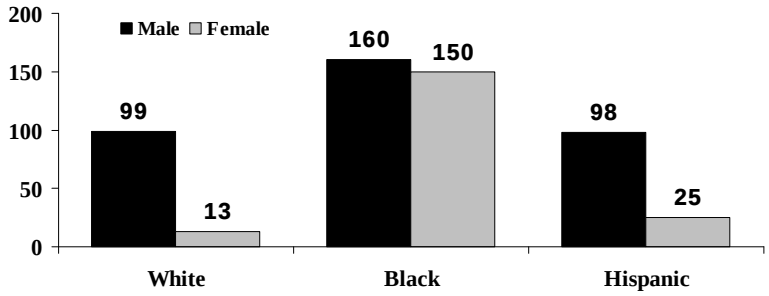


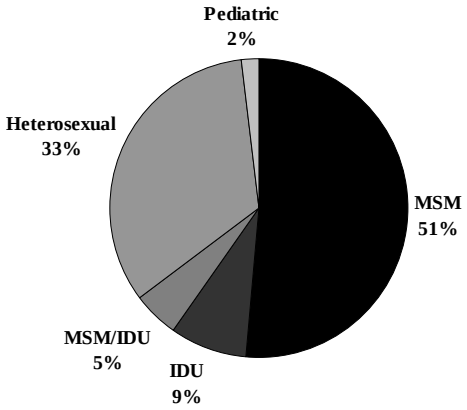
HIV and Chlamydia

Rates of Chlamydia among PLWH are much higher than they are among the general population in Texas: 848 per 100,000 compared to 467 per 100,000 in 2010. In 2010, about 58% of the cases were Black; 51% were MSM.

PLWH and Chlamydia by Mode, 2010

PLWH and Chlamydia by Sex & Race/Ethnicity, 2010

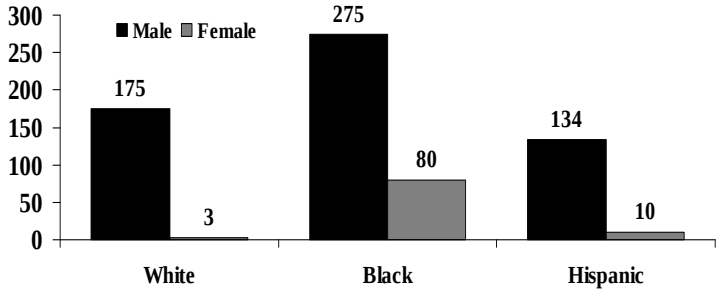




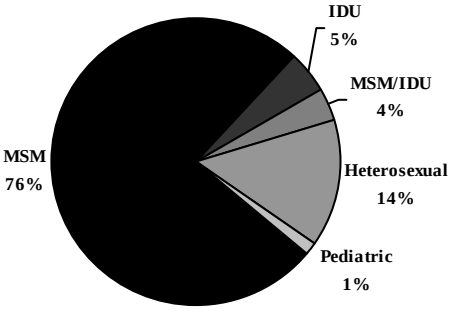
HIV and Gonorrhea

Similar to Chlamydia, PLWH carry a much higher case rate of gonorrhea than among the general population in Texas: 1,062 per 100,000 vs. 124 per 100,000 in 2010. Blacks accounted for 52% of the total co-infected cases. In terms of sex, six out of seven people with HIV and gonorrhea were male, and 76% were MSM.

PLWH and Gonorrhea by Sex & Race/Ethnicity, 2010



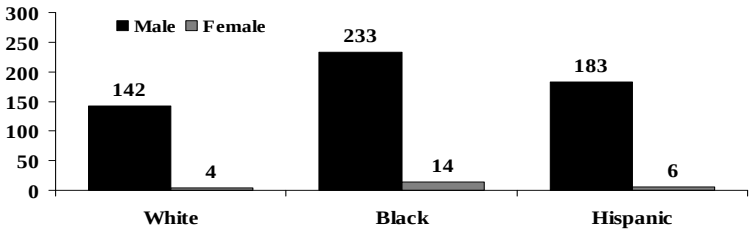
PLWH and Gonorrhea by Mode, 2010



HIV and Early Syphilis

The population of PLWH had a much higher case rate of syphilis than the general population; as with Chlamydia and gonorrhea, the syphilis rate differential is far more striking: 911 per 100,000 among PLWH vs. 4.9 per

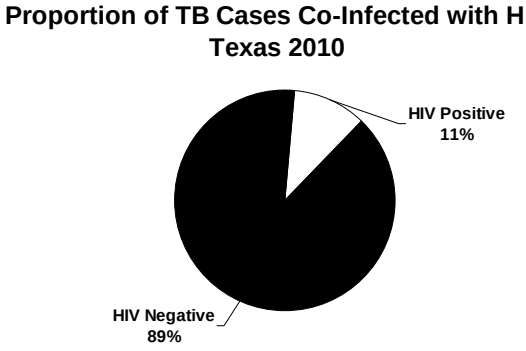
PLWH & Early Syphilis by Sex & Race/Ethnicity, 2010

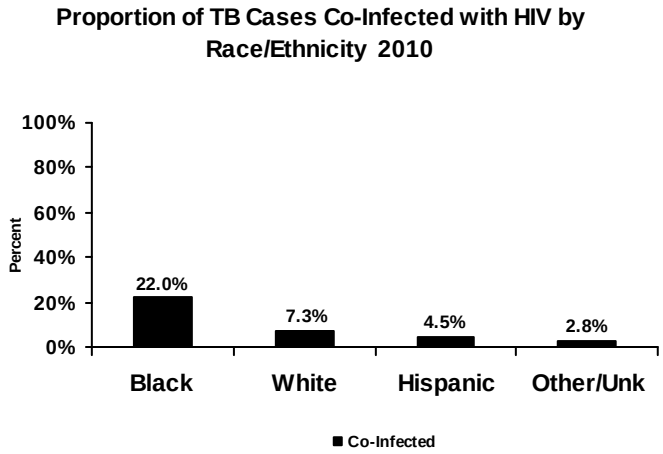


100,000 among the general population in 2010. Blacks accounted for 45% and MSM accounted for 86% of the total co-infected cases.

HIV and TB

TB is one of the leading causes of death in persons infected with HIV. Comparing to a HIV prevalence case rate of 256 per 100,000 for the Texas population in 2010, the HIV case rate among TB patients was more than 30 times higher than the case rate among the general population. By race and ethnicity, the proportion of Blacks infected with TB and co-infected with HIV is 2.5 to 6 times larger than the other race/ethnic groups.





Limitations to the Co-Morbidity Analyses

Use of prevalent HIV and incident STD data

The time interval analysis is based on total number of PLWH and a single year of STD data. Longitudinal analysis on PLWH and multiple-year STD are needed to gain additional insight into patterns of timing. For example, is there evidence that persons receiving a late diagnosis of HIV had prior incidence of STD, which might indicate missed opportunities for more timely HIV diagnosis.

Base population:

The current co-morbidity study has been based on the PLWH population as a stem. More analyses are needed for the STI population to understand patterns of co-infection among persons with a diagnosed STD.

Data system improvement and collaboration:

There is a lack of co-morbidity analysis between Hepatitis and HIV, especially for HCV or HBV. Presently, there is sparse HCV data to do accurate analysis. These data are also limited to co-diagnosis, and do not take advantage of rich systems for assessing linkage to care and treatment to determine if these persons with multiple infections have timely linkage, are maintained in care, or have other co-occurring conditions. Integration of care and treatment data,

as well as integration of behavioral health system data, would add to our understanding of the multiple challenges and possible intervention points for these individuals.

Incomplete risk characterization

No data are currently available for characterizing the gender identity of the HIV cases used as a stem in this analysis.

Texas PCSI Plan

Goals for PCSI Project

Goal 1: Create an Enriched Data Environment

Overall Goal

To create an enriched data environment for increasing the understanding co-morbidity patterns, service utilization and prevention activities among persons with or at risk for HIV, STD, TB and viral hepatitis in Texas, in order to better inform program decision-making, planning, and evaluation. Objectives to achieve this vision include data integration, data analysis of integrated data and increased data sharing with other areas of DSHS.

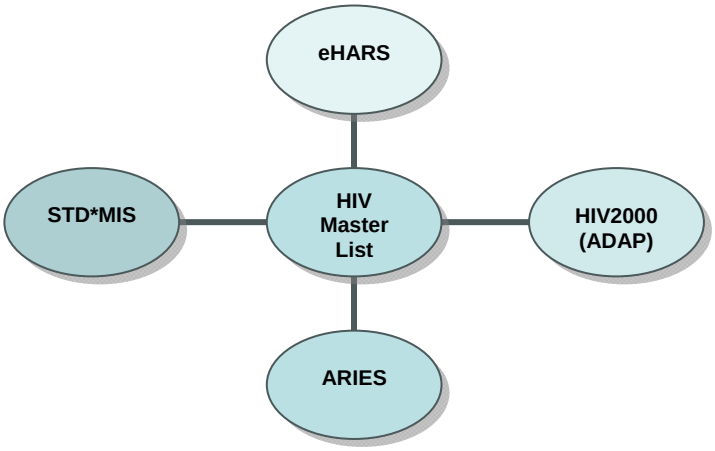
Objective1: Data Integration and Analysis

Currently, disease surveillance, service, and prevention data physically reside in multiple databases according to disease, program purpose, program jurisdiction, and funding stream. In order to create a unified view of these data, the individual databases must be extracted and linked. This process can be extremely time consuming and repetitive; identifying information on a case, which is used for linking across systems, may vary greatly between databases necessitating the use of complex matching programs which require a substantial manual review. Further, there is no one data system that captures all cases for each of the diseases of interest (HIV, gonorrhea, chlamydia, syphilis, and TB). STD (gonorrhea, chlamydia, and syphilis) data are currently maintained in separate databases according to jurisdiction, TB data are in separate databases according to year of report and HIV data are in separate databases according to purpose (e.g., an HIV infected individual who was diagnosed out of state, but receiving services in Texas may not be counted in eHARS but may be in the HIV service database).

Objective 1 Tasks

For this reason, the first step in this process will be to compile disease-specific master lists for HIV, TB, gonorrhea, chlamydia and syphilis. These master lists will be routinely updated to provide the program with an ongoing comprehensive accounting of the number of people in Texas with each infectious disease. For example, see figure A for the creation of the HIV master list:

Figure A: Creation of HIV Master List

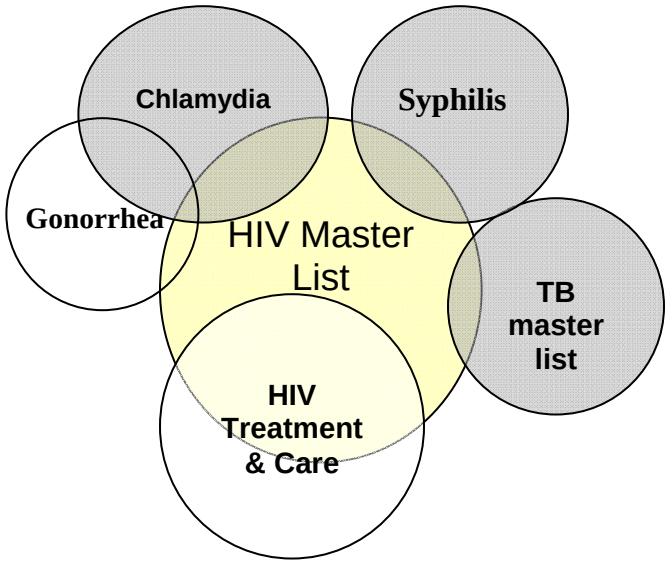


Each infectious disease master list will then be used as a basis or core condition for matching to the other disease-specific master lists. Layering information about the infectious disease history for each individual will increase our understanding of co-morbidity patterns in Texas, assist in identifying populations at risk for co-infection and enhance our ability to answer more large scale questions about co-morbidity in Texas.

Areas of interest in co-morbidity might include:

- Tracking the history of STD infections before people acquire HIV – questions arising out this analysis might include *are there any markers or patterns that could inform development of strategies to intervene earlier*?
- Tracking the history of STD infection following the acquisition of HIV – a question here might be *do any target groups emerge for intervention strategies, and might this information inform development of those strategies?*
- Examine the complexity of treatment and care, and increased cost for treating individuals with HIV and co-occurring conditions.

Figure B: Supplemental Fields Added to HIV Master List



Once each of the disease master files have been linked to each other, a number of additional priority matches will be conducted. HIV treatment and care data will be linked to the HIV master list, as well as HIV public health follow-up data. Once matching occurs, these data reservoirs can be added to over time, and will be available to professional staff across HIV/STD/TB/VH to inform programmatic decision-making.

Objective 2: Physical Integration

Physical integration of the different HIV, STD, and TB disease reporting systems into MAVEN software will provide a more permanent solution to housing of the matched disease data and reduce HIV/STD program dependence on older, unsupported software systems. Further, integration of HIV prevention and care and treatment information into a single system will increase the ease of matching and assessment of linkage and enrollment in treatment and care for persons with HIV infection. It is possible in the future that these systems will further merge.

Objective 2 Tasks

The groundwork for this project is already underway. Maven, software produced by Consiliance, has been chosen by DSHS as the platform for registry standardization, a project that spans across emergency services and preparedness, immunization, infectious disease, and HIV/STD and TB. A license for the system has been purchased, and a project plan for integration of HIV, STD, and TB data systems is currently being developed. DSHS will be customizing HIV, TB, and STD data structures for surveillance, public health follow up, and case management created by other jurisdictions as the base for the Texas system. The challenges associated with this transition are not trivial. The current TB data systems are a mixture of homegrown and CDC structure, and will present considerable challenges to the integration and transfer of legacy data. Likewise, the present STD system houses thousands of records, and does not use the most updated version of STD*MIS. Discussions are underway to determine if a “behind the scenes” transition of the current MIS data to the 5.0 schema would ease integration into Maven. eHARS transition will bring its own challenges, although the recent transition from HARS to eHARS provided an opportunity to clean and solidify the information in that system.

DSHS will work with Houston Health and Human Services to assure that the structures put into place will accommodate and mirror their own installation of Maven. DSHS staff is also in communication with colleagues from other jurisdictions that use the Consiliance product, as well as colleagues within DSHS that are also making the transition.

While DSHS peer users can serve as a rich resource on transition pathways, it also presents challenges. Consiliance has limited capacity, and DSHS has not yet determined the order of precedence for the various programs to begin programming work to transition to Maven. DSHS will update CDC with a project plan as soon as it becomes available, and whether or not PCSI funds are ultimately used to support programming for the transition.

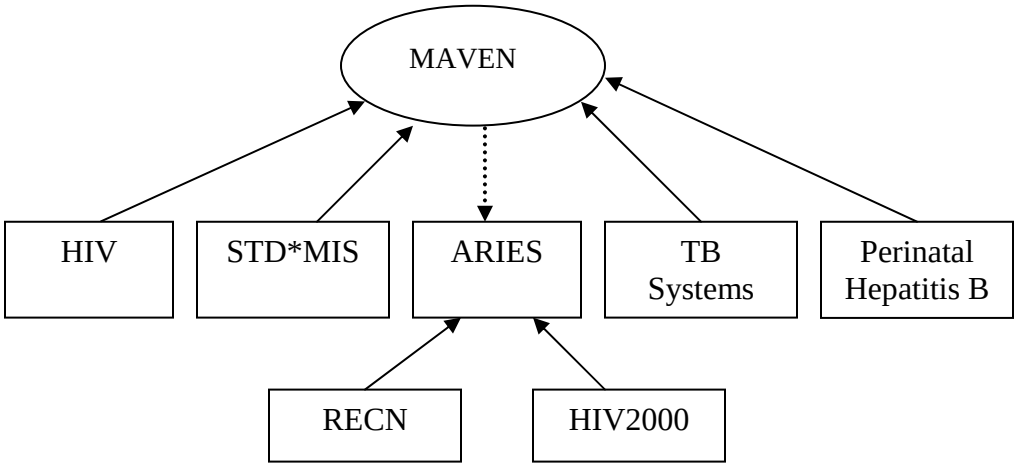
On a second front, integrating information from across prevention and treatment into one data system, there are more certain plans. Data from HIV counseling and testing sites (CTR) and health education and risk reduction (HERR) has for many years been entered and stored in the

Real-time Education and Counseling net (RECN). However, information technology support for this program has lessened over time, limiting the system's ability to adapt to a changing prevention environment. Basic and enhanced data fields designed to capture and describe HIV prevention outcomes were recently added to the AIDS Regional Information and Evaluation System (ARIES). ARIES is supported by several states and is primarily used to collect client-level Ryan White service delivery data. This ARIES enhancement will bring about the retirement of the older RECN system. The system is expected to begin receiving HIV testing data by the spring of 2012. The system will be available for entering HIV testing work by directly and indirectly funded CDC and SAMHA grantees.

A similar predicament is occurring with HIV-2000, the data system utilized for the AIDS Drug Assistance Program (ADAP) and the State Pharmacy Assistance Program (SPAP). Plans are to merge the information from this system into ARIES and retire HIV-2000 from use. Work is currently underway on specifications and model requirements, and integration and migration are expected to be completed by August 31, 2012 on this piece of the project.

As shown below, the merged disease reporting and intervention systems for HIV, STD, and TB will be housed in Maven, including electronic laboratory reporting information, with RECN and HIV2000 into ARIES. At the present time, given the enormity of these projects, information transfer from Maven to ARIES will be limited to "pushes" of information from Maven (and in the interim from ELR systems and eHARS into ARIES) to facilitate more complete reporting of laboratory information to ARIES to facilitate assessment of linkage and maintenance in care from an analysis and quality management perspective.

Figure C: Physical Data Integration into MAVEN



Objective 3: Increased Data Sharing

A key component of the National HIV/AIDS Strategy is increased collaboration and information sharing across federal funding streams. To meet this vision, the HIV/STD program has been working with the DSHS Mental Health and Substance Abuse division (MHSA) on enhanced data

sharing. There is a range of infectious disease activities occurring within MHSA and presently the HIV/STD program has little access to the data from these pursuits.

Objective 3 Tasks

In Texas, significant work on HIV outreach, testing and case management for HIV-infected persons is supported through the HIV set-aside in the SAMHSA block grant. These projects are managed in a separate division at DSHS, the Substance Abuse and Mental Health Services Division (MHSA). To better understand how these programs' contribute to Texas' efforts to implement the National HIV/AIDS strategy, and to assess the focus and level of integration of these programs, the HIV/STD program is working with MHSA to promote data sharing. The HIV/STD program has expressed interest in reducing the burden of dual reporting, and in increasing the use of MHSA grantee data in assessments of HIV testing program efficiency and effectiveness, along with integrating information from SAMHSA-funded HIV case management agencies into ARIES, the main information repository for the Ryan White Program.

Though cautious in its approach to the collaboration, MHSA appears open to the proposal. The first step was to assess the current state of the MHSA data system, the Clinical Management of Behavioral Health Services (CMBHS). This assessment found a number of the core elements necessary to accurately describe risk behavior and infectious disease testing outcomes are not currently captured in CMBHS. A second assessment is underway to determine what elements must be added to CMBHS, and how current data might be exported for examination as stand-alone data and for the suitability of matching to existing data in ARIES. As this project must receive approval from DSHS senior management as an integration project, no timeline can be provided for addition of these elements. Negotiations continue with MHSA, information technology department staff and DSHS management to determine a strategy or agreement on the sharing of HIV testing and case management data from this system.

Goal 2: Integrate Behavioral and Physical Health for Populations at Highest Risk for HIV, STD, TB, Viral Hepatitis

Overall Goal

To increase the collaboration between public health and substance abuse to promote greater integration of physical health (HIV, STD, TB and viral hepatitis screening, immunization and connection to care) and behavioral health (substance abuse and mental health treatment).

Rationale

Since the epidemic began, IDU has directly or indirectly accounted for more than one-third (36%) of the AIDS cases in the United States[1] For women, an estimated 61% of AIDS cases can

[1] Fact Sheet: Drug Associated HIV Transmission Continues in United States, Centers for Disease Control and Prevention, March 8, 2007

be attributed to injecting drug use or to sex with partners who use injection drugs[2]. Although geographic variation exists, the HCV rate among injection drug users is often higher than 60%[3]. Nearly one in every five TB patients abuses alcohol, uses illicit drugs or both. Substance abuse among TB patients is markedly higher than the prevalence of other risks factors for the disease, such as homelessness, HIV infection, or recent immigration to the U.S[4]. Substance abuse can energize sexual risk behavior and reduce inhibitions, which can translate into a higher risk for STD. All of these infectious diseases (HIV, HCV, TB and STD) converge in the substance abuse population, highlighting the interrelatedness of the substance abuse and infectious disease epidemics. Undiagnosed and untreated mental health and substance abuse issues not only accelerates risk behavior, it also reduces compliance, which exposes others, as it can affect adherence to longer term drug regimens like HIV and TB. Undiagnosed and untreated infection creates new infections in vulnerable populations with little access to medical care, and could reduce the effectiveness of behavioral interventions designed to support substance abuse recovery.

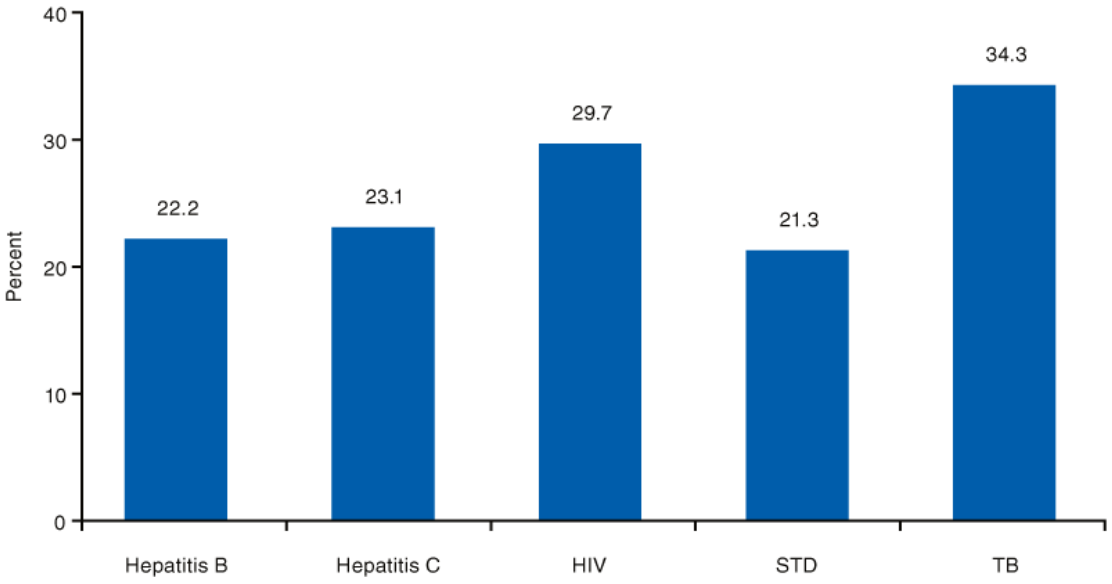
Assessment, Committee Recommendations and Planning

Substance abuse and mental health conditions are interrelated with HIV, STD, TB and viral hepatitis, yet a characteristic of the Texas system is the fragmentation of services for such co-occurring conditions. Addressing these intertwined epidemics by bridging this system gap is key to the DSHS vision of reducing the number of undiagnosed HIV, STD, TB and viral hepatitis infections.

The recognition of these connections led two earlier service integration committees to recommend the integration of infectious disease screening and immunization in substance abuse treatment. The first of these committees, the *Integration of Routine HIV Testing Workgroup*, was formed in 2007 and charged with the integration of routine HIV testing in DSHS programs and contractors. The second committee, the *Viral Hepatitis Integration Workgroup*, formed in 2009 and looked at the integration of viral hepatitis screening and immunization. Both committees were made up of representatives of a variety of programs within DSHS, including HIV/STD surveillance, TB, the laboratory, HIV/STD program, Immunizations, and viral hepatitis. Both committees reviewed epidemiologic data and national recommendations.

In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a survey of 13,648 substance abuse treatment centers across the U.S.; fewer than half of all facilities reported the availability of on-site infectious disease screening.[5]

[2] HIV/AIDS Surveillance Report, 2003, Centers for Disease Control and Prevention, 2004; 15
[3] Diaz, Theresa, et al "Factors Associated With Prevalent Hepatitis C: Differences among Young Adult Injection Drug Users in Lower and Upper Manhattan, New York City", American Journal of Public Health January 2001, Vol. 91, No.1
[4] Oeltmann, JE, et al "Tuberculosis and Substance Abuse in the United States, 1997-2006", Archives of Internal Medicine 2009; 169(2): 189-197
[5] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (February 25, 2010) *The N-SSATS Report: Infectious Disease Screening*, Rockville, Maryland.



Similar assessments were conducted of the substance abuse treatment system within MHSA in Texas. A detailed exploration of the MHSA data system found key elements missing; elements necessary to describe the outcomes of HIV, STD, TB and viral hepatitis detection and treatment referral activities. Further assessment through key informant interviews found no routine HIV and HCV testing at MHSA substance abuse treatment facilities; HIV testing is not available at all facilities, and where it does occur, it is performed intermittently by an outside testing agency. TB and syphilis testing does occur on a routine basis, but only at 1 of the 8 different types of facilities.

These assessments and other planning conversations identified a number of areas for work in order to advance the integration of physical and behavioral health:

Data Collection

Presently the MHSA data system does not collect the essential elements necessary for describing the outcomes of infectious disease activities. See Data Integration Priority for more details.

Data Reporting and Sharing

Once this information is entered into the system, outcome data from all HIV, STD, TB and viral hepatitis testing activities must be made available for analysis, review and matching with existing data.

Joint Planning and Evaluation

Jointly plan to improve outcomes and efficiency; determine best use of resources and agree on measures of program success for HIV, STD, TB and viral hepatitis detection and treatment activities.

Procurement

Influence MHSA procurement policy to implement system-wide integration of HIV, STD, TB and viral hepatitis screening and immunization in substance abuse treatment.

Integration of Mental Health and Substance Abuse Screening MHSA into HIV, STD, TB, and Viral Hepatitis Program Providers

Increase capacity to conduct screening and referral for mental health and substance abuse issues within HIV, STD, TB and Viral Hepatitis detection and treatment providers.

Objective 1: Identify a Potential Site for Integrating Behavioral and Physical Health

Public health and substance abuse were formerly two separate agencies combined into DSHS through legislative mandate in 2005. A number of barriers to collaboration existed, including disparate business culture and practices, differing view of the core mission and program focus, organizational placement within DSHS, and separate funding streams. Some members of the MHSA staff expressed concern that infectious disease screening would prove detrimental to their clients' recovery process.

This nascent relationship between the two programs made finding a starting point imperative. A strategy emerged using a diffusion of innovation model: start small, locating early and eager adopters. This idea evolved into a demonstration project to begin building the partnership, demonstrate the mutual benefits of collaboration and show the effectiveness of joint work. Over time, the innovation would be pushed out to the larger system.

The approach was teamed with the epidemiologic data, the systems assessment that highlighted the large service gap, and the recommendations of the two committees. Also, experience informed the best fit for routine testing, pointing specifically to venues with routine medical assessments. Using this design, a number of systems would already be in place at targeted venues, including the drawing of specimens, lab processing, and results-giving. Key informants identified the Opioid Therapy clinics as such a venue, coinciding with both earlier service integration committee recommendations. It was agreed that the Opioid Therapy clinics were the best platform for promoting the integration of physical and behavioral health.

Morbidity was the first consideration in determining which opioid therapy sites would be enlisted. Geographic hot spots for HIV and STD included Houston, Dallas, Austin, San Antonio and East Texas; TB morbidity lies along the Texas-Mexico border. As there is limited surveillance for HCV in Texas, high morbidity areas for this disease are largely unknown; yet logic, HIV/STD program data on HCV testing conducted in HIV testing programs, and special studies in the Texas state prison system and in El Paso, indicated that a treatment program for former injectors should yield high rates of HCV infection. Additionally, the MHSA program had long standing and strongly held beliefs about HIV and HCV prevalence in this population, estimating that the HIV rate stood at about 25% and the HCV rate at 80%, even though HIV/STD program surveillance data tended not to support this perception. In order to learn more about the population to dispel or support this belief, it became important to find a good geographic spread of sites to act as the early adopters.

The administrative group responsible for Houston providers was not interested in the participating in the project and those in Dallas could not be approached due to an administrative barrier. Austin, San Antonio and Corpus Christi (in East Texas) were therefore selected as the HIV high morbidity sites. Laredo is on the border, as well as El Paso; these sites were selected as

TB high morbidity. As the morbidity of HCV was unknown, Lubbock was added to learn more about the geographic distribution of HCV within the population.

Objective 2: Analyze Data from Integrated Sites

Ensuring the quality and completeness of the outcome data from all sites will be the first priority of new PCSI data researcher. Analyzing the testing yield will follow; examining each disease across the all sites and each site individually and comparatively. Some questions have already come up, and although this initiative originated out of earlier PCSI committees, it is an appropriate conversation for the proposed service integration committee. Some of these discussions might include:

- What is the appropriate testing yield for each disease?
- The testing yield for HBV appears to be very low. What is the value in keeping this screening test as part of the overall infectious disease protocol?
- How can we improve collaboration between these sites and local public health departments and treatment providers to enhance the success of referrals?
- What course corrections need to occur, in terms of the different sites?
- How do we begin to move this innovation into the larger substance abuse system?
- In seeking to facilitate sustainability of this initiative, what are the next steps to increasing the capacity of these providers to seek third party reimbursement?
- How do we increase the acceptability of immunizations in the population?

Goal 3: Explore How to Address Syndemics

Overall Goal

Address population-based syndemics in a focused manner through recommendations for service integration initiatives.

Rationale

While the group thinking process is meaningful way to gather ideas and solve problems, it can sometimes be counterproductive if the group is too large and expertise too varied, especially when focusing on more detailed issues. Comprehensive, diverse groups, like the current Texas PCSI committee, are much better suited for addressing overarching systemic questions.

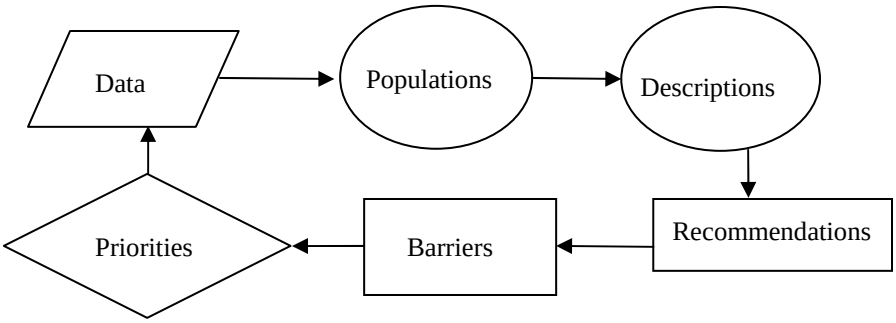
A better strategy for targeting syndemics and focusing on local priority populations most at risk for infectious disease is to bring together a smaller, more cohesive group. A leaner, homogeneous committee will:

- Facilitate shorter timelines;
- Possess extensive knowledge of HIV, STD, TB and viral hepatitis, thereby providing a clearer focus on the core functions of prevention, detection and treatment; and
- Have the ability to accurately and appropriately pinpoint gaps and opportunities for service integration within infectious disease activities.

Objective 1: Convene a Population-Focused Committee

The purpose of the service integration PCSI committee is to focus on service integration recommendations within the core public health activities of HIV, STD, TB and viral hepatitis prevention, detection and treatment.

This group will support analysis and "sense making" of co-morbidity data to identify syndemics and priority populations most affected by multiple morbidities. This will be an ongoing process as the first set of matched data will be HIV-focused; the committee will analyze additional data matches as they become available. The group will use these data to identify priority populations, including but not limited to: who are they, geographic distribution, where do they access existing services, and where are where other naturally occurring access points.



This group will also review current service delivery systems assessment opportunities and gaps; compare to the syndemics and priority populations identified to develop an initial set of HIV, STD, TB and viral hepatitis prevention, detection and treatment client level service integration recommendations. These recommendations will consider barriers and strategies to address identified barriers; leverage project facilitators, and consider feasibility and possible scale and effects of the project on prevention of new cases of HIV, STD, TB and viral hepatitis.

Group Membership

	Name	*Title*	*Area of Expertise*
1	Sydney Minnerly	Syphilis Elimination Coordinator	STD
2	Ann Robbins	Branch Manager	Principal Investigator
3	Todd Logan	PCSI Coordinator	PCSI
4	Dolores Alvarez	HIV Targeted Intervention Group	HIV Prevention
5	Felipe Rocha	Unit Manager	HIV (chair)
6	Larry Cuellar	Adult Viral Hepatitis Coordinator	Hepatitis
7	Charles Wallace	Branch Manager	Tuberculosis
8	Jim Lee	Senior Public Health Advisor	STD
7	Sharon Melville	Branch Manager	Surveillance

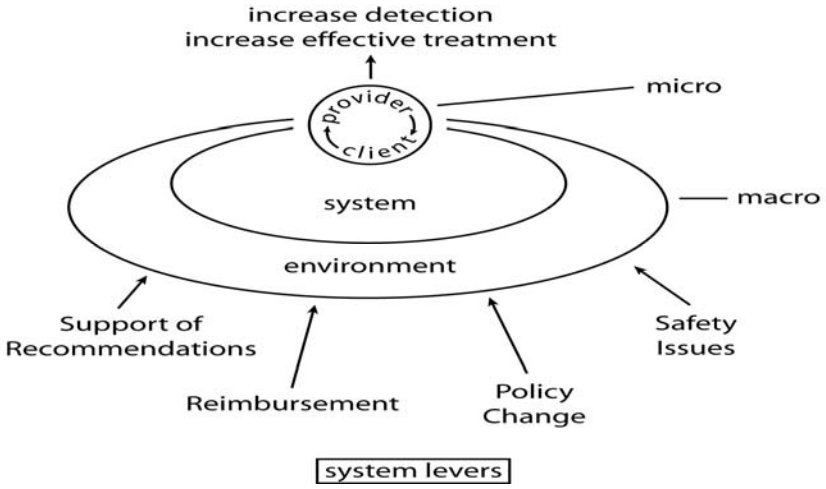
Goal 4: Explore Areas of Program Collaboration

Overall Goal

Capitalize on the unique role of the state health department to work with groups of community providers and professionals in the health care sector to promote integration of HIV, STD, TB and viral hepatitis detection and treatment in systems outside of public health.

With twenty members from across the agency, the Texas PCSI committee embodies the collaborative culture that exists within DSHS. This wide range of expertise includes program representatives from family planning, maternal and child health, Medicaid coordination, mental health and substance abuse, immunizations and the laboratory, along with staff from TB, HIV, STD and viral hepatitis.

Comprehensive, diverse groups like the current Texas PCSI committee are well suited for addressing overarching systemic questions, and the unique role of the state health department points to the need for a strategy to influence larger systems. It is this distinct position to set and influence policy, interact with large professional organizations, and to affect external systems that call for a specific focus on systems collaboration.



The Program Collaboration PCSI committee will work at the macro level to bring about service integration changes at the micro-level

This is not to say DSHS has control over these larger systems; to be sure, it is more about finding the common ground, the leverage points, and working with these larger systems to find and align mutually rewarding goals.

Objective 1: Focus the PCSI Committee on Systems Change

This committee then would not be seeking opportunities for service integration based on syndemic data for a given population; focus on client-level work would fall to the service integration committee noted in goal three. This larger committee would instead look to system assessments for gaps and opportunities for macro-level collaborations. This is a structural intervention approach, seeking ways to manipulate the larger environment within which the

service providers live, to improve outcomes, efficiency, and to increase the detection and treatment of infectious disease.

The work has already begun. The committee has identified these systems for possible collaboration:

- Health Care, including primary care and pharmacies
- Public Health
- Corrections, including jail health and law enforcement
- Substance Abuse
- Mental Health

This group's work on broader systems issues will complement the more focused, population-based group by broadening the discussion, and perhaps identify areas of system-wide opportunities for changing the way we approach our work.

Texas PCSI Plan: **Summary of Goals, Objectives and Tasks**

Goals	*Objectives*	*Tasks*	*Target*
Create an Enriched Data Environment	Data Integration	A. Create a master list for HIV B. Create a master list for TB C. Create a master list for gonorrhea, chlamydia and syphilis D. Link HIV master to TB, syphilis, gonorrhea and chlamydia E. Conduct additional priority STD and TB matches F. Analyze all data	March 2012 January 2012 January 2012 June 2012 proposed January 2013
	Physical Data Integration	A. Secure additional server space B. Purchase MAVEN C. Program ARIES with RECN elements D. Program ARIES with HIV2000 elements	Proposed Proposed March 2012 September 2012
	Increased Data Sharing	A. Program CMBHS with infectious disease outcome elements B. Negotiate data sharing agreement with MHSA	Proposed Proposed
Integrate Physical and Behavioral Health	Identify Potential Sites for the Integration of Physical and Behavioral Health		Completed
	Analyze Data From Integrated Sites	A. Ensure data quality and completeness B. Analyze testing yield for all sites and diseases C. Present project to service integration committee D. Strengthen connection to care all sites	Ongoing Quarterly December 2011 January 2012
Explore How to Address Syndemics	Convene population-focused PCSI Committee	A. Analyze co-morbidity data B. Identify and describe populations	November 2011 December 2011
	Develop priorities for service integration	A. Review assessments B. Identify barriers, facilitators and scale	December 2011 March 2012
Explore Areas of Program Collaboration	Focus PCSI committee on systems change	A. Convene committee to restart discussions	December 2011

Appendix A
Service Delivery System Assessment

Purpose

The purpose of the PCSI System Activity Assessment is to describe program collaboration and service integration initiatives associated with HIV, STD, TB and viral hepatitis core activities in Texas.

Goal 1: Decrease the number of undiagnosed HIV, syphilis, gonorrhea, TB and Viral Hepatitis infections

Targeted HIV testing

Targeted HIV testing has been a consistent presence in the Texas HIV Prevention portfolio and is supported by HIV Prevention and SAMHSA funding. Along with their core mission of targeted HIV testing, all CDC-funded Counseling, Testing and Referral (CTR) sites conduct syphilis testing, beginning in 2007. Integration of HCV at CTR sites began in 2002 with the introduction of viral hepatitis prevention messages into risk reduction counseling and training. HCV testing was implemented at a small number of CTR sites. In 2009 the new Adult Viral Hepatitis Prevention Coordinator (AVHPC) brought a renewed effort to viral hepatitis integration, with a refocus of existing HCV testing sites and expansion to new CTR sites targeting injection drug users.

	HIV							HCV					Syphilis				
		Positive		New Positive		confirm care			Positive		Confirm care			Positive		confirm care	
CTR Sites	Tested	N	%	N	%	N	%	Tested	N	%	N	%	tested	N	%	N	%
AIDS Arms	2,360	39	1.7	25	1.1	18	48.6	335	72	21.5	13	18.1	965	42	4.4	22	57.9
AIDS Outreach	1,463	17	1.2	16	1.1	16	94.1	0	0	.	0	.	0	0	0.0	0	0.0
Amarillo PH	754	4	0.5	4	0.5	4	100.0	244	20	8.2	0	0.0	77	0	0.0	0	0.0
Austin-Travis County	1,966	32	1.6	29	1.5	29	96.7	46	12	26.1	1	16.7	1,923	42	2.2	1	8.3
BEAT AIDS	2,402	19	0.8	17	0.7	19	100.0	947	135	14.3	8	6.3	447	10	2.2	4	40.0
Big Country AIDS	721	4	0.6	4	0.6	4	100.0	382	56	14.7	9	20.9	623	14	2.2	12	85.7
Brazos Valley	791	4	0.5	3	0.4	4	100.0	0	0	.	0	.	644	16	2.5	5	38.5
CARE - ATCMHMR	2,032	14	0.7	12	0.6	14	100.0	898	113	12.6	7	8.4	60	0	0.0	0	0.0
Coastal Bend	1,765	13	0.7	6	0.3	12	100.0	51	15	29.4	0	0.0	165	1	0.6	0	0.0
El Paso Public Health	1,439	18	1.3	13	0.9	16	88.9	1	0	0.0	0	.	1,177	14	1.2	5	38.5
Health Horizons	1,540	5	0.3	5	0.3	5	100.0	2	0	0.0	0	.	463	2	0.4	0	0.0
Hope Action Care	1,140	11	1.0	10	0.9	8	80.0	0	0	.	0	.	284	10	3.5	4	66.7

Appendix A
Service Delivery System Assessment

Land Manor-PALM	1,227	4	0.3	3	0.2	3	75.0	258	55	21.3	13	35.1	1,103	14	1.3	10	76.9
Laredo Health	1,806	19	1.1	19	1.1	18	94.7	350	34	9.7	8	26.7	89	0	0.0	0	0.0
Plan Parent- Gulf Cst	3,656	87	2.4	61	1.7	70	85.4	41	4	9.8	0	0.0	2,063	34	1.6	11	37.9
Plan Parent North Tex	901	11	1.2	9	1.0	4	36.4	31	3	9.7	0	0.0	247	7	2.8	2	50.0
Resource Ctr Dallas	1,270	53	4.2	48	3.8	47	95.9	14	0	0.0	0	.	920	28	3.0	20	83.3
San Angelo AIDS	119	0	0.0	0	0.0	0	.	113	21	18.6	0	0.0	0	0	0.0	0	0.0
Special Health	2,472	22	0.9	22	0.9	20	95.2	527	80	15.2	0	0.0	211	14	6.6	1	14.3
Tarrant County Health	1,911	16	0.8	14	0.7	13	86.7	255	87	34.1	1	1.8	1,107	29	2.6	10	41.7
Triangle AIDS	586	12	2.0	8	1.4	11	91.7	190	16	8.4	12	85.7	540	9	1.7	8	88.9
UTSWMC	2,102	44	2.1	44	2.1	36	90.0	605	78	12.9	10	19.6	0	0	0.0	0	0.0
United Way Ft Hood	570	11	1.9	4	0.7	11	100.0	0	0	.	0	.	457	4	0.9	4	100.0
Valley AIDS Council	2,090	24	1.1	20	1.0	24	100.0	182	13	7.1	0	0.0	831	18	2.2	12	92.3
Vida y Salud	427	5	1.2	1	0.2	5	100.0	0	0	.	0	.	341	5	1.5	2	100.0
Waco-McLennan Cty	1,178	15	1.3	10	0.8	14	93.3	3	0	0.0	0	.	448	9	2.0	2	33.3
Wichita Falls PH	585	12	2.1	6	1.0	11	91.7	0	0	.	0	.	381	1	0.3	0	0.0
Total	**39,273**	**515**	**1.3**	**413**	**1.1**	**436**	**88.3**	**5,475**	**814**	**14.9**	**82**	**12.8**	**15,566**	**323**	**2.1**	**135**	**55.3**

Integrated Services at Specific Sites or Areas

	SYPHILIS	
OBJECTIVE/INDICATOR	NUMBER	INDEX/ %
# Syphilis Cases	**1515**	
# Syphilis Cases Interviewed	**1462**	97%
# Cases With Disease Intervention	**882**	60%
# Partners Initiated on Cases	**2971**	2.03
# Clusters Initiated on Cases	**2111**	1.44
# Partners/Clusters Brought to RX	**476**	
# Partners/Clusters Preventively RX	**1116**	
# Partners/Cluster Treated	**1592**	**1.09**

- STD clinics in Texas have routinely offered a full panel of STD testing to all clients, including HIV for more than 10 years.
- Partner Services is fully integrated; Disease Intervention Specialists (DIS) across the state have routinely worked with newly diagnosed cases of syphilis and HIV since 1999.
- All Syphilis Elimination efforts also include HIV testing.

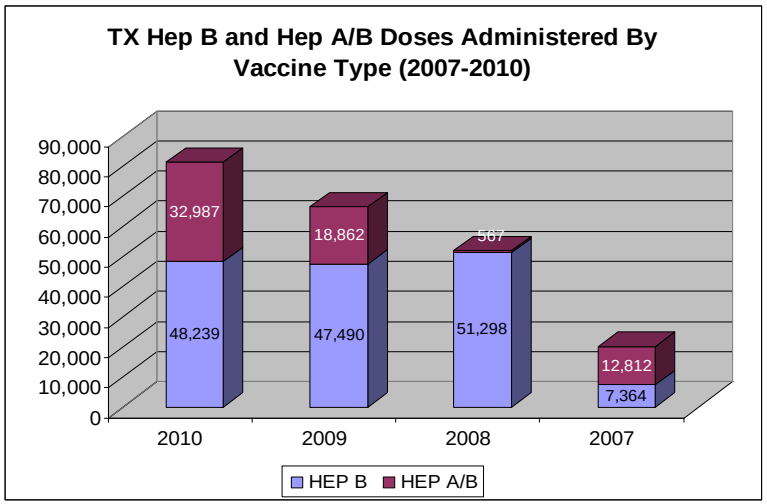
Appendix A
Service Delivery System Assessment

# Partners Not Examined	**527**	
# Partners Examined	**1529**	**74%**
	HIV	
# STD Clients Eligible for HIV Test	**40658**	
# STD Clients HIV Tested	**39770**	97.8%
# Positive	**466**	1.2%
# HIV Cases	**1890**	
# HIV Cases Interviewed	**1649**	87.2%
# HIV Cases Successfully Referred to EIP	**1571**	95.3%
# Partners Initiated on Cases	**2778**	1.68
# Clusters Initiated on Cases	**1894**	1.15
# New Partners/Clusters Exam'd	**3191**	1.94
# New Partners/Clusters Tested	**2990**	93.7%
# New Partners/Clusters Positive	**120**	4.0%
# Partners Not Examined	**577**	
# Partners Examined	**1432**	**71%**
# Partners/Clusters Rec'd from CBO	**22**	
# Partners/Clusters Initiated from CBO	**22**	100.0%

OUTREACH SCREENING		
	SYPHILIS	HIV
# Tested	10131	10101
# Positive	271	64
% Positive	2.7%	0.6%
# New Cases	70	35
% New Cases	25.8%	54.7%

Appendix A
Service Delivery System Assessment

Integrated Services at Specific Sites or Areas (cont'd)



In 2010, all STD clinics also began routinely offering HAV/HBV immunizations. Other venues within the HIV/STD and Viral Hepatitis prevention and treatment system have also begun offering adult HAV/HBV immunizations. One example are substance abuse treatment centers, specifically Opioid Therapy. In addition to an expansion in the number of enrolled sites, there has been a large increase in the number of adult vaccines administered.

Additionally, all newly diagnosed HIV positive persons entering HIV medical care are screened for syphilis, HCV, HBV and TB. This standard of care includes HAV/HBV immunizations.

Collaboration to increase routine HIV screening

The Test Texas HIV Coalition brings stakeholders together from a variety of perspectives to build the capacity of healthcare providers to implement routine HIV testing; Test Texas also seeks to provide increased access to technical assistance resources in order to make the 2006 CDC recommendations a part of regular practice. This group has seen expansion of routine opt-out HIV testing integrated into medical services at 8 emergency departments, 2 local primary care health departments, 14 community health centers, 8 corrections sites, 1 family planning clinic and 1 teen health clinic.

Fiscal Year	New HIV+	HIV+ (history unknown)	Previously HIV+	Total HIV+	Total Tests
2009	412	15	264	691	62,284
2010	600	227	532	1,359	130,82

Appendix A
Service Delivery System Assessment

Policy barrier removal

The assessment of Texas statutes identified no hindrances to HIV testing and screening; however the rules state agencies put in place to govern their practices can inhibit routine testing. .The HIV/STD program revised its rules in 2004 to remove references to mandatory risk reduction counseling. The HIV/STD program put forward a legislative initiative to align Texas law with the 2006 CDC Revised Recommendations for HIV testing; this bill became law, and program rules were revised in 2009 to reflect these changes. In 2008, through participation in the Routine HIV Testing Integration workgroup, the program assisted the state mental health hospital system in revising its rules that prohibited routine HIV testing. In 2009, the program also assisted in revising the provider manual for the Children's Health Insurance Program. All of these rule sets were revised to align with the 2006 CDC Revised Recommendations for routine HIV testing. Recently, through participation on the Interagency Coordinating Council on HIV and Hepatitis, a committee encompassing 7 different state agencies, the program began work with the Texas Department of Family and Protective Services to revise their rules to allow for routine screening of adolescents in foster care.

Challenges

Reducing Administrative Barriers

DSHS is a very large organization with many rules, policies and business practices that govern activities; these policies and business practices sometimes ease project implementation and sometimes hinder it. The administrative barriers encountered center on the contracting process:

- there is limited flexibility around who the agency can contract with;
- the process is lengthy with many steps;
- each DSHS division has its own contracting unit and sometimes the process differ from unit to unit; and
- the ability to move funds to sites with a higher disease morbidity is severely limited.

Increasing the Efficiency of Targeted HIV Testing

More must be learned about the activities of the SAMHSA funded HIV testing sites. When comparing these with the CDC funded sites, there appears to be disparate goals, different measures of productivity and limited focus on partner services. These sites do not perform syphilis testing, program philosophies differ, and there is presently no provision for joint planning.

Opportunities

Collaborations to increase screening at Substance Abuse Treatment sites

Appendix A
Service Delivery System Assessment

In 2007 SAMSHA conducted a national survey on infectious disease screening at treatment facilities; announced in March 2010, it was accompanied by SAMHSA statements on the importance of health screening for patients in recovery. Release of this survey and statement, which telegraphed the importance of infectious disease screening by SAMHSA, triggered MHSA to move forward with infectious disease screening for clients in treatment. Using the diffusion of innovation model, the goal is for HIV, STD, TB and viral hepatitis screening and immunization to be available system-wide.

Goal 2: Increase Participation in Care

Description of Collaborative and Integration Efforts
The Texas Ryan White Part B Minority AIDS Initiative (MAI) project focuses on post-incarcerated, HIV-infected individuals for the purpose of increasing access to primary medical care, which includes medications, supportive services that assist with community reintegration, and adherence to medications and staying in care. Close collaboration with the Texas Department of Criminal Justice (TDCJ) has provided DSHS staff with unprecedented access to prerelease inmates. Two MAI positions are inside the prison system, working closely with the TDCJ Reentry and Integration Division and meet with all HIV-infected inmates on the day of their release from TDCJ. They play an important role: collect updated release information; assist with applications, like ADAP and Medicaid; share the release information with ADAP and other referral agencies; provide the offender with additional information needed for successful reintegration; and reinforce medical instructions.

<u>Challenges</u>
An unanticipated barrier to participation in care is the possible shortfall to the Texas AIDS Drug Assistance Program (ADAP). ADAP provides medications to qualifying HIV positive patients in the state of Texas. Expanded enrollment and increased costs are contributing to a shortfall that has the potential to limit the number of new positives that are able to enroll in the program. There is also a perception that there are limited HIV treatment options (i.e., trained providers specializing in HIV treatment and care) within local communities; this perception is fed by a lack of knowledge of the treatment resources in communities and a lack of understanding of the primary care providers' role in the treatment of HIV.

At Opioid Therapy clinics implementing the integrated infectious disease panel, linkage to medical care for those testing positive can be quite complex, as each disease requires its own system for connection to care. The SAMHSA-funded HIV Early Intervention program has been a key partner for linking those found to be HIV positive to HIV medical care; for syphilis and TB, the local health

department is the point of referral. These relationships, between the provider and the local health department, need to be strengthened and formalized active referral processes worked out.

Opportunities
Finding HIV positive persons who are out of care has always been somewhat difficult; a small integration pilot project in two cities seeks to improve this issue and bring more HIV-infected persons into medical care. In the last year, CD-4 and viral load counts for HIV positive persons became reportable; while presently only in the planning stage, the idea is to first match these reportable CD4 and viral load counts to the master list of HIV positive persons. Those HIV positive persons who have not had a CD4 or viral load in within one year will be considered out-of-care. Disease Intervention Specialists (DIS) will contact each one of these individuals in their area to facilitate their return to medical care.

Goal 3: Increase the Quality of Integrated Data

Description of Collaborative and Integration Efforts
Activities to Increase Data Quality Assurance
As a large state with a high incidence of HIV, the coordination of accurate and timely data collection can be a challenge. The HIV/STD program has been coordinating with data specialists to revamp existing data collection systems to streamline program data collection. The HIV/STD program is integrating HIV prevention data elements into AIDS Regional Information and Evaluation System (ARIES), the multi-state/jurisdiction system used to report Ryan White Program data. It is anticipated that this revised system will be ready for prevention program use in mid-2011.

Improvements have also been made to STD*MIS (centralization) and the development of a monthly partner services analysis file will allow for greater evaluation of partner services. DSHS has noticed a gap between eHARS and STD*MIS; a small but still substantial number of persons appear in one system but not in the other.

One of the HIV/STD Program's recently developed strategic goals is improved distribution and use of information. DSHS is investigating ways to promote key messages related to the HIV epidemic in Texas and reach better concordance with external partners on these key messages. A consultation and capacity-building workshop for surveillance specialists, analysts, and epidemiologists associated with local health department was held in June 2010. This workshop focused on improving local capacity to conduct

meaningful analysis of their HIV and STD data, on applying these data to local decision-making and program improvement, and effective dissemination of these data.

Opportunities

Increasing the Completeness of Data

All newly diagnosed HIV positive persons entering HIV medical care are screened for syphilis, HCV, HBV and TB. This standard of care has been in place for many years and includes HAV/HBV immunizations. Most all local providers utilize an electronic medical record and document testing outcomes here; however entering or matching the local data with the central data source is inconsistent. Increased collection of this existing data may yield a better understanding of co-morbidities within the HIV-infected population in care.

Routine HIV testing is a new initiative for the TB program; the HIV/STD program began collaborative work TB management toward implementation of this goal just two years ago. Since that time, performance of routine HIV testing for all TB cases and suspects has increased greatly. While there continues to be room for improvement in performance of the test, data collection around testing outcomes has proven inconsistent and emerged as a new issue. Renewed exploration and support for this initiative appears to be in order.

While some SAMSHA funded sites utilize the HIV prevention data system (RECN), others utilize another data system (CMBHS) that is not aligned in data collection elements and does not share information with HIV prevention. A project is underway to increase the alignment of these systems and to gain access to the outcome data.

Goal 4: Increase Provider Ability to Seek Third Party Reimbursement

Description of Collaborative and Opportunistic Efforts

Medicaid Provider Manual

The HIV/STD program was opportunely brought in to the revision of the Texas Medicaid provider manual; while this was a long process, HIV/STD program insertions were accepted. These revisions aligned the Medicaid provider manual with the 2006 CDC Revised Recommendations for HIV testing and helped establish a foundation for reimbursement of HIV testing by the Texas Medicaid programs. (See also Opportunities)

Appendix A
Service Delivery System Assessment

Opioid Therapy Project
What began as a service integration project has grown into a collaborative opportunity to learn more about the Medicaid billing issue firsthand. Prior to implementation of this project, HIV/STD program staff was fairly naïve on the process. Reimbursement to the opioid sites for the integrated infectious disease protocol was based on the Medicaid reimbursement process. While there is much yet to learn, much has been learned also; staff has gained basic understanding of Medicaid coding, billing for lab testing and other such issues.

Challenges
Limited Capacity
The capacity of the HIV/STD program to promote third party reimbursement is limited; also limited is the capacity of providers in the billing process. Yet third party reimbursement has been a part of the discussion from the first committee meeting and is of high interest to all members. The DSHS Medicaid liaison is a committee member and has expressed willingness to assist with this issue. The identification of resources, the pooling of ideas and the development of strategies to move a number of programs within DSHS toward obtaining reimbursement will be just a few of the steps necessary on the path.

Opportunities
Medicaid Provider Manual
Revisions to the manual by the HIV/STD program centered on routine HIV testing and did not include recommendations for STD testing. As a collaborative path has already been established, and staff with jurisdiction over the provider manual has proven open to input, it appears a renewed effort may be in order.

HIV Prevention															
program area	core service	target populations	venues	infectious disease screening								other screening		gaps or possible integration points	barriers and facilitators
				HIV	HCV	HBV	syphilis	GC	CT	immuniz	TB	SA	MH		
CTR	risk counseling targeted HIV testing	MSM IDU African American Hispanic	CBO local health depart local jails	X routine	X risk		X routine							GC and CT testing MH and SA screen	unknown yield cost capacity time in CTR
HERR	EBI - group community individual	MSM IDU African American Hispanic	CBO local health depart	X intermit			X intermit					X intermit		HIV and syphilis testing all EBI HCV, SA screening and immunization IDU focused EBI	needs assessment may be in place needs further assessment
Perninatal	case management connection to services connection to medical and prenatal care	HIV + pregnant women HIV positive women of childbearing age	CBO											how is this same or different from HBV Perinatal?	needs further assess may be in place requires extensive cross-training
Expanded Testing	integrate routine HIV testing into medical settings	all persons within venue (venue chosen based on access by at risk population)	hospitals community clinics local jails urgent care clinics	X routine			X limited							expanded team now talking with providers about STD screening	investigate how to support, evaluate effort
Viral Hepatitis	integration of hepatitis testing & vaccination into already existing service venues provide for education and support groups	IDU MSM	already existing service contractors		X risk					X intermitt				expand immunization where possible and appropriate	continue efforts

HIV Care and Services

program area	core services	target populations	venues	infectious disease screening																other screening				gaps or possible integration points	barriers and facilitators
				HIV		HCV		HBV		syphilis		GC		CT		immuniz		TB		SA		MH			
HIV Medical Care and Services	outpatient medical care case management support services	HIV positive persons	health clinic CBO	X	routine	X	routine	X	routine	X	routine	X	routine	X	routine	X	routine	X	routine	X	routine	X	routine	increase completeness of data around these activities	needs further assessment to determine issues
Medications (ADAP)	provide HIV medications	low-income HIV positive persons	central office thru contracted pharmacies																					none noted	
Minority AIDS Initiative (MAI)	connect newly released HIV infected offenders medical care and services in the community	HIV positive incarcerated	TDCJ and local agencies																					none noted	
Housing for People with AIDS	provide housing for low income HIV positive persons	HIV positive	CBO Section 8																					none noted	

STD Prevention, Treatment and Partner Services															
program area	core service	target populations	venues	infectious disease screening								other screening		gaps or possible integration points	barriers and facilitators
				HIV	HCV	HBV	syphilis	GC	CT	immuniz	TB	SA	MH		
STD Clinical Services	diagnose and treat persons suspected of having HIV/STD	at risk persons persons suspected of having HIV/STD	local health depart STD clinics some regional health departments	X routine	X risk		X routine	X routine	X routine	X routine				support expansion of EPT	evaluate to determine if new strategies required
Partner Services	locate, test & interview persons with HIV/STD, their partners, and high risk persons	HIV/STD positive persons, suspects and associates	local and regional health depart field work	X routine			X routine	X limited	X limited					DIS follow-up on HIV infected not in care appears similar to TB contact tracing	two pilot sites presently underway research feasibility
Syphilis Elimination	partner services case-based screening jail screening rapid response teams social marketing	African-American MSM HRH infected partners	local health depart CBO local jails field work in high morbidity counties	X routine			X routine	X routine	X routine					none noted	
Mobile Van	outreach prevention and screening in high morbidity areas	populations at risk for HIV/STD	local health depart	X routine	X risk		X routine	X routine	X routine	X routine				none noted	

Tuberculosis and Hansen's Disease

program area	core service	target populations	venues	infectious disease screening: HIV	HCV	HBV	syphilis	GC	chlam	immuniz	TB	other screening: SA	MH	gaps or possible integration points	barriers and facilitators
TB Prevention and Control	diagnosis and treatment of TB disease and LTBI contact investigation	suspect/known TB/LTBI HIV-infected foreign born homeless correctional inmates and employee long term care facilities	local and regional health depart	X routine	X risk	X risk					X routine			increase performance and documentation of routine HIV testing similar to DIS followup	evaluate progress to determine if reinvigorated research feasibility appropriateness
Correctional	provide technical assistance and testing supplies	correctional inmates and employees	correction facilities with >100 beds								X routine			use of nurse TB testing as a natural point for other testing	strategy in use where possible in local correctional
HBV Perinatal														cross-training of regional nurses to talk about other STI HIV with clients	already proposed by regional infectious disease managers
Hansen's Disease	diagnosis & treatment of Hansen's disease	patients suspected or known to have HD	Dallas & Houston local HD Tx Ctr for ID											none noted	

outpatient treatment followed for >1year; other clinical testing does occur

Appendix B
Assessment of Texas Laws on HIV

Purpose
Examine Texas statutes on HIV/AIDS to determine barriers to PCSI initiatives.

Background
There are a large number of laws governing HIV that stretch across the Texas codes of Health and Safety, Education, Insurance, and Criminal Procedure. These statutes regulate many different aspects of the disease, including consent for testing, the handling of prisoners with HIV, requirements around home testing kits, mandatory testing for those accused of assault, and surveillance reporting requirements. No new measures on infectious disease passed during the 2010-2011 legislative session.

Summary of findings
Consent
While Texas has a long history of using a separate consent for HIV testing in medical and prevention settings alike, the Health and Safety Code has never actually required a separate consent form for HIV testing. According to the law, a general consent for treatment is considered sufficient. Statute does mandate informed consent for HIV testing; informed consent is construed as an opt-out model: notice of testing, an opportunity for the patient to ask questions, and the option to decline. Informed consent has not presented a barrier to HIV activities.

Counseling
Pre-test counseling and post-test counseling for persons testing negative are not required. Texas law does mandate face-to-face post-test counseling for initial diagnosis of HIV infection. At STD clinics, hospital emergency departments and other settings where HIV testing occurs, mandatory post-test counseling for newly diagnosed HIV-infected persons is the responsibility of the Disease Intervention Specialist (DIS). In this interaction, the DIS also provides partner services and connection to HIV medical care.

Criminalization of HIV
Even with the nationwide trend to position HIV infection with assault rather than infectious disease, Texas has not criminalized unprotected sex for persons infected with HIV, STD, TB and viral hepatitis. Also, no duty to warn exists in Texas. Persons accused of physical or sexual assaults are required to submit to testing.

Education
Sex education for school students, including education around HIV, is a politically charged issue in Texas. While not prohibited by statute, administrative barriers exist; it is considered inappropriate for the HIV/STD program to be directly involved in the sexual or infectious disease education of minor students.

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Texas Health and Safety Code	Title	Sub-Title	Chapter	Sub-Chapter	Section	Communicable Diseases	Weblink
Texas Health and Safety Code	**2**	**D**	**81**	**A**		**General Provisions**	http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.81.htm
Texas Health and Safety Code	2	D	81	A	81.001	Short Title	
Texas Health and Safety Code	2	D	81	A	81.002	Responsibility of State and Public	
Texas Health and Safety Code	2	D	81	A	81.003	Definitions	
Texas Health and Safety Code	2	D	81	A	81.004	Administration of Chapter	
Texas Health and Safety Code	2	D	81	A	81.005	Contracts	
Texas Health and Safety Code	2	D	81	A	81.006	Funds	
Texas Health and Safety Code	2	D	81	A	81.007	Limitation oon Liability	
Texas Health and Safety Code	2	D	81	A	81.008	Communicable Disease in Animals; Exchange of Information	
Texas Health and Safety Code	2	D	81	A	81.009	Exemption from Medical Treatment	
Texas Health and Safety Code	2	D	81	A	81.010	Interagency Coordinating Council for HIV and Hepatitis	
Texas Health and Safety Code	2	D	81	A	81.011	Request for Information	
Texas Department of Safety Code	**2**	**D**	**81**	**B**		**Prevention**	
Texas Department of Safety Code	2	D	81	B	81.021	Board's Duty	
Texas Department of Safety Code	2	D	81	B	81.022	Health Education	
Texas Department of Safety Code	2	D	81	B	81.023	Immunization	
Texas Department of Safety Code	2	D	81	B	81.024	Reports by Board	
Texas Health and Safety Code	**2**	**D**	**81**	**C**		**Reports and Reportable Diseases**	
Texas Health and Safety Code	2	D	81	C	81.041	Reportable Disease	
Texas Health and Safety Code	2	D	81	C	81.042	persons Required to Report	
Texas Health and Safety Code	2	D	81	C	81.043	Records and reports of Health Authority	
Texas Health and Safety Code	2	D	81	C	81.044	Reporting procedures	
Texas Health and Safety Code	2	D	81	C	81.045	MRSA Reportin Procedures Pilot Program	
Texas Health and Safety Code	2	D	81	C	81.045	Reports of Death	
Texas Health and Safety Code	2	D	81	C	81.046	Confidentiality	
Texas Health and Safety Code	2	D	81	C	81.047	Epidemiological Reports	
Texas Health and Safety Code	2	D	81	C	81.048	Notification of Emergency Personnel, Peace Officers, Detention Officers, County Jailers. And Fire Fighters	
Texas Health and Safety Code	2	D	81	C	81.049	Failure to Report; Criminal Penalty	
Texas Health and Safety Code	2	D	81	C	81.050	Mandatory testing of Persons Suspected of Exposing Certain Other Persons to Reportable Disease, Including HIV Infection	

Texas Health and Safety Code	2	D	81	C	81.051	Partner Notification Programs; HIV Infection	
Texas Health and Safety Code	2	D	81	C	81.052	Reports and Analyses Concerning AIDS and HIV Infection	
Texas Health and Safety Code	**2**	**D**	**81**	**D**		**Investagation and Inspection**	
Texas Health and Safety Code	2	D	81	D	81.061	Investigation	
Texas Health and Safety Code	2	D	81	D	81.062	Witnesses;Documents	
Texas Health and Safety Code	2	D	81	D	81.063	Samples	
Texas Health and Safety Code	2	D	81	D	81.064	Inspection	
Texas Health and Safety Code	2	D	81	D	81.065	Right of Entry	
Texas Health and Safety Code	2	D	81	D	81.066	Concealing Communicable Disease or Exposure to communicable Disease; Criminal Penalty	
Texas Health and Safety Code	2	D	81	D	81.067	Concealing, Removing, or Disposing of an infected or Contaminated Animal, Object, Vehicle, Watercraft, or Aircraft; Criminal Penalty	
Texas Health and Safety Code	2	D	81	C	81.068	Refusing Entry or Inspection; Criminal Penalty	
Texas Health and Safety Code	**2**	**D**	**81**	**E**		**Control**	
Texas Health and Safety Code	2	D	81	E	81.081	Board's Duty	
Texas Health and Safety Code	2	D	81	E	81.082	Administration of Control measures	
Texas Health and Safety Code	2	D	81	E	81.083	Application of Control Measures to Individual	
Texas Health and Safety Code	2	D	81	E	81.084	Application of Control Measures to property	
Texas Health and Safety Code	2	D	81	E	81.085	Area Quarantine; Criminal Penalty	
Texas Health and Safety Code	2	D	81	E	81.086	Application of Control Measures to Private and Common Carriers nd Private Conveyances	
Texas Health and Safety Code	2	D	81	E	81.087	Violation of Control Measure Orders; Criminal Penalty	
Texas Health and Safety Code	2	D	81	E	81.088	Removal, Alteration, or Destruction of Quarntine Devices; Criminal Penalty	
Texas Health and Safety Code	2	D	81	E	81.089	Transportation; Criminal Penalty	
Texas Health and Safety Code	2	D	81	E	81.090	Serologic Testing During Pregnancy	
Texas Health and Safety Code	2	D	81	E	81.091	Ophthalmia Neonatorum Prevention; Criminal Penalty	
Texas Health and Safety Code	2	D	81	E	81.092	Contracts for services	
Texas Health and Safety Code	2	D	81	E	81.093	Persons Procecuted for Certain Crimes	

Texas Health and Safety Code	2	D	81	E	81.094	Testing by Hospitals of Persons indicted for Certain Crimes	
Texas Health and Safety Code	2	D	81	E	81.095	Testing for Accidental Exposure	
Texas Health and Safety Code	2	D	81	E	81.0955	Testing for Accidental Exposure Involving a Deceased Person	
Texas Health and Safety Code	**2**	**D**	**81**	**F**		**Test for Acquired Immune Deficiency Syndrome and Related Disorders**	
Texas Health and Safety Code	2	D	81	F	81.101	Definitions	
Texas Health and Safety Code	2	D	81	F	81.102	Tests: Criminal Penalty	
Texas Health and Safety Code	2	D	81	F	81.103	Confidentiality: Criminal penalty	
Texas Health and Safety Code	2	D	81	F	81.104	Injunction: Civil Liability	
Texas Health and Safety Code	2	D	81	F	81.105	Informed Consent	
Texas Health and Safety Code	2	D	81	F	81.106	General Consent	
Texas Health and Safety Code	2	D	81	F	81.107	Consent to test for certain Accidental exposures	
Texas Health and Safety Code	2	D	81	F	81.108	Testing by Insurers	
Texas Health and Safety Code	2	D	81	F	81.109	Counseling Required for Positive Test Results	
Texas Health and Safety Code	**2**	**D**	**81**	**G**		**Court Orders for Management of Persons with Communicable Disease**	
Texas Health and Safety Code	2	D	81	G	81.151	Application for Court Order	
Texas Health and Safety Code	2	D	81	G	81.1511	Applicability of Subchapter to Group	
Texas Health and Safety Code	2	D	81	G	81.152	Form of Application	
Texas Health and Safety Code	2	D	81	G	81.153	Appointment of Attorney	
Texas Health and Safety Code	2	D	81	G	81.1531	Appointment of Attorney for Group	
Texas Health and Safety Code	2	D	81	G	81.154	Sertting on Application	
Texas Health and Safety Code	2	D	81	G	81.055	Notice	
Texas Health and Safety Code	2	D	81	G	81.156	Disclosure of Information	
Texas Health and Safety Code	2	D	81	G	81.157	District Court Jurisdiction	
Texas Health and Safety Code	2	D	81	G	81.158	Affidavit of medical Evalution	
Texas Health and Safety Code	2	D	81	G	81.159	Designation of Facility	
Texas Health and Safety Code	2	D	81	G	81.160	Liberty Pending Hearing	
Texas Health and Safety Code	2	D	81	G	81.161	Motion for Order of Protective Custody	
Texas Health and Safety Code	2	D	81	G	81.162	Issuance of Order	
Texas Health and Safety Code	2	D	81	G	81.163	Apprehension Under Order	
Texas Health and Safety Code	2	D	81	G	81.164	Appointment of Attorney	
Texas Health and Safety Code	2	D	81	G	81.165	Probable Cause Hearing	
Texas Health and Safety Code	2	D	81	G	81.166	Order for Continued Detention	
Texas Health and Safety Code	2	D	81	G	81.167	Detention in Protective Custody	
Texas Health and Safety Code	2	D	81	G	81.168	Release From Detention	
Texas Health and Safety Code	2	D	81	G	81.169	General Provisions Relating to Hearing	

Texas Health and Safety Code	2	D	81	G	81.170	Right to Jury	
Texas Health and Safety Code	2	D	81	G	81.171	Release After Hearing	
Texas Health and Safety Code	2	D	81	G	81.172	Order for Temporary Management	
Texas Health and Safety Code	2	D	81	G	81.173	Order for Extended Management	
Texas Health and Safety Code	2	D	81	G	81.174	Order of Care of Commitment	
Texas Health and Safety Code	2	D	81	G	81.175	Court ordered Outpatient Services	
Texas Health and Safety Code	2	D	81	G	81.176	Designation of Facility	
Texas Health and Safety Code	2	D	81	G	81.177	Commitment to Private Facility	
Texas Health and Safety Code	**2**	**D**	**81**	**H**		**Blood Borne Pathogen Exposure Control Plan**	
Texas Health and Safety Code	2	D	81	H	81.301	Definitions	
Texas Health and Safety Code	2	D	81	H	81.302	Applicability of Subchapter	
Texas Health and Safety Code	2	D	81	H	81.303	Exposure Control Plan	
Texas Health and Safety Code	2	D	81	H	81.304	Minimum Standards	
Texas Health and Safety Code	2	D	81	H	81.305	Needleless Systems	
Texas Health and Safety Code	2	D	81	H	81.306	Sharps Injury Log	
Texas Health and Safety Code	2	D	81	H	81.307	Device Registration	

Texas Health and Safety Code	Title	Sub-Title	Chapter	Sub-Chapter	Section	Aquired Immune Deficiency Syndrome and Human Immunodeficiency Virus	Weblink
Texas Health and Safety Code	**2**	**D**	**85**	**A**		**General provision and Education Programs**	http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm
Texas Health and Safety Code	2	D	85	A	85.001	Short Title	
Texas Health and Safety Code	2	D	85	A	85.002	Definitions	
Texas Health and Safety Code	2	D	85	A	85.003	Department as Lead Agency and Primary Resource	
Texas Health and Safety Code	2	D	85	A	85.004	Education Programs	
Texas Health and Safety Code	2	D	85	A	85.005	Special Components of Education Programs	
Texas Health and Safety Code	2	D	85	A	85.006	Education programs for Disabled Persons	
Texas Health and Safety Code	2	D	85	A	85.007	Education programs for Minors	
Texas Health and Safety Code	2	D	85	A	85.008	Distribution of Education Programs	
Texas Health and Safety Code	2	D	85	A	85.009	Educational Programs Available on Request	
Texas Health and Safety Code	2	D	85	A	85.010	Educational Course for employees and Clients of Health Care Facilities	
Texas Health and Safety Code	2	D	85	A	85.011	Contracts for education programs	
Texas Health and Safety Code	2	D	85	A	85.012	Model Workplace Guidelines	
Texas Health and Safety Code	2	D	85	A	85.013	Funding Information	
Texas Health and Safety Code	2	D	85	A	85.014	technical Assistance to communtiy Organizations	
Texas Health and Safety Code	2	D	85	A	85.015	Contract for Services; Duration	
Texas Health and Safety Code	2	D	85	A	85.016	Rules	
Texas Health and Safety Code	**2**	**D**	**85**	**B**		**State Grant Program to Community Organizations**	
Texas Health and Safety Code	2	D	85	B	85.031	State Grant Program to Communtiy Organizations	
Texas Health and Safety Code	2	D	85	B	85.032	Rules; Program Structure	
Texas Health and Safety Code	2	D	85	B	85.033	Coordination of Services	
Texas Health and Safety Code	2	D	85	B	85.034	Application Procedures and Eligibility Guidelines	
Texas Health and Safety Code	2	D	85	B	85.035	Applicant Information	
Texas Health and Safety Code	2	D	85	B	85.036	Awarding of Grants	

Texas Health and Safety Code	2	D	85	B	85.037	Restrictions on Grants	
Texas Health and Safety Code	2	D	85	B	85.038	Restrictions on Funds	
Texas Health and Safety Code	2	D	85	B	85.039	Information Provided by Funded Program	
Texas Health and Safety Code	2	D	85	B	85.040	Evaluation of Funded Programs	
Texas Health and Safety Code	2	D	85	B	85.041	Records and Reports	
Texas Health and Safety Code	2	D	85	B	85.042	Financial Records	
Texas Health and Safety Code	2	D	85	B	85.043	Due Process	
Texas Health and Safety Code	2	D	85	B	85.044	Advisory Committee	
Texas Health and Safety Code	**2**	**D**	**85**	**C**		**HIV Medication Program**	
Texas Health and Safety Code	2	D	85	C	85.061	HIV Medication Program	
Texas Health and Safety Code	2	D	85	C	85.062	Eligibility	
Texas Health and Safety Code	2	D	85	C	85.063	Procedures and Eligibility Guidelines	
Texas Health and Safety Code	2	D	85	C	85.064	Funding	
Texas Health and Safety Code	2	D	85	C	85.065	Sliding Fee Scale to Purchase Medication	
Texas Health and Safety Code	2	D	85	C	85.006	Advisory Committee	
Texas Health and Safety Code	**2**	**D**	**85**	**D**		**Testing Programs and Counseling**	
Texas Health and Safety Code	2	D	85	D	85.081	Model Protocols for Counseling and testing	
Texas Health and Safety Code	2	D	85	D	85.082	Department Voluntary Testing Programs	
Texas Health and Safety Code	2	D	85	D	85.083	Registration of Testing Program	
Texas Health and Safety Code	2	D	85	D	85.084	For Profit Testing Program	
Texas Health and Safety Code	2	D	85	D	85.085	Physician Supervision of Medical Care	
Texas Health and Safety Code	2	D	85	D	85.086	Reports	
Texas Health and Safety Code	2	D	85	D	85.087	Training of Counselors	
Texas Health and Safety Code	2	D	85	D	85.088	State-Funded Health Clinics	
Texas Health and Safety Code	2	D	85	D	85.089	Disciplinary Action	
Texas Health and Safety Code	**2**	**D**	**85**	**E**		**Duties of State Agencies and State Contractors**	
Texas Health and Safety Code	2	D	85	E	85.111	Education of State Employees	
Texas Health and Safety Code	2	D	85	E	85.112	Workplace Guidelines	
Texas Health and Safety Code	2	D	85	E	85.113	Workplace Guidelines for State Contractors	
Texas Health and Safety Code	2	D	85	E	85.114	Education of Certain Clients, Inmates, Patients, and Residents	

Texas Health and Safety Code	2	D	85	E	85.115	Confidentiality Guidelines	
Texas Health and Safety Code	2	D	85	E	85.116	Testing and Counseling for State Employees Exposed to HIV Infection on the Job	
Texas Health and Safety Code	**2**	**D**	**85**	**F**		**Demonstration Projects on Nursing Care**	
Texas Health and Safety Code	2	D	85	F	85.131	Research on Nursing Care	
Texas Health and Safety Code	2	D	85	F	85.132	Demonstration Projects in Nursing Facilities	
Texas Health and Safety Code	**2**	**D**	**85**	**G**		**Policies of Correctional and Law Enforcement Agencies, Fire Departments, and Emergency Medical Services Providers**	
Texas Health and Safety Code	2	D	85	G	85.141	Model Policies Concerning Persons in Custody	
Texas Health and Safety Code	2	D	85	G	85.142	Adoption of Policy	
Texas Health and Safety Code	2	D	85	G	85.143	Content of Policy	
Texas Health and Safety Code	**2**	**D**	**85**	**I**		**Prevention of Transmission of HIV and Hepatitis B Virus By Infected Care Workers**	
Texas Health and Safety Code	2	D	85	I	85.201	Legislative Findings	
Texas Health and Safety Code	2	D	85	I	85.202	Definitions	
Texas Health and Safety Code	2	D	85	I	85.203	Infection Control Standards	
Texas Health and Safety Code	2	D	85	I	85.204	Modification of Practice	
Texas Health and Safety Code	2	D	85	I	85.205	Disciplinary Procedures	
Texas Health and Safety Code	2	D	85	I	85.206	Retention of License;Permitted Acts	
Texas Health and Safety Code	**2**	**D**	**85**	**J**		**Home Collection kits for HIV infection Testing**	
Texas Health and Safety Code	2	D	85	J	85.251	Definitions	
Texas Health and Safety Code	2	D	85	J	85.252	Prohibitions Relating to Home Collection Kit	
Texas Health and Safety Code	2	D	85	J	85.253	Prohibitions Relating to Home Testing	
Texas Health and Safety Code	2	D	85	J	85.254	Package of Services	
Texas Health and Safety Code	2	D	85	J	85.255	Qualified Facility	

Texas Health and Safety Code	2	D	85	J	85.256	Oral Reporting	
Texas Health and Safety Code	2	D	85	J	85.257	Counseling; Counseling Protocol	
Texas Health and Safety Code	2	D	85	J	85.258	Labeling	
Texas Health and Safety Code	2	D	85	J	85.259	Enforcement	
Texas Health and Safety Code	2	D	85	J	85.261	Confidentiality	
Texas Health and Safety Code	2	D	85	J	85.261	Certain Technology Prohibited	
Texas Health and Safety Code	2	D	85	J	85.262	Reports	

Texas Insurance Code	Title	Sub-Title	Chapter	Sub-Chapter	Section	Section Title	Weblink
Texas Insurance Code	**2**	**A**	**38**			**Data Collection and Reporting Relating to HIV and AIDS**	**http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.38.htm**
Texas Insurance Code	2	A	38	C	38.101	Definitions	Provides definition for HIV and AIDS
Texas Insurance Code	2	A	38	C	38.102	Purpose	Ensures Adequacy and Accessiblity of health coverage
Texas Insurance Code	2	A	38	C	38.103	Data Collection Program	data and information relating to the effect of HIV and AIDS on the availability, adequacy, and affordability of health benefit plan coverage
Texas Insurance Code	2	A	38	C	38.104	Compliation of Data and Information; Report	compile the data and information included in reports
Texas Insurance Code	2	A	38	C	38.105	Recommendations and Reports to Legislature	commissioner may submit to the legislature written recommendations for legislation the commissioner considers necessary to resolve problems related to the effect of HIV and AIDS
Texas Insurance Code	2	A	38	C	38.106	Information Confidential	If report reveals the identity of an individual or associate an individual with a company, the commissioner shall declare the information or reports confidential, and the information or reports may not be made available to the public.
Texas Insurance Code	**2**	**A**	**38**	**D**		**Liability Insureance Closed Claim Reports**	**This report defines and identifies the process that must take place regarding closed claim reports. This is not HIV/AIDS specific but does related to closed or confidential reporting.**
Texas Insurance Code	**5**	**C**	**544**			**Prohibited Discrimination**	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.544.htm#00
Texas Insurance Code	5	C	544	A	54.001	Applicability of Subchapter	General Prohibitions Against Discrimination by an Insurer or Health Maintenance Organization
Texas Insurance Code	5	C	544	A	54.002	Unfair Discrimination	
Texas Insurance Code	5	C	544	A	54.003	Exceptions	
Texas Insurance Code	5	C	544	A	54.004	Enforcement Actions	
Texas Insurance Code	**5**	**C**	**544**	**B**		**Other General Prohibitions Against discrimination By Insurers**	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.544.htm#544.051
Texas Insurance Code	5	C	544	B	54.051	Applicability of Subchapter	
Texas Insurance Code	5	C	544	B	544.032	Unfair Discrimination	
Texas Insurance Code	5	C	544	B	544.053	Exceptions	

Texas Insurance Code	5	C	544	B	544.054	Judicial Action; Award by Court	
Texas Insurance Code	**5**	**C**	**545**			**HIV Testing**	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.545.htm
Texas Insurance Code	5	C	545	A		General Provisions	
Texas Insurance Code	5	C	545	A	545.001	Definitions	Defines terms used through out the statute
Texas Insurance Code	5	C	545	A	545.002	Exculsive Applicability	exclusively govern the practices of an issuer in testing applicants to determine
Texas Insurance Code	5	C	545	A	545.003	Rules	Rule Adoption by Commissioner
Texas Insurance Code	5	C	545	B		Issuer Powers and Duties	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.545.htm
Texas Insurance Code	5	C	545	B	545.051	HIV-Related Testing Authorized	Request or Require an applicant to Take an HIV-related test
Texas Insurance Code	5	C	545	B	545.052	Nondiscriminatory Basis Required	Rationale for Requesting or Requiring applicant to take an
							HIV related Test
Texas Insurance Code	5	C	545	B	545.053	Explanation and Authorization	Explanation and Authorization for Required HIV Related Test by Issuer
Texas Insurance Code	5	C	545	B	545.054	Inquiries Regarding Previous Tests	
Texas Insurance Code	5	C	545	B	545.055	Notice of Postive Test Results; Fee	
Texas Insurance Code	5	C	545	B	545.056	Adverse Underwiting Decision; Test Protocol Rules	
Texas Insurance Code	5	C	545	B	545.057	Confidentiality of Text Result Required	
Texas Insurance Code	5	C	545	O		Santions and Penalties	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.545.htm
Texas Insurance Code	5	C	545	O	545.701	Santions	
Texas Insurance Code	5	C	545	O	545.702	Civil Action; Penalty	
Texas Insurance Code	5	C	545	O	545.703	Criminal Penalty	
Texas Insurance Code	8	A	1202	B	1202.051	Renewabilllity and Continuation of Individual Health Insurance Policies	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1202.htm
Texas Insurance Code	8	A	1202	B	1202.052	Cancellation Prohibited for AIDS or HIV	
Texas Insurance Code	**8**	**E**	**1364**			**Converage Provisions Relating to HIV, AIDS, or HIV -Related Illness**	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1364.htm
Texas Insurance Code	8	E	1364	A		Exclusion from or Denial of Coverage Prohibited	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1364.htm
Texas Insurance Code	8	E	1364	A	1364.001	Applicability of Subchapter	Applies only to group health benefit plan
Texas Insurance Code	8	E	1364	A	1364.002	Exception	Identifies Exceptions
Texas Insurance Code	8	E	1364	A	1364.003	Prohibition	Prohbition on group health plan exclusion or denalio of coverage

Texas Insurance Code	8	E	1364	A	1364.003	Rules	Adoption of Rules by commissioner
Texas Insurance Code	8	E	1364	B		Cancellation of Group Coverage Prohibited	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1364.htm#1364.051
Texas Insurance Code	8	E	1364	B	1364.051	Definitions	As related to meaning of HIV and AIDS per Health and Safety Code Section 81.101
Texas Insurance Code	8	E	1364	B	1364.052	Applicability of Subchapter	Applices to an insurer that delivers group health insureance policy or contract
Texas Insurance Code	8	E	1364	B	1364.053	Prohibition	Insure may not cancel because the individuals has been diagnosed,treated for HIV/AIDS
Texas Insurance Code	8	E	1364	C		Certain Coverages Provided by Local Governments	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1364.htm#1364.101
					1364.101		Prohibition on exclusion or limitation of coverages
Texas Insurance Code	8	H	1601	C	1601.109	Coverage for AIDS, HIV or Serious Mental Illness	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1601.htm
Texas Insurance Code	8	H	1601	C	1601.110	Disease Management Services	http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1601.htm#1601.110

TEXAS CODES	Title	Sub-Title	Chapter	Sub-Chapter	Section	Section Title	Weblink
Government Code	4	G	501	B	501.054	Inmate: AIDS and HIV Education; Testing	http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.501.htm#501.054
Government Code	4	G	507	B	507.023	State Jail: AIDS and HIV Education; Testing	http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.507.htm#507.023
Government Code	4	G	501	E	501.049	DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition including HIV, AIDS	http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.501.htm#501.149
Government Code	4	I	531	B	531.0972	PILOT PROGRAM TO PREVENT THE SPREAD OF CERTAIN INFECTIOUS OR COMMUNICABLE DISEASES. The commission may provide guidance to the local health authority of Bexar County in establishing a pilot program funded by the county to prevent the spread of HIV, hepatitis B, hepatitis C, and other infectious and communicable diseases.	http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.531.htm#531.0972
Government Code	4	I	533	A	533.009	SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that managed care organizations under contract with the commission to provide health care services to recipients develop and implement special disease management programs to manage a disease or other chronic health conditions	http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.533.htm#533.009
Local Government Code	5	B	157	A	157.006	PAYMENTS FOR CERTAIN HEALTH INSURANCE COVERAGE. (a) A hospital district created under Article IX of the Texas Constitution or a county may purchase and pay the premiums for a conversion policy or other health insurance coverage for a person who is diagnosed as having HIV or AIDS	http://www.statutes.legis.state.tx.us/Docs/LG/htm/LG.157.htm#157.006

Education Code	3	A	51	Z	51.919	HIV and AIDS Policy: Information Dissemination	http://www.statutes.legis.state.tx.us/Docs/ED/htm/ED.51.htm#51.919
Education Code	3	B	61	C	61.082	Encourage, recognize and support institutio of higher education in applied and basic HIV related research	http://www.statutes.legis.state.tx.us/Docs/ED/htm/ED.61.htm#61.082
Human Resource Code	2	B	22		22.023	DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES: The department may purchase and pay the premiums for a conversion policy or other health insurance coverage for a person who is diagnosed as having AIDS, HIV, or other terminal or chronic illness and whose income level is less than 200 percent of the federal poverty level, based on the federal Office of Management and Budget poverty index in effect at the time coverage is provided, even though a person may be eligible for benefits under Chapter 32 of this code.	http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.22.htm#22.023
Human Resource Code	2	C	32	B	32.057	CONTRACTS FOR DISEASE MANAGEMENT PROGRAMS. The department shall request contract proposals from providers of disease management programs to provide program services to recipients of medical assistance with chronic disease including HIV and AIDS	http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.32.htm#32.057
Occupations Code	3	I	504	E	504.205	CONTINUING EDUCATION REQUIREMENTS.	http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.504.htm#504.205
Occupations Code	3	I	504	E	504.206	Chemical Dependency Counselors: Continuing Education Relating to HIV, hepatitis C and STD	http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.504.htm#504.206
Occupations Code	7	A	1101	Q	1101.802	Real Estate Brokers and Salespersons: Liability Relating to HIV Infection or AIDS	http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.1101.htm#1101.802

Occupations Code	7	A	1101	Q	1101.803	GENERAL LIABILITY OF BROKER. A licensed broker is liable to the commission, the public, and the broker's clients for any conduct engaged in under this chapter by the broker or by a salesperson associated with or acting for the broker.	http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.1101.htm#1101.802
Occupations Code	7	A	1101	L	1101.556	DISCLOSURE OF CERTAIN INFORMATION RELATING TO OCCUPANTS. license holder is not required to inquire about, disclose, or release information relating to whether: a previous or current occupant of real property had, may have had, has, or may have AIDS, an HIV-related illness, or an HIV infection as defined by the Centers for Disease Control and Prevention of the United States Public Health Service;	http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.1101.htm#1101.556
Occupations Code	3	I	504	E	504.205		
Code of Criminal Procedure	1		17		17.45	Requiring AIDS and HIV Instruction to certain inmates	http://www.statutes.legis.state.tx.us/Docs/CR/htm/CR.17.htm#17.45
Code of Criminal Procedure	1		21		21.31	TESTING FOR AIDS AND CERTAIN OTHER DISEASES. A person who is indicted for or who waives indictment for an offense under Section 21.02, 21.11(a)(1), 22.011, or 22.021, Penal Code, shall, at the direction of the court on the court's own motion or on the request of the victim of the alleged offense, undergo a standard diagnostic test	http://www.statutes.legis.state.tx.us/Docs/CR/htm/CR.21.htm#21.31

Code of Criminal Procedure	1		56	A	56.02	Crime Victims' Rights: (11)the right to counseling, on request, regarding acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection and testing for acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, antibodies to HIV, or infection	http://www.statutes.legis.state.tx.us/Docs/CR/htm/CR.56.htm#56.02
Code of Criminal Procedure	1		42		42.037	Restitution: Test and treatment for victim	http://www.statutes.legis.state.tx.us/Docs/CR/htm/CR.42.htm#42.037
Family Code	1	A	2	A	2.01	AIDS Information: Information regarding HIV and AIDS to be provide to persons applying for Marriage License	http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.2.htm#2.010
Family Code	1	A	2	A	2.404	Recording of certificate or Declaration of Informal marriage: County clerk the clerk shall distribute to each party printed materials about acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV).	http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.2.htm#2.404
Family Code	3		54		54.033	Juvenile Justice Code: Judicial Proceeding: Conduct testing for sexually transmitted disease, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.	http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.54.htm#54.033
Family Code	5	E	261	D	261.314	Testing: The department shall provide testing as necessary for the welfare of a child who the department believes, after an investigation under this chapter, has been sexually abused, including human immunodeficiency virus (HIV) testing of a child who was abused in a manner by which HIV may be transmitted.	http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.261.htm#261.314

Family Code	1	A	2	A	2.009	Issuance of License: County Clerk shall distribute to each applicant printed materials about acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV) and note on the license that the distribution was made;	http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.2.htm#2.009

Appendix C:
Assessment of the Infectious Disease Activities and Reporting For the Mental Health and Substance Abuse (MHSA) Division

Purpose
Assess the level of HIV, STD, TB and viral hepatitis service activities occurring within MHSA and assess the state of data collection around the outcomes of these activities.

Background
Until 2005, the Texas Department of State Health Services (DSHS) Mental Health and Substance Abuse division (MHSA) had been its own agency. As a result, MHSA remains structurally set apart from the rest of DSHS, with a different culture, business practices, philosophy and perceived mission.

Assessment of HIV, STD, TB and viral hepatitis activities
Funded through the Substance Abuse and Mental Health Service Administration (SAMHSA), a number of infectious disease activities occur under the purview of MHSA:

Programs with an infectious disease mission

1. HIV Outreach
   MHSA funds community-based organizations to perform HIV testing at substance abuse treatment centers and in local neighborhood areas where drug users congregate.
2. HIV Early Intervention
   MHSA supports case managers who link HIV-infected persons to substance abuse treatment and medical care. Identifying undiagnosed infections is the first step; connecting the newly diagnosed person to medical care is imperative for their own health, for their recovery, and to stop the spread of infection in an already vulnerable population.

Infectious disease activities

1. Opioid Therapy Clinics
   A joint project between MHSA and the TB/HIV/STD and Viral Hepatitis unit involving six MHSA contracted opioid therapy clinics; all clients are screened for HIV, Hepatitis C, and receive Hepatitis A and B immunizations at assessment. Also by MHSA rule, all clients are screened for syphilis and Tuberculosis.
2. TB and syphilis testing
   By MHSA rule, all inpatient or residential substance abuse treatment centers must conduct routine syphilis and TB testing for all clients; the TB testing is required on an annual basis. Including the 6 opioid sites, there are 120 DSHS-funded inpatient centers statewide.
3. HIV screening
   Aside from the 6 opioid sites, no substance abuse treatment center performs HIV testing on a routine basis. Of the DSHS substance abuse staff believes about 70% of sites offer HIV testing using an outside HIV testing program or agency. This

service is offered intermittently, generally 1-2 afternoons weekly for 1-3 hours on a volunteer basis.

4. Hepatitis testing

   Aside from the 6 opioid sites, no hepatitis B testing is presently offered. Substance abuse staff believe only a third of sites offer Hepatitis C testing. When offered, it is intermittently, generally 1-2 afternoons weekly for 1-3 hours on a volunteer basis.

Assessment of MHSA Information Technology (IT)

Upon merging into DSHS, MHSA began building a new IT resource as their data system was almost two decades old. The Clinical Management of Behavioral Health Services (CMBHS) came on line in September 2010. Regardless of scope of work, all MHSA funded contractors utilize the CMBHS. While HIV, STD, TB and syphilis activities within MHSA tend to be of smaller scale, capturing and sharing the data on the outcomes of these activities is a priority. Presently the HIV/STD program has not had access to this information and has not fully understood what information is collected.

The HIV/STD program did obtain permission for a data run; a look at CMBHS data on TB and syphilis found that less than 1/3 of clients in inpatient substance abuse treatment had evidence of testing or the outcome of testing for these infectious diseases.

The next step was to determine what information is currently captured in CMBHS on HIV, STD, TB and viral hepatitis screening. It was found that CMBHS does not capture the essential elements necessary to fully analyze HIV, STD, TB and viral hepatitis outcomes. (see attached screen shots) Also see attached initial analysis of elements that need to be programmed into the data system.

There is presently no sharing of outcome data between the two divisions.

issue	screen	area or type	result details	test	existing data fields		additional data fields requested	
sexual risk information	Substance Abuse Assessment	Hepatitis-B/C and or Human Immunodeficiency Virus (HIV)			has the client ever had unprotected sex (vaginal/oral/anal) without condoms or latex barrier?	Y/N	gender of sexual partners: male female	 Y/N Y/N
HIV	Substance Abuse Assessment	General Health			has the client experienced any of the following conditions?	HIV	if HIV positive, is the client currently attending HIV medical care?	Y/N
	Lab/Test Results	HIV	HIV Antibody Tests	HIV-1 EIA and HIV Western Blot	result test date	N/P dd/mm/yyyy	Does the client decline HIV testing? If HIV positive/infected: Was client referred to medical care? Did the client attend the first HIV medical care appointment?	Y/N Y/N Y/N
Hepatitis C	Substance Abuse Assessment	General Health			has the client experienced any of the following conditions?		*(add Hepatitis C to this list)*	Hep C
	Lab/Test Results	Hepatitis	Hepatitis Results	Antibody to Hepatitis C Virus	result test date	N/P dd/mm/yyyy	Does the client decline Hep C testing? If Hep C positive/infected: has the client been referred to medical care for further assessment, or to supportive or educational resources?	Y/N Y/N
Hepatitis B	Lab/Test Results	Hepatitis	Hepatitis Results	Hepatitis B Surface Antigen	result test date	N/P dd/mm/yyyy	Does the client decline Hep B testing? If Hepatitis B positive/infected: has the client been confirmed to medical care for further assessment?	Y/N Y/N

issue	screen	area or type	result details	test	existing data fields		additional data fields requested	
Syphilis	Substance Abuse Assessment	General Health			has the client experienced any of the following conditions?	Sexually Transmitted Disease		
	Lab/Test Results	Syphilis ***(tab/screen to be added)***					date specimen collected RPR test result if reactive, date reported to the local health department feedback from local health department or medical provider: was treatment for infection received?	dd/mm/yyyy reactive/ non-reactive dd/mm/yyyy Y/N/History no treatment required
TB	Substance Abuse Assessment	General Health			has the client experienced any of the following conditions?	Tuberculosis		
		Tuberculosis (TB)			Has the client had a persistent cough (longer than 3 months) for which they have not seen a doctor? Has client been tested (screened for TB) within the past year?	Y/N Y/N		
	Lab/Test Results	Tuberculin Skin Test			Date/Time Administered Arm on which adminstered Induration	mm/dd/yyyy hh:mm left/right mm	***need to add IGRA (TB blood test)*** date adminstered result if positive, referred to local health dept	 dd/mm/yyyy reactive/ non-reactive/ indeterminate dd/mm/yyyy

issue	screen	area or type	result details	test	existing data fields	additional requested data fields
	Lab/Test Results *cont'd from above*					response from local health department: 0 no exposure not infected 1 TB exposure not infected 2 TB infection no disease 3 TB disease clinically active 4 TB disease not clinically active 5 diagnosis pending

CMBHS
Clinical Management for Behavioral Health Services

04/06/2011 - Build 1

Provider Tools | Business Office | Data | Account Management | System Management | Help | Logout

Provider: Substance Abuse Treatment Center - Do Not Use | Client Name: Client, Test | User Name: Davis, Kevin | Episode Of Care:

Location: SA Location 1 | Client Number: 681034 | Local Case: 681034 | 2/21/2010

- Home
- Find/Add Client
- Intake
- Assessment
- Service Planning
- Service Management
- Service Documentation
- Consents & Referrals
- Discharge

Substance Abuse Adult Treatment Assessment - Update AST022

Save and Continue | Save | Cancel

General | Education & Employment | Family & Social | Legal | Medical | Mental Health | Substance Use | Diagnosis | Recommendation

General Health

Does the client suffer from a chronic painful condition? * Yes No

Sleep Pattern? * None Selecte

How many meals does the client eat each day? *

Does the client have any difficulty eating? * Yes No

*

Does the client use emetics, diuretics or laxatives for the purpose of losing weight? * Yes No

Has the client experienced a significant change in weight during the: Last 30 days? * None Selected Last 3 months? * None Selected

Does the client have any of the following conditions?

- * None
- Unknown
- Alzheimer's disease
- Anemia
- Arthritis
- Autoimmune Disease
- Cancer
- Circulatory System Disease
- Diabetes
- Gastrointestinal Disorder
- Heart Disease
- Hepatitis
- HIV
- Hypertension
- Injury
- Kidney Disease
- Liver Disease
- Other
- Parkinson's Disease
- Pneumonia
- Respiratory/Lung Disease
- Seizure Disorder
- Sexually Transmitted Disease
- Stroke
- Tuberculosis

Describe the client's medical conditions *

Comments

Allergies and Adverse Drug Reactions

CMBHS
Clinical Management for Behavioral Health Services

04/04/2011 - Build 1

Provider Tools | Business Office | Data | Account Management | System Management | Help | Logout

Provider: Substance Abuse Treatment Center - Do Not Use | Client Name: Client, Test | User Name: Davis, Kevin | Episode Of Care:

Location: SA Location 1 | Client Number: 681034 | Local Case: 681034 | 2/21/2010

- Home
- Find/Add Client
- Intake
- Assessment
- Service Planning
- Service Management
- Service Documentation
- Consents & Referrals
- Discharge

Lab/Test Results NTS028

Save Cancel

Result Type

Type * HIV

Result Details

HIV Antibody Tests

	Test	Result	Test Date
☐	HIV–1 EIA		
☐	HIV–1/HIV–2 combination EIA		
☐	HIV–1 Western blot/IFA		
☐	Other HIV Antibody Test:		

Comments

HIV Detection Tests

	Test	Result	Test Date
☐	Culture		
☐	Antigen		
☐	PCR, DNA, or RNA Probe		
☐	Other:		

Comments

Detectable Viral Load Tests

	Test	Copies/ML	Test Date
☐	NASBA (Organon)		
☐	RT-PCR (Roche)		
☐	bDNA(Chiron)		
☐	Other:		

Comments

Immunologic Lab Tests	☐ CD4 Count ☐ CD4 Percent Comments
Service Type	None Selecte
Entered By	* None Selected
Document Status	* Draft
New Comments	

Save Cancel

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☐ None

New Allergy/Drug Reaction

Substance	Description of reaction
No records found	

Edit Remove

Comments

Current Medications

☐ None

New Medication

Medication	Form	Type	Strength	Route	Frequency
No records found					

Edit Remove

Comments

Medical Treatment History

How many times in the past 12 months has the client been in a general hospital including the emergency room? * Number of times

How many times in the client's life have they been in a general hospital including the emergency room? * Number of times

*

How many days in the past 30 days was the client in an environment supervised by a doctor, physician's assistant or nurse? * Number of days

*

Comments

Disability

Does the client receive financial support for a disability? * ○ Yes ○ No

* Brain Injury
Hearing Impairment
Learning Disability
Medical Disability

*

*

Comments

Risk Assessment for Communicable Diseases

Hepatitis-B/C and or Human Immunodeficiency Virus(HIV)

Has the client ever injected drugs?	* Yes No
Has the client ever shared injecting equipment?	* Yes No
Has the client ever shared equipment for snorting drugs?	* Yes No
Does the client have tattoos and/or piercings?	* Yes No
Has the client ever had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier?	* Yes No
Has the client ever had unprotected sex with someone known to inject drugs?	* Yes No

Comments

Tuberculosis (TB)

Has the client had a persistent cough (longer than three months) for which they have not seen a physician?	* Yes No
Has the client been tested (screened for TB) within the past year?	* Yes No

Comments

Client Rating

How many days has the client experienced medical problems in the past 30 days?	*
How troubled or bothered has the client been by medical problems in the past 30 days?	* None Selecte
How important to the client now is treatment or counseling for medical problems?	* None Selecte

Comments

Interviewer Impressions

Is the above information significantly distorted by the client's misrepresentation?	* Yes No
Is the above information significantly distorted by the client's difficulty understanding?	* Yes No

Medical Status Severity * None Selected

Comments

Document Status	* Draft
Document Status Date	04/25/2011

Previous Next

Save and Continue Save Cancel

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CMBHS
Clinical Management for Behavioral Health Services

04/06/2011 - Build 1

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Lab/Test Results NTS028

Save Cancel

Result Type

Type	* Hepatitis

Result Details

	Test	Result	Test Date
Hepatitis Results	☐ Total antibody to hepatitis A virus [total anti-HAV]		
	☐ IgM antibody to hepatitis A virus [IgM anti-HAV]		
	☐ Hepatitis B surface antigen [HBsAg]		
	☐ Total antibody to hepatitis B core antigen [total anti-HBc]		
	☐ IgM antibody to hepatitis B core antigen [IgM anti-HBc]		
	☐ Antibody to hepatitis C virus [anti-HCV] Supplemental anti-HCV assay [e.g., RIBA]		
	☐ HCV RNA [e.g., PCR]		
	☐ Antibody to hepatitis D virus [anti-HDV]		
	☐ Antibody to hepatitis E virus [anti-HEV]		

Service Type	None Selecte
Entered By	* None Selected
Document Status	* Draft
New Comments	

Save Cancel

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CMBHS
Clinical Management for Behavioral Health Services

04/06/2011 - Build 1

Provider Tools | Business Office | Data | Account Management | System Management | Help | Logout

Provider: Substance Abuse Treatment Center - Do Not Use | Client Name: Client, Test | User Name: Davis, Kevin | Episode Of Care:

Location: SA Location 1 | Client Number: 681034 | Local Case: 681034 | 2/21/2010

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Lab/Test Results NTS028

Save Cancel

Result Type

Type	* Tuberculin Skin Test

Result Details

Date/Time Administered	* mm/dd/yyyy * hh:mm * AM PM
Arm on which administered	* Left Right
Date/Time of Reading	* mm/dd/yyyy * hh:mm * AM PM
Induration	* mm
Adverse reaction(s) and/or comments	
Administered By	
Read By	
Service Type	None Selecte
Entered By	* None Selected
Document Status	* Draft
New Comments	

Save Cancel

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