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ANNUAL REPORT

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Texas Department of Health
Bureau of HIV and STD Prevention

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PREFACE

Thanks to the following staff of the Bureau of HIV and STD Prevention, Texas Department of Health, for contributing to this report: Susan Hillman; and, in alphabetical order, Jimmy Beard, MHA; Ginny Dimario, Jim Lee, Linda Moore, M.S., R.N; Laura Ramos, Evelyn Shewmaker, Sheral T. Skinner, LMSW-ACP; Bea Sneed, and Liz Tomich.

I. EXECUTIVE SUMMARY

Estimates suggest that anywhere from 45,000 to 66,000 Texans are infected with human immunodeficiency virus (HIV). From the beginning of the epidemic in the early 1980s to the end of 1994, more than 30,000 acquired immunodeficiency syndrome (AIDS) cases have been reported in Texas. Over 83,000 cases of syphilis, chlamydia and gonorrhea were reported in Texas in 1995. Youth aged 15-19 years accounted for 40% of chlamydia, 31% of gonorrhea and 14% of primary and secondary syphilis reported. With AIDS and other sexually transmitted diseases (STDs) reported in 1995, the total is more than 89,000, or approximately one STD for every 208 Texas residents.

The total operating budget for HIV and STD programs for fiscal year (FY) 1995 was \$48,283,013. The Bureau of HIV and STD Prevention distributed \$32,736,551 to regional and local health departments and community based organizations throughout the state in 1995. Over \$6 million were spent on providing HIV and STD medications to Texas residents in 1995.

HIV prevention efforts focused on the high risk target populations identified through community planning. 148,887 persons were counseled and tested for HIV in Texas in 1995, resulting in the identification of 1,967 HIV positive individuals. Health education and risk reduction messages were delivered by peer educators in over 6,500 sessions across the state. Over 10,000 persons with AIDS and HIV infection received basic HIV-related social and medical services in Texas in 1995. Housing and utility assistance were provided to almost 3,500 persons with HIV and AIDS in Texas.

Sexually Transmitted Disease (STD) clinics across Texas reported more than 117,000 clinic visits in 1995. Disease Intervention Specialists (DIS) interviewed and managed 4,110 reported syphilis cases in Texas in 1995. A total of 2,378 contacts for syphilis were referred by DIS and provided preventative therapy, resulting in the prevention of 713 cases of syphilis and savings of over \$600,000 in medical costs in 1995.

In 1995, over 500 HIV counselors, including 22 hearing impaired counselors, were trained in 32 locations across Texas. The Texas HIV/STD InfoLine, which provides a telephone link between the people of Texas and the Texas Department of Health (TDH), received over 27,000 calls in 1995. The 1995 HIV Prevention Conference in Austin on May 14-17, 1995 attracted over 650 health care professionals.

The Texas HIV Medication Program distributed over \$5 million dollars in antiretrovirals and other prophylactic medications in 1995. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Medication Reimbursement Initiative (MRI) paid deductibles and co-insurance payments in the amount of \$11,831. This support allowed MRI applicants to access almost \$200,000 of HIV-related medication. The Texas STD Medication Program distributed \$561,538 in STD medications and related supplies to 52 sites statewide in 1995.

II. BUREAU OF HIV AND STD PREVENTION

During 1994, the Bureau of HIV and STD Prevention reorganized. The STD Control Division and the HIV Division were integrated and restructured along functional, rather than disease lines. The result was two new Divisions: the HIV/STD Health Resources Division, and the Epidemiology Division (Figure 1). The HIV/STD Health Resources Division is responsible for policy and planning, field operations, training and other programmatic operations. The Epidemiology Division includes surveillance, assessment and evaluation, data management and other technical functions.

Mission Statement

Our mission is to prevent, treat, and/or control the spread of HIV, STD, and other communicable diseases to protect the health of the citizens of Texas. In keeping with this mission, we procure, allocate, and manage fiscal and human resources so that we may:

*Provide HIV/STD education and information,
Collect, interpret, and distribute data relating to HIV and STD,
Provide guidance to those who oversee, plan for, or provide HIV and STD services, and
Provide medication and supplies to prevent, manage, and treat communicable diseases.*

In pursuit of this mission, we will make every effort to assure that the citizens of Texas receive quality services.

The Texas Department of Health (TDH), Bureau of HIV and STD Prevention, is dedicated to preventing the spread of HIV infection and STDs, and minimizing complications and costs. This is achieved primarily through education, counseling and testing, partner elicitation, and the provision of medical and social services and medications. The TDH provides some of these services directly, but most often contracts with local agencies to provide community based services when appropriate. This report documents many of the activities and accomplishments of the Bureau of HIV and STD Prevention (Bureau) in 1995 and provides an epidemiologic assessment of HIV, AIDS, and STDs in Texas.

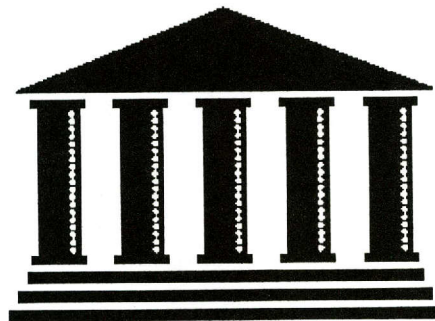
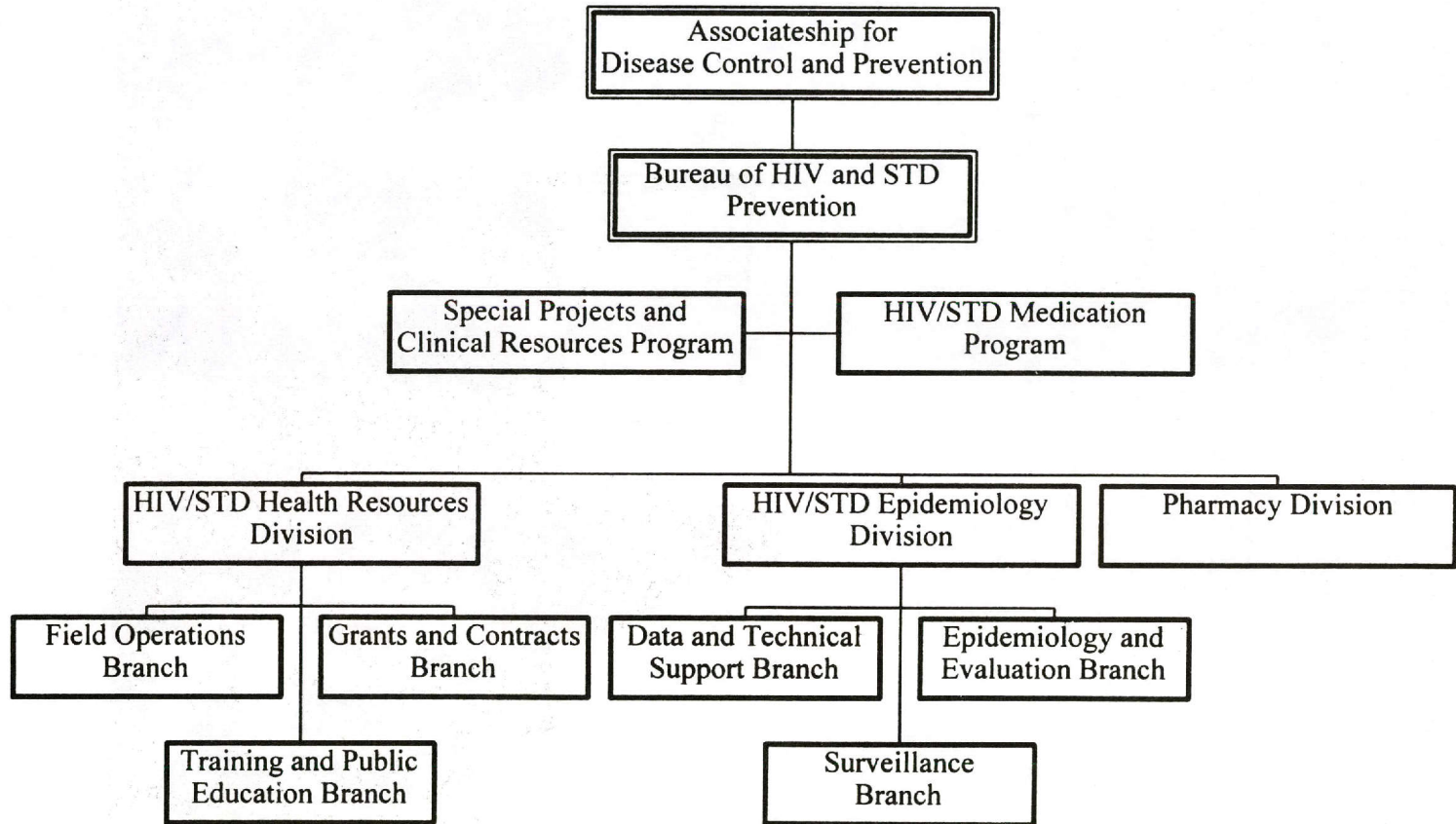


Figure 1
Associateship for Disease Control and Prevention
Bureau of HIV and STD Prevention



III. FUNDING - FY 1995

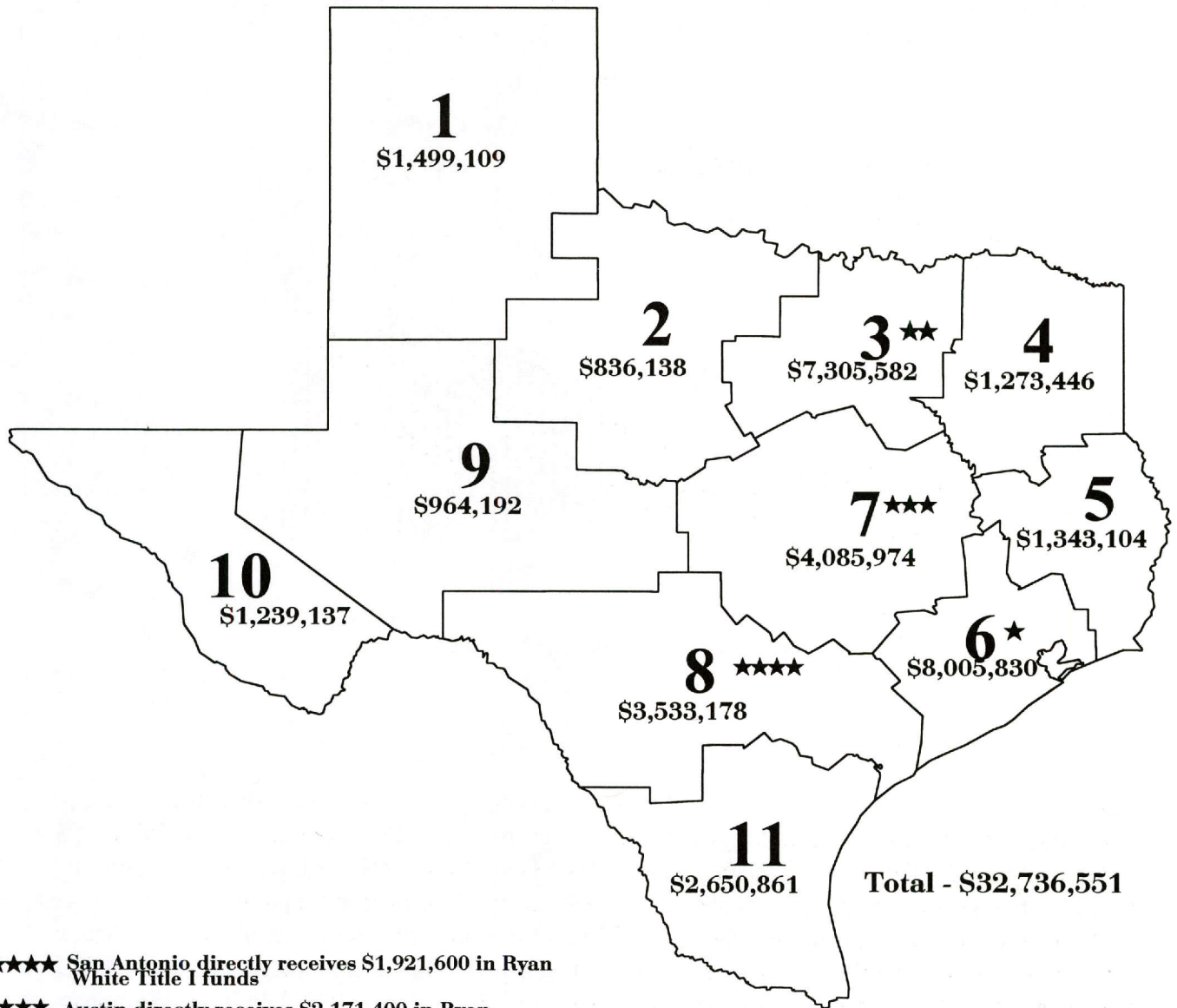
The total operating budget for HIV and STD programs for FY 1995 was \$48,283,013. Almost two-thirds of the budget (\$31,492,229) was provided by federal HIV and STD grants, just over one-third (\$16,790,784) by State funds. The HIV and STD funds were allocated as follows: \$17,130,711 for prevention; \$22,085,777 for services; \$5,110,759 for medication; and \$3,955,766 for surveillance.

Nearly 70% of the HIV and STD resources were distributed to regional and local health departments or other contracted community based agencies through prevention and services contracts (See Figure 2). A total of 12% of the resources were spent providing HIV and STD medications in Texas. Other Bureau expenditures included training and public education, regional and central office administrative costs, laboratory costs, travel, supplies and equipment, and public health promotion. Administration encompasses activities such as program planning and development, quality control and technical assistance to contractors, contract monitoring and grants management, and related programmatic and support services.



Figure 2

HIV/STD Prevention & Services Contracts Awarded by Region
1995 State & Federal Funds



- ★★★★ San Antonio directly receives \$1,921,600 in Ryan White Title I funds
- ★★★ Austin directly receives \$2,171,400 in Ryan White I funds
- ★★ Dallas directly receives \$6,770,800 in Ryan White Title I funds
- ★ Houston directly receives \$15,531,050 in Ryan White Title I & CDC Prevention funds

IV. HIV, AIDS AND STDS IN TEXAS - EPIDEMIOLOGIC ASSESSMENT

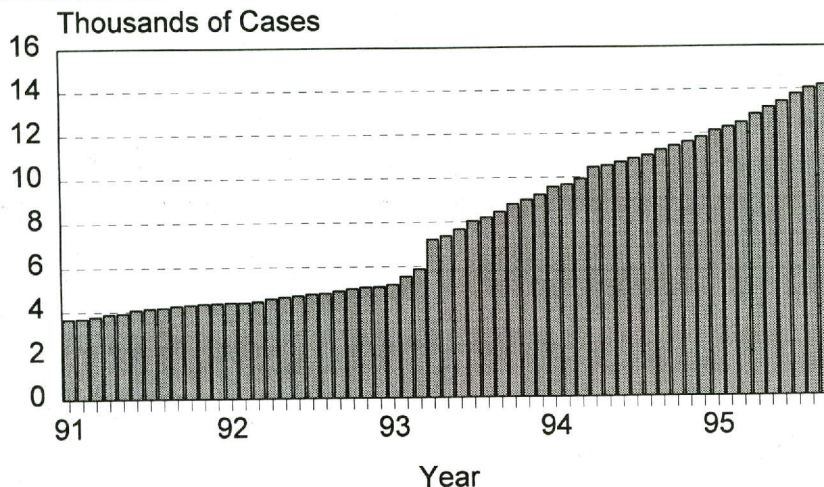
HIV/AIDS

Estimates suggest that anywhere from 45,000 to 66,000 Texans are infected with HIV. Through the end of 1994, 30,943 AIDS cases had been reported in Texas, with 5,596 (18%) being reported in 1994. Nationally, Texas ranked fourth in the number of AIDS cases reported in 1994 and had the eighth highest annual rate: 32 cases per 100,000 population. The number of Texans living with AIDS as of August 31, 1995 (14,198) is three times higher than it was four years ago indicating an increasing need for services (Figure 3).

Figure 3

Number of Reported Living AIDS Cases in Texas

14,198 Living AIDS Cases as of August 31, 1995

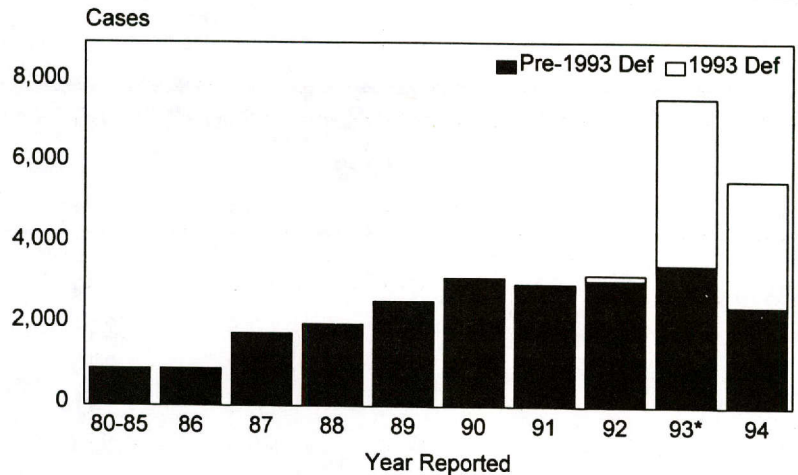


Based on cases and deaths reported as of August 31, 1995
AIDS case definition changed January 1, 1993

AIDS Case Definition

The AIDS case definition has been modified and expanded over time to reflect the increased knowledge and improved technology related to the disease. The 1993 revised case definition for AIDS included all HIV-infected persons with a CD4+ T-cell count of fewer than 200 per microliter of blood or those for whom the percent of CD4+ cells is less than 14% of total lymphocytes. Prior to this change, the case definition relied primarily on the identification of one of several indicator diseases in HIV-infected patients to determine when a patient should be diagnosed with AIDS. Several additional indicator diseases were added with the 1993 revised AIDS definition: pulmonary tuberculosis, recurrent pneumonia and cervical cancer.

Figure 4
AIDS Cases by Year of Report, 1980-94
 30,943 Cumulative Cases Reported through 12/31/94



* Expanded AIDS definition is implemented
 Based on AIDS data as of 12/13/95

The inclusion of the CD4+ criteria caused a marked increase in cases reported in 1993 (Figure 4). However, the apparent peak seen in 1993 and the lower number seen in 1994 *should not* be interpreted as a true decline in AIDS morbidity. Rather, the 1993 count was artificially inflated due to the tremendous number of cases added that year to the reporting system as a result of the new case definition. In large part, the 1993 increase reflects the reporting of cases involving persons with previously diagnosed HIV infection meeting this new criteria but not yet diagnosed with a condition meeting the pre-1993 definition.

The 1993 definition change makes it difficult to analyze disease trends. The only way to compare 1994 reports with previous years is to identify those cases that meet the pre-1993 definition and see how that number compares to earlier totals. However, this method may also prove to be misleading as an indicator of disease trends. Since the criteria for the newer AIDS case definition are more easily identified and documented, cases meeting both the current definition and the pre-1993 definition were most likely reported under the newer criteria causing an artificial decrease when compared to previous years. The number of cases reported in 1994 under the pre-1993 definition is lower than previous years (Figure 4). This decrease does not indicate a decline in morbidity but instead merely reflects the nature of reporting methods and the changing criteria of the case definition.

Gender and Ethnicity

Because of the revised AIDS case definition, comparing rates or the number of cases reported in 1994 to previous years, especially 1993, would not indicate underlying trends. However, comparing the percent share of cases for different demographic groups and modes of exposure indicates that

trends observed in recent years continue. Among demographic groups, the percentage of cases reported for white males declined from 56% in 1992 to 50% in 1994. African Americans had the largest increase in share of cases. For African American males, the percent share rose from 20% in 1992 to 22% in 1994. The percent share for African American females rose from 4.5% in 1992 to 6% in 1994 (Table 1).

Sex	Race	1992		1994	
		Cases	(%)	Cases	(%)
Males					
	White	1,819	55.8	2,770	49.5
	African American	635	19.5	1,243	22.2
	Hispanic	494	15.2	879	15.7
	All Other	13	0.4	31	0.6
	<i>Total Males</i>	<i>2,961</i>	<i>90.9</i>	<i>4,923</i>	<i>88.0</i>
Females					
	White	96	2.9	197	3.5
	African American	148	4.5	348	6.2
	Hispanic	51	1.6	127	2.2
	All Other	1	<0.1	1	<0.1
	<i>Total Females</i>	<i>296</i>	<i>9.1</i>	<i>623</i>	<i>12.0</i>
Total Cases		3,257	100.0	5,596	100.0
* AIDS data according to database as of 12/13/95.					

One intent of the 1993 revised case definition was to adjust for possible bias that might cause underreporting of women with AIDS. Reported cases of AIDS have increased among females in 1994 with the percent share of cases rising to 12% from 9% in 1992. Although this increase for females is substantial, an even larger increase between these years might have been expected. Although not in effect until 1993, the proposed changes were widely noted in 1992. This awareness may have altered surveillance activities, thus increasing 1992 case finding for females in anticipation of the upcoming changes.

The AIDS case rate for Texas females in 1994 was 7.3 per 100,000 population. The rate was significantly higher in the African American female population with a rate of 31.7. Hispanic females had a rate of 5.1, and white females a rate of 3.6. The 1994 AIDS rate for males was 54.6 per 100,000 population. The African American male population had the highest rate, 122.3, followed by white males at 53.0, and Hispanic males at 34.4 AIDS cases per 100,000 population.

Modes of Exposure

The percent share of AIDS cases reported with male-to-male sex as the mode of exposure decreased as shares attributed to other modes of exposure such as injecting drug use (IDU) and heterosexual sex rose. Male-to-male sex as a mode of exposure constituted a 64% share of cases in 1992, compared to 58% in 1994. Heterosexual sex as a mode of exposure had the greatest increase: from a share of 5% in 1992 to 8% in 1994. Exposure by injecting drug use increased from a share of 14% of AIDS cases in 1992 to 15% in 1994 (Table 2).

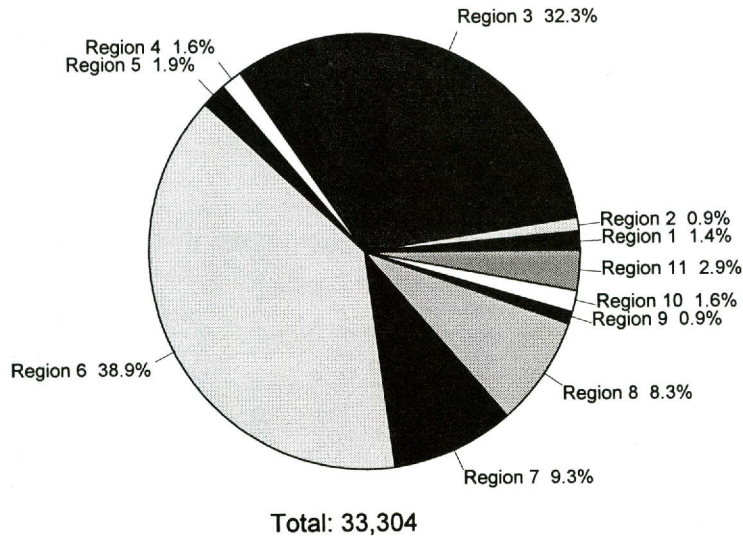
Mode of Exposure	1992		1994	
	Cases	(%)	Cases	(%)
Male-Male Sex	2,067	63.5	3203	57.2
Injecting Drug Use (IDU)	459	14.1	846	15.1
Male-Male Sex and IDU	306	9.4	437	7.8
Hemophiliac	15	0.5	19	0.3
Heterosexual Contact	165	5.1	423	7.6
Transfusion	49	1.5	48	0.9
Risk Not Yet Identified**	162	5.0	572	10.2
Pediatric Cases	34	1.0	48	0.9
Total Cases	3,257	100.0	5,596	100.0

* AIDS data according to surveillance database as of 12/13/95.
 **The percent of cases in this category are higher in the more recent year since less time has elapsed to investigate and determine mode of exposure for these cases.

Geographic Distribution

In 1994 the majority of AIDS cases in Texas were reported from urban areas. However, only 40 of the 254 counties in Texas have not reported an AIDS case since the epidemic began in the early 1980s. The disease continues to spread to less urban areas of the state. AIDS is no longer confined to specific groups or geographic regions. Public health strategies for prevention and channeling of resources must be tailored to meet the continuing changes in the epidemic.

Figure 5
AIDS Cases by Public Health Region*
 Cumulative Through 8/31/95



* Does not include 815 cases from the Texas Department of Criminal Justice

SYPHILIS

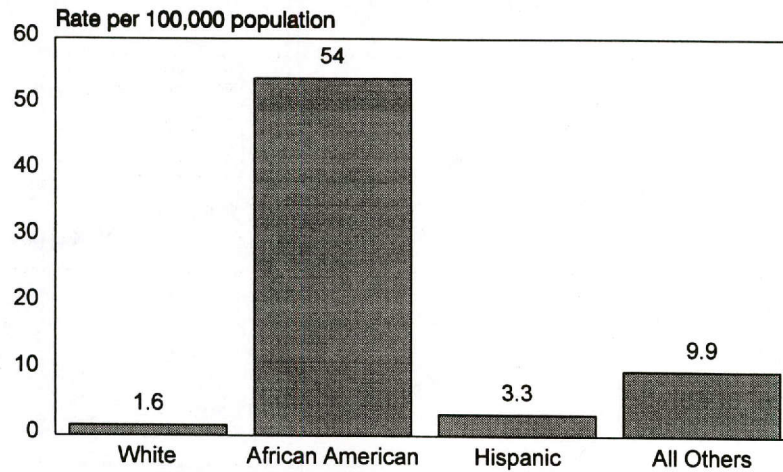
Primary and Secondary Syphilis (P&S)

Texas reported 1,557 P&S syphilis cases in 1995, continuing the downward trend with a decrease of 19% over cases reported in 1994. The number of cases reported in 1995 is less than one-third of the P&S syphilis cases reported in 1990. The overall state rate for P&S syphilis was 8.4 cases per 100,000 population. More than one-third of cases were between the ages of 15 to 24 years. African Americans continue to account for the majority (75%) of P&S syphilis cases reported in Texas. The case rate for P&S syphilis among African Americans was 54 per 100,000 in 1995. Although more than 20% lower than the 1994 rate of 70 per 100,000, it remains extremely high compared to other ethnic groups (Figure 6). The case rate for Hispanics was 3.3 per 100,000, for whites, 1.6, and for other ethnic groups (including cases with race unspecified) 9.9 per 100,000. African American women aged 15-19 and 20-24 had the highest rates of P&S syphilis reported, 121 and 176 cases per 100,000 population, respectively. African American males with the highest rates were ages 20-24 (132) and 30-34 (112). Those aged 25-29 and 15-19 were high as well at 97 cases per 100,000 and 69 cases per 100,000, respectively. The extremely high case rate for both genders indicates the continuing severity of the problem of P&S syphilis among young African Americans in Texas.

In 1994, the number of women reported with P&S syphilis exceeded the number of men for the first time. However, 1995 reports indicate women were once again slightly outnumbered by men with P&S syphilis. Women accounted for 769 cases (49.4% of the total) compared with 787 cases among

Figure 6

Primary and Secondary Syphilis in Texas, 1995 Rate by Ethnicity



men. As the case numbers are very close, so are the rates: 8.2 per 100,000 for women and 8.6 per 100,000 for men.

Early Latent Syphilis (EL)

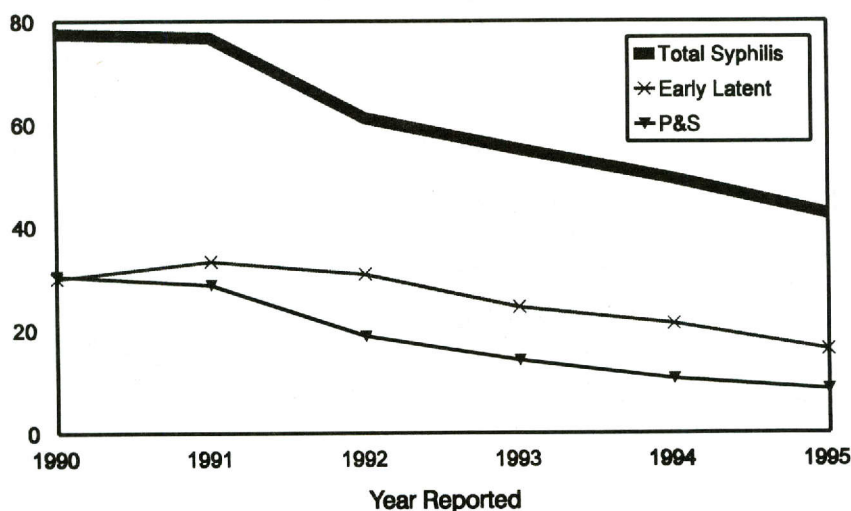
Analysis of both P&S syphilis and EL syphilis is important in identifying disease trends. In 1990, there were slightly over 5,000 cases of both P&S and EL syphilis reported with similar rates of 30.4 and 29.9, respectively (Figure 7). Since that time, P&S syphilis has steadily declined, but EL syphilis cases increased substantially in 1991 and then began to decrease at a much slower rate than P&S syphilis. Although both are considerably lower in 1995 compared with 1990, the number of EL syphilis cases (3,019) remains twice as high as P&S in Texas. The overall rate of EL syphilis in 1995 of 16.2 cases per 100,000 is almost twice the rate for P&S syphilis, 8.4 per 100,000.

In 1995, African Americans constituted 68% of all EL syphilis cases, followed by 17% Hispanic and 11% white. Females age 15-29 made up almost 60% of all female EL syphilis cases while males of this age group contributed slightly more than 40% of all male cases.

Figure 7

Syphilis in Texas, 1990-1995

Case Rates per 100,000 population



Congenital Syphilis

In 1995, 192 cases of congenital syphilis were reported marking the third straight year of decline. The smaller number of 1995 congenital syphilis cases represents a 14% decrease from 1994, and fewer cases than were reported in 1990. With 88 cases, Harris County (Houston) had the highest number of congenital cases, 3 cases more than in 1994. Jefferson County had the second-highest number at 14 cases, 36% less than this county reported last year during a syphilis outbreak. Sixty percent of the cases were found among African Americans and 22% among Hispanics. Hispanics constitute a higher proportion of congenital syphilis cases than either P&S or early latent cases. This occurrence will be further examined in order to determine the causal factors.

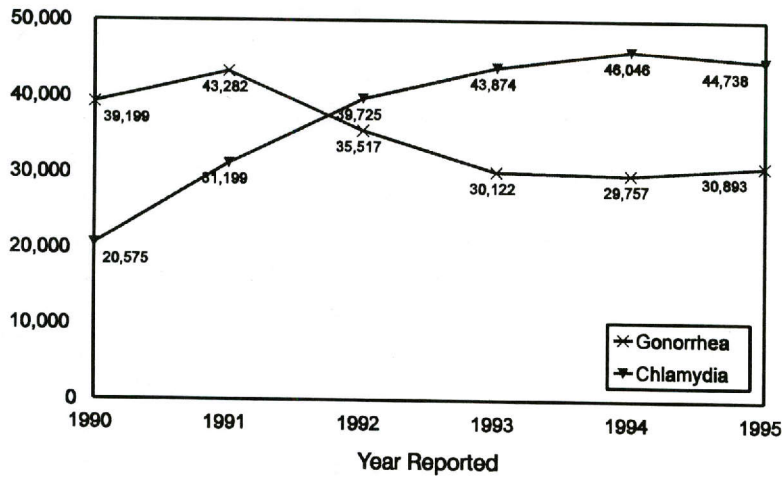
CHLAMYDIA, GONORRHEA, AND PELVIC INFLAMMATORY DISEASE (PID)

Chlamydia

Reports of chlamydia in 1995 totalled 44,738, a 3% decline from the previous year. Although slight, this decrease is the first hint of the number of cases levelling since chlamydia became reportable in 1987 (Figure 8). Of the total chlamydia cases reported, 86% were females. Females are more likely to be tested by routine screening. Males are often asymptomatic and therefore, do not seek treatment. Given that men make up such a small proportion (less than 15%) of chlamydia cases reported, there is no way to estimate the true incidence of chlamydia in the Texas population.

Figure 8

Gonorrhea and Chlamydia Cases Texas, 1990-1995



Because of the increased risk of severe outcomes (including the potential to infect a newborn child), chlamydia screening programs focus on women.

Due to the overwhelming proportion of female cases, gender-specific rates should be examined. The 1995 female case rate was 407 cases per 100,000, with African American women having the highest rate (977) followed by Hispanic women (567) and whites (140 cases of chlamydia per 100,000 population). Men showed the same racial/ethnic distribution as women but with far lower rates. It should be remembered, however, that if males were equally targeted for screening and tested when presenting with symptoms, male rates would most likely be high as well.

Looking at cases reported by age group reveals 73% of chlamydia cases were 15-24 years of age. With more than 28,000 cases reported for females 15-24 years of age alone, the rates for chlamydia among young women age 15-19 years and 20-24 years are 2,408 and 1,840 per 100,000, respectively.

Gonorrhea

In Texas, 30,893 cases of gonorrhea were reported in 1995; this is an increase over the previous two years. Except for an increase in 1991, gonorrhea in Texas had been decreasing since 1978 when almost 90,000 cases were reported. Cases reported in 1995 were 4% higher than in 1994 (Figure 8). Region 3 (including Dallas and Fort Worth) accounted for 37% of all reported gonorrhea cases in 1995, compared to 33% in 1994. All other public health regions decreased or remained stable.

The 1995 overall rate was 166 per 100,000, with males (172 per 100,000) having a higher rate than females (158 per 100,000). Among age groups, the highest rate for females was found among 15-19 year old women (872 per 100,000) followed by 20-24 years (608 cases per 100,000). Men in these age groups also had higher rates than other males. Gonorrhea among women aged 15-24 years comprised 68% of all female cases; men of the same age group accounted for 52% of all male gonorrhea cases.

Examining racial/ethnic groups, the African American rate of 911 cases per 100,000 is 10 times greater than the Hispanic rate (88 cases per 100,000) and 25 times higher than the white rate (36 per 100,000). African American males had the highest rate of all race-gender groups with 1,111 cases per 100,000 population. As was seen for gonorrhea cases of all races, African Americans aged 15-24 account for the greatest share of African American cases, 60% of those reported. They also represent 38% of total cases reported, regardless of race or age group.

Pelvic Inflammatory Disease (PID)

PID is a serious, sometimes life-threatening complication of untreated chlamydia and gonorrhea in women. Acute PID caused by chlamydia and gonorrhea increases a women's risk of recurrent PID, chronic pelvic pain, ectopic pregnancy and infertility. In 1995, 1,261 cases of PID were reported, a 23% increase over 1994. However, this number is still 50% less than the 2,519 cases reported in 1990. PID attributed to gonorrhea accounted for 22% of cases reported, and 19% of cases were related to chlamydia infection. Almost 60% of PID cases were of undetermined etiology, a higher share than any year in the past 5 years. As expected, the occurrence of PID follows trends of other STDs. African Americans account for the highest number of cases, and women aged 15 to 24 years are most often afflicted.

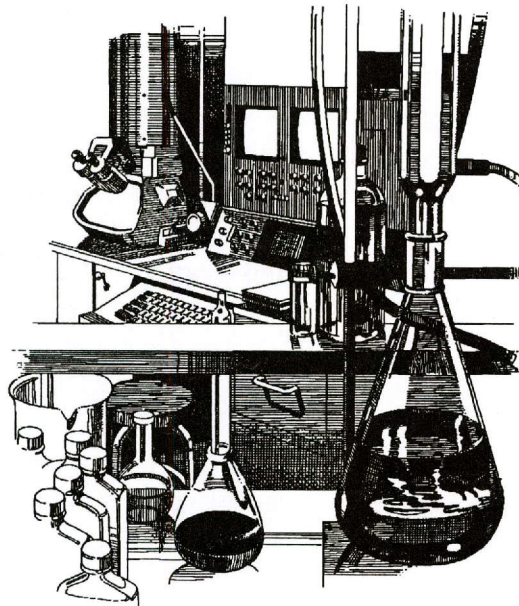
Other Sexually Transmitted Diseases

The Bureau received almost 6,000 voluntary reports of sexually transmitted diseases other than syphilis, HIV/AIDS, chlamydia, and gonorrhea in 1995. The majority of these case reports are for non-gonococcal urethritis, mucopurulent cervicitis, human papilloma virus (HPV), non-specified pelvic inflammatory disease, and genital herpes (Table 3). Because reporting of these diseases is not mandated, the actual number of cases may be several times higher than these figures. Due to the lack of consistent reporting, the number of cases reported may also represent follow up visits to treat chronic viral infections and therefore not represent a new case.

Human papilloma virus (HPV) causes genital warts, one of the most common STDs. In Texas, 575 cases were reported in 1995; the true incidence is probably much higher. Some strains of the virus are associated with the development of cervical cancer which kills more than 300 women a year in Texas. If infected women could be identified and followed with more frequent screening for cancer, this related morbidity might be prevented. In addition, pregnancy may accelerate the growth of the warts which can be passed from an infected mother to her newborn. In both adults and children, the disease is difficult to treat and recurrences are common.

Genital herpes is also a viral STD of concern. Although the infection is not frequently fatal in adults, no cure currently exists for genital herpes, and the person may remain infectious for his/her entire life. In addition, it is painful and may be more serious in immunocompromised persons. Herpes infection during pregnancy is associated with an increased risk of spontaneous abortion or premature birth as well as life-threatening infection in newborns. Proper medical intervention for pregnant women may prevent the transmission of this disease at birth. In Texas, 779 cases of herpes were reported in 1995.

Table 3. Voluntarily Reported Sexually Transmitted Diseases in Texas, 1995	
Disease	Reported Cases
Non-Specified Pelvic Inflammatory Disease	738
Non-Gonococcal Urethritis	1,760
Mucopurulent Cervicitis	2,066
Granuloma Inguinale	1
Genital Herpes	779
Lymphogranuloma Venereum	7
Human Papilloma Virus (HPV)	575
Adult Molluscum Contagiosum	4



V. HIV PREVENTION AND SERVICES

HIV PREVENTION

HIV Prevention has two essential components: health education and risk reduction (HERR) and counseling, testing, referral, and partner elicitation (CTRPE). All Prevention services are planned through a community planning initiative mandated by the Centers for Disease Control and Prevention (CDC) in 1993.

The TDH awarded over \$7.5 million dollars directly to local health departments and community based organizations providing prevention services to their communities in 1995. Houston also received an additional \$3.9 million dollars in direct federal assistance from the CDC.

Community Planning

Community planning is the process which enables local communities to have significant input into regional HIV planning and priority setting. The TDH will use the priorities identified by the HIV Regional Planning Coalitions in the establishment of future HIV Cooperative Agreements with the CDC. The TDH, in partnership with the ten HIV Prevention Regional Planning Coalitions (Coalitions), instituted major initiatives in the community planning process.

The HIV Prevention Partnership, the statewide planning body made up of representatives from the ten Coalitions, was dissolved in January 1995. The roles and responsibilities that had been held by the Partnership, mainly to shape the statewide plan and issue votes of concurrence and non-concurrence with the final product, were given to the ten Coalitions. The Coalitions are also responsible for determining community priorities and intervention strategies based on local and regional needs assessments.

The goal is for each Coalition to seat members who represent the unique profile of affected populations within its jurisdiction. An open nomination process for membership ensured parity, inclusion and representation (PIR) from those most affected by HIV. The Coalitions include minority males and females, adolescents, substance abusers, HIV infected individuals, gays, and local HIV prevention workers. Membership in the Coalitions represents the cultural, ethnic and other diversities of the Texas population most impacted by HIV and AIDS.

ACCOMPLISHMENTS

- The ten Coalitions in partnership with the TDH developed the *1995 Comprehensive Prevention Plan* which listed eleven targeted population groups and identified specific interventions tailored to meet the prevention needs of these groups.

- The TDH headed a statewide recruitment effort, ensuring the openness of the nomination process by conducting a well-publicized, broad-based, and inclusive solicitation for nominations and applications. Coalitions aggressively solicited local participation from individuals from Persons Living with AIDS and HIV (PLWA/HIV) support groups, gay organizations, and from other affected groups.
- The Coalitions began the process of developing the 1996 Comprehensive HIV Prevention Plan. They were provided with a 643-page Epidemiologic Profile with glossary, 11 regional profiles and 10 county profiles, including zip code data in highly populated areas. A resource inventory of HIV prevention services was completed and analyzed. Coalitions also collected qualitative data to complete the needs assessment process.
- An extensive handbook, the *Texas HIV Prevention Community Planning Handbook*, was created to orient new Coalition members to the community planning process. This book contains information on guidance from the CDC, the roles and responsibilities of Coalition members, rules on travel reimbursement, confidentiality, conflict resolution, conflict of interest, and outlines of the nomination process and needs assessment process.
- An uniformed and fact-based priority setting process was developed that offered greater levels of regional freedom in defining targeted populations and a very structured process for exploring needs and prioritizing populations and interventions.
- Supplemental prevention funds (\$145,000) were made available to the Coalitions which were used to provide for expertise and technical assistance in developing their regional plans.

FUTURE PLANS

- PIR, priority setting process and the resource inventory component of the needs assessment process are the primary target issues for community planning in 1996.
- The ten articles of the draft bylaws will be reviewed and ratified. These ratified bylaws will provide more infrastructure to the Coalitions, as well as provide guidance on roles, responsibilities and procedures.
- The TDH will develop a task timeline for 1996 that keeps Coalitions on track for producing a new plan in 1998.
- The TDH will ensure that each Coalition has identified technical and training needs for Coalition members and will provide continued guidance on managing financial resources available to the Coalitions.

Health Education and Risk Reduction

The goal of the Health Education and Risk Reduction (HERR) component is to prevent the spread of HIV by educating high risk persons about disease transmission and assisting them in establishing realistic, personalized risk reduction plans. TDH staff develop and manage the competitive application and review process for selecting HERR contractors who will provide health education/risk reduction within their communities. These public and private contractors target specific populations with HIV health education messages designed to convey prevention messages in culturally sensitive, appropriate language and form. The majority of the direct delivery staff are indigenous to the population served, which helps them establish and maintain the rapport necessary for effective communication. They conduct educational activities in a variety of sites such as community hangouts, streets, parks, jails, STD waiting rooms, schools, local health department clinics, and other local agencies.

TDH staff also provide technical and programmatic assistance, as well as conduct monitoring of HERR contractors. This ensures that contractors are consistent in their application of HIV prevention messages, and that contract dollars are spent in accordance with accepted contract objectives. Another important role of this component is to provide ongoing information and HIV educational material to both contractors and non-contractors for distribution to the general public.

ACCOMPLISHMENTS

- The TDH directed HERR contractors to focus on the high risk target populations identified by the Coalitions. HERR contractors exceeded the 1995 goals for reaching many of the target populations.
- HERR contractors conducted 6,532 educational sessions, dispensed 280,585 condoms, and distributed 196,295 brochures across the state in 1995.
- The TDH directed contractors to accelerate the use of peer-based educational approaches in HERR activities. Peer-based approaches include the following methods: conducted by an indigenous member of the targeted groups or by an individual who is sensitive to the situation of the targeted population; conducted where the risk activities of the targeted population take place or where the population congregates; or conducted as one-on-one encounters or with groups of ten or fewer individuals.
- The TDH implemented a pilot prevention case management program called Intensive Behavioral Counseling (IBC) at the University of Texas at Denton. Training for counselors consisted of course work in behavior analysis, conducting information gathering interviews, as well as AIDS 101 and Gay Lifestyle 101.

FUTURE PLANS

- The TDH will provide guidance and technical assistance to ensure that HERR contractors reach the targeted populations as outlined by the Coalitions.
- The TDH will develop administrative reporting forms and data collection methods for contractors to report time allocated to intervention and contacts with members of the target populations.

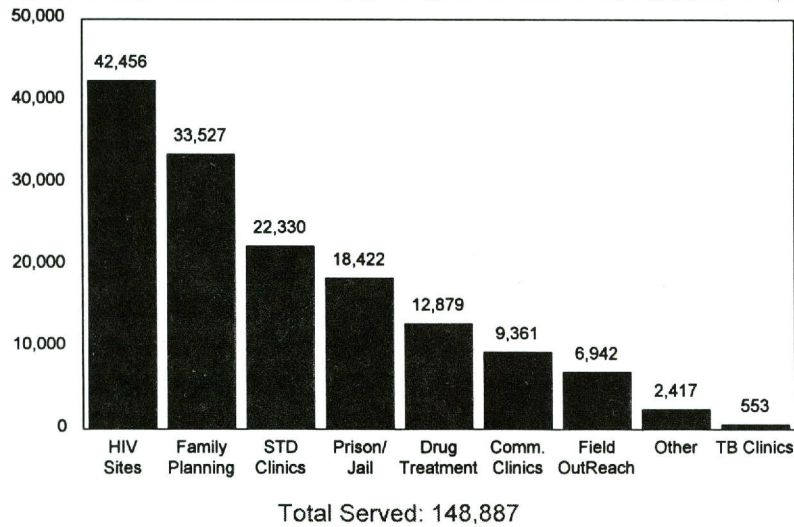
Counseling, Testing, Referral and Partner Elicitation

TDH provides Counseling, Testing, Referral, and Partner Elicitation (CTRPE) services statewide by contracting with local health departments, community based organizations, women's health clinics, and substance abuse programs. Some CTRPE services are provided directly through regional TDH programs.

The CTRPE process consists of several elements: pretest counseling, venipuncture, posttest counseling when the client receives test results, referral of HIV positive clients to services, and elicitation of sex and/or needle partners exposed to HIV. Trained specialists conduct all phases of CTRPE activities. An important goal of pretest counseling is to help clients assess their personal risk of HIV infection and to identify ways of modifying those behaviors which put them at risk. When clients return to learn their test results, they always receive personal posttest counseling. If the client tests negative for HIV infection, posttest counseling reinforces behavior changes identified by the client to keep from becoming infected. If the client tested positive for HIV, posttest counseling encompasses a range of issues. The CTRPE staff provide referrals to link clients with medical, psychological and social services. They also elicit the names of sex and/or needle sharing partners in order to assist the client in managing confidential partner notification, handled by Disease Intervention Specialists, so that others at risk can be given the opportunity to receive counseling and learn their HIV status. Finally, posttest counseling reinforces behavior changes the client has identified to maintain personal health and prevent transmitting the infection.

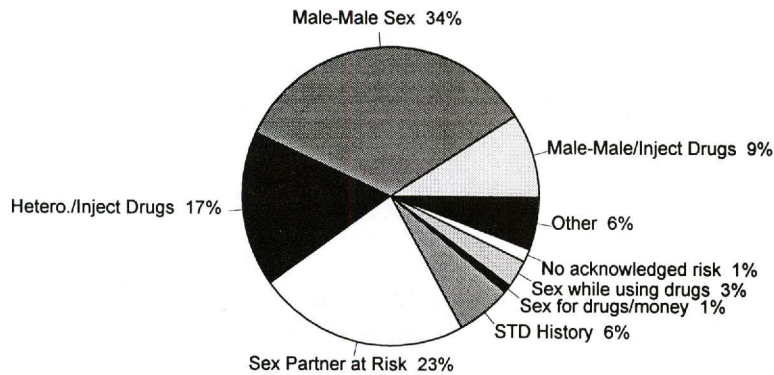


Figure 9
HIV Counseling and Testing
 Clients Served by Agency Type
 FY 1995



TDH staff provide technical assistance to contractors and monitor contracts to ensure compliance with objectives and appropriate use of program funds. Additionally, the CTRPE component maintains data collection and reporting systems that provide important information for planning and implementing prevention activities. The TDH collects data on the number of persons tested by type of agency/testing site (Figure 9), and by the kind of risk behavior reported by the individual (Figure 10). The TDH uses this information to determine which populations are currently at greatest risk of HIV infection, and to identify the specific behaviors that put people at risk. Prevention staff can then develop and target interventions to address specific populations and behaviors effectively and appropriately.

Figure 10
HIV Counseling and Testing
 HIV Positive Clients by Mode
 FY 1995



Total Positive Clients: 1,967

Other includes healthcare exposure, perinatal, blood products, sexual assault and those stated as other.
 Less than .1% had mode unspecified.

ACCOMPLISHMENTS

- 148,887 Texans received HIV pretest counseling services through TDH-supported CTRPE programs in FY 1995. Of these, 1,967 tested positive for HIV infection.
- CTRPE contractors were successful in reaching the newly defined high risk target populations identified by the Coalitions in the *1995 HIV Comprehensive Plan*.
- Preliminary data from contractor quarterly reports indicate that 89% of HIV positive clients identified at CTRPE contractor sites in 1995 who returned for their posttest counseling session were referred to an early intervention system of care.
- The TDH performed 43 formal site reviews with CTRPE contractors to augment contract monitoring and program evaluation. All CTRPE contractors received technical assistance either in person or by telephone in 1995; 75% of the contractors received a formal site or technical assistance visit by the end of 1995.

FUTURE PLANS

- The TDH will increase its emphasis on the importance of conducting at least 25% of the counseling and testing activities aimed at priority populations in non-traditional, field settings.

- The TDH will incorporate the CDC Prevention Counseling model into the CTRPE program. This client-centered model focuses on developing risk reduction plans for clients to reduce their risk of becoming HIV infected or if infected from spreading HIV to others. Although the prevention counseling model does not stress that clients be tested for HIV, TDH will still encourage testing for persons at significant risk in counseling sessions.
- The TDH is currently developing educational materials aimed at clients and health care workers that addresses HB 1345, the law that requires that all pregnant women be offered an HIV test by health care providers. All women testing HIV positive at CTRPE contractor sites who are identified as pregnant will be referred for prenatal care for perinatal prophylaxis.

HIV SERVICES

Texas HIV Services projects were established in 1989 in response to *AIDS in Texas: Facing the Crisis*, the final report of the Texas Legislative Task Force on AIDS. In supporting basic treatment, health, social services to HIV infected Texans, the Texas Legislature charged the HIV/STD Health Resources Division (Division) to:

- coordinate the use of local, federal and private HIV Services funds;
- encourage the provision of community based HIV services;
- address needs not met by other funding sources;
- provide statewide distribution of HIV Services funds that reflect regional needs; and
- encourage cooperation among local HIV service providers (Health and Safety Code, Chapter 85, sec. 85.032).

During 1995 the Division distributed \$21,220,154 in service contracts throughout the state. Legislatively appropriated state revenues contribute 38% of the services funds awarded in 1995. Federal Ryan White Title II Comprehensive AIDS Resources Emergency (CARE) ACT monies accounted for 50%. Federal Housing Opportunities for Persons with AIDS (HOPWA) resources contributed the remainder. Dallas and Houston also received an additional \$6.7 million dollars and \$11.6 million dollars, respectively, in direct federal Ryan White Title I grants. For the first time, Austin and San Antonio directly received \$2.1 million dollars and \$1.9 million dollars, respectively, in federal Ryan White Title I funds.

To award HIV Service funds as extensively and equitably as possible, the Division divides the eleven Texas Public Health Regions into 26 HIV Service Delivery Areas (HSDAs). Each HSDA is served by a local HIV CARE Consortium made up of public and private HIV service providers, community based organizations, HIV infected individuals and community leaders. The Consortium determines the needs of its community and allows local providers to coordinate services. This ensures that a wide variety of medical and psychosocial services are available to the local HIV infected population.

The TDH contracts with an administrative agency designated by the Consortium members to manage the TDH award. The funds available to each HSDA are determined through a funding formula based on the population living in the HSDA (50%), the number of AIDS cases reported in the most recent 24-month period (50%), and an adjustment for the local poverty index.

Basic HIV services supported by TDH contracts with local health departments and community based organizations include:

- * aerosolized drug therapy
- * attendant care
- * case management services
- * client transportation
- * counseling
- * day or respite care
- * day treatment
- * dental care
- * diagnostic services
- * food pantry
- * home health aide services
- * home intravenous services
- * homemaker services
- * hospice care
- * housing
- * insurance assistance program
- * lab services
- * medical services
- * nutrition services
- * physician services
- * volunteer services

Physical and mental health services enable HIV infected persons to remain healthier and independent, extending the time they can care for themselves and others without support. HIV services reduce the need for expensive hospitalizations and more costly treatments by providing preventative services and less costly home-based care. Since many HIV/AIDS clients are economically devastated by the disease, many must rely on publically funded care. Providing cost-effective HIV services benefit all Texas residents by reducing health care costs supported by taxpayers.

ACCOMPLISHMENTS

- The TDH HOPWA program provided short term rent, mortgage, and utility payments and tenant-based rental assistance to 3,488 clients for the period of July 1, 1994 - June 30, 1995.
- Over 10,000 clients received basic HIV-related social and medical services in FY 1995.
- The annual two-day workshop of Administrative Agency Executive Directors and consortia chairpersons was conducted in Dallas on November 28-29, 1994. A representative from each consortia presented information regarding programs, services, barriers, problems, and solutions in his/her area. In addition, a focus group was organized to discuss future policies and procedures emanating from the TDH.

- The third annual conference to provide technical assistance to contractors and to enhance provider skills was held November 30-December 2, 1994, in Dallas; over 350 providers attended. Extensive networking and interaction among participants was accomplished, with the goal of providing better services to HIV/AIDS clients.
- On June 28-30, 1995, three representatives from the Division, attended the National Ryan White Title I and Title II Technical Assistance Conference in Washington, D.C.
- A collaborative arrangement with the TB Elimination Division at the TDH was established in December 1994, as required by FY 1995 Ryan White Grant. This arrangement formalized relations between the two Divisions at TDH, with the HIV Care Consortia contractors, and with the TB contractors around the State through letters of agreement.

FUTURE PLANS

- In collaboration with Consortia and administrative agencies, the TDH will expand written policies and procedures for efficient Consortia operation.
- The TDH will continue to provide technical assistance to Consortia and administrative agencies to improve their working relationships and incorporate broad community input into their processes.

Case Histories

The impersonal numbers reflecting HIV service needs and achievements take on an added reality when described in case managers reports. The following case histories illustrate the real accomplishments and successes. These true stories come from organizations around the State.

Client Overcomes Fear and Isolation

Mr. B is a 65 year-old African-American gentleman who was first referred to a HIV/AIDS service provider by a dentist who was associated with the provider. Initially, Mr. B refused to go to the office or allow a HIV service worker to go to his home. The case manager met Mr. B at a local fast food restaurant for the intake; however, over time he came to trust the agency and the idea of case management.

He now asks for assistance with benefits applications and other matters, and even initiates visits to the agency. He recently spent time at the agency to get information on how to use their client handbook. This sounds like a small thing, but for Mr. B. this was a great stride towards reducing his isolation and increasing his understanding of the disease. It has taken three years to arrive at this point.

Exceptional Results Noted

Ron lives in a small town approximately an hour away from Tyler. He was discharged from a Tyler hospital with two weeks remaining on a three-week course of IV antibiotics. The administration of this medication requires the supervision of a Registered Nurse; however, Ron does not have Medicaid or insurance. His only choices were to remain in the hospital, go to an extended care facility, or drive himself to Tyler seven days per week. With the help of Title II funding, a Registered Nurse was hired to provide home health services to oversee the administration of the antibiotic and Ron recovered and is back at work.

Forty-two Year Old Female Improves

Three years ago, a forty-two year old woman tested positive for HIV. During the past two years a local HIV clinic had observed her blood work drop dramatically with multiple complaints and symptoms. Approximately three months ago she became predominantly bedridden because of extreme weakness, fatigue, weight loss and anorexia. In April, she started on the drug 3TC. At this time, her CD4 (t-cells) has escalated to 275 from 83. She is now ambulatory and caring for her home and family again.

Program Provides Healthier Lifestyle for Clients

Mr. T has been a client of a HIV/AIDS service provider since February 1991, the date of his diagnosis. Besides being diagnosed HIV+, he has been diagnosed as a schizophrenic long before the HIV. A local mental health facility assists Mr. T with his mental condition. It has taken a while to get Mr. T involved in his HIV medical care. His parents are deceased and his siblings are not very involved in his life. Due to his mental disability and lifestyle he has been taken advantage of and beaten up.

With some encouragement from his case manager, Mr. T now spends his day at the agency's client activity center, meeting with other clients and building a much healthier social circle. Mr. T is now very involved in his routine medical and dental care and appointments.



VI. STD PREVENTION AND SERVICES

The goal of STD prevention and services is to prevent the spread of the high priority STDs - syphilis, chlamydia, HIV, and gonorrhea. The foundation of this effort is built on four primary components: surveillance and case detection, disease intervention activities, direct client services, and training and technical resources. Three of these components are discussed below; training and technical resources highlights are addressed in the Training and Public Education section of the report.

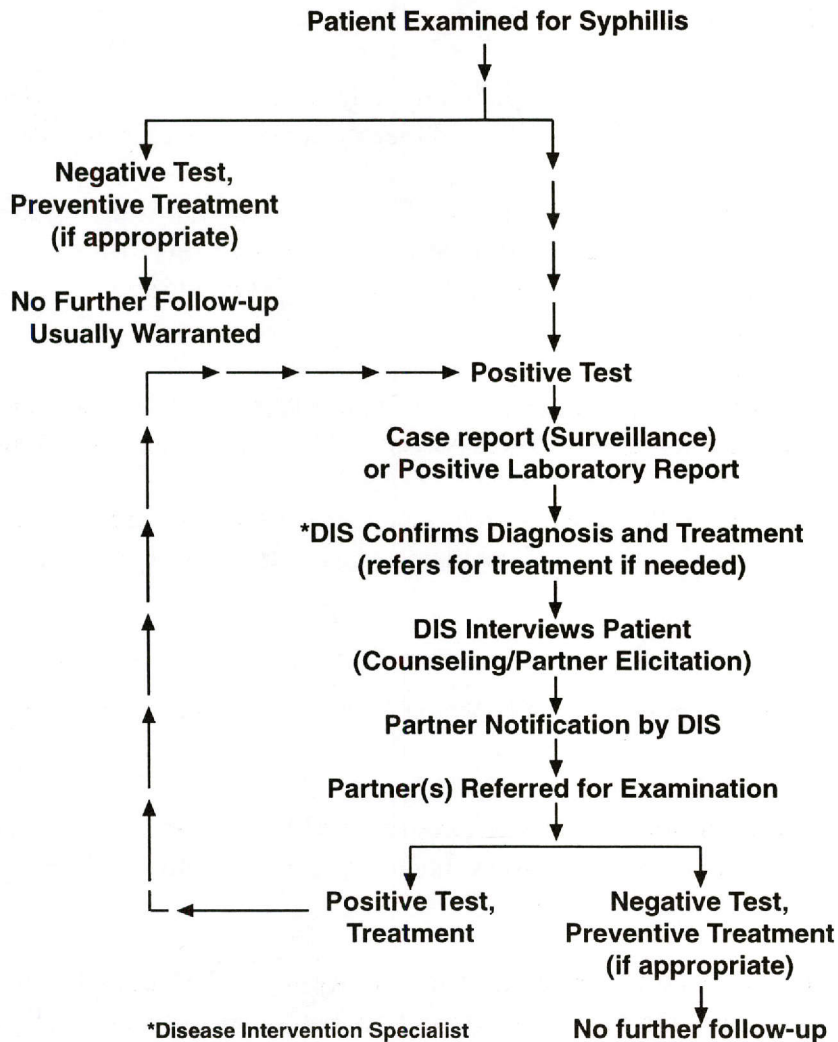
Health care providers and laboratories in Texas are required to report syphilis, gonorrhea, chlamydia, chancroid, AIDS, and HIV infections. Surveillance, the collection and analysis of data about the occurrence of disease, is crucial to the success of any disease control effort. Analyzing case reports provides information needed to plan appropriate prevention and control activities and predict disease trends. The Bureau uses a computerized morbidity surveillance system developed by the CDC. Both the TDH regional STD programs and local health department programs collect disease reports within their jurisdiction, and transmit the information to the Bureau central office. The central office monitors the extent of the statewide STD problem and changes in demographics and geographic distribution of cases. This information is used to prioritize problems, allocate program resources, plan and direct activities to respond to changing conditions.

Highly trained Disease Intervention Specialists (DIS) perform syphilis case finding, interviewing and management, HIV counseling and testing, and both syphilis and HIV partner notification activities. The disease intervention process usually begins when a DIS receives a report of an infected or at risk client. The DIS locates this person, teaches him or her ways to handle the infection or exposure, and to reduce the risk of acquiring or transmitting STDs and HIV in the future. The DIS elicits names, addresses, and other locating information of sex and/or needle sharing partners, and through field investigation, locates and refers these partners for examination, treatment and/or counseling. The cycle continues with each infected partner identified (Figure 11). All disease intervention activities are always completely confidential.

The Bureau purchases and distributes medicines to regional and local health departments and other key providers to treat priority STDs through the STD Medication Program. The STD Medication Program is highlighted later in the report. The Bureau also pays local physicians to examine and treat STD patients exposed to syphilis, chlamydia and gonorrhea when no publicly funded facilities are available.

Similarly, the Bureau funds client services delivered by the Baylor College of Medicine Teen Clinic in Houston. Through a cooperative agreement, STD resources support STD examinations and treatment at three clinics. These teen clinics serve high risk adolescent females who otherwise would not seek health care. This partnership ensures that teenagers in Houston have access to needed STD services.

Figure 11
The Disease Intervention Process



ACCOMPLISHMENTS

- 2,378 contacts for syphilis were referred by DIS and provided preventive therapy, resulting in the prevention of 713 cases of syphilis in 1995.
- During 1995, DIS interviewed and managed 4,110 reported syphilis cases.
- STD clinics across Texas reported more than 117,000 clinic visits in 1995.
- DIS conducted 574 separate neighborhood outreach screenings in 1995, resulting in 3,362 high risk persons receiving syphilis tests. Of those tested, 141 (4.2%) had positive tests. Ninety-seven (97) new cases of syphilis were identified and treated.

- The 1995 gonorrhea screening activities tested 245,580 women, identifying 7,246 positives (2.95%). The 1995 chlamydia screening activities tested 235,795 women resulting in the identification of 15,661 positives(6.64%).
- The Bureau collaborated with TDH family planning and maternity clinics and with Planned Parenthood affiliates to provide STD screening and medication to their clients.
- Ten colonia residents, "Promotoras," were recruited in Hidalgo County from among low-income women and teens and trained to conduct STD awareness and education sessions and to make referrals for testing and treatment among their peers. Over 6,000 adults and almost 800 teens in Hidalgo County were reached in 1995.
- DIS maintained surveillance activities with physicians, hospitals, public/private laboratories, and community health centers including visits to encourage STD reporting and surveillance.
- DIS posttest counseled 494 HIV positive individuals in 1995 resulting in the location, counseling, and testing for HIV 427 sex and needle partners of these HIV positive clients.

FUTURE PLANS

- The Bureau is investigating the possibility of HIV becoming a standardized test in free standing STD clinics.
- Field STD programs will continue to establish coordinated efforts with local agencies and programs such as jails, youth detention centers, homeless shelters, and neighborhood health facilities.
- 1996 collaborative activities include exploring additional areas for STD and HIV coordination to maximize program resources and improve or expand delivery of services, especially regarding women offered STD screening outside of STD clinics.
- The Bureau will provide the STD, HIV, AIDS Reporting Electronic System (SHARES), an updated surveillance software, to local and regional STD programs.

VII. TRAINING AND PUBLIC EDUCATION

The Training and Public Education (Training) Branch plans, develops, conducts, and evaluates HIV and STD training for the TDH, other State agencies, local health departments, and community based organizations involved in HIV and STD activities. HIV and STD training include technical and disease information as well as administrative and managerial workshops. As part of this process, Training staff develop program-specific education materials and guidelines for use in disease prevention activities. Training staff facilitate the delivery of training by:

- Providing direct training for courses such as the "HIV Test Counseling and Partner Elicitation" course and the "Introduction to Sexually Transmitted Disease Intervention" course;
- Providing "Train the Trainer" courses in which Training Branch instructors teach other State agency and community based organization staff to present TDH approved instructional packages;
- Developing and providing customized training to individual programs to address specific needs; and
- Developing and disseminating HIV/STD curriculums, literature, audiovisuals and other educational materials.

The Training Branch also maintains the Texas Counseling and Testing Registry of all HIV counselors who have successfully completed the HIV courses required by TDH for HIV counseling in Texas. This Branch is responsible for planning and presenting the annual Texas HIV/STD Prevention and Services Conference. Training also compiles and distributes the statewide HIV/AIDS Community Resource Directory and operates the 1-800 Texas AIDSLINE which provides a telephone link between the people of Texas and the TDH.

Training staff provide technical assistance to HIV prevention contractors and STD programs in evaluating their training needs and ensuring that those needs are met. The Training Branch is responsible for assessing the Bureau's staff career development needs and coordinating training.

ACCOMPLISHMENTS:

- The CTRPE course was offered 32 times in locations across the Texas. A total of 499 participants were trained. Three CTRPE courses for 22 hearing impaired participants were offered in 1995.
- The Texas AIDSLINE received over 27,000 calls in 1995. Of these calls, 1,772 callers spoke to an AIDSLINE operator and asked specific questions. Of the 1,772 callers who spoke to an operator, 5 percent (or 91 callers) were Spanish speakers.

- The CDC HIV Prevention Counseling course was merged into the current TDH HIV counselor course. The new curriculum, HIV Prevention Counseling and Partner Elicitation (HIV PC/PE) was piloted with HIV Regional Coordinators, Field Operations Staff, and other trainers October 6-10, 1995.
- 652 health care professionals participated in the HIV Prevention Conference in Austin on May 14 - 17, 1995.
- Training provided four Introduction to Sexually Transmitted Disease Intervention (ISTDI) courses in 1995. A total of 35 new Disease Intervention Specialist (DIS) were trained.
- Training disseminated news releases in conjunction with World AIDS Day to all major media outlets in Texas. In addition, an adaptable new release and surveillance report were sent to each contracting organization to facilitate a community based approach to local media coverage of the epidemic.

FUTURE PLANS:

- The TDH conducted a statewide survey of HIV, STD, and TB field staff to identify needs related to field safety. The survey will provide needed data that will be combined with existing curricula from other states to develop a comprehensive multimedia curriculum that will enhance the field safety knowledge of staff on a statewide level.
- The Training Branch will coordinate the first combined HIV and STD Conference August 26-29, 1996 in Austin. We expect at least 1,000 participants representing regional and local HIV and STD prevention and service agencies across the state.
- Plans to develop and coordinate a statewide Cultural Competency training project are well under way. The TDH Centers for Minority Health and Cultural Competency facilitated a session titled *Introduction to Cultural Competency* attended by 40 participants. The second phase of the project will allow the TDH to contract with a private company to develop and provide Public Health Region specific curriculum on Cultural Competency.
- The Texas AIDSLINE will be modified to include an addition of a selection for educational information on the risks of oral sex. Information on STDs will be incorporated into AIDSLINE educational messages. The AIDSLINE has been renamed the Texas HIV/STD InfoLine to reflect the incorporation of STDs.
- The Bureau will develop and implement training for community based organizations to integrate HIV and STD messages, thus increasing public awareness of STD prevention and the adverse affects of STDs.

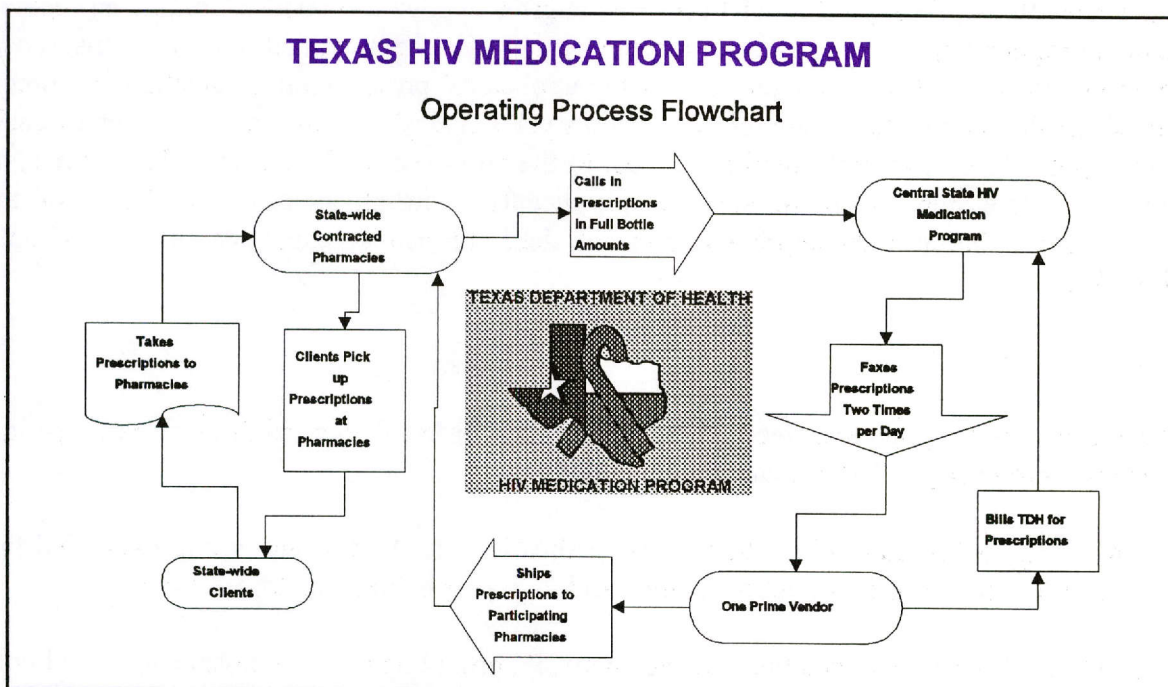
VIII. MEDICATION PROGRAMS

TEXAS HIV MEDICATION PROGRAM

The HIV Medication Program evaluates and approves applications from HIV-infected individuals statewide for HIV-related medications. Working through 158 participating Texas pharmacies, the program purchases and distributes over \$5 million annually in antiretrovirals and other prophylactic medications.

Since its inception in late 1987, the Medication Program has provided HIV medications to over 16,000 Texans. Currently, the program receives and approves more than 35,000 medication orders each year. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. Figure 12 shows how the program operates to ensure that individuals anywhere in Texas have access to needed medications in a simple and timely manner.

Figure 12



The program also develops and maintains confidential data files which provide valuable statistical information regarding medication usage to the Surveillance section of the HIV/STD Epidemiology Division, service providers and lawmakers. It collaborates with the Medicaid Vendor Drug Program to ensure optimum service delivery and avoid duplication of services. In order to maximize its medication purchasing flexibility and utilization of funds, the program developed and maintains its own accounting systems.

In addition to its regular services, the Medication Program operates the Medication Reimbursement Initiative (MRI). This program, formerly known as the Pilot Insurance Program, is operating in its third year of existence. The MRI program pays the deductibles and co-insurance payments required by insurance companies of the Medication Program's approved applicants, who then receive medications directly at their homes. The MRI program affords eligible HIV-infected persons the opportunity to use their insurance pharmacy benefits while keeping the TDH costs (state support) to a minimum by utilizing private sector funds. Persons with insurance benefits that provide for prescription medications would be disqualified from receiving regular Medication Program services.

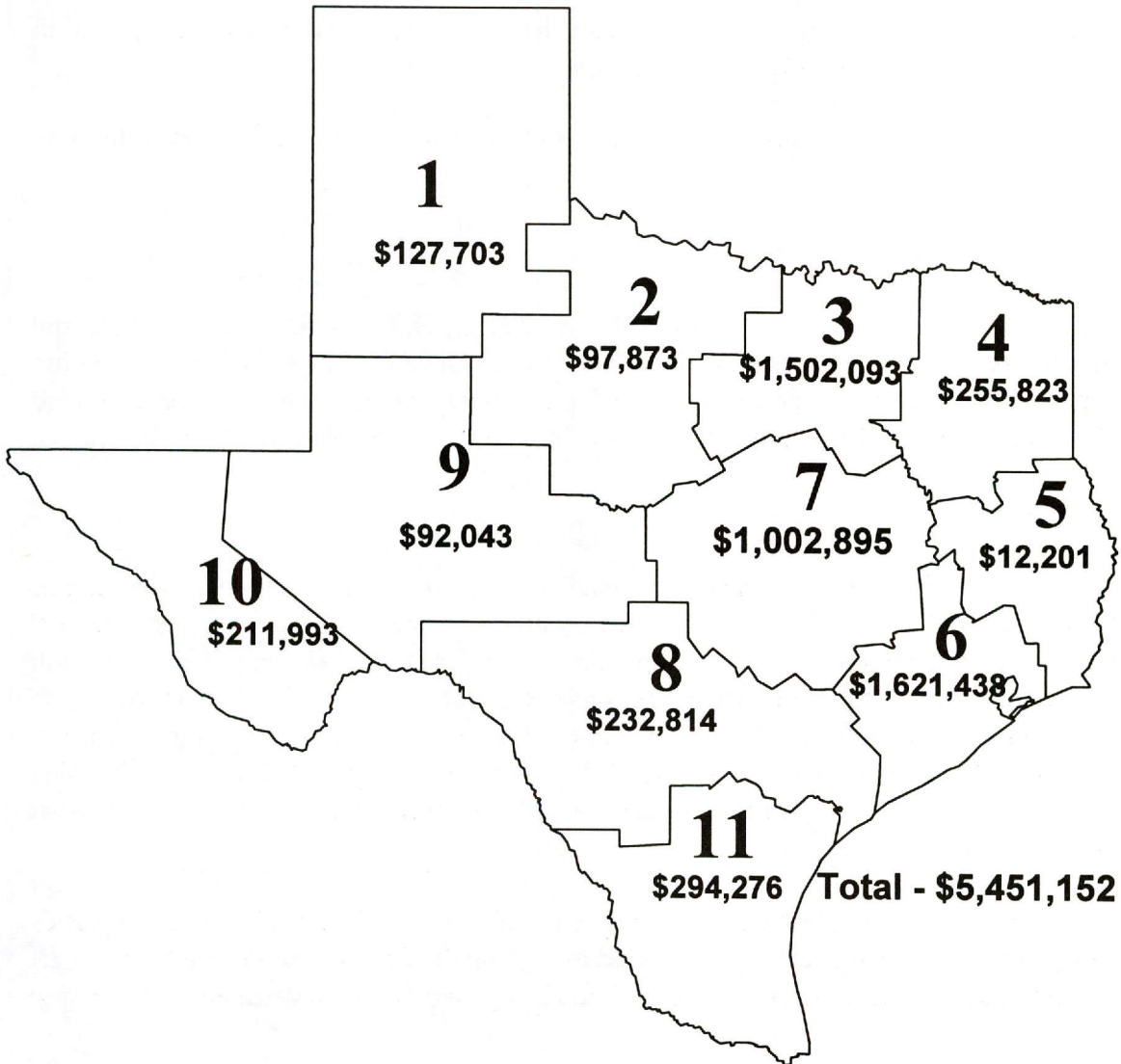
The Medication Program has contracted with Priority Pharmacy in San Diego, California to provide MRI medications. Priority Pharmacy has specialized in home delivery pharmacy services to HIV patients since 1987. To apply for MRI services, eligible applicants submit a completed regular Medication Program application and a completed client profile sheet with all the correct insurance information. Priority Pharmacy then verifies the applicants' prescription medication insurance benefits from this completed client profile. Priority Pharmacy also agrees to deliver to each approved applicant by overnight mail at no cost to the approved applicant or TDH. They also provide a toll-free number to all approved applicants, their physicians, and TDH for all communications relating to the approved applicant, their prescriptions, and access to an on-staff social worker.

ACCOMPLISHMENTS:

- The Medication Program approved 35,000 medication orders dispensed through participating pharmacies to nearly 5,000 individual clients.
- The Medication Program added three new medications to the formulary and expanded the medical eligibility criteria for antiretrovirals and PCP prophylaxis/treatment drugs.
- Twenty-one pharmacies joined the statewide network, providing greater convenience for clients and reducing client loads at individual pharmacies.
- For Fiscal Year 1995, the Medication Program paid MRI deductibles and co-insurance payments in the amount of \$11,831. This total allowed approved applicants to access HIV-related medications at a total allowable cost of \$192,710. The MRI program served a total number of 25 approved applicants in Fiscal Year 1995.

Figure 13

HIV Medication Allocations by Region 1995



- The Medication Program and the Medicaid Vendor Drug Program entered a joint arrangement in December of 1994 in which clients must fill their first three prescriptions each month using their Medicaid entitlement. Participating pharmacies will then contact the Medication Program for HIV-infected persons who need pharmacy assistance beyond the three-prescription-per-month Medicaid limit. The system has allowed clients to utilize both programs more effectively and ensures maximum utilization of the Medicaid program before TDH provides medication to Medicaid clients.

FUTURE PLANS:

- Develop clear clinical indicators in order to provide the new FDA-approved triple combination of antiretrovirals and protease inhibitors statewide.
- Prioritize the Medication Program drug formulary to be utilized in case of a potential funding shortfall.

TEXAS STD MEDICATION PROGRAM

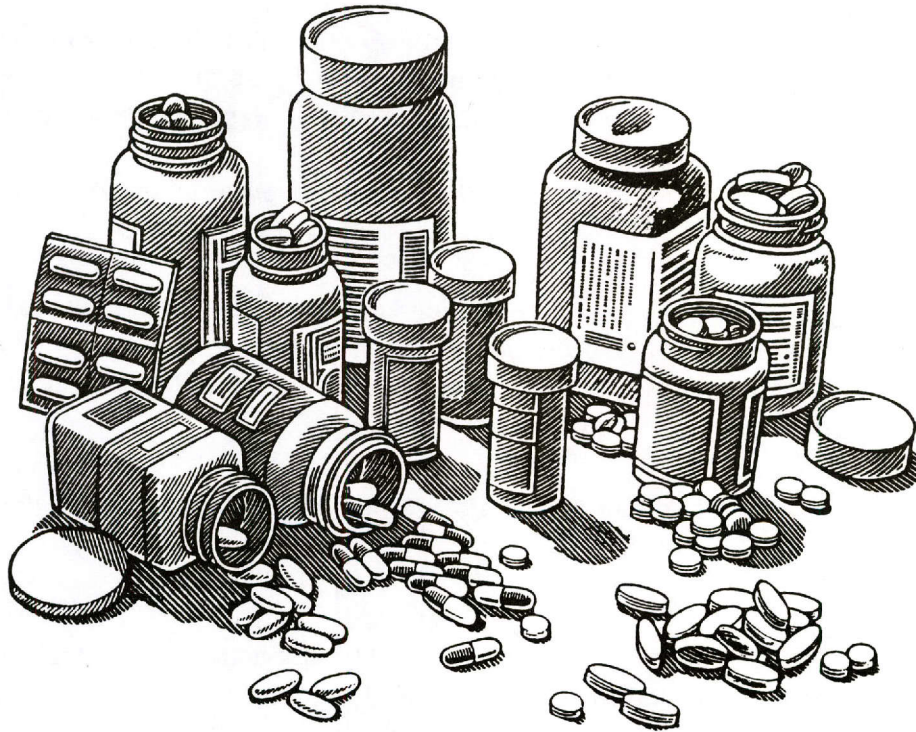
The Texas STD Medication Program distributed \$561,538 in STD medications, needles, and protective needle adapters to 52 sites statewide in 1995. These sites include Public Health Region Offices, county health departments, and local health departments. These sites then deliver treatment directly to STD clients or supply the medications to the community providers who treat the clients.

ACCOMPLISHMENTS

- The Texas STD Medication Program staff planned and developed an extensive overhauling of its statewide medication distribution and inventory control systems. The purpose of the new system is to reduce the number of direct shipment sites statewide and to centralize medication inventory control to the local health departments and regional offices. It ties STD morbidity to actual medication allotment in an effort to encourage more timely and more accurate reporting of STDs statewide. This relation also is intended to help the program set realistic stock levels of STD medications for each of its shipment sites, rather than relying on experiments of what levels would be most efficient.
- Bureau staff traveled to each Public Health Region to hold meetings with all concerned parties throughout the year. These meetings were held to explain the new distribution system, to get feedback, and address the concerns of the individual regional health departments and service providers.

FUTURE PLANS

- The program plans to implement the new statewide distribution and inventory control system for all STD related medications. The program will, pending available funding, provide enough medication to treat a case and two contacts each for gonorrhea, chlamydia, syphilis, and pelvic inflammatory disease.
- The TDH Bureau of Women and Children privatized its clinics and will work with the Bureau to provide STD medications to the clinics that provide STD treatment. An agreement has been reached between the STD Medication Program and the TDH Bureau of Women and Children. Local health department STD Program Managers will identify high priority clinics and provide them with STD medications.



IX. SPECIAL PROJECTS AND CLINICAL RESOURCES PROGRAM

The Special Projects and Clinical Resources Program (SPCR) is responsible for conducting annual and as needed site reviews of projects funded by the Bureau to provide clinical and/or case management services to clients who are HIV-positive or have AIDS. The program provides clinical consultation regarding HIV and other STDs to health professionals employed in regional and local health departments and in community-based organizations statewide, as well as the HIV and STD technical staff. The program also conducts periodic clinical reviews of state funded STD clinics. The SPCR Program is responsible for investigating complaints which involve clinical or case management services. Additionally, the program is responsible for the administration of the HIV/AIDS Interagency Coordinating Council and writing the Council's annual report to the Governor and the Legislature, as well as developing and implementing special projects for the Bureau.

ACCOMPLISHMENTS

- The SPCR Program is currently monitoring twenty-nine projects statewide. Each project is evaluated annually to ensure the quality clinical and/or case management services are being provided to clients. Technical assistance is also provided to projects as needed.
- The program developed the *Clinical Guidelines for Management of the HIV-Positive Maternity Client*.
- The program played a major role in the implementation of HB 1345 in Texas by coordinating the activities of the Training and Public Education Branch, including the development of an educational pamphlet on HIV and STD in pregnancy and the distribution of educational materials and news releases statewide.
- The program is in the process of writing the annual report for the Coordinating Council.

FUTURE PLANS

- Currently, the program has two staff members, the Director and a nurse consultant. The program is planning to increase the staff by contracting for three advanced nursing positions which will be located in Dallas, Houston, and San Antonio. The nurses in these positions will be responsible for monitoring the clinical and case management programs in projects located in each of the catchment areas.
- The SPCR Program is planning a statewide case management training workshop in the near future. The purpose of the workshop will be to provide the case managers in each project site basic information on the roles and responsibilities of case managers.

X. APPENDIX

October - December 1995

TEXAS AIDS SURVEILLANCE REPORT

SUMMARY OF CUMULATIVE DATA

1. Disease Category	Adult/Adolescent *		Pediatric *		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	13416 (38)	10554 (79)	109 (38)	75 (69)	13524 (38)	10629 (79)
Other Disease w/o PCP	10712 (30)	7401 (69)	173 (61)	78 (45)	10885 (31)	7479 (69)
KS Alone	1278 (4)	923 (72)	1 (0)	0 (0)	1279 (4)	923 (72)
No Diseases Listed	9936 (28)	2282 (23)	2 (1)	1 (50)	9938 (28)	2283 (23)
Total	35342 (100)	21160 (60)	284 (100)	154 (54)	35636 (100)	21314 (60)

2. Age *	Cases (%)	3. Race/Ethnicity	Adult/Adolescent *	Pediatric *	Total
			Cases (%)	Cases (%)	Cases (%)
Under 5	221 (1)	White, Not Hispanic	21111 (60)	78 (27)	21189 (59)
5-12	63 (0)	Afr/Am, Not Hispanic	8256 (23)	140 (49)	8396 (24)
13-19	223 (1)	Hispanic	5823 (16)	65 (23)	5888 (17)
20-29	8396 (23)	Asian/Pacific Is.	99 (0)	1 (0)	104 (0)
30-39	16912 (47)	Am. Indian/Alaskan	45 (0)	0 (0)	45 (0)
40-49	7131 (20)	Unknown	8 (0)	0 (0)	8 (0)
Over 49	2680 (8)	Total	35342 (100)	284 (100)	35626 (100)
Unknown	0 (0)				
Total	35626 (100)				

4. Patient Groups	Adult/Adolescent Transmission Modes**		
	Males (%)	Females (%)	Total (%)
Homosexual or bisexual Men	22905 (70)	0 (0)	22905 (65)
Intravenous (IV) drug User	3216 (10)	1115 (40)	4331 (12)
Homo/Bi IV drug User	3304 (10)	0 (0)	3304 (9)
Coagulation disorder	215 (1)	7 (0)	222 (1)
Heterosexual contact	693 (2)	1084 (39)	1777 (5)
Transfusion with blood/products	354 (1)	179 (6)	533 (1)
Risk not reported/Other	1846 (6)	424 (15)	2270 (6)
Total	32533 (100)	2809 (100)	35342 (100)

	Pediatric Transmission Modes		
	Males (%)	Females (%)	Total (%)
Coagulation disorder	20 (13)	0 (0)	20 (7)
Parent at risk/has AIDS/HIV	117 (74)	106 (85)	223 (79)
Transfusion with blood/products	20 (13)	15 (12)	35 (12)
Risk not reported/Other	2 (1)	4 (3)	6 (2)
Total	159 (100)	125 (100)	284 (100)

* Classification at time of AIDS diagnosis.

**27 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3; and as Adult "Risk/Other" cases in table 4.

County of Residence	Cumulative Reported	1995 Deaths	1995 To Date	County of Residence	Cumulative Reported	1995 Deaths	1995 To Date	County of Residence	Cumulative Reported	1995 Deaths	1995 To Date
ANDERSON CO.	22	15	4	GALVESTON CO.	457	288	74	OCHILTREE CO.	2	1	0
ANDREWS CO.	5	4	1	GARZA CO.	1	1	0	ORANGE CO.	61	33	11
ANGELINA CO.	41	27	3	GILLESPIE CO.	4	4	0	PALO PINTO CO.	6	1	0
ARANSAS CO.	12	8	2	GONZALES CO.	6	3	0	PANOLA CO.	5	3	0
ARCHER CO.	3	3	0	GRAY CO.	6	4	2	PARKER CO.	27	10	4
ARMSTRONG CO.	1	1	0	GRAYSON CO.	66	32	12	PARMER CO.	1	0	1
ATASCOSA CO.	8	4	1	GREGG CO.	99	47	16	PECOS CO.	7	2	3
AUSTIN CO.	5	2	1	GRIMES CO.	14	11	0	POLK CO.	39	24	7
BAILEY CO.	2	1	0	GUADALUPE CO.	21	12	5	POTTER CO.	167	101	29
BANDERA CO.	2	2	1	HALE CO.	16	6	2	PRESIDIO CO.	1	1	0
BASTROP CO.	49	24	6	HAMILTON CO.	3	1	0	RAINS CO.	3	3	0
BAYLOR CO.	1	0	1	HARDEMAN CO.	5	2	1	RANDALL CO.	33	22	7
BEE CO.	11	9	0	HARDIN CO.	31	20	3	REAL CO.	1	0	0
BELL CO.	144	68	36	HARRIS CO.	12,214	7,847	1,182	RED RIVER CO.	3	3	1
BEXAR CO.	2,636	1,480	410	HARRISON CO.	32	17	5	REEVES CO.	4	2	2
BLANCO CO.	4	1	0	HASKELL CO.	3	3	0	REFUGIO CO.	1	0	1
BOSQUE CO.	4	1	0	HAYS CO.	55	31	8	ROBERTSON CO.	10	8	2
BOWIE CO.	81	50	12	HENDERSON CO.	31	13	10	ROCKWALL CO.	17	10	3
BRAZORIA CO.	160	112	12	HIDALGO CO.	196	102	32	RUNNELS CO.	3	3	0
BRAZOS CO.	99	59	16	HILL CO.	13	8	1	RUSK CO.	18	11	2
BREWSTER CO.	3	3	1	HOCKLEY CO.	11	9	2	SABINE CO.	5	4	0
BRISCOE CO.	1	1	0	HOOD CO.	10	3	4	SAN AUGUSTINE C.	11	11	2
BROOKS CO.	2	1	0	HOPKINS CO.	11	7	1	SAN JACINTO CO.	10	8	1
BROWN CO.	10	4	1	HOUSTON CO.	11	6	4	SAN PATRICIO CO.	43	33	2
BURLESON CO.	5	4	0	HOWARD CO.	29	21	1	SAN SABA CO.	2	2	0
BURNET CO.	12	8	1	HUNT CO.	47	26	5	SCHLEICHER CO.	1	0	0
CALDWELL CO.	20	12	3	HUTCHINSON CO.	4	2	0	SCURRY CO.	4	1	0
CALHOUN CO.	11	6	0	JACK CO.	2	1	0	SHELBY CO.	23	16	5
CALLAHAN CO.	5	2	0	JACKSON CO.	6	4	1	SHERMAN CO.	1	1	0
CAMERON CO.	188	101	41	JASPER CO.	12	8	2	SMITH CO.	136	70	18
CAMP CO.	4	2	2	JEFFERSON CO.	369	185	65	SOMERVELL CO.	2	0	2
CARSON CO.	2	1	2	JIM HOGG CO.	3	3	0	STARR CO.	10	6	0
CASS CO.	13	7	2	JIM WELLS CO.	16	9	4	STEPHENS CO.	3	2	0
CASTRO CO.	3	1	0	JOHNSON CO.	59	36	7	STONEWALL CO.	1	1	0
CHAMBERS CO.	9	8	0	JONES CO.	5	3	0	SUTTON CO.	1	0	0
CHEROKEE CO.	23	10	4	KARNES CO.	1	0	0	SWISHER CO.	2	2	0
CHILDRESS CO.	9	5	0	KAUFMAN CO.	49	30	9	TARRANT CO.	2,161	1,172	215
CLAY CO.	2	0	0	KENDALL CO.	9	5	3	TAYLOR CO.	100	56	9
COKE CO.	2	2	1	KERR CO.	29	20	2	TERRELL CO.	1	0	0
COLEMAN CO.	3	1	0	KIMBLE CO.	1	0	0	TERRY CO.	2	1	0
COLLIN CO.	134	71	31	KINNEY CO.	3	2	0	THROCKMORTON	1	1	0
COLORADO CO.	10	8	1	KLEBERG CO.	23	18	3	TITUS CO.	11	4	1
COMAL CO.	29	17	4	LA SALLE CO.	3	3	0	TOM GREEN CO.	53	34	11
COMANCHE CO.	5	3	0	LAMAR CO.	14	9	2	TRAVIS CO.	2,495	1,513	313
CONCHO CO.	1	1	0	LAMB CO.	6	2	0	TRINITY CO.	6	0	3
COOKE CO.	17	12	1	LAMPASAS CO.	9	7	2	TYLER CO.	8	4	2
CORYELL CO.	14	6	3	LAVACA CO.	1	0	0	UPSHUR CO.	17	6	1
CRANE CO.	1	1	0	LEE CO.	3	1	1	UVALDE CO.	9	6	2
CROCKETT CO.	3	2	1	LEON CO.	5	0	1	VAL VERDE CO.	11	9	1
CROSBY CO.	2	1	0	LIBERTY CO.	40	28	6	VAN ZANDT CO.	22	13	3
CULBERSON CO.	1	1	1	LIMESTONE CO.	5	2	0	VICTORIA CO.	56	27	7
DALLAM CO.	4	2	1	LIPSCOMB CO.	1	0	1	WALKER CO.	31	22	5
DALLAS CO.	8,203	4,923	1,180	LIVE OAK CO.	6	2	4	WALLER CO.	23	11	2
DAWSON CO.	2	1	0	LLANO CO.	6	5	1	WARD CO.	9	4	1
DE WITT CO.	6	6	1	LUBBOCK CO.	182	114	15	WASHINGTON CO.	7	4	1
DEAF SMITH CO.	6	1	1	MADISON CO.	11	9	0	WEBB CO.	128	68	19
DENTON CO.	259	140	41	MARION CO.	2	0	1	WHARTON CO.	23	7	8
DICKENS CO.	3	3	0	MARTIN CO.	4	3	0	WICHITA CO.	125	67	14
DIMMIT CO.	1	0	0	MASON CO.	1	0	1	WILBARGER CO.	7	2	1
DONLEY CO.	2	1	0	MATAGORDA CO.	23	16	3	WILLACY CO.	4	1	0
DUVAL CO.	3	3	0	MAVERICK CO.	19	7	4	WILLIAMSON CO.	91	57	13
EASTLAND CO.	6	3	0	MCCULLOCH CO.	7	6	1	WILSON CO.	8	4	2
ECTOR CO.	103	59	15	MCLENNAN CO.	157	94	25	WINKLER CO.	5	3	1
EDWARDS CO.	2	1	0	MEDINA CO.	10	6	2	WISE CO.	14	6	4
EL PASO CO.	548	304	135	MIDLAND CO.	77	47	8	WOOD CO.	23	10	7
ELLIS CO.	60	34	10	MILAM CO.	10	7	1	YOAKUM CO.	2	1	0
ERATH CO.	13	10	0	MITCHELL CO.	2	1	0	YOUNG CO.	9	4	2
FALLS CO.	6	5	1	MONTAGUE CO.	6	4	1	ZAPATA CO.	3	3	0
FANNIN CO.	6	3	2	MONTGOMERY CO.	163	112	16	ZAVALA CO.	4	3	0
FAYETTE CO.	4	2	2	MOORE CO.	5	4	1	TDC CO.	979	367	286
FISHER CO.	2	1	0	MORRIS CO.	11	5	3				
FLOYD CO.	3	1	0	NACOGDOCHES C.	30	18	6				
FOARD CO.	1	0	0	NAVARRO CO.	22	11	6				
FORT BEND CO.	222	138	32	NEWTON CO.	3	2	2				
FREESTONE CO.	7	3	1	NOLAN CO.	11	8	1				
FRIO CO.	3	3	1	NUECES CO.	365	224	56				
GAINES CO.	2	2	0								
								TOTAL THIS REPORT	35,626	21,314	4,703
								TOTAL COUNTIES REPORTING		222	

County Residency	Chanc	CT	GC	County Residency	Chanc	CT	GC	County Residency	Chanc	CT	GC
ANDERSON	0	45	25	GLASSCOCK	0	0	0	MOTLEY	0	3	0
ANDREWS	0	22	0	GOLIAD	0	4	0	NACOGDOCHES	0	90	36
ANGELINA	0	153	177	GONZALES	0	46	19	NAVARRO	0	152	64
ARANSAS	0	16	2	GRAY	0	54	29	NEWTON	0	26	22
ARCHER	0	2	3	GRAYSON	0	254	160	NOLAN	0	63	65
ARMSTRONG	0	5	3	GREGG	0	163	37	NUECES	2	1,168	373
ATASCOSA	0	15	2	GRIMES	0	19	33	OCHILTREE	0	30	5
AUSTIN	0	22	10	GUADALUPE	0	93	33	OLDHAM	0	3	1
BAILEY	0	13	4	HALE	0	133	63	ORANGE	0	146	53
BANDERA	0	9	0	HALL	0	7	5	PALO PINTO	0	43	4
BASTROP	0	33	26	HAMILTON	0	3	0	PANOLA	0	49	24
BAYLOR	0	2	1	HANSFORD	0	4	0	PARKER	0	48	18
BEE	0	93	4	HARDEMAN	0	13	4	PARMER	0	7	0
BELL	1	1,408	667	HARDIN	0	70	66	PECOS	0	23	3
BEXAR	0	4,348	1,914	HARRIS	0	8,035	6,920	POLK	0	29	26
BLANCO	0	1	0	HARRISON	0	71	150	POTTER	0	711	387
BORDEN	0	0	1	HARTLEY	0	0	0	PRESIDIO	0	8	1
BOSQUE	0	8	2	HASKELL	0	4	5	RAINS	0	0	0
BOWIE	0	179	127	HAYS	0	175	45	RANDALL	0	185	84
BRAZORIA	0	327	186	HEMPHILL	0	1	0	REAGAN	0	0	0
BRAZOS	0	308	159	HENDERSON	0	49	26	REAL	0	0	0
BREWSTER	0	19	0	HIDALGO	0	921	78	RED RIVER	0	17	10
BRISCOE	0	0	0	HILL	0	20	3	REEVES	0	7	1
BROOKS	0	27	0	HOCKLEY	0	42	21	REFUGIO	0	6	3
BROWN	0	99	33	HOOD	0	40	8	ROBERTS	0	0	0
BURLESON	0	21	14	HOPKINS	0	45	5	ROBERTSON	0	42	41
BURNET	0	24	3	HOUSTON	0	25	15	ROCKWALL	0	13	7
CALDWELL	0	18	15	HOWARD	0	38	13	RUNNELS	0	5	2
CALHOUN	0	6	9	HUDSPETH	0	1	0	RUSK	0	24	11
CALLAHAN	0	5	0	HUNT	0	152	119	SABINE	0	5	2
CAMERON	0	732	56	HUTCHINSON	0	60	18	SAN AUGUSTINE	0	6	1
CAMP	0	7	3	IRION	0	0	0	SAN JACINTO	0	6	1
CARSON	0	2	1	JACK	0	4	0	SAN PATRICIO	0	124	19
CASS	0	33	13	JACKSON	0	6	5	SAN SABA	0	2	0
CASTRO	0	30	7	JASPER	0	116	110	SCHLEICHER	0	1	0
CHAMBERS	0	13	4	JEFF DAVIS	0	2	0	SCURRY	0	48	37
CHEROKEE	0	42	40	JEFFERSON	0	738	689	SHACKELFORD	0	1	0
CHILDRESS	0	20	12	JIM HOGG	0	4	2	SHELBY	0	13	6
CLAY	0	3	0	JIM WELLS	0	74	5	SHERMAN	0	1	2
COCHRAN	0	4	1	JOHNSON	0	146	38	SMITH	0	505	402
COKE	0	0	0	JONES	0	11	8	SOMERVELL	0	5	1
COLEMAN	0	20	2	KARNES	0	38	5	STARR	0	48	2
COLLIN	0	260	123	KAUFMAN	0	110	35	STEPHENS	0	10	4
COLLINGSWORTH	0	6	3	KENDALL	0	7	1	STERLING	0	0	0
COLORADO	0	39	44	KENEDY	0	0	0	STONEWALL	0	0	0
COMAL	0	91	22	KENT	0	0	0	SUTTON	0	0	1
COMANCHE	0	15	1	KERR	0	45	22	SWISHER	0	43	15
CONCHO	0	0	0	KIMBLE	0	0	0	TARRANT	0	2,541	2,443
COOKE	0	45	24	KING	0	0	0	TAYLOR	0	353	175
CORYELL	0	126	25	KINNEY	0	0	0	TERRELL	0	0	0
COTTLE	0	8	3	KLEBERG	0	84	18	TERRY	0	48	11
CRANE	0	2	0	KNOX	0	4	2	THROCKMORTON	0	0	0
CROCKETT	0	3	0	LAMAR	0	59	35	TITUS	0	46	22
CROSBY	0	27	3	LAMB	0	30	10	TOM GREEN	0	296	87
CULBERSON	0	3	0	LAMPASAS	0	35	0	TRAVIS	0	2,979	1,601
DALLAM	0	23	0	LA SALLE	0	18	0	TRINITY	0	4	8
DALLAS	18	5,117	8,029	LAVACA	0	16	11	TYLER	0	14	16
DAWSON	0	24	2	LEE	0	5	4	UPSHUR	0	18	14
DEAF SMITH	0	86	13	LEON	0	11	9	UPTON	0	0	0
DELTA	0	3	2	LIBERTY	0	47	18	UVALDE	0	103	6
DENTON	0	366	193	LIMESTONE	0	61	43	VAL VERDE	0	81	17
DE WITT	0	28	5	LIPSCOMB	0	0	0	VAN SANDT	0	20	2
DICKENS	0	12	3	LIVE OAK	0	8	0	VICTORIA	0	356	222
DIMMIT	0	21	2	LLANO	0	2	0	WALKER	0	228	96
DONLEY	0	10	3	LOVING	0	0	0	WALLER	0	177	74
DUVAL	0	30	2	LUBBOCK	0	1,154	593	WARD	0	0	1
EASTLAND	0	16	5	LYNN	0	14	5	WASHINGTON	0	20	32
ECTOR	0	299	142	MC CULLOCH	0	10	1	WEBB	0	202	17
EDWARDS	0	0	0	MC LENNAN	1	1,047	684	WHARTON	0	134	80
ELLIS	0	141	72	MC MULLEN	0	0	0	WHEELER	0	9	6
EL PASO	0	1,248	159	MADISON	0	24	13	WICHITA	2	483	380
ERATH	0	67	7	MARION	0	13	3	WILBARGER	0	12	10
FALLS	0	43	43	MARTIN	0	3	2	WILLACY	0	39	3
FANNIN	0	44	29	MASON	0	2	1	WILLIAMSON	1	128	39
FAYETTE	0	32	12	MATAGORDA	0	81	71	WILSON	0	23	3
FISHER	0	1	2	MAVERICK	0	8	1	WINKLER	0	8	0
FLOYD	0	10	1	MEDINA	0	39	2	WISE	0	38	7
FOARD	0	2	0	MENARD	0	0	0	WOOD	0	12	3
FORT BEND	0	253	114	MIDLAND	0	221	170	YOAKUM	0	19	2
FRANKLIN	0	1	0	MILAM	0	28	28	YOUNG	0	24	1
FREESTONE	0	22	18	MILLS	0	3	0	ZAPATA	0	4	2
FRIO	0	30	3	MITCHELL	0	6	2	ZAVALA	0	45	5
GAINES	0	14	1	MONTAGUE	0	10	4				
GALVESTON	1	710	540	MONTGOMERY	0	167	60				
GARZA	0	17	2	MOORE	0	47	4				
GILLESPIE	0	12	1	MORRIS	0	16	6	*TDCJ	0	1	0
								STATE TOTALS	26	44,738	30,893

Texas Surveillance Report on Syphilis – Congenital, Primary & Secondary, Early Latent, and Total Cases

Jan-Dec 1995

County Residency	Cong	P&S	EL <1	Total	County Residency	Cong	P&S	EL <1	Total	County Residency	Cong	P&S	EL <1	Total
ANDERSON	0	1	4	7	GLASSCOCK	0	0	0	0	MOTLEY	0	0	0	0
ANDREWS	0	0	17	2	GOLIAD	0	0	0	0	NACOGDOCHES	2	5	17	25
ANGELINA	0	15	0	32	GONZALES	0	1	1	3	NAVARRO	0	1	1	6
ARANSAS	0	0	0	2	GRAY	0	1	1	2	NEWTON	0	0	0	0
ARCHER	0	0	0	0	GRAYSON	0	2	11	18	NOLAN	0	0	0	0
ARMSTRONG	0	0	0	0	GREGG	0	68	27	98	NUECES	1	8	29	62
ATASCOSA	0	0	0	0	GRIMES	1	14	5	25	OCHILTREE	0	0	0	0
AUSTIN	0	3	0	4	GUADALUPE	0	0	0	2	OLDHAM	0	0	0	0
BAILEY	0	0	0	1	HALE	0	0	1	2	ORANGE	2	3	14	22
BANDERA	0	0	0	0	HALL	0	0	0	1	PALO PINTO	0	0	1	1
BASTROP	0	0	2	2	HAMILTON	0	0	0	0	PANOLA	0	2	1	3
BAYLOR	0	0	0	0	HANSFORD	0	0	0	0	PARKER	0	0	0	1
BEE	0	0	1	10	HARDEMAN	0	0	0	0	PARMER	0	0	0	0
BELL	3	25	27	74	HARDIN	2	3	6	12	PECOS	0	0	2	2
BEXAR	10	50	161	395	HARRIS	88	412	888	2,668	POLK	0	4	7	11
BLANCO	0	0	0	0	HARRISON	0	17	11	29	POTTER	0	5	3	13
BORDEN	0	0	0	0	HARTLEY	0	0	0	0	PRESIDIO	1	0	0	4
BOSQUE	0	0	0	0	HASKELL	0	0	0	0	RAINS	0	0	0	0
BOWIE	1	14	7	22	HAYS	0	6	3	10	RANDALL	0	0	0	0
BRAZORIA	1	4	6	19	HEMPHILL	0	0	0	0	REAGAN	0	0	0	0
BRAZOS	0	23	29	59	HENDERSON	0	0	5	5	REAL	0	0	0	0
BREWSTER	0	0	2	6	HIDALGO	9	10	21	156	RED RIVER	0	0	1	1
BRISCOE	0	0	0	0	HILL	0	1	2	3	REEVES	0	0	0	8
BROOKS	0	0	2	2	HOCKLEY	0	1	0	2	REFUGIO	0	0	3	3
BROWN	0	0	0	0	HOOD	0	0	1	2	ROBERTS	0	0	0	0
BURLESON	0	1	4	6	HOPKINS	0	1	0	1	ROBERTSON	0	6	1	7
BURNET	0	0	1	1	HOUSTON	0	4	15	19	ROCKWALL	0	1	0	1
CALDWELL	0	0	1	2	HOWARD	0	0	3	28	RUNNELS	0	0	0	0
CALHOUN	0	3	0	4	HUDSPETH	0	0	0	0	RUSK	0	6	5	11
CALLAHAN	0	0	0	0	HUNT	0	2	0	7	SABINE	0	0	0	0
CAMERON	2	2	28	77	HUTCHINSON	0	0	0	1	SAN AUGUSTINE	0	0	1	1
CAMP	1	8	5	15	IRION	0	0	0	0	SAN JACINTO	0	0	0	0
CARSON	0	0	0	0	JACK	0	0	0	0	SAN PATRICIO	0	0	4	6
CASS	0	1	3	6	JACKSON	0	9	4	13	SAN SABA	0	0	0	0
CASTRO	0	0	0	0	JASPER	0	7	13	20	SCHLEICHER	0	1	0	2
CHAMBERS	0	0	2	3	JEFF DAVIS	0	0	0	0	SCURRY	0	0	0	0
CHEROKEE	0	0	7	7	JEFFERSON	14	74	220	347	SHACKELFORD	0	0	0	0
CHILDRESS	0	0	0	1	JIM HOGG	0	0	0	0	SHELBY	0	2	12	14
CLAY	0	0	0	0	JIM WELLS	0	0	1	1	SHERMAN	0	0	0	0
COCHRAN	0	0	0	0	JOHNSON	0	4	7	12	SMITH	1	10	24	40
COKE	0	0	0	0	JONES	0	0	0	0	SOMERVELL	0	0	0	0
COLEMAN	0	0	0	0	KARNES	0	1	1	3	STARR	0	0	0	5
COLLIN	0	1	7	16	KAUFMAN	0	1	1	4	STEPHENS	0	0	0	0
COLLINGSWORTH	0	0	0	0	KENDALL	0	0	0	0	STERLING	0	0	0	0
COLORADO	0	2	2	8	KENEDY	0	0	0	0	STONEWALL	0	0	0	0
COMAL	0	0	2	2	KENT	0	0	0	0	SUTTON	0	0	0	0
COMANCHE	0	0	0	0	KERR	0	0	0	1	SWISHER	0	0	0	0
CONCHO	0	0	1	16	KIMBLE	0	0	0	0	TARRANT	12	140	280	492
COOKE	0	0	1	1	KING	0	0	0	0	TAYLOR	0	0	0	0
CORYELL	0	1	2	8	KINNEY	0	0	0	0	TERRELL	0	0	0	0
COTTLE	0	0	0	0	KLEBERG	0	0	1	4	TERRY	0	0	6	15
CRANE	0	0	0	0	KNOX	0	0	0	0	THROCKMORTON	0	0	0	0
CROCKETT	0	0	0	0	LAMAR	0	1	0	1	TITUS	0	4	5	10
CROSBY	0	0	0	0	LAMB	0	0	1	2	TOM GREEN	0	1	3	5
CULBERSON	0	0	0	0	LAMPASAS	0	0	0	0	TRAVIS	0	17	79	183
DALLAM	0	0	0	0	LA SALLE	0	0	0	0	TRINITY	0	1	1	2
DALLAS	12	268	410	1,025	LAVACA	0	2	0	3	TYLER	0	1	4	5
DAWSON	0	0	1	1	LEE	0	0	0	0	UPSHUR	0	1	3	4
DEAF SMITH	0	0	0	3	LEON	0	0	0	0	UPTON	0	0	0	0
DELTA	0	0	0	0	LIBERTY	0	4	12	17	UVALDE	0	0	0	0
DENTON	0	1	10	17	LIMESTONE	0	0	2	9	VAL VERDE	0	0	0	0
DE WITT	0	1	0	1	LIPSCOMB	0	0	0	0	VAN ZANDT	0	0	0	2
DICKENS	0	0	0	0	LIVE OAK	0	0	0	0	VICTORIA	1	21	14	39
DIMMIT	0	0	0	0	LLANO	0	0	0	0	WALKER	0	13	12	29
DONLEY	0	0	0	2	LOVING	0	0	0	0	WALLER	1	4	15	20
DUVAL	0	0	0	0	LUBBOCK	0	4	4	24	WARD	0	0	0	0
EASTLAND	0	0	0	0	LYNN	0	0	0	0	WASHINGTON	0	6	7	13
ECTOR	0	0	4	8	MC CULLOCH	0	0	0	0	WEBB	3	1	9	63
EDWARDS	0	0	0	0	MC LENNAN	2	15	15	46	WHARTON	0	9	18	32
ELLIS	1	4	4	9	MC MULLEN	0	0	0	0	WHEELER	0	0	0	0
EL PASO	4	2	21	142	MADISON	0	4	1	5	WICHITA	0	2	3	12
ERATH	0	0	0	0	MARION	0	3	1	4	WILBARGER	0	0	2	5
FALLS	0	2	2	7	MARTIN	0	0	0	0	WILLACY	0	0	1	7
FANNIN	0	0	0	0	MASON	0	0	0	0	WILLIAMSON	0	1	2	5
FAYETTE	0	1	1	3	MATAGORDA	0	6	10	20	WILSON	0	0	0	1
FISHER	0	0	2	2	MAVERICK	0	0	0	1	WINKLER	0	0	0	0
FLOYD	0	0	0	0	MEDINA	0	0	3	3	WISE	0	0	0	0
FOARD	0	0	0	0	MENARD	0	0	0	0	WOOD	1	1	1	4
FORT BEND	2	12	19	40	MIDLAND	0	0	9	19	YOAKUM	0	0	0	0
FRANKLIN	0	0	0	0	MILAM	0	4	1	6	YOUNG	0	0	0	0
FREESTONE	1	2	0	5	MILLS	0	0	0	0	ZAPATA	0	0	0	0
FRIO	0	0	2	3	MITCHELL	0	0	0	0	ZAVALA	0	0	0	0
GAINES	0	0	0	0	MONTAGUE	0	1	0	1					
GALVESTON	12	17	64	105	MONTGOMERY	1	17	33	59	*TDCJ	0	112	223	815
GARZA	0	0	0	0	MOORE	0	0	0	1					
GILLESPIE	0	0	0	0	MORRIS	0	4	0	4	STATE TOTALS	192	1,557	3,019	7,919

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