

**South Carolina  
HIV/AIDS  
Strategy  
2017-2021**

**South Carolina  
Department of Health and  
Environmental Control  
(S.C. DHEC)**

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Little River Medical Center  
Lowcountry AIDS Services  
Low Country Health Care System  
Lexington Richland Alcohol and Drug Abuse Council  
Mecklenburg County Health Department, Charlotte TGA  
Medical University of South Carolina Adult Infectious Diseases  
Medical University of South Carolina Outpatient Pediatric AIDS Clinic  
New Horizon Family Health Services  
Palmetto AIDS Life Support Services  
Piedmont Care  
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## Section 1: Introduction

In 2015, South Carolina noted a fifth consecutive decline in annual new cases of HIV/AIDS. The South Carolina Department of Health and Environmental Control (S.C. DHEC) provided prevention services in 2015 including 75,887 HIV tests conducted in community and clinical settings. From those testing services, **565 persons were identified as HIV positive**. S.C. DHEC's HIV prevention programs also supported the distribution of 2,640,796 condoms in calendar year 2015.

Per the SC Department of Health and Environmental Control, there were 16,222 individuals diagnosed with HIV in SC at the end of 2014, including 773 total new infections in the year.

Individual and group-level behavioral interventions and strategies, which include risk reduction prevention counseling, perinatal prevention case management, supportive group education programs, and activities to link HIV positive persons into treatment and care, were provided to more than 1,400 individuals of which 84% were persons living with HIV/AIDS (PLWHA).

The Ryan White Part B Program served a total of 8,816 clients in CY2015 including 820 new clients. These clients received life-sustaining HIV medical care through 13 Ryan White Part B Regional Service Providers. Services included: Core services of outpatient and ambulatory health services, pharmaceutical assistance, oral health care, health insurance premium and cost sharing assistance, home health care, medical nutrition therapy, mental health services, substance abuse outpatient care, and medical case management, including treatment adherence services. Support services include case management services (non-medical), emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, linguistic services, medical transportation services, outreach services, psychosocial support services, referral for health/care/supportive services, rehabilitation services, substance abuse services (residential), and treatment adherence counseling. In addition, South Carolina's AIDS Drug Assistance Program (ADAP) provided Direct Dispensing services to 3,656 clients, Insurance Assistance Program services to 2,851 clients, and Medicare Assistance Program services to 337 clients, for CY2015.

Additionally, 11 Ryan White Part C providers and four Ryan White Part D providers funded directly by HRSA serve People Living with HIV/AIDS in South Carolina with Ryan White eligible core and supportive services.

Despite this progress, there continues to be unmet challenges. African-Americans represented 73% of new HIV diagnoses in 2014, although they represent only one-third of the South Carolina population. Men who Have Sex with Men (MSM), particularly younger MSM and African-American MSM, are being diagnosed at the highest rates. Linkage to and retention in care continue to present significant challenges for individuals living with HIV. For example, two-thirds of South Carolinians who are diagnosed with HIV received any medical care. One-half of South Carolinians diagnosed with HIV have achieved viral suppression.

Despite the national expansion of state health care programs, the SC Medicaid Program is not expanding to cover PLWHA with income below the Federal Poverty Level (63% of RW Part B consumers in CY 2014). The SC RW Part B program continues to serve as the largest HIV/AIDS-specific safety-net program in SC. Per the 2015 HIV Epidemiologic Profile, there were 16,222 PLWHA in SC as of December 31, 2014. The RW Part B-funded providers served 8,749 or 54% of PLWHA in SC in CY 2014. ADAP served 5,554 or 34%. Of the 8,749 served by RW Part B in CY 2014, 866 or 10% were new to the RW Part B care system. There is much opportunity to maintain the affordability of HIV/AIDS Care and Treatment due to the Affordable Care Act (ACA) and continued contributions from the State of SC Legislative Budget. However, continuation and expansion of collaborative strategies is required from all HIV/AIDS stakeholders to maintain levels of funding that support the NHAS-related needs of PLWHA in SC.

### Supporting the National HIV/AIDS Strategy

S.C. DHEC’s STD/HIV Division has used the Statewide Coordinated Statement of Need (SCSN) process as an opportunity to identify complex issues facing South Carolinians who are at risk for HIV. The SCSN also addresses issues for people living with HIV which impede access to and retention in care and medical treatment. The Integrated Prevention and Care Plan (IPCP) demonstrates S.C. DHEC’s commitment to using state-of-the-art surveillance and best-practice interventions to address the challenges along the points of care in the HIV Care Continuum. While not an easy challenge, S.C. DHEC and its partners across South Carolina will strive to: (1) prevent new HIV infections; (2) identify individuals living with HIV who are unaware of their status; (3) link and retain to high-quality medical services; (4) assure availability of antiretroviral therapy (ART); and (5) address health disparities underpinning the epidemic in South Carolina.

### National HIV/AIDS Strategy Goals for 2020

National HIV/AIDS (NHAS) Strategy Indicators by 2020	South Carolina HIV Care Continuum Data CY 2014
Reduce the number of new HIV diagnoses by at least 25 percent.	773 New Infections in 2014 <sup>1</sup>
Increase the percentage of people living with HIV who know their serostatus to at least 90 percent.	79.66% <sup>2</sup>
Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent.	75% <sup>3</sup>
Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent.	54% <sup>4</sup>
Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.	Data not available outside of Ryan White/HOPWA reports <sup>5</sup>
Increase the percentage of persons with diagnosed HIV — infection who are virally suppressed to at least 80 percent.	53% <sup>6</sup>

1. **Data Source:** South Carolina Department of Health and Environmental Control.
2. **Data Source:** South Carolina – 2014 HIV Care Continuum. CDC estimates about 19,200 people in South Carolina are living with HIV, including about 3,200 people who are undiagnosed. (15,296/19,200 = 79.66%) Percentage calculations for PLWHA who are unaware of their HIV status may vary depending on the methodology used.
3. **Data Source:** South Carolina Department of Health and Environmental Control. CDC calculation of Newly Diagnosed for PLWHA in 2014 who were linked to care within 30 days of diagnosis. (577 /773 = 75%)
4. **Data Source:** South Carolina – 2014 HIV Care Continuum. Percentage of persons with Diagnosed HIV, who had  $\geq 2$  CD4 or viral load test results at least 3 months apart during 2014.
5. Data not available for all persons diagnosed with HIV SC.
6. **Data Source:** South Carolina – 2014 HIV Care Continuum. Percentage of persons with Diagnosed HIV, who had a Viral Load  $\leq 200$  copies/mL at most recent test during 2014.

## **Supporting the DHEC Strategic Plan**

In addition to supporting the NHAS, this plan also supports the DHEC Strategic Plan as follows:

### Vision

Healthy people living in healthy communities

### Mission

To improve the quality of life for all South Carolinians by protecting and promoting the health of the public and the environment

### Core Values

Pursuing Excellence  
Inspiring Innovation  
Promoting Teamwork  
Embracing Service

### Agency Strategies

Education and Engagement  
Science in Action  
Leadership and Contribution  
Service and Accessibility  
Operational Excellence

## Section 2: Overview of the Process

### Description of the planning process

The SCSN began in late 2015 with discussions with S.C. DHEC and the HIV Planning Council (HPC) outlining a process to move forward. S.C. DHEC's contractual administrator for the HPC, Capitol Consultants, released a Request for Proposals (RFP) soliciting bids from contractors to conduct the SCSN and collaboratively develop the IPCP for South Carolina. Capitol Consultants, with S.C. DHEC's STD/HIV Division approval, awarded the contract to the independent firm of JL Sacco & Associates, a small business entity based in Atlanta, Georgia.

Working with the firm's principal, James Sacco, the STD/HIV Division finalized their plans and timeline for the SCSN and IPCP development. Working with the HPC and the Ryan White All Parts Meeting participants, the STD/HIV Division developed a comprehensive plan to assess gaps and unmet needs in prevention and care and create a plan to address these gaps and unmet needs. The outline for the project included a series of needs assessment meetings, a series of surveys, an analysis of the data, and meetings of stakeholders to gather qualitative input and suggest interventions to incorporate into the comprehensive plan.

A series of regional client needs assessment surveys were administered in the fourth quarter of 2015 and concluded in March 2016. Each of the 13 Part B Regional Service Providers was instructed to assess client needs and develop a report of findings which are summarized in this document. In addition, the plan created included an initial kick-off combined HPC and Ryan White All Parts Meeting, a series of meetings to gather consumer and stakeholder input on gaps, unmet needs and strategies and/or interventions to eliminate gaps in care and meet the needs, and a final meeting to let stakeholders review the needs assessment findings and the IPCP goals.

The implementation of the planning process was executed without any variation in the time frames agreed upon. The final SCSN and IPCP were submitted to Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC) in September 2016.

### Description of SCSN/Integrated Plan

From the beginning of the planning process, an overriding concern was that the process involved multiple levels of stakeholders. The initial plan called for substantial consumer input and monitoring that was a priority throughout the process. Therefore, guidance from the HPC was imperative, as 50% of the HPC membership consist of consumers. Additionally, input from participants at the Ryan White All Parts meetings and other meetings was important as they included executive directors, medical case managers, peer navigators and prevention providers. The SCSN incorporated input from HIV federal and state-funded prevention and care partners in South Carolina.

For the development of the SCSN, a comprehensive review of existing Ryan White services in South Carolina was conducted along with a review of the HIV epidemiological data for the state. Once it became clear that the planned activities might not sufficiently gather the input of individual HIV medical care providers, a recommendation was made to create and distribute a survey designed to gather the input of individual HIV care medical providers. This survey was initiated in February 2016 and summaries of the findings have been incorporated into the SCSN.

The IPCP was prepared based on the data and information gathered through the SCSN process, a review and understanding of HRSA's Quality Management requirements, and input gathered during a stakeholder meeting designed to develop strategies and action steps to address the barriers and gaps in care. The guiding principles throughout the process were that the steps in the IPCP would be realistic and achievable within S.C. DHEC and for its contract agencies. The overarching purpose of South Carolina's IPCP is to create a success story outlining a decrease in new HIV infections and enhancements at every level along the Care Continuum.

### Describe HIV Planning Council/Role in oversight of prevention and care

The HIV Planning Council (HPC), established in 2005, is an integrated prevention and care planning body. South Carolina was among the first states to recognize the value of combining prevention and care planning processes. The 34 representatives from across South Carolina include 17 persons living with HIV/AIDS, a total of 50% of the HPC membership.

For this planning cycle, the HPC was intimately involved at all phases. As suggested earlier, the HPC convened the January 2016 statewide 'kick-off' meeting in which a wide range of stakeholders, including Ryan White All Parts providers, were informed about the SCSN process, captured unmet needs and gaps and were encouraged to participate in future meetings. The contractor presented at the March meeting of the HPC's Positive Advocacy Committee (PAC) to advise the planning group of progress toward the SCSN and IPCP goals and gather information on the needs and strategies for meeting those needs. Finally the group plus the Ryan White All Parts members convened in June 2016 to review and offer input on the Plan goals and activities. During the August 2016 Meeting, HPC provided a Letter of Concurrence (See Appendix).

The HPC meetings occur five times a year and are convened by a community co-chair and a health department co-chair. The charge of the planning group is comprehensive oversight of all prevention and care planning for S.C. DHEC's HIV-related activities. At each meeting, S.C. DHEC presents updates and progress on planning goals and advises the HPC of any funding changes or opportunities including changes to any implementation plans. Finally, the HPC is charged with keeping informed of S.C. DHEC's progress toward prevention and care goals. Prevention and care staff share program updates to both inform the group of the STD/HIV Division's progress and also to offer recommendations and suggestions on enhancements to existing planned activities.

## Participation in SCSN by All Ryan White Parts/Key Stakeholders

As stated earlier, inclusiveness and broad engagement were at the core of the SCSN process. The initial kick-off meeting included representatives from all Ryan White (RW) Parts (Part A, Part B, Part C, Part D, and Part F – AETC). Additionally, the SCSN process included HOPWA grantees, the State’s Substance Abuse and Mental Health Services Administration (SAMHSA) grantee Department of Alcohol and Other Drug Abuse Services (DAODAS), all 13 Regional RW Part B Service Providers, all 11 RW Part C Providers, all four RW Part D Providers, and SCHAC which is the sole CDC-funded HIV prevention organization in South Carolina.

Internally, S.C. DHEC staff including Division leadership, prevention and care program staff, surveillance staff, and field staff provided input and guidance to be included in the SCSN and IPCP development processes.

Finally, the goal of substantive and meaningful input of persons living with HIV/AIDS (PLWHA) was clearly achieved. In addition to members of the HPC, PLWHA were engaged in each of the Regional client needs assessment surveys and were involved in the planning and review of the IPCP.

## Section 3: Statewide Coordinated Statement of Need (SCSN)

### [Epidemiologic Overview](#)

Please find the SC Epidemiologic Profile of HIV and AIDS for 2015: **Appendix 1.**

## [HIV Care Continuum](#)

Please find the SC HIV Care Continuum: **Appendix 2.**

## [Financial and Human Resources Inventory](#)

### **Financial Resources**

#### *Federal funding for HIV care and services inventory*

##### **CDC and State Prevention Funding**

HIV Prevention Program funds are provided by CDC to the S.C. DHEC STD/HIV Division. S.C. DHEC awarded funds to 10 community-based organizations (CBOs) through a competitive process. The overall goal is to reduce the number of new HIV infections, focusing particularly on reducing the disproportionate impact of HIV infection in racial/ethnic minority populations. These efforts use interventions that are targeted to the state's priority populations: African American and white men who have sex with men (MSM); African American heterosexual men and women; Hispanics/Latinos; injection drug users; and people living with HIV/AIDS. Funding is also provided to a grantee for the provision of comprehensive prevention case management with HIV positive pregnant women during their pregnancies and postpartum.

In addition to community grantees' programs, CDC HIV and state HIV/STD prevention funds support health department-based prevention services including HIV testing, disease intervention and Partner (notification) Services, risk reduction counseling, and linkage to supportive and medical care services for persons diagnosed with HIV.

S.C. DHEC receives CDC funding for the Syphilis Prevention Program and HIV Expanded Testing (ET) Program. A portion of the funds are provided for very specific, targeted community-based HIV testing, syphilis screening, treatment referrals and education efforts to men who are most at risk for HIV and syphilis in South Carolina.

HIV ET Program funds are also used to increase routine HIV testing services in clinical settings in areas of the state with significant HIV incidence and prevalence numbers.

S.C. DHEC also receives CDC funding titled "Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies" (STD AAPPS) for the purpose of strengthening STD prevention in SC.

##### **HRSA Ryan White Funding**

S.C. DHEC is the recipient of Ryan White Part B funds, including the ADAP earmark funds. A full array of Ryan White Part B eligible services is available to people living with HIV/AIDS in South Carolina. Services available are determined at the local level, so, while not every Ryan White Part B provider provides every service, the following Ryan White eligible services may be provided through the Ryan White Part B care system in South Carolina:

**Core Medical Services** - Outpatient/ambulatory medical care, oral health care, early intervention services, health insurance and premium cost sharing assistance, home health care, home and community based services, hospice services, mental health services, medical nutrition therapy, medical case management and substance abuse services.

**Support Services** - Case management (non-medical), child care services, early intervention services, emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, legal services, linguistics services, medical transportation services, outreach services, psychosocial support services, referral for health care/supportive services, rehabilitation services, respite care, substance abuse services residential, and treatment adherence counseling. While support services are critical to connecting and retaining people living with HIV/AIDS to medical care and treatment, the Ryan White Part B providers must focus on the provision of core medical services in keeping in line with HRSA's policy to spend no less than 75% of funding on core medical services.

S.C. DHEC funds a total of 13 service providers covering all 46 counties in SC with Part B funds. Thirteen are funded with Part B Base funds. Of those 13, the five with the highest prevalence of minority HIV prevalence are also funded with Minority AIDS Initiative funds, and three providers in the HRSA designated Emerging Communities of Columbia and Charleston are funded with Emerging Communities funds. All service provider contracts are awarded through a competitive Request for Grant Applications process.

In addition, HRSA directly funds eleven health care organizations through Ryan White Part C across South Carolina to do Early Intervention Services (EIS) and awards grantees in Charleston and Columbia with Ryan White Part D funding to provide for Women and Children's Services.

The University of South Carolina located in Columbia, SC, receives Part F-AETC funds through a subcontract with Vanderbilt University.

#### Other funded HIV care and services inventory

Non Ryan White funded HIV care and services being provided in South Carolina include, private medical services for patients with insurance (including Private Insurance, Medicaid, and Medicare). Many of the services covered by Medicaid, Medicare, and private insurance are provided by Ryan White funded agencies. Housing Opportunities for Persons with AIDS (HOPWA) services is awarded through the Department of Housing and Urban Development (HUD) to the state and several city jurisdictions, covering all 46 counties in SC with funds to help prevent homelessness among PLWHA. The Ryan White Part B ADAP program generates pharmaceutical rebates which have been used primarily to fund ADAP services.

The South Carolina Department of Corrections (DOC) also expends state funds for HIV testing and care and treatment services for inmates at state institutions. Approximately 315 HIV infected inmates are housed at DOC at any given time. South Carolina also has one organization, the AIDS Benefit Foundation, which conducts fund-raising events and makes small grants available to AIDS Service Organizations (ASO) to support services, prevention and capacity-building programs.

State support of HIV care and prevention services continues in the form of state funding to the ADAP Direct Dispensing Program and local health department HIV testing programs.

Funding Sources

Federal and state funding sources for prevention and care for FY 2016 are listed in the table below. Federal funds have decreased. State and local funding have remained relatively stable over the past several years. However, the epidemic continues to grow. SC is reliant on other available funding sources, including pharmaceutical rebates, to meet the growing need in SC. Total estimated federal and state prevention and care funding for FY 2016 is \$51,013,059.

**Federal and State Prevention and Care Funding, FY 2016**

<b>HIV Prevention</b>	<b>Funding Amount</b>	<b>Percent of Total</b>
CDC HIV Prevention	\$5,332,673	10.1%
DAODAS (SAMHSA HIV Testing)	\$1,153,576	2.2%
SCHAC CDC Direct Funding	\$350,000	.7%
State Prevention Funding*	\$3,599,578	6.8%
<b>STD Prevention</b>	<b>Funding Amount</b>	<b>Percent of Total</b>
CDC STDAPPS	\$1,565,283	3.0%
<b>HIV Care/Support Services</b>	<b>Funding Amount</b>	<b>Percent of Total</b>
HRSA Ryan White (All Parts) FY14	\$31,484,000	59.9%
HUD/HOPWA (All Jurisdictions)	\$3,434,376	6.5%
State Funds (ADAP)	\$5,658,856	10.8%
<b>Total Federal Funds</b>	<b>\$43,319,908</b>	<b>82.4%</b>
<b>Total State Funds</b>	<b>\$9,258,434</b>	<b>17.6%</b>
<b>Prevention and Care Total</b>	<b>\$52,578,342</b>	<b>100.0%</b>

\*State prevention funding is for integrated HIV and STD DHEC programs.

Funding Summary

S.C. DHEC is the principal HIV grantee with a total of prevention and care awards at just over 43 million dollars in FY 2016 including prevention, care, and housing funds. Beyond S.C. DHEC, the SAMHSA grantee is the Department of Alcohol and Other Drug Abuse Services (DAODAS). SAMHSA funding is designated for HIV prevention and testing in Alcohol and Other Drug (AOD) abuse and treatment settings. Ryan White Part C and D awards are directly funded to providers

in South Carolina. There are five (5) HOPWA Competitive Grants awarded directly to the following county/city: cities of 1) Columbia 2) Charleston, 3) Greenville, 4) Augusta (for Aiken and Edgefield Counties); and 5) County of Mecklenburg (York, Lancaster, and Chester counties).

CDC funds S.C. DHEC for HIV and STD Prevention. The South Carolina HIV/AIDS Council (SCHAC) is a CDC directly-funded CBO providing HIV testing and other prevention services in the Midlands region. SCHAC receives \$350,000 annually from the CDC.

To ensure a balanced system of funding, the Health Resources and Services Administration (HRSA) requires Ryan White Part B Programs, including SC ADAP to establish a system of fiscal projections and expenditures to achieve the following: 1) project ADAP costs including growth by service tier (type of enrollee insurance), drug cost fluctuations, and high levels of service utilization among ADAP enrollees; 2) forecast rebates from manufacturers for eligible insurance services; 3) spend rebate dollars in the year they are received before requesting federal funding; and 4) report any unspent federal dollars as unobligated balance to be returned to the program without penalty. This system of fiscal fluidity –when paired with collaborative all-Parts funding strategies – is needed to ensure appropriate funding levels for ADAP services and potential funding to support fiscal needs for service improvements including but not limited to: 1) DHEC-direct service contracts where statewide service enhancements are needed and 2) medical care, medications, and support services as new PLWHA are identified each year and as PLWHA return to care as a result of wide-scale Outreach Workforce expansion. While these funds are not guaranteed, each year - when available - they will be used to continue the goals and activities of the SC HIV/AIDS Strategy as outlined in the Workplan.

**Resource Inventory**

Below is a series of tables summarizing prevention/care agencies, the counties/areas they serve, and the services provided.

**S.C. DHEC Ryan White Part B Funded Organizations**

<b>Agency</b>	<b>Counties Served</b>	<b>Services Provided Summarized (RW eligible services provided determined at local level depending on need and available funds)</b>	<b>HIV Care Continuum Step Impacted</b>
Beaufort Jasper Hampton Comprehensive Health Services	Beaufort, Colleton, Hampton, Jasper	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
AID Upstate	Anderson, Greenville, Oconee, Pickens	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

CARETEAM+	Georgetown, Horry, Williamsburg	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Affinity Health Center	Chester, Lancaster, York	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth, Inc. – Pee Dee Region	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth – Edisto Region	Bamberg, Calhoun, Orangeburg	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth – Lower Savannah Region	Aiken, Allendale, Barnwell	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Lowcountry AIDS Services	Berkeley, Charleston, Dorchester	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Medical University of South Carolina	Berkeley, Charleston, Dorchester	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Piedmont Care	Cherokee, Spartanburg, Union	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

Sumter Family Health Center	Sumter	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
University of South Carolina, School of Medicine, Dept. of Medicine Immunology Center	Clarendon, Fairfield, Kershaw, Lee, Lexington, Newberry, Richland, Sumter	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
South Carolina HIV/AIDS Council	Statewide/ Midlands	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Cooperative Ministry	Clarendon, Fairfield, Kershaw, Lee, Lexington, Newberry, Richland, Sumter	Ryan White Part B Eligible Core and Support Services	Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Upper Savannah Care Services	Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	Ryan White Part B Eligible Core and Support Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

**Ryan White Part C Funded Organizations**

<b>Agency</b>	<b>Counties Served</b>	<b>HIV Care Continuum Step Impacted</b>
Beaufort-Jasper Comprehensive Health Services, Inc.	Beaufort and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Caresouth Carolina, Inc.	Darlington and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

Affinity Health Care, Inc.	York and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth	Florence and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Little River Medical Center	Horry and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Low Country Health Care System, Inc.	Hampton and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
New Horizon Family Health Services, Inc.	Greenville and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Laurel Medical Practice	Richland and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Roper St. Francis Foundation	Charleston and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Sandhills Medical Foundation, Inc.	Sumter and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Spartanburg Regional Healthcare System	Spartanburg and surrounding counties	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

**Ryan White Part D Organizations**

<b>Agency</b>	<b>Area Served</b>	<b>HIV Care Continuum Step Impacted</b>
Medical University of South Carolina – Adult ID Clinic and Outpatient Pediatric AIDS Clinic (OPAC)	Charleston/Lowcountry Region	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

University of South Carolina – School of Medicine, Dept. of Medicine Immunology Center, School of Medicine, Dept. of Pediatrics Region	Columbia/Midlands	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
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**S.C. DHEC HOPWA Funded Organizations**

<b>Agency</b>	<b>Counties Served</b>	<b>Services Offered</b>	<b>HIV Care Continuum Step Impacted</b>
AID Upstate	Oconee	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
AID Upstate - The Laurel	Statewide	Community Care Housing Facility	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Beaufort Jasper Hampton Comprehensive Health Services	Beaufort, Colleton, Hampton, Jasper	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
CARETEAM+	Georgetown, Horry, Williamsburg	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
S.C. DHEC Pee Dee Region - Sumter Office	Sumter, Clarendon, Lee	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Fort Mill Housing Services, Inc.	All SC counties except those funded by city jurisdictions	Tenant Based Rental Assistance, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

HopeHealth Pee Dee	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth Edisto	Orangeburg, Bamberg	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth Lower Savannah	Allendale, Barnwell	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
PALSS	Newberry	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Piedmont Care Inc.	Cherokee, Spartanburg, Union	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Sumter Family Health Center	Sumter, Clarendon, Lee	Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
The Cooperative Ministry	Sumter, Clarendon, Lee	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Upper Savannah Care Services	Abbeville, Greenwood, McCormick	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

STRMU = Short Term Rent, Mortgage, Utility  
HP = Housing Placement

**S.C. DHEC Health Department-Based HIV Prevention Program Models by Region CY2016 - Funded by CDC Grant PS12-1201**

<b>S.C. DHEC Region w/Counties</b>	<b>Funded Program Models</b>	<b>HIV Care Continuum Step Impacted</b>
<p><b>Upstate:</b>  Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union</p>	Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution	HIV-Diagnosed, Linkage to Care
<p><b>Midlands:</b>  Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York</p>	Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution	HIV-Diagnosed, Linkage to Care
<p><b>Pee Dee:</b>  Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg</p>	Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution	HIV-Diagnosed, Linkage to Care
<p><b>Lowcountry:</b>  Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg</p>	Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution	HIV-Diagnosed, Linkage to Care

**S.C. DHEC-Funded Community-Based HIV Prevention Program Models by Organization  
CY2016-Funded By CDC Grant PS12-1201**

<b>Organization</b>	<b>Funded Program Models</b>	<b>HIV Care Continuum Step Impacted</b>
<b>ACCESS Network, Inc.</b> (Beaufort*, Hampton)	Targeted HIV Testing Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>Acercamiento Hispano/Hispanic Outreach</b> (Aiken*, Kershaw, Lexington*, Newberry, Richland*, Saluda, Sumter*)	Targeted HIV Testing Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>Affinity Health Center</b> (Chester, Lancaster, York*)	Targeted HIV Testing <i>Many Men, Many Voices</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>AID Upstate, Inc.</b> (Anderson*, Greenville*, Greenwood, Laurens, Oconee, Pickens, Spartanburg*)	Targeted HIV Testing <i>Healthy Relationships</i> <i>WILLOW</i> <i>Many Men, Many Voices</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>CARETEAM, Inc.</b> (Georgetown, Horry*, Williamsburg)	Targeted HIV Testing <i>Healthy Relationships</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care

<b>HopeHealth</b> (Bamberg, Calhoun, Darlington, Florence*, Marion, Marlboro, Orangeburg*)	Targeted HIV Testing <i>Healthy Relationships</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>Lowcountry AIDS Services</b> (Berkeley, Charleston*, and Dorchester)	Targeted HIV Testing <i>Healthy Relationships</i> <i>WILLOW</i> <i>Many Men, Many Voices</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>PALSS</b> (Fairfield, Kershaw, Lexington*, Newberry, Richland*, Sumter*)	Targeted HIV Testing <i>Healthy Relationships</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>SCHAC</b> (Kershaw, Lexington*, Richland*, Sumter*)	Targeted HIV Testing <i>Healthy Relationships</i> <i>Many Men, Many Voices</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
<b>USC School of Medicine</b> (Midlands area*)	<i>Comprehensive Risk Counseling and Services (CRCS)</i> Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care

\*Indicates counties that are among the top 13 in South Carolina for the number of recent (CY 2013 – CY 2014), newly-identified HIV infections and the number of persons living with HIV/AIDS.

**S.C. DHEC-Funded Expanded HIV Testing-Clinical Grantee Program-  
Funded By CDC Grant PS12-1201**

<b>Expanded HIV Testing – Clinical Grantee Program Sites</b>	<b>HIV Care Continuum Step Impacted</b>
<b>Care South Innovations</b> (Pee Dee area*)	HIV-Diagnosed, Linkage to Care
<b>Eau Claire Cooperative</b> (Midlands area*)	HIV-Diagnosed, Linkage to Care
<b>Fetter Health Care Network</b> (Charleston area*)	HIV-Diagnosed, Linkage to Care
<b>Greenville Hospital System –Greenville Memorial Hospital</b> (Greenville*)	HIV-Diagnosed, Linkage to Care
<b>Medical University of South Carolina (MUSC)</b> (Charleston area*)	HIV-Diagnosed, Linkage to Care
<b>Sumter Family Health Center</b> (Sumter*)	HIV-Diagnosed, Linkage to Care

\*Indicates counties that are among the top 13 in South Carolina for the number of recent (CY 2013 – CY 2014), newly-identified HIV infections and the number of persons living with HIV/AIDS

### **Inventory of Services (by County and Region)**

CDC and HRSA require an Inventory of Service Resources (IOS) “to accelerate progress toward reaching the goals of the National HIV/AIDS Strategy [NHAS,] which include preventing new HIV infections, increasing access to care and improving health outcomes, and reducing HIV-related health disparities.”

The Inventory of Services is a required and important component of the Statewide Coordinated Statement of Need (SCSN) to identify unmet need throughout the state. The Inventory of Services serves as a localized review of service tangibility to achieve the following for statewide planning efforts over the 5-year period:

- 1) To determine a priority list of community health services – across HIV Prevention, Care and Treatment-that are identified by consumers as needed to attain the goals of the NHAS;
- 2) To test that all services are indeed accessible for the consumers who will need them *and* at the time services are needed along the HIV Care Continuum;
- 3) To produce county-specific service accessibility data, while building the local service system knowledgebase in partnership with Ryan White providers;
- 4) To make consumer-centered recommendations for actionable service model improvements that will tangibly reach potential consumers in the service area;
- 5) To provide a directory of available services to Ryan White providers and consumers, ensuring service awareness;
- 6) To establish systems of Ryan White service and/or funds for wrap-around solutions where needed, eligible, and available

### **Inventory of Services: Process Enhancements for 2017-2021**

The SC HIV Care Continuum, Early Identification of Individuals with HIV/AIDS (EIIHA), 2015 HIV Epidemiological Profile, and Ryan White Program data reports show that not all PLWHA in SC are aware of their status and that many who know their status are not consistently engaged in medical care. Meanwhile, a comprehensive list of services that support NHAS improvement appear to be available from federal, state, and local systems of funding. The IOS Project approach is designed to find the gaps that *must* exist in the seams of these programs and services, in order to achieve targeted NHAS improvement.

There are several process enhancements that strengthen the IOS Project for 2017-2021 including: 1) designated Project Lead [ADAP Patient Advocate]; 2) meaningful consumer inclusion through the participation of Positive Advocacy Committee members; and 3) available summary datasheet that includes resources and statistics by County and Region to support staged planning, prioritizing, and evaluation over the 5-year period.

The Inventory of Services Project (2017-2021) engages consumers through its process of reviewing service options in each of the 46 counties of the state to identify barriers consumers may face when attempting to access those services. The service-testing method involved contacting Ryan White-funded providers to ensure that services prioritized by consumers are known to the provider for each county. Throughout the project, this system of service review builds on the established Ryan White provider network, to standardize provider knowledge of local service options that are important to consumers and any related accessibility barriers. If a service was not found using these methods, it is documented as not available *in* and *for* the county.

Reference: SCSN Guidance  
 HRSA Website: <http://hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf>

Inventory of Services: Planning Timeline

On February 18, 2016, the members of the Positive Advocacy Committee (PAC), a committee of the SC HIV Planning Council (HPC), accepted the challenge to conduct the IOS Project for 2017-2021 planning. The ADAP Patient Advocate hosted a conference call with consumers on March 9, 2016 to identify the 36 services and to divide the counties among PAC members.

Nine (9) PAC members committed to 16 of 46 counties in SC. The remaining counties were divided between the ADAP Patient Advocate and Ryan White Case Managers throughout the community. A webinar was held on March 31, 2016 with consumers to collaborate on methods of testing service accessibility. The method adopted was to contact providers known to offer services specifically for PLWHA. During each contact, reviewers stated their purpose and requested information on how clients apply to or are referred for the service. The information gathered in the IOS Project was then compiled and presented to the Ryan White Part B program in July 2016.

Inventory of Services by County Tool

The **IOS by County Tool** includes 36 services that are not considered widely available by consumers and care system data reports. The scope of service is limited to those that impact the HIV Care Continuum in one or more areas. The tool captures the following: 1) Service available *for* the county; 2) Service location *in* the county; 3) Method of review; 4) Name of agency providing service review; 5) Name of person providing information to the reviewer; 6) Eligibility requirements to obtain service; 7) Known barriers to accessing the service; and 8) Service caps/limits where applicable.

**IOS Project Tool – List of Services Reviewed for 2017-2021**

Service Description	Service Group	Is Service Group Eligible for Ryan White Part B?	Primary Funding Source
Legal Assistance - Non-profit	Advocacy	Yes	State Programs

Child Care	Employment/Education	Yes - For Medical Care Visits*	State Programs; Not currently funded for HIV Medical Care Visits
Food Bank – non-Ryan White	Food Bank	Yes	Federal; State; Local Programs; Ryan White
Perinatal Intervention	Health HIV	Yes	CDC Prevention; Ryan White; FQHC; Insurance
Pediatric HIV Care	Health HIV	No	Ryan White Part D; FQHC; Insurance
Private Physician for Patients with HIV	Health HIV	Yes	Insurance; Ryan White
Primary Care- Federally-Qualified Health Center (FQHC)	Health Non HIV	Yes	FQHC; SC Primary Care; Rural Health Programs
Primary Care - Free Clinic	Health Non HIV	Yes	Community Providers
Obstetrics/Gynecology (OB/GYN)	Health Non HIV	Yes	Ryan White; FQHC; Insurance
Nursing Home – Facility	Health Non HIV	Yes (Medical Case Management and ADAP only)*	Ryan White (MCM); HOPWA, Medicaid; Insurance; Hospice
Hospital	Health Non HIV	Yes (Medical Case Management, Discharge Planning only)*	Ryan White (MCM, Discharge Planning); Insurance; State Programs
Urgent care/Walk-in Clinic-not Emergency Room	Health Non HIV	Yes (Medical Case Management, Discharge Planning only)*	Insurance; Self-pay
Mental Health-non-Ryan White	Health Nonmedical	Yes	State Programs
Substance Abuse-non Ryan White	Health Nonmedical	Yes	State Programs
Oral Health-non Ryan White	Health Nonmedical	Yes	Ryan White; FQHC; Insurance (Not Covered by SC Medicaid)
Substance Abuse Outpatient-non Ryan White	Health Nonmedical	Yes	State Programs; Federal Programs, Ryan White
Substance Abuse Residential – non Ryan White	Health Nonmedical	Yes	State Programs; Federal Programs
HIV Testing	HIV Prevention	No - Confirmatory Tests Only*	CDC Prevention; Health Department; Ryan White

			Parts A,C,D
Condoms and HIV Prevention	HIV Prevention	Yes - HIV Positive Only*	CDC Prevention; Health Department; Ryan White; Insurance; FQHC
HOPWA - Short term, Rent, Mortgage and Utility (STRMU)	Housing	Yes	HOPWA
Housing Assistance - non Ryan White	Housing	Yes	HOPWA;, HUD; City/County Utility Assistance Programs
Section 8 Housing	Housing	Yes	HUD; HOPWA – TBRA
Transitional Housing - Post Substance Abuse	Housing	Yes	Funding Source Unknown
Transitional Housing - Post Incarceration	Housing	Yes	Funding Source Unknown
Health Insurance Enrollment -Non Ryan White	Insurance	Yes	Federal Programs, Ryan White, FQHC
Copayment Assistance - non HIV Medication	Insurance	Yes	Ryan White, 340B Programs
Copayment Assistance - non HIV Medical Care	Insurance	Yes	Ryan White
Disability Application Assistance - Non-profit	Insurance	Yes	Social Security Disability Office; Client Self-pay Legal Fees
Immunizations	Public Health	Yes	Health Department; Ryan White; Insurance; FQHC
STD Treatment	Public Health	Yes	Health Department; Ryan White; Insurance; FQHC
Teen Pregnancy Prevention	Public Health	Yes - HIV Positive Only*	Federal Programs; State Programs; Community/School Programs
Sexual Assault Victim Services - including Post-exposure Prophylaxis	Public Health	No	Hospitals; FQHC; State Programs; Victims Assistance Programs
Transportation Systems - Bus	Transportation	Yes	City
Transportation Systems - Medicaid	Transportation	Yes (when Medicaid does not meet client privacy/scheduling	Medicaid

		needs)*	
Transportation Systems - Cab system	Transportation	Yes	Private; Client Self-pay; Ryan White
Transportation - Gas card or voucher	Transportation	Yes	Ryan White
1. Item indicated by (*) refers to Service Description rather than Service Group. 2. "Insurance" includes Private Insurance, Medicare and Medicaid.			

### Inventory of Services: Results

The results from the IOS Project reveal two (2) categories of services: 1) those widely available with some accessibility barriers and 2) those not widely available.

#### Services Consistently Available:

Services that are consistently available include: HIV-related Medical Care; Medical Case Management; Copayment Assistance for HIV-related medications and visits; and ADAP. These services were more thoroughly reviewed via the SCSN Integrated Planning process (i.e. Consumer Needs Assessment, Medical Provider Survey, Medical Case Management Survey and stakeholder meetings). Therefore, the scope of their review is limited in the IOS Project Tool. However, the IOS Project does include a brief review of these services, each with some barriers limiting accessibility. The chart below contains descriptions of accessibility benefits and challenges for widely available services.

### **IOS Project Results – Services Widely Available with Accessibility Challenges and Benefits - 2017-2021**

<b>Service</b>	<b>Accessibility Challenges</b>	<b>Accessibility Benefits</b>
HIV Medical Care	Often limited to HIV Medical Care	Income eligibility
AIDS Drug Assistance Program (ADAP)	Need adherence intervention; Specialized service needs	Income eligibility; Service flexibility for all insurance types
Copay Assistance (meds and visits)	Limited to HIV; May require sliding fee from client	Service available via Ryan White, ADAP and 340B programs
STD Testing and Treatment (including HIV)	Hours; Appointment required; Privacy/knowledge of service; May be too targeted	Strong Surveillance and Testing Programs (includes Partner Notification); Strategic prevention programs
Medical Case Management (MCM)	Services vary within and across counties; Often	Large number of providers; Existence of Ryan White

	MCM services are conditioned to medical care location (i.e. some providers require clients to receive MCM services where they receive Medical Care)	network well known to PLWHA
Transportation	Limited to HIV; Limited options that address the needs of employed and privacy	Large number of providers; Existence of Ryan White network well known to PLWHA

**Services Not Consistently Available:**

Services that are not consistently available require local and statewide efforts to ensure cultural competence and availability at the appropriate time to achieve targeted NHAS improvement. For example, one important IOS Project component is to review each service to determine if it is available *for* a county versus *in* the given county. Federal and state programs are often available through a provider that serves several counties in a regional funding model. The service funding maps show that all counties in the region – often whole state- have the service *available*. In reality, the distance from the consumer-in-need and the actual service location often renders the service less *accessible*. Services are often available *for* residents of the county – but are not be provided *in* the consumer’s immediate transportation area.

**IOS Project Results – Services Not Widely Available with Accessibility Challenges - 2017-2021**

Service	Accessibility Challenges	Availability Benefits
Housing	Strict eligibility and limited funds	HOPWA Programs are available for each county
Transportation- non HIV	No public transportation; Limited transportation options; Advance notice required; Medicaid transportation is only for medical appointments; Ryan White transportation options vary across the care system	Ryan White funds are eligible to be used to transport eligible clients for Core and Support-related services; HOPWA funds may be used for transportation
Mental Health	Limited number of providers with a psychiatrist; State/County systems are back-logged	FQHC offer mental health on a sliding scale fee to supplement Ryan White
Transitional Housing (Post-Incarceration or Substance Abuse)	Limited facilities; Cost; Distance; Limited availability of housing options	Limited regional transitional housing is available
Disability Application	Strict eligibility; Client needs	Ryan White providers may

Assistance	help with process; Legal fees for appeals	assist with initial application or refer to the Social Security office with transportation.
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The IOS results **Regional Service Review Summary** table demonstrates areas of unmet need and shows variation in reasons for accessibility barriers by region (i.e. eligibility, adequate funds, transportation, target population for service, hours of availability, etc.).

**IOS Project Results – Regional Service Review Summary - 2017-2021**

Region	Counties in Region	% of Services not in county	Services with barriers	Service groups with barriers
Upstate	11	45%	80%	Housing, Transportation, Health non-medical, Public health, Health HIV, Health non HIV, Employment/education, Insurance, Food, Advocacy
Midlands	12	45%	80%	Housing, Transportation, Health non-medical, Public health, Health HIV, Health non HIV, Employment/education, Insurance, Food
Pee Dee	12	26%	55%	Housing, Transportation, Health non-medical, Public health, Health HIV, Health non HIV, Employment/education, Insurance, Food
Low Country	11	31%	56%	Housing, Transportation, Health non-medical, Public health, Health HIV, Health non HIV, Employment/education, Insurance, Food, Advocacy

IOS Recommendations

The IOS County Review Sheets (results by County and Region) show consumer-specific service gaps that require solutions to be determined and implemented locally, as funding systems vary in each county (i.e. Ryan White service models, transportation systems, availability of jobs with health insurance, etc.). An IOS Project Review should be conducted annually with Ryan White-funded providers in each region of the state to achieve the following:

- 1) To identify local community resources and service gaps from a consumer-centered perspective, including the selected services deemed important to consumers to facilitate targeted NHAS improvement;
- 2) To isolate funding needs for new service systems with less restrictive target populations and/or eligibility criteria;

- 3) To ensure services are usable for consumers and culturally competent for all populations including but not limited to: African Americans, Hispanics, Women, MSM, Emerging Seniors, Men, Youth, Transgendered, and other PLWHA with specialized care needs;
- 4) To identify Ryan White wrap-around solutions for existing service systems that may have limited accessibility;
- 5) To develop localized plans to implement service-gap solutions, in partnership with state resource planners over the 5-year period

### IOS Infrastructure for 5-year Plan

The ADAP Patient Advocate (PA) and Ryan White Quality Management (QM) Coordinator will meet with Ryan White providers in each of the four (4) regions – with consumers and stakeholders – to review the IOS Results by County and Service. The IOS 5-Year Plan will be established by the providers and consumers and monitored by the state Ryan White Part B program for technical assistance and resource prioritization. Recommended activities include but are not limited to:

- 1) Ryan White Part B program (PA and QM) will facilitate community meetings with local providers, using existing stakeholder meeting framework (i.e. Medical Case Management Workgroup, Quality Management Steering Committee, etc.)
- 2) Discuss issues and solutions using the IOS Project Results by County and Service
- 3) Determine priorities and develop 5-year Plan for each region
- 4) Integrate improvements into Ryan White service systems

### System-level solutions

While an established statewide Ryan White and HOPWA service framework exists for services such as housing and transportation, a consistent theme throughout SC is that housing and transportation are constant barriers. Commonly reported barriers to housing are: 1) consumer knowledge/experience of the service; 2) funds are not adequate for the demand of housing need; 3) limited number of landlords that accept HOPWA rental agreement terms; 4) HOPWA services vary by service area; and 5) limited availability of long-term housing solutions such as Section 8, HOPWA Tenant-based Rental Assistance, and Transitional Housing.

### Statewide Solution 1: Housing Services for PLWHA

As established in the US Department of Housing and Urban Development (HUD) Report “The Connection Between Housing And Improved Outcomes Along The HIV Care Continuum”, unstable housing threatens consumer access along every point of the HIV Care Continuum. The IOS Project results show housing service barriers in every county of the state, suggesting that statewide HIV/AIDS supplemental housing programs are needed. In the SCSN Workplan, the Ryan White Part B program proposes a Housing Expansion Program that will provide additional funds beyond current HOPWA funding levels to more flexible housing solutions for PLWHA in

need of assistance. The results of this service expansion will be closely monitored within the recommended IOS infrastructure for annual re-evaluation.

### Statewide Solution 2: Ryan White Statewide Transportation System

All Ryan White-funded providers offer transportation services. Yet, transportation is often reported as widely unavailable at the region and county level. Many areas have no mass public or private transportation systems. Medicaid transportation is limited to medical appointments, does not offer service that allows privacy for HIV services, and does not align with pick-up/return schedules for employed consumers who need to attend appointments on workdays. Based on the wide-spread IOS Project results (i.e. percentage of services not available *in* the county of residence), systems of transportation must be addressed at the state health care system level to ensure consistent options of transportation that consider the following: 1) privacy/discretion; 2) options for consumers who are employed and unable to secure a full day off to attend medical appointments; 3) rural areas where no other private or public transportation options exist; and 4) reduced advance-scheduling requirements for emergency/acute care visits that are not planned weeks ahead of the scheduled appointment. Consistent systems of transportation must exist for consumers to: 1) apply for service at the required location, 2) obtain needed documentation for proof of eligibility; 3) attend Medical Care and other related appointments; and 4) attend necessary referral appointments.

### Statewide Solution 3: Fund statewide all-Parts NHAS Initiatives

For the 2016-2017 grant year, the Ryan Part B program expects to release a packet of supportive services that are expected to substantially improve client engagement in care and treatment services. These services include but are not limited to funds for: 1) Outreach Workforce that is linked to Data to Care and the In+Care Campaign; 2) Specialized Medical Case Management Workforce for PLWHA as they re-engage care; 3) Peer Treatment Adherence Workforce and Peer Training Program to promote retention in care and therapy; 4) Housing expansion; and 5) Viral Hepatitis expansion for PLWHA through the ADAP. This nearly \$6 million of funds each year - for up three (3) years - will be awarded from the SC ADAP to eligible providers funded under all Ryan White Parts.

Reference: HUD Report “The Connection Between Housing And Improved Outcomes Along The HIV Care Continuum”

HUD Website: <https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf>

### **IOS Project Acknowledgements:**

The HIV Planning Council expresses its sincere thanks to the Positive Advocacy Committee, Ryan White Medical Case Managers, and ADAP Patient Advocate for devoting relentless hours to the

completion of the IOS Project and for your commitment to continuous improvement of HIV/AIDS Prevention, Care and Treatment services in SC.

## **Workforce Capacity**

The work of HIV prevention and care in South Carolina is accomplished by a network of highly-skilled and committed professionals in multiple disciplines. HIV primary care is provided by physicians and mid-level providers (physician assistants, nurse practitioners) in Ryan White and private clinics throughout South Carolina. Medical Case Managers are employed throughout the state to coordinate health care services. Psychosocial needs are also addressed by peer navigators, mental health providers, substance abuse treatment providers, and other behavioral health professionals. Additional core medical services are provided by contracts with private dental offices, nutritional counselors, and S.C. DHEC employees in HIV and STD roles overseeing early intervention services.

Ryan White Part B manages both ADAP enrollment and encourages participation in the health care marketplace. Staff in all Ryan White sites are engaged in assessing coverage, assisting consumers in obtaining health care (Marketplace, Medicaid, or Medicare) and assisting with medical insurance co-pays and deductibles where indicated. Where no other payer source is found, consumers are enrolled and receive HIV medication through the ADAP Direct Dispensing Program.

Prevention work is done by multidisciplinary teams in health departments and community-based organizations. HIV testing and counseling in S.C. DHEC clinical sites is primarily done by licensed nurses employed in county health departments. In addition, S.C. DHEC Disease Intervention Specialists (DIS) are involved in both HIV testing activity and linkage and re-engagement in care. CBO staff includes masters and bachelors prepared employees, most often in social work or human service fields. Outreach workers, peer specialists, and group facilitators are an integral part of the prevention activities in most CBOs. The expanded testing clinical sites include community health centers and hospital systems in six sites across the State.

### **Health Professional Shortage Areas (HPSA)**

Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. There are three categories of HPSA designation based on the health discipline that is experiencing a shortage: (1) primary medical; (2) dental; and (3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need.

South Carolina has a total of 90 Primary Care HPSA Designations; representing 24.51% unmet need with an additional 110 primary medical providers needed to meet the need.

South Carolina has a total of 79 Dental Care HPSA Designations; representing 42.17% unmet need with an additional 162 dental care providers needed to meet the need.

South Carolina has a total of 46 Mental Health Care HPSA Designations; representing 45.03% unmet need with an additional 110 primary medical providers needed to meet the need.

Reference: Kaiser Family Foundation

State Health Facts: <http://kff.org/state-category/providers-service-use/?state=SC>

## **Service Continuity**

South Carolina's Ryan White Part B Program is housed within the STD/HIV Division along with the STD/HIV Prevention programs. The prevention portfolio for the Division includes HIV expanded testing and the adult viral hepatitis programs. The STD/HIV Division is part of the Bureau of Disease Control at S.C. DHEC along with the Division of (STD/HIV) Surveillance and Technical Support (STS), Division of Acute Disease Epidemiology (which includes the state TB Control Program), and the Immunization Division. The STD/HIV Division is housed within the same data-secured office suite with STS staff. This allows for close working relationships across programs towards the delivery of a continuum of comprehensive HIV prevention and care programs and serves as a bridge between prevention and care systems.

In addition to Health Department services, S.C. DHEC also directly provides prevention services and contracts with local organizations to deliver community-based prevention services. HIV counseling and testing services are provided by each of the 46 county health departments. Partner counseling/notification services are also offered. Through the CDC Expanded Testing Initiative South Carolina has established routine, hospital-based emergency department HIV testing, thereby reaching many more people. Persons who test HIV positive are informed of HIV care providers in their region and referred to the provider of their choice. Community organizations that also provide testing through contracts with S.C. DHEC include several Part C funded agencies, 10 other organizations, and one CDC directly-funded organization. Other prevention services such as risk reduction counseling and group interventions are provided by the CDC directly funded community organization and 11 organizations contracted by S.C. DHEC. Efforts are targeted to persons at greatest risk of HIV according to the state HIV prevention plan.

Coordination of services is imperative in SC, a resource poor state, to ensure the best use of limited resources to serve the most people without duplication of services. Current plans for sustainability and continuity of services include ongoing capacity-building efforts of staff using internal S.C. DHEC resources and collaborating closely with the AIDS Education and Training Center local performance site in South Carolina. Cross-training of staff is consistently encouraged in awarded contracts and contract monitoring visits, and focus on staff retention is included in S.C. DHEC's technical support of its grantees.

## Accessing Gaps and Unmet Needs

This section summarizes the efforts of the S.C. DHEC to analyze unmet needs, gaps and barriers in both HIV-related prevention and care throughout the state. Information was collected via surveys, interviews and meetings. Information from those receiving services via Ryan White Part B Programs was collected via a **Consumer Needs Assessment Survey by Region** while input from staff of those Ryan White Part B Programs was collected via a **Staff Survey**. Throughout the state, clinical staff representing all Ryan White Parts were asked to provide input via an **On-line Clinical Provider Survey** posted to SurveyMonkey. To complement this survey-based data, a series of **Meetings** was conducted with providers, PLWHA, and other stakeholders to provide valuable in-depth qualitative insights for this assessment process. Additionally, a **Housing Needs Assessment** was conducted with all S.C. DHEC-funded HOPWA providers. All of these activities are described below in more detail along with a summary of findings.

### Ryan White Part B Consumer Needs Assessment Surveys by Region

From 2015 through early 2016, S.C. DHEC embarked on a comprehensive evaluation and assessment of all Ryan White Part B Programs throughout the state. S.C. DHEC distributed a set of questions, which had been originally developed by the Part B providers, to be used as a foundation for assessment surveys of consumers, and allowed each program to distribute them in a manner that best meet the needs of its clients. Surveys included questions on demographics, history of diagnosis, current involvement in HIV-related services, adherence to medication requirements, insurance and other means of paying for medical care including medications, access to HIV-related education and support, and other medical social service needs. Surveys were completed by 2,056 consumers.

### Overview of key findings from consumer surveys

The following is a summary of key findings across all participating entities and regions. Primary themes that emerged from survey respondents are listed below based on the continuum of care along with suggested recommendations:

#### *Commonly cited barriers to linkage to care*

- Not knowing where to go or who to call
- Not knowing the importance of receiving HIV medical care services sooner/as soon as possible
- Being afraid; concerned about others learning of my status from office visits

#### *Commonly cited barriers to care/retention in care*

- Stigma and associated anxiety/fear of people finding out
- Lack of financial support - especially in terms of HIV-related (and non-HIV-related) medications and medical care
- Lack of translation services - particularly among Spanish-speaking populations

- Lack of transportation to medical appointments
- Lack of stable/affordable housing
- Unavailable/inconvenient clinic hours/appointments
- Poor communication between and with clinic staff
- Lack of privacy/confidentiality
- Lack of knowledge of available resources
- Competing life responsibilities

*Commonly cited barriers to medication adherence*

- Forgot to take them
- Difficulty paying for them
- Difficult schedule
- Side effects

*Commonly cited services deemed “important” or needed*

- Good case management, especially staying in contact with clients
- Mental health counseling
- Help understanding how/why to take my medications
- Transportation to medical appointments
- Support group
- Food pantry
- Help with housing expenses
- Help with dental care, vision care
- Help getting/paying for non-HIV medications
- Help paying for health insurance
- More privacy/confidentiality in clinic
- Patient/client/peer advocates
- Pain management clinic

*Satisfaction with current services*

Overall, across all programs, clients were generally pleased with the services provided. Most survey respondents reported that they were “very satisfied” with the organization/clinic, medical advice they had received and with the communication between client and organization. Also, in general, most clients reported that the care they received was “excellent” and helpful in meeting their needs. Further, most respondents reported that they would recommend the clinic to friends needing similar help.

*Overall recommendations for improving services:*

- Provide affordable services/financial support for PLWHA, especially in terms of their HIV-related and non-HIV-related medications and medical care
- Provide additional services (and financial support for) such as dental care, mental health counseling/support groups, transportation and food
- Enhance client confidentiality/privacy by providing such services as web-based/home-

based visits

- Extend service hours/days of the week-add 24 hour hotline
- Provide culturally and linguistically appropriate outreach and materials including translation/interpretations services
- Conduct lab work in clinic rather than off-site

### Staff Surveys

In addition to the consumer needs assessment surveys, five Ryan White Part B Programs administered surveys among their staff including physicians, nurses, physician's assistants, case managers, and social workers. Survey questions related to level and quality of care provided, suggested areas of improvement, additional services needed, quality of clinical staff, areas of excellence, level and quality of supportive services and additional healthcare needs. A total of 67 staff members were surveyed.

### Overview of Key Findings from staff surveys

Overall, clinical staff across all agencies had a positive/very positive opinion of their clinic as well as the quality of care/services they provide to clients. Most staff believed they were effective in acting as an advocacy/resource/referral agency for PLWHA as well as effective in working cooperatively with social service organizations, although it is important to note that this was not unanimous among staff.

#### *Overall recommendations by these providers for their programs included:*

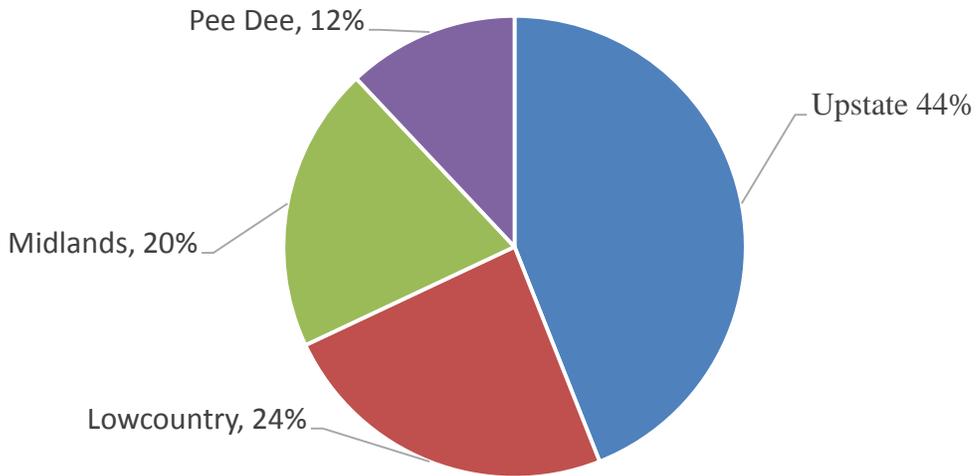
- Providing continued emphasis upon prevention/education in the clinic, with agency partners, and as a part of a community awareness/outreach program for the general public
- Sharing a comprehensive checklist of all services provided at the clinic with agency partners
- Obtaining additional funding to support integrated/comprehensive medical care
- Expanding case management (and staffing)
- Improving referral system with out-of-clinic health care providers

### All Ryan White Parts On-line Clinical Provider Surveys

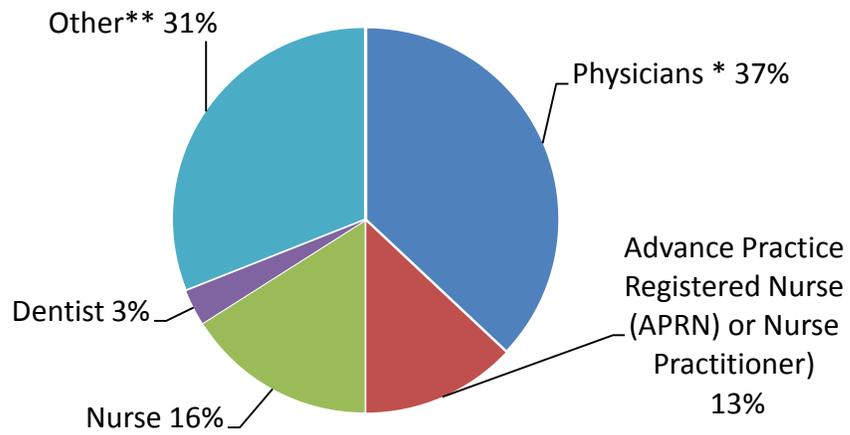
In early 2016, a survey was developed to gather information from HIV clinical care providers throughout the state and was administered via SurveyMonkey. Information collected focused on barriers to linkage to care, retention in care, and achievement of viral suppression. A summary of the responses from 41 clinicians is reported below:

#### *Region of practice of providers (n=41):*

### Primary Region of Practice (n=41)



### Discipline (n=38)



\*Physicians specialized in Infectious Disease/HIV, Internal Medicine, OB/GYN, or Pediatric Infectious Disease

\*\*Other included: social worker, medical case manager, office/program manager, director of medical services, Ryan White Program Coordinator

### HIV Testing

Top three most cited barriers to HIV testing (n=37):

- Stigma

- Fear of diagnosis
- Low perceived risk or denial of risk

*Other commonly cited barriers included:*

- Absence of routine testing in medical settings
- Unsure of where to go to get tested
- Lack of access to testing services/health care
- Mental health disorders/issues

*Top three most cited strategies/interventions which may be utilized to increase awareness and benefits of HIV testing (n=33):*

- Provide more public/community education via a variety of channels in a variety of settings (TV, radio, social media, billboards, hotlines, churches, schools)
- Provide more training for primary care facilities for better delivery of information/standardized messaging and testing
- Make HIV testing routine part of care for individuals age 15 and older

#### Linkage to Care and Retention in Care

*Top five most cited factors which may inhibit/prevent HIV positive individuals from linking to care (n=36):*

- Stigma
- Lack of transportation
- Denial
- Asymptomatic
- Lack of social support

*Most commonly cited strategies/interventions to enhance linkage to care (system issues, provider issues) (n=23):*

- Provide a care navigator/follow-up/support
- Provide transportation
- Provide longer hours of service/quicker connection with provider/labs
- Provide care providers with more training on communicating with clients and utilizing an immediate referral process

*Top five cited barriers to retention in care (n=35):*

- Lack of social support
- Lack of transportation
- Mental health disorders/issues
- Competing priorities (e.g. work, childcare)
- Lack of follow-up for the identification of patients who have fallen out of care

*Most commonly cited strategies/interventions to improve retention in care (n=22):*

- Follow up with/engage clients
- Provide transportation

- Promote importance of staying in care to clients

### HIV Care

*Top three gaps in HIV care (n=33):*

- Mental health treatment
- Affordable housing
- Transportation

*Most cited barriers to medication adherence (n=34):*

- Side effects of medications
- Psychosocial issues
- Lack of knowledge about the disease and effectiveness of medications
- Lack of symptoms

### Viral Suppression

*Most commonly cited strategies/interventions to assist patients in achieving viral suppression (n=23):*

- More education about connection between medication adherence and viral suppression
- More follow-up/connection with clients by providers

### HIV-related and non-HIV-related Services

*Most commonly cited services currently available (n=34):*

- Medical case management
- HIV medical care
- ADAP Drug Assistance
- Assistance with co-pays and deductibles
- Dental care
- Assistance with insurance premiums
- Mental health treatment
- Substance abuse services
- Transportation
- Nutrition therapy

*Most commonly cited strategies for how DHEC can allocate resources/interventions to enhance HIV care and service delivery (n=23)*

- Provide more funding for transportation, HIV medication and housing
- Provide more mental health/substance abuse assistance
- Improve engagement with clients to improve retention

## Summary of Findings from Provider Surveys

Providers in all four regions of the state noted the need for additional social services for clients including mental health treatment, housing and transportation, especially in more rural counties. Stigma continues to be a barrier for HIV testing and linkage to HIV care. Barriers to medication adherence include side effects, psychosocial issues, lack of knowledge about the benefits of medications and a lack of symptoms where clients don't feel sick and therefore, choose not to take medications. Providers call for continued/more education regarding medication adherence and viral suppression to benefit clients.

### Housing Needs Assessment

A Housing Needs Assessment was conducted via conference call in the fall of 2015 as part of the State's five Year Consolidated Housing Plan required for HOPWA. All S.C. DHEC funded HOPWA providers and Ryan White Part B providers were invited to participate. Twenty-three representatives from 17 organizations participated in the call. A summary of needs includes:

- More subsidized housing for clients
- More affordable & available housing
- Shorter waiting lists before approval of subsidized housing/permanent housing
- More supportive housing to address mental health and substance abuse needs
- Increased client income opportunities
- More availability of shelters and emergency housing
- More places for persons who are coming out of institutions
- More housing vouchers
- More available units connected to other resources (ex: grocery stores)
- More cost effective housing that passes HUD inspections

### Meetings

To ensure valuable input into the SCSN process from PLWHA, prevention and care providers and other stakeholders, a series of meetings were conducted in connection (i.e. as part of the agenda) with other, established meetings of those same individuals. Those established meeting groups included the Positive Advocacy Committee of the SC HIV Planning Group, S.C. DHEC prevention providers, S.C. DHEC prevention-funded CBOs, and the MCM workgroup. Through a series of interactive activities, these groups listed and prioritized barriers to the activities along the HIV care continuum: HIV testing, HIV prevention services, HIV care services and retention in care. Additionally, these groups provided recommendations for enhancing these activities. Input from these meetings is summarized below along with the findings from other data collection methods listed above.

### **Summary of Identified Gaps/Unmet Needs Intervention Recommendations**

The stakeholder meetings, community forums, and surveys conducted during the SCSN process gathered input from some 2000+ stakeholders—providers, consumers, advocates, and PLWHA. This input was framed around the Care Continuum and included barriers and recommendations regarding stable housing. The following attempts to summarize findings regarding barriers to

prevention and care and collates recommendations from the series of stakeholder engagement sessions and surveys conducted.

Barriers and Intervention Recommendations:

HIV Prevention

*Top barriers/gaps:*

- Stigma
- Lack of concern/empathy (provider/client)
- Rural areas-transportation/lack of services
- Lack of access to services (hours, locations)
- Unmet ancillary needs/services
- Lack of funding/restricted funding

*Other barriers/gaps:*

- Cultural inappropriate services (disconnect between providers and clients)
- Fear
- Technology limitations
- Not aware of prevention services
- Lack of Housing
- Inability to link/Lack of Linkage to Prevention Services
- Behavioral Health Interventions are out of date/not tailored to community
- Lack of peer services/support
- Social barriers/conflicts
- Competition among CBOs/ASOs
- Lack of inclusivity of PLWHA
- Not enough community involvement/engagements

Intervention recommendations:

- Facilitate community involvement/engagement
- Provide more programs: *WILLOW, Healthy Relationships, Support Groups, 3MV, Project Connect*
- Provide Cultural Competence training for providers
- Enhance collaboration among providers
- Provide *SATIR*
- Provide peer navigation
- Provide PrEP/TasP/nPEP
- Utilize *ARTAS*
- Provide PCC (Personalized Cognitive Counseling)
- Provide HIV Prevention Counseling
- Train/Utilize Motivational Interviewing
- Partner with *Common Threads*

- Incorporate *Safe in the City* video
- Increase condom education/distribution
- Facilitate a Women's Empowerment Academy

## PrEP Barriers

### *Top barriers/gaps:*

- Lack of funding, especially labs/follow-up care
- Lack of knowledge/awareness (provider/client)
- Health care worker judgment toward client
- Lack of access to services (hours, locations)

### *Intervention recommendations:*

- Provide education/training for providers about PrEP
- Provide more community education PrEP
- Provide education about PrEP to PLWHA to share with negative partners

## HIV Testing

### *Top barriers/gaps:*

- Internal/external stigma
- Not identifying their own risk behavior/active substance abuse
- Challenges in navigating logistics/testing not convenient (can't get off work for appointments, lack of transportation, etc.)
- Unaware of treatment benefits
- Denial

### *Other barriers/gaps:*

- Transportation
- Fear of needles
- Not enough test sites
- Providers not wanting to give results

### *Intervention recommendations:*

- Expand routine opt-out testing
- Universal testing in emergency departments
- Make HIV testing part of all routine medical visits (just like taking blood pressure, weight, etc.)
- Provide couples testing as requirement for marriage licenses
- Geo-mapping to identify 'hot spots' for testing
- Social networking to bring people in for testing
- Faith-based testing events

- Allocate resources for marketing testing
- Enforce comprehensive sexuality education in schools
- Include HIV testing with all other STD testing
- Enhance training for working with the Latino population

### Linkage and Retention

#### *Top barriers/gaps:*

- Transportation
- Stigma (in community and in provider offices)
- Timeline to enter care (lack of providers, lab delays, appointment delays)
- Inability to maintain contact/communications
- Depression/substance abuse
- Unstable housing

#### *Intervention recommendations:*

- Increase and diversify transportation services (peer transportation)
- Expand office hours for medical appointments and case management
- Continue ARTAS
- Replicate SPNS Jail Component
- Focused mental health case managers
- Expand education for PLWHA – peer education trainings, peer navigators
- Enhance funding for communications support and logistical expansion – pay for ASOs to provide cellphones for texting
- Implement peer program
- Enhance quality of care with staff training on cultural competency [gender, class, SES, language]
- On site substance abuse/behavioral health
- Supportive services associated with clinic visits [child care at appointments, job training, GED]
- Increase HOPWA funding
- Intensive case managers

### HIV Care Services

#### *Top barriers/gaps:*

- Unstable housing
- Lack of transportation
- Substance abuse/mental health
- Lack of dental services
- Lack of childcare

#### *Other barriers/gaps:*

- Lack of vision services
- More education about adherence and service availability
- Lack of support groups
- Lack of gas vouchers
- Lack of CBOs in rural areas
- Lack of mental services

*Barriers to Medication Adherence:*

- Lack of support
- Hiding medication
- Stigma
- Lack of care coordination
- Lack of adherence support
- Lack of stable housing
- Communication between provider/pharmacy/patient relational factors

*Intervention recommendations:*

- Core Medical Services
  - Add Tele-Health partnerships
  - Implement peer programming (training to offer support to peers)
  - Provide youth-focused/friendly services
  - Increase outreach to private dental services
  - Provide childcare during service hours
  - Streamline patient care
  - Fund food banks/farmers markets to provide better quality foods to clients
- Housing
  - Build landlord relationships
  - Network with banks and church credit unions
  - Use funds to pay for expungement
  - Enhance job readiness and build employment support into clinic visits
  - Put rent controls including caps on charges
- Transportation
  - Release funds for transportation provider
  - Write grants to support car repair for consumers
  - Develop satellite services
  - Provide gas cards instead of gas vouchers
- Testing in community pharmacies
  - Pharmacy/DHEC collaborations
  - Testing in emergency departments
  - Supporting paid peers to conduct testing
- Food Co-op
  - Use EFA funds
  - SNAP enrollment

- Cultural competence training on working with transgender consumers
- Support services
  - Pay for post office boxes for clients who need it
  - Financial/budgeting classes
  - Computer classes
  - Child care
  - Legal services
  - Provide job training to clients
  - Provide GED courses for clients
  - Provide outreach to churches

## Data Utilized for SCSN: Access, Sources, and Systems

### DHEC Surveillance Systems

HIV Care Continuum is developed using data from the Enhanced HIV/AIDS Reporting Surveillance System (eHARS). All health care providers, hospitals, and laboratories in South Carolina are required to report people diagnosed with confirmed HIV infection and/or AIDS to S.C. DHEC. Each year approximately one-third of new cases are reported from county health departments, one-third from hospitals, one-fifth from physicians, and the remainder from state/federal facilities (including prisons) and laboratories. S.C. DHEC's surveillance system, eHARS, serves various functions: (1) monitoring the incidence and demographic profile of HIV/AIDS; (2) describing the modes of transmission among people with HIV/AIDS; (3) guiding the development and implementation of public health intervention and prevention programs; and (4) assisting in evaluating the efficacy of public health interventions. It is the principal source of knowledge regarding trends in the number and characteristics of HIV-infected people. It includes people in all age, gender, race/ethnic, and mode-of-HIV-exposure groups; and it provides a historical perspective in trends dating to the earliest recognition of the AIDS epidemic.

Ryan White HIV/AIDS Program Services Reports (RSR) were used to show services currently being provided in SC. The RSR is an annual report that captures information regarding the services provided by all Ryan White funded entities. Providers report on all clients who received services eligible for Ryan White Parts A, B, C or D funding. SC Ryan White Part B providers use Provide Enterprise (PE) to collect, report, and analyze data. Several Part C providers also use PE. Others use HRSA's CAREWare. All Parts A, B, C, D providers are equipped to run the HRSA required RSR.

S.C. DHEC is mandated by PS12-1201 to use CDC's Evaluation Web for CDC reporting. Evaluation Web is a secured database developed by Luther Consulting used to collect information on Counseling, Testing, and Referral Services (CTRS) in the form of rapid HIV testing information received from grantees funded by S.C. DHEC. Grantees are required to enter all HIV rapid test

results (reactive, non-reactive, and indeterminate) on a monthly basis. This testing information is uploaded to CDC in order to monitor South Carolina's PS12-1201 deliverable progress. Evaluation Web is also used to collect information such as linkage to medical care, referral to prevention services, partner services interviews, and enrollment information in evidence-based interventions.

The 2016 SCSN used the available S.C. DHEC surveillance data from eHARS and utilization data from RSRs and Evaluation Web to advise creation of the survey tools. Data for the care continuum, accessed through the Part B surveillance staff, was used to form questions regarding challenges in linkage and retention in care. Community involvement was at the heart of the consumer-based surveys with robust outreach conducted by case managers to recruit a representative sample of PLWHA providing individual-level data. Provider-focused surveys allowed input at the system level. Findings from the qualitative meetings with stakeholders (e.g. PLWHA, prevention and care providers) were collated and common themes identified. The findings from existing needs assessments provided a contextual foundation for the integration of both the newly acquired qualitative and quantitative data; thereby creating a comprehensive, well-informed picture of the current state of prevention and care within the state. All necessary data to assist in the SCSN was available.

## **Section 4: Integrated HIV Prevention and Care Plan**

Using the National HIV AIDS Strategy as a guide, the following plan has been created as a response to the identification of gaps and unmet needs in the South Carolina Statewide Coordinated Statement of Need (S.C. SCSN). Goals and activities have been adapted from suggestions in each of the community forums and synthesized by South Carolina Department of Health and Environmental Control (S.C. DHEC) staff into this document.

## 2010-2015 NHAS GOAL 1: Reduce New HIV Infections

**Objective 1: By the end of 2021, increase the percentage of South Carolinians living with HIV who know their sero-status to at least 90%.**

### **Strategy 1: Intensify prevention efforts in communities where HIV is most prevalent.**

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC	Use available data and existing research to identify communities experiencing HIV-related health disparities within South Carolina.	People Living with HIV/AIDS (PLWHA)	Surveillance data
By the end of 2021:	S.C. DHEC Funded Community Based Organizations (CBOs) Primary Care Providers	Increase HIV testing among clinical and non-clinical providers.	Individuals seeking primary medical care and priority populations	No. of HIV tests Positivity rate
By the end of 2021:	S.C. DHEC Funded CBOs Clinical Providers	Increase the number of individuals referred to or linked to Pre-Exposure Prophylaxis (PrEP) providers.	Targeted populations Qualified candidates	Assessments completed by providers and CBOs
By the end of 2021:	S.C. DHEC Funded CBOs	Increase HIV testing among Young Men who have Sex with Men (YMSM) (ages 18-29).	YMSM	No. of HIV tests Positivity rate

By the end of 2021:	S.C. DHEC Funded CBOs	Increase number of YMSM (ages 18-29) referred or linked to PrEP providers.	Targeted populations Qualified candidates	Assessments completed by providers and CBOs
By the end of 2021:	S.C. DHEC Funded CBOs	Increase comprehensive HIV/STI/HCV prevention education among Men who have Sex with Men (MSM) and other targeted populations.	Targeted populations YMSM	No. of participants reached or attended
By the end of 2021:	CBOs providers Ryan White Providers CBOs Community	Advocate for science based comprehensive sexuality education in S.C. public schools	State Legislature	State policy change
<b>Strategy 2: Using surveillance system to identify transmission networks.</b>				
<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activity</b>	<b>Target Population</b>	<b>Data Indicators</b>
By the end of 2021:	S.C. DHEC	Use 4 <sup>th</sup> generation testing to identify HIV sub-groups.	MSM and other priority populations	HIV genotyping data
By the end of 2021:	S.C. DHEC Funded CBOs Primary Care Providers	Increase target testing in at risk areas using 4 <sup>th</sup> generation testing after HIV sub-groups are identified.	MSM and other priority populations	No. of HIV tests Positivity rate
By the end of 2021:	S.C. DHEC Funded CBOs Ryan White Providers	Expand the use of DHEC surveillance data to determine community viral loads through geo-coding/mapping	Priority Populations	Completed data requests

<b>Strategy 3: Intensify services inclusive of HIV testing for partners of those infected.</b>				
<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activity</b>	<b>Target Population</b>	<b>Data Indicators</b>
By the end of 2021:	S.C. DHEC Ryan White Providers	Reduce late testing by implementing and/or enhancing high risk partner services at Ryan White (RW) sites including HIV testing and referral of partners to high risk interventions.	Partners of positives	Percentage of patients with a diagnosis of Stage 3 HIV (AIDS) within 3 months of diagnosis of HIV per Ryan White SC Quality Management Performance Measure (SC QM #1.0)
By the end of 2021:	S.C. DHEC Ryan White Providers	Reduce late testing by implementing and/or enhancing Early Intervention Services (EIS) at RW sites.	PLWHA	No. of EIS services reported through Ryan White HIV/AIDS Program Services Report (RSR)
By end of 2021:	S.C. DHEC	Increase recruitment and outreach to partners by DHEC Disease Intervention Specialist (DIS) Staff.	Partners of PLWHA	No. of partners identified No. of partners interviewed No. of partners tested

**Objective 2: By the end of 2021, reduce the number of new diagnoses in South Carolina by at least 25%.**

<b>Strategy 1: Expand efforts to prevent HIV using CDC recommended effective, evidence-based interventions.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	S.C. DHEC CBOs	Increase annually the number of African American MSM who receive evidence-based interventions.	African American MSM	No. of African American MSM enrolled in intervention
By the end of 2021:	S.C. DHEC CBOs	Increase annually the number of African American MSM who receive counseling and treatment for PrEP.	African American MSM	Assessment of clients reached by providers
By the end of 2021:	S.C. DHEC CBOs	Increase annually the number of PLWHA who receive evidence-based interventions.	PLWHA	No. of PLWHA enrolled in intervention
By the end of 2021:	S.C. DHEC CBOs	Increase annually the number of PLWHA (sero-discordant or HIV status unknown partners) who receive counseling and treatment for PrEP.	High Risk Negative individuals	Assessment of clients reached by providers
<b>Strategy 2: Expand efforts to prevent HIV using structural interventions.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	S.C. DHEC CBOs	Increase the number of condom distribution sites within high prevalence communities.	Priority populations	No. of sites
By the end of 2021:	S.C. DHEC CBOs	Increase the number of condoms distributed to PLWHA and those most at-risk for acquiring HIV.	Priority populations	No. of condoms distributed

Current and ongoing by the end of 2021:	S.C. DHEC CBOs	Continue to build statewide collaborative partnerships in community groups (i.e., S.H.A.P.E., initiatives)	Prevention and Care Providers  Stakeholders  Consumers	No. of groups
Current and ongoing by the end of 2021:	S.C. DHEC CBOs	Continue statewide forums for planning, and exchanging and/or sharing information (i.e., HIV Planning Council, Positive Advocacy Committee, and Ryan White All Parts Meetings)	Prevention and Care Providers  Stakeholders  Consumers	No. of meetings held
<b>Strategy 3: Expand access to, and supportive services for, pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP).</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	S.C. DHEC  Primary Care Providers	Increase awareness of PrEP and nPEP via a combination of capacity-building, provider training, community education and print/social media sources.  Increase the number of providers distributing PrEP and nPEP.  Increase the number of priority populations receiving PrEP and nPEP.	Priority populations (HIV negative)  Primary Care Providers	No. of materials developed/distributed  No. of trainings offered/participants reached  No. of providers distributing PrEP  No. of priority populations receiving PrEP and nPEP

By June 30, 2017:	S.C. DHEC	Develop (and update annually) PrEP and nPEP directory of South Carolina providers.	Priority populations (HIV negative) Clinical Providers CBOs	PrEP Directory with annual updates nPEP Directory with annual updates
By the end of 2021:	S.C. DHEC CBOs Clinical Providers	Support comprehensive implementation of PrEP and nPEP (Medication adherence, counseling, and condom use).	Priority populations (HIV negative) Clinical Providers CBOs	No. of sessions No. of people on PrEP No. of clinics providing PrEP
By the end of 2021:	S.C. DHEC CBOs Clinical Providers	Through research of funding options and advocacy for PrEP, allocate funding for labs and follow up visits as funds are available.	Priority populations (HIV negative)	No. of clinics providing PrEP

## 2010-2015 NHAS GOAL 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV/AIDS

**Objective 1: By the end of 2021, increase the percentage of newly HIV diagnosed persons linked to HIV medical care within one month of their diagnosis to at least 85%.**

### Strategy 1: Establish seamless systems to link people to care immediately after HIV diagnosis.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC CBOs	Enhance and further develop collaborative partnerships with medical providers to ensure immediate linkage to care.	Primary care providers CBOs	No. of Memorandum of Agreement (MOAs)
By the end of the 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Decrease wait time for initial medical appointment via continuing and enhancing utilization of HIV rapid-rapid testing statewide, funding confirmatory testing at RW sites, and implementing brief assessment at RW Part B sites for quicker eligibility determination.	CBOs Primary care providers HIV providers	No. of prevention contracts specifying rapid-rapid testing Care Continuum Linkage to Care data <i>Provide Enterprise (PE)</i> Date of diagnosis to 1 <sup>st</sup> medical appt.
By the end of 2018 (and ongoing):	S.C. DHEC	As funding is available, direct additional funding to enhance payments systems to include premiums, co-payments and deductibles for medical visits and medications ensuring affordable care services.	PLWHA	Affordable Care Act (ACA) Enrollment Insurance Assistance Program (IAP) Enrollment Health Insurance Premiums and Cost Sharing services provided reported on RSR

By the end of 2019 (and ongoing):	S.C. DHEC	Enhance relationships with jail, prisons, and expanded testing sites to link clients at release or provide eligible services where other federal or state resources are not available for HIV care.	PLWHA	Minority AIDS Initiative (MAI) Linkage data from MAI funded providers
<b>Strategy 2: Continue and increase options for PLWHA for access to public health strategies (e.g. ARTAS, Project CONNECT, STYLE, CRCS).</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC  CBOs	Increase annually the number of PLWHA who receive public health strategies.	PLWHA	No. of strategies offered  No. of PLWHA enrolled
By the end of 2017 (and ongoing):	S.C. DHEC	Increase opportunities for providers to be trained in public health strategies.	Providers	No. of trainings provided  No. of providers enrolled
<b>Strategy 3: Develop strategies to support enhanced linkage to care services.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC	Develop and update policies and protocols related to enhanced linkage to care services.	S.C. DHEC staff and contractors	No. of policies developed and implemented
By the end of 2017:	S.C. DHEC	Increase educational, marketing and capacity-building efforts related to the importance of early linkage and entry into care.	PLWHA Primary Care Providers HIV Providers Testing sites	No. of materials developed/ distributed  No. of trainings offered  No. of electronic tracking units

<b>Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90% through comprehensive, coordinated patient-centered care for PLWHA.</b>				
<b>Strategy 1: Assess client needs and align service models with client need to reduce barriers to client retention.</b>				
<b>Timeframe</b>	<b>Responsible Parties</b>	<b>Activity</b>	<b>Target Population</b>	<b>Data Indicators</b>
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Ensure that every client enrolled in medical case management is assessed for needs (e.g. transportation, mental health, substance abuse, and housing).	PLWHA	No. of assessments completed  (SC QM: #08.O, #06.O, #05.O)
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Ensure the development of a care plan by medical case managers to address client individualized needs and barriers to care.	PLWHA	Percentage of medical case management patients who have a medical care plan developed and or updated two or more times (SC QM #11.0)
By the end of 2019 (and ongoing):	S.C. DHEC Ryan White Providers	Increase number of clinics with non-traditional hours to meet the needs of clients.	PLWHA	Clinics with non-traditional hours
By the end of 2019 (and ongoing):	S.C. DHEC Ryan White Providers	Increase the use of telehealth to decrease client barriers, such as transportation, in effort to meet the needs of clients.	PLWHA	No. of clinics with telehealth services.

By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Expanding Medical Case Management (MCM) services to include Specialized Medical Case Managers to focus on clients who have fallen out of care and are returning to care and those who are at risk for falling out of care. Specialized MCM will have lower caseloads allowing for more frequent contacts with clients.	PLWHA	No. of Specialized MCMs  Percentage of patients, over the age of 24 months, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits (SC QM #12.0A)
<b>Strategy 2: Support development of Ryan White services that are highly valued by PLWHA.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Continuing and enhancing RW eligible core and supportive services (e.g. housing, medical case management, transportation, food, mental health).	PLWHA Providers	No. of services provided through RSR
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Continue Housing Opportunities for Persons with AIDS (HOPWA) program. Expand Short-Term Mortgage, Rent and Utility (STRMU) and housing placement services through a statewide contractor as funding becomes available.	PLWHA Providers	No. of housing services provided on RSR and CAPER

By the end of 2017 (and ongoing):	S.C. DHEC Ryan White providers	Build relationships with other statewide and local housing organizations. For example, S.C. DHEC RW and HOPWA Program are represented on the S.C. Coalition for the Homeless. Attend other local meetings to align and coordinate available resources.	PLWHA	Meetings attended
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Enhance medical case management services through the revision of the Part B MCM Standards, reducing caseloads by hiring more MCMs as funds are available, implementing targeted interventions such as trauma-informed care, and expanding MCM services to include specialized case managers to focus on clients who have fallen out of care and are returning to care and those who are at risk for falling out of care.	PLWHA	MCM Services reported on RSR  Clients returned to care through Outreach efforts
By the end of 2020 (and ongoing):	S.C. DHEC Ryan White Providers	As funds are available, additional resources may be allocated to hiring and training mental health providers, including mental health counselors, to serve on staff at Ryan White sites.  Establish collaborative relationships with the Department of Mental Health and local Mental Health providers.	PLWHA	Mental Health Services on RSR
By the end of 2018 (and ongoing):	S.C. DHEC Ryan White Providers	Expand transportation options provided by RW providers to include: researching the use of federal funds for the purpose of leasing vehicles, utilizing gas cards rather than gas vouchers to be used in locations more convenient to client's home. Ensure all public transportation options are available. Research contracting with local transportation providers to establish	PLWHA	Transportation services reported on RSR

		transportation services.		
By the end of 2019 (and ongoing):	S.C. DHEC  Ryan White Providers	As funds are available, establish food banks at Ryan White provider sites and/or relationships with other community resources offering food bank services. Share best practices of those providers already providing food bank services through QM Steering Committee and other statewide venues to expand availability of nutritious food options for PLWHA.	PLWHA	Food Bank Services reported on RSR
By the end of 2020 (and ongoing):	S.C. DHEC  Ryan White Providers	As funds are available, expand nutritional services at Ryan White providers.	PLWHA	Medical Nutrition Services reported on RSR
By the end of 2018 (and ongoing):	S.C. DHEC	As funds are available, assist in the treatment of Hepatitis C Virus (HCV) with co-infected clients through the ADAP Direct Dispensing Program. As funds are available, utilize Telehealth technology for Hepatitis treatment consultation for medical providers.	PLWHA	HCV drugs dispensed
<b>Strategy 3: Ensure medical visits using data-driven strategies to track retention.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC  Ryan White Providers	Ensure that each HIV positive client has at least one medical visit with a provider with prescribing privileges within each 6 month period within the 24 month measurement period.	PLWHA	No. of clients who have a medical visit within 6 month period within the 24 month assessment (SC QM #12.0A)

Current and ongoing through 2021:	S.C. DHEC  Ryan White Providers	Continue Quality Management program for monitoring outcomes and identifying areas of improvement and those with opportunities for improvement, ensuring compliance with National Institutes of Health (NIH) Guidelines. Continue and expand communications and activities with the PAC to garner their input into improvement strategies.	Ryan White Providers	QM Data reported via Clinical Report Card
By the end of 2021:	S.C. DHEC  Ryan White Providers	Conduct a statewide All Parts annual consumer needs assessment to gather input from consumers of Ryan White programs on the gaps and barriers and align strategies to meet the need	CBOs	Needs Assessment Results

<b>Objective 3: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.</b>				
<b>Strategy 1: Provide public health strategies for medication adherence.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC  Ryan White Providers  CBOs	Increase annually the number of PLWHA who receive medication adherence strategies (e.g. <i>Every Dose Every Day, Project Helping Enhance Adherence to Anti-Retroviral Therapy (HEART), and Partnership for Health</i> ).	PLWHA	No. of strategies offered  No. of PLWHA enrolled
By the end of 2017 (and ongoing):	S.C. DHEC	Increase opportunities for providers to be trained in medication adherence strategies.	Providers	No. of trainings provided  No. of providers enrolled

<b>Strategy 2: Increase access to HIV medications.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC  Ryan White Providers	Medical providers of HIV care will continue to prescribe Anti-Retroviral Therapy (ART) to clients as indicated.	PLWHA	Percentage of patients being prescribed ART (SC QM#2.O)
By the end of 2017 (and ongoing):	S.C. DHEC	Ensure AIDS Drug Assistance Program (ADAP) resources are available to continue the direct dispensing program for uninsured PLWHA and expand the insurance assistance program.	PLWHA	No. of clients enrolled in ADAP programs
<b>Strategy 3: Develop, enhance and implement peer-navigation program for treatment adherence.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC  Ryan White Providers  CBOs	As funds are available, support recruitment and utilization of peers to provide treatment adherence services to PLWHA served by Ryan White providers.	PLWHA	No. of peers recruited  No. of peers trained  No. of agencies funded
By the end of 2017 (and ongoing):	S.C. DHEC  HIV Planning Council (HPC)	Provide Peer Training as designed by the HIV Planning Council's (HPC) Care and Support Committee to build skills and knowledge necessary for working within an HIV organization and to ensure consistency in the care and services provided to patients/clients living with HIV/AIDS statewide.	Peers	Peers Trained through Peer Institute
By the end of 2017 (and ongoing):	S.C. DHEC  Ryan White Providers  CBOs	Support development and implementation for the provision of peer treatment adherence programs through the establishment of a statewide Peer Adherence Workforce Committee.	PLWHA	Peer Adherence Specialist Workforce Committee Meeting Minutes

<b>Objective 4: By the end of 2021, decrease the percentage of previously diagnosed PLWHA not in care to no more than 3,146 (which represents 50% of those currently out of care).</b>				
<b>Strategy 1: Implementation of Data-to-Care Program.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC HIV Providers CBOs	Support development and implementation of policies and protocols for the use of Data-to-Care services.	PLWHA	No. of signed Data Sharing Agreements
By the end of 2017 (and ongoing):	S.C. DHEC CBOs PLWHA	Develop marketing material and strategies for Data-to-Care Program.	PLWHA	No. of calls to STD/HIV hotline  No. of clicks on S.C. DHEC website for Data-to-Care information
By the end of 2017 (and ongoing):	S.C. DHEC	Monitor clients from initial encounter to viral suppression.	PLWHA	Client reported labs to surveillance at 3, 6, 9, and 12 month intervals
By the end of 2017 (and ongoing):	S.C. DHEC CBOs HIV Providers	Increase in the percentage of clients linked/re-engaged to care through Data-to-Care initiative.	PLWHA	No. and percentage of clients linked/reengaged to HIV medical care through Data-to-Care
<b>Strategy 2: Implementation of other public health strategies (e.g. STYLE).</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC CBOs	Increase annually the number of PLWHA who receive other public health strategies.	PLWHA	No. of strategies offered No. of PLWHA enrolled

By the end of 2017 (and ongoing):	S.C. DHEC	Increase opportunities for providers to be trained in other public health strategies.	Providers	No. of trainings provided No. of providers enrolled
<b>Strategy 3: Implementation of expanded Ryan White outreach services.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Increase annually the number of PLWHA who receive RW outreach services by providing funding, as available, to RW providers for Outreach Services.	PLWHA	No. of services offered
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Implement <i>Returning to Care Assessment</i> through Outreach Workforce to determine individualized reasons why people fall out of care and use data to enhance services that will retain clients in care.	Providers	Assessment results
By the end of 2017 (and ongoing):	S.C. DHEC Ryan White Providers	Support development and implementation for the provision for enhanced and expanded Ryan White outreach services through the Outreach Workforce Committee.	PLWHA	Outreach Workforce Committee Meeting Minutes

## 2010-2015 NHAS GOAL 3: Reducing HIV-related Disparities and Health Inequities

**Objective 1: By the end of 2021, reduce by at least 15% the rate of new diagnoses among young Black gay and bisexual men.**

**Strategy 1: Assess services intended to reduce HIV-related disparities experienced by gay and bisexual men.**

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017:	S.C. DHEC  Ryan White Providers  CBOs	Conduct an assessment to identify health and human services and gaps (e.g. transportation, mental health, substance abuse, and housing).	Young Black gay and bisexual men (HIV negative and HIV positive)	Completed assessment
By the end of 2019:	S.C. DHEC	Conduct analysis of assessment and dissemination of results. Consider mitigation strategies based on assessment analysis of findings.	Young black gay and bisexual men (HIV negative and HIV positive)	Analysis of completed assessment

**Strategy 2: Expand services to reduce HIV-related disparities experienced by young Black gay and bisexual men and transgender persons.**

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	S.C. DHEC	Increase opportunities for providers to be trained in culturally sensitive or culturally aware practices and services for young Black gay and bisexual men and transgender persons.	Clinical Providers  CBOs	No. of trainings provided  No. of providers participated

By the end of 2021:	S.C. DHEC	Increase number of health and human service providers who deliver culturally sensitive services to young Black gay and bisexual men and transgender persons.	Clinical Providers CBOs	No. of providers who have young Black gay and bisexual men-friendly environmental conditions  No. of providers with written protocols inclusive of young Black gay and bisexual men
By the end of 2021:	S.C. DHEC CBOs	Collaborate with partners and utilize existing resources to support education and outreach efforts to reduce HIV related disparities (Minorities, Lesbian, Gay, Bisexual & Transgender [LGBT] Groups, S.C. MSM Workgroup, National Alliance of State & Territorial AIDS Directors [NASTAD], S.C. YMSM Advisory).	Gay, bisexual, and transgender individuals CBOs Clinical Providers	No. of MOU's and MOAs that include education and outreach efforts to reduce disparities
By the end of 2021:	S.C. DHEC CBOs	Increase sexual health education and awareness among black gay men and transgender persons to reduce number of infections among population.	Gay, bisexual, and transgender individuals CBOs	No. of materials, messages, and trainings developed
By the end of 2021:	S.C. DHEC	Utilize and enhance surveillance resources and systems, with guidance from CDC, to monitor transgender infection rates to direct evidence-based interventions	CBOs Clinical Providers	No. of modifications made to data reporting in surveillance systems

<b>Strategy 3: Increase access to HIV prevention including HIV testing and other services.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	S.C. DHEC	Increase funding awards targeted to support innovative strategies for black gay men and bisexual men such as PrEP, social media, education, testing, and utilization of our YMSM Advisory.	CBOs	Percentage of total dollars awarded
By the end of 2021:	S.C. DHEC	Increase funding to expand service hours and options (e.g. locations, activities, public health strategies) to meet the individualized needs of the clients.	CBOs	Percentage of total dollars awarded
By the end of 2021:	SC DHEC	Coordinate efforts with the DHEC Office of Minority Health to reduce health disparities.	CBOs	Coordination efforts with Office of Minority of Health
<b>Strategy 4: Train providers in cultural competency and cultural awareness.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2020:	S.C. DHEC AETC HIV Providers	Work with AIDS Education and Training Centers (AETC) to increase cultural competency and cultural awareness of all staff working to provide HIV testing, medical care, pharmacy services, and supportive services.	HIV Care and Services providers	Training records

By the end of 2021:	S.C. DHEC Ryan White Providers	Implement statewide consumer satisfaction surveys to monitor ongoing satisfaction of services provided.	Ryan White Providers	Consumer satisfaction survey results
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<b>Objective 2: By 2021, increase by 25% the health communication messages to address stigma and to promote evidence-based public health approaches to HIV prevention and care.</b>				
<b>Strategy 1: Increase DHEC web-presence, print, broadcast and other electronic media regarding HIV prevention and care messages.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	S.C. DHEC	Develop messages and utilize National campaign to promote awareness and prevention of HIV/STIs/HCV (e.g., Act Against AIDS, “Ask me about AIDS”.) Promote recognition of national health observances (ex. World AIDS Day, National Testing Day).	Priority populations and general populations	No. of messages developed  No. of published messages/materials distributed
By the end of 2017 (and ongoing):	S.C. DHEC	Secure support for implementation of prevention and care messages.		No. of approved messages  No. of page views
<b>Strategy 2: Increase community partners opportunities to expand health communications.</b>				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators

By the end of 2017 (and ongoing):	S.C. DHEC	Increase funding award options to develop and implement messages associated with major national observances (National Testing Day, World AIDS Day) and campaigns (e.g. Act Against AIDS, "Ask me about AIDS").	CBOs	Percentage of funding awarded
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Resources

<https://aidsinfo.nih.gov/guidelines>  
 CDC-recommended evidence-based interventions and public health strategies:  
<https://effectiveinterventions.cdc.gov/>

## Anticipated challenges or barriers in implementing the plan

There are a few challenges which may impact the capacity to execute this plan. Chief among the concerns is the uncertainty of Federal funding for HIV prevention and care services. As uncertainty over the future of HRSA funding continues, questions arise about continuity of services—particularly in a State without Medicaid expansion. By continuing to use rebate funds wisely, it is hoped that S.C. DHEC can continue to pave the future of services for PLWHA. Continued need for housing, transportation, behavioral health, and other ancillary services continue to arise as barriers for individuals living with HIV. The complex challenges faced by consumer's present complex needs that may be costly to address. Continuing to work to enroll patients in health insurance plans and work with any available resources will be additional strategies which may result in cost-savings which ultimately may be used to meet ancillary needs.

The issues of stigma and lack of awareness have been long-standing barriers to HIV prevention and care. As HIV continues to disproportionately impact people of color—especially MSM of color—the intersection of racism, poverty, and homophobia continue to call on S.C. DHEC and partners to renew efforts to change community norms as well as individual's behavior to promote lasting impact. Finally, the growing, national opiate epidemic must certainly be monitored. While absolute rates of injection drug related HIV continue to be low, recent outbreaks of HIV (believed to be linked to opiate injection) in rural Indiana and Kentucky serve as a warning to S.C. DHEC to carefully work with DAODAS and prevention and treatment providers. Efforts should assure HIV prevention services will be available if an increase in drug injection occurs in S.C.

## Collaborations, Partnerships, and Stakeholder Involvement

As suggested earlier, the SCSN and planning process sought to reach a wide range of stakeholders. All Part B and HIV Prevention funded grantees and all representatives from all Ryan White participants (Part C, Part D, and Part F) and both SAMHSA and CDC funded organizations participated in the process. The HIV Planning Group (HPC) hosted an SCSN kick-off meeting, including RW All Parts meeting to introduce the planning process in January 2016. The same group met again to review the SCSN findings and offer input into the strategies and interventions. At the August 2016 meeting, the HPC offered a letter of concurrence with the Integrated Plan. No relevant stakeholders have been identified as 'not engaged' in the planning and needs assessment process.

## Persons Living With HIV (PLWH) and Community Engagement

DHEC continues its long tradition of substantive participation by PLWHA in this SCSN process. As stated earlier, half of the HPC is comprised of individuals living with HIV. The regional needs assessments captured consumer input regional surveys and took into account both anonymity and convenience (e.g. allowed mailing of completed survey, on-site completion, or on-line completion) to encourage participation as well as encourage honest and candid responses.

Recruitment of survey participants relied heavily on case manager outreach to current clients. Although the vast majority of respondents were current clients of RW-funded clinics, one region also actively conducted outreach to include PLWHA who had not received services in over a year. Through this survey process, PLWHA had an opportunity to provide valuable input on timeliness between their own diagnosis and first-time medical care, quantity and quality of their current medical care including medication adherence, and suggestions to enhance first-time connection to medical care and on-going retention in care for themselves and others. PLWHA also provided input on insurance and means of paying for medical care to include HIV-related medications, access to HIV-related education and support, and other medical and social service needs.

The representation of individuals with HIV in surveys and community forums roughly reflects the demographics of the epidemic in SC. Approximately 60% of participants in the SCSN process were African-American; more than half of the African Americans were females. A significant percentage of stakeholders (including PLWHA) identify as MSM, and representation included transgender and gender non-conforming community members.

Care providers participated in multiple ways, including meetings and needs assessment. It became clear after the SCSN was underway that clinicians may be under-represented and so a separate survey was constructed to further identify, from their unique perspective, system-level barriers among PLWHA to accessing secondary services as well as system-level enhancements to increase PLWHA linkage to care.

Opportunities to contribute to the planning process were achieved by widespread distribution of surveys during Regional needs assessments. Ryan White providers were encouraged to send consumer representation to the Positive Advocacy Committee's SCSN Planning Meeting in March.

Stakeholder engagement—particularly PLWHA—has been essential to the success of the SCSN. The involvement of the HPC in the planning of the SCSN process, their oversight and collaboration, and their final input into goals and activities is essential to the success of the Integrated Plan. Their critical insights, including strategies for engaging other stakeholders and intervention approaches to address barriers, have made this plan stronger and more relevant.

## Section 5: Monitoring and Improvement

### HIV Planning Council Engagement/Monitoring

The goal of the HPC is to improve the effectiveness of South Carolina's HIV prevention and care programs by strengthening the scientific basis, relevance and focus of prevention and care strategies and interventions. This goal is accomplished in collaboration with the S.C. DHEC in support of the National HIV/AIDS Strategy by carrying out the steps in HIV high impact prevention planning and Health Resources and Services Administration (HRSA) guidelines for the Ryan White Treatment Modernization Act program grantees. The role of HPC in the HIV Prevention and Care Planning Process is as follows: (1) Delineate technical assistance and capacity development needs for effective community participation in the planning process; (2) Review available epidemiological, evaluation, behavioral and social science, quality assurance indicators, cost-effectiveness, and community services assessment data and other information required to prioritize HIV prevention and care needs. Collaborate with HPC partners on how best to obtain additional data and information; (3) Assess existing community resources to determine the community's capability to respond to the HIV epidemic; (4) Identify unmet HIV Prevention and Care needs within defined populations; (5) Prioritize HIV Prevention and Care needs among target populations as based on the HIV epidemiologic data in South Carolina and propose high priority strategies and interventions; (6) Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation; (7) Ensure that a) HIV counseling, testing, and referral services (CTRS; with particular emphasis on linkage to care), early intervention, primary care, specialty care, drug assistance, and other HIV-related services; b) sexually transmitted disease, viral hepatitis, tuberculosis and substance abuse prevention and treatment; c) mental health services; and d) other public health needs are addressed in the comprehensive HIV Prevention and Care Plan.

The progress and/or challenges in meeting the goals of the plan will be discussed during HPC meetings each year. In addition to routine sharing of information, a central function of the HPC is assisting in developing community-focused plans where performance targets are not being met.

During typical HPC meetings, Division staff provides updates on progress toward prevention and care targets, and frequently presents surveillance and care continuum data to advise HPC priority-setting. Historically, the HPC has been involved in providing feedback and recommendations which Division staff, in turn, use to revise program activities.

The input of the HPC also guides training and capacity-building efforts. The Division supports staff in attending training events like the SC Annual HIV/STD/VH Conference, one of the premier statewide infectious disease conferences. As Conference Planning Members, several HPC members are intimately involved in the planning and oversight of the annual conference and serve in leadership positions for the conference. Further, additional training topics and initiatives are frequently suggested by HPC members and the training staff within the Division use this input to advise training/TA opportunities.

Additionally, there are multiple opportunities for updating Ryan White providers, who are not members of HPC, on the progress of plan implementation, soliciting feedback, and using the feedback to plan for improvements. The Ryan White All Parts Meeting facilitated by S.C. DHEC meets annually. The Ryan White All Parts Quality Management (QM) Steering Committee facilitated by S.C. DHEC meets semi-annually. The Ryan White Part C providers meet every other month and the Part B Directors meet quarterly with monthly contractor calls.

### Continuous Quality Improvement

The data sources identified in the plan are readily available data sources, such as HIV/AIDS Bureau (HAB) Performance Measures and report data required for submission to CDC or HRSA.

The Ryan White Quality Management Steering Committee includes all Ryan White providers (Parts A, B, C, D, & F). In order to provide a framework for continuous monitoring and evaluation of the care and services provided, the QM Steering Committee previously reviewed national, state and local HIV quality initiatives. Performance measures from various quality initiatives were aligned with the milestones along the HIV Care Continuum beginning with linkage to care, antiretroviral therapy, retention in care and viral suppression.

Evaluation of the Ryan White Programs for progress on the SCSN and Integrated Plan will continue statewide through the Quality Management program data collection and reporting of Performance Measures. Additionally, evaluation will take place through the required semi-annual Ryan White Part B progress reports and the annual RSR data reporting.

The prevention activities funded by S.C. DHEC are documented using multiple data-collection tools. S.C. DHEC is mandated by PS12-1201 to use CDC's Evaluation Web for reporting. Evaluation Web is a secured database developed by Luther Consulting used to collect information on Counseling, Testing, and Referral Services (CTRS) in the form of rapid HIV testing information received from grantees funded by S.C. DHEC. Grantees are required to enter all HIV rapid test results (reactive, non-reactive, and indeterminate) on a monthly basis. This testing information is uploaded to CDC in order to monitor South Carolina's PS12-1201 deliverable progress.

Evaluation Web is also used to collect information such as linkage to medical care, referral to prevention services, partner services interviews, and enrollment information in evidence-based interventions.

S.C. DHEC prevention grantees are required to submit quarterly narrative reports (QNR) at the end of each quarter. The QNR is an internal report that requires grantees to provide information of meeting contract deliverables, condom distribution, challenges and barriers, and technical assistance needs. Also, grantees are required to submit a monthly CTR summary which includes a breakdown of the total number of rapid tests administered for each month by priority population, non-priority population and number tested positive. This is cross checked with Evaluation Web to ensure reporting consistency and reporting of progress.

In addition to formal data analysis, a critical arm of the Division's monitoring plan involves site visits with all funded partners to measure their progress toward strategic goals. These site visits provide Division staff with an important perspective on implementation activities. These site visits typically include review of records, staff interviews, and review of consumer feedback. The combination of review of quantitative data and site visit impressions allows Division staff to craft a TA plan that is designed specifically to build on the strengths of the organization and to address challenges in succinctly targeted ways.

#### Implementation and Monitoring Plan

Building on the strength of existing quality management activities, the Division implementation and monitoring plan involves two strategic activities.

First, Division staff will use the plan goals and activities as a 'map' of internal progress and review progress toward strategic outcomes at least semi-annually. This data review will look at targets established and measure progress toward the goals. Regularly measuring the outcomes against data sources-particularly Care Continuum data-allows for course correction. Where problems exist, reallocation of additional resources, development of supplemental strategies, and provision of additional training and technical assistance will be indicated.

Second, Division staff will utilize quantitative and observational methods described above to advise contractors and S.C. DHEC staff regarding progress towards benchmarks and need for program improvement plans. Following the analysis of data, S.C. DHEC staff will share findings with partners. Where problems exist, the intention is to work collaboratively to develop solutions and an implementation timeline.

## Appendix 1: Epidemiologic Profile

# An Epidemiologic Profile of HIV and AIDS in South Carolina 2015



Division of Surveillance and Technical Support  
Bureau of Disease Control  
South Carolina Department of Health and  
Environmental Control

### Executive Summary

In June 1981, the CDC published a report which documented five cases of *Pneumocystis carinii* pneumonia in otherwise healthy young men in Los Angeles, California; these would be considered the first cases of AIDS identified in the United States. That report would prompt AIDS case reports from other areas of the U.S. such as New York, San Francisco, and in 1982, South Carolina.

Since 1986, more than 27,671 people have been diagnosed with HIV infection (including AIDS) in South Carolina through December 2014. During 1985-1990 an average of 860 cases were diagnosed each year. In the subsequent three years (1991-1993), newly diagnosed HIV/AIDS cases averaged 1,306. The increase during this period was in part due to the artificial rise in AIDS cases as a result of the change in case definition in 1993. For the past five years, the average number of newly diagnosed cases has been about 759 per year. According to the CDC however, many more people are infected but have not been tested.

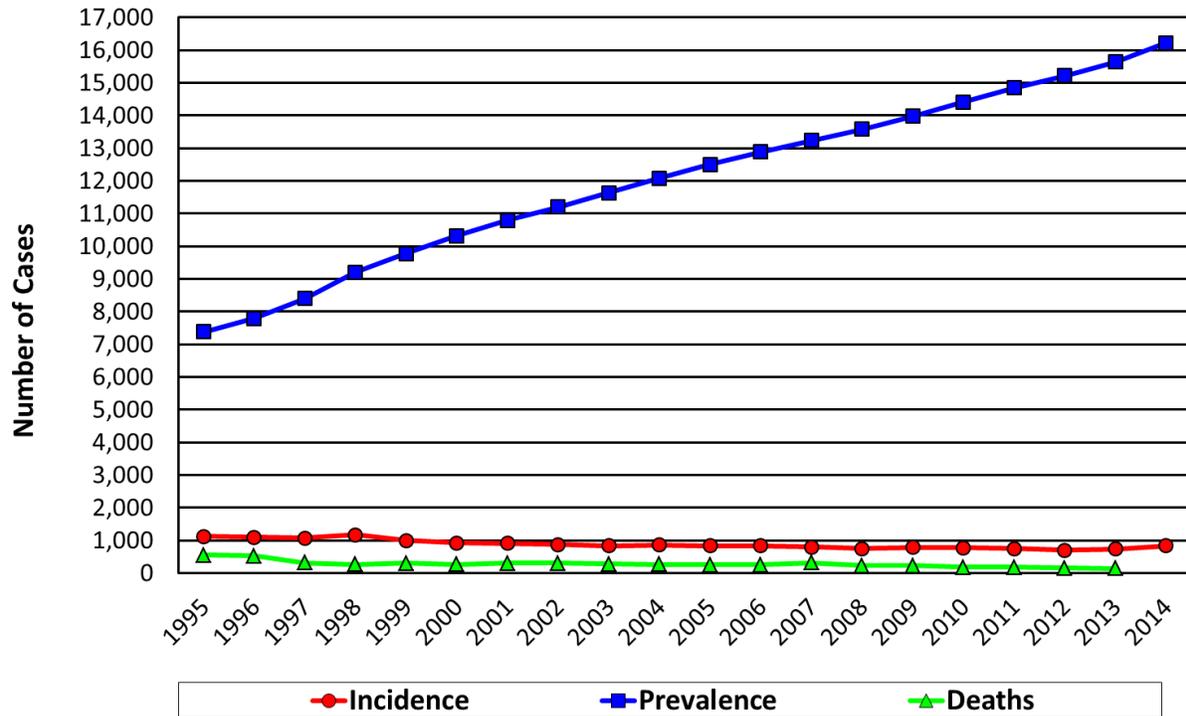
Some of the changes over time in numbers of new cases are largely the result of reporting patterns or targeted testing initiatives. The initial steep rise in the epidemic reflects the early years when less was known about the transmission of HIV and effective medical treatments did not exist. As a result, infection rates increased and more HIV-infected individuals went on to develop AIDS. Most experts believe that when more was learned about HIV and the behaviors involved in its spread, effective prevention strategies reduced the overall number of new infections, and medical treatment, for some individuals, postponed the onset of AIDS. In more recent years, however, there is concern nationally that the epidemic may grow, particularly among young men who have sex with men.

Since 1994, new anti-retroviral drugs and strengthened care services have contributed to a decline in overall AIDS deaths. This decline is illustrated by the 145 AIDS related deaths in 2013, a 45 percent decrease from the 266 deaths in 2004. It is important to note that despite the decline in deaths due to AIDS and the apparent stabilization of the number of new HIV/AIDS cases diagnosed annually, the prevalence of HIV infection (the number of people estimated to be living with HIV/AIDS) is continuously increasing. The number of people living with HIV/AIDS (PLWHA) at the end of each year has increased 30 percent from 2005 to 2014. It is also important to note that there are differences among certain populations in the number and rate of new and prevalent infections, as this profile will indicate.

## Epidemiologic Profile

Figure 1.01 shows total incidence (the number of new cases within a specified time period), deaths, and prevalence of HIV/AIDS cases in South Carolina since 1994.

**Figure 1.01: South Carolina HIV/AIDS incidence, prevalence, and deaths**



Note: number of cases diagnosed in S.C. only; excludes out of state cases returning to S.C.

The epidemic in South Carolina is predominantly driven by sexual exposure, primarily among men who have sex with men and heterosexuals at risk. Injecting drug use appears to be diminishing as a risk for HIV.

African-Americans are disproportionately affected by HIV/AIDS and are over-represented among all risk populations.

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## Overview of Epidemiologic Profile

The purpose of this Epidemiologic Profile is to provide information to the S.C. HIV Planning Council (HPC) on the number and characteristics of people becoming HIV infected. The HPC has a primary responsibility to review the Epidemiologic Profile and ensure that HIV prevention services and resources are directed by DHEC to the populations and geographic areas with the greatest disease burden.

This Epidemiologic Profile includes a list of definitions and describes the data sources used, the limitations of each data type, and presents the data in order to answer the following questions:

**What are the socio-demographic characteristics of the population?**

**What is the impact of HIV/AIDS on the population?**

**Who is at risk for becoming infected with HIV?**

**What is the geographic distribution of HIV infection? \***

**What are the patterns of service utilization of people living with HIV/AIDS?**

**What are the characteristics of people who know they are HIV-positive but who are not in HIV primary care?**

These questions will be explored through analyses of currently living with HIV/AIDS (prevalence) and newly diagnosed (incidence) HIV/AIDS cases; a description of seroprevalence data from HIV counseling and testing sites and other studies; a summary of other risk behavior profiles and community-based HIV risk assessment information; and a discussion of related sociodemographic, health and risk behavior indicators.

## Definitions

**AIDS** – Acquired Immunodeficiency Syndrome, the end stage of HIV infection characterized by life-threatening or severely disabling disease.

**HIV** – Human Immunodeficiency Virus, the cause of HIV infection.

**HIV/AIDS** – Includes those people with HIV infection, as well as those who have progressed to AIDS. Unless noted, most HIV data in this profile includes people diagnosed with AIDS.

**HIV Only** – Includes only people with HIV infection who did not develop AIDS within 365 days of report of positive HIV test.

**Health Professional Shortage Area (HPSA)** – A Department of Health and Human Services (HHS) designation system to identify areas facing a critical shortage of primary medical, dental, or mental health care professionals.

**Incidence** – The number of new HIV/AIDS cases newly diagnosed and reported each year. Incidence cases may be combined in two or three year periods.

**Incidence Rate** – Number of new cases occurring during a period of time, divided by the annual average population, multiplied by 100,000. It is a measure of the frequency with which an event occurs in a population over a period of time. It is also a measure of risk of getting the disease.

**Natural Breaks (Jenks)** – Is a data classification method designed to determine the best arrangement of values into different classes. This is done by seeking to minimize each class's average deviation from the class mean, while maximizing each class's deviation from the means of the other groups.

**Other Risks** – In relation to Risk Exposures, the term “Other” or “Other Risks” is used to describe a group of risks which include such categories as: hemophilia, blood transfusion, and perinatally acquired infection.

**PLWHA** – People Living With HIV/AIDS.

**Prevalence** – The number or proportion of people estimated to be living with HIV/AIDS at the end of a particular period of time (e.g. year).

**Prevalence Rate** – Total number of living HIV/AIDS cases (both old and new cases) during the year of report, divided by the annual average population multiplied by 100,000. It is the proportion of people in a population who have a particular disease or attribute at a specified point in time (or specified period of time).

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### Rates are used to:

- measure the frequency of disease (in this case, HIV/AIDS) or other outcomes of interest,
- describe the distribution of disease occurrence in human populations,
- allow comparison of the risk of disease or burden of disease across populations,
- characterize the risk of disease for a population, and
- identify determinants of disease.

### They may also be used to help:

- prioritize prevention programs among competing causes,
- identify target groups for intervention,
- acquire funding for resources, and
- compare events across geopolitical boundaries.

## Types and Quality of Data

Because no one epidemiologic data set will provide a complete picture of HIV/AIDS in the community, or the state for that matter, we have assembled data from several categories and sources. Data from a variety of categories provide a more accurate picture of past, present and future HIV/AIDS infection trends. Keeping in mind that not all data are equal, data sources must be considered in the context of their objectives, strengths and limitations; who the target populations are; how the data were collected; and the validity of the data.

As described above, several data sets are used to illustrate the South Carolina populations diagnosed with HIV/AIDS and to characterize the nature of risk-taking behaviors. All of these data sets share limitations or have similar types of bias introduced, in that most are reported by third parties, largely providers, who must seek information from the affected individual as to illness, transmission mode, and demographic characteristics. These reports are limited both by the willingness of providers to ask about these factors and that of clients to report on personal behaviors. These data are also limited in their ability to broadly characterize populations. For instance, STD (sexually transmitted disease) or HIV/AIDS case report data can only characterize people with STD or HIV who seek treatment, or data on estimated condom use among women cannot characterize all women but only those who agree to participate in selected behavioral surveys. Individuals who seek treatment for STD (and who are offered HIV testing) may be very different from those individuals who do not. However, each of the data sets referred to in this profile provide information to describe the relative risk and impact of this disease on the people of South Carolina.

The following summarizes data sources, and limitations, used by the data work-group to complete the South Carolina Epidemiologic Profile of HIV/AIDS.

### **Selected Data Source Description and Limitations:**

#### **DHEC, Enhanced HIV/AIDS Reporting Surveillance System (eHARS)**

All health care providers, hospitals, and laboratories in South Carolina are required to report people diagnosed with confirmed HIV infection and/or AIDS. Each year approximately one-third of new cases are reported from county health departments, one-third from hospitals, one-fifth from physicians, and the remainder from state/federal facilities (including prisons) and laboratories. DHEC's surveillance system, eHARS, serves various functions: 1) monitoring the incidence and demographic profile of HIV/AIDS; 2) describing the modes of transmission among people with HIV/AIDS; 3) guiding the development and implementation of public health intervention and prevention programs; and 4) assisting in evaluating the efficacy of public health interventions. It is the principal source of knowledge regarding trends in the number and characteristics of HIV-infected people. It includes people in all age, gender, race/ethnic, and mode-of-HIV-exposure groups; and it provides a historical perspective in trends dating to the earliest recognition of the AIDS epidemic.

This profile primarily presents data on the total infection/disease spectrum: HIV infection including AIDS (not AIDS alone). Because of the long and variable period from HIV infection to the development of AIDS, trends in AIDS cases data do not represent recent HIV infections or all HIV-infected people. AIDS surveillance data do not represent people whose HIV infection is not recognized or diagnosed. AIDS cases have declined nationwide; however, because AIDS surveillance trends are affected by the incidence of HIV infection, as well as the effect of treatment on the progression of HIV disease, future AIDS trends cannot be predicted.

Because trends in new diagnoses of HIV infection are affected when in the course of disease a person seeks or is offered HIV testing, such trends do not reflect the total incidence of HIV infection in the population. In addition, because not all HIV-infected people in the population have been diagnosed, these data do not represent total HIV prevalence in the population. Interpretation of these data is complicated by several factors, ranging from a person having both HIV then AIDS diagnoses in the same year, varying time between reporting HIV and AIDS cases, and numerous reasons why the number of new HIV diagnoses changed (increased, decreased, or stable).

Some data is provided on HIV infection-only (people reported with HIV infection who do not have an AIDS diagnosis within 365 days of being diagnosed with HIV). This data, while highly dependent on people seeking or receiving HIV testing early in their infection stages, provide an opportunity to compare people presumably infected more recently with those infected as long as ten or so years ago (AIDS diagnosis).

Risk categories are assigned similar to the methods described above in HIV Counseling and Testing. There are some slight differences in the type of categories between HIV/AIDS surveillance reports and HIV Counseling and Testing reports. In South Carolina, about 37 percent of adult/adolescent HIV infection/AIDS cases reported in 2014 did not have risk categories reported. These cases are defined as "No Identified Risk"- (NIR). The proportion of NIR cases has been increasing nationally as well. The primary reason for incomplete risk information is that reports from laboratories do not include risk and an increasing proportion of cases result from heterosexual transmission but are not able to be defined in CDC's definition of heterosexual transmission. For example, people who report having multiple

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heterosexual partners or who have sex for money/drugs but the status of their partners is not known, are not classified as “heterosexual”, they are “No Identified Risk”.

### **DHEC, Sexually Transmitted Diseases Management Information System (STD\*MIS)**

Health care providers and laboratories are required by law to report certain sexually transmitted diseases (including syphilis, chlamydia, gonorrhea, chancroid, hepatitis) to DHEC. A sexually transmitted disease, other than HIV infection, represents a visible and immediate health problem that stems from unprotected intercourse with an infected partner. Research from several studies strongly indicates that STDs increase the possibility of acquiring and transmitting HIV infection. The emerging problem of heterosexual HIV transmission in the South closely parallels that of syphilis and gonorrhea. Gonorrhea, syphilis, and chlamydia incidence and prevalence data are used by programs to: 1) monitor local, and state trends; 2) identify high-risk groups and geographic areas in which unsafe sexual behaviors occur, 3) guide the development and implementation of public health intervention and prevention programs; and 4) assist in evaluating the efficacy of public health interventions.

Considering the short incubation periods for these infections, gonorrhea, syphilis, and chlamydia incidence represent recent consequences of unsafe sexual behavior and point to populations who are potentially at very high risk for acquiring and transmitting HIV infection. Unfortunately, an often unrecognized aspect of STDs, including bacterial STDs, is how frequently people with these infections have no symptoms or do not recognize symptoms. Most studies of STDs are conducted in health-care settings specifically for people who do recognize symptoms; therefore, these studies usually overestimate the proportion of infected people who are symptomatic. Studies of STD screening in non-health-care settings (e.g., jails, workplaces, and communities) or health-care settings where STD treatment is not the primary function (e.g., family-planning clinics) suggests that most people with gonorrhea or chlamydia are asymptomatic.

Limitations: STD data lack much information that would help to better understand HIV risk, such as mode of transmission. Also, bias is introduced for some diseases, such as chlamydia, where screening of asymptomatic people is done much more frequently in women than in men. For example, all women <25 years attending family planning and STD clinics in county health departments are routinely screened for chlamydia and gonorrhea. Also, there may be bias in that the majority of reports are from public clinics; the personal nature of STD's may affect providers' willingness to report. This may account, in part, for the likelihood of some STDs to occur at much higher rates among African-Americans who are more likely to seek care in public clinics, where there is more complete reporting.

### **HIV Counseling and Testing Program Data from DHEC Clinics**

Counseling and testing data, while highly informative about people who seek counseling and testing, does not tell us anything about people who do not seek testing or choose not to test. All states provide HIV counseling and testing services and maintain data to quantify HIV counseling and testing services delivered in publicly-funded sites and to determine the characteristics of people receiving those services. These data are used by prevention programs to plan and target services for high-risk individuals. The type of data collected in South Carolina includes the counseling and testing site type, number of clients tested and number positive for each risk group, number tested, number positive by type of test site, and number tested and number positive by race/ethnicity gender, and age group. Clients receive confidential counseling and testing in each of the 46 county health department clinics.

The counseling and testing data system is standardized and has been in place for several years. Data in this Epi-Profile reflect number of individual clients tested during a specific period of time. People who received multiple tests during the report period are only counted once. It includes people tested in family clinics, maternity clinics, TB, STD clinics and people voluntarily requesting services or referred through partner counseling services. Approximately one third of the total of newly diagnosed and reported people with HIV infection each year is from DHEC counseling and testing sites. People tested in other settings, such as physician offices, hospitals, state facilities, etc. are not included in the DHEC counseling and testing database.

To determine a client's level of risk, each person is assigned a risk status: men who have sex with men (MSM), injection drug use (IDU), or heterosexual contact with a person at risk for or infected with HIV. Since most clients acknowledge multiple risks, risk status is determined by using the CDC's hierarchy of risk. This process assigns the client's "highest" risk. The highest possible risk in the hierarchy is sex with a person with HIV/AIDS, while the least significant risk is "no acknowledged risk". A person is only represented in their highest risk category regardless of how many risks the client acknowledges.

The CDC's hierarchy of risk includes a category for the combined risks of MSM and IDU; in previous HIV/AIDS Epidemiologic Profiles, the combined risks of MSM and IDU have been grouped and reported within the single category of 'Injection Drug Use'. This report leaves the combined risks of MSM and IDU as a stand-alone category. This CDC risk hierarchy can limit interpretability of data; it also does not reflect associated risks such as other non-injecting substance use, i.e. crack-cocaine.

Counseling and testing data in South Carolina and nationally is distinct from blinded, HIV seroprevalence surveys which generate an estimate of HIV seroprevalence that is unbiased by client self-selection. The DHEC counseling and testing system only includes clients who seek out counseling and testing services or agree to be tested after consultation with a counselor at a clinic site. However, for those clinic sites in which clients can obtain services other than counseling and testing for HIV, and in which all or nearly all clients actually receive HIV testing, (for example, maternity and STD clinics), data for those sites approximates the reliability of the blinded surveys.

### **Ryan White Program Data Report**

The Ryan White HIV/AIDS Program Data Report (RDR) is an annual report that captures information regarding the services provided by all Ryan White funded entities. The RDR is divided into sections including: service provider information; client information; service information; HIV counseling and testing; and medical information. Providers report on all clients who received services eligible for Ryan White Parts A, B, C or D funding, regardless of the actual funding source used to pay for those services. The South Carolina Ryan White Part B contractors complete the RDR forms and submit them to DHEC. DHEC assembles all of the reports and submits the data to Health Resources and Services Administration (HRSA).

### **South Carolina Community Assessment Network (SCAN)**

Its purpose is to provide basic reference data for a variety of users. The primary use of SCAN is to enumerate and characterize mortality attributed to HIV infection. The data were also used to compare trends in HIV infection mortality with other leading causes of death and to characterize the impact of HIV infection on mortality. Data on causes of death are based on information recorded by hospitals, physicians, coroners, midwives and funeral directors. Recorded information may be inaccurate or incomplete due to underreporting of certain causes of deaths, the number of HIV-related deaths and the conditions may be underestimated. Vital statistics data are not as timely as AIDS case reports due in part to processing time.

SCAN is also used to enumerate and characterize birth attributes.

### **U.S. Department of Health and Human Services (DHHS): National Survey on Drug Use and Health (NSDUH)**

The National Survey on Drug Use and Health is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS). Supervision of the project comes from SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ).

Through a competitive bidding process, SAMHSA selected Research Triangle Institute (RTI) to conduct the NSDUH through 2014. RTI has successfully conducted the survey since 1988. RTI's role in this long-term national effort includes study design, sample selection, data collection, data processing, analysis, and reporting.

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. To assess and monitor the nature of drug and alcohol use and the consequences of abuse, NSDUH strives to:

- provide accurate data on the level and patterns of alcohol, tobacco and illegal substance use and abuse;
- track trends in the use of alcohol, tobacco, and various types of drugs;
- assess the consequences of substance use and abuse; and
- identify those groups at high risk for substance use and abuse.

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A scientific random sample of households is selected across the United States, and a professional RTI interviewer makes a personal visit to each selected household. After answering a few general questions during the in-person visit by the interviewer, one or two residents of the household may be asked to participate in the survey by completing an interview. Since the survey is based on a random sample, each selected person represents more than 4,500 United States residents.

Participants complete the interview in the privacy of their own home. A professional RTI interviewer personally visits each selected person to administer the interview using a laptop computer. Individuals answer most of the interview questions in private and enter their responses directly into the computer so even the interviewer does not know the answer entered. For some items, the interviewer reads the question aloud and enters the participant's response into the computer.

Each interview data file – identified only by a code number – is electronically transmitted to RTI on the same day the interview is conducted. Combined with all other participants' answers, the data are then coded, totaled, and turned into statistics for analysis. As a quality control measure, participants may receive a telephone call or letter from RTI to verify the interviewer completed the interview with them in a professional manner.

### **Youth Risk Behavior Surveillance System (YRBSS)**

The Youth Risk Behavior Survey (YRBS) was developed cooperatively by the Centers for Disease Control and Prevention (CDC), several federal agencies, and state departments of education to measure the extent to which adolescents engage in health risk and health enhancing behaviors. The system consists of national, state, and local school-based surveys. In South Carolina, the YRBS consists of questionnaires administered to middle school (6th-8th grade) and high school (9th-12th grade) students in the public school system. A two-stage sampling process is used to provide a state-wide sample at each level. In the first stage, regular public schools with any of the target grades are sampled with probability proportional to the school enrollment. In the second stage, intact classes are sampled randomly and all students in these classes are eligible to participate. The overall response rate is calculated as the percentage of sampled schools that participate multiplied by the percentage of sampled students that complete useable surveys. If this overall response rate is 60% or greater, the resulting data are weighted to be representative of the state as a whole.

There are 367 private K-12 schools in South Carolina; however, none of them are included in the survey. Also, while schools are randomly selected for participation some may choose not to participate. The survey includes questions about injury and violence, tobacco use, alcohol and other drug use, sexual risk behaviors, physical activity, and nutrition behaviors (the specific questions can vary from year to year).

This survey is conducted by S.C. Healthy Schools at the Department of Education, and relies heavily on surveillance methods and self-reports; so it depends on how well respondents understand the questions and how well they can accurately and honestly answer the question. However, the questionnaire has demonstrated good test-retest validity and the data are edited, checked and weighted. These data are representative of only public middle school students (grades 6-8) or public high school students (grades 9-12) in South Carolina.

## What are the sociodemographic characteristics of the population?

The HIV epidemic in the United States, and in South Carolina, is a composite of multiple, unevenly distributed epidemics in different regions and among different populations. These populations may comprise people who practice similar high-risk behavior, such as injecting drugs or having unprotected sex with an infected person. Although race and ethnicity are not risk factors for HIV transmission, they are markers for complex underlying social, economic, and cultural factors that affect personal behavior and health. Low socioeconomic status is associated with increased disease morbidity and premature mortality. Unemployment status is correlated to limited access to health care services, resulting in increased risk for disease. This section provides background information on South Carolina's populations and contextual information, i.e. education, poverty level, housing, etc., for assessing potential HIV impact. The social, economic, and cultural context of HIV infection must be considered when funding, designing, implementing and evaluating HIV prevention programs for diverse populations.

### The State

South Carolina lies on the southeastern seaboard of the United States. Shaped like an inverted triangle, the state is bounded on the north by North Carolina, on the southeast by the Atlantic Ocean, and on the southwest by Georgia. It ranks 40th among the 50 states in size and has a geographic area of 30,061 square miles. South Carolina has a diverse geography that stretches from the Blue Ridge Mountains in the northwest corner to the beaches along the Atlantic coast. Manufacturing is the state's leading industry, followed by tourism and forestry.

### Populations

Based on Census Bureau data, the total number of South Carolinians is 4,832,482 (2014 estimate). Of this total, 64 percent were Caucasian, 27 percent were African-American, 0.4 percent were Native American/Alaskan, 1.5 percent were Asian/Pacific Islander and 5.4 percent were of Hispanic origin. Fifty-one percent are female and 49 percent are male. 67 percent of the population distribution in South Carolina is defined as metropolitan; 33 percent is non-metropolitan. (Figure 1.02).

**Figure 1.02: Selected demographic information  
South Carolina and United States**

	South Carolina	United States
Population (2014 est.)	4,832,482	318,857,056
Proportion of Persons Living in Non-Metropolitan Areas, 2013	33%	14%
Median Age, 2014	38.8	37.7
Racial/Ethnic Distribution of Pop. (2014 est.)		
White	64%	62%
Black	27%	12%
Hispanic	5%	17%
Educational Attainment 2013		
High school grad. or higher	85%	86%
Bachelor's degree or higher	25%	29%
Unemployment Rate, 2014	6.4	6.2
Median Household Income, 2013	\$44,779	\$53,046

Sources: U.S. Census Bureau.

**Education & Earnings**

Educational attainment is strongly correlated with poverty, and South Carolina continues to rank low in percent of people over 25 years of age who have bachelor’s degrees or higher (40th of fifty states and District of Columbia). Just over fifteen percent (15.1 percent) of the population has less than a high school education. By race, 11 percent of the white population, and 21 percent of the African American population, over the age of 25 in South Carolina have an educational attainment of less than a high school diploma.

In comparison, African-Americans and people of Hispanic origin have lower per capita incomes, averaging 38 percent below the state’s mean income, while Asian and whites earned 10 percent above the state’s mean income. (Figure 1.3)

**Figure 1.03: S.C. Per Capita Income by Race and Ethnicity**

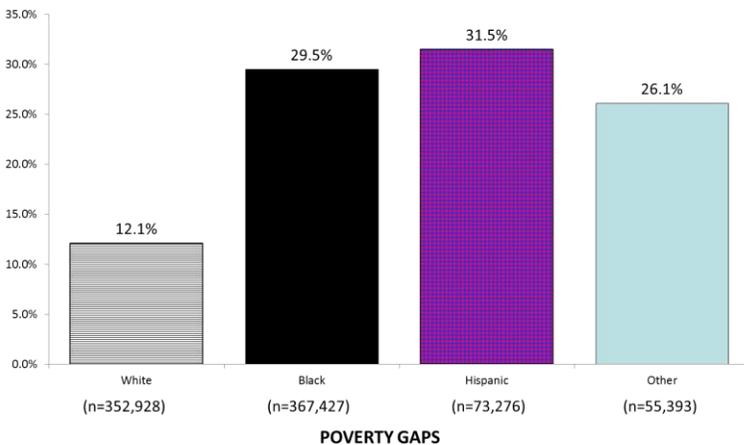
Per Capita (mean) Income (2013 Inflation-Adjusted Dollars)	Estimate	Relative to African-Americans
African-American	\$ 15,627	1.0
American Indian/Alaska Native	\$ 17,962	1.1
Asian	\$ 23,768	1.5
Hispanic or Latino origin (of any race)	\$ 13,572	0.9
Native Hawaiian/Other Pacific Islander	\$ 18,083	1.2
White (non-Hispanic)	\$ 28,295	1.8
<b>South Carolina Overall :</b>	<b>\$ 23,687</b>	<b>1.5</b>

Data Sources: U.S. Census Bureau

**Poverty Level**

Despite the economic strides made in recent years, South Carolina remains among states with the highest percentage of people who live below the poverty level (10th of fifty states, District of Columbia, and Puerto Rico). According to US Census Bureau data, in South Carolina approximately 18.1 percent of individuals and 13.7 percent of families live below the poverty level.

**Figure 1.04: Percent of each racial/ethnic pop. living below federal poverty level: S.C. 2013**



Data Source: U.S. Census Bureau, American Community Survey.

An estimated 30 percent of African-American South Carolinians were below the poverty level in 2013, compared to 32 percent of people of Hispanic descent, 12 percent among whites and 26 percent of people categorized as ‘Other’, which includes Asian, Pacific Islanders and Native Americans (Figure 1.04).

**Insurance/Access to Primary Care**

Almost sixteen percent (15.8 percent) of South Carolinians do not have health insurance coverage and 35 percent have some type of public health insurance. In South Carolina, all or part of forty-five (out of forty-six) counties are designated as Health Professional Shortage Areas (HPSA). An estimated 1,253,951 South Carolinians live in HPSAs; or approximately 27.1 percent of the South Carolina’s population, compared to 17.7 percent of the total U.S. population (Figure 1.05).

**Figure 1.05: Selected access indicators, S.C. and U.S.**

	South Carolina	United States
Total Population Uninsured, 2013	15.8%	14.5%
Individuals Below 200% Poverty Level, 2013	40.1%	34.8%
Population living in a Primary Care Health Professional Shortage Area, 2012	27.1%	17.7%
Population with public health insurance coverage, 2013	34.5%	31.6%

Data Source: U.S. Census Bureau, American Community Survey.

**Employment**

South Carolina’s unemployment rate at mid-year 2014 was 6.4 percent, slightly higher than the US rate of 6.2 percent. The median household income in South Carolina was \$44,779 (\$8,000 below the US median income of \$53,046).

**Housing**

According to the US Census, 68 percent of the state’s homes were owned. The S.C. Council on Homelessness estimates there were 5,040 homeless adults and children in 2014.

**Summary**

South Carolina, as many southern states, ranks high for poverty, low educational attainment and uninsured population compared to other US states. These factors can affect one’s ability to access prevention and health care services and adhere to regimens for treatment and care of diseases that may lead to more severe consequences.

## What is the impact of HIV/AIDS on the population?

In the United States, HIV/AIDS remains a significant cause of illness, disability, and death, despite declines in new AIDS cases and deaths. Current surveillance activities provide population-based HIV/AIDS data for tracking trends in the epidemic, targeting and allocating resources for prevention and treatment services, and planning and conducting program evaluation activities.

In South Carolina, AIDS cases have been reported since 1981, and confirmed cases of HIV infection have been reportable since February 1986. During the calendar year of 2013, according to the CDC HIV/AIDS Surveillance Report, South Carolina ranked 13th among states, the District of Columbia, and U.S. dependent areas with an AIDS case rate of 10.5 per 100,000 population (*the first time S.C. has not been in the top 10 states*). The epidemic is continuing to grow with an average of 70 cases of HIV infection reported each month during 2014. As of December 31, 2014, among South Carolina residents 16,222 people have been reported living with HIV infection (including AIDS). The incidence rate in South Carolina for 2014 is 17.4 per 100,000 population.

This section summarizes the overall toll of the epidemic in South Carolina based on total reported HIV/AIDS cases and deaths.

### Gender

Figure 2.01 shows the impact of HIV on the men and women in South Carolina. Men unequivocally are disproportionately affected by HIV/AIDS. Men make up 49 percent of South Carolina's total population, but comprise 71 percent of PLWHA (prevalence). HIV/AIDS diagnosed cases during the two-year period 2013-2014 gives an estimate of more recent infections or potentially emerging populations.

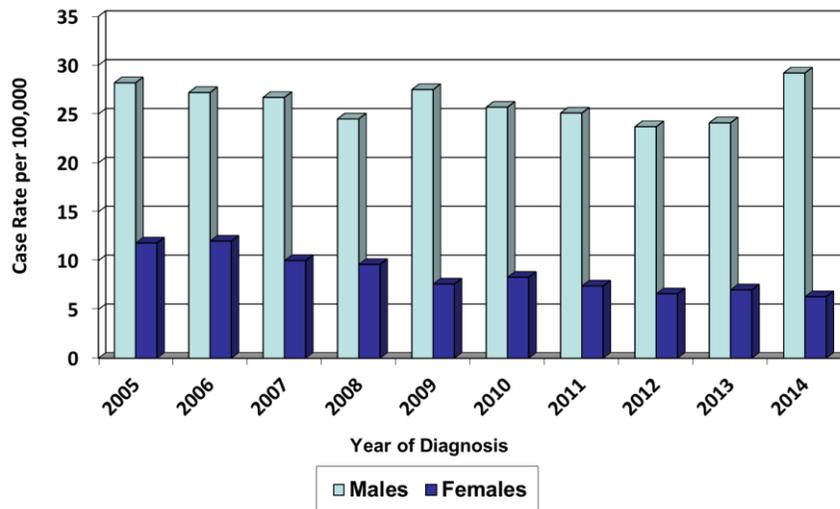
**Figure 2.01: Disproportionate S.C. HIV impact by sex**

SEX	S.C. Total Population, 2014 est.		Total Estimated Living With HIV/AIDS, 2014		Total HIV/AIDS Diagnosis, 2013-2014	
	No.	%	No.	%	No.	%
Male	2,349,394	49%	11,482	71%	1,243	79%
Female	2,483,088	51%	4,740	29%	328	21%
Total	4,832,482		16,222		1,571	

## Epidemiologic Profile

Figure 2.02 shows the rate per 100,000 population for males and females diagnosed with HIV/AIDS from 2005 to 2014. The graph shows how the case rate fluctuates from year-to-year for both men and women. The rate for females has a downward trend, and the rate for 2014 was 10 percent lower than the rate in 2013. For males, the rate has more pronounced fluctuations; with the rate for 2014 being 21 percent higher than the rate in 2013.

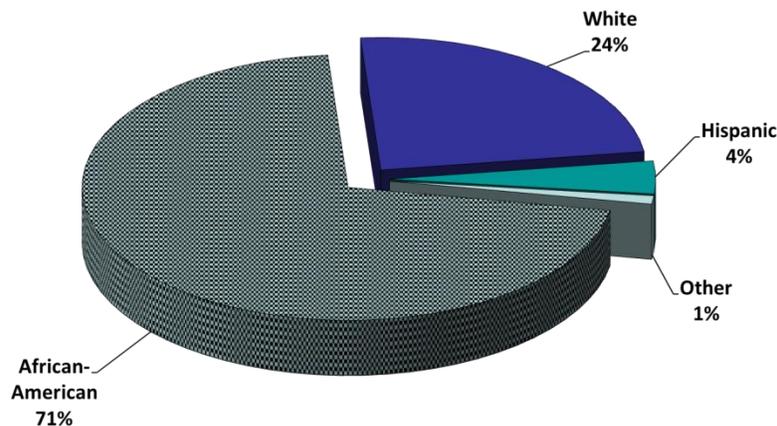
**Figure 2.02: S.C. HIV/AIDS case rate per 100,000 for males and females, 2005-2014**



### Race/Ethnicity

African-Americans are disproportionately impacted by HIV/AIDS in South Carolina. African-Americans comprise 28 percent of the state's total population, yet 71 percent of the total people living with HIV are African-American. Four percent of total cases are Hispanics, who comprise five percent of the state's population (Figure 2.03).

**Figure 2.03: Proportion of persons living with HIV/AIDS by race/ethnicity, 2014**



## Epidemiologic Profile

African-American men, who comprise only 13 percent of the state’s population, make up the largest proportion of both PLWHA in 2014 and new diagnosis in 2013/2014 (48 percent and 54 percent respectively).

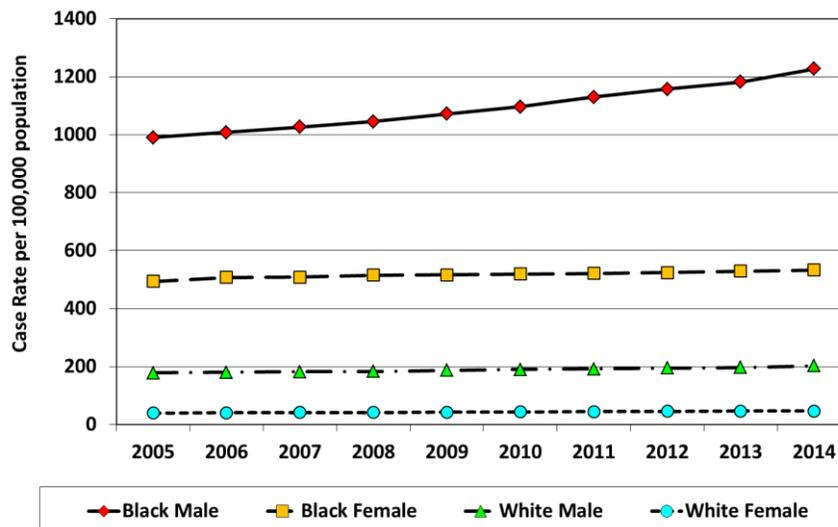
African-American women, who similarly comprise 15 percent of the population, make up 24 percent of PLWHA in 2014 and 16 percent of new diagnosis in 2013/2014. Whites, who comprise the largest proportion of the population in South Carolina (32 percent males; 33 percent females), make up 24 percent of PLWHA in 2014 (19 percent males; five percent females) and 23 percent of new diagnosis in 2013/2014 (19 percent males; four percent females), (Figure 2.04).

**Figure 2.04: Disproportionate HIV impact by race/ethnicity/gender, S.C.**

Race/Ethnicity & Gender	SC Total Population		Total Persons Living With HIV/AIDS, 2014		Total HIV/AIDS Diagnosis, 2013-2014	
	No.	%	No.	%	No.	%
Black Males	632,321	13%	7,760	48%	847	54%
Black Females	716,223	15%	3,815	24%	247	16%
White Males	1,528,126	32%	3,103	19%	297	19%
White Females	1,594,167	33%	742	5%	59	4%
Hispanic Males	141,679	3%	459	3%	60	4%
Hispanic Females	120,073	2%	122	1%	13	1%

Each year the number of all people living with HIV/AIDS continues to grow. Case rates per 100,000 by race and gender show the disparate burden of HIV among African-Americans. As Figure 2.05 shows, the rate per 100,000 population in 2014 is six times higher for black males than for white males, and eleven times higher for black females compared to white females.

**Figure 2.05: S.C. HIV/AIDS prevalence rates by race/gender, 2005-2014**

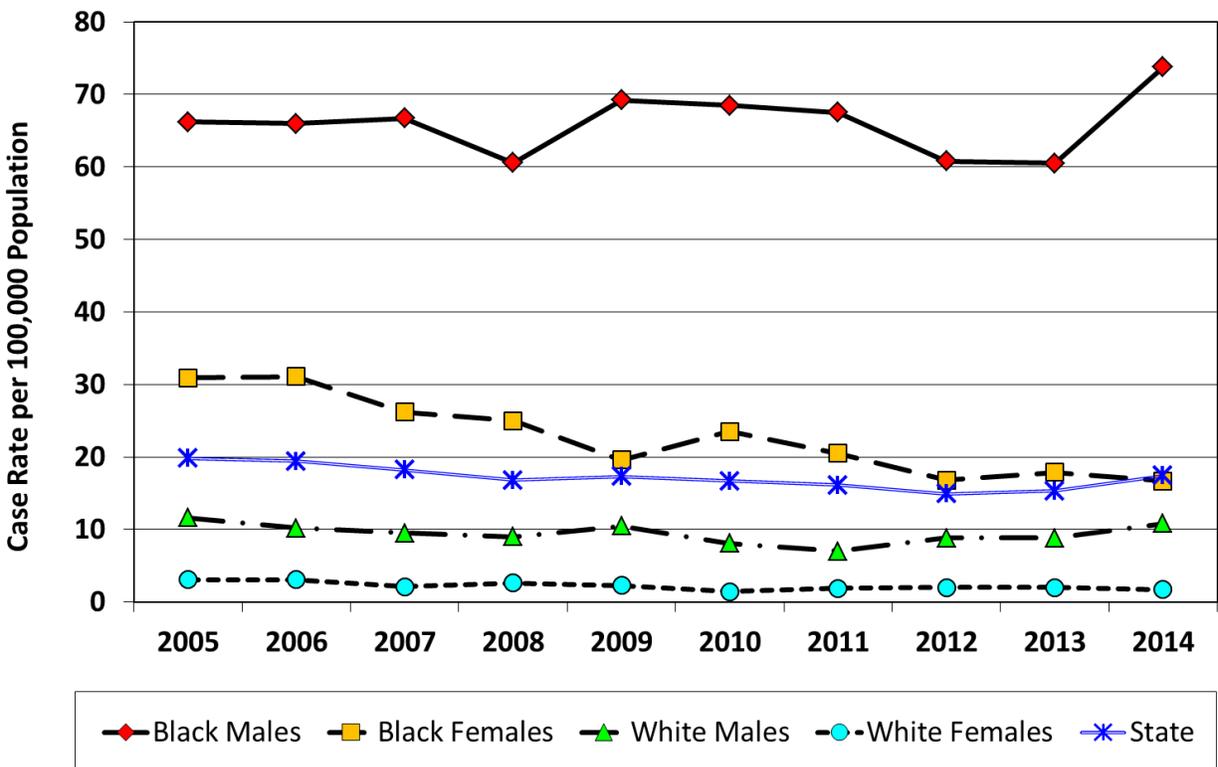


In South Carolina, the trend in the number and rate of people newly diagnosed with HIV/AIDS each year has been declining; with a 12 percent decrease in the rate per 100,000 population between 2005 (19.8) and 2014 (17.4). However, during this ten year time period, there have been high and low fluctuations from one year to the next; the 2014 rate is 14 percent higher than the rate in 2013 (15.3). There are also important differences in the rates among race/gender populations (Figure 2.06).

Women have seen the sharpest decline in rate of newly diagnosed HIV/AIDS. The rate for African-American women has decreased 46 percent between 2005 (30.9) and 2014 (16.7) and the rate for white women has decreased 45 percent over the same time period (3.1 to 1.7). Even in 2014 when the state rate increased from 2013, the rate for women decreased; seven percent for African-American women (17.9 to 16.7) and 15 percent for white women (2.0 to 1.7).

Men have not seen the same decline in the rate of newly diagnosed HIV/AIDS as women have; the rate in 2014 for African-American males (73.8) is 11 percent higher than the rate in 2005 (66.2), while the rate for white males decreased seven percent over the same time period (11.6 to 10.8). From 2013 to 2014, the rate of newly diagnosed HIV/AIDS increased for both African-American males (60.5 to 73.8) and white males (8.8 to 10.8), a 22 percent and 23 percent increase (respectively).

**Figure 2.06: S.C. HIV/AIDS case rates by race/gender and year of diagnosis, 2005-2014**



**Age**

People between the ages of 20 and 44 are disproportionately impacted. They make up 32 percent of the total population yet they represent about 42 percent of PLWHA and 67 percent of newly diagnosed cases (Figure 2.07).

**Figure 2.07: Disproportionate S.C. HIV impact by age**

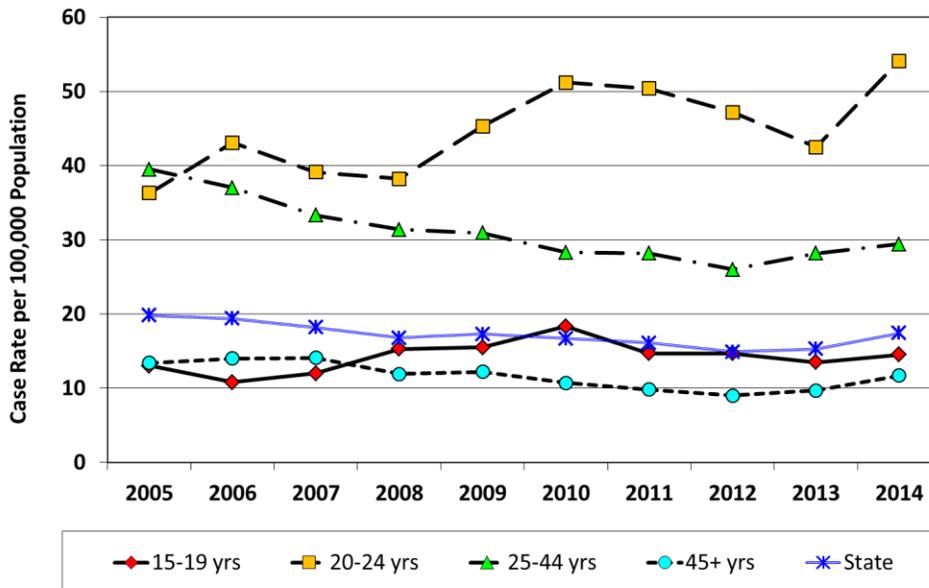
Age Range	SC Population		Total Persons Living with HIV/AIDS, 2014		Total HIV/ AIDS Diagnosis, 2013-2014	
	No.	%	No.	%	No.	%
<15 Years	903,343	19%	46	0.3%	10	0.6%
15-19 Years	310,676	6%	81	0.5%	87	6%
20-24 Years	352,705	7%	749	5%	342	22%
25-44 Years	1,223,680	25%	5,971	37%	701	45%
45+ Years	2,042,078	42%	9,375	58%	431	27%

Figure 2.08 shows HIV/AIDS case rates by year of diagnosis for selected age groups. Between 2005 and 2014, people 15-24 had the largest increase in the rate of newly diagnosed HIV/AIDS.

The rate for people 20-24 years of age increased 49 percent from 2005 (36.3) to 2014 (54.1) and the rate for people 15-19 increased 12 percent over the same time period (13.0 to 14.5).

While people age 25-44, and 45 and over, saw a decrease in the rate of newly diagnosed HIV/AIDS over the same ten year time period. The rate in 2014 for people age 25-44 (29.4) is 27 percent lower than the rate in 2005 (39.5), and the rate for people age 45 and over decreased 13 percent from 2005 to 2014 (13.4 to 11.7). From 2013 to 2014, the rate of newly diagnosed HIV/AIDS increased for all age groups. For people age 15-19, there was a seven percent increase (13.5 to 14.5), people age 20-24 had the highest increase of 27 percent (42.5 to 54.1), people age 25-44 had the smallest increase at four percent (28.2 to 29.4), and people age 45 and over had the second highest increase of 21 percent (9.7 to 11.7).

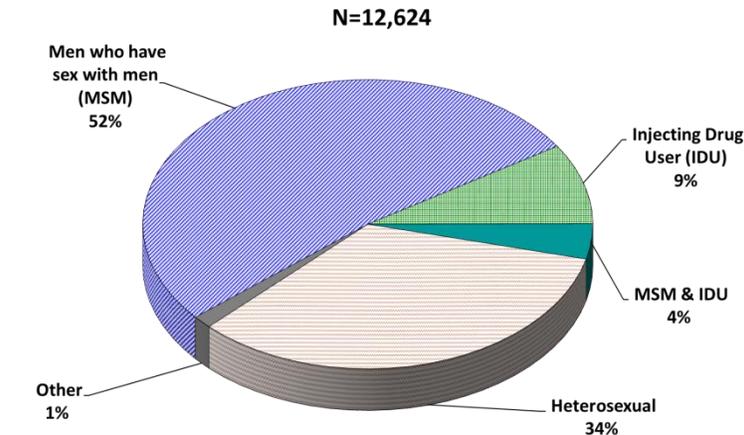
**Figure 2.08: S.C. HIV/AIDS Incidence case rate by year of diagnosis and age, 2005-2014**



**Risk Exposure**

Of the cases with an identified risk factor, men who have sex with men was the highest reported risk factor in 2014 for PLWHA (52 percent). Heterosexual contact accounted for 34 percent of reported risk factors. Nine percent reported a risk of injecting drug use (IDU). Four percent reported the combined risks of MSM and IDU (Figure 2.09).

**Figure 2.09: Proportion of persons living with HIV/AIDS by risk exposure, 2014**

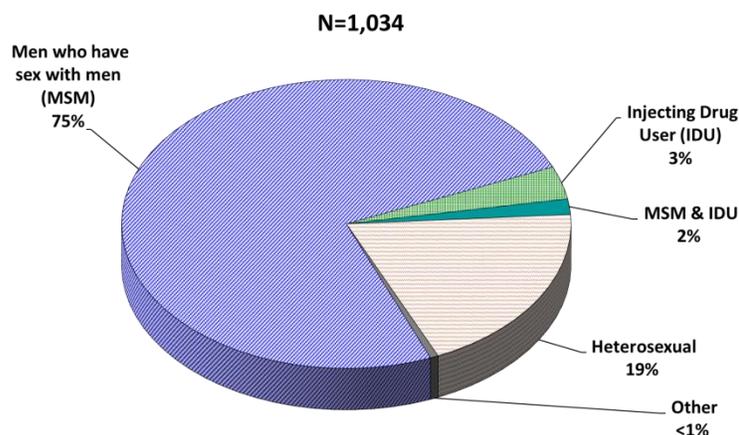


Note: Total excludes cases with no risk identified.

Other risks include blood transfusions, hemophilia, and perinatal transmission; all of which account for a very small proportion of PLWHA. Of the total estimated number of PLWHA in 2013, 22 percent had no risk identified.

Figure 2.10 shows reported risk for people newly diagnosed with HIV/AIDS during 2013-2014. The proportion of new cases with a reported risk of MSM was 75 percent and with a reported risk of heterosexual contact was 19 percent; IDUs made up three percent and the combined risk of MSM and IDU two percent. Twenty-two percent of new cases had no risk identified. Over time, the proportion of cases with no risk identified in a given year decreases as risks are determined through follow-up surveillance activities.

**Figure 2.10: Proportion of HIV/AIDS cases diagnosed 2013-2014 by risk exposure**



Note: Total excludes cases with no risk identified.

## Epidemiologic Profile

The race/gender profile of newly diagnosed cases in 2013-2014 with no risk reported is relatively close to the total proportion of HIV/AIDS cases by race/gender (Figure 2.11).

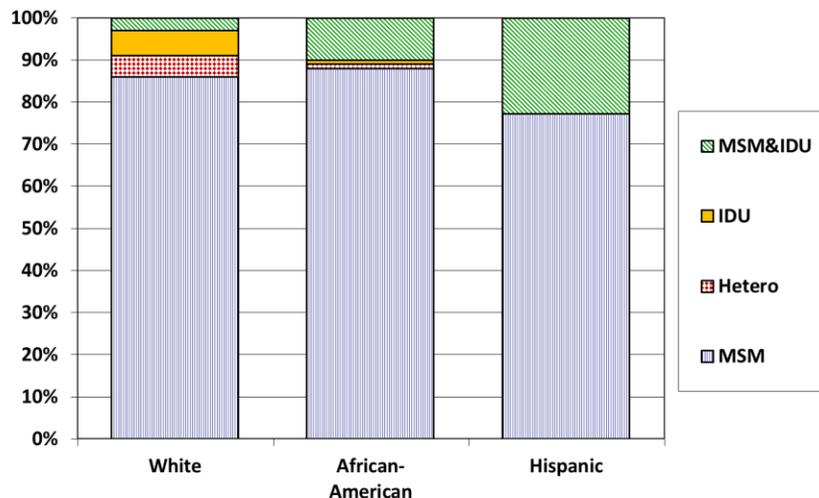
**Figure 2.11: New S.C. HIV/AIDS cases (2013-2014)  
Race/Ethnicity and Gender: Proportion of No Risk Identified  
Compared to Proportion of Reported Cases**

Race/Gender (Adult/Adolescent Cases)	New HIV/AIDS Cases 2013-2014	
	% with No Risk Identified (N=511)	% Cases Reported (N=1,523)
Black Male	48%	56%
Black Female	29%	16%
White Male	13%	20%
White Female	5%	4%
Hispanic Male	4%	4%
Hispanic Female	1%	1%

*Note: Primary reasons for risk exposure information not reported were explained in the South Carolina HIV/AIDS Surveillance System section of the introduction.*

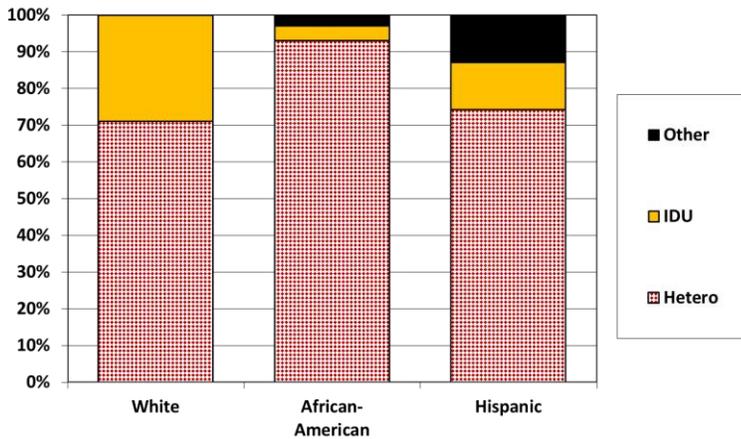
Of reported risks for newly diagnosed case in 2013-2014, among African-American men, most cases were attributed to MSM contact (88 percent) and heterosexual risk (10 percent). For white men, most cases were attributed to MSM contact (86 percent), the combined risk of MSM and IDU (six percent), IDU only (five percent), and heterosexual risk (three percent). Of Hispanic men with reported risk factors, most cases were attributed to MSM contact (78 percent) and heterosexual risk (23 percent), (Figure 2.12). Twenty-eight percent of men diagnosed in 2013-2014 had no indicated risk.

**Figure 2.12: Proportion of Male HIV/AIDS cases by exposure category, diagnosed 2013-2014**



Excludes persons with no risk reported. The exposure category "Other" = <1% for each race/ethnicity.

**Figure 2.13: Proportion of Female HIV/AIDS cases by exposure category, diagnosed 2013-2014**

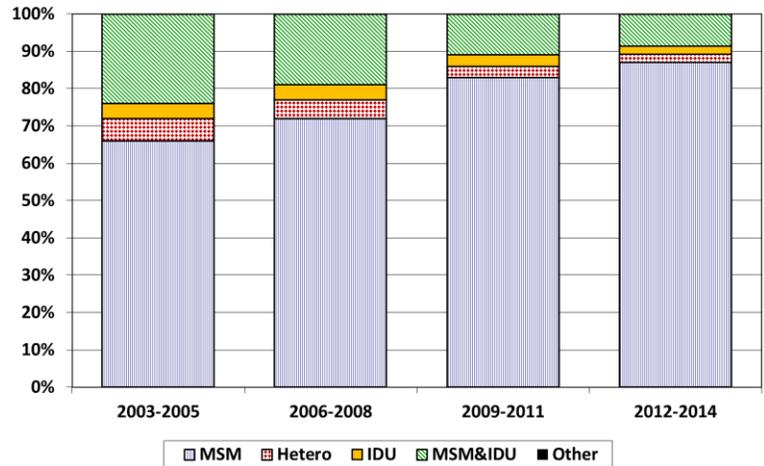


Excludes persons with no risk reported.

Among women diagnosed during 2013-2014 Heterosexual contact is the most often reported risk (87 percent). Ninety-three percent of African-American women reported Heterosexual contact as their risk, while 75 percent of Hispanic women and 71 percent of white women reported a risk of Heterosexual contact. White women report Injecting Drug Use more often (29 percent) than Hispanic women (13 percent) or African-American women (four percent), (Figure 2.13). Fifty-seven percent of women diagnosed in 2013-2014 had no indicated risk.

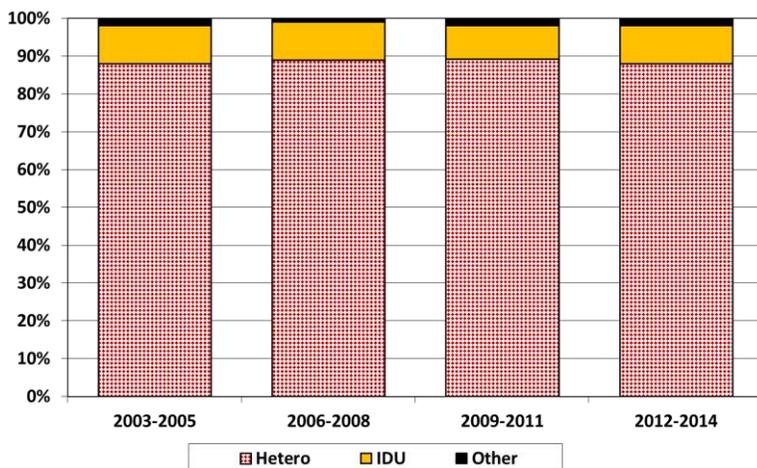
Figures 2.14 and 2.15 show the proportion of total HIV/AIDS cases diagnosed during four periods from 2003 to 2014 by sex and risk exposure category for males and females in South Carolina. The reported risk of Injecting Drug User continues to decrease for men; two percent of reported risks for 2012-2014, down 20 percent from 2009-2011.

**Figure 2.14: Proportional distribution of male HIV/AIDS cases by exposure category, diagnosed 2003-2014**



Excludes persons with no risk reported.

**Figure 2.15: Proportional distribution of female HIV/AIDS cases by exposure category, diagnosed 2003-2014**



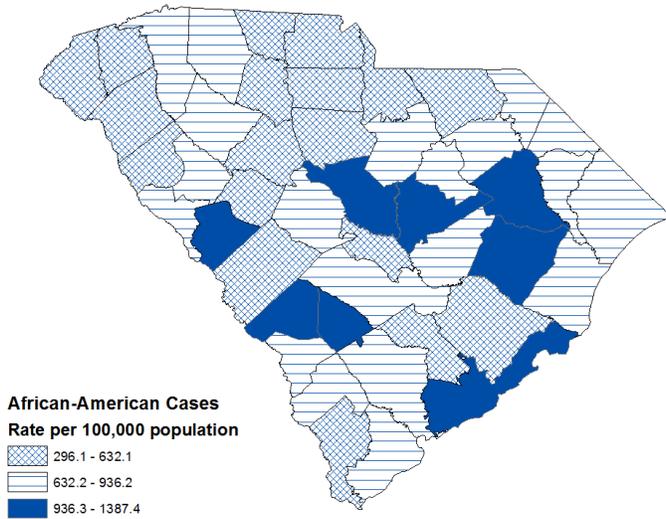
Excludes persons with no risk reported.

Women, however, saw an 18 percent increase in the reported risk of Injecting Drug User (10 percent of reported risks for 2012-2014). The proportion of heterosexual risk decreased two percent for men and one percent for women during the same time periods.

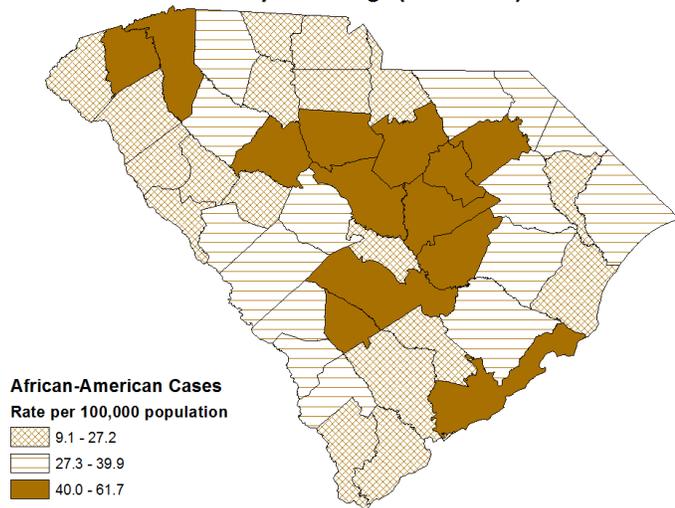
**Residence**

People living with HIV/AIDS are widespread throughout the state. Figure 2.16 shows the 2014 prevalence rate and Figure 2.17 shows the three year average (2012-2014) incidence rate for African-Americans. Twenty-eight percent of South Carolina counties have a prevalence rate greater than the state prevalence rate for African-Americans (858.3 per 100,000 population). Thirty percent of South Carolina counties have a three year average (2012-2014) incidence rate for African-American greater than the state three year average incidence rate for African-Americans (39.7 per 100,000 population)

**Figure 2.16: S.C. HIV/AIDS prevalence rates 2014**



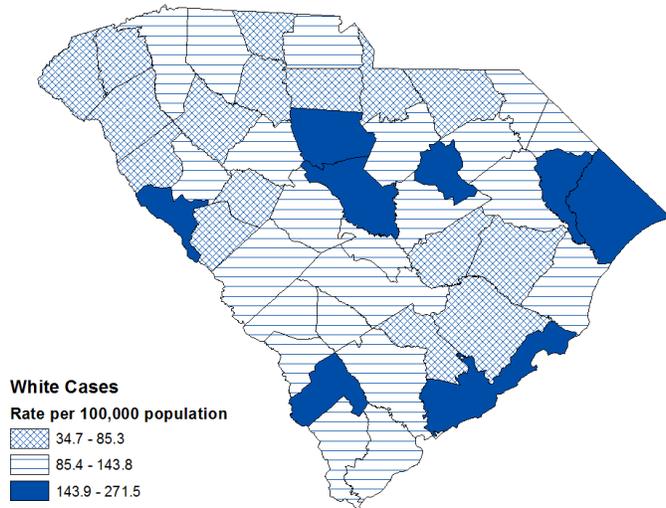
**Figure 2.17: S.C. HIV/AIDS incidence rate:  
Three year average (2012-2014)**



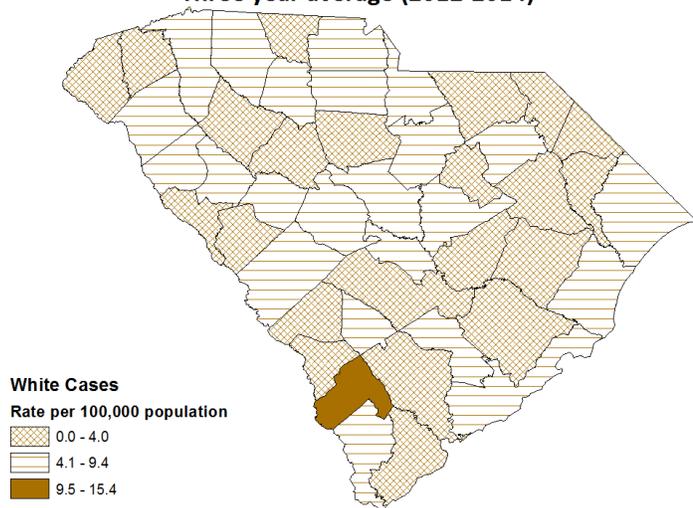
## Epidemiologic Profile

While the HIV/AIDS rate for whites in South Carolina is significantly lower than for African-Americans, the distribution throughout the state is not dissimilar. Figure 2.18 shows the 2014 prevalence rate and Figure 2.19 shows the three year average (2012-2014) incidence rate for whites. Twenty-six percent of South Carolina counties have a prevalence rate greater than the state prevalence rate for whites (123.2 per 100,000 population). Thirty-five percent of South Carolina counties have a three year average (2012-2014) incidence rate for whites greater than the state three year average incidence rate (5.6 per 100,000 population).

**Figure 2.18: S.C. HIV/AIDS prevalence rates 2014**



**Figure 2.19: S.C. HIV/AIDS incidence rate:  
Three year average (2012-2014)**



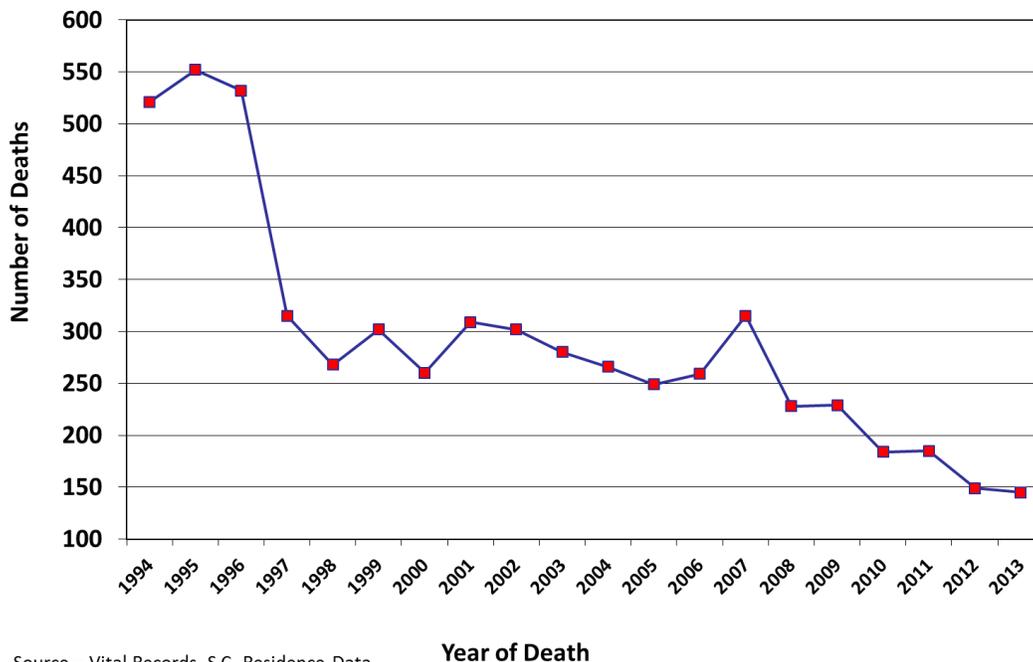
**Mortality**

With the advent of combination therapies and the use of prophylaxis, people infected with HIV are living longer and delaying the progression of AIDS, which is the advanced stage of the disease. These medications have also led to the decrease in AIDS-related deaths.

Large declines in AIDS mortality nationally essentially occurred during 1996-1997. Officials at the Centers for Disease Control and Prevention (CDC) cautiously attributed the sudden drops in deaths to new antiretrovirals, protease inhibitors, combination therapies, and increased prophylaxis for opportunistic illnesses. However, the initially reported gains were tempered by reports of demographic differentials that suggested only certain groups were benefiting from these new therapies.

Figure 2.20 shows the largest decline in deaths in South Carolina was in 1997, with AIDS related deaths dropping to 317 from 532 the previous year. Since 1997, the number of AIDS deaths per year has continued to decline; however, as seen in the graph, there are fluctuations in the number of AIDS deaths from year to year. Reasons for this may include delay in diagnosis of HIV infection until severe symptoms arise, difficulty in adherence to prescribed medical treatments, and development of viral resistance to therapy.

**Figure 2.20: Deaths Due to AIDS (HIV) in South Carolina, 1994-2013**



Source – Vital Records, S.C. Residence Data.

## Epidemiologic Profile

In addition to representing 48 percent of PLWHA, African-American males accounted for the majority of people who died from AIDS (60 percent) in 2013. African-American females accounted for 20 percent of AIDS related deaths followed by white males (18 percent). By age group, the majority of deaths occurred among people age 45 and older (64 percent) (Figure 2.21).

**Figure 2.21: Characteristics of persons who died of AIDS, 2013**

	Number	Percent
<b>Race/Sex</b>		
Black Male	85	60%
Black Female	29	20%
White Male	26	18%
White Female	2	1%
<b>Age Group</b>		
<15	1	1%
15-24	3	2%
25-44	48	33%
45+	93	64%

Source – Vital Records, S.C. Residence Data.

Public Health Region 3 and Region 4 are the areas with the highest number of deaths from AIDS in South Carolina in 2013 (Figure 2.22). These areas are also among those that have the highest prevalence of HIV/AIDS in the state.

**Figure 2.22: Number of persons who died of AIDS by health region, 2013**

Health Region	No.	%
Region 1	8	6%
Region 2	17	12%
Region 3	32	22%
Region 4	20	14%
Region 5	19	13%
Region 6	18	12%
Region 7	22	15%
Region 8	9	6%
<b>TOTAL</b>	<b>145</b>	<b>100%</b>

Source – Vital Records, S.C. Residence Data.

*Note: Vital Records 2013 data reported using eight regions.*

## Who is at risk for becoming infected with HIV?

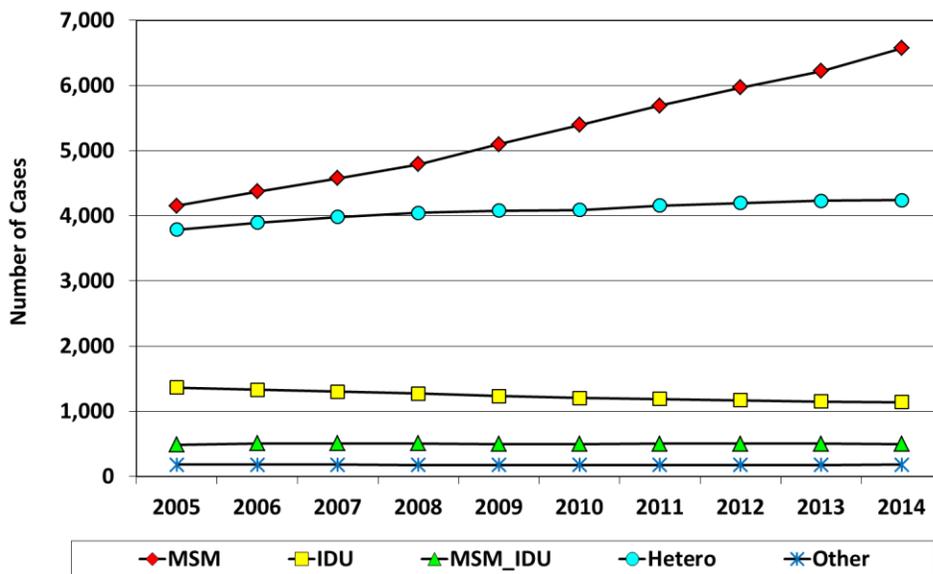
HIV can be transmitted via blood coming in contact with an infected person’s blood, breast milk, or sexual fluids. The people most likely to become infected with HIV are those who engage in high-risk behaviors which place them at greater than normal risk. Transmission happens most often during sexual or drug-using activity, and the frequency of the high-risk behavior combined with HIV prevalence in sexual or drug-using networks determines a person’s risk for becoming infected. In order to accurately target STD/HIV prevention and treatment activities, it is important for community planning groups (and program providers) to have information on the number and characteristics of people who become newly infected with HIV and people whose behaviors or other exposures put them at various levels of risk for STD and HIV infection. This section summarizes HIV infection among population groups at high risk for HIV infection, sexually transmitted disease data, and behavioral data.

### Characteristics of HIV/AIDS in People at Highest Risk

Analysis of characteristics of people with HIV/AIDS helps identify people at greatest risk for becoming infected. Risk for infection can be determined by assessing the frequency of high-risk behavior (e.g., unprotected sex, needle-sharing) in combination with the estimated prevalence of HIV/AIDS and incidence of HIV/AIDS.

Figure 3.01 shows the number of people in South Carolina living with HIV/AIDS at the end of each year by reported risk. MSM comprise the greatest number of people living with HIV, followed by heterosexuals. IDU, MSM and IDU, and other risks comprise fewer numbers.

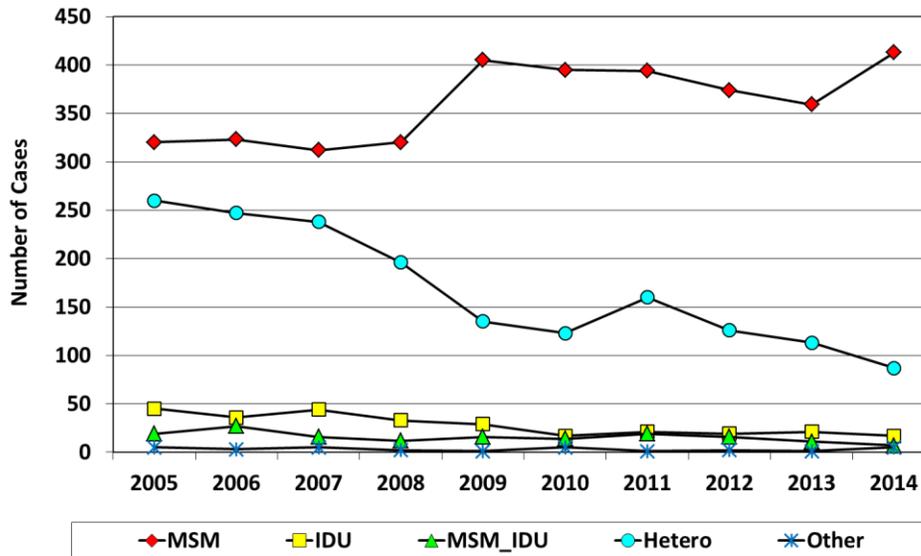
**Figure 3.01: Number of people living with HIV/AIDS by year and reported risk, 2005-2014**



Excludes persons with no risk reported.

Prior to 2005, heterosexual contact was the most often reported risk; however, beginning in 2005, more people are reporting their risk as men who have sex with men (Figure 3.02). While not validated, many local experts believe the number of heterosexuals among African-American men may be artificially high due to fears of discrimination; therefore, men do not reveal male to male sex as a risk behavior. The number of injecting drug users, and the combined risks of MSM and IDU reported each year has declined over the past decade.

**Figure 3.02: Number of new HIV/AIDS cases by year of diagnosis and reported risk, 2005-2014**



Excludes persons with no risk reported.

Based on data in this profile, the following primary populations have been identified as being at the highest risk of HIV/AIDS: men who have sex with men (MSM), high-risk heterosexuals, injecting drug users (IDUs), and men who have sex with men and injecting drug use. Women will be described in the heterosexual and injecting drug user section, and teenagers/young adults will be described within each population category.

**Men who have Sex with Men**

**Estimates of Men Who Have Sex with Men Behavior in South Carolina**

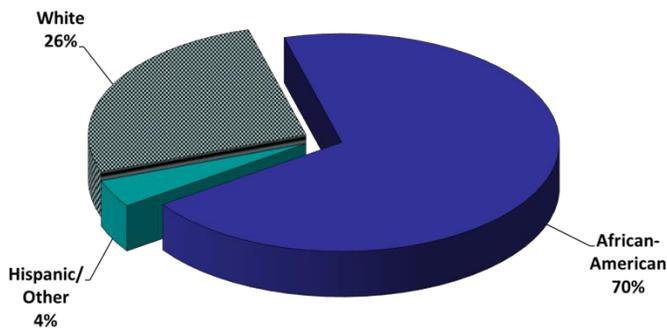
According to the U.S. Census Bureau, there are an estimated 1,543,523 males in South Carolina between the ages of 15-64, which is the age range when people are most sexually active. Review of literature and other state profiles, indicates that the estimated percentage of men who have sex with men (MSM) ranges from 2.1 percent to 10.1 percent, with the average at 2.7 percent. This would mean the number of MSM in South Carolina could be estimated to 41,675; although the estimated range is much broader.

**Characteristics of men who have sex with men**

Of PLWHA in South Carolina with a reported risk, the largest proportion is men who have sex with men (52 percent). MSM also accounted for the highest proportion (75 percent) of recently diagnosed adult/adolescent cases in 2013-2014.

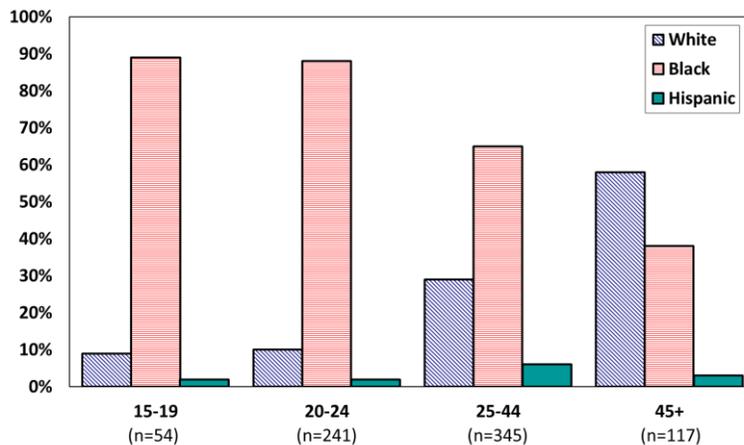
As Figure 3.03 demonstrates, the majority of MSM cases diagnosed during 2013-2014 were African-American (70 percent). White men accounted for 26 percent of the new cases and four percent were Hispanic or other races.

**Figure 3.03: Proportion of men diagnosed with HIV/AIDS in 2013-2014 who reported a risk of MSM by race/ethnicity (N=757)**



The majority of MSM diagnosed during 2013-2014, were 25-44 years of age (46 percent); 32 percent were 20-24 years old and 15 percent were 45+ years. For men recently diagnosed, African-Americans accounted for the highest proportion for each age group except those 45 and older, where whites accounted the highest proportion (58 percent) (Figure 3.04).

**Figure 3.04: Percent of MSM HIV/AIDS cases diagnosed 2013-2014 by age group & race/ethnicity (N=772)**

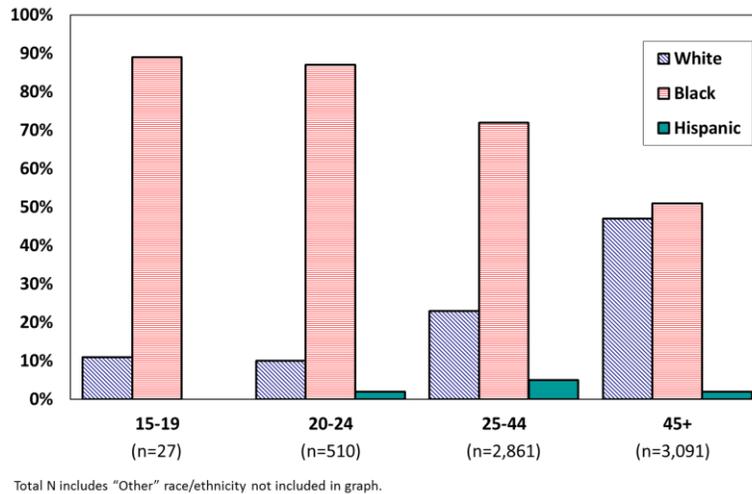


Total N includes "Other" race/ethnicity not included in graph.

## Epidemiologic Profile

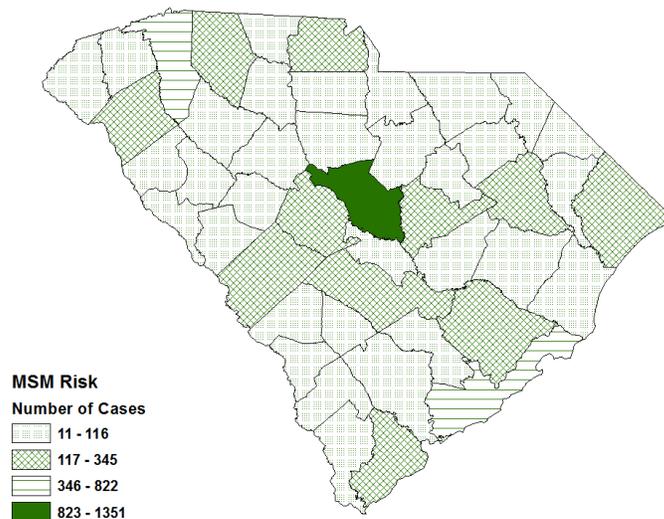
Of men who have sex with men living with HIV/AIDS in 2014, 63 percent were African-American, 34 percent were white and three percent were Hispanic men. As Figure 3.05 shows, for MSM age 15 to 44, African-Americans comprise the greatest proportion. However, among those 45 years and older, the proportion is almost equal for both white (47 percent) and African-American (51 percent) men.

**Figure 3.05: Percent of MSM living with HIV/AIDS by age/race, 2014 (N=6,570)**



Richland County has the greatest number of MSM living with HIV/AIDS in 2014 (1,351), with Greenville (822) and Charleston (605) having the next highest numbers. Most South Carolina counties had fewer than 117 MSM living with HIV/AIDS (Figure 3.06).

**Figure 3.06: S.C. HIV/AIDS 2014 prevalence**



### Summary

Among men who have sex with men, African-American men account for over half the proportion of both living with HIV/AIDS (63 percent) and newly diagnosed HIV/AIDS cases (70 percent). And of men who have sex with men under the age of forty-five, African-American men comprised 74 percent of cases living with HIV/AIDS and 75 percent of newly diagnosed HIV/AIDS.

## High Risk Heterosexuals

### Estimates of High-Risk Heterosexual Behavior in South Carolina

It is difficult to make an assessment of the number of people in South Carolina who engage in heterosexual contact that puts them at high risk for becoming infected with HIV. While there are some differences in the population of people with HIV/AIDS and the population of those with a non-HIV STD, most experts acknowledge that a diagnosis of an STD would suggest the individual is engaging in unsafe sexual practices. During 2014, 27,120 cases of chlamydia, 7,944 cases of gonorrhea and 249 cases of infectious syphilis were reported in South Carolina. More data on STDs, as well as other behavioral indicators such as teenage pregnancy and condom use, is described later.

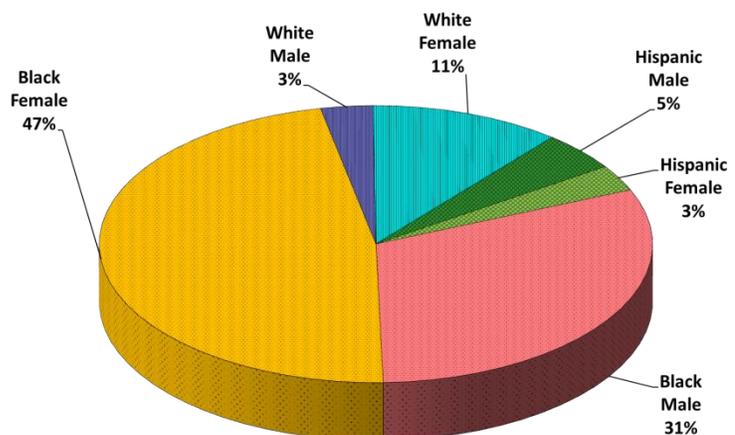
In order for a case of HIV or AIDS to be considered as heterosexual transmission, it must be reported that the individual had heterosexual contact with a person who has documented HIV infection or AIDS, or had heterosexual contact with a person who is in a high risk group for HIV (MSM or IDU).

### Characteristics of high risk heterosexuals

People with documented high-risk heterosexual contact comprise 34 percent of the total adult/adolescent PLWHA at the end of 2014 and 19 percent of people more recently diagnosed during 2013-2014 (excluding people with no risk identified for both new and prevalent cases). Of PLWHA in 2014 who reported a risk of heterosexual contact, almost half were African-American women (47 percent), 31 percent were African-American men, 11 percent were white women, and three percent were white men. The number of heterosexual cases diagnosed has decreased 29 percent from 2010 to 2014.

Figure 3.07 shows that African-American men and women comprise a disproportionate 78 percent of recently diagnosed heterosexual HIV/AIDS cases. African-American women account for 47 percent of recent cases and white women account for 11 percent. Thirty-one percent are African-American men while white men account for only three percent of recent cases with a reported risk of heterosexual contact.

**Figure 3.07: Proportion of heterosexual HIV/AIDS cases by race/ethnicity, diagnosed 2013-2014 (N=197)**



## Epidemiologic Profile

**Figure 3.08: S.C. HIV/AIDS cases attributed to heterosexual transmission, by sex and year of diagnosis**

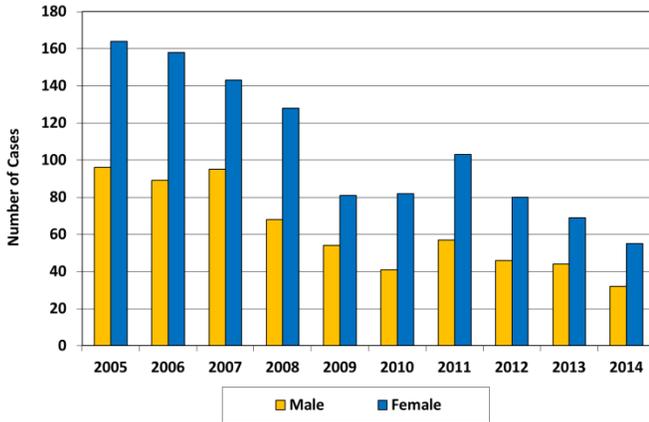
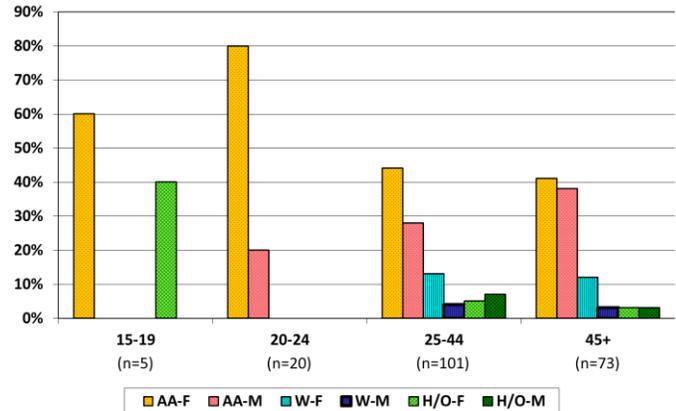


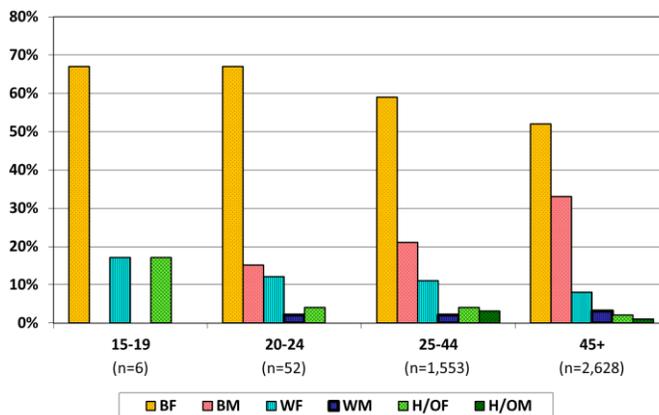
Figure 3.08 shows the number of heterosexually acquired HIV cases in men and women in South Carolina from 2005 to 2014. During most of this period, the proportion of female cases averaged 72 percent higher than males. The number of men and women reporting heterosexual risk has steadily decreased over the past several years. 2011 saw a slight increase; however, the numbers have continued to decline since.

The majority of high risk heterosexuals diagnosed in 2013-2014 were 25-44 years of age (51 percent); 37 percent were 45 years and older and 13 percent under 25 years. African-American women and men comprised the greatest proportion of cases in each age group (Figure 3.09). Among young women less than 45 years of age, newly diagnosed with HIV/AIDS, eight out of every ten are African-American.

**Figure 3.09: Percent heterosexual S.C. HIV/AIDS cases diagnosed 2013-2014 by age/race/sex (N=199)**



**Figure 3.10: Percent of heterosexuals living with HIV/AIDS by age group and race/ethnicity/gender, 2014 (N=4,239)**



Eight of every ten women under age 25 living with HIV/AIDS are African-American. Within the 25 to 44 age group, African-American women comprise the largest proportion (59 percent). Of PLWHA in 2014 who reported a risk of heterosexual contact, 62 percent were age 45 and over; African-American women comprised the greatest proportion (52 percent), followed by African-American men (33 percent) (Figure 3.10). White men and women account for 12 percent of PLWHA who reported a risk of heterosexual contact across all age groups.

# Epidemiologic Profile

**Figure 3.11: S.C. HIV/AIDS 2014 prevalence**

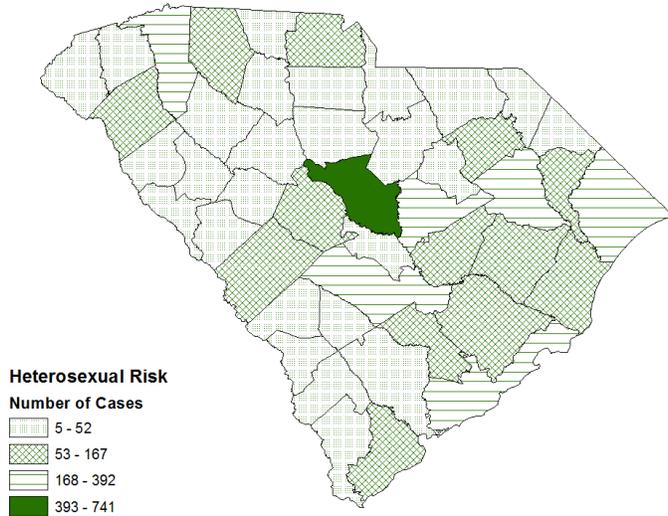
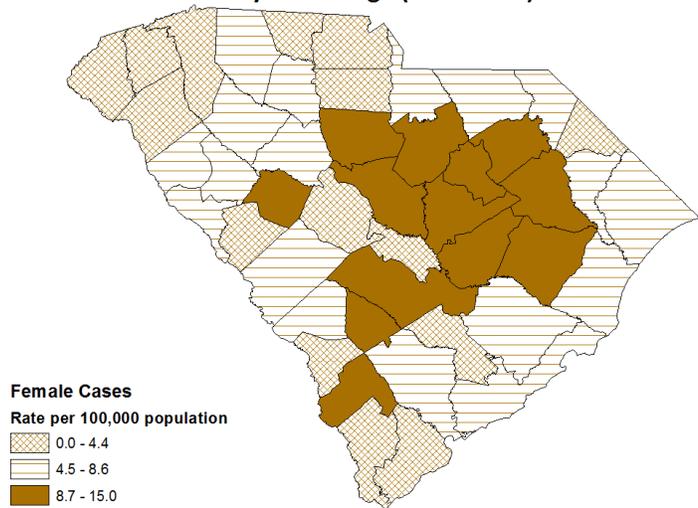


Figure 3.11 shows the counties with the highest prevalence of PLWHA due to heterosexual transmission. Richland county has the highest number of reported cases (741), followed closely by Charleston, Florence, Greenville, Horry, Sumter, and Orangeburg. Eighty-five percent of South Carolina counties each have less than 168 reported cases.

Figure 3.12 shows the case rate for 2012-2014 among women, an indicator for more recent heterosexual risk. Lee and Orangeburg counties have the highest case rates in the state (15.0 and 14.6 per 100,000 population respectively). Seventy-two percent of counties have case rates below 8.6 (the state rate is 6.6).

**Figure 3.12: S.C. HIV/AIDS incidence rate:  
Three year average (2012-2014)**



## Summary

Among heterosexually exposed cases, African-American women account for almost half of newly diagnosed HIV/AIDS cases (47 percent) and African-American men account for 30 percent. Among people living with HIV/AIDS with a reported risk of heterosexual contact, African-American women account for 55 percent and African-American men account for 29 percent. African-American men and women 25-44 years of age account for eight out of every ten PLWHA and seven out of every ten people diagnosed in 2013-2014.

## Injecting Drug Users

### Characteristics of Injecting Drug Users (IDU)

Injecting drug users' account for nine percent of people living with HIV/AIDS in 2014 and four percent of people recently diagnosed with HIV/AIDS during 2013-2014.

The number of new HIV/AIDS diagnosis with a reported risk of injecting drug use has averaged about 16 per year over the last ten years. Historically, men have accounted for the largest proportion of those reporting injecting-drug-use as their risk; however, between 2011 and 2013, women outnumbered men. With 2014 data men once again accounted for the largest proportion of IDU: 88 percent (Figure 3.13).

**Figure 3.13: Number of HIV/AIDS cases due to injecting drug use by sex and year of diagnosis, 2005-2014**

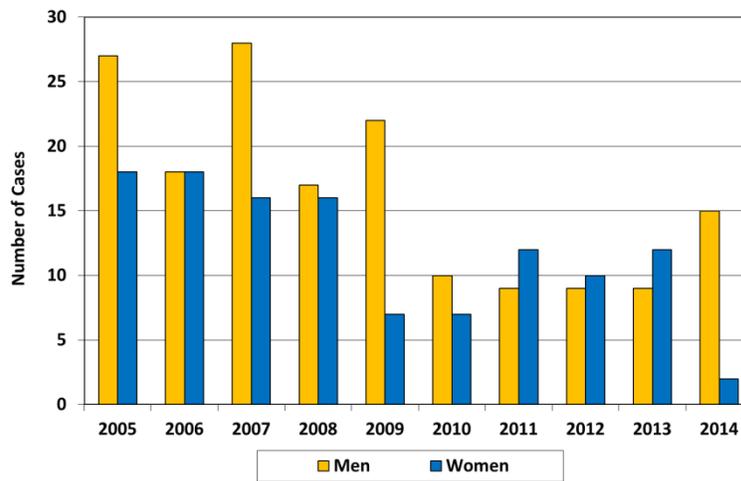
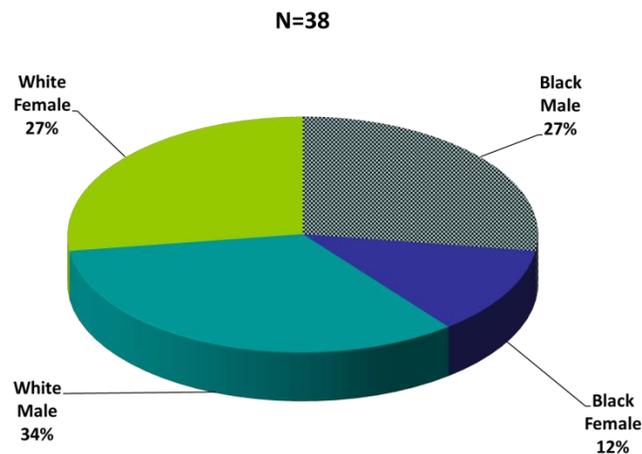


Figure 3.14 shows the race and gender proportions of recently diagnosed (2013-2014) IDU cases. Whites comprise the largest proportion 61 percent and African-Americans 39 percent. White males are the highest proportion (34 percent), while white women and African-Americans males account for 27 percent each; African-American women accounted for 12 percent.

**Figure 3.14: Proportion of injecting drug users diagnosed with HIV/AIDS 2013-2014 by race/sex**

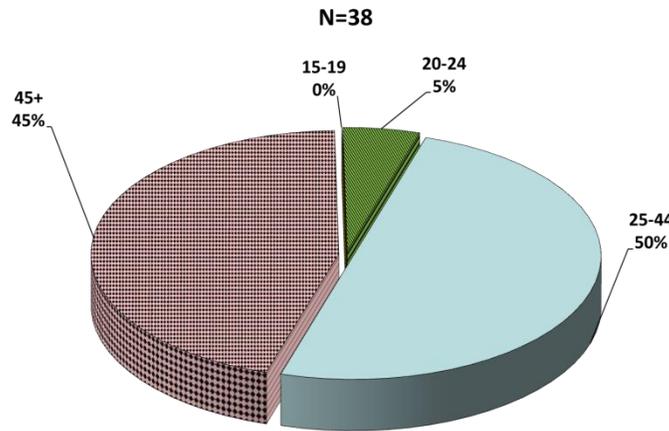


Total N includes other race/sex not included in graph.

## Epidemiologic Profile

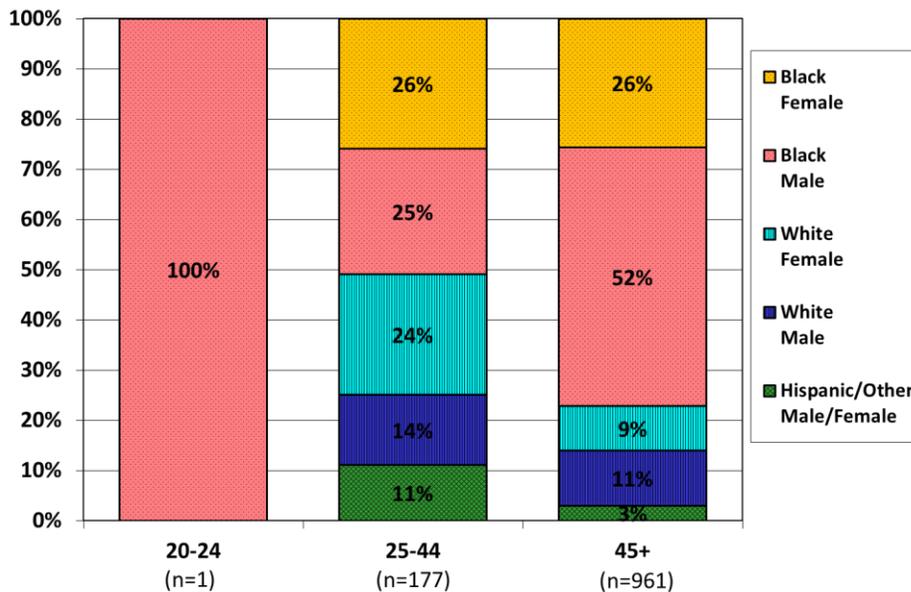
Figure 3.15 shows that 50 percent of IDU cases diagnosed in 2013-2014 are age 25-44 and 45 percent are age 45 and over.

**Figure 3.15: Percent of injecting drug users diagnosed with HIV/AIDS 2013-2014 by age group**



Of PLWHA with IDU as identified risk factor, most (84 percent) are 45 years of age and older. African-Americans account for the greatest proportion of cases over the age of 45, with African-American women accounting for 52 percent and African-American men accounting for 26 percent. Within the 25-44 age group, African-American women account for the greatest proportion (26 percent) and African-American men the next highest proportion (25 percent), followed by white women at 24 percent. (Figure 3.16).

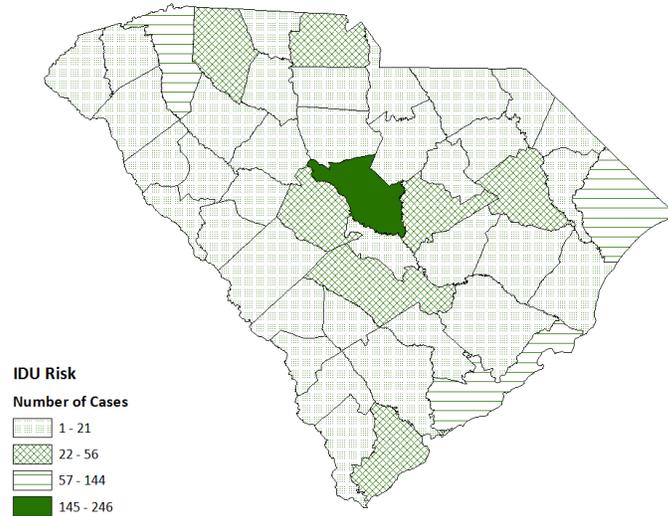
**Figure 3.16: Percent of IDU persons living with HIV/AIDS by race/sex and age group, 2014 (N=1,139)**



## Epidemiologic Profile

Figure 3.17 shows Richland County has the highest number of PLWHA with IDU as identified risk factor. As with other risks, the more urban counties have the greatest numbers.

**Figure 3.17: S.C. HIV/AIDS 2014 prevalence**



### **Other Populations at Risk**

Other populations at varying risk for HIV are described below and include people with sexually transmitted diseases, infants and children, and pregnant teen age women.

### **People with Sexually Transmitted Diseases (STDs)**

STDs are primary risk factors for HIV infection and a marker of high risk, unprotected sexual behavior. Many STDs cause lesions or other skin conditions that facilitate HIV infection. Trends in STD infection among different populations (e.g. adolescents, women, men who have sex with men) may reflect changing patterns in HIV infection that have not yet become evident in the HIV/AIDS caseload of a particular area.

**Chlamydia**

Figure 3.18 shows the increase in chlamydia over the last decade; some of this increase may be attributed to initiating routine screening for all young women attending family planning and STD clinics in health departments statewide. In 2014, there were 27,120 cases of chlamydia diagnosed in South Carolina. Among those cases with a reported race, 52 percent were African-American women and 20 percent were white women. African-American men comprised 21 percent of chlamydia cases, and white men accounted for six percent. Thirty-four percent of chlamydia cases have ‘Unknown’ race; this is attributed to the fact that these conditions are primarily reported by labs, which frequently do not collect a race.

**Figure 3.18: South Carolina count of reported Chlamydia cases by year of diagnosis, 2005-2014**

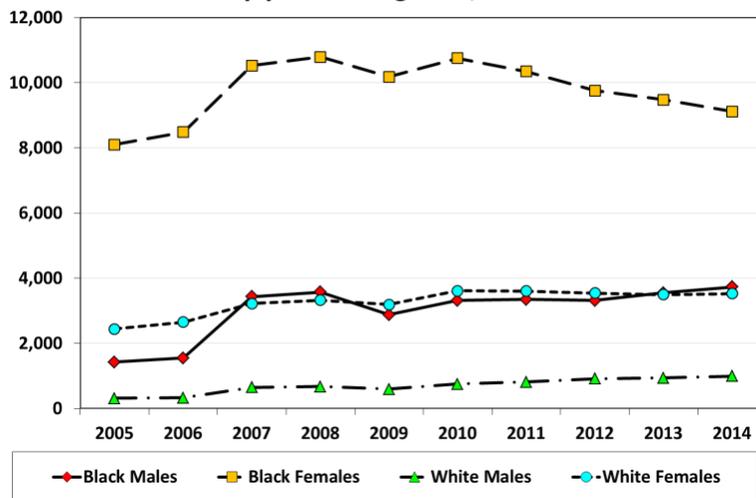
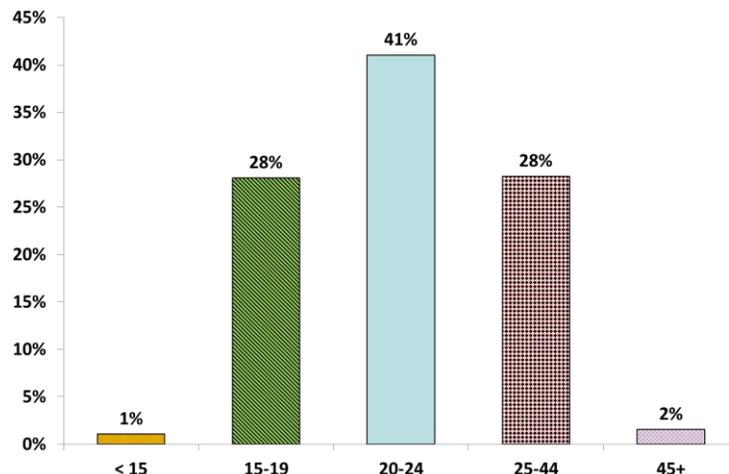


Figure 3.19 shows that in 2014, young adults 20-24 make up the highest proportion of chlamydia cases (41 percent) in the state. In 2014, Persons age 19 and under, and 25 to 44, each accounted for 28 percent of chlamydia cases.

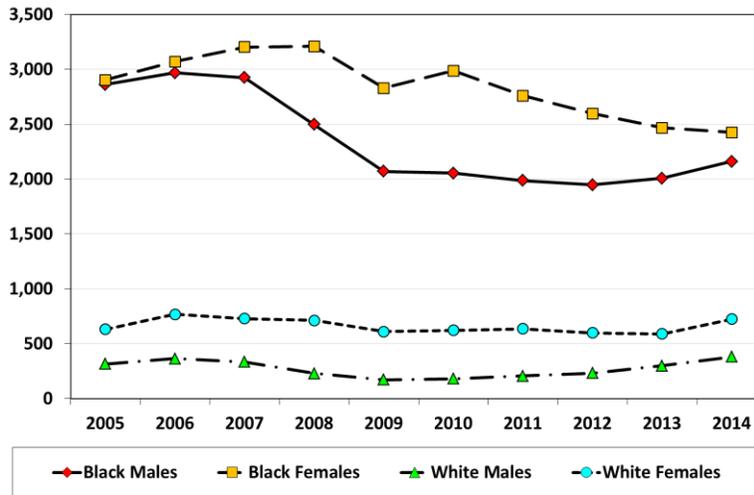
**Figure 3.19: Proportion of 2014 Chlamydia cases by age group**



**Gonorrhea**

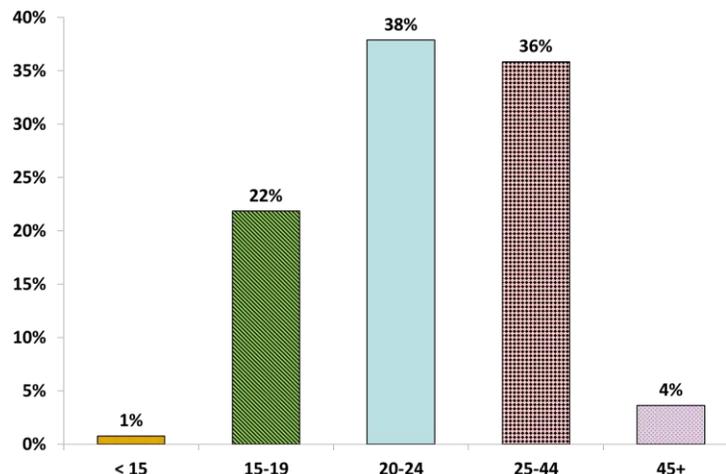
In 2014, 7,944 gonorrhea cases were diagnosed. Of cases with a reported race, African-American men and women account for 81 percent of reported cases; African-American women 43 percent and African-American men 38 percent. As with chlamydia, twenty-seven percent of reported gonorrhea cases have an 'Unknown' race. Figure 3.20 shows trends among reported race/gender by year.

**Figure 3.20: South Carolina count of reported gonorrhea cases by year of diagnosis, 2005-2014**



Gonorrhea cases most affect young adults under the age of 25 (60 percent of total). Thirty-eight percent of cases in 2014 were to people age 20-24, with people age 19 and under comprising 22 percent. People 25-44 comprised 36 percent of reported cases (Figure 3.21).

**Figure 3.21: Proportion of 2014 Gonorrhea cases by age group**



**Infectious Syphilis**

In 2014, 249 cases of infectious syphilis were diagnosed; this is down from the 272 cases reported in 2013 (an eight percent decrease). The number of infectious syphilis cases in 2014 is a 58 percent increase from the number of cases reported in 2010 (158), and a 204 percent increase from 2005 (82).

**Figure 3.22: South Carolina count of reported Infectious Syphilis cases by year of diagnosis, 2005-2014**

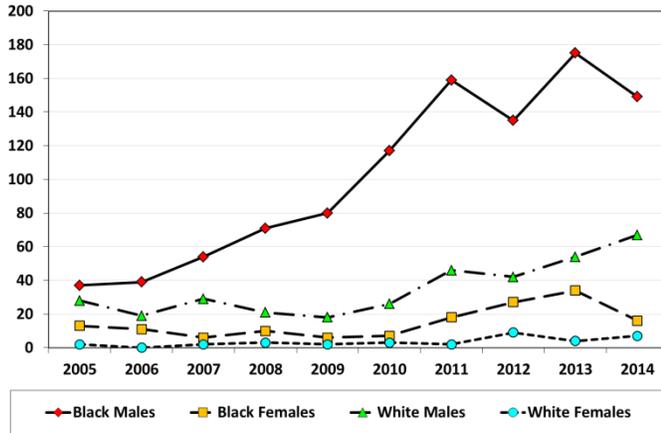
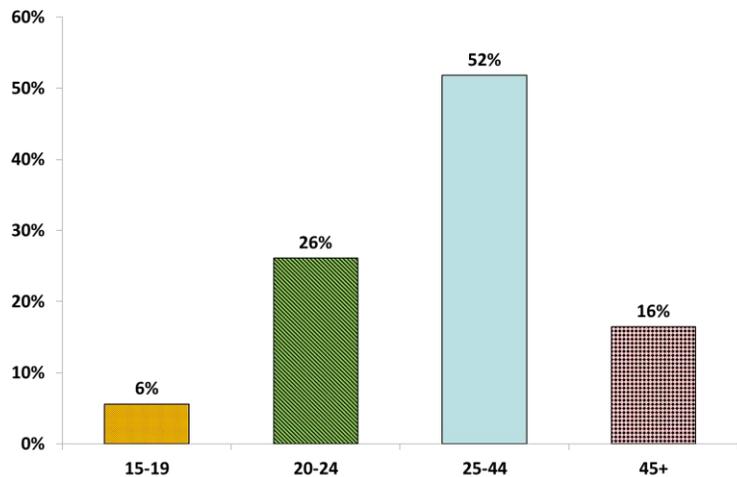


Figure 3.22 shows the number of cases in 2014 increased among white men (24 percent increase) and white women (75 percent increase) over the numbers in 2013. The number of cases decreased 15 percent for African-American men and 53 percent for African-American women over the same time period. Men continue to represent the majority of cases (91 percent); African-American men specifically, are most impacted, accounting for 60 percent of total cases, and white men accounting for 27 percent. Women account for nine percent of the total infectious syphilis cases; African-American women comprised 70 percent of women diagnosed. In 2014, less than one percent (0.4%) of infectious syphilis cases has 'unknown' or 'other' for race.

Figure 3.23 shows the proportion of 2014 infectious syphilis cases by age group. People age 25-44 comprise the largest proportion (52 percent) while people 20-24 comprised 26 percent. However, unlike chlamydia and gonorrhea where people over 45 comprise a small proportion of cases (two percent and four percent respectively), persons over 40 comprise 16 percent of infectious syphilis cases diagnosed in 2014.

**Figure 3.23: Proportion of 2014 Infectious Syphilis cases by age group**

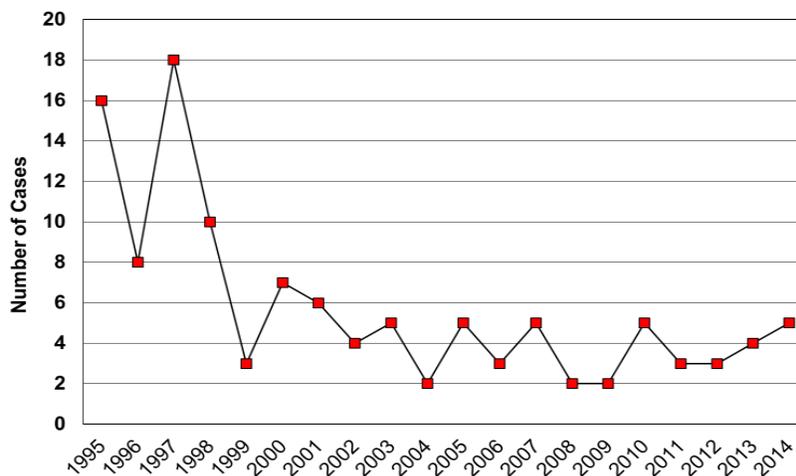


**Infants and Children: (Children under 13 years of age)**

Cumulatively, through December 2014, there have been 237 HIV infection cases diagnosed among children less than 13 years of age; this represents one percent of the total reported AIDS and HIV infection cases.

Most infants and children infected with HIV acquired it perinatally from their mother. There has been significant progress during the past twenty years in reducing the number of infants with perinatal acquired HIV infection (see Perinatally HIV exposed births below). When reporting small numbers of cases, trend graphs, such as the one in Figure 3.24, tend to display a lot of fluctuation over the given time period. The highest number of cases reported was 21 in 1993 (not on graph); the lowest number is 2 cases. There were five cases in 2014.

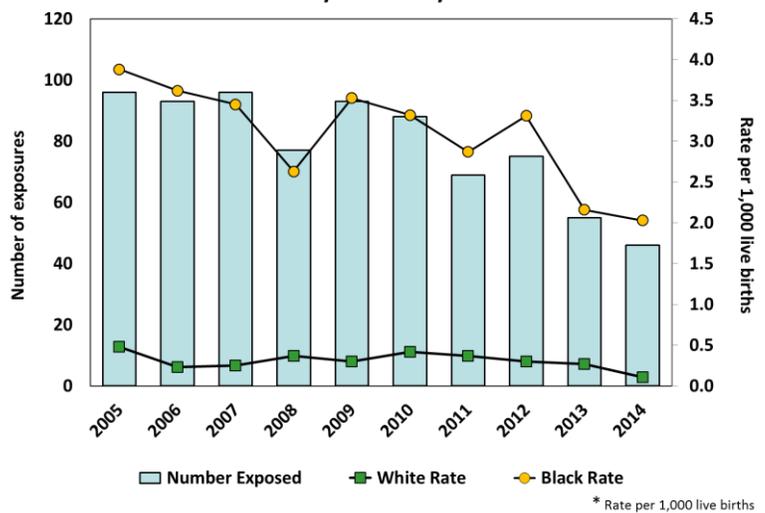
**Figure 3.24: Number of children <13 years old diagnosed with HIV/AIDS in South Carolina, 1995-2014**



**Perinatally HIV exposed births**

The number of perinatally HIV exposed births averages around 79 per year, while perinatally acquired HIV cases average one per year. This translates into 1.5 percent of perinatally HIV exposed births testing positive for HIV. Figure 3.25 shows number of perinatally HIV exposed births (values on left) and the rate by race of mother (values on right). In 2014, the exposure rate for African-American women is 19 times higher compared to white women.

**Figure 3.25: Perinatally HIV exposed births by year of birth and rate\* by race and year of birth**



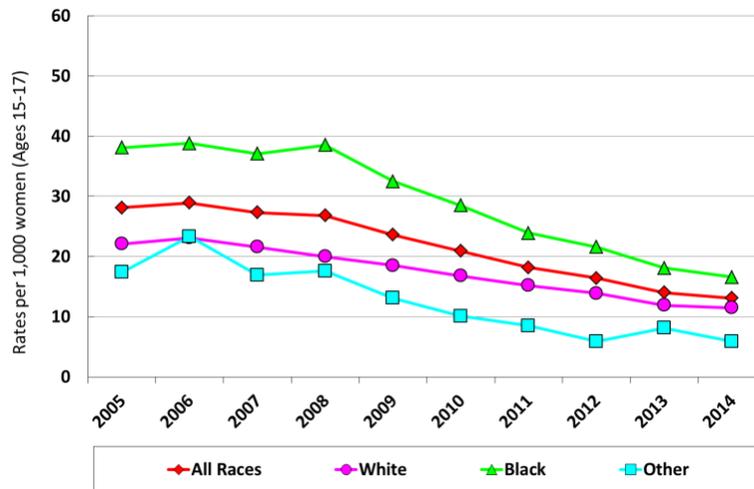
### Teenage Pregnancy

Pregnancy, birth and abortion rates, like STD rates, are indications of the extent of unprotected sexual activity in a population.

African-American girls between the ages of 10 and 14 have continued to have higher rates of live births than their white counterparts. However, the rate has decreased from 1.7 in 2005 to 0.6 per 1,000 live births in 2014.

Teenage live births among 15-17 year old South Carolinians have decreased from a rate of 28.1 per 1,000 live births in 2005 to 13.1 in 2014; a 53.4 percent decline (Figure 3.26). This success is also seen when viewing teen birth rates by racial/ethnic subgroups. The rate for white 15-17 year old teens was 22.1 in 2005 and 11.5 in 2014, representing a 48 percent decline. The rate for African-American 15-17 year old teens declined 56 percent from 38.1 per 1,000 live births in 2005 to 16.6 in 2014.

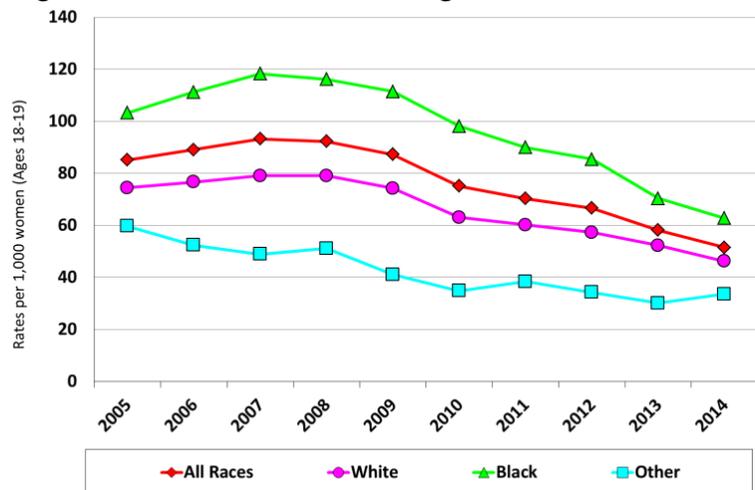
**Figure 3.26: South Carolina teens age 15 - 17 live birth rate**



Source – SCDHEC, Vital Records, SC Residence Data

Figure 3.27 shows the teen birth rates (per 1,000 live births) for 18 and 19 year olds. As with the previous age groups, African-American teenage girls continue to have higher live birth rate than other races. All races have seen an overall decrease in the live birth rates from 2010 (75.1 per 1,000 live births) to 2014 (51.5 per 1,000 live births).

**Figure 3.27: South Carolina teens age 18 – 19 live birth rates**



Source – SCDHEC, Vital Records, SC Residence Data

### **People Receiving HIV Counseling and Testing At County Health Departments**

Data from local HIV counseling and testing sites (county health departments) generally reflect similar trends as HIV/AIDS surveillance data in terms of who is most likely to be HIV infected, risk category, and county of residence. As stated in the Introduction, the data reflects only those people tested voluntarily in local health departments. This data reflects number of individuals tested, not the number of tests. In 2014, African-Americans comprised 67 percent of the total people tested, and 76 percent of the total positive. Men accounted for 31 percent of people tested and 84 percent of total positive. People 20-39 years of age represented the highest proportion tested (77 percent) and the highest proportion total positive people (71 percent). People over the age of 40 comprised 14 percent of the total people tested, and 26 percent of the total positive.

Public Health Regions (PHR) that accounted for the greatest proportion of people tested who were positive include those with the same urban counties of highest prevalence:

Lowcountry PHR (includes Charleston County) – 28 percent of total positives;

Midlands PHR (includes Richland County) - 27 percent of total positives tested;

Pee Dee PHR (includes Sumter and Florence counties) – 11 percent of total positives;

Upstate PHR (includes Greenville and Spartanburg Counties) – 29 percent of total positives;

### **Other Behavioral/Risk Data**

#### **Behavioral Risk Factor Surveillance System (BRFSS)**

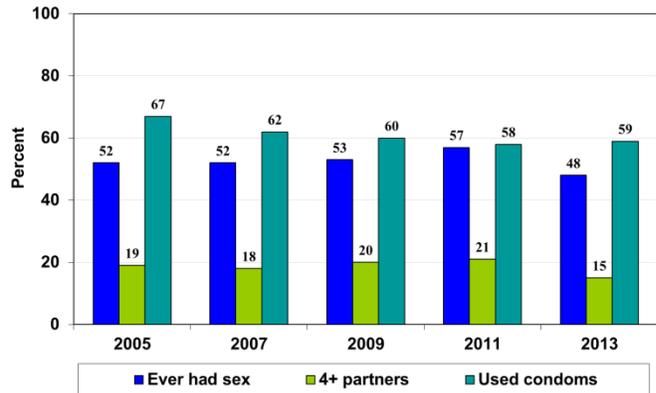
Behavior Risk Factor Surveillance System is the world's largest random telephone survey of non-institutionalized population aged 18 or older that is used to track health risks in the United States. In 1981, the Centers for Disease Control and Prevention (CDC), in collaboration with selected states, initiated a telephone based behavioral risk factor surveillance system to monitor health risk behaviors. South Carolina began administering BRFSS in 1984. Several core questions address knowledge, attitudes, beliefs, and behaviors regarding sexually transmitted diseases, particularly AIDS.

The HIV/AIDS questions for the 2010 survey focused on respondents HIV/AIDS testing history. Results show that when asked about ever being tested for HIV themselves, only 40.8 percent of respondents indicated ever being tested. African-Americans were more likely (59.9%) to have been tested than Caucasians (33.7%). Hispanics are less likely to have been tested, with only 25.1% reporting having ever been tested. Men are only slightly less likely to have been tested than women (39.5% versus 42.0%). Of those reporting having ever been tested, 14.9% reported being tested in 2010 and 59.5% reported being tested between 2005 and 2009.

**Youth Risk Behavior Survey (YRBS)**

The YRBS has been conducted in SC high schools every other year since 1991 and in middle schools since 2005. The survey is part of a national effort to monitor priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. Figure 3.28 shows the proportion of high school students who have been sexually active, report having had four or more lifetime partners, and report using a condom at last sexual intercourse (had intercourse in past 3 months). Number of partners and condom use are important because of the increased risk of exposure to HIV.

**Figure 3.28: Proportion of high school students indicating sexual risks, 2005-2013**



Source – SC Dept. of Education & CDC

**Substance Use**

Drug use is known to be a major factor in the spread of HIV infection. The Centers for Disease Control (CDC) specifically includes Injection Drug Use (IDU) as a transmission category for the classification of cases that summarizes a person’s possible HIV risk factor. IDU is considered a high risk because shared equipment (primarily used needles, but also other equipment) can carry HIV, which is drawn up into a syringe and then injected along with the drug by the next user of the syringe. Sharing equipment for using drugs can also be a means for transmitting hepatitis B, hepatitis C, and other serious diseases.

Additionally, non-injecting drug use, including methamphetamine or alcohol, is linked with unsafe sexual activity, which increases the risk of becoming infected with HIV or another sexually transmitted disease. Often, substance users have multiple sexual partners and do not protect themselves during sexual activity. Also, substance users may have an increased risk of carrying sexually transmitted diseases; this can increase the risk of becoming infected with HIV, or of transmitting HIV infection.

According to the Office of National Drug Control Policy, from the 2009-2010 National Survey on Drug Use and Health, 8.88 percent of South Carolina residents reported using illicit drugs in the past month. The national average was 8.82 percent. Additionally, 3.9 percent of South Carolina residents reported using an illicit drug other than marijuana in the past month (the national average was 3.6 percent). According to data from the El Paso Intelligence Center’s National Seizure System (EPIC-NSS), the number of meth lab seizure incidents in South Carolina increased 158%, from 130 incidents in 2008 to 335 incidents in 2011. (Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.)

## What are the patterns of service utilization of HIV-infected people?

### Ryan White Part B

In 1990, Congress enacted the Ryan White CARE Act to provide funding for states, territories and Eligible Metropolitan Areas to offer medical care and support services for people living with HIV disease who lack health insurance and financial resources for their care. Congress reauthorized the Ryan White CARE Act in 1996 and 2000 to support Titles I through IV, Special Projects of National Significance (SPNS), the HIV/AIDS Education Training Centers and the Dental Reimbursement Program, all of which are part of the CARE Act. The legislation was reauthorized again in 2006 when it became the Ryan White HIV/AIDS Treatment Modernization Act and finally in 2009 with the Ryan White HIV/AIDS Treatment Extension Act.

Ryan White Part B funding is used to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families living with HIV.

**Figure 4.01: Characteristics of Ryan White Part B clients compared to S.C. persons living with HIV/AIDS in 2014**

	Ryan White Part B Clients, N=8,749	Persons Living with HIV/AIDS, N=16,222
<b>Race/Ethnicity</b>		
White, not-Hispanic	23%	24%
Black, not-Hispanic	73%	71%
Hispanic	3%	4%
Other	1%	1%
<b>Sex</b>		
Male	67%	71%
Female	33%	29%
Transgender	<1%	---
<b>Age Group</b>		
< 24	6%	5%
25-44	38%	37%
45+	56%	58%

During 2014, 8,749 clients received services through the Ryan White Part B funds. Figure 4.01 presents the distribution of Part B clients by race/ethnicity, sex and age as well as for PLWHA in South Carolina through December 2013. Clients served through Part B are representative of the population affected with HIV/AIDS in all categories.

HRSA has directed that states should allocate funds for essential core services:

- 1) Primary Medical Care consistent with Public Health Service (PHS) Treatment Guidelines;
- 2) HIV Related Medications;
- 3) Mental Health Treatment;
- 4) Substance Abuse Treatment;
- 5) Oral Health; and
- 6) Medical Case Management.

## Epidemiologic Profile

Figure 4.02 shows a breakdown of Ryan White Part B clients who received six of the core services through funding and the average number of visits per clients. Among the 8,749 clients who received services, the majority of clients obtained medical case management services (n=7,615) followed by medical care (n=6,132), Medication Assistance (n=4,502 utilization of HIV related medications is described in the ADAP section), mental health services (n=1,094), dental care (n=908) and substance abuse services (n=464).

**Figure 4.02: South Carolina Ryan White Part B Service Utilization by Service Type, 2014**

	No. of clients receiving service	No. of visits per category	Avg. no. of visits per client
Medical Care	6,132	22,889	4
Medication Assistance (ADAP)	4,502	See SC ADAP Data	See SC ADAP Data
Oral/Dental Care	908	1,839	2
Mental Health	1,094	2,757	3
Substance Abuse	464	1,178	3
Medical Case Management	7,615	80,555	11

Of those services utilized most by clients (visits/clients), medical case management services were among the highest (11 visits per clients), followed by medical care (4 visits per client), substance abuse (3 visits per client), mental health services (3 visits per client), and dental care services (2 visits per client).

Additional services obtained by clients in 2014 included treatment adherence, counseling, food bank/home delivered meals, health education/risk reduction, referral for health care and supportive services, psychological support services, housing assistance and transportation services.

## AIDS Drug Assistance Program (ADAP)

The South Carolina AIDS Drug Assistance Program (S.C. ADAP) operates under the Ryan White HIV/AIDS Treatment Modernization Act to provide access to medications that treat HIV disease and to prevent the serious deterioration of health arising from HIV disease in eligible individuals. The S.C. ADAP provides medication assistance via the following service tiers: 1) Direct Dispensing to provide medications via mail-order through a contracted pharmacy; 2) Insurance Assistance to reimburse costs for private insurance premiums, copayments, and deductibles; and 3) Medicare Assistance to provide support for Medicare Part D copayment and deductible costs. S.C. ADAP enrollment and services are centrally managed by the S.C. Department of Health and Environmental Control.

Currently there are 90 drugs on the approved S.C. ADAP formulary. The S.C. ADAP has an advisory body of infectious disease (ID) physicians and program staff that meet regularly to review the S.C. ADAP formulary and make recommendations for program improvements. In the past, once an antiretroviral medication received FDA approval, it was automatically added to the S.C. ADAP formulary. With the new development of extremely expensive therapies, such drugs are added as appropriate, after a thorough medical and fiscal review and in compliance with ADAP performance measures. Fuzeon, Selzentry, and pegylated interferon currently require prior authorization for approval. As of April 1, 2014, prior authorization is not required for abacavir-containing medications or ribavirin. There are no restrictions or caps on the number of antiretroviral medications per client.

Eligibility for S.C. ADAP includes verified HIV-positive status, South Carolina residency, and income criteria per ADAP service tier. The financial requirement is measured according to the Federal Poverty Guidelines. Eligibility for the ADAP direct dispensing service tier is 300 percent of the Federal Poverty Level (FPL). Eligibility for the ADAP insurance assistance service tier is 550 percent of FPL. Eligibility for the Medicare Assistance service tier is 550 percent of FPL and applies for individuals who do not qualify for the Medicare Part D Full Low-income Subsidy (FLIS). Expenditures are carefully monitored and projections are reviewed monthly.

Figure 4.03 lists the characteristics of clients enrolled in ADAP during 2014. Clients served through ADAP have a similar distribution to that of PLWHA in South Carolina. The majority of the clients are non-Hispanic African-American (70 percent), male (72 percent) and in the 45+ year age group (52 percent).

**Figure 4.03: Characteristics of ADAP clients compared to S.C. persons living with HIV/AIDS in 2014**

	ADAP Clients, N=5,554	Persons Living with HIV/AIDS, N=16,222
<b>Race/Ethnicity</b>		
White, not-Hispanic	24%	24%
Black, not-Hispanic	70%	71%
Hispanic	5%	4%
Other	1%	1%
<b>Sex</b>		
Male	72%	71%
Female	27%	29%
Transgender	1%	N/A
<b>Age Group</b>		
< 24	5%	5%
25-44	43%	37%
45+	52%	58%

## Epidemiologic Profile

Figure 4.04 shows a similar list of characteristics by Service Type. Men comprise the largest proportion across all three service types (72 to 77 percent). ADAP's Direct Dispensing served the largest number of clients and has a similar distribution to that of PLWHA in South Carolina. African-American's also comprise the largest proportion within the Insurance Program and Medicare Part D Assistance.

**Figure 4.04: 2014 ADAP Patient Profile Compared to Persons Living with HIV/AIDS**

	S.C. HIV/AIDS Prevalence N=16,222	Direct Dispensing N=4,132	Insurance Program N=1,848	Medicare Part D Assistance N=320
<b>Race/Ethnicity</b>				
White, not-Hispanic	24%	21%	30%	44%
Black, not-Hispanic	71%	72%	66%	55%
Hispanic	4%	5%	3%	1%
<b>Sex</b>				
Male	71%	72%	72%	77%
Female	29%	27%	28%	23%

Figure 4.05 shows a breakdown of SC ADAP clients who received each of three types of services that support access to medications and the average number of services per client. The majority of SC ADAP enrollees received prescriptions, via mail order for uninsured clients and at retail pharmacies with insurance copayment/deductible assistance from SC ADAP (n=5,257). The SC ADAP paid health insurance premiums for enrollees with access to private insurance (n=1,020) and supported out-of-pocket costs for enrollees with Medicare Part D coverage (n=326).

**Figure 4.05: South Carolina ADAP Service Type, 2014**

	Number of clients receiving service	Number of visits per category	Average number of Services per client
Prescription Refills: (Direct Dispensing & Insurance Copayments/Deductibles)	5,257	100,770	19
Premiums: Health Insurance Premiums (including Pre-existing Condition Plans)	1,020	4,549	4
Medicare Copayments/Deductibles*	326	8,546	26

\*Insurance Copayments and Deductibles are associated with specific prescriptions and are reported as Refills/Medications.

### In Care vs. Not In Care

This section looks at the number and characteristics of people who know they are HIV positive but who are not receiving HIV primary medical care.

eHARS data was used to determine the in-care/not-in-care status of PLWHA in South Carolina. The selection criteria included all people diagnosed through December 31, 2014, who were alive as of December 31, 2014, and have South Carolina as their current residence. Cases meeting these criteria were linked to laboratory tests (CD4 and viral load tests have been reportable since January 1, 2004) from January 1, 2014 through December 31, 2014. A person was considered “in care” if they had at least one CD4 or viral load test in 2014 and that test was at least thirty days after the initial date of diagnosis; people with no CD4 or viral load test in this time period were considered “not in care”.

**Figure 5.01: People living with HIV/AIDS (2014) proportion estimated in care vs. not in care (N=18,253)**

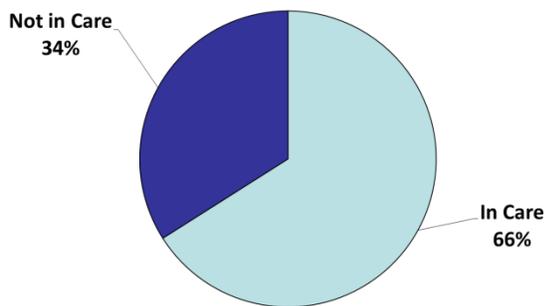
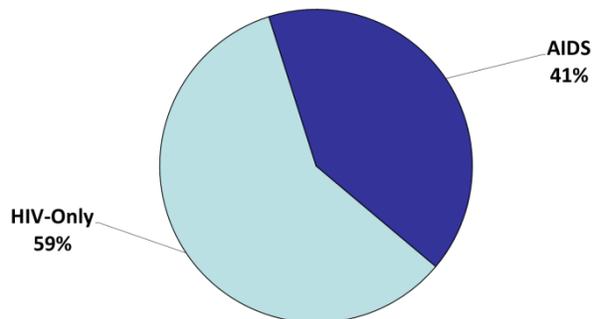


Figure 5.01 shows that of the 18,253 PLWHA as of December 2014, 34 percent (6,292) did not receive a CD4 or viral load test report within the specified time period, and therefore are reported as not in care. Sixty-six percent are defined as in care.

Of the 6,292 PLWHA not in care, 59 percent have a diagnosis of HIV-only and 41 percent have been diagnosed with AIDS (Figure 5.02).

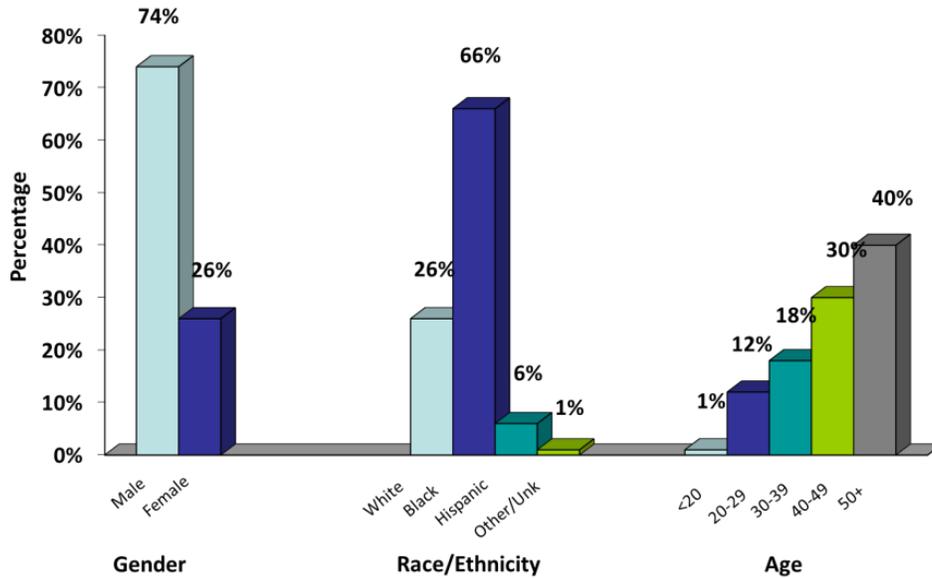
**Figure 5.02: People living with HIV/AIDS (2014) estimated not in care: HIV-only vs. AIDS (N=6,292)**



## Epidemiologic Profile

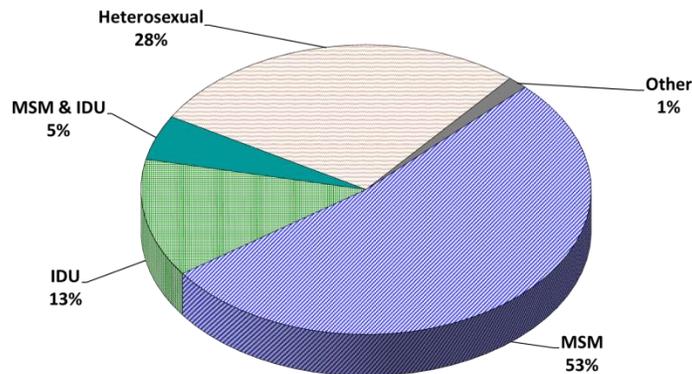
A comparison of PLWHA who are not in care by gender shows men account for the largest proportion (74 percent); when compared by race/ ethnicity, the majority (66 percent) are African-American; when compared by age groups, seventy percent are over the age of 40 (40-49 thirty percent and 50+ forty percent). (Figure 5.03)

**Figure 5.03: People living with HIV/AIDS (2014) estimated not in care: Comparison within select demographics of individuals**



An analysis by mode of exposure of PLWHA indicates most people not in care are MSM (53 percent) and heterosexuals (28 percent) followed by IDUs (13 percent) (Figure 5.04).

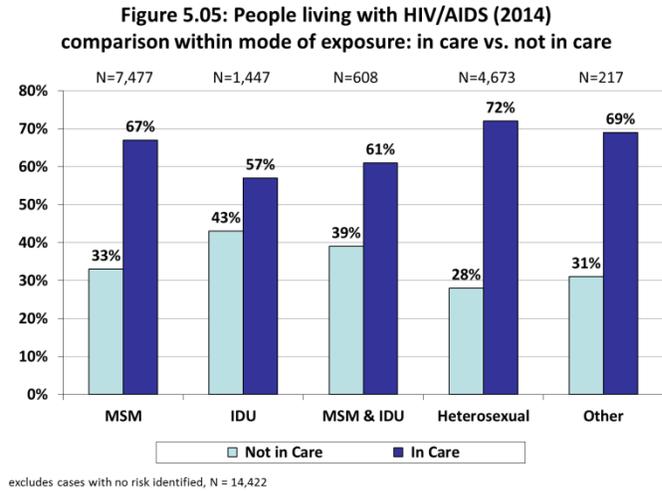
**Figure 5.04: People living with HIV/AIDS (2014) estimated not in care by reported risk**



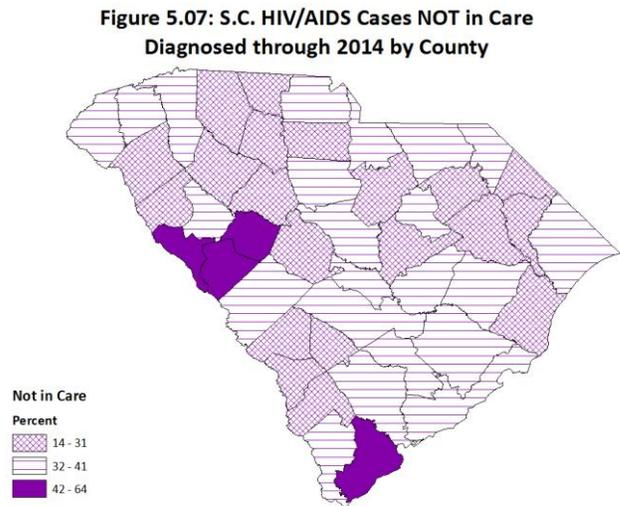
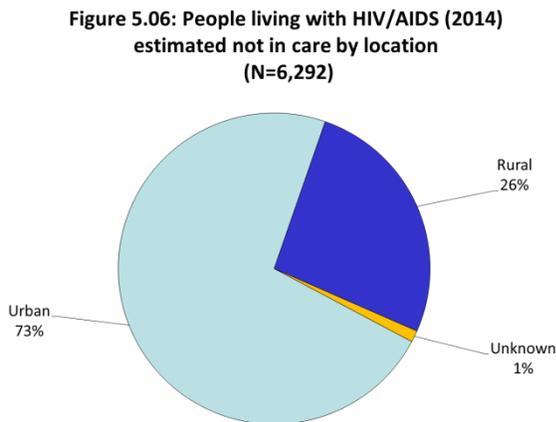
Excludes cases with no risk identified. N = 4,683

## Epidemiologic Profile

Figure 5.05 goes further to compare those in-care versus those not-in-care within each risk category. Among all MSM living with HIV/AIDS, more are in care (67 percent) than not in care. For people whose mode of exposure was injecting drug use (IDU), the proportion of those in care (57 percent) is similar to those in care whose mode of exposure was the combined risk of MSM and IDU (61 percent). Among heterosexuals with HIV/AIDS, 72 percent are in care.



The location of a person's residence may have an impact of whether or not they are in care. Of people not in care, more people are in urban areas (73 percent) versus rural areas (26 percent) (Figures 5.6 and 5.07).



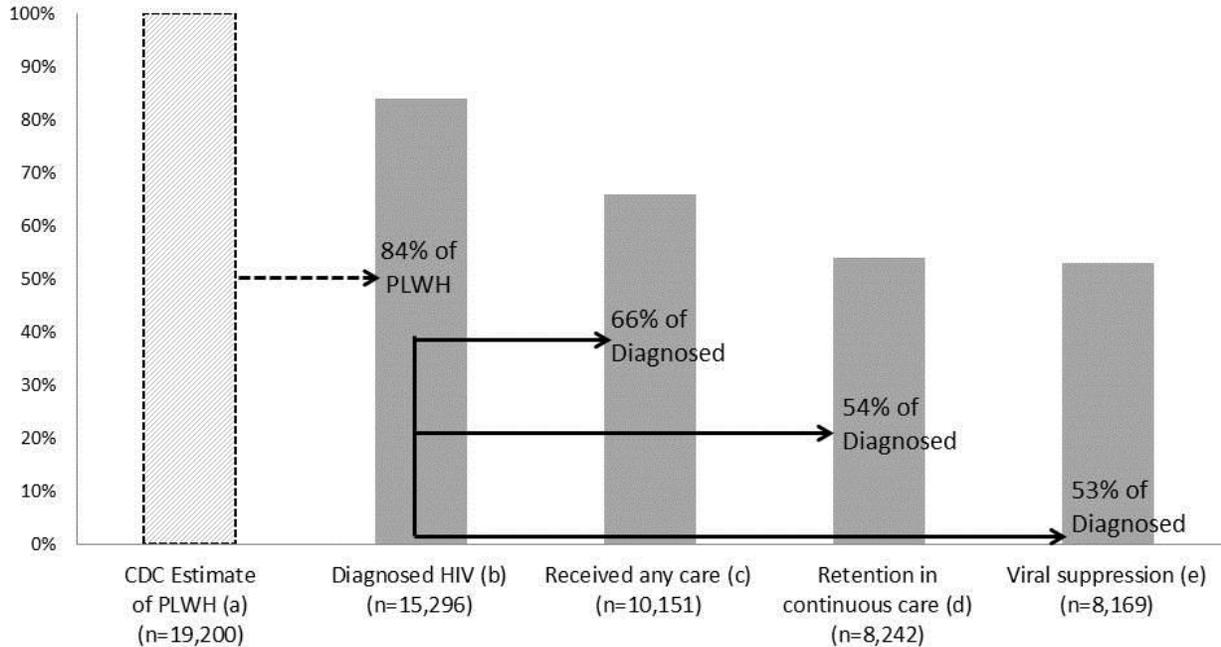
*Note: Border counties, such as Aiken and Edgefield (the two solid fill counties), may have artificially high percentages of not in care due to S.C. residents receiving care in other states, where test results are not provided to S.C. (Note: In 2014, S.C. entered into a data sharing agreement with Georgia to receive test results for S.C. residents.)*



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# Appendix 2: HIV Care Continuum

Numbers and percentages of persons engaged in each step of the HIV continuum of care, 2014



Data source: Estimate of People Living with HIV – CDC (2012 Data: [www.cdc.gov/mmwr/preview/mmwrhtml/mm6424a2.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6424a2.htm)).

Diagnosed HIV - South Carolina Department of Health and Environmental Control (DHEC). As of 05/02/2016

a. CDC estimates about 19,200 (95% CI: 18,200-20,100) people in South Carolina are living with HIV and about 3,200 (95% CI: 2,000-4,000) people (16.6%) are undiagnosed.

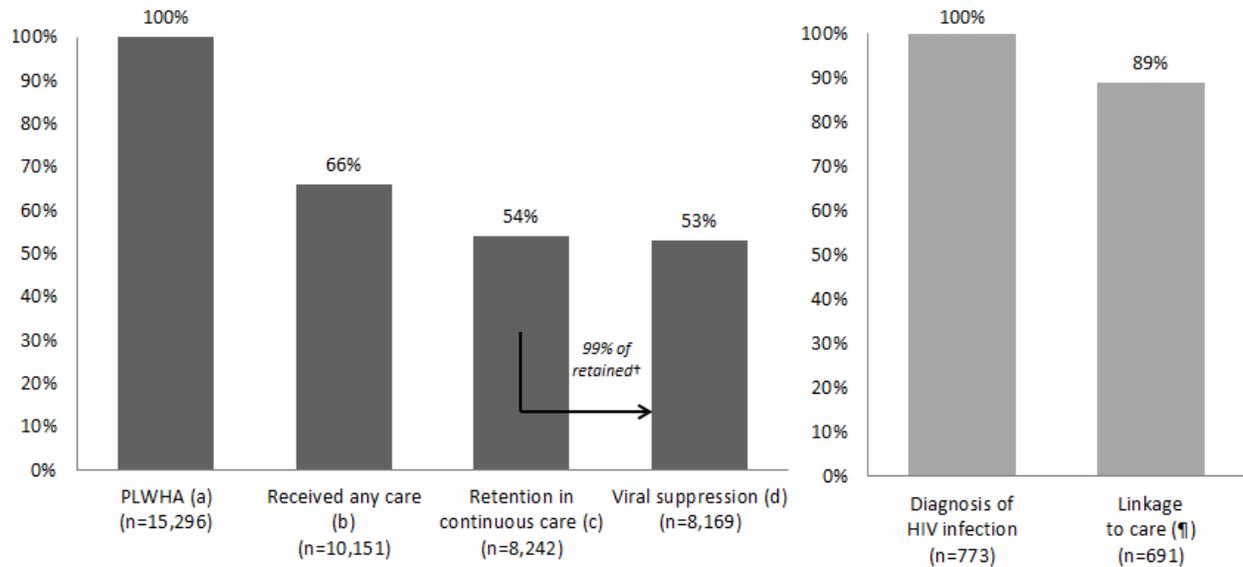
b. Persons diagnosed with HIV infection (regardless of stage of disease) through year-end 2013, who were alive at year-end 2014.

c. Percentage of persons with Diagnosed HIV, with  $\geq 1$  CD4 or viral load test result during 2014.

d. Percentage of persons with Diagnosed HIV, who had  $\geq 2$  CD4 or viral load test results at least 3 months apart during 2014.

e. Percentage of persons with Diagnosed HIV, who had a Viral Load  $\leq 200$  copies/mL at most recent test during 2014.

## Numbers and percentages of persons engaged in each step of the continuum of HIV care, 2014



Data source: South Carolina Department of Health and Environmental Control (DHEC). As of 05/02/2016  
a. PLWHA, Defined as persons diagnosed with HIV infection (regardless of stage of disease) through year-end 2013, who were alive at year-end 2014.

b. Percentage of persons with  $\geq 1$  CD4 or viral load test result during 2014 among PLWHA.

c. Percentage of persons who had  $\geq 2$  CD4 or viral load test results at least 3 months apart during 2014 among PLWHA.

d. Percentage of persons who had a Viral Load  $\leq 200$  copies/mL at most recent test during 2014, PLWHA.

¶ Percentage of persons who had suppressed VL ( $\leq 200$  copies/mL) at most recent test during 2014, among those who were retained in care during 2014.

Data source: South Carolina Department of Health and Environmental Control (DHEC).

¶ Calculated as the number of persons linked to care within 3 months after HIV diagnosis during 2014, among the total number of persons ( $>= 13$  years of age) diagnosed with HIV infection in 2014.

## Appendix 3: Letter of Concurrence

Please find the Letter of Concurrence on the next page.



September 19, 2016

Donna Alexander  
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Re: Letter of Concurrence: S.C. Integrated HIV Prevention and Care Plan

Dear Mr. Bryant and Ms. Alexander:

The South Carolina HIV Planning Council (HPC) has completed the review of the S.C. Integrated HIV Prevention and Care Plan (IHPCP), within the S.C. HIV/AIDS Strategy (SCHAS). The HPC concurs with the submission of the IHPCP by the S.C. Department of Health and Environmental Control. The signatures below confirm the concurrence. This submission is in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of the IHPCP.

HPC members have been actively involved in the development of the IHPCP at HPC meetings and through opportunities for input in smaller group settings such as with the Positive Advocacy Committee, Ryan White Medical Case Managers, and at other events. Prior to the August 16 meeting, members were provided with the IHPCP. At the meeting detailed information about the concurrence process and voting forms were distributed.

Of the 34 HPC voting member positions, there are three vacancies. Of the filled 31 positions, 28 voted for concurrence with three non-respondents. The 28 members verified that the IHPCP describes how programmatic activities and resources are proposed to be allocated to the most disproportionately affected populations and geographical areas that bear the greatest HIV disease burden. The HPC concurs that the IHPCP submission fulfills the requirements put forth by the CDC Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance. Please contact us at the numbers or e-mail addresses below if there are questions.

Sincerely,

*Gary Rhett*

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