South Carolina HIV/AIDS Strategy 2022-2026

September 2022

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Acknowledgements

This document represents the hard work and commitment of hundreds of South Carolinians living with HIV and responding to the epidemic. Stakeholders from throughout the state—including all state-funded prevention and care grantees and representatives of all Ryan White Parts—responded with honest and clear input on the gaps and unmet needs for the Statewide Coordinated Statement of Need (SCSN) and offered creative and thoughtful input for the goals and objectives of the Integrated HIV Prevention and Care (IHPC) Plan.

The process was overseen by the South Carolina HIV Planning Council (HPC), a care and prevention planning body that has guided the state's response to HIV for more than 25 years. The HPC was involved in early planning for the SCSN, in the execution of the needs assessment activities, and in the process of developing IHPC Plan goals and objectives. The strong representation of persons with HIV (PWH) on the HPC assures that this process has been grounded in addressing the real gaps and needs of PWH in South Carolina. A Letter of Concurrence from the HPC accompanies this document and appears as Appendix B.

The staff of the Department of Health and Environmental Control (DHEC)—including care, prevention, and surveillance staff—contributed countless hours to the planning and execution of the SCSN and IHPC Plan. Their dedication to caring for individuals living with HIV and addressing the prevention needs of those at risk speaks to the highest principles of public health practice.

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Abbeville Area Medical Center
AccessHealth Lowcountry
Affinity Health Center
AID Upstate
AIDS Healthcare Foundation
Aiken Center for Alcohol & Other Drug Services
Alpha Phi Alpha Fraternity
Alston Wilkes Society
Axis I Center of Barnwell
Beaufort Jasper Hampton Comprehensive Health Services
Benedict College
BirthMatters
Black Men's Health Initiative
CAN Community Health
CareSouth
Care Innovations
Careteam+ Family Health & Specialty Care
Challenges Inc.
Charleston Center
Charleston County School District
Charleston Hispanic Association
Circle Park - Chrysalis Center
Circle Park BHS
Citizens Center for Public Life
City of Charleston
Columbia College
Columbia Urban League
Community Advocate
Cooperative Health
Cumulus Media
DAODAS
Delta Sigma Theta/St. John AME Church
Dreams with Open Arms
East Coast Migrant Head Start Project – Farmworker Services-
El Informador Newspaper
EMPOWERR Program at MUSC
Epworth Children's Home
Fact Forward
Fairfield County School District
Family Health Centers, Inc.

FOCUS
Francis Marion University
Greenville Free Medical Clinic
Hispanic Ministry St. Peter's Church
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Lexington Sheriff Department
Links, Inc.
Little River Medical Center
Low Country Health Care System
LRADAC
Maud & Company Rehab Service
McLeod School of Medical Technology
Medical University of South Carolina
Medical University of South Carolina Center for Telehealth
Mid-Carolina Area Health Education Consortium
Midlands Technical College
MUSC OBGYN
NAMI Piedmont Tri-County
National Coalition of 100 Black Women, Inc. Columbia (SC) Chapter
New Digital Press DBA En Nuestro Estado
New Horizon Family Health Services
Nuestro Estado
Palmetto AIDS Life Support Services
Harriet Hancock LGBT Center
Palmetto Community Care
PASOs
Pee Dee WIC
PRISMA Health USC Medical Group
Piedmont Care
Positive Coalition Project
Positive Women’s Network
Richland School District One
Roper St. Francis Ryan White Wellness Center
Ryan White Wellness Center
Sandhills Medical Foundation
SC AIDS Education and Training Center
SC Appleseed Legal Justice Center

SC Center for Rural and Primary Healthcare
SC Commission for Minority Affairs
SC DHEC
SC DHHS
SC DMH
Wright Wellness Center
SC MOCHA
SC Office of Rural Health
SC Primary Health Care Association
SC Agricultural Worker Health Program
Shalom Recovery Services
Shoreline Behavioral Health Services
South University
Southern AIDS Coalition
Spartanburg Regional Health Services District
St. John Baptist Church
Sumter Behavioral Health Services
Syntrell C. Thompson Marketing Group & Associates
Tandem Health
The Center for ID
The Family Effect
The Phoenix Center
The Wright Wellness Center
Tidelands Community Resources
Trident Technical College
United Way of Greenwood and Abbeville Counties
Unity Empowerment Resource Center
USC
Uplift LGBTQ+ Youth Outreach Center
Upper Midlands Rural Health Network
Upper Savannah Care Services

Statewide Coordinated Statement of Need

Section I: Executive Summary

This document represents the culmination of nearly a year of planning, strategizing, and executing a comprehensive plan to address gaps and unmet needs in HIV prevention and care and develop goals and objectives for a five-year plan to address these unmet needs. Using the CDC/HRSA guidance document, staff from the Division of HIV, STD, and Viral Hepatitis have worked collaboratively with internal and external stakeholders to forge a path toward reducing new infections, enhancing HIV care, and working towards ending the HIV epidemic.

The process devised built on the 2020 efforts in the development of a plan to support the South Carolina Ending the HIV Epidemic (EHE) efforts underway in targeted cities and states in the U.S. Given this effort, a decision was made that the focus of this process would be on needs not as carefully considered in the EHE engagement process. The framework for the assessment focused primarily on the access to and the quality of Ryan White core services funded through DHEC's Part B efforts.

The document and the process align with the SCSN/IHPCP Guidance released in June 2021. What follows is an in-depth discussion of the community engagement steps in the SCSN, findings from that needs assessment, an inventory of resources, and a comprehensive set of goals and objectives in the IHPCP designed to enhance prevention and care services and address gaps and unmet needs identified.

No meaningful attempt to address HIV prevention and care in South Carolina can avoid addressing the inequities in HIV among South Carolinians and addressing the social determinants of health (SDoH). Simply put, the disease burden among African Americans is unacceptable. Challenging social and environmental conditions contribute to persistent and growing HIV-related health disparities - such as higher rates of HIV infection and poorer health-related outcomes - for people of color, most strikingly African Americans. For the period 2018-2019, there were 1,556 new HIV infections in South Carolina. Of these, 60% were among African Americans even though they make up only 26% of the population. While still a relatively small number, the rate of Hispanic/Latino males living with an HIV diagnosis is 2.7 times that of White males.

In South Carolina, these health-related disparities for people of color are influenced by health inequities including inadequate access to care, poverty, homelessness, lack of education, lack of social support networks, lack of services in certain geographic areas, and lack of culturally and linguistically appropriate services. These conditions affect the ability to receive HIV treatment, care, and support.

Finally, unacceptable disparities exist for men who have sex with men (MSM), and homophobia, intolerance, and access to health services all must be addressed moving forward. In 2019, South Carolina reported that 80 percent of new HIV cases involved men; and 80 percent of new cases involved gay, bisexual, and other men who have sex with men.

People living with HIV and those at risk of infection experience additional barriers to testing and treatment when they encounter discrimination and prejudice due to attitudes, beliefs, practices, policies, and services that perpetuate negative social perceptions about HIV. The interventions proposed in this Plan are infused with a commitment to normalizing HIV testing, creating an enabling environment for HIV treatment and care services, and reinforcing that discrimination against PWH will not be tolerated. Anti-stigma efforts will include supporting an enabling environment for ending HIV criminalization in South Carolina.

This Plan will maximize the availability of lifesaving, transmission-interrupting treatment for HIV, saving lives, and improving the health of South Carolinians. It will move South Carolina from a history of having an unacceptable disease burden and poor health outcomes to a future where new infections are rare and those living with the disease have normal lifespans with few complications.

Section II: Community Engagement/Jurisdiction Planning Process

Planning Bodies/Collaboration with RW Parts

The process for the 2022 SCSN began in consultation with the SC HIV Planning Council (HPC). The Council is made up of 35 voting members from CDC-funded prevention programs (both directly and indirectly funded), Ryan White (RW) Treatment Modernization Act-funded care and support services programs (Parts A, B, C, and D), collaborating state agencies, community-based organizations (CBOs), faith-based programs, and interested community members. Participation from consumers with HIV is ensured, with the bylaws mandating that 7 of the 35 members be persons who are HIV positive. The SC HPC currently consists of at least 14 persons who are HIV positive.

The Council meets at least five (5) times throughout the year. Membership applications are sent out in the fall of each year as well as distributed at the annual S.C. HIV, STD, and Viral Hepatitis Conference. The membership of the HPC reflects, as much as possible, the demographic characteristics of the HIV epidemic in South Carolina. The following criteria are utilized to assist in the selection of members:

- Anyone impacted by HIV, particularly persons living with HIV;
- At least two years of experience providing HIV prevention and/or care services;
- Expertise in the following HIV-related program services areas: HIV clinical care, linkage to care, case management, housing, mental health, substance use prevention or treatment, counseling and testing services, partner services, comprehensive risk counseling services, and/or evidence-based health education/risk reduction programs;
- Representation from a geographical area highly impacted by HIV; and
- Representative of priority populations for targeting high-impact prevention services: persons living with HIV, African American Men who have Sex with Men, African American Men who have Sex with Women, White Men who have Sex with Men, African American Women who have Sex with Men, Transgender Men and Women, Hispanics/Latinos, and Persons Who Inject Drugs (PWID).

In addition to standing committees, the HPC also has workgroups that address issues related to priority populations and emerging trends in the field of HIV prevention, care, and treatment. STD/HIV Division staff members provide staff support to the workgroups, which report on their activities at each HPC meeting.

SCSN Initial Kick-Off

Hosted by the HPC, the initial kick-off for this SCSN was held on Tuesday, March 1, 2022, via Zoom. The agenda allowed all participants to be oriented to the SCSN process, to receive relevant prevention and care updates, and to hear from prevention, care, and surveillance staff about the most current available data/epidemiological trends.

Nearly 100 DHEC staff and external stakeholders participated in this four-hour meeting. Participants included staff and leadership from predominant HIV service providers and clinicians across the state. All Ryan White parts were represented in the meeting including Charlotte/Mecklenburg Part A representatives who collaborate with ex-urban Charlotte providers. Updates from key programs were offered and relevant surveillance data was shared. The consultant overseeing the community engagement process introduced the plans for the upcoming SCSN and offered an overview of the intended outcomes.

Discussion of Priority Gaps/Unmet Needs

The plan devised by the internal planning group in collaboration with the HPC yielded an overarching plan to identify unmet needs and gaps to be prioritized as the outcome of the SCSN process. Given the extensive community engagement associated with the 2020 EHE effort, a decision was made to have the SCSN augment existing input. The decision was that prevention activities—including gaps and unmet needs—were covered extensively in the EHE process. The consensus of the planning body was that the pragmatic approach to the SCSN would be to focus on identifying gaps and unmet needs related to the Ryan White core services.

This process focuses on the following key questions:

1. How is DHEC doing in terms of delivery of RW core services?
2. What challenges exist in delivering core services?
3. What are the gaps and unmet needs for individuals with HIV?
4. How can DHEC proceed in the Integrated HIV Prevention and Care Plan to address gaps and unmet needs?

The design called for a series of qualitative meetings to gather input from a wide range of stakeholders and to devise a survey to gather quantitative input from Ryan White providers, especially clinical providers for whom the ability to provide input may be challenging. The remainder of this section summarizes the important findings from the community engagement process.

Consumer Input: Engagement of PWH

The initial community engagement effort focused on the input of approximately 20 individuals living with HIV who are mostly long-standing advocates and advisors to DHEC in a variety of settings. DHEC has a long and successful partnership with the HPC Positive Advocacy Committee (PAC) and is committed to the SCSN/IHPC Plan process to assure the input of PWH is considered. The meeting was held on March 15 and the results will be incorporated into the planning process.

There was broad agreement on the strengths of available high-quality medical care and medical case management in every area of the state. Several individuals highlighted strong linkage to care efforts and rapid engagement and re-engagement efforts in multiple regions of the state.
Concerns focused on staff turnover in clinical settings, especially among case managers and medical providers. There is significant concern about access to transportation and nutrition services and broad agreement that affordable housing remains a priority concern, especially in the Myrtle Beach region and in the Charleston area.

There was a mixed reaction to the availability of behavioral health services. In some regions this is problematic, but in other regions, there is easy access including services that are co-located in the care setting. There are apparent inconsistencies in ADAP, and several participants indicated nutritional counseling services are not available.

A detailed list of observations from the meeting with PWH includes:

Successes

- Medical care Midlands/Fairfax
- Service network is established
- Medical care except for physician turnover
- Case management going well
- ADAP and premium assistance going well in Fairfax
- Good dentist
- Low Country—Linkage to Care better
- Re-entry to care
- Case management as strength, regular check-ins
- ADAP going well
- Efforts of peers
- Existence of programs/services in SC
- Case management and linkage to care is going well

- Medical care is the overall strength (Midlands Region)
- ADAP/Premium Assistance solid
- Medical care excellent, fantastic ID specialist, case managers onsite for each location, ADAP smooth, and premium assistance is smooth as well. They have a mental health professional also. Linkage to all areas is very smooth. Efforts of peers (PWH) during this pandemic and all their efforts to be included as a strength as well. (Fairfax/Allendale Area)
- Medical care is a strength in SC. ADAP/Premium is also a strength.
- Linkage to Care for newly diagnosed is much more rapid than before, now generally occurring 24 hours or less. (Lowcountry)
- Case management has been excellent during the pandemic. ADAP recertification was taken care of as well. (Midlands)
- Case management and physicians as well as dental care (Midlands Region/Rock Hill)
- Identifying peer efforts via phone calls, social media, out-of-the-box efforts, etc.
- Case management and linkage to care is going well in Greenville, SC (AID Upstate)
- Medical care here in SC is a strength but there are physician turnovers.
- ADAP/Premium Assistance is also a strength
- Case management and physicians. They really make sure that patients are well taken care of (Rock Hill)
- Dental care was amazing for me as well (Rock Hill)
- Peers are vital to the success to any treatment

Gaps/Unmet Needs

- ADAP funds not being utilized when a client transitions [create the standard for transitions]
- Staff turnover, especially case managers
- Peers need services but policies won't allow them to receive them at their agency
- Communication between service providers, especially CBOs and medical care providers
- Providers leaving and clients not notified
- Lack of collaboration within agencies
- New hires are too new in HIV/need more training
- Where services are outsourced to other agencies
- Need for Cultural Humility training (e.g., 'patients not complying')
- Need centers large enough for comprehensive care
- Training needed on Cultural Competence in working with Hispanic patients
- ADAP needs to add Cavenuva to formulary
- 'Turf wars' inhibit collaboration

- DHEC needs to watch turnover and address underlying problems
- DHEC needs to monitor regional challenges
- Nutrition is 'spotty'; some agencies are linked to food pantries. Need for grocery vouchers.
- Lack of nutrition counseling in Low Country
- Need to enhance PAC
- Low Country residential substance use disorder (SUD) services: hard to access
- Transportation to services needed
- Lack of mental health services
- Too much physician turnover/medical turnover
- The consistency in the ADAP/Premium experience (issue with the use of an off-marketplace)
- Clinic turnover (case managers) causing folks to fall out of care: as they get comfortable with the clinic, they're thrown off and sometimes not even notified of the change, etc.
- Also, peers are not able to access certain services such as mental health as it's a conflict of interest, etc. Medicare and Medicaid patients not being able to get certain things.
- Communication between the clinic part and CBOs causes a lack between services and many fall through the gaps. There is a misunderstanding between case management and medical case management, so this needs to be made clear. This includes FQHCs.
- Turnover in case management
- Lack of follow-through and communication of case managers
- Lack of collaboration among organizations
- Training of new hires needed: clients are having to tell the new case managers how to get them the services
- Providers or infectious disease care doctors are needed at each facility full-time as opposed to a couple of days a week
- Some agencies send clients to other facilities to get certain services which is a barrier for clients. Need comprehensive one-stop systems.
- Training to address Cultural Humility and attitude
- Agencies working in silos and clients get caught up in turf wars due to a lack of collaboration among the agencies
- DHEC not coming to look at and investigate problems at clinics (experienced, long-time employees leaving at the same time due to issues and no one investigating to see why and troubleshoot the problems). DHEC at one time would check on clinics/issues but not anymore. Communication from DHEC central office to the regions/field needs to improve
- No nutritional counseling (Lowcountry)

- Housing is an issue for those with minimum income, long wait lines as well
- HOPWA doesn't provide enough funding in SC to meet the epidemic here
- A set standard of how HOPWA fundings are distributed and made available to clients is needed (many times within an agency it boils down to whether I like or don't like the client)
- Are the Hispanic communities taken into consideration for this service analysis?
- Why can't peers, working in the agency, receive services?
- Why can't one agency give referrals to the other agency for a particular service needed? Rather than a client having to transfer services
- Case managers are not fully trained
- Need for a seamless system to access services
- Not explaining the service to clients
- Access to primary care
- With the pandemic, I feel the Consumer Advisory Boards are lacking in most agencies
- Transportation in outlying areas
- Housing is an issue for those who have a minimum income
- Lack of transgender health services
- Transportation
- Getting back those out of care with addiction care
- Housing
- Follow-ups for patients who begin to not adhere to personal health service, a regular point of contact to ensure client-centered services
- More housing because some PWH are homeless
- We only have one Safe house for PWH in Greenville. Having more than one would greatly help!
- Requirement of CM enrollment to obtain HOPWA services
- There is zero dedicated housing for PWH in the Charleston area
- Housing for us is overlooked and discriminated
- Inpatient treatment for SUD, outpatient treatment as well (residential & outpatient)

Outreach Workforce Consultation

The contractor next joined the bi-monthly meeting of nearly 75 members of the SC Ryan White Interactive Outreach Workforce Committee on March 17. This multi-disciplinary group is engaged in both prevention and care outreach and advises DHEC on issues like community prevention, testing, linkage to care, and re-engagement into care for PWH.

The group agreed that access to care—both linkage and re-engagement--are happening effectively. Concerns included issues of stigma and transportation. The group outlined challenges in both housing and behavioral health services as well.

Gaps/Unmet Needs

- Stigma in rural areas and risks to confidentiality in certain areas (care package visits)
- Transportation
- Housing across all communities needs to be addressed
- Mental health and substance abuse need to improve referrals for these services and work on ways to keep them in care
- A need to increase bilingual services such as literature and bilingual staff to support Latinx outreach and education
- Stigma is pernicious
- Transportation services
- Mental health needs and substance abuse have increased recently. It is hard to keep people in care and refer them to where they need to go.
- Housing
- Housing is a big barrier in both groups
- Issues around case management retention/turnover, address case management caseloads, reduce the paperwork burden (in reference to PCN 21-02) for clients and case managers while ensuring we remain compliant with HRSA policies and procedures
- An agency told me yesterday that they've been trying for a long time to get their HIV testing staff to reach out to the Latinx community, but the staff has refused. I'm guessing the language barrier is an issue
- Language barrier – Spanish-speaking clients - No current staff that speaks Spanish. Perhaps offer or allow beginner's courses to staff
- We really need to meet more of our Trans community and engage them in care, and bring them to the table in these meetings
- Affordable housing
- Educating clients re: available services
- Language is a barrier (agencies sending staff to beginner Spanish classes, etc.)
- The referral process from infectious disease doctors and primary care doctors is horrendous, especially for PWH who are aging

Medical Case Management Meeting

The consultant was able to be on the agenda for the Part B Medical Case Management Work Group on March 24. This group is a statewide advisory group from Part B-funded entities doing medical case management across the state. Nearly 30 case managers were in attendance and discussed successes in current service delivery as well as gaps and unmet needs.

Strengths identified include the ease with which agencies transitioned to telehealth services and the continuity of care that was maintained. Expansion of dental and peer services was identified as a program strength.

There was great concern about the lack of available and affordable housing. The supply of existing apartments means that rents are very high, and quality is not a concern. Essentially, landlords do not have to be responsive to the needs of tenants or agencies, and the number of available housing units that are affordable continues to decline. There was significant concern about the case management workforce. New case managers seem to lack 'passion' for HIV services, and the net result shows up in problems with services and retention of CM staff. As in other meetings, access to behavioral health services was a concern in some areas and not as large an issue in other areas.

Successes

- Dental, expanded partnerships, and services
- Telehealth
- Medical
- Rapid engagement
- Mental health/substance abuse services on-site
- Success with a mobile unit and several new positions: now have a linkage coordinator and retention coordinator, an advisory board and a suggestion box for input from clients
- Initiated a good test and treat access program (referred to and treated by them with meds in the same day)
- Medical care and case management going very well
- Behavioral health provider in ID suite which helps with initial intake and assistance needed for those clients
- Increase in people on ACA, have our mental health provider onsite with a medical clinic; more MCMs on staff
- Bilingual MCM, improved Jail/ MAI relationships & processes
- Meeting a lot of dental and vision needs for our clients too
- More support for transgendered individuals & housing
- Case Management retention - solid and qualified staff.
- Transition to telehealth services

Gaps/Unmet Need

- Mental health and substance abuse services had a person in-house but now having to refer out is a challenge for patients
- More support for transgender services and housing

- Need bilingual case management
- Need more mental health providers on-site
- More MCM staff
- Job vs. Career – hiring the right folks into MCM positions
- Improve hiring and MCM retention
- Housing
- Bilingual staff
- More collaboration for individuals with mental health/substance abuse issues
- Enhanced collaboration of all core services is needed
- Shelter shortages
- Not enough housing, rent higher and unaffordable in certain parts of the state (beach), lack of voucher acceptance, sharp divergence in funding from HOPWA DHEC and HOPWA by the cities, negotiating with landlords, a spike in rental rates by landlords
- Retention and trauma of case managers and staff
- Loss of funding in domestic violence agencies
- Inconsistency of federal funds has been a huge issue
- In some cases, the clients that are employed at local plant-type jobs often have difficulty taking off from work
- More late clinic hours needed
- Housing...we have very high rent here since we are close to the beach
- Must get tested & be identified- the Lowcountry is still in denial. Gaps in services to the transient community.
- Landlords not willing to accept housing vouchers
- Cities are not increasing housing funds for HOPWA to providers as DHEC has been over the last few years
- Housing units that accept vouchers not passing inspections, landlords not willing to make repairs, then clients must move... can't find a new unit
- Staying within the Fair Market Rate after COVID has been nearly impossible because of rental increases
- They are spiking the rental rates with no increase in housing quality
- I think landlords got used to not doing any housing repair/improvements because of the pandemic, not wanting to go into units, and not being able to get materials/appliances for repair. But now that materials and service providers are available again, they don't want to tackle the backlog of repairs that have accumulated.
- Units were not inspected properly during the pandemic
- Business/service hours are a barrier for those working

RESPOND Pillar Consultation

A focused consultation with internal and external stakeholders to determine strategies to enhance HIV outbreak response and evaluate the existing goals and activities was held on April 8th. The group was asked to think about the current strengths of the existing goals and objectives to address outbreak response and add any suggested enhancements or opportunities for improvement.

In terms of strengths, there was a broad consensus that DHEC staff implanting cluster responses are effective and community partnerships have been established. At the same time, there was broad agreement that the model proposed has some challenges in execution: specifically, there is room to enhance communication between surveillance staff, case managers, and peer specialists working in regions.

The suggestions for improvement included expanding the input of external stakeholders and looking at DHEC policies that can be changed to enhance collaboration with community partners in the field. Concerns were raised about the consent documents and the fact that conducting genotype/phenotype testing may mandate a different discussion of confidentiality.

The discussion also raised the issue of Disease Intervention Specialists (DIS) and their effectiveness in responding to cluster events. There were concerns raised by some about the sensitivity of some DIS, but others expressed concern that there were both effective and less effective DIS, and individual-level training and technical assistance might be indicated.

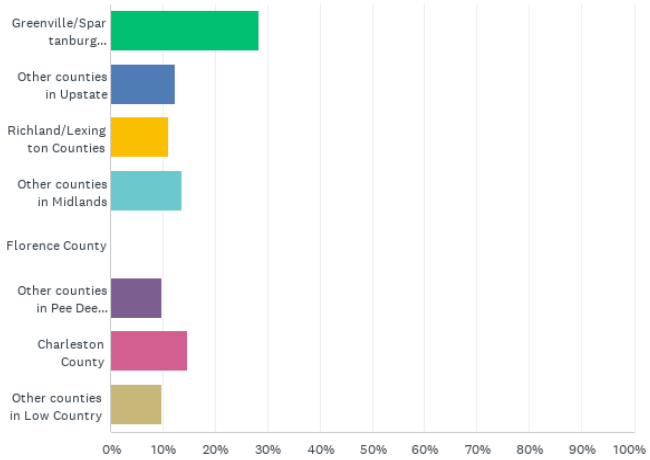
Clinician Survey

With the guidance of the HPC, a survey instrument was designed to capture the input of Ryan White clinicians, including physicians, mid-level providers, dental staff, behavioral health providers, and administrative staff. There was a total of 81 responses and a summary of findings follows—including some sorted by region.

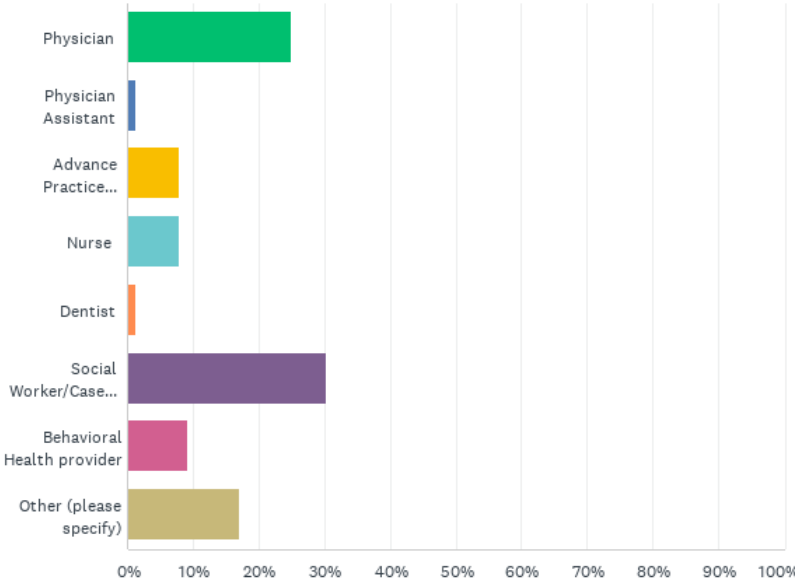
The overarching goal of the survey was to identify available services and barriers to accessing core services for individuals living with HIV. The survey asked participants to identify challenges in their regions for consumers being linked to care, remaining in care, and gaps in core services. The survey invited suggestions for promoting engagement in care and asked how DHEC could better support regional administration of core services.

In terms of regional responses, the largest area by far were responses from Greenville/Spartanburg and other upstate counties. In the mid-range were responses

from the Midlands and Lowcountry regions. The fewest responses were obtained from Florence and other Pee Dee counties. The chart below illustrates respondents by region.



In terms of responses by profession, the largest percentage of respondents were physicians and social workers/medical case managers. Nurses and nurse practitioners were the third-largest group represented, followed by behavioral health providers. The chart below offers a complete breakdown of total respondents by profession.



The review of **available services** showed wide availability of medical care, medical case management, ADAP services, and access to dental services (each was noted as being available by >90% of respondents). In addition, ADAP drug assistance, transportation, assistance with co-pays and deductibles, assistance with insurance premiums, and substance abuse services were noted as available by >80% of respondents. Hospice

care and home health were the least available services, at 49% and 46% respectively, according to all respondents.

Overall responses to the survey showed several **challenges associated with linking consumers to HIV care**. Two-thirds of respondents said that stigma remained a challenge, and 50% listed lack of transportation. Also, substance misuse, housing instability/ homelessness, and mental health disorders/issues were noted as challenges by at least 40% of respondents.

The most common responses from the overall survey about **patient factors** that may result in not staying in care included the following: substance misuse/abuse (60%), mental health disorders/issues (53%), housing instability/homelessness (44%), stigma (41%), lack of social support (36%), and competing priorities, such as work or childcare (36%).

The most common response from the overall survey about **system factors** that may result in patients not staying in care was lack of transportation (73%). Additional system factors that challenge retention in care included lack of follow-up for the identification of patients who have fallen out of care (41%), staff/provider attitudes (29%), difficulty accessing appointments/scheduling (27%), and clinic hours not being matched to patient needs (24%).

The survey asked respondents to **list any strategies or interventions to improve retention in care.** Among the 81 respondents, 37 (46%) suggested strategies. The most common strategies addressed transportation gaps, housing, mental health issues, and substance misuse/abuse.

For transportation, several respondents suggested mobile HIV services. Providing access to transportation through Uber and Lyft was also recommended.

For mental health and substance misuse issues, respondents most expressed the need for services rather than providing specific strategies. However, among the suggested interventions were having a social worker/mental health provider assess the client in conjunction with the medical provider and providing more support services for mental health.

Additional recommended strategies included using virtual platforms to supplement in-person appointments for HIV care/services and to reach rural and underserved areas more easily; increasing medical appointment access with extended hours after 5:00 p.m.; having more regular check-ins with patients; “creating more transitional housing programs to decrease clients’ neglecting their medical care.”

When asked about the top **gaps in HIV core services**, respondents noted four key challenges: affordable housing (74%), transportation (51%), mental health treatment (48%), and substance abuse services (48%). Other gaps, such as dental care, nutrition therapy, and home health, were noted by 16% or fewer of respondents.

The survey asked respondents **how DHEC can allocate resources/interventions to enhance HIV core service delivery in their area.** Of the 81 respondents, 32 (40%) provided answers.
As with earlier questions, the most common issues that respondents asked to be addressed were transportation gaps, lack of affordable housing, and inadequate mental health services.
Several respondents noted that transportation remained a large barrier, especially in rural areas. Suggestions for the allocation of DHEC resources to address the issue included allowing HIV+ patients to use Medicaid transportation services and providing Uber vouchers to patients so they can go to their medical and lab appointments.

For housing issues, respondents recommended "working with landlords to improve opportunities for affordable housing"; providing more resources for housing; and "advocating for affordable and transitional housing programs that assist individuals to have a safe and stable environment to live and access medical care."

Respondents also noted that mental health services were expensive and/or not available. "We need psychiatrists and therapists on site (preferably as employees) of our HIV medical practices," noted one respondent.

Additional suggestions about how DHEC can allocate resources included increasing the number of testing sites, providing better marketing of services, and providing education to clients on how to create a budget to maintain household expenses.

June HPC Meeting

Preliminary findings and a draft of the Integrated HIV Prevention and Care Plan were presented for input and comment. Overall, the response was positive and HPC membership seemed engaged. Suggestions made during the meeting included:

- Emphasize the rural nature of SC and make the connection to the impact of inflation on gas prices and fruit prices. Consider additional support for food security and gas/transportation services.
- Be sure that behavioral health needs include both SUD and mental health.

- It is important the plan address the needs of Latinx consumers in both prevention and care.
- Address the unmet sexual/reproductive health needs of women of childbearing age living with HIV through linkage and referral

Input from Updates to Other Strategic Plans Used to Meet Requirements

The qualitative input from focus groups and the survey findings will be extremely important in the development of the Integrated Prevention and Care Plan for South Carolina. DHEC plans to build on the strong foundation of the EHE Plan established in 2020 to guide the statewide prevention and care efforts. The goals and objectives of the existing plan—using the format from the National HIV/AIDS Strategy—will be revisited and updated; progress will be noted and areas for improvement and enhancement will be noted. Input from the community engagement process will be central to DHEC efforts to adapt existing prevention and care goals.

Section III: Contributing Data Sets and Assessments

Epidemiological Profile -- *[See Appendix C]*

HIV Prevention, Care and Treatment Resource Inventory

Funding Sources

Federal and state funding sources for prevention and care for FY 2021 are listed in the table below. Federal, 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 need in SC. The total estimated federal and state prevention and care funding in SC for FY 2021-22 is $68,754,722.

Federal and State Prevention and Care Funding [1]

HIV Prevention	Funding Amount	Percent of Total
CDC Prevention Funds to DHEC:		
HIV Prevention and Surveillance	$6,116,420	8.9%
Prevention – Ending the HIV Epidemic	$2,785,979	4.1%
Prison Inmates Project	$782,502	1.1%
Subtotal	**$9,684,901**	**14.1%**
DAODAS (Early Intervention Services and Recovery Community Organization)	$155,188	0.2%
PALSS CDC Direct Funding	$441,625	0.6%
State Prevention Funding*	$5,192,143	7.6%
STD Prevention	**Funding Amount**	**Percent of Total**
CDC STD PCHD	$3,032,674	4.4%
HIV Care/Support Services**	**Funding Amount**	**Percent of Total**
Ryan White Part B (including $13,152,1453 ADAP Earmark)	$24,091,178	35.0%
Ryan White Part B Supplemental	$2,212,664	3.2%
ADAP Shortfall	$5,333,444	7.8%

Ryan White B – Ending the Epidemic	$1,833,043	2.7%
HOPWA (State/Jurisdiction, not including City Jurisdictions)	$2,574,853	3.7%
HOPWA (Charleston, Columbia, and Greenville City Jurisdictions)	$3,190,662	4.6%
State Funds (ADAP)	$4,285,996	6.2%
Ryan White Part C	$5,599,763	8.1%
Ryan White Part D	$1,126,588	1.6%
Total Federal Funds	**$59,276,583**	**86%**
Total State Funds	**$9,478,139**	**14%**
Prevention and Care Total	**$68,754,722**	**100.0%**

[1] Funding cycles include FY 2021 and FY 2022 due to varying funding cycles.

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

**Rebates are in addition to the available federal and state funds.

Funding Summary

DHEC is the principal HIV grantee with a total of prevention and care awards at just over $58 million between FY 2021-22 including prevention, care, and housing funds. Beyond 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, amounting to $6,726,351. There are three (3) cities in SC awarded directly with HOPWA funds: 1) Columbia 2) Charleston, 3) Greenville amounting to $3,190,662 in funding. And, HOPWA funds are awarded directly to Augusta, GA to include Aiken and Edgefield Counties; and HOPWA funds are awarded directly to the County of Mecklenburg, NC to include York, Lancaster, and Chester counties.

CDC funds DHEC for HIV and STD Prevention. Palmetto AIDS Life Support Services (PALSS) is also a CDC directly funded CBO providing HIV testing and other prevention services in the Midlands region.

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 an unobligated balance to be returned to the program without penalty. This system of fiscal fluidity –when paired with collaborative funding strategies – is needed to ensure appropriate funding levels for ADAP services and potential funding to continue the goals and activities of the SC HPC 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.

DHEC Ryan White Part B Funded Organizations

Agency	Counties Served	Services Provided Summarized (RW eligible services provided determined at the local level depending on need and available funds)	HIV Care Continuum Step Impacted
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
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
AIDS Healthcare Foundation	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
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
CAN Community Health, Inc.	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

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
HopeHealth, Inc. – Florence	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 – Orangeburg	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 – Aiken	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
Little River Medical Center	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
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
Palmetto AIDS Life Support Services	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
Palmetto Community Care	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

Tandem Health	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
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

DHEC Ryan White Part B Ending the Epidemic Funded Organizations

Agency	Counties Served	Services Provided Summarized (Rapid Entry and Treatment)	HIV Care Continuum Step Impacted
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
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
AIDS Healthcare Foundation	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

CAN Community Health, Inc.	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
Palmetto AIDS Life Support Services	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
Palmetto Community Care	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

Ryan White Part C Funded Organizations

Agency	Counties Served	HIV Care Continuum Step Impacted
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 Center	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
Cooperative Health Center	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

Agency	Area Served	HIV Care Continuum Step Impacted
Cooperative Health Center	Statewide through subrecipients	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression

DHEC HOPWA Funded Organizations

Agency	Counties Served	Services Offered	HIV Care Continuum Step Impacted
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
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	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth Florence	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth Orangeburg	Orangeburg, Bamberg	STRMU, HP, Supportive Services	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
HopeHealth Aiken	Allendale, Barnwell	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
Tandem Health	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
University of South Carolina, Supportive Housing Services	Newberry	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

DHEC Health Department-Based HIV Prevention Program Models by Region Funded by CDC Grants PS18-1802 & PS20-2010 (+ denotes EHE-funded services)

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

DHEC-Funded Community-Based HIV Prevention Program Models by Organization Funded by CDC Grants PS18-1802 & PS20-2010 (+ denotes EHE-funded services)

Organization	Funded Program Models	HIV Care Continuum Step Impacted
Acercamiento Hispano de Carolina del Sur/SC Hispanic Outreach (Aiken*, Kershaw, Lexington*, Newberry, Richland*, Saluda, Sumter*)	Targeted HIV Testing+ Targeted Condom Distribution+	HIV-Diagnosed, Linkage to Care
Affinity Health Center (Chester, Lancaster, York*)	Targeted HIV Testing Targeted Condom Distribution Comprehensive PrEP Services+ STD Testing Referrals In-house Medical Care	HIV-Diagnosed, Linkage to Care
AID Upstate, Inc. (Anderson*, Greenville*, Greenwood, Laurens, Oconee, Pickens, Spartanburg*)	HIV Testing -Targeted -Mobile+ -Self/Home+ Comprehensive PrEP Services+ STD Testing In-house Medical Care Hepatitis B/C testing and linkage *Healthy Relationships* *Many Men, Many Voices* *TWIST* Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
CAN Community Health (Aiken*, Kershaw, Lexington*, Newberry, Richland*, Saluda, Sumter*)	HIV Testing -Targeted -Mobile+ -Self/Home+ Comprehensive PrEP Services+ STD Testing In-house Medical Care Hepatitis B/C testing and linkage *Many Men, Many Voices* Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care

CARETEAM, Inc. (Georgetown, Horry*, Williamsburg)	HIV Testing -Targeted -Mobile+ -Self/Home+ Comprehensive PrEP Services+ STD Testing In-house Medical Care Hepatitis B/C testing and linkage Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
HopeHealth (Bamberg, Calhoun, Darlington, Florence*, Marion, Marlboro, Orangeburg*)	Targeted HIV Testing Comprehensive PrEP Services+ In-house Medical Care *Healthy Relationships* Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
Palmetto AIDS Life Support Services (PALSS) (Fairfield, Kershaw, Lexington*, Newberry, Richland*, Sumter*)	HIV Testing -Targeted -Mobile+ -Self/Home+ Comprehensive PrEP Services+ STD Testing In-house Medical Care Hepatitis B/C testing and linkage Medication Adherence Intervention Enhanced HIV Navigation Services *Healthy Relationships* *ARTAS* Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
Palmetto Community Care (Berkeley, Charleston*, and Dorchester)	HIV Testing -Targeted -Mobile+ -Self/Home+ Comprehensive PrEP Services+ STD Testing In-house Medical Care *Healthy Relationships* *Many Men, Many Voices* Targeted Condom Distribution	HIV-Diagnosed, Linkage to Care
USC School of Medicine (Midlands area*)	*Choosing Life: Empowerment, Actions, Results (CLEAR)* 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 2019 – CY 2020), newly-identified HIV infections and the number of persons living with HIV/AIDS.

Additional DHEC-Funded Community-Based HIV Prevention Program Models By Organization
Funded by CDC Grant PS18-1802 for Targeted Condom Distribution

Organization	HIV Care Continuum Step Impacted
Joseph H. Neal Health Collaborative (Midlands areas)	Targeted condom distribution impacts persons with HIV and those vulnerable for HIV at various steps on the care continuum.
Piedmont Care (Spartanburg, Cherokee, and Union Counties)	Targeted condom distribution impacts persons with HIV and those vulnerable for HIV at various steps on the care continuum.
Roper St. Francis Ryan White Wellness Center (Charleston)	Targeted condom distribution impacts persons with HIV and those vulnerable for HIV at various steps on the care continuum.

DHEC-Funded HIV Testing - Clinical Grantee Programs
Funded by CDC Grants PS18-1802 & PS20-2010 ($^{+}$ denotes EHE-funded services)

Expanded HIV Testing – Clinical Grantee Program Sites	HIV Care Continuum Step Impacted
CareSouth Innovations (Pee Dee area*)	HIV-Diagnosed, Linkage to Care
Cooperative Health (Midlands area*)	HIV-Diagnosed, Linkage to Care
Fetter Health Care Network^{+} (Charleston area*)	HIV-Diagnosed, Linkage to Care
Prisma Health Upstate (Greenville*)	HIV-Diagnosed, Linkage to Care
Medical University of South Carolina (MUSC) (Charleston area*)	HIV-Diagnosed, Linkage to Care

*Indicates counties that are among the top 13 in South Carolina for the number of recent (CY 2019 – CY 2020), newly-identified HIV infections and the number of persons living with HIV/AIDS.

Substance Use Disorder (SUD) Approaches and partnerships

Among the most important partnerships is the connection between the Division of HIV/STD/Viral Hepatitis and the SC Department of Alcohol and Drug Abuse Services (DAODAS).

The South Carolina Department of Health and Environmental Control (DHEC), STD/HIV and Viral Hepatitis Division works in partnership with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) to provide continued support to the

statewide HIV Early Intervention Services (EIS) program. The services consist of providing training to build the capacity of Alcohol and Other Drug (AOD) agency staff to conduct HIV risk screening, pre-and post- counseling, HIV rapid testing, and linkage into HIV specialty care in all cases of HIV positive test results.

DHEC and DAODAS also provide continued support to the State Opioid Response (SOR) grant's HIV/HCV Testing and Linkage to Care Recovery Community Project. This project supports individuals receiving services by a select recovery community organization (RCO) staff, who are identified as high risk for or who have been diagnosed with HIV and/or Hepatitis C Virus (HCV). DHEC provides training, technical assistance, quality assurance, and laboratory support services to build the capacity of select RCO staff to conduct HIV/HCV counseling, testing, and linkage to HIV/HCV specialty care.

Needs Assessment

Part B Needs Assessment

The Ryan White Part B program asks grantees to do an annual needs assessment to guide their clinical care and future planning. Fourteen grantees submitted assessments to DHEC in the 4th quarter of 2021; they were conducted between the 1st quarter of 2018 and the 4th quarter of 2019. A total of 1,598 respondents participated in the needs assessments. A variety of assessment tools were used by the different grantees.

Several themes emerged as agencies polled consumers about both how satisfied they were with the services provided and perceived gaps in services and unmet needs. First, it is important to note that the majority of respondents reported high levels of satisfaction about the quality of care they received or about the engagement of providers in their medical care. "The excellent care I receive at the clinic has made a huge difference in my life" and "Everyone at the clinic is wonderful, caring, and compassionate" were typical of the positive comments provided by respondents.

At the same time, several key **barriers** were consistently reported from the different assessments. For example, when asked about issues that kept respondents from getting needed HIV medical care, the top three answers were:

1) a lack of transportation (respondents reported having to rely on rides from friends or relatives for medical appointments and missing appointments when rides were not available);

2) a fear of disclosure about one's HIV status ("I'm worried about someone finding out I am positive"); and

3) Agency's hours of operations (difficulty caused when respondents could not attend appointments when the clinic was open).

Respondents also reported **unmet needs and gaps in services**. It was difficult to quantify the number or percentages of these unmet needs because these figures were not always reported in the assessment results. However, there were several unmet needs that appeared consistently across the various assessments. The top responses included:

1) the challenge of getting treatment for non-HIV related illnesses and/or paying for the medications for those illnesses ("The single greatest challenge for patients is non-HIV related illnesses not covered under the Ryan White program");

2) dental care (for example, in one clinic's assessment, more than 20% of respondents reported not receiving dental care in more than five years);

3) mental health services ("I need mental health care for anxiety and panic");

4) housing security; and

5) vision care.

Additional gaps in services that multiple respondents reported included:

- Financial assistance and financial education
- A sufficient number of qualified case managers
- Enhanced food pantry services and nutritional services
- Access to medical cannabis
- Other tangible resources (e.g., food, jobs, housing, insurance, cellphones)

HOPWA Needs Assessment

The SC HOPWA program conducts a needs assessment annually. The survey was administered electronically in early November 2021. Needs identified by service providers included:

- More subsidized/low-income housing for clients
- More affordable & available housing
- Intensive case management

- Increased HOPWA funds
- Second Chance landlords
- More resources that can help with utilities and rent
- Education and employment training
- More available units connected to other resources and lifestyle skills
- More cost-effective housing that passes HUD inspections
- Housing in safer neighborhoods and near transportation options

Housing needs for PWH include Short-term Rent, Mortgage and Utility assistance (STRMU), Permanent Housing Placement, Tenant-Based Rental Assistance, Facility-Based Housing, and Supportive Services, all services provided through HOPWA funding.

Even when an individual with HIV/AIDS is not homeless, there are multiple risks of becoming homeless. Throughout many communities, persons living with HIV or AIDS risk losing their housing due to compounding factors, such as increased medical costs and limited incomes or reduced ability to keep working due to AIDS and related illnesses.

HOPWA project sponsors report an ongoing need for short-term rent, mortgage, and utility assistance, and requests for supportive services such as transportation, mental health counseling, peer support groups, and alcohol and other drug abuse counseling/treatment. Service providers identified the following supportive services needed to assist PWH to reduce homelessness:

- Employment services and job development
- Permanent supportive housing services (housing, in-home case management home visits, in-home mental health services)
- Medical case management (medical, mental health, AOD services)
- Access to mental health/AOD services/medical care
- More supportive housing
- Budgeting courses

Service providers utilize a comprehensive, standardized intake format for case managers working with persons affected by HIV, resulting in a more thorough assessment of client needs and a corresponding increase in referrals to programs such as HOPWA that can help clients stay in their homes or in shelters and off the streets where they are even more susceptible to opportunistic infections. Additional information is gathered from service providers concerning client needs through the following:

- Working directly with clients
- Client surveys
- Client assessments
- Knowledge of housing trends in the local area

Section IV: Situational Analysis: Summary of Priorities/Approaches

The following section summarizes the major themes shared by stakeholders throughout the planning process and the qualitative and quantitative work conducted. This aligns with and has been adapted from findings from the 2020 EHE planning process.

KEY SUCCESSES

Primary Medical Care. There was near uniform agreement that the quality of clinical services available in all DHEC care sites was exceptional. Patient satisfaction surveys consistently show rates of satisfaction about the 95th percentile. As in other medical settings, patients dislike changing providers so the main reservation reminds DHEC that staff retention and working toward consistency in clinical care is an important consideration. DHEC Quality Improvement echoes the qualitative input; clinical outcomes are consistently tracked at or above the threshold set in the QI process. Strong evidence exists of consistent implementation of current clinical care guidelines.

Medical Case Management Services. As with medical care, there is widespread enthusiasm among consumers for the skills of and support from Medical Case Managers in RW Care settings. Consumer focus groups show almost universal support for the role and performance of case managers. Case Managers expressed unique concerns about staff retention and recruitment of new case managers.

Peer Support. Almost all larger RW Care sites offer trained Peers to provide support and navigation for multiple consumers. This service was identified as extremely valuable in many of the qualitative discussions with participants and showed that some consumers felt they benefitted from interaction with an HIV-positive peer in ways that couldn't have been impacted by another team member.

Access to Dental Care. A very significant enhancement in the delivery of core services involves access to dental services. Compared with prior SCSN findings, there were virtually no concerns about access to and quality of dental services for individuals with HIV is South Carolina. This success can be attributed to the vision of the Part B program but mostly to RW clinics that have made access to dental care a priority goal. The wise use of 340 (b) funds has also been an important factor in this important shift.

Behavioral Health Services. This finding is not generalizable to all care settings, but significant enhancements to the availability of behavioral health (BH) services for individuals within RW care were noted. Several clinics have added BH support in the facility which makes access and referral much less cumbersome. Again, it appears clinics are utilizing 340 (b) funds in some settings to allow this expansion. Still, access

to behavioral health remains a significant concern in a few areas in the state. More rural clinics—and care sites outside a health center model—seem to be less able to provide these services.

KEY BARRIERS

***Lack of Transportation*.** The most frequent and often first reported barrier to HIV prevention, testing, and care across all DHEC Regions was the lack of transportation. Lack of readily available transportation – especially in rural SC – inhibits or delays access to testing sites, medical appointments, and medication, especially for those who do not take medication deliveries at home for confidentiality reasons. Suggestions made to address this barrier included:

> *Public transportation in rural areas just doesn't exist… and most of South Carolina is rural.*
>
> *-PWH stakeholder*

- expanding locations of services to include more readily accessible locations such as pharmacies, community events, community centers, and primary care providers
- expanding collaborations among service providers to share transport vehicles, perhaps those used in outreach activities
- expanding outreach services to "meet the client where they are – geographically"
- expanding telehealth combined with home HIV testing, PrEP education, and treatment

Access in rural SC. In addition to a lack of transportation, stakeholders shared a lack of general accessibility of both prevention and care services due to long distances, too few providers, and a lack of comprehensive services under one roof (i.e., "one-stop shopping" or "bundled services"). Providers and other stakeholders pushed for opt-out, routine rapid HIV testing both in all clinical settings (e.g., ERs, primary care offices, STI settings) and alongside other routine health checks (e.g., blood pressure checks, diabetes testing, cholesterol testing) taking place in the community such as at health fairs. Other suggestions included embedding more Ryan White services in federally qualified health centers and providing more outreach services to "meet the clients where they were – literally meeting them in their own safe space.

> *Don't always force us to come [to the agency] for services – a big help would be for the services to come to us.*
>
> *-PWH stakeholder*

Stakeholders also discussed that one of the key barriers to PrEP is a lack of access to providers who are willing to prescribe this medication perhaps because of their lack of knowledge about PrEP, lack of skills to communicate with their clients about PrEP, or their own biases about "those kind of people" who they deem might benefit from PrEP. Prioritizing partners of PWH for PrEP access at Ryan White sites and increasing education and training about PrEP among primary providers and their staff were suggested actions to address these barriers.

Further, providers, PWH, and other stakeholders insisted that the expeditious initiation of ART in people newly diagnosed with HIV remains a high priority and, as such, expansion of a rapid ART protocol needs to be shared and engaged statewide to enhance access to rapid ART.

***Lack of education*.** Across all public health regions, stakeholders discussed the need for basic HIV education for the general public. Many reported that the public's general lack of HIV education and awareness contributes to the pervasive stigma that further complicates prevention and care efforts. Stakeholders suggested statewide-level funding to purchase and disseminate anti-stigma messaging throughout the state as well as utilizing stigma reduction resources already available through such entities as CDC. Further, they suggested that this education and messaging should include the following information: what HIV is, how transmission occurs, and how it is treated with reinforcement messages that, "HIV is not a death sentence" and "Viral suppression is the goal: undetectable equals untransmittable (U=U)." Additional suggestions to address the lack of education among the public included expanded comprehensive sexuality education in schools and utilizing social media (e.g., Facebook) and apps (e.g., PrEP Locator and hook-up sites such as Grindr and Scruff) to share information and link to people to services.

In addition to the public, stakeholders discussed the need for education among non-HIV-specific providers such as primary care providers, mental health providers, substance abuse counselors, nurses, social workers, and others who work with high-risk populations or PWH. This education and training would include HIV prevention and care, PrEP, post-exposure prophylaxis (PEP), and linkage to services.

> *We don't see HIV information out there anymore. We see PrEP commercials but they're always about MSM. Other people need to know about PrEP, too.*
>
> *-Stakeholder*

Another education/awareness component discussed at numerous stakeholder forums was the need for a user-friendly directory of available prevention and care services easily

accessible by both the public and by providers. Too often, PWH do not know where (or at which agency) prevention and Ryan White services are available or even if they are available in their area. Unfortunately, many agency staff are also unaware of the services available in their area and therefore these resources go un-identified and un-used by those in need.

Poor customer service. Across multiple meetings, PWH and other stakeholders discussed the barrier of "poor customer service" in prevention and care efforts. Poor customer service included: the use of disrespectful, judgmental and outdated language based on HIV status, race, class, sexual orientation, and gender identity (e.g., "full-blown AIDS," "AIDS patient," "he/she" instead of "they"), extremely long wait times, lack of available appointments, confidentiality breaches, lack of rapport with case managers and other staff, lack of comprehensive services under one roof, lack of bilingual staff, and non-client-centered care. Stakeholders, especially PWH, strongly suggested that providers and their staff (clinical and non-clinical) receive customer service training that is client-centered and focused on cultural sensitivity. Further, across the state, stakeholders highlighted the need for interpreters (especially for Spanish-speaking clients), extended service hours beyond 9:00 a.m.-5:00 p.m. and including weekends, reserved appointment times to rapidly engage newly diagnosed clients, utilization of engagement standards, expanded use of peer navigators, and the creation of a user-friendly environment.

> *To serve clients well is to know, and use, their preferred language.*
>
> *-PWH stakeholder*

Poor customer service was also discussed from the perspective of agency staff who felt unable to provide the best care possible because of feeling "overwhelmed" or "burned out" due to a lack (or poor quality) of training, case/client overload, a lack of providers and staff to fulfill needed roles, lack of comprehensive services available in-house, and lack of time with clients to explain/teach about their diagnosis. Stakeholders requested additional staffing, specialized case managers, bilingual staff, changes to staff utilization within agencies, improving infrastructure, and expansion of resources within and across agencies.

Underlying issues. Across the state, stakeholders identified "underlying issues" that negatively impacted testing, linkage to care, and retention in care efforts. Underlying issues included housing instability, mental health challenges, substance use disorders, lack of primary care, intimate partner

> *We have people who can't pay their rent or are homeless and for them, HIV is not a top priority. If we could help them with housing, we could begin to build trust.*
>
> *-Stakeholder*

violence, behavioral health, lack of a social support system, lack of documentation, lack of consistent insurance coverage, financial hardships, and competing priorities (e.g., work, school). To address these barriers, stakeholders suggested more collaborations across agencies to share needed services and resources, additional funding to provide comprehensive services within each agency, and the creation and adherence to a rapid linkage to care protocol.

Underlying issues – housing instability. Of the underlying issues discussed, housing instability was of primary concern particularly among participating PWH stakeholders. DHEC Ryan White Part B Program administered a Housing Needs Assessment Survey via Survey Monkey in November 2020 to all service providers that are awarded Housing Opportunities for Persons With AIDS (HOPWA) funds. The needs that were identified through this survey included:

1. More subsidized/low-income housing for clients
2. More affordable & available housing
3. Intensive case management
4. Increased HOPWA funding
5. Second Chance Landlords
6. More resources that can help with utilities and rent
7. Education and employment training
8. More available units connected to other resources and lifestyle skills
9. More cost-effective housing that passes HUD inspection
10. Housing in safer neighborhoods

Even when an individual with HIV is not homeless, there are multiple risks for becoming homeless. In many communities, persons living with HIV risk losing their housing due to compounding factors, such as increased medical costs and limited incomes or reduced ability to keep working due to HIV and related illnesses, and now direct and/or indirect effects of the COVID-19 pandemic.

HOPWA project sponsors report an ongoing need for short-term rent, mortgage, and utility assistance, as well as requests for supportive services such as transportation, mental health counseling, peer support groups, and alcohol and other drug (AOD) abuse counseling/treatment. Service providers identified the following supportive services as needed to assist PWH to reduce homelessness:

1. Employment services
2. Job development
3. Permanent supportive housing services (housing, in-home case management home visits, in-home mental health services)

4. Medical case management (medical, mental health, AOD services); MCM maintains stable housing and linkage to care
5. Access to mental health/AOD services/medical care
6. More supportive housing
7. Budgeting courses

Service providers utilize a comprehensive, standardized intake format for case managers working with persons living with and/or affected by HIV, resulting in a more thorough assessment of the client's needs and a corresponding increase in referrals to programs, such as HOPWA, that can help clients stay in their homes or shelters and off the streets where they are even more susceptible to opportunistic infections and other negative outcomes. Additional information is gathered from service providers concerning client needs through the following:

1. Working directly with clients
2. Client surveys
3. Client assessments
4. Knowledge of housing trends in the local area

Recommendations to Address Gaps

Continue building on the success of medical case management services. Recruitment and retention of case managers should be a high priority. While assessment findings consistently pointed to the delivery of high-quality case management services, PWH reported frustrations at case managers leaving employment and "having to start all over" with new case managers.

Innovative models of service delivery should be considered. As innovative collaborations have been identified as a strength of the SCSN, the Integrated Plan should continue to foster collaboration between prevention and care providers, private sector providers, DHEC-funded entities, and other health centers (e.g. CHCs, FQHCs). A broad agreement was reached that, due to COVID, telehealth expansion was successful and unprecedented. Moving into this next five-year plan, innovation in terms of offering telehealth consultation, especially in more rural areas, may be something to consider.

Enhancing access to behavioral health services is an ongoing issue that continues to merit attention. For care sites that are receiving both Part B services and other HRSA funding as a health center, accessing behavioral health tends to be easier. The availability of funding (including 430(b) funds) means CHCs appear to be a model for others to emulate. Innovative inter-agency collaborations or other cost-sharing may allow more clinical sites to expand behavioral health services.

Guide to help with PrEP clinic set-up. To increase PrEP access, some agencies are eager to create their in-house PrEP clinic and delivery system. Unfortunately, their efforts have been hampered because there is no readily available guide that outlines the steps for implementing such a clinic. Identifying or creating such a guide would be helpful to agencies.

> *We're eager to offer PrEP to our clients but don't know where to begin and who to bring to the table.*
>
> *-Stakeholder*

Surveillance Data. Stakeholders noted that to provide efficient cluster response, surveillance data would need to be updated in a timelier fashion as it is often "lagging and not current." Further, data is not shared across the state, is often stored in non-compatible software systems (e.g., eHARS and SCION are not consistent data systems), and is not always comprehensive (e.g., eHARS does not collect ethnicity). Also, the quality of surveillance data can have problems and therefore may not always provide an accurate picture. Moreover, security and confidentiality laws inhibit the sharing of information across systems and agencies, thereby hindering the identification and response to a cluster outbreak. The feedback from stakeholders suggests some misconception of surveillance processes and data systems.

To provide the most accurate and complete data to the public, surveillance data goes through a complex cleaning and deduplication process (and numbers can, and will, change dramatically during that process). Surveillance data systems are continuously updated, as new lab tests and other information are imported or manually entered daily. Data reports that are used to fulfill data requests may be considered “lagging and not current” because the data is a year behind due to the data cleaning processes conducted by surveillance. Some suggestions from internal stakeholders suggest ensuring the accuracy of data from providers and laboratories initially could help to ensure data is received in a timelier manner with minimal data clean-up efforts from surveillance. Often, surveillance receives inaccurate demographic information that is updated during the cleaning process. Surveillance data systems can collect and receive all demographic information, including ethnicity, but this information is not always provided directly to surveillance from all laboratory or provider reports and must be collected during follow-up procedures.

Surveillance and stakeholders will need to work together more closely to create a solution to more initial complete data reporting to create timelier data on the front-end which may assist with minimizing data clean-up efforts through surveillance processes.

Foster Enhanced Collaborations. During discussions of prevention, testing, linkage to care, and cluster response, the need for collaborations was noted repeatedly. Stakeholders believe effective collaborations would allow for connectivity across data systems to identify those in need of re-engagement into care as well as those in need of retention into care when changing locations or providers. Effective collaborations would also provide the ability to share resources and specific services across agencies to enhance rapid linkage to care and in some cases provide a “one-stop-shopping” experience for clients. Stakeholders called for the creation, strengthening, or re-activation of collaborations in their respective regions.

Priority populations

A key function of the HIV Planning Council has been the identification of priority populations for prevention support. The following groups represent priority populations receiving targeted high-impact prevention services: persons living with HIV (PWH); African American Men who have Sex with Men (AAMSM); Transgender Men and Women; African American Heterosexuals at High Risk; White Men who have Sex with Men (WMSM); Hispanics/Latinos, and Persons Who Inject Drugs (PWID).

Integrated HIV Prevention and Care Plan

Section V: 2022-2026 Goals and Objectives

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 engagement forums and synthesized by South Carolina Department of Health and Environmental Control (DHEC) staff into this document. Both the pillars of the EHE process and HIV/AIDS Strategy—and accompanying interventions—have been reviewed in the creation of this plan.

Overarching Goal: Reduce new HIV infections by 90% by 2030

DIAGNOSE: By December 31, 2026, at least 90% of South Carolinians living with HIV will be aware of their HIV status.

Objective 1: Increase the capacity of health care delivery systems, public health, and the health workforce to diagnose HIV.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023 (and ongoing), 100% of funded clinical and non-clinical providers conducting HIV testing will be trained by DHEC with an approved testing curriculum.	DHEC, DAODAS, FQHCs, CBOs, other funded sub-recipients	CDC Prevention, CDC EHE,	Increase capacity to deliver HIV testing	Training records
By 12/31/2023 (and ongoing), quality assurance of 100% of trained staff will be conducted by supervisors or DHEC.	DHEC, DAODAS, FQHCs, CBOs, other funded sub-recipients	CDC Prevention, CDC EHE,	Increase capacity to deliver quality HIV testing	Training records, site visit documentation
By 12/31/2024 (and ongoing) 80% of funded clinical and non-clinical providers will be trained in Cultural Humility or a related course by DHEC-sponsored training entity.	DHEC, Part F grantee, other contract agencies	CDC Prevention	Increase capacity to deliver culturally and linguistically competent services	Training records, program monitoring records

Objective 2: Develop new and expanded implementation of effective, evidence-based models for HIV testing that improve convenience and access.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2026, all DHEC health departments will enhance provision of high-quality HIV testing.	DHEC, health departments	CDC Prevention, CDC EHE	Increase quality of HIV testing services.	Clinical reports, evaluation QA reports

By 12/31/2026, at least 25% of DHEC health departments will increase access to HIV testing through expanded hours, community outreach, mobile testing, or non-traditional HIV testing.	DHEC, health departments	CDC Prevention, CDC EHE	Increase access to HIV testing services. Increase in the no. of HIV tests performed	Clinical reports
By 12/31/2026, DHEC will collaborate with DAODAS to expand HIV testing interventions by 10%.	DHEC, DAODAS	CDC Prevention, DAODAS	Increase quality of HIV testing services.	No. of testing sites, no. of HIV tests performed
By 12/31/2023 (and ongoing), DHEC will promote a status-neutral approach to HIV testing, offering linkage to prevention services for individuals who test negative and provide immediate linkage to HIV care and treatment for who test positive.	CDC	CDC HRSA Ryan White HRSA Ryan White Part B	Increased referrals to prevention services Increased referrals and linkage to HIV care and treatment	EvaluationWeb
By 12/23/2023 (and ongoing), DHEC will provide partner services to persons diagnosed with HIV and their partners to ensure at least 90% of those newly identified as HIV positive are interviewed for partner services	CDC	CDC	Increased percentage of persons who are interviewed for partner services (Baseline 2021 – 40%)	SCION EvaluationWeb
By 12/31/2024 (and ongoing), implement and/or enhance high-risk partner services at Ryan White sites including increasing EIS services and referral of negative partners to high-risk interventions by 5%.	DHEC Ryan White Providers	HRSA Ryan White	Increase testing access	Ryan White Program Services Report (RSR) – EIS Services

NOTE: To meet the National HIV/AIDS (NHAS) Objective 1.2. Increase knowledge of HIV status, DHEC will continue to support and expand HIV testing services as detailed in the 2020 EHE Plan including:

- Community-based mobile HIV testing
- Latinx community-based HIV testing
- Distribution of HIV home/self-testing kits
- Retail pharmacy HIV testing

- Jail-based HIV testing
- Promotion of routine-opt out HIV testing for clinical providers

Goal: Improve HIV-Related Health Outcomes for People with HIV in South Carolina

TREAT: By December 31, 2026:

- More than 90% of newly diagnosed individuals will be linked to care within 14 days of receipt of their HIV test results (aligns with NHAS Objective 2.1).
- More than 75% of newly diagnosed individuals will be initiated on ART within 30 days of receipt of their HIV test results (aligns with NHAS Objective 2.1).

Objective 1: Increase the capacity of health care delivery systems, public health, and the health workforce to provide clinical services to PWH.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2022 (and ongoing), DHEC will continue the Medical Case Management Educational Training series offering required and elective courses available to all Medical Case Managers statewide. Courses will be updated as determined by MCM supervisors, DHEC, and AETC staff based on emerging needs over the next 5 years.	DHEC, AIDS Education Training Center (AETC), Ryan White Providers	HRSA Ryan White B	Routine, relevant training for new and continuing medical case managers accessible to all medical case managers statewide	Medical Case Management Educational Training Series Training Calendar
By 12/31/2023 (and ongoing), 100% of Ryan White Part B (RHB) Medical Case Managers providing Ryan White services will complete required MCM Educational Training series as outlined in the SC Ryan White Part B MCM Standards. Training will be available to all MCMs statewide regardless of Ryan White Part funding.	DHEC, AETC, Ryan White Providers	HRSA Ryan White B	Increased capacity for delivering MCM services statewide	Training records
By 12/31/2024 (and ongoing) 80% of DHEC- funded clinical and non-clinical staff providing RW and HOPWA services will be	DHEC, AETC, Ryan White Providers,	HRSA Ryan White B	Increased capacity to deliver culturally and	Training records

required to complete Cultural Humility training by a DHEC-sponsored training entity.	HOPWA Providers		linguistically competent services	
By 12/31/2023 (and ongoing), annually, SC Quality Management Steering Committee (which includes PWH representation) will include AETC in a Steering Committee Meeting to review clinical courses needed to meet basic and emerging HIV care and treatment needs based on clinical quality management performance indicators.	DHEC, AETC, Ryan White Providers	HRSA Ryan White B	Increase clinical capacity to deliver HIV medical services	Training records, Clinical Report Card
By 12/31/2023 (and ongoing), implement and continue on twice-a-year basis a Statewide Peer Training Program through HRSA's NMAC Program.	DHEC, PWH, Ryan White Providers, NMAC	HRSA Ryan White B	Increase capacity to deliver Peer Services	Training records
By 12/31/2023 (and ongoing) conduct twice a year Outreach In-service training for RWB Program funded new and continuing (as needed) Outreach, Specialized MCM, and Peer Adherence staff.	DHEC, Ryan White Providers	HRSA Ryan White B	Increase capacity to provide Outreach, SMCM, and Peer Adherence services statewide	Training records
By 12/31/2022 (and ongoing) MCM Workgroup Meetings will be held bi-monthly consisting of medical case management leadership from each RWB-funded organization and DHEC staff to discuss topics including, but not limited to, compliance with MCM Standards and MCM staffing strategies related to turnover, caseloads, recruitment, retention, and training.	DHEC, Ryan White Providers	HRSA Ryan White B	Increase capacity for MCMs to meet the SC RWB Service Standards and SC RWB MCM Standards	Meeting Attendance
By 12/31/2023, DHEC will establish a Public Health Academic Detailing program to assist providers with the implementation of evidence-based clinical practices related to HIV treatment.	DHEC, AETC	HRSA Ryan White Part B and State Funds	Documented changes in provider practices via surveys and evaluations.	Public Health Detailing Guidance

Notes: Related to NHAS Objective 2.4, SC's EHE Plan includes increasing provider capacity by providing training on staff retention and supportive supervision, trauma-informed care, and Anti-retroviral Treatment and Access to Services (ARTAS).

Objective 2: Provide high-quality HIV care aligned with HIV care guidelines and HRSA standards across all RW and HOPWA programs.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023 (and ongoing) continue adherence to applicable established national and state guidelines and standards, and any revisions made, including: HRSA HIV National Monitoring Standards, HOPWA Regulations, SC Ryan White Part B Service Standards, SC Ryan White Part B Medical Case Management Standards, HHS Treatment Guidelines, Rapid Engagement Metrics, and SC HOPWA Guidelines. Continually update and publicly communicate SC guidelines and standards in accordance with federal changes on the DHEC website and at HPC and Ryan White All Parts Meetings.	DHEC, RW Providers, HOPWA providers	HRSA Ryan White	Communicated, updated guidelines and standards in compliance with HRSA, HUD, and state requirements.	Guidelines and Standards
By 12/31/2023 (and ongoing), continue and increase the provision of RW-eligible core and supportive services to PWH by 3% annually (e.g. outpatient ambulatory health, oral health, medical case management, mental health, transportation, substance abuse services)	DHEC, Ryan White Providers	HRSA Ryan White	Provision of RW core and supportive services to PWH	RSR – Total Clients Served
By 12/31/2026, 90% of all RW provider sites will provide rapid entry to care and rapid treatment as started through RWB EHE funding.	DHEC, Ryan White Providers	HRSA Ryan White HRSA Ryan White Part B EHE	Access to treatment within 7 days of diagnosis. Increased retention in care and viral suppression rates	*Provide Enterprise (PE)* Date of diagnosis to 1st medical appointment HIV Care Continuum

(For non-RWB EHE-funded RW providers, eligibility determination will be facilitated through the use of rapid-rapid testing, on-site confirmatory testing, and a brief assessment.)				
By 12/31/2023 (and ongoing), increase utilization by 5% annually of Housing Opportunities for Persons with AIDS (HOPWA) program services, including supportive services, STRMU, permanent housing placement, TBRA, and facility-based housing.	DHEC, HOPWA Providers	HOPWA	Provision of HOPWA services to PWH decreasing risk of homelessness and increasing retention in care	HOPWA CAPER Report HIV Care Continuum
By 12/31/2023 (and ongoing), ensure ADAP resources are available to meet the needs of the Direct Dispensing Program (DPP) providing medications for uninsured PWH.	DHEC, Ryan White Providers	HRSA Ryan White Part B	Provision of ADAP DDP services to uninsured PWH to achieve viral suppression	Number of clients enrolled in DDP HIV Care Continuum
By 12/31/2023 (and ongoing), expand the ADAP Insurance Assistance Program (IAP) by 10% annually increasing access for PWH to insurance coverage for HIV care and HIV medications (insurance benefits also cover non-HIV care needs.)	DHEC, Ryan White Providers	HRSA Ryan White Part B	Provision of ADAP IAP services to PWH to achieve viral suppression	Number of clients enrolled in ADAP IAP HIV Care Continuum
By 12/31/2023 (and ongoing), continue and expand the ADAP Health Insurance Premium Contracts to 100% of RWB providers increasing access for PWH to insurance coverage for HIV care and HIV medications (insurance benefits also cover non-HIV care needs).	DHEC, Ryan White Providers	HRSA Ryan White Part B	Increased access for PWH to ADAP IAP to achieve viral suppression	Number of ADAP Health Insurance Premium contracts HIV Care Continuum
By 12/31/2023 (and ongoing), update ADAP formulary (in accordance with HRSA HAB requirements) as new medications and classes of medications become available.	DHEC	HRSA Ryan White Part B	Access to medications for PWH to achieve viral suppression	ADAP Formulary

By 12/31/2023 (and ongoing) increase enrollment of PWH in ADAP Medicare Assistance Program (MAP) by 2% annually and increase the PWH participation in the Medicare premium payment program by 5% annually.	DHEC, Ryan White Providers	HRSA Ryan White Part B	Assistance with Medicare premiums, copayments, and deductibles for PWH to achieve viral suppression	Number of clients enrolled in MAP and MAP Premium Programs HIV Care Continuum
By 12/31/2024, explore additional partnerships with Department of Mental Health for possibly increasing capacity and access to mental health services.	DHEC RW Providers	HRSA Ryan White	Increase access to mental health services	RSR – Mental Health Services

Note: Related to NHAS Objective 2.5, expand capacity to whole-person care, the SC EHE Plan includes improvement of the coordination of housing programs for PWH statewide. DHEC will continue to support the implementation of the SC EHE Plan including:

- Rapid linkage to care and rapid initiation of ART with RWB EHE Funds as detailed in the 2020 SC EHE Plan.
- Increasing housing assistance through HOPWA

Objective 3: Identify, engage, or reengage people with HIV who are not in care or not virally suppressed.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023 (and ongoing), maintain the Outreach Program, including the implementation of the PE Outreach Module for monitoring and evaluation of the Outreach Program, including continuous improvements to the enhanced care plan. As funding is available, consider increasing staffing, as needed.	DHEC, Groupware Technologies Incorporated, RW Providers	HRSA Ryan White Part B	Outreach workforce reducing the number of PWH out of care, increasing retention in care rates.	RSR – Outreach Services Not in Care List HIV Care Continuum
By 12/31/2023 (and ongoing), maintain the Specialized Medical Case Management Program ensuring specialized medical case management staff are available to focus on clients who have fallen out-of-care, returning to care and those who are at risk	DHEC, RW Providers	HRSA Ryan White Part B	Specialized Medical Case Managers reducing the number of PWH out of care, increasing retention in care rates.	Not in Care List HIV Care Continuum

of falling out-of-care. (Specialized MCM will have lower caseloads allowing for more frequent contacts/providing services to clients returning to care.) As funding is available, consider increasing staffing, as needed.				
By 12/31/2023 (and ongoing), maintain and expand Peer Services, by supporting recruitment and utilization of peers to provide services to clients served by RW providers.	DHEC, RW Providers	HRSA Ryan White HRSA Ryan White Part B HRSA Ryan White Part B EHE	Increased number of PWH employed or volunteering in delivering RW services to PWH at RW providers, increasing retention in care and viral suppression rates.	*Provide Enterprise*, Peer Services provided HIV Care Continuum
By 12/31/2026, rebuild Consumer Advisory Boards at RW Providers offering opportunity for PWH input into local program planning. 80% of RWB providers will have CABs by 12/31/26.	DHEC RW Providers	HRSA Ryan White	Increase PWH local planning opportunities to impact linkage, retention, and viral suppression rates.	Number of Consumer Advisory Boards HIV Care Continuum
By 12/31/2023 (and ongoing), maintain the Data to Care Program utilizing the Health Dept Model to engage and re-engage PWH in care. Continue work with DHEC Division of Surveillance, Assessment, and Evaluation (SAE) for data enhancements.	DHEC	HRSA Ryan White Part B EHE CDC Prevention EHE	Reduce the number of PWH out of care, increase linkage and retention in care rates, and increase viral suppression.	Not in Care List EHE Tri-Annual Report HIV Care Continuum
By 12/31/2023 (and ongoing), enhance Outreach and Data to Care coordination efforts to reengage PWH in care.	DHEC RW Providers	HRSA Ryan White Part B HRSA Ryan White Part B EHE	Streamline processes to support the coordination of Data to Care and the Outreach program working simultaneously to increase linkage and retention in care rates.	Not in Care Line HIV Care Continuum

		CDC Prevention EHE		
By 12/31/2024 (and ongoing), maintain and enhance relationships with jail, prisons, and expanded testing sites to link clients that are released or provide eligible services where other federal or state resources are not available for HIV care	DHEC RW Providers SC Department of Corrections	HRSA Ryan White HRSA Ryan White Part B MAI CDC Demonstration Project - Prison	Increase the number of testing sites that link clients to RW providers, increasing retention in care rates.	RSR - MAI Services HIV Care Continuum

Note: DHEC will continue to support implementation of the SC EHE Plan including:

- Maintain social work staff in the DHEC public health regions to facilitate rapid linkage to care.

Objective 4: Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2024 (and ongoing), 95% of clients enrolled in medical case management will have a care plan developed to address their individualized needs and barriers (e.g., transportation, mental health, substance abuse, housing, nutrition) that is reviewed by the mcm with the client at the mid-point check-in and the annual re-assessment.	DHEC Ryan White Providers	HRSA Ryan White	Increased retention in care and viral suppression rates	Percentage of MCM clients who have a medical care plan developed (Clinical Report Card – SC QM #11.0) HIV Care Continuum
By 12/31/2026, increase the number of RW providers to 70% offering non-traditional hours to meet the needs of clients.	DHEC Ryan White Providers	HRSA Ryan White	Increased access to care	Number of RW providers with non-traditional hours

By 12/31/2026, expand transportation options increasing transportation services by 5% annually at RW providers to include the following: purchase/lease of vehicles (as allowable), hiring drivers, gas cards, public transportation, Uber/Lyft services, contracting with local transportation providers, coordinating regionally available vehicles and drivers, etc…. Continue HPC Care and Support Committee work on transportation services.	DHEC Ryan White Providers	HRSA Ryan White HRSA Ryan White Part B EHE	Increased access to care	RSR – Transportation Services
By 12/31/2026, decrease client transportation barriers by taking services to clients by expanding locations/sites and expanding telehealth and mobile health options offered by RW providers by 30%.	DHEC Ryan White Providers	HRSA Ryan White HRSA Ryan White Part B EHE	Increased access to care	Number of sites where RW Services are provided Telehealth and mobile health services documented in *Provide Enterprise*
By 12/31/2023 (and ongoing), DHEC will expand DHEC HOPWA funded services available by adding HOPWA "Short Term Housing" to allow for the services of Transitional Shelter Rent and Hotel/Motel Leasing as allowable services funded with HOPWA. DHEC will pilot a HOPWA-funded Employment Services Program with one HOPWA Provider	DHEC HOPWA Providers	HOPWA	Decrease risk of homelessness, increase retention in care, and viral suppression rates	HOPWA CAPER HIV Care Continuum
By 12/31/2023 (and ongoing, as needed), conduct focus groups and/or convene a statewide and/or regional housing planning committee including PWH to determine barriers to housing, especially considering	DHEC RW Providers	HRSA Ryan White HOPWA	Decrease risk of homelessness, increase retention in care and viral suppression rates	Meeting agendas and minutes

recovery from COVID impacts and the increasing rental rates, and develop solutions within the RW and HOPWA guidelines and standards. Also see SC EHE Plan.	HOPWA Providers			
By 12/31/2026, as funds allow, including targeting new funding opportunities, increase mental health services provided by RW Providers by 10% annually through increasing local referral partners for mental health services and/or hiring mental health providers to provide services on-site. See also SC EHE Plan.	DHEC RW Providers	HRSA Ryan White HRSA Ryan White Part B EHE	Decrease barriers to care and increase retention in care and viral suppression	RSR – Mental Health Services HIV Care Continuum
By 12/31/2026, as funds allow, including targeting new funding opportunities, increase substance abuse services provided by RW Providers by 10% annually through an increase of local referral partners for substance abuse services and/or hiring substance abuse providers to provide services on-site. See also SC EHE Plan	DHEC RW Providers	HRSA Ryan White HRSA Ryan White Part B EHE	Decrease barriers to care and increase retention in care and viral suppression rates	RSR – Substance Abuse Services HIV Care Continuum
By 12/31/2026, as funds allow, including targeting new funding opportunities, increase Peer services available at RW Providers. Training will be provided through the NMAC training twice per year, as above.	DHEC RW Providers	HRSA Ryan White HRSA Ryan White Part B EHE	Increase retention in care and viral suppression rates	Training records HIV Care Continuum

See also SC EHE Plan.				
By 12/31/2024, establish local relationships with local food banks and, as funds are available, establish food banks or a food voucher program on-site at RW Providers to increase Food Bank referrals and services provided by 5%.	DHEC RW Providers	HRSA Ryan White	Increase retention in care and viral suppression rates	RSR HIV Care Continuum
By 12/31/2024, increase linguistic services by hiring bi-lingual staff and ensuring translation services are available, as needed, through contracted translation services decreasing barriers.	DHEC RW Providers	HRSA Ryan White	Increase retention in care and viral suppression rates	RSR – Linguistic Services HIV Care Continuum

Note: DHEC will continue to support the 2020 SC EHE Plan including:

- Behavioral health needs, including mental health and substance abuse
- Increasing housing assistance through HOPWA and collaboration with statewide HOPWA providers
- Pilot projects to decrease barriers to transportation
- Expansion of Peer Services

Objective 5: Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving organizational, local, and national goals.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/23 (and ongoing), conduct annual Client Needs Assessment. Prepare and distribute a statewide summary of the needs assessment on the DHEC website and at HPC and RW All Parts Meetings for use in state and local planning.	DHEC, RW Providers	HRSA Ryan White	Distribution of summary statewide report for use in program planning.	Needs Assessment Summary
By 12/31/24 (and ongoing), implement a Consumer Satisfaction	DHEC, RW Providers	HRSA Ryan White Part B	Implementation of the survey and distribution	Consumer Satisfaction Survey Summary

Survey to monitor ongoing satisfaction of RW services provided. And, prepare and distribute a statewide summary of the Consumer Satisfaction Survey on the DHEC website and at HPC and RW All Parts Meetings for use in state and local planning.			of statewide summary reports for use in program planning.	
By 12/31/23 (and ongoing), maintain the statewide Clinical Quality Management Program, including ADAP, in adherence to HRSA HAB's PCN 15-02 with Performance Measures reported via the Clinical Report Card.	DHEC, RW Providers	HRSA Ryan White	Continuous quality improvement	Clinical Report Card (CRC)
By 12/31/23 (and ongoing), DHEC will monitor 100% of DHEC funded RWB and HOPWA Providers to include: site visits reviewing fiscal, services, and quality; RSR reporting in compliance with HRSA, and Quarterly Compliance Reporting.	DHEC, RW Part B Provers	HRSA Ryan White Part B	Evaluation of programs	Site Visit Summary Report RSR Quarterly Compliance Reports

NOTE: Related to NHAS Objectives 2.1 and 2.2, DHEC will continue to support clinical care as detailed in the 2020 EHE Plan including:

- Rapid linkage to care
- Rapid initiation of ART

PREVENT: By December 31, 2026, there will be a 75% reduction in new HIV cases in South Carolina.

Objective 1: Integrate programs to address the syndemic of HIV, sexually transmitted infections (STIs), viral hepatitis, and substance use and mental health disorders				
Strategies	Partners	Funding	Outcomes	Data Source

By 12/31/2023 (and on-going), DHEC will promote an understanding of the syndemics of HIV, STIs, viral hepatitis, and substance use disorders through its Ending the Epidemics campaign and at least 5 national observances.	DHEC, CDC, HRSA	CDC	Increased awareness of HIV, STIs, viral hepatitis, and substance use disorders.	EtEs Plan, National Observances
By 12/31/2023, DHEC will continue to support integrated services (HIV, STIs, and Hepatitis) among at least 8 HIV prevention community-based providers and 46 local DHEC health departments.	DHEC, CDC, CBOs	CDC	Increased number of HIV, STIs, and Hepatitis screenings	BOL Data; EvaluationWeb
By 12/31/2023, DHEC will continue partnering with DAODAS for training and technical assistance to deliver HIV and HCV testing in at least 4 Recovery Community Organizations (RCOs) and at least 10 Alcohol and other Drug Sites (AODs).	DHEC, CDC, DAODAS	DAODAS	Increased capacity to provide HIV and HCV testing among RCO and AOD sites	DAODAS contract, training records
By 12/31/2023, DHEC will hire at least 4 Community Health Workers (CHWs) to support the four pillars of EHE in the regions.	DHEC	CDC	Increased community engagement Increased PrEP referrals Increased community awareness	Position descriptions

Objective 2: Expand and improve implementation of effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options. Aligns with NHAS Objective 1.3.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023, DHEC will establish a Public Health Detailing program to assist	DHEC, USCSOM	CDC STD, CDC (EHE), and MUSC	Expansion of PrEP services	Public Health Detailing Guidance

providers with the implementation of PrEP services within their clinics.			Increased number of PrEP providers (baseline = 59?) Increased access to PrEP services	PrEPMeSCDirectory
By 12/31/2025, DHEC will offer PrEP telemedicine in all 4 public health regions in partnership with the Medical University of South Carolina.	DHEC, MUSC	MUSC	Increased access to PrEP services (baseline = 2 regions providing PrEP telemedicine in 2022) Increased number of individuals receiving PrEP services	Contract between DHEC & MUSC; PrEP Telemedicine report
By 12/31/2023, DHEC will continue to promote harm reduction materials and offer data to decision-makers regarding syringe services and the needs of persons who inject drugs.	DHEC	CDC	Increased awareness of harm reduction and the benefits of syringe services	Harm reduction materials Determination of need
By 12/31/2026, DHEC will reduce barriers to PrEP through supporting PrEP labs for funded subrecipients (approximately 320 clients annually).	DHEC, CBOs	CDC	Increased access to PrEP services	No. of PrEP clients and labs supported annually through BOL
By 12/31/2026, DHEC will support the adoption of innovative PrEP service models and modes of medication delivery.	DHEC, CBOs, CDC	CDC Prevention, CDC EHE	Increased number of individuals receiving PrEP services	EvaluationWeb, AHEAD Dashboard

Objective 3: Identify and implement best practices including behavioral interventions and communication strategies.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023 (ongoing), DHEC will continue to support at least 3 evidence-based and evidence-	DHEC, CBOs	CDC Prevention, CDC EHE	Increased number of persons seeking HIV testing following	Training Records Annual Deliverables

informed behavioral interventions among at least 4 community-based HIV providers.			completion of prevention interventions	
By 12/31/2023 (ongoing), HIV/STD/VH division will continue to work with DHEC Communications division to identify effective communication strategies to reach vulnerable populations.	DHEC	CDC Prevention, CDC EHE	Increased number of communication outlets	Communication Plan

Objective 4: Engage, employ, and provide public leadership opportunities at all levels for people with or at risk for HIV. Aligns with NHAS Strategy 3.2.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023, DHEC will encourage funded sub-recipients to recruit and employ individuals with lived experience.	DHEC, CBOs	CDC, HRSA Ryan White	Increased opportunity for persons with lived experience	DHEC contracts
By 12/31/2023, DHEC will actively recruit candidates with lived experiences for HIV prevention positions.	DHEC	CDC	Increased opportunity for persons with lived experience	DHEC contracts

Objective 5: Address social determinants of health and co-occurring conditions that exacerbate HIV- related disparities.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2026, DHEC and sub-recipients will work toward increasing the assessment of social determinants of health, regardless of HIV status.	DHEC, CBOs	CDC Prevention, CDC EHE	Decrease health disparities/barriers to prevention and care	Evaluation Web

By 12/31/2026, DHEC staff and community partners will enhance referrals to community agencies with tangible resources to address SDoH.	DHEC, CBOs, social service agencies	CDC Prevention, CDC EHE	Increased referrals/ Decrease health disparities	Evaluation Web/Provide
By 12/31/2026, HIV testing clients in DHEC and DHEC-funded sites will be screened for and referred to essential support services.	DHEC, CBOs, social service agencies	CDC Prevention, CDC EHE	Decrease health disparities/barriers to prevention and care	Evaluation Web

Note: DHEC will continue to support HIV prevention services as detailed in the 2020 EHE Plan including:

- Funding community-based comprehensive PrEP services
- Increase HIV PrEP training for clinicians
- Harm reduction approaches as allowed under SC law
- Increase services for the Latinx community including additional staff
- Increase the use of social media and marketing
- Continue to support local/regional SHAPE initiatives

RESPOND: By December 31, 2024, DHEC and community partners will have all systems in place for seamless response to HIV outbreaks in South Carolina.

Objective 1: Increase the capacity of health care delivery systems, public health, and the health workforce to respond to HIV outbreaks.				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023 (an on-going), DHEC will increase the number of internal DHEC, and external stakeholders involved in cluster detection and response (CDR) planning, implementation, and evaluation.	DHEC, CBOs, FQHCs, community partners	CDC	Increased capacity to respond to HIV outbreaks	No. of CDR stakeholders

By 12/31/2023 (and on-going), DHEC's SAE will continue the monthly analysis to identify molecular clusters and time-space clusters using Secure HIV-Trace and SAS	CDC, DHEC SAE	CDC	Increased identification of new clusters or growths in clusters No. of clusters identified through HIV-Secure Trace Increases identified by Time-Space Analysis	HIV-Secure Trace, eHARS
By 12/31/2023 (and ongoing), the CDR working group will meet at least quarterly to prepare and plan for response efforts and to debrief and perform continuous quality improvement activities following outbreaks.	DHEC, CBOs, FQHCs, community partners	CDC	Increased capacity to respond to HIV outbreaks	CDR workgroup meeting agenda and/or minutes
By 12/31/2023 (and ongoing), the cluster detection and response plan will be reviewed annually	DHEC, CBOs, FQHCs, community partners	CDC	Increased capacity to respond to HIV outbreaks	CDR Plan
By 12/31/2023, DHEC will increase the capacity to identify DIS and Provider detected clusters by educating DIS and Providers	DIS	CDC	Increased number of DIS and/or provider identified clusters	SCION

Objective 2: Enhance the quality, accessibility, sharing, and use of data to identify and respond to HIV outbreaks.				
Strategies	Partners	Funding	Outcomes	Data Source
By December 31, 2023 (and ongoing), DHEC will promote the importance of genotype testing among providers in the state	DHEC, clinical providers	CDC	Increased genotypes	eHARS

By December 31, 2023 (and ongoing), DHEC will increase the number of data sharing agreements (DSA) and memorandum of understanding (MOUs) to assist in the response to HIV outbreaks	DHEC, CBOs, FQHCs	CDC	Increased data sharing/usage agreements	DSAs, MOUs

Goal: Reduce HIV-Related Disparities and Health Inequities

Objective 1: South Carolina will reduce HIV-related stigma and discrimination				
Strategies	Partners	Funding	Outcomes	Data Source
By 12/31/2023 (and ongoing), DHEC will ensure funding opportunities align with priority populations and areas of greatest need	DHEC	CDC HRSA Ryan White	Funding alignment with needs	Request for Grant Applications
By 12/31/2023 (and ongoing), DHEC will publish an annual Epidemiological Profile to increase the awareness of HIV-related disparities	DHEC	CDC	Increased awareness and dissemination of HIV-related disparities	Epi Profile

Note: DHEC will continue to support stigma reduction activities as detailed in the 2020 EHE Plan including:

- Customer service/client-centered culture training
- Development of anti-stigma campaigns
- Cultural humility training
- Increasing bilingual staff to enhance Latinx services
- Build capacity of PWH to provide input at health departments and community forums

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

Anticipated Challenges or Barriers

The current plan is an aggressive one, but DHEC and its partners feel confident in their ability to build on existing successes and continue improving prevention and care services. Key issues to monitor and address include:

Changing Funding Levels. With limited state funding for HIV services, DHEC and partners have consistently relied on Federal funds with unique mandates. Over the last several funding cycles, DHEC looks to build sustainability into funding applications and has deepened its internal commitment to capacity building. With this increased focus on sustainable interventions, the prevention and care staff feel they are addressing a key potential challenge. Finally, a significant number of external partners have a 340(b) pharmacy program in place. This allows those agencies to make a profit on medications and treatment and to use that profit to support other prevention and care activities.

Personnel Needs. Like much of the public health workforce, HIV prevention and care providers are aging out of the workplace and the gaps being left have been noted. DHEC has a long history of working with students in schools of preparation (medicine, nursing, social work, etc.) to serve as fellows and interns and gain exposure to public health as part of their schooling. In addition, DHEC continues a long and successful collaboration with the AETC in South Carolina. As part of the Part F requirements, the AETC in South Carolina performs an annual needs assessment and works closely with DHEC to identify training needs and implement those as part of their annual plan.

"Siloed" Approach to Service Delivery. No doubt partly due to discreet funding streams, HIV providers have, at times, not been as effective at collaboration as they might have been. Recent efforts at enhancing linkage to care and retention in care have brought about unprecedented levels of collaboration within DHEC surveillance, prevention, and care offices, In turn, they have supported regional staff and external partners to follow suit. As the 2022 plan is rolled out, there will be an increase in collaboration internally and that expectation will be conveyed to prevention and care agencies funded by DHEC.

Section VI: Updates to Other Strategic Plans Used to Meet

Updates to other strategic plans used to meet requirements

As suggested earlier, this 2022-2026 planning/implementation approach builds on the successful initial phases of the 2020 SC EHE Plan. This plan coincides nicely with the activities proposed in the EHE plan and that synergy will assure that the most comprehensive response to barriers and gaps in both HIV prevention and care services are being prioritized.

In addition, DHEC staff reviewed the 2016 SC AIDS Strategy to glean insights and develop models that addressed the National HIV/AIDS Strategy. Based on input from Federal monitors, the decision to use the goals of the HIV/AIDS Strategy was determined to be the best match for organizing the goals and activities to address the needs outlined in the SCSN. A detailed set of goals, objectives, and activities was drafted by internal DHEC staff and brought to the HPC for input at the June 2022 HPC meeting. The document was revised and presented at the August 2022HPC meeting where the planning council voted to support the plan and a letter of concurrence was approved as part of the meeting proceedings.

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 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;
(3) Collaborate with HPC partners on how best to obtain additional data and information;
(4) Assess existing community resources to determine the community's capability to respond to the HIV epidemic;
(5) Identify unmet HIV prevention and care needs within defined populations;
(6) Prioritize HIV prevention and care needs among target populations based on the HIV epidemiologic data in South Carolina and propose high-priority strategies and interventions;
(7) Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation;

(8) Ensure that the following services and needs are addressed in the comprehensive HIV Prevention and Care Plan: a) HIV counseling, testing, and linkage services; b) early intervention, primary care, specialty care, drug assistance, and other HIV-related services; c) sexually transmitted disease, viral hepatitis, tuberculosis and substance abuse prevention and treatment; d) mental health services; and e) other public health needs.

The progress and/or challenges in meeting the goals of the plan will be discussed during HPC meetings each year. 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 and Viral Hepatitis Conference, one of the premier statewide infectious disease conferences. Several HPC members serve on the conference's planning committee and are involved in the development and oversight of the annual event. 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 DHEC is held annually. The Ryan White All Parts Quality Management (QM) Steering Committee facilitated by DHEC meets semi-annually. The Ryan White Part C providers meet every other month, and the Part B Directors meet quarterly with monthly sub-recipient 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). 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, the 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 DHEC are documented using multiple data-collection tools. DHEC is mandated by PS18-1802 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 Linkage Services in the form of rapid HIV testing information received from grantees funded by DHEC. Grantees are required to enter all HIV rapid test results (reactive, non-reactive, and indeterminate) monthly. This testing information is uploaded to CDC to monitor South Carolina's PS18-1802 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.

DHEC prevention grantees are required to submit a monthly monitoring and evaluation report (MMER). The MMER is an internal report that requires grantees to provide information of meeting contract deliverables, condom distribution, challenges and barriers, and technical assistance needs. This report also 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 crossed 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 a 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 DHEC staff regarding progress towards benchmarks and the need for program improvement plans. Following the analysis of data, DHEC staff will share findings with partners. Where problems exist, the intention is to work collaboratively to develop solutions and an implementation timeline.

APPENDICES

APPENDIX A—Glossary of Terms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
CDC	Centers for Disease Control and Prevention
DHEC	Department of Health and Environmental Control
DIS	Disease Intervention Specialists
EHE	Ending the HIV Epidemic
FQHC	Federally Qualified Health Centers
HOPWA	Housing Opportunities for People with AIDS
HPC	HIV Planning Council
HRSA	Health Resources and Services Administration
IHPCP	Integrated HIV Prevention and Care Plan
MAI	Minority AIDS Initiative
MAT	Medication Assisted Treatment
MCM	Medical Case Manager
PAC	Patient Advocacy Council
PWH	Persons with HIV
PrEP	Pre-exposure prophylaxis
SCSN	Statewide Coordinated Statement of Need
SUD	Substance Use Disorder

Letter of Concurrence: Submitted as a separate file

Epidemiological Profile: Submitted as a separate file

Plan Guidance Checklist: Submitted as a separate file