Carolina Health Centers (CHC) is an FQHC in the Lakelands region of South Carolina, with a service area of 7 counties: Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry and Saluda. The most recent statistics on HIV in our area is from 2019. The prevalence of individuals living with HIV in all of our counties ranged from 202 to 575 per 100,000. The rate of new diagnoses of HIV in all of our counties ranged from 0 to 30.7 per 100,000. The rate of PrEP use in our counties ranged from 26 or less to 34 per 100,000. The state averages for these rates are 404 per 100,000 living with HIV, 16 per 100,000 newly diagnosed HIV and 35 per 100,000 PrEP users.[1]

NEED

According to the South Carolina Department of Health and Environmental Control (SCDHEC), the prevalence of HIV cases is steadily increasing while the number of new cases reported each year remains flat, meaning there are more patients each year going undiagnosed. There is an epidemic of HIV/AIDS in South Carolina that is worsening each year. According to SCDHEC, the epidemic's primary drivers are sexual exposures between men who have sex with men and associated heterosexual partners at risk. SCDHEC also reports African Americans are the most affected and therefore are the most at risk population group[2].

Most barriers to testing in our service area are attributable to socioeconomic factors, misperceived HIV risk and stigma around HIV/AIDS. There is very little opportunity for free HIV testing in our area. Those without resources would most likely have to turn to the health department with limited access and limited times and locations, or the free clinic, with even more limited access and strict financial documentation requirements. Many patients do not understand their risk of acquiring HIV, or they hide the activities that put them at risk and do not seek testing. Many still see HIV as that shameful disease of the gay man that always ends up in death and so live in denial of the risks and have no desire to consider screening. For screening to increase, there must be more free (or affordable) testing opportunities and more open discussion on risk factors and general education about HIV/AIDS.

Using the "Estimates of Persons with Indications for Preexposure Prophylaxis" website[3] and approximating the population of men who have sex with men (MSM) based on our service area population in proportion to the entire state population, our service area should have a MSM population of 1,192. Using that estimation, the total population of individuals with indications for PrEP would be 440, with 220 being in the MSM group, 120 being in the heterosexual group and 30 being in the intravenous drug user population. CHC is the primary provider of PrEP services in our service area and we currently have 43 individuals active in the program.

There are multiple barriers to PrEP services in our service area. Access to services is very limited, with CHC being the only facility in our service area listed on SCDHEC's Statewide PrEP Provider Directory[4], updated in November, 2021. We also have only one Ryan White

[1] https://map.aidsvu.org/map
[2] https://scdhec.gov/sites/default/files/media/document/SC-HIV-Epi-Profile-2020.pdf
[3] https://prepind.shinyapps.io/prepind2/
[4] https://scdhec.gov/sites/default/files/Library/CR-012460.pdf

program available for care management services for our entire service area of seven counties. There is very little education and outreach to the at-risk population groups, and most seem unaware of the benefits of PrEP. The barriers to PrEP are paralleled to the barriers of testing regarding socioeconomic status, misperceived risk, and stigma.

COVID-19 has affected HIV testing, treatment and the use of PrEP for patients in our service area. The pandemic has limited patient access in general, but also has caused fear of being in a medical facility for health issues that are not related to COVID. Staffing issues have also limited the amount of access available to patients. Focusing more on acute problems such as COVID has reduced the attention to general screening, lifestyle issues and counseling regarding risk factors for HIV/AIDS.

Based on 2020 US Census data, the total population of our seven counties is 252,949[5]. Based on this population, there should be roughly 1000 HIV patients needing linkage to HIV care and treatment. CHC is caring for 187 or less. There are only two other active HIV providers in our service area, one of whom is no longer taking new patients and the other only takes a small number of new patients. Even if those providers have double the patients of CHC, that would still leave close to 500 HIV patients that have not been diagnosed, or do not have care in the Lakelands region, and nowhere for newly diagnosed patients to go.

Barriers to linkage to HIV care are related to those already stated. There are very few providers in the service area. The other two providers of HIV care in the area generally require insurance or some type of sponsorship for care. They do not have sliding fee scales and often have more restrictive office policies. Patients referred out of the area face significant transportation issues, as often it may be an hour drive or longer to the referral.

RESPONSE

Activities: Outreach, Training, Testing

CHC will create an Infectious Disease (ID) Program that will consolidate current isolated efforts at various sites. This program will outline outreach strategies, training of staff and providers, and community testing efforts. Defined within the program will be the roles and responsibilities of newly created positions of ID Coordinator, ID Care Manager, and the ID Behavioral Health Counselor.

The ID Program will describe CHC's **outreach** strategies. CHC will connect with organizations, communities, businesses, collaborations, and Ryan White grantees within our service area. The purpose of this outreach will be to identify individuals, groups of individuals, and communities who are at increased risk of HIV/AIDS. Those identified will be counseled and encouraged to be tested for HIV/AIDS, and free testing will be offered in the community and/or population. Those who test positive will be linked to care within CHC for initiation and continuation of treatment. With COVID-19 creating barriers to patients coming into our health centers, this effort will bring the counseling, testing and referral for care to the community and/or population.

[5] https://www.southcarolina-demographics.com/counties_by_population

Training will consist of baseline and continuing training of appropriate clinical staff and providers regarding: HIV/AIDS risks, counseling regarding those risks, and identification and prevention of infectious diseases. There will also be training on the most effective ways of gathering specific information from patients regarding their sexual preferences and practices. To complement this training, EHR workflow will be enhanced by a flowsheet of risk questions that will trigger notification on a positive response. Training will also be provided on when, where and how to test for the virus that causes HIV/AIDS and how to minimize barriers to training. Finally, training will be provided regarding eligibility and recommendations for pre-exposure prophylaxis (PrEP). Providers will be trained on the PrEP Protocol, as published by the New England Aids Education and Training Center[6]. Providers will also be trained on medication assistance programs and other patient resources, including Ready, Set, PrEP, to help patients afford the medication.

The strategy for **testing** as laid out in the ID Program will consist of a two-pronged approach: one for patients being seen within CHC and one for the general public and/or specifically identified populations. For patients already in a CHC facility, testing will be increased in the at-risk population by better identification through more complete questioning of patients' risk factors, reporting on those who have had recent sexually transmitted infections (STI), and generally making testing more discussed and available. The EHR system has a workflow involving a series of risk factor questions for HIV. This workflow will be implemented, as if the questioning is positive, the system will prompt the provider for a discussing regarding testing or PrEP. For testing outside of CHC facilities, the outreach strategy should identify pockets of at-risk individuals. To reach those populations, CHC will operate a free community testing site in a variety of locations and settings, such as health fairs, faith-based organizations, communities with high needle-exchange usage and/or high IV drug use, apartment complexes and others. Those who test positive for HIV or Hepatitis C will be contacted by the ID Care Manager for linkage to care, counseling and follow-up. The partners of those who test positive will be contacted by the ID Care Manager to arrange for counseling and initiation of PrEP.

The HIV screening, testing and referral process in our health center sites will be totally integrated with the normal health services provided to our patients. The goal will be to screen every patient in the health center, no matter the reason or diagnosis for the visit, to determine if they are at increased risk of HIV. If they are at increased risk, then the counseling and testing will be done during that same visit, while the patient is still in the health center. This will allow for optimal health outcomes for all our patients and will advance health equity in the screening and treatment of HIV/AIDS.

Personnel: Coordinator, Care Manager, Behavioral Health Counselor

The **ID Coordinator** will be the primary manager of the ID Program. This position will be responsible for the community outreach, the development of the training plan and planning the testing events. The coordinator will also be responsible for the training of staff and providers in relevant topics such as discussing personal sexual behaviors. This position will develop and

[6] https://aidsetc.org/sites/default/files/resources_files/PrEPProtocolFeb062020SS_Final.pdf

maintain contacts with key organizations, community leaders, and population groups that will help identify those at high risk for HIV/AIDS. This position will also supervise and manage the ID Care Manager.

The **ID Care Manager** will be primarily responsible for reaching out to those patients identified with HIV/AIDS and those in the PrEP program. This position will assist these patients with making and keeping medical and counseling appointments. The care manager will also assist patients in maintaining their medication regimens, knowing the full extent of assistance options available to the patients, including patient assistance programs, 340b benefits and the Ready, Set, PrEP program. This position will assist the ID Coordinator with outreach, training and testing efforts. The care manager will ensure that each patient is set up with a MyChart account so that appointment reminders, medication requests and general medical inquiries can be made between the provider and the patient in a safe, secure and HIPAA compliant manner.

The **ID Behavioral Health Counselor (BHC)** will be responsible for counseling services for those identified with HIV/AIDS and those identified needing PrEP services. Counseling is essential in this population to ensure compliance with medications and medical follow-up, as well as to combat often comorbid mental health conditions. This position will work closely with the ID Care Manager and the ID Coordinator to ensure appropriate access to BHC services for all patients identified. The BHC will also engage those with high-risk activities such as intravenous drug use in attempts to help them cease these activities. This position may also help with outreach, training, and testing but their primary responsibility will be clinical counseling for this designated population.

COLLABORATION

CHC already has an established relationship with the sole Ryan White HIV/AIDS Program in our service area, Upper Savannah Care Services[7]. We have three local substance use disorder treatment facilities under the South Carolina Department of Alcohol and Other Drug Abuse Services. We have strong working relationships with two of these organizations, Cornerstone[8] and Gateway Counseling Center[9]. We will continue to enhance and deepen these relationships and increase bidirectional referrals and collaboration. The third facility is Westview Behavioral Health Services[10] with which we have no current relationship, but we will pursue and establish a working relationship and start collaborative efforts in the two counties this facility serves. We will also reach out to the local addiction recovery programs and homeless shelters seeking contact with at risk individuals. There is also a regional needle exchange program that sends a significant number of needles into our service area, Challenges Inc[11]. We will collaborate with that organization as well to target specific populations for both HIV testing and PrEP services.

[7] https://uppersavannahcare.org/
[8] https://www.cornerstonecares.org/
[9] https://gatewaycounseling.org/
[10] https://www.westviewbehavioral.org/
[11] https://challengesinc.org/

CHC has the most active HIV providers of any other organization in our service area. We will continue to expand our capacity as HIV providers to remain open to newly diagnosed patients. We will coordinate with SCDHEC to help respond to any identified cluster and outbreak of HIV in our area.

RESOURCES/CAPABILITIES

CHC has experience in screening for, identifying and treating HIV/AIDS. We have had an active HIV provider for over 11 years and have increased capacity such that we are currently up to 4 full-time providers who actively treat HIV patients. Those same providers are also providing PrEP services. The plan will be to expand PrEP services to other providers at CHC and ultimately expand the number of providers who actively treat HIV. CHC implemented universal HIV screening in 2020 and most recent data shows we have screened 43.6% of our patient population aged 15 to 65 years old and continues to climb. CHC is active with the Southeast AIDS Education and Training Center (AETC)[12] and is an active participant in the Southeast Practice Transformation Expansion Project (SEPTEP).

The individual identified for our ID Coordinator is a master's level Clinical Mental Health counselor, has completed HIV Prevention Certified Provider certification through HealthHIV.org[13], is a certified Community Health Specialist, has been actively involved in the SEPTEP program and trainings, and has relationships with the local Ryan White organization and other community resources. She has attended multiple trainings regarding HIV risk factors, taking effective sexual histories, and implementing culturally competent workflows in the organization. She will lead the training of staff in cultural competence around testing and history taking.

For trainings and technical assistance, we will continue to access the SC AETC program and continue to participate in the SEPTEP project. Our 4 HIV providers meet regularly to discuss cases in an internal peer support program and also to present cases to an infectious disease specialist from the University of South Carolina College of Medicine, part of the SC AETC program. CHC will also utilize a practice transformation consultant group to implement evidence-based prevention and treatment strategies to help mobilize our workforce towards these efforts.

EVALUATIVE MEASURES

Baseline

The UDS report for calendar year 2020 showed CHC had tested 3,781 of 12,329 patients for HIV (30.7%), prescribed 0 patients PrEP and out of 2 newly diagnosed HIV patients, linked 1 to care within 30 days (50%). While the data for HIV screening is straightforward, there probably is some inaccuracy in the 0 PrEP patients for that period. CHC is referred many established HIV

[12] https://www.seaetc.com/
[13] https://healthhiv.org/programs/hpcp/

patients, but despite general screening, we found very few newly diagnosed patients for that period.

Estimated Increases

CHC will increase the number of patients tested for HIV. The data for the UDS report on calendar year 2021 has already improved and will continue to improve for subsequent years through 2023. There has been a linear increase in the percentage of our eligible patients tested for HIV, and the trendline of the progression points to at least 60% by the end of 2023.

CHC will increase the number of patients on PrEP. Currently, CHC has 28 patients on PrEP. Through more thorough risk factor evaluation, more attention to the need for and prescribing of PrEP, and more referrals from outside organizations, the need and thus the prescribing of PrEP will increase. Estimating a slow ramp-up period involving training of staff and providers, the estimated number of PrEP patients would be at least 70 by the end of 2023.

CHC will increase the percentage of HIV patients linked to care. By identifying more at-risk individuals and populations, and increasing testing, more HIV positive individuals will be identified. Those patients will be referred directly into care with CHC's HIV providers, who will ensure available appointments so that the initial visit will be before 30 days. CHC's current baseline is statistically weak due to low numbers, but we will aim to have 80% of all HIV patients linked to care within 30 days. More testing will be done throughout the organization and thus more patients will be identified. A future goal will be to increase HIV providers.

CHC currently does not have HIV prevention listed as a specific item in the QI Program. That will change as we add it as a specific section to the document. CHC already reports monthly HIV screening rates, but monthly PrEP patients will be added to regular reporting. This data gets reported to the board monthly and to all providers quarterly. Using these reports, we can tell which site is performing well with testing and newly diagnosed HIV and Hep C. We will use this data to inform changes within the system, to allow those high performing centers to help the lower performing ones.