2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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"Link and Retain PLWHA in Care for Lifelong Success!"

SC Ryan White Part B Program

Including SC ADAP

About the SC HIV/AIDS Care Network

- Awards Ryan White Part B (RWB) funds to DHEC for SC
  - Base funding levels are based on state's reported number of HIV/AIDS cases
- Serves through a network of contracted service providers
  - Provides Core Medical and Support services
- Includes SC AIDS Drug Assistance Program (ADAP)

Ryan White Part B:
All Parts Responsibilities

- Through the Ryan White legislation, Part B is responsible for the following All Parts initiatives:
  - AIDS Drug Assistance Program (ADAP), including Direct Dispensing and Health Insurance Programs
  - SC Quality Management Program
  - Development of the Statewide Coordinated Statement of Need and Integrated Plan (with CDC Prevention)
  - Early Identification of Individuals with HIV/AIDS (EIIHA)

Who We Serve?

SC HIV Program Growth

Population	2012	2013	2014	2015	2016	2017
People Living with HIV or AIDS (PLWHA)	15,305	15,695	16,222	18,340	**18,998**	**19,749**
Served by Ryan White Part B (RWB - Care)	8,112	8,475	8,760	8,816	**9,089**	**9,393**
Percent of Prevalence Served by RWB - Care	53%	54%	54%	48%	**48%**	**48%**
PLWHA Out of Care [1]	36%	37%	34%	32%	**37%**	**32%**
Uninsured in ADAP	76%	75%	74%	65%	**55%**	**53%**
Unemployment (General Population)[2]	9.2%	7.6%	6.4%	5.7%	**4.8%**	**4.2%**

Data Source: *SC Epi Profile 2013, 2014, 2015, 2016, 2017*

1. PLWHA Out of Care is based on absence of HIV tests at intervals within the calendar year.

2. Based on data published by the US Bureau of Labor Statistics.

SC ADAP Service Tiers

- Direct Dispensing Program (DDP)
  - Provides medications to uninsured enrollees
- Insurance Assistance Program (IAP)
  - Reimburses contracted service providers for private insurance premiums, copays and deductibles
- Medicare Assistance Program (MAP)
  - Provides support for Med D copayment year-round and deductible costs during the donut hole coverage period
  - Payments made by ADAP count toward client Out-of-Pocket Maximums (TrOOP)

Who We Serve? (cont.)

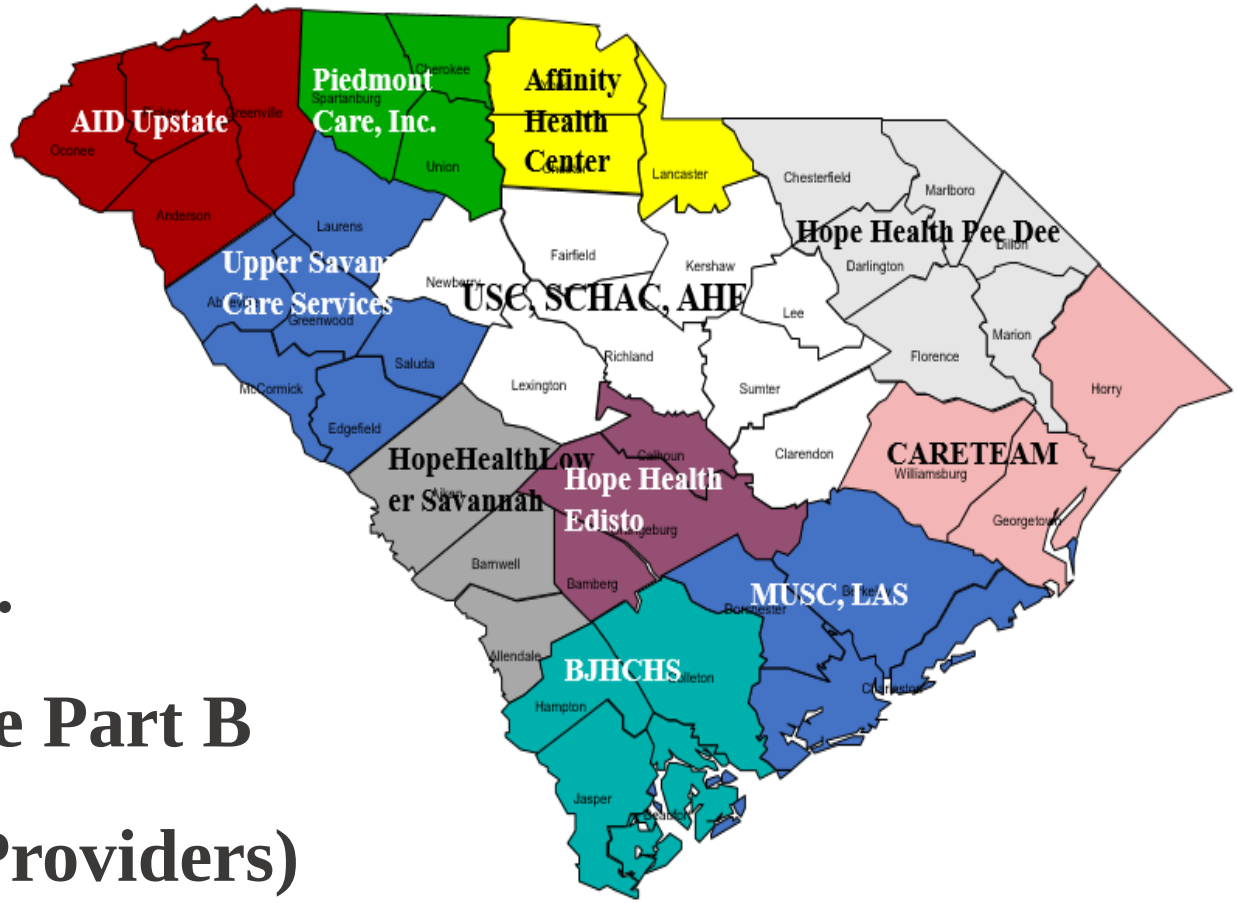
SC AIDS Drug Assistance Program (SC ADAP)

Program Growth (served by ADAP)

SC ADAP Population (Served)	2012	2013	2014	2015	2016	2017
Direct Dispensing (DDP) – Uninsured	3,616	3,983	4,132	3,656	3,187	3,051
Insurance Assistance (IAP) – Private Insurance	1,185	1,304	1,848	2,251	3,129	3,138
Medicare Part D Assistance (MAP)	245	299	320	350	349	329
Total SC ADAP – Service Tiers	4,754	5,301	5,554	5,580	5,765	

Data Source: *SC ADAP*

Who We Are?

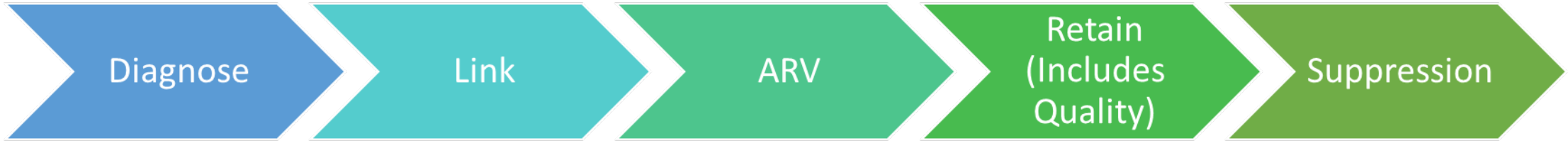


S.C.

Ryan White Part B

(14 Service Providers)

What We Need?



National HIV/AIDS Strategy:

Goal 2: Increasing Access to Care and Improving Health Outcomes

Localized to SC: SCHAS!

STEP 2.A		Establish seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.
2.A.**1**		Ensure continuity of high-quality comprehensive health care coverage to support access to HIV care.
2.A.**2**		Ensure linkage to HIV medical care and improve retention in care for people living with HIV.
2.A.**3**		Support and strengthen capacity to implement innovative and culturally appropriate models to more effectively deliver care along the care continuum.
2.A.**4**		Prioritize and promote research to fill gaps in knowledge along the care continuum.
2.A.**5**		Provide information, resources, and technical assistance to strengthen the delivery of services along the care continuum, particularly at the State, Tribal, and local levels.

Source: *https://files.hiv.gov/s3fs-public/nhas-update.pdf*

National HIV/AIDS Strategy:

Goal 2: Increasing Access to Care and Improving Health Outcomes

STEP 2.B		Take deliberate steps to increase the capacity of systems as well as the number and diversity of available providers of clinical care and related services for people living with HIV.
2.B.**1**		Increase the number of available providers of HIV care.
2.B.**2**		Strengthen the current provider workforce to ensure access to and quality of care.
2.B.**3**		Support screening for and referral to substance use and mental health services for people living with HIV.

Source: *https://files.hiv.gov/s3fs-public/nhas-update.pdf*

National HIV/AIDS Strategy:

Goal 2: Increasing Access to Care and Improving Health Outcomes

STEP 2.C		Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-occurring conditions and challenges in meeting basic needs, such as housing.
2.C.**1**		Address policies to promote access to housing and other basic needs and other supportive services for people living with HIV.
2.C.**2**		Improve outcomes for women in HIV care by addressing violence and trauma, and factors that increase risk of violence for women and girls living with HIV.

Source: *https://files.hiv.gov/s3fs-public/nhas-update.pdf*

Performance Targets and SC Baseline Data 2016 (CDC Formula)

Goal	2016	Difference Between Baseline and Target
1. **Reduce** the number of new HIV diagnoses by at least **25%**	792	**198 (25%)**
2. **Increase** the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least **85%**	67%	**18%**
3. **Increase** the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least **90%**	54%	**36%**
4. **Increase** the percentage of persons with diagnosed HIV infection who are virally suppressed to at least **80%**	53%	**27%**

Data Source: *South Carolina Department of Health and Environmental Control.*
Data Source*: South Carolina – 2016 HIV Care Continuum. Percentage of persons with Diagnosed HIV, who had ≥2 CD4 or viral load test results at least 3 months apart during 2016.*
Data not available for all persons diagnosed with HIV SC.

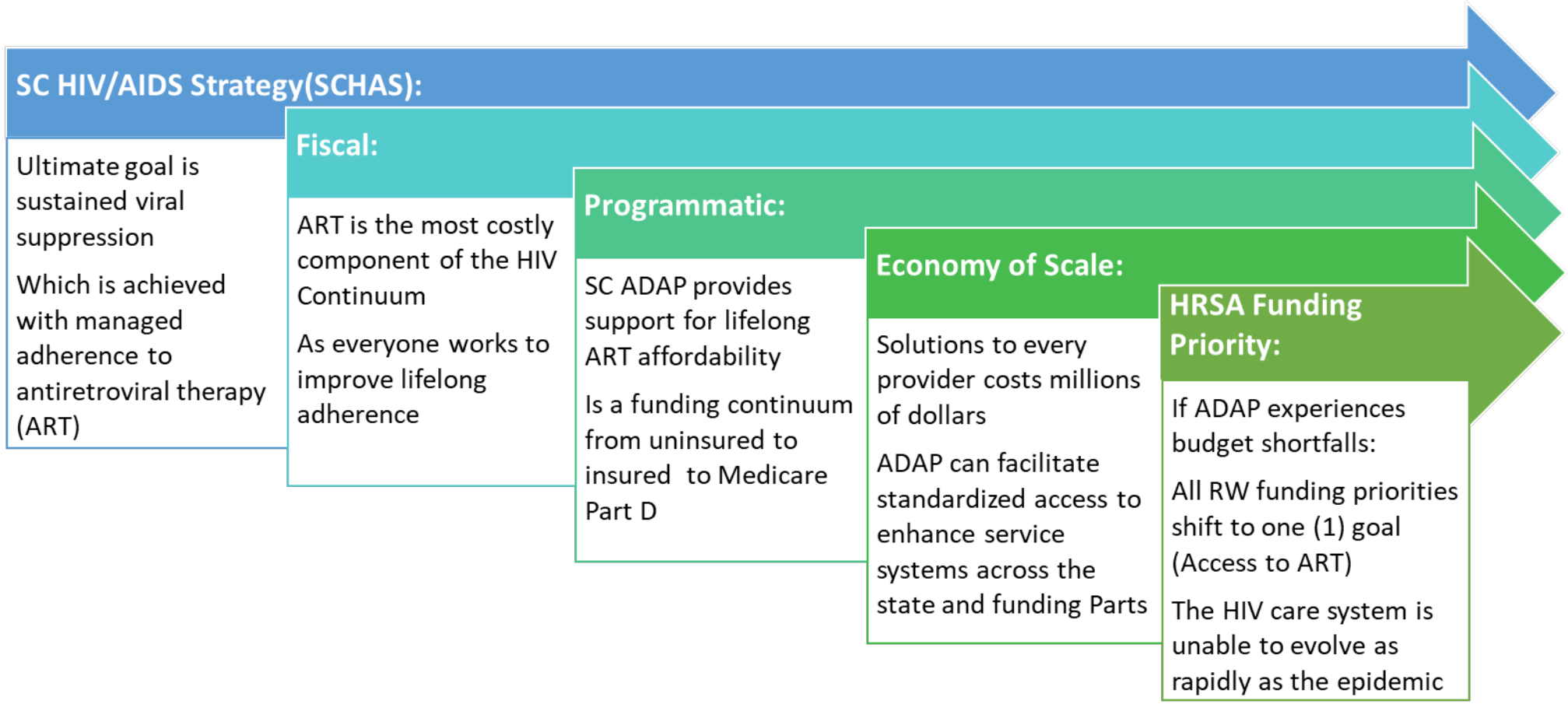
Data Source*: South Carolina Department of Health and Environmental Control. CDC calculation of Newly Diagnosed for PLWHA in 2016 who were linked to care within 30 days of diagnosis.*
Data Source*: South Carolina – 2016 HIV Care Continuum. Percentage of persons with Diagnosed HIV, who had a Viral Load <=200 copies/mL at most recent test during 2016.*

SC Care Continuum Yearly Comparison

Care Continuum	2015	2016	Average
Received Any Care	68%	66%	**67%**
Retention in Continuous Care	54%	54%	**54%**
Viral Suppression	54%	53%	**54%**

Data Source: *SC Epi Profile, 2015, 2016, 2017*

Why Begin with ADAP



SC ADAP in 2014

Fiscal Reality Snapshot

Table 1.0: Aggregate Level of Need (All Service Tiers)

Calendar Year	Total PLWHA in SC	% Served by SC ADAP
2012	15,351	31% (4,278)
2013	15,695	34% (5,031)

Source: *SC HIV/AIDS Epidemiology Profile 2014.*

Table 2.0: Funding awarded to SC ADAP FY2013-14

Award Source (Rounded)	Award Amount
RW Part B (ADAP)	$12,000,000
RW Part B Supplemental	$1,000,000
State of SC	$5,400,000
Total	$18,400,000

RW Part B ADAP Base award is $12,700,000 for GY: 2016-17.

Table 3.0: Program Growth from 2008 to 2013:

Statistic Reported	Rate of Increase	% Increase
Enrolled June (Whole ADAP)	1.53	153%
Served June (Whole ADAP)	1.64	164%
Annual Expenditures	2.37	237%

Increase in expenditures reflects program growth, as drug costs/capita decreased.

Table 4.0: Current SC ADAP Expenditures (in $millions)

Monthly Expenditures	Expenditures/ Month	Expenditures/ Year
Drugs uninsured (not including dispensing costs)	$2.4	$28.8 million
All other SC ADAP Costs	$0.6	$7.2 million
Total	$3.0/month	$36 million/year

Balance of funds needed is generated from 340B rebates.

Measurable Collaboration

Rebates Earned by ADAP (Input)

- Balance needs of uninsured and insured
- Earned as clients become insured AND remain in ADAP
- Reflect collaboration vs. competition in appropriate ratio of insured in ADAP vs Uninsured (by provider)
- Avails funding to providers to establish statewide infrastructure to fill continuum gaps
- ADAP is ‘non-PART-isan’

SC ADAP Involves All Stakeholders in Solutions

Healthcare Systems/Funders

- CDC Prevention
- Surveillance
- RW Part B and HOPWA
- SC ADAP
- Private Insurers
- CMS – Medicare/Medicaid
- Pharmaceutical Rebates
- State Funds

Direct Service Providers

- RW Providers
- Clinical
- Medical Case Management
- Specialized non-medical
- Pharmacy service providers
- Federally Qualified Health Centers
- Housing
- Providers participating in planning bodies

Need to “Improve” must be a “given”.

Measurable Collaboration:
Number of ADAP-Direct Contracts (Output)

Funds for Workforce Expansion

- Workforce Expansion:
  - Outreach Specialist(s)
  - Early Intervention Specialist(s)
  - Specialized Medical Case Managers
  - Peer Adherence Coach
  - Insurance Enrollment/Payment Support
  - Data to Care Staff

Other Funding Awards Included

- Standard of Care:
  - Entry to Care and Return to Care Testing
- Capacity and Data Management:
  - EMR to Provide Enterprise Interface
  - MCM Training
  - Outreach Program In-service
  - Data Security
  - Technology
  - Needs Assessment

Statewide Coordinated Statement of Need

South Carolina HIV/AIDS Strategy 2017-2021

SCSN Process Improvements for 2017-2021

- Federal requirement for an Integrated Prevention and Care Plan
- In SC, the combined RW All Parts and HIV Planning Council (HPC) allowed for larger and broader body of stakeholders for needs assessment and planning
- Plan follows National HIV/AIDS Goals
- **Enhanced inventory of services (IOS) included a consumer lead review of service accessibility and availability based on consumer experience**
- RW Part B (ADAP) as fiscal backbone for expansion projects
- Annual Evaluation updates through continued combined All Parts and HPC Meetings

Inventory of Services

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

How do you focus on *everything?*

National and Local Strategies

Strategies and define success as: **85%** Linked to Care in 30 days

- Do we focus on the **85%** who DO link to care?

Or

- Focus on the **15%** who DON'T?

Historically, limits to fiscal awards, program management staff, and intervention workforce narrowed the scope of large-scale innovation and forced difficult choices.

What's Our Approach?

Clients do not enter into a group in the continuum and stay there (i.e. retained or suppressed) without additional intervention and/or support as life changes

- Examples of Changes:
  - Loss of job
  - Loss of partner
  - Loss of insurance
  - Change in insurance
  - Loss of transportation or housing
  - Loss of income
  - Periods of incarceration for client and/or family
  - Program practices that assist with health care participation, but are not implemented universally (i.e. in practice here but not there)
  - Program policies that inhibit health care participation (often unintentionally)

Establish Concurrent Service Systems

Medical Case Management and EIS

Focuses on the *many (i.e. 85%)*

- Link
- Retain
- Assist
- Connect
- Coach to independence

Outreach Services

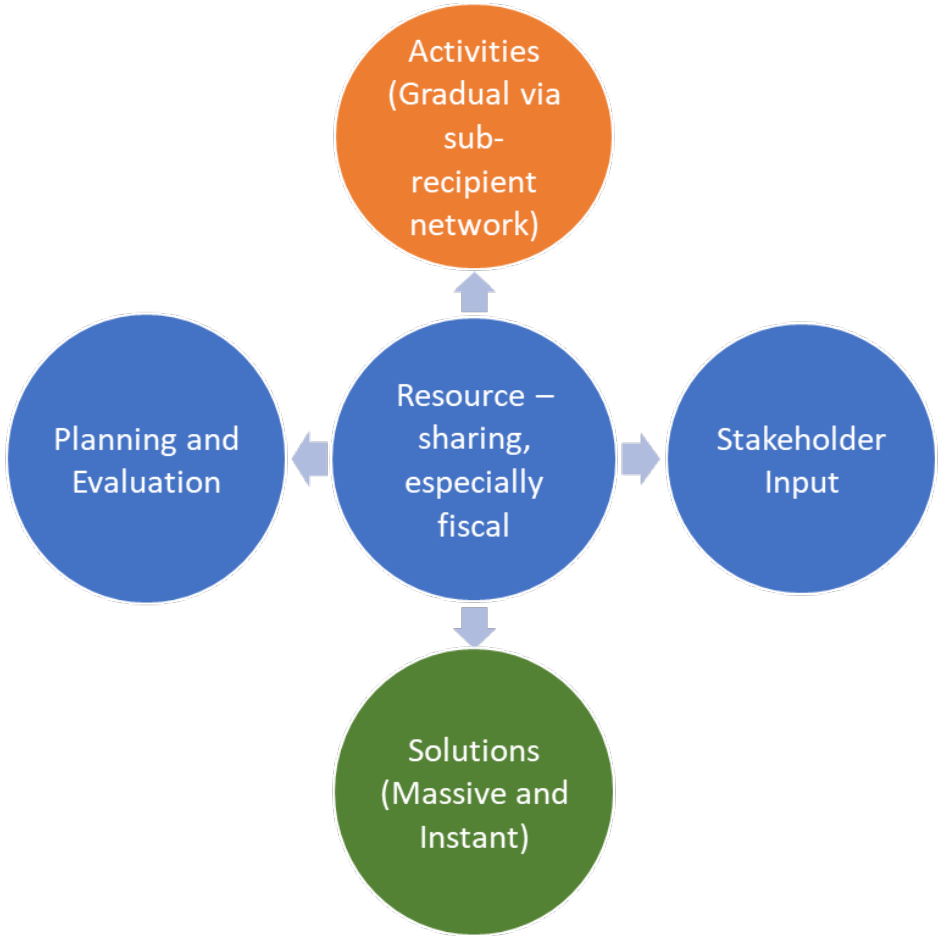
Focuses on the *few (i.e. 15%)*

- Re-link
- Obtain client feedback
- Develop service solutions
- Expand and include client support systems
- Right level of assistance at the right time

Our SC HIV Care System

Remodeling for Success

SCSN Implementation



Concurrent Tracks of Improvement

Solutions

- Implemented at statewide scale
- Require millions of dollars and infrastructure
- Require stakeholder engagement from other state or federal programs
- Ensure equal attention to a given problem
- Accompanied by mass data system supports
- Reflected in population-level data

Activities

- Implemented through sub-recipient networks and prevention contractors
- Reflects sub-recipient budget and timeline priorities
- Gradually improve acceptance of “improve”
- Accompanied by expanding the use of existing data system tools
- Integrated into annual programmatic site visits
- Reflected in RW-related data

Statewide Solution 1 – For rollout GY2019-20

- Statewide Solution 1: Housing Services for PLWHA
- Statewide Solution 2: Ryan White Statewide Transportation System
- ***Statewide Solution 3: Fund Statewide All-Parts Interventions***

SC Care Continuum Reveals:
Workforce Expansion and Synergy Are Needed

Continuum Weakness		Solution for Expansion and Coordination
PLWH who know their status are out of Care	→	Outreach Services
Sustainable re-linkage programs that customize services as PLWH re-engage care and treatment	→	Specialized Medical Case Management (SMCM)
Consumer involvement in linkage and lifelong adherence	→	Peer Adherence Services
Funding for providers to serve more while improving service experience	→	Special Projects – Capacity-building and Technology

Diagram of Outreach Program Including D2C

PLWHA Out of Care in SC (Estimated: >6,000[1])

RW All Parts Outreach Workforce (Estimate: 3,800 or 64%)				DHEC Public Health Outreach (Estimate: 2,200 or 36%)			
Identify and prioritize Not in Care (NIC)	Locate PLWHA based on available information	Quickly build rapport with client to voluntarily reengage care[2]	Develop retention focused intervention	Identify and prioritize Note in Care (NIC)	Locate PLWHA based on available information	Quickly build rapport with client to voluntarily re-engage care[2]	Refer to care provider based on geographic payment source, and client preference

1. Estimate for PHWHA out of care in SC does not exclude PLHWA who have achieved sustained viral suppression.
2. While D2C follow-up activities are a Public Health function, PHLWA cannot be forced by law to re-engage medical care

NHAS Initiatives Vision:

Returning to care

Step 1: Client RTC

Assertive Outreach locates clients.

(Note: If client was out of care elsewhere but is new to your agency, follow New Client pathway.)

Step 2: Introduce New Services

Client Pathway 1

Outreach Specialist

(Focus on rapport and compassion)

Client Pathway 2

SMCM

(Focus on new services and service options)

Notes:

1. Outreach should participate in first 1-2 SMCM visits if client has no support system.
2. Client pathways may be provided concurrently to reduce number of separate visits for clients.

Step 3: Link to RW Services

Determine reasons Out of Care

(Conduct HPC Return to Care [RTC] Assessment)

SMCM Reassessment

(Use HPC RTC Assessment results to set service goals and priorities)

Step 3 A: Customize Services

Enhanced Care Plan
Based on RTC Assessment Results
(See NHAS Initiatives Guidance)

Transition to TMCM:
As Client Becomes More Independent
(See SBAR Format)

Step 4: Re-link to Medical Care

Establish RTC Support System[1]

(SMCM and Client Family/Friend/Partner)

SMCM re-link and accompany to Medical Care (as needed)

Step 4 A: Empower Client Support System

Outreach
HIV Test for Client Partner/Family/Friend

New Client Pathway:
If Family/Friend /Partner is HIV positive
(See NHAS Initiatives Vision : New Client)

Step 5: Strengths-based Monitoring

Client brings in Family/Friend/ Partner?

(If "Yes" See Step 4A)

Client enrolls in SMCM?

(If "Yes" See Step 3A)

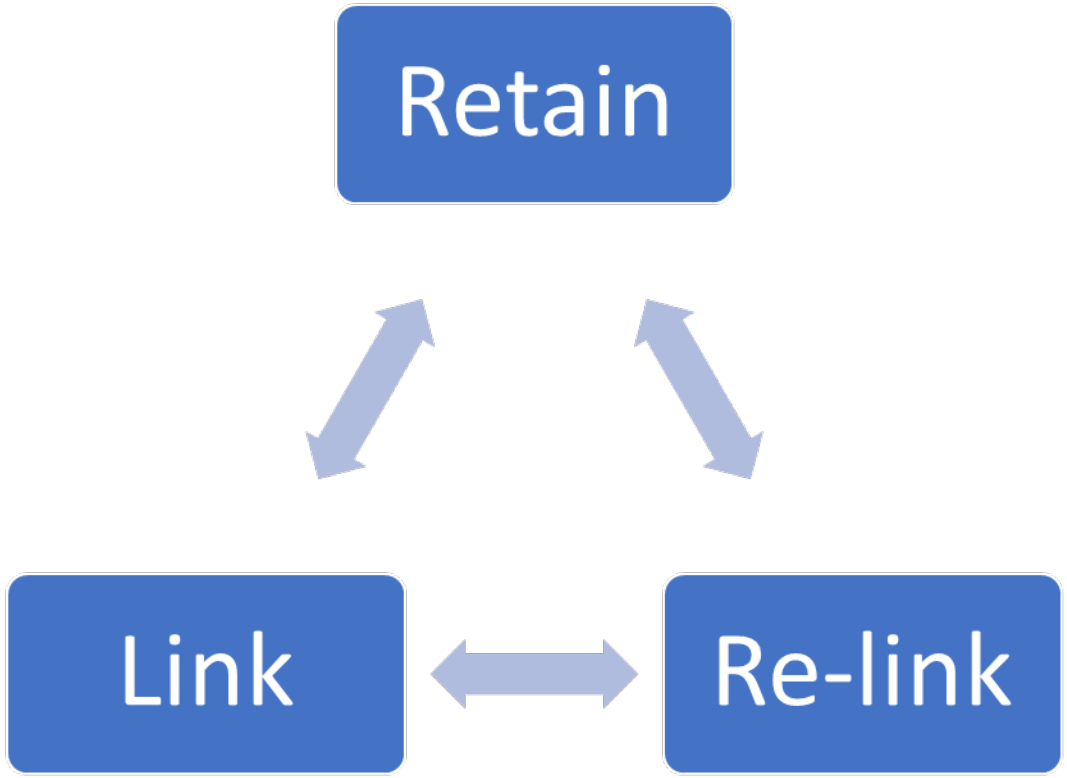
RW Part B/ADAP Commitment to Data to Care

Supportive Strategy

- Collaborative funding sources
- Data management technical assistance
- Deduplication of effort

Story of Success

Program efforts to build Outreach Program innovates the whole care system!



Story of Success

Key Components of Outreach Services

- Preventive Outreach
- Assertive Outreach
- Return to Care Needs Assessment
- Client support system inclusion (testing partners)
- Service Improvements
  - “Cool New Services”
  - Grievance
  - Service Standards (and exceptions)
  - Consumer Engagement
  - Collaborative Engagement
  - ADAP Enhancements
  - MAI focuses on Jail (Provide MCM/OMAC while in jail, Provide ADAP, Monitor Care Plan, Discharge Planning)
  - Prison Discharge

Commitment to Workforce Expansion!

- **1** Outreach Program Coordinator
- **1** Peer Adherence Coordinator
- **21** Outreach Specialists
- **14** Specialized MCM
- **11** Peer Adherence Coordinators
- Shifting resources for SMCM Coordinator
- **1** Data to Care Program Coordinator
- **7** Regional Service Coordinators
- **1** Statistician

Example of Activity in SCSN (Gradual Implementation via Provider Network)

2010-2015 NHAS GOAL 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV/AIDS				
Objective 1: By the end of 2021, increase the percentage of newly HIV diagnosed persons linked to HIV medical care within one month of their diagnosis to at least 85%				
Strategy 1: Establish seamless systems to link people to care immediately after HIV diagnosis				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	SC DHEC CBOs	Enhance and further develop collaborative partnership with medical providers to ensure immediate linkage to care.	Primary care providers CBOs	No. of Memorandum of Agreement (MOAs)
By the end of 2017 (and ongoing):	SC DHEC Ryan White Providers	Decrease wait time for the initial medical appointment via continuing and enhancing utilization of HIV rapid-rapid testing statewide, funding confirmatory testing at RW sites, and implementing brief assessment at RW Part B sites for quicker eligibility determination.	CBOs Primary care providers HIV providers	No. of prevention contracts specifying rapid-rapid testing Care Continuum Linkage to Care data *Provider Enterprise (PE)* Date of diagnosis to 1st medical appt.

Client Choice of Provider

RWB Providers (New)

- Two (2) New Providers:
  - One (1) with clinical focus
  - One (1) Part B,C,D and HOPWA Provider

ADAP-funded Providers (New)

- Six (6) New providers:
  - Three (3) Part C
  - Two (2) Pediatrics
  - One (1) HIV Service Organization

Note: SC ADAP funded contracts may include services. Services are not limited to ADAP Enrollees.

Rapid/Rapid and Confirmatory Testing

Rapid/Rapid

- All about Eligibility for Ryan White services (Immediate access to care)
- Partnership with HRSA and CDC
- Rolled out as partnership with DHEC Care and Prevention Contractors
- Eligible for RW on second rapid test

Confirmatory Testing (ETC and RTC Testing)

Funds may be used for ADAP and non-ADAP enrollees

- T-cell panel CD4 count/complete blood panel and HIV Viral Load;
- Screening for Syphilis and other STIs;
- Screening for Hepatitis
- Screening for Tuberculosis
- Drug sensitivity and resistance testing

ADAPted for Treatment Success

ADAPted for Treatment Success	
	▪ **Formulary Expansion and HepDAP***
	▪ **Medicaid Wrap-around**
	▪ **College student accessibility**
	▪ **Jail Inmate accessibility**
	▪ **Out-of-state transition support**
	▪ **Patient Advocate**
	▪ **Self-certification of zero income**
	▪ **Clinical Review Process**

SC ADAP is also able to synergize:

- Enhanced clinical monitoring for pregnant women
- Twice-annual recertification with RW Part B Recertifications
- Client service discretion enhancements
- FPL Requirements across all service tiers
- Using the same system (*Provide Enterprise*) as RWB and many RWC providers
- Condensed application for clients whose insurance changes

Client Concern/Compliment Line

How it works?

- RWB providers are required to give program-level number for client concerns
- Program works with client and provider to ensure client stays in care
- RW Part B Service Manager must be informed and/or of client issue and service need

What it does?

- Helps program management staff better understand service models and referral systems
- Helps grasp the tangibility/accessibility of service
- Assists the client and provider with the issue, while preventing client attrition

Consumer Engagement

Positive Advocacy Committee

- Key participating body in SCSN Planning and Evaluation
- RWB regularly attends meetings by request from consumers or to share information with consumers

Upcoming projects

- Review grievance process and accessibility
- Update Client Satisfaction Survey process for SC ADAP

RW HOPWA Helpdesk

For Providers

- Answer questions about invoicing, contracts, standards of care, quality and more.
- Opportunity to better support providers, who support our clients.

MCM Standards and Checklists

Standardized Service and Supports for staff and clients

- Each standard includes: 1) Requirement; 2) Clarification; and 3) Support Provided
- Standardizes scope and quality of MCM services across the state
- Rollout includes self-populating checklists for each Point-in-Care
- Rollout includes a New Intake Form with a Brief Assessment (eligibility screening) to expedite Entry in to Care (often follows Rapid/Rapid Testing)

Research Partnerships

Working with the University of South Carolina, School of Public Health using Surveillance and/or HIV Care Data for:

- Predictive factors on why PLWH may fall out of care
- Rural vs. urban care participation outcomes
- Outcomes based on health insurance coverage

Supportive HRSA Requirements

- Rebates Spending Order
- Ryan White Services Report
- Flexible ADAP Structure (Varies state to state)
- Monitoring Standards
- Performance Measures
- SCSN
- Programmatic Site Visits (RWB to Sub-recipients)
- Service Standards for all services

Where we stand?

SC Ryan White Rankings:

Retention in Care

RSR 2016: Retention Performance for SC vs. Nation

Retention in Care	Served	Retention in Care	Percent Retained
South Carolina	9,167	7,792	85.0%
Nation	330,579	270,142	81.7%

SC RW providers (Parts A-D) perform significantly higher than the national benchmark in CY2016:

- 100% of SC-funded RW Providers (Parts A – D) completed and submitted an RSR for CY2016.
- Retention in care was based on data for PLWH who had at least 1 outpatient ambulatory medical care visit by September 1 of the measurement year, with a second visit at least 90 days after

Data Source: *RW HIV/AIDS Program Annual Client-Level Data Report 2016, as derived from Ryan White Services Report (RSR) data*
https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf

SC Ryan White Rankings:

Retention in Care

RSR: Retention in Care Year-to-Year Comparison

Retention	Rank	Rate	Total Clients	Total Clients Retained
2012	Unavailable	85.4%	7826	6687
2013	Unavailable	87.5%	8343	7304
2014	#2	87.1%	8266	7200
2015	#1	86.3%	8879	7663
2016	#6	85.0%	9167	**7792**

SC RW providers (Parts A-D) ranked #6 in the nation among all providers submitting RSR data for CY2016:

- 100% of SC-funded RW Providers (Parts A – D) completed and submitted an RSR for CY2016.
- Retention in care was based on data for PLWH who had at least 1 outpatient ambulatory medical care visit by September 1 of the measurement year, with a second visit at least 90 days after.
- The national average for Retention in Care (CY2016) is 81.7%

Data Source: *RW HIV/AIDS Program Annual Client-Level Data Report 2016, as derived from Ryan White Services Report (RSR) data*
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SC Ryan White Rankings:

Viral Suppression

RSR 2016: Viral Suppression Performance Data

Viral Suppression	Total Evaluated for VL	Suppressed	Percent Suppressed
South Carolina	9,653	8,176	84.7%
Nation	344,161	292,227	84.9%

SC RW providers (Parts A-D) fall in line with the national benchmark for Viral Suppression:

- Viral suppression includes PLWH served who had at least 1 medical care visit during the CY2015 & whose most recent viral load test result was <200 copies/µL.
- 100% of SC-funded RW Providers (Parts A – D) are required to complete and submit a Ryan White Services Report (RSR) – Client-level data for CY2016.

Data Source: *RW HIV/AIDS Program Annual Client-Level Data Report 2016, as derived from Ryan White Services Report (RSR) data*
https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf

SC Ryan White Rankings:

Viral Suppression

RSR: Viral Suppression Year-to-Year Comparison

Viral Suppression	Rate	Total Clients	Total Clients Virally Suppressed
2012	76.9%	8,270	6,363
2013	79.5%	8,730	6,943
2014	81.7%	8,762	7,162
2015	83.9%	9,272	7,778
2016	**84.7%**	**9,653**	**8,176**

SC RW providers (Parts A-D) fall in line with the national benchmark for Viral Suppression:

- Viral suppression includes PLWH served who had at least 1 medical care visit during the CY2015 & whose most recent viral load test result was <200 copies/µL.
- 100% of SC-funded RW Providers (Parts A – D) are required to complete and submit a Ryan White Services Report (RSR) – Client-level data for CY2016.

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SC Ryan White Rankings:

Viral Suppression

RSR: Viral Suppression Year-to-Year Comparison