RECOMMENDATIONS
for Strategically Addressing
HEPATITIS C IN SAN FRANCISCO

Final Report of the
San Francisco Hepatitis C Task Force

December 2010

With funding support from the San Francisco Foundation

Document prepared by
Amphora Consulting: for Health and Social Justice

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Dedication

The San Francisco Hepatitis C Task Force dedicates this report to the loving memory of our esteemed colleague and friend, Randy Allgaier. Randy lived proudly and openly with HIV/AIDS and hepatitis C (HCV), making it easier for others to do the same. He served as Co-Chair of this Task Force until his untimely death on November 27, 2010. When we lost Randy, we lost a great ally and advocate, but we will continue to feel his presence through implementation of this report and our ongoing efforts to combat HCV.

At the time of his death, in addition to co-chairing this Task Force, Randy was the Director of the San Francisco HIV Health Services Planning Council. For over two decades he played a key role in shaping public policy related to HIV/AIDS and HCV. He served on nearly a dozen committees, councils, and boards, always ensuring that the voices of people living with HIV and HCV were included in program and policy developments that affected their lives.

Randy's legacy extends well beyond Northern California. At the national level, Randy was a member of the Board of Directors of the National Working Positive Coalition and the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition. He was known for his expertise on Medicare/Medicaid issues and was a strong proponent of increased AIDS Drug Assistance Program (ADAP) funding. In 2008, Randy became a founding member of the Coalition for a National AIDS Strategy (NAS), which spearheaded the creation of the Obama administration's HIV/AIDS plan. In recognition of this leadership, Randy was invited to the White House for the NAS release in July 2010. His broad and enduring commitment to social justice included serving as a founding director of the California Alliance for Pride and Equality (now Equality California) and as a member of Human Rights Campaign's National Board of Governors.

Soon after Randy's death, Congresswoman Nancy Pelosi observed, "few people understood the intricacies of national HIV/AIDS policy better than Randy Allgaier. He dedicated his career to enhancing the lives of people living with HIV/AIDS in every aspect, working quietly and tirelessly to shape national policy, increase funding, and improve systems of care." Similarly, few people were as dedicated to confronting the HCV epidemic, or as responsible for increasingly making it a public health priority. Randy won many awards and commendations, including the National Association of People Living with AIDS Positive Leadership Award. He was also named one of POZ magazine's top 100 AIDS fighters in the December 2010 issue. He was only 53 when he died, yet had accomplished more and been recognized as much as many well beyond his years.

Apart from his considerable contributions on behalf of people living with HIV/AIDS and HCV, Randy taught us a great deal about living life fully. In June, 2008 Randy married his partner of 20 years Lee Hawn, during the brief window when same sex marriages were legal in California. Randy and Lee together adopted their beloved beagle Darwin in 1998 and Randy soon became involved with Pets Are Wonderful Support, serving as a member and then president of the Board of Directors. Randy cared deeply for Lee, Darwin, everyone who shared their love of pets, and anyone who needed a strong voice and caring spirit.

Randy's contributions to battling HIV/AIDS and HCV were unparalleled. He was a relentless fighter, an eloquent spokesperson, and a force for justice and change. He was uncommonly smart, thoughtful, and compassionate. He was a mentor and friend to many of us, and a role model for each of us. We loved and admired Randy for his passion, his humor, and his undying commitment to speaking out and encouraging all of us to raise our voices. We will continue to confront HCV with Randy in our hearts, hearing his voice and knowing he'd expect us to keep working—especially on behalf of those who are not able to.

Thank you, Randy. This report is for you.

Executive Summary

San Francisco has been severely impacted by the hepatitis C epidemic. There are an estimated 12,000 people infected with the hepatitis C virus (HCV) in the City (SFDPH, 2010), with many unaware of their status. Hepatitis C disproportionately affects African Americans, Latinos, veterans, parolees returning to the community, injection drug users (IDUs), immigrants and low-income residents. HCV is estimated to infect 90% of IDUs (aged 30 and over) (Falster, Kaldor & Maher, 2008); among IDUs who are under 30, approximately 45% are HCV-positive (Hahn et al., 2001). San Francisco began surveillance of HCV in 2009; that year, African Americans represented 34.7% of HCV cases while comprising only 7.3% of the San Francisco population (SFDPH, 2010).

Additionally, people living with HIV/AIDS (PLWHA) are also disparately impacted by HCV. Approximately 30% of PLWHA are co-infected with HCV, and co-infection makes them more likely to develop liver disease and to have adverse reactions to HCV treatment than individuals who are mono-infected with HIV (Harm Reduction Coalition).

Hepatitis C can lead to liver disease, cirrhosis, liver cancer, liver failure and death. According to the Centers for Disease Control and Prevention (CDC), liver cancer from hepatitis B and C kills more people in the San Francisco Bay Area than anywhere else in the country. HCV is now one of the leading causes of death for PLWHA in San Francisco.

However, many people at risk for or infected by HCV are neither tested nor treated due to lack of public awareness about hepatitis and lack of access to care. Thus, they are not able to protect their health or prevent spreading HCV to others. Although not all people with HCV have a history of injecting drugs, the stigma attached to injection drug use and its relationship with HCV affects the ability of many to get appropriate health care and support.

Recognizing the severe impact of the hepatitis C epidemic in San Francisco, in early 2008 numerous people came together with the purpose of creating a local response. They met several times with the Mayor's staff, and in May, 2009, San Francisco Mayor Gavin Newsom created the San Francisco Hepatitis C Task Force, to begin meeting in November, 2009. The Task Force was charged with developing a comprehensive set of recommendations to address the hepatitis C epidemic in San Francisco by the end of 2010. The Mayor appointed 32 members to the Task Force, including medical and social service providers, public health officials, hepatitis C advocates, people living with and affected by hepatitis C, and other stakeholders and experts. To provide the public and members with information about Task Force activities, the Task Force developed a website: *www.hepcsf.org*.

The Task Force began its work grounded in a vision of a San Francisco where:

- Everyone is educated about hepatitis C and has the opportunity to know their hepatitis C status;
- Everyone living with hepatitis C receives the highest level of care and support to ensure their quality of life and longevity; and
- There are no new hepatitis C transmissions.

The Drug Policy Alliance agreed to serve as the lead sponsor of the Task Force, with Project Inform and the HCV Advocate/Hepatitis C Support Project serving as co-sponsors. The San Francisco Foundation provided funding to support creation of this final report delineating the Task Force's recommendations to the City and County of San Francisco.

To help inform the development of its recommendations, the Task Force invited experts on HCV in San Francisco to present on a variety of HCV-related topics at its meetings. The Task Force also convened two community forums to draw attention to and better understand two particularly important issues for San Francisco related to hepatitis C: 1) the impact of hepatitis C co-infection with HIV and sexual transmission of hepatitis C among men who have sex with men; and 2) the disproportionate impact of hepatitis C among African Americans.

Four Task Force committees were convened and met monthly during the majority of 2010 to develop recommendations focused on the following areas:

- ***Care and Treatment***
- ***Prevention, Education, Awareness and Testing***
- ***Research and Surveillance***
- ***Public Policy***

The committees identified a total of seven strategic directions. Each strategic direction delineates practical vision statements to describe the desired outcomes, recommendations, and specific action steps for implementation. These strategic directions and recommendations are outlined immediately below. Additional details including the practical vision statements and action steps for implementation of the recommendations are provided in the full report.

Strategic Direction 1

To improve surveillance capacity and data use

Recommendations

1) Develop, compile and share HCV surveillance data and generate San Francisco-specific surveillance reports.
2) Engage medical providers, healthcare organizations, laboratory staff and SFDPH personnel to evaluate, modify as needed, and implement HCV reporting requirements to improve quality and use of HCV surveillance data.
3) Increase acute HCV surveillance capacity.
4) Increase chronic HCV surveillance capacity.
5) Support HCV research and development.

Strategic Direction 2

To educate the public and providers about hepatitis C virus

Recommendations

1) Update, reprint, and disseminate existing SFDPH viral hepatitis resource guide.
2) Develop and implement health promotion and awareness strategies for educating the public about HCV.
3) Engage the community to help increase HCV awareness among adults and youth.

Strategic Direction 3

To increase hepatitis C testing

Recommendations

4) Broaden HCV screening criteria.
5) Increase HCV screening and prevention efforts for high-risk and incarcerated populations.
6) Increase awareness of the need for and availability of HCV testing.
7) Increase HCV testing capacity and services.
8) Increase HCV laboratory testing capacity.

Strategic Direction 4

To provide accurate risk information and effective hepatitis C prevention interventions

Recommendations

9) Provide accurate information about the sexual transmission of HCV.
10) Increase access to sterile injection equipment and other harm reduction services.
11) Increase HCV prevention services for people who are involved in the criminal justice system.
12) Improve policies and practices in tattoo and piercing parlors and nail salons.
13) Provide substance use treatment to all who request it.

Strategic Direction 5

To improve health outcomes of people living with hepatitis C virus in San Francisco

Recommendations

1) Improve case finding by ensuring providers are knowledgeable about risk factors and high-risk populations.
2) Train primary care providers (including providers of care to those living with HIV) regarding HCV.
3) Train non-clinical public health and community providers who serve at-risk individuals.
4) Expand HCV resources available for providers.
5) Ensure that HIV/HCV co-infected individuals have access to evaluation and care by clinicians skilled in the management of co-infection.
6) Ensure that all persons who test positive for HCV antibodies have confirmatory molecular (viral load) testing planned unless they decline.
7) For all people living with chronic HCV, strive to provide liver biopsy when indicated, as the gold standard, or other noninvasive blood testing.

8) Ensure that all persons living with chronic HCV be offered a baseline abdominal ultrasound.
9) Expedite treatment referrals for acute HIV cases.
10) Establish a uniform and centralized system through SFDPH for authorization of care and treatment.
11) Educate providers about, and ensure that all persons who are living with HCV be considered potential candidates for antiviral treatment.
12) Require that when antiviral treatment is offered to persons living with HCV, it represents current state-of-the-art treatment, including newly FDA-approved HCV treatments.
13) Require that HCV treatment and care be provided as needed in all SFDPH and SFDPH-funded community-based clinics.
14) Fund and facilitate access to support services that assist individuals who are interested in HCV treatment to become appropriate treatment candidates.
15) Provide community access to subsidized acupuncture and related medically necessary treatments for persons who are HCV symptomatic or undergoing HCV treatment.
16) Promote wellness of people living with HCV through medical and alternative clinical treatment at every disease stage.
17) Strengthen access to care navigation, psychosocial support, and mental health services for people living with HCV.

Strategic Direction 6

To improve San Francisco's response to the hepatitis C epidemic through funding, legislative, and policy strategies and initiatives

Recommendations

1) Improve integration and coordination of San Francisco HCV programs and services.
2) Provide adequate funding for HCV care, treatment, prevention, education, and research programs in order to ensure availability of a comprehensive range of services.
3) Ensure San Francisco meets the needs of people living with and at risk for HCV by preparing for health care reform implementation.
4) Explore opportunities to work with corporate and non-profit organizations and foundations.
5) Establish drug policy initiatives that address drug use as a public health issue and not as a criminal justice issue.
6) Ensure that comprehensive substance use services are available and accessible for people living with and at risk for HCV.
7) Monitor SFDPH-funded agencies that provide substance use, STD, and HIV treatment and prevention services, and/or programs that serve drug users to ensure adherence to the SFDPH Harm Reduction Policy.
8) Ensure comprehensive services are available and accessible for the incarcerated and other people in the criminal justice system who are living with HCV.
9) Provide leadership, media, and advocacy training for community members including how to educate policymakers about HCV and its impact in their communities.

Strategic Direction 7

To leverage San Francisco's influence at the state and federal levels to secure legislation and funding to address the hepatitis C epidemic in California and the United States

Recommendations

10) Prioritize efforts to ensure state government policies and funding effectively address needs for HCV surveillance, research, prevention, testing, care, treatment, and syringe access services.

11) Prioritize efforts to ensure federal government policies and funding effectively address needs for HCV surveillance, research, prevention, testing, care, treatment, and syringe access services.

While the recommendations are focused on implementation by the City and County of San Francisco, the Task Force is aware of the need for leveraging and coordinating additional resources to achieve the recommendations. The Task Force encourages innovative approaches including strategic local government-initiated partnerships with community-based organizations (CBOs), individual community members, the business community, philanthropy, and state and federal governments.

Nearly two years ago, community members identified the urgent need for a comprehensive assessment and response to the HCV epidemic in San Francisco. These recommendations were developed after a year of hard work and thoughtful consideration by Task Force members based on extensive community input and consultation with a wide range of experts. In order to build on this momentum and ensure a comprehensive approach and more effective HCV prevention, education, screening, testing, care, treatment, research, surveillance, and public policy, the San Francisco Hepatitis C Task Force also considered next steps for implementing these recommendations.

Therefore, the Task Force voted at its December, 2010 meeting to:

- Continue as an independent community coalition with the current organizational sponsors, Drug Policy Alliance, HCV Advocate/Hepatitis C Support Project, and Project Inform continuing as organizational sponsors;
- Remain comprised of current Task Force members who want to continue to work; and
- Work from January through March to determine the coalition's structure (including membership and voting) and scope of work for 2011 (with the help of a consultant, funding permitting).

Overview of Hepatitis C (HCV)

The hepatitis C virus (HCV) is a blood-borne virus that causes inflammation in the liver and can lead to cirrhosis, liver cancer, and liver disease (Franciscus and Highleyman, 2009). HCV is an infectious disease spread by blood-to-blood contact and can be classified as acute or chronic. Acute cases are those that clear themselves within six months of infection and chronic infections are life-long unless successfully treated with medication. An estimated 80–85% of individuals infected with HCV are chronically infected (Harm Reduction Coalition). In addition to being classified as acute or chronic, there are six identified genotypes of HCV, of which genotype 1 is the most common in the United States. There is treatment available for chronic HCV, although the success rates for treatment varies by genotype as well as by affected population. For instance, overall, the virus clearing rate is approximately 50% for those with genotype 1 (Franciscus and Highleyman, 2009); however, the treatment success rate for African Americans with genotype 1 is lower than all other racial or ethnic groups at 30% (Ghany, et al., 2009). Even if the acute or chronic HCV clears naturally or with treatment intervention, this does not preclude an individual from becoming re-infected with the virus if exposed to HCV again.

The Scope of Hepatitis C: Data Summary

In the United States, approximately 4 million people are estimated to be infected with HCV (Ghany, et al., 2009); in San Francisco, it is estimated that 12,000 people are living with HCV (SFDPH [SFDPH], 2010). SFDPH began its surveillance of HCV in 2009, and during that year, 3,387 individuals were identified as currently or previously infected with HCV. Of these cases, the majority were male (68.8%), and White (53.6%); and, 35.7% were between the ages of 45 and 54. African Americans were disproportionately represented (34.7% while African Americans comprise 7.3% of the San Francisco population) (SFDPH, 2010).

While San Francisco now conducts surveillance of HCV, the data are very limited. According to SFDPH's *2009 Chronic Hepatitis B and Hepatitis C Surveillance Report*, HCV infection data may be inaccurate and incomplete for a multitude of reasons, including: unreported, anonymous testing; testing prior to 2009; infected individuals who have not been tested; lack of reporting (or lack of timely and comprehensive reporting) by some physicians and groups; and, insufficient resources for assessment reports. The insufficient assessment reports also lead to the inability to distinguish between acute, chronic, and cleared HCV cases. Furthermore, in order to classify the HCV infection, multiple tests and data points are needed and SFDPH does not currently have the capacity to analyze that dynamic data. All of these limitations contribute to the inability to determine accurate prevalence and incidence of HCV in San Francisco, which would better inform targeted testing, prevention, and treatment.

Although few conclusions can be drawn from San Francisco's HCV data, San Francisco's HCV-infected population is presumably similar to that of the United States as a whole, with injection drug users (IDUs), African Americans, Latinos, veterans, immigrants and low-income individuals bearing the burden of the disease. In addition, people living with HIV/AIDS (PLWHA) are disparately impacted by HCV, with approximately 30% of PLWHA co-infected with HCV. These co-infected individuals are also more likely to develop liver disease and have more adverse reactions to HCV treatment than those who are mono-infected with HCV. Moreover, it is estimated that in urban areas of the United States, up to 90% of PLWHA who acquired HIV through injection drug use are also infected with HCV (Harm Reduction Coalition).

The Hepatitis C Virus

Transmission

HCV is spread through blood-to-blood contact and it is most commonly spread through contaminated shared injection equipment. Anyone who received a blood transfusion prior to 1992 is also at high risk. HCV can also be spread, via blood-to-blood contact, through unprotected sex and from a mother to her baby during birth. Although the exact level of risk is not known, HCV is transmittable through contaminated equipment used in tattooing, body piercing, manicures/pedicures, and acupuncture. Injection drug users (IDUs) are at the highest risk: injecting drugs with shared equipment—including needles, water, cottons and other works—is the most efficient mode of HCV transmission. HCV can be transmitted even through small amounts of blood and can live in open air and inside needles for some time; it is believed the virus can live up to three weeks in a needle and for at least 16 hours and no longer than 4 days outside the body at room temperature, according to the Centers for Disease Control and Prevention (CDC) (CDC, 2010). While individuals who are acutely infected with HCV do clear the virus on their own, they can still—often unknowingly—transmit the virus to others during the time they are infected.

Disease Progression

Within the first few (two to six) months an individual is infected with HCV, the body tries to fight the virus and approximately 15–25% of individuals successfully clear the virus without treatment (termed acute HCV) (CDC, 2010). If the virus does not clear, it becomes a chronic HCV infection. Of the individuals living with chronic HCV who do not receive treatment or whose treatment is unsuccessful, 60–70% will develop chronic liver disease and, of these, 5–20% will develop cirrhosis. It is estimated that in the United States, 12,000 individuals die from HCV-related illnesses each year (CDC, 2010). Most people with HCV do not have symptoms and thus, do not seek testing. However, some symptoms people with HCV report include: headaches; loss of appetite; nausea; stiff/aching joints; brain fog/cloudy head; and depression. During late-stage HCV, symptoms of liver damage may manifest in the form of pain in the area of the liver; constant lethargy; jaundice; severe itching, water retention; easy bruising and bleeding; and severe mental confusion.

Screening and Diagnosis

Acute HCV is often undiagnosed, as symptoms are uncommon and the virus is cleared relatively quickly. To screen for chronic HCV, blood is tested to detect the presence of antibodies to the virus. This antibody screening can detect possible infection between four and 10 weeks after exposure and has a greater than 97% accuracy rate six months after exposure (CDC). However, an RNA (viral load) test (to measure viral nucleic acid) can detect the RNA for the hepatitis C virus as early as two to three weeks after infection. The viral load test is the diagnostic test that confirms if HCV is in the blood (the antibody test only provides the information that someone was infected at some point, not if they are still infected). The viral load test is a particularly important test for individuals with HIV, as their suppressed immune systems often prohibit them from making antibodies to HCV, which could create a false-negative HCV antibody test.

After an individual tests positive, the CDC recommends that the healthcare professional then measures the alanine aminotransferase (ALT) liver enzyme in the blood, as an elevated ALT indicates inflammation of the liver and the need for further checks for chronic liver disease. However, ALT enzyme levels can remain normal, or fluctuate, despite having chronic HCV. Genotype testing is also recommended, as the genotype helps to inform the treatment.

Treatment

Once chronic HCV infection is confirmed through viral load testing (and, ideally, the HCV genotype is determined) a healthcare provider should work with the infected individual to assess treatment readiness and viability. This assessment is based on the HCV screening and tests, as well as the client's overall physical and mental health. Currently, the treatment for HCV is a combination therapy with pegylated interferon and ribavirin, which is 40 to 80% effective at clearing HCV. The genotype is indicative of the success rate of treatment and helps inform whether or not medical treatment is the best option, which is why genotype must be determined prior to treatment. Identifying the genotype also determines the length of treatment. Typically, a 48-week course of treatment is recommended for individuals with genotype 1 and often a 24-week course is adequate for genotype 2 and 3. After an individual starts treatment, the healthcare provider periodically checks on the progress of treatment, commonly at 12 weeks and then again at 24 weeks, to determine the further course of treatment.

While treatment of HCV can be successful, there are a number of side effects associated with the medications, which can provide significant barriers to individuals receiving or remaining on treatment (Ghany, et al., 2009). Side effects of HCV treatment include depression, suicidal ideation, mania, and relapse of drug and alcohol use. For this reason—and because excess alcohol intake may increase HCV RNA replication, interfere with response to treatment (Ghany et al., 2009), and play a role in liver disease and cirrhosis—behavioral health treatment and support are important complements to HCV treatment.

Prevention

Overall, public knowledge about HCV is minimal and there is a need for wide-spread educational campaigns, including information on how HCV is spread and precautions for at-risk populations. Because of the disproportionate impact of HCV on specific groups, such as IDUs, people living with HIV/AIDS, African Americans, and those who are currently or who have been incarcerated, there is a need for direct risk-reduction prevention education to be provided for these groups. It is estimated that nearly 90% of IDUs are infected with HCV nationwide (Harm Reduction Coalition), with equally high percentages in San Francisco according to the UCSF Urban Health Study (Hahn, et al., 2001). For this reason, education on HCV risk, safe injection procedures, and equipment sterilization for IDUs is critical, as is access to clean needles, legal safer injection locations, and comprehensive substance use treatment.

San Francisco Hepatitis C Task Force

History, Purpose, and Vision

Recognizing that San Francisco has been hit hard by the HCV epidemic, in early 2008 numerous people came together with the purpose of creating a local response. The group included representatives from the American Liver Foundation, the California Hepatitis Alliance, Project Inform, City College of San Francisco, Asian & Pacific Islander Wellness Center, HCV Advocate/Hepatitis C Support Project, and the Drug Policy Alliance.

After a series of meetings with the Mayor's staff, in May, 2009, San Francisco Mayor Gavin Newsom created the San Francisco Hepatitis C Task Force (Task Force), appointed individuals to serve on the Task Force, and charged the group with developing a comprehensive set of recommendations to address the HCV epidemic in San Francisco. At the same time, the Mayor issued a proclamation honoring May 19th as *World Hepatitis Day*.

Task Force Vision Statement

We envision a San Francisco where:

- Everyone is educated about hepatitis C and has the opportunity to know their hepatitis C status;
- Everyone living with hepatitis C receives the highest level of care and support to ensure their quality of life and longevity; and
- There are no new hepatitis C transmissions.

Task Force Goals

- Promote better understanding about the impact of hepatitis C on San Francisco and its residents.
- Develop better surveillance and reporting of hepatitis C.
- Raise awareness regarding hepatitis C on both the community and individual levels.
- Improve access to care and support services and increase quality of life for people with hepatitis C.
- Make hepatitis C screening and testing widely available and accessible.
- Promote partnerships among the public/private health care sector, community organizations, advocates, and individuals affected by hepatitis C.
- Identify existing assets and gaps in access to hepatitis C education, prevention, screening, testing, and care.
- Serve as liaison and coordinate with the San Francisco Hep B Free Coalition to address common issues and strengthen partnership between hepatitis C and B advocates.

Process for Developing Recommendations

The Drug Policy Alliance agreed to serve as the lead sponsor of the Task Force and provide administrative support, with Project Inform and the HCV Advocate/Hepatitis C Support Project serving as co-sponsors. In addition, the Drug Policy Alliance developed and submitted a successful proposal to the San Francisco Foundation to support the development of this report.

The Mayor appointed 32 members to the Task Force, including medical and social service providers, public health officials, HCV advocates, people living with and affected by HCV, and other stakeholders and experts (see list of Task Force members in appendix). The inaugural meeting of the Task Force was November 9, 2009; subsequent meetings were held monthly through 2010 and open to the public, in accordance with local regulations (e.g., the Sunshine Ordinance).

The Task Force developed bylaws and elected Co-chairs Randy Allgaier, Emalie Huriaux, and Dominique Leslie, and convened committees to develop recommendations in four areas: 1) Care and Treatment; 2) Prevention, Education, Awareness, and Testing; 3) Public Policy; and 4) Research and Surveillance. The Task Force elected a Steering Committee—comprised of a chairperson from each committee, the Task Force Co-chairs, and two at-large members—to plan meetings and coordinate the work of the Task Force and committees. Committee members researched relevant issues and discussed and crafted recommendations at monthly committee meetings which were also open to the public pursuant to local regulations.

To provide the public and Task Force members with detailed information about Task Force and committee meetings, the Task Force developed a website: *www.hepcsf.org*. The website contains the Task Force bylaws, meeting agendas, minutes, presentations, and general HCV information and resources.

Expert Presentations

The Task Force scheduled presentations by experts on a variety of topics related to HCV in San Francisco for their meetings. Topics included: the California Adult Viral Hepatitis Strategic Plan; How SFDPH's System of Care Addresses HCV; How the San Francisco Veterans Affairs Medical Center addresses HCV in San Francisco; HIV/HCV Co-infection Focus Group Findings; HCV among Patients at the Housing and Urban Health Clinic; HCV among Patients at the South of Market Health Center; HCV among Patients at the Curry Senior Center; Drug Policy and HCV; the UFO Study, a Longitudinal Study of HCV among Young People who Inject Drugs; HCV in the Lives of People who use Drugs; and Hepatitis C Surveillance in San Francisco (see list of presenters in appendix).

Community Forums

During the year that the Task Force met, two community forums were held to draw attention to two particularly important issues for San Francisco related to HCV: 1) the impact of HCV co-infection with HIV and sexual transmission of HCV among men who have sex with men (MSM); and 2) the disproportionate impact of HCV among African Americans.

On June 7, 2010 at the Eureka Valley Recreation Center in the Castro District, the Task Force hosted *HIV / Hepatitis C Co-Infection and Sexual Transmission of Hepatitis C*, a community forum conducted in collaboration with the HIV Health Services Planning Council. Over 40 people attended to hear presentations and ask questions about co-infection and sexual transmission of HCV among MSM. Speakers included:

- Brad Hare, MD and Val Robb, RN from the UCSF Positive Health Program, who provided information about HIV/HCV co-infection and health and support services available for co-infected individuals.
- Erika Tekada, Harder + Company, who presented results from a focus group funded by the HIV Health Services Planning Council. The focus group was comprised of co-infected MSM and findings related to the following topics: HIV/HCV and Health and Medical Needs; Challenges with HCV Diagnosis and Treatment; and the Need for HCV Support and Services.

- The final presentation was a panel discussion with three gay men living with HIV and HCV. The panelists discussed their experiences living with HCV and described both supportive responses from their community and experiences of stigmatization related to their HCV status.

On October 20, 2010 at City College of San Francisco's Southeast Campus, the Task Force hosted *Hepatitis C in the African-American Community*. The forum was co-sponsored by the African American Health Disparities Project, Bayview Hunters Point Foundation, Black Coalition on AIDS, City College of San Francisco's Health Education Department, Glide, HCV Advocate/Hepatitis C Support Project, Positive Directions Equals Change, and SFDPH's STD Prevention & Control Services. Over 50 people attended to hear presentations and discuss the disproportionate impact of HCV among African Americans. Speakers included:

- Dr. Dan Wlodarczyk, from Southeast Health Center and SFGH's Positive Health Program, and Val Robb, RN, from SFGH's Positive Health Program, who provided general information about HCV, and more specific information about the impact of HCV among African Americans.
- Task Force member Theresa Hughes, an economist and President/Founder of Wings for Life, who discussed some of the economic impacts of HCV in the African American community and described the relationship between incarceration and HCV.
- Task Force member Rodney McClain, from the Veterans Administration Medical Center, who facilitated a panel of individuals who spoke about their experiences living with HCV. Panelists described successes and challenges they have had managing, and in some cases treating, their infection.

At both forums, attendees asked many questions and expressed much interest, concern, and energy about addressing the HCV epidemic in general and particularly in their communities. The Task Force hopes that more community-based events like these occur in the near future to educate San Franciscans about HCV and hear from communities about their concerns.

Recommendations for Strategically Addressing Hepatitis C in San Francisco[1]

Research and Surveillance Recommendations

Strategic Direction 1

To improve surveillance capacity and data use

Practical Vision

- An **accurate epidemiological profile** of HCV morbidity and mortality in San Francisco
- **Advancement of HCV research and development of prevention, care and treatment** in San Francisco

Recommendations and Action Steps

Accurate Epidemiological Profile

1) Develop, compile and share HCV surveillance data and generate San Francisco-specific surveillance reports.
    a. Use surveillance data and other research to develop HCV prevalence estimates by neighborhood.
    b. Use surveillance data and other research to develop HCV prevalence estimates by risk factors.
    c. Develop integrated surveillance reports to assess rates of HIV, STD, HBV, TB and HCV co-morbidities.
    d. Develop fact sheets summarizing incidence, prevalence and co-infection estimates via a monthly report.
    e. Disseminate a yearly report summarizing incidence, prevalence, co-infection and other relevant data.
    f. Post surveillance reports on the SFDPH website and share them with medical providers, CBOs and other related agencies.

1 The San Francisco Hepatitis C Task Force gratefully acknowledges the California Adult Viral Hepatitis Prevention Coordinating Committee, the California Department of Public Health/Center for Infectious Diseases, and particularly Rachel McLean, California Adult Viral Hepatitis Prevention Coordinator for providing the model structure for this section; select recommendations are also adapted for local use from the California Adult Viral Hepatitis Prevention Strategic Plan, 2010–2014.

2) Engage medical providers, healthcare organizations, laboratory staff and SFDPH personnel to evaluate, modify as needed, and implement HCV reporting requirements to improve quality and use of HCV surveillance data.

   a. Develop and distribute guidance on HCV reporting mechanisms and requirements:

   b. Collaborate with the SFDPH Microbiology Lab and Clinical Lab and private laboratories to ensure that labs are following CDC and California guidelines to report acute HCV cases and confirm and report cases of chronic HCV.

   c. Collaborate with SFDPH Microbiology Lab and Clinical Lab and private laboratory directors to standardize data elements for electronic lab reporting of HCV cases.

   d. Engage directors of the SFDPH Microbiology Lab and Clinical Lab and private laboratories to improve collection of all requisite data on the Confidential Morbidity Report (CMR), including race/ethnicity, gender, and patient address on laboratory requisition forms and to transmit this information in lab reports to the Communicable Disease Control & Prevention section of SFDPH.

   e. Develop strategies for receiving HCV case reports from the Veterans Affairs Medical Center.

   f. Implement changes to the CMR to include transgender as a gender option, using the recommendations for the collection of this field from the SFDPH working group charged with determining how SFDPH should collect gender information.

   g. Implement changes to the CMR to include more relevant risk factors within the "suspected exposure type" section, including, but not limited to the following:

      - vertical transmission
      - sharing of injection equipment
      - non-IDU blood exposure
      - sexual transmission

   h. Implement changes to the CMR to include HCV viral load and genotype.

3) Increase acute HCV surveillance capacity.

   a. Identify mechanisms and SFDPH staff to investigate and report all acute HCV cases.

   b. Create a confidential case report for all acute cases of HCV to capture more detailed information on risk factors.

   c. Partner with STD Prevention and Control for case evaluation, partner services, and follow-up for acute cases of HCV infection.

Table 1: Possible Hepatitis C Reporting Requirements

1. Hepatitis C Laboratory Reporting Requirements
2. Reporting and Documenting Acute Hepatitis C Cases
3. Confirming and Reporting Chronic Hepatitis C Cases
4. Confidential Morbidity Report (CMR) Guidelines

4) Increase chronic HCV surveillance capacity.
    a. Identify mechanisms to monitor HCV trends.
    b. Identify mechanisms and systems to identify HCV outbreaks.
    c. Work with medical providers and labs to identify and implement practical strategies for noting the pregnancy status of women when ordering HCV lab tests as part of the prenatal visit.

5) Support HCV research and development.
    a. Develop a Hepatitis C Research Working Group comprised of SFDPH researchers and public and private research institutions, such as San Francisco State University, UCSF, RTI International, California Pacific Medical Center, Quest Clinical Research.
    b. SFDPH should fund a rapid assessment of HCV in populations not included in 2009 surveillance data (e.g., Latinos, transgenders).
    c. SFDPH should ensure populations not represented in 2009 surveillance data are included in the future (e.g., Latinos, transgenders).
    d. Support increased representation of individuals coinfected with HIV; African Americans, Latinos, and other under-represented groups; active substance users; people with mental illness; and youth in HCV clinical trials in San Francisco.
    e. Establish collaborations between SFDPH, public and private universities and other research institutions to develop an evidence base for HCV prevention programs.
    f. Conduct a survey of HCV resources, including primary medical care, complementary therapies, support groups, harm reduction programs, and other services.

Table 2: Potential Hepatitis C Research Project

1. Prevalence of HCV in the transgender community
2. Prevalence of HCV among individuals injecting steroids
3. Prevalence of HCV among non-injecting drug users
4. Re-infection rate of HCV among individuals receiving treatment
5. Incidence and prevalence of HCV in the fetish/BDSM community
6. Sexual transmission of HCV among MSM
7. Prevalence of HCV in San Francisco jail populations

Prevention, Education, Awareness and Testing Recommendations

Strategic Direction 2

To educate the public and providers about the hepatitis C virus (HCV)

Practical Vision

- ▲ **Increased public knowledge** and understanding of HCV, transmission risks, health complications, and prevention strategies.
- ▲ **Community engaged** to increase awareness of HCV among adults and youth.

Recommendations and Action Steps

Increased Public Knowledge

1) Update, reprint, and disseminate existing SFDPH viral hepatitis resource guide.
    a. Ensure resource guide is available in Spanish and other relevant languages (e.g. Chinese, Tagalog, Russian).
    b. Distribute and post online the resource guide for use by clinicians, service providers and individuals.

Table 3: Considerations for Developing Public HCV Awareness Messages

- Produce materials for general audiences that are at an eight-grade reading level
- Emphasize that everyone is affected; most people don't know they're infected; and most don't have any visible symptoms
- Include patient stories and tie to local outreach
- Aim to create a safe environment for accessing information, testing and care, particularly in underserved communities
- Include messages about pre-1992 blood transfusions and past drug use ("back in the day")
- Highlight the similarities and differences among HAV, HBV and HCV transmission routes and disease progression
- Emphasize the areas of difference and similarity in transmission of viral hepatitis with HIV, STDs and TB

2) Develop and implement health promotion and awareness strategies for educating the public about HCV.

   a. Create a citywide HCV website to serve as an information clearinghouse and include testing and screening sites, fact sheets, links, etc. and printable PDF documents (similar to sfhiv.org).

   b. Develop and implement a coordinated local response for World Hepatitis Day (May 19) 2011 and for subsequent years.

   c. Adapt and distribute public service announcements to local radio, print, television, web and other media outlets to promote awareness about HCV among the general public and to promote the citywide HCV website. Venues include newspapers, MUNI, radio, etc.

   d. In collaboration with communities affected by HCV, develop, launch and evaluate targeted, strengths-based social marketing campaigns that include an ability to meet increased demand for services that the campaigns generate.

Community Engaged to Increase HCV Awareness

3) Engage the community to help increase HCV awareness among adults and youth.

   a. Develop a speaker's bureau of people affected by HCV.

   b. Build a citywide HCV awareness network to share information about awareness strategies and to promote collaboration among community awareness groups.

   c. Review current HIV/STD education curricula used in schools, revise curricula to include medically accurate and age-appropriate HCV prevention information, and work with San Francisco Unified School District to distribute them.

Table 4: Considerations for Developing and Delivering Targeted HCV Prevention Messages for At-Risk Adults

- Collaborate with individuals, families and groups from impacted communities to identify culturally sensitive, linguistically appropriate and data-driven messages
- Emphasize the overall health and wellness of the priority populations, rather than focusing solely on disease prevention and risk behaviors, and ensure that prevention messages do not further stigmatize at-risk groups
- Acknowledge structural barriers to reducing individual-level risk when developing health education and prevention materials

Strategic Direction 3

To increase hepatitis C (HCV) testing

Practical Vision

- ▲ **Everyone in San Francisco knows their HCV status and transmission risks.**
- ▲ **Expanded HCV screening criteria and increased testing availability, including rapid tests.**
- ▲ **Increased understanding of HCV transmission risk among medical providers, service providers and the general public.**
- ▲ **Adequate resources and funding to carry out HCV testing, counseling, and education.**

Recommendations and Action Steps

Expanded HCV Screening Criteria and Increased Testing Availability

4) Broaden HCV screening criteria.

   a. Develop a community standard for screening to provide HCV testing to the following categories of people:

Table 5: Recommended HCV Screening[1]

a. Anyone who asks for a test
b. People with any history of injecting drugs or other substances, including illicit drugs, hormones, or steroids
c. People who have tattoos or piercings
d. People who have shared needles, razors, or other cutting or piercing implements for any other purpose
e. People who have shared drug paraphernalia including straws and crack pipes
f. Anyone who received a blood transfusion before 1992
g. People who may have had blood contact during sex, including through BDSM activities, fisting, and sharing sex toys
h. People with multiple sex partners
i. The "Baby Boomer" generation: those born between 1946–1964
j. United States Veterans
k. Those who are incarcerated or who have a history of incarceration
l. People who are HIV positive
m. People who are hepatitis B positive
n. Homeless individuals
o. People who have received medical or dental services in other countries
p. Emergency department employees, EMTs, paramedics, and health care workers with blood exposure
q. Children born to HCV positive mothers
r. People with high ALT liver function test results

1 Adapted from Department of Veterans Affairs. Source: *http://www.hepatitis.va.gov/vahep?page=test-01-01*

5) Increase HCV screening and prevention efforts for high-risk and incarcerated populations.
    a. Require that all persons with risk factors who are receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco be offered an HCV antibody test as part of their standard wellness visits.
    b. Require that frequent HCV screening (every 3 months) be offered for high-risk populations at SFDPH and SFDPH-funded clinics, and that providers are knowledgeable about what populations are at high risk for HCV.
    c. Require that all persons seeking HCV antibody testing at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco be offered testing/counseling.
    d. Require screening and prevention efforts for incarcerated populations.

Increased Understanding of HCV Transmission Risk

6) Increase awareness of the need for and availability of HCV testing.
    a. Conduct an organized campaign around HCV testing, promoting awareness of HCV, transmission risks, and the need for getting tested.
    b. Make HCV testing available and easy to access for the general population.
    c. Determine optimal locations and events to offer HCV testing and ensure testing is available.
    d. Address the fear and stigma associated with an HCV test and rationalize the test for the public.
    e. Increase education about the need to test people in the "Baby Boomer" generation, born between the years of 1946–1964.
    f. Increase funding for CBOs to carry out education and testing campaigns in their communities and provide necessary services, especially in the African American community and other communities heavily impacted by HCV.

Adequate Resources and Funding

7) Increase HCV testing capacity and services.
    a. Increase HCV antibody and RNA testing availability, including the use of emerging technology such as rapid HCV testing, prioritizing testing resources for people with known risk factors.
    b. Integrate HCV prevention, education, testing, and referral services into settings providing HIV testing or STD testing.
    c. Increase the number of providers and settings offering HCV testing.
    d. Provide the necessary resources to increase testing including:
        - Test kits
        - Trained counselors, as needed
        - Trained phlebotomists, as needed
        - Rapid HCV test training and certification
    e. Create cost effective testing algorithms which include follow up testing.
    f. Develop and provide disclosure assistance for clients.

8) Increase HCV laboratory testing capacity.
    a. Expand laboratory HCV testing capacity within SFDPH to process increased volume of antibody, RNA, viral load, and genotype tests.

Strategic Direction 4

To provide accurate risk information and effective hepatitis C (HCV) prevention interventions

Practical Vision

- ▲ **Shared understanding** of HCV transmission risks.
- ▲ **Increased access** to effective prevention interventions and services.

Recommendations and Action Steps

Shared Understanding of HCV Transmission Risks

9) Provide accurate information about the sexual transmission of HCV.

   a. Compile and disseminate accurate information about the sexual transmission of HCV.

   b. Hold community forums to provide accurate information about HCV, including sexual transmission, in the BDSM, kink, and LGBT communities.

   c. Create an educational campaign focused on HCV to better educate relevant communities on HCV sexual acquisition and transmission.

   d. Train medical providers, service providers and health care providers on the transmission of HCV, including sexual transmission.

   e. Increase education on the dual diagnosis of HIV and HCV.

   f. Provide consistent information and messages on information regarding HCV.

Increased Access to Effective HCV Interventions and Services

10) Increase access to sterile injection equipment and other harm reduction services.

   a. Expand and fund syringe access programs including satellite syringe access programs, toward the goal that **every IDU has a sterile syringe per injection event.**

   b. Increase access to syringes and other injection equipment (e.g., cookers, cottons, water) in primary care clinics, HIV prevention programs, drug treatment programs, mental health clinics, drop-in centers, mobile health vans, and other settings serving IDUs.

   c. Encourage all pharmacists in San Francisco to participate in the non-prescription syringe sales program.

   d. Remove any structural or legal barriers to non-prescription access to syringes and other sterile equipment used for injection.

   e. Support and fund the creation of a legal supervised injection facility in San Francisco.

   f. Increase syringe disposal access throughout San Francisco.

   g. Provide sterile split kits (i.e., kits to assist IDUs to split drugs without blood contamination).

   h. Provide sterile drug using equipment for non-injection drug use (e.g., glass pipes).

   i. Decriminalize the possession of drug use equipment and paraphernalia.

j. Increase education of law enforcement staff about, and their support for, syringe access programs.

k. Support research on heroin-assisted treatment.

l. Expand overdose prevention activities, including provision of take-home naloxone, and integrate with HCV prevention activities, to ensure that at-risk populations are being reached and that services are effective and available for those who need them.

m. Address the misconceptions regarding HCV in the IDU community by providing accurate information at programs serving IDUs (e.g., syringe access programs, substance use treatment programs).

11) Increase HCV prevention services for people who are involved in the criminal justice system.

a. Collaborate with the San Francisco Sheriff's Department and Jail Health Services to develop effective HCV protocols and pilot programs.

12) Improve policies and practices in tattoo and piercing parlors, sex toy stores, and nail salons.

a. Ensure that tattoo parlor regulations are developed and monitored by persons familiar with tattooing procedures.

b. Educate tattooists throughout San Francisco about safe tattooing practices.

c. Conduct outreach to the owners of sex toy stores and leather shops and urge them to offer cleaning supplies and instructions with each purchase and to provide autoclaving services and/or referrals.

d. Clarify proper cleaning procedures among sex toy shop and leather shop owners in San Francisco.

e. Provide HCV training to staff who work in the following types of facilities: gyms, sex play spaces, salons, spas, and massage parlors.

f. Enforce autoclaving of equipment used in tattoo and piercing parlors and nail salons.

Table 6: Recommended HCV Protocols and Pilot Programs for Criminal Justice System

- Standard HCV prevention, education, and testing protocol for all facilities
- Use of rapid HCV tests as available
- Standard transitional case management protocol for people with chronic HCV who are returning to the community, including a summary of the person's test results and treatment history and referrals to follow-up services
- Pilot vocational sterile tattooing program
- Pilot sterile syringe access program
- Comprehensive, integrated viral hepatitis, HIV, STD, and tuberculosis peer health education program

13) Provide substance use treatment to all who request it.

a. Fully fund a comprehensive range of culturally appropriate and evidence-based substance use programs, including harm reduction modalities.

b. Ensure multiple points of access to treatment programs.

c. Support research into new substance use treatment modalities, including heroin-assisted treatment.

Care and Treatment Recommendations

Strategic Direction 5

To improve health outcomes of people living with hepatitis C virus (HCV) in San Francisco

Practical Vision

- Improved Case Finding Measures: Existing and new cases of HCV are identified.
- Expanded Capacity of Providers: Providers, paraprofessionals, and volunteers are trained to increase knowledge and skills and support treatment, care, screening, prevention, referrals, linkage, and care navigation for people living with and at risk for HCV.
- Standardized Evaluation Procedures: (1) HCV viremia, (2) disease stage, and (3) treatment candidacy/readiness are identified.
- Expanded Access to Care and Treatment: Inclusive access to care including antiviral treatment for people living with HCV.
- Improved Maintenance Care: Wellness of people living with HCV is promoted through medical and alternative clinical treatment at every disease stage.
- Enhanced Supportive Services: Access to care navigation, psychosocial support, and mental health services for people living with HCV is strengthened through service expansion and referral.

Recommendations and Action Steps

Improved Case Finding Measures

1) Provide ongoing continuing medical education (CME) for providers regarding risk factors, high-risk populations, testing, care, and treatment options.

Expanded Provider Capacity for Care, Treatment, Screening, and Prevention Interventions

2) Train primary care providers (including providers of care to those living with HIV) regarding HCV.
    a. Provide training to primary care providers in identification and evaluation of HCV.
    b. Provide training to primary care providers (including through community-based pilot programs and nurse training programs) in treating HCV within primary care clinics, when appropriate.
3) Train non-clinical public health and community providers—including paraprofessionals, outreach workers, peer educators, and volunteers—who serve at-risk individuals regarding HCV care, prevention interventions, and related information.
    a. Develop or adapt training curricula on HCV prevention, education, testing, and care for relevant audiences. Compile existing HCV training resources and post links on the SFDPH website.
    b. Require HCV prevention and treatment education for staff at SFDPH and SFDPH-funded organizations and programs focused on primary care, STD, HIV, housing, and behavioral health services.

c. Use conferences and meetings of coalitions, professional associations, and other groups serving people living with or at risk for HCV as opportunities to promote tailored HCV awareness and service integration messages.

d. Create opportunities for service providers and local health officials to share experiences integrating HCV prevention, education, testing, and care into their services and use those as an opportunity to update providers on recent findings regarding HCV.

e. Coordinate with current HIV and STD testing centers and health care centers to promote awareness and recommend onsite HCV testing.

f. Provide training in care navigation.

g. Train a (peer) volunteer corps to conduct home visits and assess individuals' support needs.

h. Include in training opportunities: HCV-positive peers; caregivers; volunteers; interns; and people working in correctional facilities, CBOs, HIV organizations, educational facilities, syringe access programs, primary care clinics, drop-in centers, shelters, behavioral health programs, STD clinics, immigrant and refugee health, and other fields serving at-risk adults.

4) Expand HCV resources available for providers.

a. Decentralize HCV treatment services by ensuring the San Francisco General Hospital Liver Clinic has the capacity to provide training and clinical consultation services to support primary care physicians within SFDPH and SFDPH-funded primary care clinics in treating HCV.

b. Create an online hub or portal that allows providers and people living with and affected by HCV to share HCV–related information, resources, data, referrals, and best practices. (Potential model is Tibotec's HIV Case Manager Portal: *www.hivcasemanager.com/home*)

5) Ensure that HIV/HCV co-infected individuals have access to evaluation and care by clinicians skilled in the management of co-infection.

Standardized Evaluation Procedures

6) Ensure that all persons who test positive for HCV antibodies who are receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco have confirmatory molecular (viral load) testing (e.g. polymerase chain reaction [PCR]) planned unless they decline.

7) For all people living with chronic HCV, strive to provide:

- Liver biopsy when indicated, as the gold standard; OR
- Other noninvasive blood testing.

8) Ensure that all persons living with chronic HCV and receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco be offered a baseline abdominal ultrasound.

9) Expedite treatment referrals for acute HIV cases.

Table 7: Considerations for Cross-Training Health Professionals

Targeted Providers	Tailored Message
Substance Use	Enrollment in drug treatment is an ideal opportunity for testing, care, and treatment.
Mental Health	People with depression, bipolar disorder, and schizophrenia, and active drug users, can be successfully treated for HCV with proper monitoring and support.
Minority Health	African Americans are disproportionately affected by HCV and have lower treatment response rates.

Expanded Access to Care and Treatment

10) Establish a uniform and centralized system through SFDPH for authorization of care and treatment including pre-approvals for medications from insurance companies, patient assistance programs, and other forms of patient support, regardless of healthcare coverage status; explore existing systems including ones used by specialty pharmacies; consider creating a payment navigator position.

11) Educate providers and require that all persons who are living with HCV and receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco be considered potential candidates for antiviral treatment.

The following tables (tables 8–10) are from the American Association for the Study of Liver Diseases (AASLD) Practice Guidelines.[3] The inclusion of the AASLD tables does not indicate endorsement by the San Francisco Hepatitis C Task Force.

Table 8: Characteristics of Persons for Whom Therapy is Widely Accepted

- Age 18 years or older, and
- HCV RNA positive in serum, and
- Liver biopsy showing chronic hepatitis with significant fibrosis (bridging fibrosis or higher), and
- Compensated liver disease (total serum bilirubin <1.5g/dL; INR 1.5; serum albumin >3.4, platelet count 75,000 mm and no evidence of hepatic decompensation (hepatic encephalopathy or ascites), and
- Acceptable hematological and biochemical indices (Hemoglobin 13g/dL for men and 12 g/dL for women; neutrophil count 1500 /mm3 and serum creatinine <1.5 mg/dL, and
- Willing to be treated and to adhere to treatment requirements, and
- No contraindications (Table 10)

Table 9: Characteristics of Persons for Whom Therapy Should be Individualized

- Failed prior treatment (non-responder and relapsers) either interferon with or without ribavirin or peginterferon monotherapy
- Current users of illicit drugs or alcohol but willing to participate in a substance use program (such as a methadone program) or alcohol support program. Candidates should be abstinent for a minimum period of six months
- Liver biopsy evidence of either no or mild fibrosis
- Acute hepatitis C
- Co-infection with HIV
- Under 18 years of age
- Chronic renal disease (either requiring or not requiring hemodialysis
- Decompensated cirrhosis
- Liver transplant recipients

3 Ghany, M.G., Strader, D.B., Thomas, D.L., & Seeff, L.B. April, 2009. Diagnosis, Management and Treatment of Hepatitis C: An Update. Hepatology, p 1347. *http://www.natap.org/2009/HCV/aasld.pdf*

Table 10:Characteristics of Persons for Whom Therapy is Currently Contraindicated

- Major uncontrolled depressive illness
- Solid organ transplant (renal, heart, or lung)
- Autoimmune hepatitis or other autoimmune condition known to be exacerbated by peginterferon and ribavirin
- Untreated thyroid disease
- Pregnant or unwilling to comply with adequate contraception
- Severe concurrent medical disease such as severe hypertension, heart failure, significant coronary heart disease, poorly controlled diabetes, chronic obstructive pulmonary disease
- Age less than 2 years
- Known hypersensitivity to drugs used to treat HCV

12) Require that when antiviral treatment is offered to persons receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco, it represents current state-of-the-art treatment available in the community, including newly FDA-approved HCV treatments.

13) Require that HCV treatment and care be provided as needed in all SFDPH and SFDPH-funded community-based clinics.

14) Fund support services that assist individuals who are interested in HCV treatment to become appropriate treatment candidates; facilitate access to support services as needed.
    a. Fund and facilitate access to drug and alcohol treatment programs.
    b. Fund and facilitate access to mental health services.

15) Provide community access to subsidized acupuncture and related medically necessary treatments for persons who are HCV symptomatic or undergoing HCV treatment.

Improved Maintenance Care

16) Promote wellness of people living with HCV through medical and alternative clinical treatment at every disease stage.
    a. Require that all persons with chronic HCV receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco be screened for HIV infection on an opt-out basis.
    b. Require that all persons with HCV infection receiving services at SFDPH and SFDPH-funded clinics and/or covered by Healthy San Francisco be offered and have access to education, counseling, and support services to increase health-protective behaviors known to drive positive health outcomes.
    c. Require that all persons with chronic HCV be counseled to avoid excessive alcohol consumption and offered a referral to an alcohol treatment program if indicated.
    d. Require care for persons with chronic HCV to include evaluation and management of cirrhosis and end-stage liver disease (ESLD), including appropriate screening for hepatocellular carcinoma (HCC), and referrals for liver transplantation.
    e. Ensure that culturally sensitive hospice and palliative care is made available to all patients with ESLD who are not treatment or transplant candidates or who choose not to undergo treatment.

Enhanced Supportive Services

17) Strengthen access to care navigation, psychosocial support, and mental health services for people living with HCV through service expansion and/or referral.

    a. Provide funding to support an HCV care navigation program for all individuals living with HCV, including those who for medical reasons or personal choice are not on treatment, or those whose previous treatment was unsuccessful.

    b. Work with CBOs to establish and maintain a network of community-based support groups for people living with HCV, as well as their family members, caregivers, etc.

    c. Provide funding to support community-specific support groups for all individuals living with HCV.

    d. Provide funding to ensure benefits counseling is available as needed for all individuals living with HCV.

    e. Support extension of meal programs to include people who are unable to provide for themselves due to their HCV infection (currently on treatment, on transplant wait list, or living with ESLD).

Model Program

The Multidisciplinary Integrated Care for Substance-Using Persons (MICSUP) is a novel collaborative approach to provide active drug users recruited from community settings with effective treatment for hepatitis C through integrated care in five domains: (a) antiviral therapy; (b) psychiatry; (c) substance abuse treatment; (d) primary medical care; and (e) intensive case management: *http://weill.cornell.edu/research/researcher/bredlin/lab_projects2.html*

Public Policy Recommendations

Strategic Direction 6

To improve San Francisco's response to the hepatitis C (HCV) epidemic through funding, legislative, and policy strategies and initiatives

Practical Vision

- ▲ **Improved integration and coordination** of HCV programs and services.
- ▲ Availability of **adequately funded HCV care, treatment, prevention, education, surveillance, and research** programs.
- ▲ **Drug policy initiatives that address drug use as a public health issue** and not as a criminal justice issue.
- ▲ Availability of **comprehensive substance use services for people living with and at risk for HCV.**
- ▲ **Community members trained as leaders, media spokespersons, and advocates** to educate the public and policymakers about HCV and its impact in their communities.

Recommendations and Action Steps

Improved Integration and Coordination

1) Improve integration and coordination of HCV programs and services.
    a. Establish and fund a HCV coordinator position at SFDPH.
    b. Establish and coordinate a standing HCV community planning council, modeled after the HIV Health Services and HIV Prevention Planning councils.
    c. Support and sustain efforts to integrate HCV programs and services into existing health care and prevention efforts, particularly in HIV/AIDS programs.

Adequately Funded Comprehensive Range of HCV Services

2) Provide adequate funding for HCV care, treatment, prevention, education, surveillance, and research programs in order to ensure availability of a comprehensive range of services.
    a. Provide sufficient funding for Healthy San Francisco to ensure full access to HCV screening, testing, care and treatments to uninsured residents. All drugs necessary to treat HCV and its side effects should be covered by the program.
    b. Provide funding to expand the existing set of patient navigation/benefits counselors, including possible coordination of in-home support volunteer corps, and ensure they have the comprehensive training needed to help people with HCV navigate the current health care system and to enroll in the appropriate level of coverage provided through health care reform (expanded Medi-Cal or private insurance through the new exchanges) and to understand their benefits and responsibilities.
    c. Create and fund an HCV research section in SFDPH.
3) Ensure San Francisco meets the needs of people living with and at risk for HCV by preparing for health care reform implementation.
    a. Ensure that San Francisco is preparing for implementation of the Patient Protection and Affordable Care Act and that the needs of people living with and at risk for HCV are addressed throughout the implementation process.
    b. Ensure that San Francisco continues to care for people not included in health reform, including undocumented individuals.
    c. Vigorously oppose any efforts to repeal or weaken the Patient Protection and Affordable Care Act.
4) Explore opportunities to work with corporate and non-profit organizations and foundations.
    a. Identify new and innovative ways to negotiate with pharmaceutical and diagnostics companies for grant money, support, and education at primary care clinics providing HCV testing, treatment, and care. SFDPH should endeavor to work with pharmaceutical companies to utilize patient assistance programs for no or low-cost drugs or assistance with co-pays.
    b. Negotiate and advocate for best pricing of HCV treatments.
    c. Partner with foundations and philanthropic organizations to provide funding for HCV services and programs.

Drug Policy Initiatives

5) Establish drug policy initiatives that address drug use as a public health issue and not as a criminal justice issue.

    a. Work with the Board of Supervisors and SFDPH to establish a pilot legal supervised injection facility as an HCV prevention intervention.

    b. Lead the nation in establishing drug policies that address drug use as a public health issue and not a criminal justice issue, including decriminalization of personal drug possession.

    c. Support efforts to change California and national drug policy to approach drug use as a public health issue and not as a criminal justice issue.

Comprehensive Substance Use Programs for People Living With and at Risk for HCV

6) Ensure that comprehensive substance use services are available and accessible for people living with and at risk for HCV.

    a. Ensure that SFDPH policy supports HCV treatment for active substance users who choose to engage in treatment in coordination with their medical provider.

    b. Fully fund a comprehensive range of culturally appropriate and evidence-based substance use programs, including harm reduction modalities, and ensure multiple points of access to substance treatment programs.

7) Monitor SFDPH-funded agencies that provide substance use, STD, and HIV treatment and prevention services, and/or programs that serve drug users to ensure adherence to the SFDPH Harm Reduction Policy.

Community Members Trained as Leaders, Media Spokespersons, and Advocates

8) Provide leadership, media, and advocacy training for community members including how to educate policymakers about HCV and its impact in their communities.

Strategic Direction 7

To leverage San Francisco's influence at the state and federal levels to secure legislation and funding to address the hepatitis C (HCV) epidemic in California and the United States

Practical Vision

▲ **Improved state and federal government policies and funding** to comprehensively address the HCV epidemic

State Level

9) Prioritize efforts to ensure state government policies and funding effectively address needs for HCV surveillance, research, prevention, testing, care, treatment, and syringe access services.

    a. Direct San Francisco's state lobbyist to prioritize advocacy on state hepatitis legislation, policy and funding (in the absence of any full-time state hepatitis advocates).

b. Direct San Francisco's lobbyist to advocate for implementation of the California Adult Viral Hepatitis Prevention Strategic Plan and reinstatement of state funding for HIV testing, which included the only state funds for HCV testing.

c. Urge San Francisco representatives in the State Legislature to lead efforts to secure state funding for viral hepatitis programs and services and to ensure that California is prepared for implementation of health care reform.

Federal Level

10) Prioritize efforts to ensure federal government policies and funding effectively address needs for HCV surveillance, research, prevention, testing, care, treatment, and syringe access services.

a. Direct San Francisco's Washington, DC lobbyist to advocate on federal HCV legislation, policy and funding, including passage of The Viral Hepatitis and Liver Cancer Control and Prevention Act, increased funding for viral hepatitis prevention/surveillance programs at the CDC, HCV research at the National Institutes of Health (NIH), and implementation of the Institute of Medicine recommendations from its report Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C.

b. Urge the Bay Area's Congressional delegation and California's two United States Senators to co-sponsor HCV legislation, support increased funding for viral hepatitis programs, and take a leadership role in Congressional efforts related to World Hepatitis Day (May 19).

c. Urge Congress to remove all restrictions on federal funding for syringe access and create funding streams for syringe access programs, working with the CDC and other HHS agencies to ensure that regulations support the broadest possible syringe access.

Conclusion

The above recommendations were developed by the San Francisco Hepatitis C Task Force over a year of deliberation and input through expert presentations and community forums focused on significant areas of HCV impact in San Francisco: co-infection with HIV and sexual transmission of HCV MSM; and HCV among African Americans. Task Force members believe the recommendations represent a comprehensive and effective approach to addressing HCV-related prevention, education, screening, testing, care, treatment, research, surveillance, and public policy needs in San Francisco. Additionally, implementation of the recommendations is imperative for ensuring that the Task Force's vision is ultimately achieved: everyone is educated about HCV and has the opportunity to know their HCV status; everyone living with HCV receives the highest level of care and support to ensure their quality of life and longevity; and there are no new HCV transmissions.

Toward this end, the San Francisco Hepatitis C Task Force voted at its December, 2010 meeting to:

- Continue as an independent community coalition with the current organizational sponsors, Drug Policy Alliance, HCV Advocate/Hepatitis C Support Project, and Project Inform continuing as organizational sponsors;
- Remain comprised of current Task Force members who want to continue to work; and
- Work from January through March to determine the coalition's structure (including membership and voting) and scope of work for 2011 (with the help of a consultant, funding permitting) .

Appendix

Citations

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Glossary of Terms, Acronyms, and Abbreviations

Acupuncture: A traditional Chinese healing technique that involves inserting thin needles into different acupuncture points on the body, used for many conditions, including pain and addiction.

Acute: Rapid-onset, short-term initial stage of a disease.

ALT: Alanine Aminotransferase is an enzyme produced in the liver when the membranes of liver cells break down. ALT levels are measured to help assess the degree of liver damage and determine how well HCV treatment is working.

Antibody (Immunoglobulin): A protein produced by plasma cells (a type of immune system white blood cell) when they encounter foreign invaders. Specific antibodies bind to specific invaders, or antigens, and target them for destruction. The presence of antibodies indicates current infection with or past exposure to a pathogen.

BDSM: Bondage and discipline, dominance and submission, sadism and masochism is a type of role-play or lifestyle choice between two or more individuals who use their experiences of pain and power to create sexual tension, pleasure, and release.

CCSF: City College of San Francisco.

CDC: Centers for Disease Control and Prevention is the United States federal government agency within the Department of Health and Human Services that monitors the occurrence of diseases and develops policies for preventing disease and maintaining the health of the population.

Chronic: A long-term or persistent disease.

Cirrhosis: A type of liver damage in which normal liver cells are replaced with fibrous scar tissue. In compensated cirrhosis, the liver is damaged but can still function. In decompensated cirrhosis, liver function is severely impaired and scar tissue interferes with normal blood flow through the liver, potentially leading to bleeding varices, ascites, "brain fog," and other symptoms.

Coinfection: concurrent infection with more than one disease-causing organism (e.g., HCV and HIV).

CPMC: California Pacific Medical Center.

ESLD: End-stage liver disease.

Genotype: The genetic makeup of an organism. HCV has six major genotypes, designated by the numbers 1 through 6.

HAV: The hepatitis A virus.

HBV: The hepatitis B virus.

HCV: The hepatitis C virus.

HCC: Hepatocellular Carcinoma is a type of primary liver cancer seen in some people with long-term liver damage due to chronic hepatitis C or hepatitis B.

HHS: The United States Department of Health and Human Services.

ESLD: End-Stage Liver Disease or liver failure.

False-negative: A negative test result for a person who in fact has the disease or condition being tested.

False-positive: A positive test result for a person who in fact does not have the disease or condition being tested.

IDU: Injection Drug User.

Kink: a colloquial term for non-normative sexual behavior.

LGBT: Lesbian, Gay, Bisexual, and Transgender.

Liver Biopsy: A liver biopsy is a procedure whereby small pieces of liver tissue are removed in order to be sent to a laboratory for examination.

Liver Cancer: Malignant proliferation of cells in the liver. The most common type of liver cancer in people with chronic hepatitis is hepatocellular carcinoma.

Liver Failure: The inability of the liver to perform its normal synthetic and metabolic function as part of normal physiology.

MSM: Men who have sex with men.

Paraprofessional: A job title given to persons in various occupational fields, such as education, healthcare, engineering and law, who are trained to assist professionals but are not themselves licensed at a professional level.

Phlebotomy: The withdrawal of blood from a vein, usually preformed by a phlebotomist.

PLWHA: People Living With HIV/AIDS.

RNA (and RNA testing): A single-stranded nucleic acid that encodes genetic information. RNA is made up of sequences of four building blocks: adenine, cytosine, guanine, and uracil. The presence of viral RNA in the blood indicates that a virus is actively replicating.

SFDPH: San Francisco Department of Public Health.

SFSU: San Francisco State University.

Split Kits: Kits to assist IDUs to split drugs without blood contamination.

SRO: Single room occupancy.

STD/STI: Sexually transmitted disease/infection.

UCSF: University of California, San Francisco.

Vertical Transmission (Perinatal Transmission): Transmission from a mother to a fetus or newborn, may occur in utero (in the womb), intrapartum (during birth), or postpartum (e.g., via breast-feeding).

Viremia: The presence of a virus in the blood.

Virological Response: Reduction in viral replication in response to treatment. In HCV, a complete virological response means that a person's HCV RNA becomes undetectable with treatment.

Best/Promising Practices, Model Programs, and Other Resources

Best/Promising Practices and Model Programs

New York State's Hepatitis C Continuity Program
Promoting HCV treatment completion for prison inmates *www.health.state.ny.us/diseases/aids/corrections/hepcprogram.htm*; *www.ncbi.nlm.nih.gov/pmc/articles/PMC1831802/*

Ontario HCV Nurses Program
Helping marginalized patients stay on treatment for hepatitis C
www.accessaidsnetwork.com/programs/ontario-hepatitis-c-nursing-program/

Tibotec's HIV Case Manager Portal
Potential model for online hub or portal
www.hivcasemanager.com/home

Other Resources

- American Association for the Study of Liver Diseases (AASLD) Practice Guidelines: Diagnosis, Management, and Treatment of Hepatitis C: An Update. Hepatology, Vol. 49, No. 4, 2009.
- California Adult Viral Hepatitis Strategic Plan: *www.cdph.ca.gov/Documents/California_Adult_Viral_Hepatitis_Prevention_Strategic_Plan,_2010-2014.Final.pdf*
- California Department of Public Health, Office of Viral Hepatitis Prevention: *www.cdph.ca.gov/programs/pages/ovhp.aspx*
- California Hepatitis Alliance (calHEP): *www.calhep.org/*
- California Hepatitis C Task Force: *www.californiahcvtaskforce.org/*
- Centers for Disease Control and Prevention (CDC): *www.cdc.gov/hepatitis/Resources/index.htm*
- Centers for Disease Control and Prevention Viral Hepatitis Website: *www.cdc.gov/hepatitis/*
- Drug Policy Alliance: *www.drugpolicy.org/*
- Harm Reduction Coalition: *www.harmreduction.org*
- Hep C Advocate: *www.hcvadvocate.org/*
- Hepatitis Education project: *www.hepeducation.org/*
- Hep C Connection: *www.hepc-connection.org/*
- Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C (Institute of Medicine Report, 2010): *www.iom.edu/Reports/2010/Hepatitis-and-Liver-Cancer-A-National-Strategy-for-Prevention-and-Control-of-Hepatitis-B-and-C.aspx*
- National AIDS Treatment Advocacy Project: Latest Articles about Hepatitis C: *www.natap.org/*
- San Francisco Adult Viral Hepatitis Resource Guide (2008): *www.hepcsf.org/uploads/SF_guide_english.pdf*
- San Francisco Hep B Free: *www.sfhepbfree.org/*
- United States Department of Veterans Affairs: *www.hepatitis.va.gov/*

Acknowledgments

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Individuals

- Ryan Clary, Project Inform
- Johnna Fandel
- Yvonne Frazier
- Liz Highleyman
- Jenni Jain, Drug Policy Alliance
- Rachel McLean, California Adult Viral Hepatitis Prevention Coordinator
- Nick Panagopolous, former Liaison to the LGBT community and Districts 8 and 9, Office of Mayor Gavin Newsom
- Alex Randolph, former Liaison to the LGBT community and District 8, Office of Mayor Gavin Newsom
- Robin Roth, City College of San Francisco
- Matthew Simmons, Shanti
- Students in Robin Roth's City College of San Francisco Hepatitis A, B, C class
- Laura Thomas, Drug Policy Alliance

Organizations

- African American Health Disparities Project
- Bay Area Reporter
- Bayview Hunters Point Foundation
- Black Coalition on AIDS
- California Adult Viral Hepatitis Prevention Coordinating Committee and California Department of Public Health Center for Infectious Diseases
- City College of San Francisco's Health Education Department
- Drug Policy Alliance
- Glide
- HCV Advocate / Hepatitis C Support Project
- Positive Directions Equals Change
- Project Inform
- San Francisco Department of Public Health, particularly the HIV Prevention Section and STD Prevention & Control Services
- San Francisco Drug Users' Union
- San Francisco HIV Health Services Planning Council
- Shanti
- United States Department of Veterans Affairs

Presenters at San Francisco Hepatitis C Task Force meetings and community forums

Josh Bamberger, MD; Peter Berman, MD; Lucille Bozman; Scott Clark; Barbara Garcia; Steve Gaynes; Brad Hare, MD; Reggie Harris; Patricia Hogan; Theresa Hughes; Miriam Johnson; Alana Kane, NP; Hobert Lee; Steve Manley; David Margolis; Linette Martinez, MD; Rodney McClain; Rachel McLean; Alexander Monto, MD; Kimberly Page, PhD, MPH; Todd Rego; Val Robb, RN; Melissa Sanchez, PhD, MA; Jim Stillwell; Gauge Strongarm; Erika Tekada; Laura Thomas; Dan Wlodarczyk, MD; Richard Zercher, MD.

San Francisco Hepatitis C Task Force Members

SHIRLEY BARGER
Prevention, Education, Awareness, and Testing Committee Member
Shirley Barger, now 60, has lived in San Francisco since 1968. She attended City College of San Francisco and graduated from SFSU. She has worked in Information Technology at City College since 1981. She was diagnosed with HCV in 2003 and began attending CPMC's Hep C Group, a patient-led support group that meets twice monthly. For two years, she has co-facilitated that group. Shirley has gone through one standard treatment of interferon and ribavirin (2004–2005) and participated in a clinical trial (2007–2008). She relapsed after each.

ROSE CHRISTENSEN
Steering Committee Member
Chairperson of Care and Treatment Committee
Rose Christensen has lived and worked in San Francisco for almost 40 years, where she was a small business owner for over 25 years. She began as a volunteer for the Hepatitis C Support Project in 1998, shortly after being diagnosed with HCV. She facilitated the support group at CPMC for 8 years. Rose successfully completed treatment in 2005 and has been virus free since. Rose began working at the Hepatitis C Support Project in 2002 as part of the office staff. She now serves as Office Manager and assists Alan Franciscus in organizing trainings throughout the United States.

RYAN CLARY
Secretary of San Francisco Hepatitis C Task Force and Steering Committee, Chairperson of Public Policy Treatment Committee
Ryan Clary is Director of Public Policy at Project Inform, a national HIV/AIDS and HCV/advocacy organization based in San Francisco. Ryan advocates at the federal level for programs that provide access to treatment and healthcare for people living with HIV/AIDS, including the Ryan White Program, the AIDS Drug Assistance Program, and Medicaid. He also advocates on HCV funding and legislative issues at the national, state, and local levels. He represents Project Inform in many coalitions, including the steering committees of the National Viral Hepatitis Roundtable and the California Hepatitis Alliance, the Hepatitis C Appropriations Partnership and the executive committee of the HIV Medicaid/Medicare Working Group. Ryan also oversees projects and activities designed to help individuals and organizations to communicate with their elected representatives and administrative officials about HIV/AIDS and HCV legislative and funding issues.

MISHA RUTH COHEN, OMD, L.Ac.
Co-Chairperson Care and Treatment Committee
Dr. Cohen is recognized internationally as a practitioner, lecturer, researcher and leader in the field of traditional Chinese medicine. She has practiced Asian medicine for 35 years and works with Western physicians to conduct research and co-manage patients. Dr. Cohen is the author of "The Chinese Way to Healing", "The HIV Wellness Sourcebook," and "The Hepatitis C Help Book." She is Clinical Director of Chicken Soup Chinese Medicine, Executive Director of the Misha Ruth Cohen Education (MRCE) Foundation and Research Specialist for Integrative Medicine at UCSF. Nationally, she is Secretary of the Society for Acupuncture Research and sits on the Brainstorming Team of the Hepatitis C Caring Ambassadors Program. As a principal investigator in Chinese herbal medicine studies for viral-related cancers and cancer prevention in HPV, HIV and HCV she is currently conducting a clinical trial and translational research for the prevention of anal cancer in HIV+ people at the UCSF Clinical Research Center. More than 17 years ago, Dr. Cohen implemented the Hepatitis C Professional Certification Program, a unique educational opportunity for Eastern and Western primary care practitioners. This MRCE Foundation program has certified more than 400 practitioners

in integrative therapies for HCV and sponsors educational programs to promote awareness and self-care for people affected by viral hepatitis.

JANE DALUGDUGAN
Prevention, Education, Awareness and Testing Committee Member
At age eleven, Jane Dalugdugan was inspired by Ryan White, and as a Lakers fan (now reformed), Magic Johnson was her hero. So naturally, at her 6th grade elementary school graduation, she chose to speak about her aspirations to cure HIV/AIDS (still working on that). From an early age, she shared her parent's passion for social justice and for over 14 years has worked with diverse organizations and communities to reduce health disparities. Starting out, Jane provided health education to college peers and to youth in group homes. She has empowered immigrant parents to communicate with their children about health issues, inspired girls to become health advocates, taught age-appropriate sex education to children and developed after school programs in Oakland housing communities. Jane is currently the Community Development Program Manager at the Asian & Pacific Islander Wellness Center in San Francisco, a health services, education, research and policy organization targeting Asian & Pacific Islander communities around sexual health and HIV/AIDS services. She promotes the integration of HIV-related services and equal access to optimal HIV treatment by managing a training and technical assistance program in Santa Clara County and by providing HIV-related treatment and public benefits training, in a culturally competent framework, for service providers throughout California. Jane is a certified HIV test counselor and encourages people to get screened for HIV and hepatitis.

JENNA FERRARA
Prevention, Education, Awareness and Testing Committee Member
Jenna Ferrara, a San Francisco native, graduated from San Francisco State University with a degree in Health Education/Public Health. While at SFSU, Jenna focused heavily on research related to HCV prevention, transmission, and treatment among incarcerated populations, injection drug users, and military veterans. Jenna has been a volunteer and per diem staff member at the San Francisco AIDS Foundation's needle exchange program since 2005. Currently Jenna works as a project coordinator/case manager for a HCV Care Coordination study with methadone patients at San Francisco General Hospital. Previously Jenna worked at UCSF's Correctional Medicine Consultation Network as the Viral Hepatitis & Liver Disease Program Coordinator where she was part of a team providing health care to California's prison population.

ALAN FRANCISCUS
Care and Treatment Committee Member
Alan Franciscus, a nationally recognized authority on HCV, has appeared in various local and national publications as well as on television, radio and several documentaries. He is the Founder & Executive Director of the Hepatitis C Support Project, Publisher and Editor-in-Chief of the HCV Advocate and HBV Advocate, national web sites—*www.hcvadvocate.org* & *www.hbvadvocate.org*—and Treasurer of the California Hepatitis Alliance.

TODD FREDERICK MD
Care and Treatment Committee Member
Todd Frederick MD, is an Hepatologist with California Pacific Medical Center's Liver Disease Management & Transplant Program in San Francisco, currently serving as Director of Clinical Protocols and Quality for the Division. In his primary roles as clinician and clinical researcher, Dr. Frederick has been treating patients with HCV for the past 9 years. Through his primary office in San Francisco and several outreach clinics throughout Northern California, he has had the opportunity to interact with, treat, and counsel thousands of patients with HCV. Prior to this position, he was a fellow in gastroenterology/hepatology at University of California San Diego. Dr. Frederick received his medical degree from New York Medical College and completed his internal medicine residency at University of California San Diego where he was designated Superior Resident. He has lectured on the management of viral hepatitis, advanced liver disease, artificial liver support systems, and portal hypertension, among other topics. Dr. Frederick is a member of several professional societies, including the American Gastroenterological Association, the American Association for the Study of Liver Diseases, the American Society of Transplantation, and the European Association for the Study of the Liver. He recently completed five years of service on the board of the Northern California Society for Clinical Gastroenterology. He has authored several book chapters, abstracts, and manuscripts, and his research has been published in prestigious journals including the New England Journal of

Medicine, the Journal of Clinical Gastroenterology, and Human Genetics. Dr. Frederick is a Bay Area native and resides in San Francisco with his family.

ISELA GONZÁLEZ, MPA
Public Policy Committee Member
Isela González is the HIV Prevention Services Coordinator for the Forensic AIDS Project, a program of Jail Health Services, the division of the SFDPH responsible for providing healthcare services to prisoners in the San Francisco City and County jails. She has over 15 years of experience providing HIV prevention and care services, the past 12 years working specifically with incarcerated adult men, women and transgenders. She has been instrumental in ensuring that prisoners in the San Francisco jails receive the same HCV prevention and care services available to those offered in the community. She has worked closely with the Jail Health Services staff to ensure viral hepatitis information, related medical services and treatment are delivered in a culturally, linguistically and client centered manner to all prisoners. She currently serves as Community Co-Chair of the San Francisco HIV Prevention Planning Council and as the San Francisco steering representative on the Urban Coalition for HIV/AIDS Prevention Services. She is a Community Advisory Board member of both TRANS:THRIVE and the Transgender Economic Empowerment Initiative, and a member of San Francisco HIV Prevention Section's Transgender Advisory Group.

NINA GROSSMAN
Public Policy Committee Member
Nina Grossman has lived in San Francisco for the last 25 years and has been an HIV/AIDS activist and community health educator for more than 15 years. She has dedicated her career to helping those both infected and affected by HIV/AIDS and HCV. She worked for the Marin AIDS Project and Centerforce as a Prison Project Coordinator in the early 1990s. She developed and implemented an HIV/AIDS Peer Educator Program where she trained HIV-Positive inmates to be peer educators inside of San Quentin State Prison. She then moved to the San Francisco AIDS Foundation in 1999 where she directed both the needle exchange program and the California State AIDS Hotline. She worked closely with the community, SFDPH, and the San Francisco Police Department to ensure that needle exchange was funded and not subject to police harassment. Nina is still a huge advocate of needle exchange programs and injector's rights, and still volunteers at the Sixth St. exchange site. In 2006, she was awarded the Mayor's Volunteer Service Award for her work with needle exchange. Nina is currently a Community Liaison Manager for Tibotec Therapeutics. In this role, she provides free HIV/AIDS educational programs to both staff and clients of HIV/AIDS organizations in the Pacific North region.

BRAD HARE, MD
Care and Treatment Committee Member
Brad Hare, MD, is Associate Professor of Medicine at the UCSF, and also serves as Medical Director of the Positive Health Program (HIV/AIDS Unit) at San Francisco General Hospital. Dr. Hare received his Doctor of Medicine degree from Duke University School of Medicine and completed his residency in internal medicine at the Massachusetts General Hospital of Harvard University. Following residency, Dr. Hare pursued specialty fellowships both in Infectious Diseases and in Experimental Pharmacology and Toxicology at the UCSF. Dr. Hare is board certified in internal medicine and infectious diseases. During his career, Dr. Hare has been honored with numerous awards, including receiving the Harry S. Truman Foundation Scholarship for public service and being named a Eugene Stead Research Scholar at Duke University. He is the director of the Hepatitis Initiative at Ward 86, San Francisco General Hospital, and is active in research studying the transmission and treatment of HCV in individuals with HIV coinfection.

THERESA HUGHES
Steering Committee Member
Chairperson Research and Surveillance Committee
Theresa Hughes is the President/Founder of Wings for Life, and is recognized for her innovative work in developing socio-economic statistical models to demonstrate the social, economic, and medical costs impact of prison health care on communities of color. These economic models enable medical providers, pharmaceutical companies, correctional systems, social services, and federal and state governments to target resources (i.e., education, medical care, cultural resource programs) nationally to the zip codes and neighborhoods where inmates/ex-offenders flow between correctional systems and the communities of return. Ms. Hughes conducted statewide seminars and workshops on prison health care for Kaiser Permanente and Health and Human Services Region IX. She is a consultant on race and ethnic issues for the California Institute on Mental

Health. As a consultant to Kaiser Permanente she has conducted seminars on Unresolved Trauma for Members of Color for Kaiser Northern California psychologists, psychiatrists, and social workers. She serves on the CalHEP Steering Committee. At the invitation of former-Congresswoman Ellen Tauscher, Ms. Hughes testified before a Congressional Military Briefing on The Impact of Domestic Violence and Child Abuse on Military Readiness. She analyzed the Pentagon's directive on addressing domestic violence, presenting statistical analysis of civilian versus military domestic violence, and the military priority of combat readiness over the needs of spouses and children. *www.wingsforlife-intl.org*

EMALIE HURIAUX, MPH
Chairperson of the San Francisco Hepatitis C Task Force and Steering Committee Prevention, Education, Awareness and Treatment Committee and Research and Surveillance Committee Member
Emalie Huriaux, MPH is a Health Program Coordinator at the SFDPH. In this role she provides oversight, training, and capacity-building assistance to substance use programs integrating HIV testing and prevention services, coordinates the integration of HCV testing with HIV testing in community settings, and provides support to syringe access and disposal programs. Prior to her work at the Department, Emalie worked in community-based organizations addressing sexual and drug user health issues. At the Women's Community Clinic she helped establish an outreach and health education program for homeless and marginally housed women in San Francisco's Mission District and the County Jail and co-founded "Ladies' Night," a women's harm reduction drop-in program. At the Harm Reduction Coalition she managed the Drug Overdose Prevention & Education Program, overseeing all aspects of an innovative overdose prevention and naloxone prescription program. In addition to her work with the SFDPH, Emalie is a consultant providing harm reduction training to community-based organizations and is a member of the Harm Reduction Therapy Center's Board of Directors.

DOMINIQUE LESLIE
Chairperson of the San Francisco Hepatitis C Task Force and Steering Committee Care Treatment Committee Secretary
Ms. Dominique Rosa Leslie is a 53 year old, mixed race, bisexual, transgender female who has lived her whole life in the Bay Area and has been living in San Francisco since 1978. She has been in continuous recovery from drugs/alcohol since 1988. She has worked since 1990 as a substance use/abuse counselor, a case manager, a HIV/AIDS Prevention and Education Outreach worker, and as a consultant. Her specialty is HIV/AIDS, substance use/abuse, and transgender issues. In 1995 she was the principal author of "Transgender Protocol-Treatment Services Guidelines for Substance Abuse Providers," which was accepted as standard of practice by the SFDPH. She was also principal author of the transgender chapter of "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals," by United States Department of Health and Human Services, Center for Substance Abuse and Mental Health Services, Center for Substance Abuse Treatment, 2001. She has served on the LGBT Constituent Committee of the State of California's Alcohol and Drug Programs, 1998–2001 (appointed by both Governors Wilson and Davis); the Transgender Civil Rights Task Force, 2000–2001 (appointed by San Francisco Board of Supervisors); the Drug Abuse Advisory Board, 1995–1997 (appointed by San Francisco Board of Supervisors); the LGBT Substance Abuse Task Force of CSAS, San Francisco Department of Public Health, 1994–1996; the SFLGBT Pride Parade Board, 1996–1997. She is currently CEO & Consultant for ReDiscovery Consulting in San Francisco.

RODNEY McCLAIN
Prevention, Education, Awareness and Treatment Committee Member
Since 2008 Rodney McClain has been working with AMVETS as a veteran Community Health Worker, providing counseling and referrals services, and assisting with filing claims for veterans. Diagnosed with HCV and homeless for many years, Randy works with homeless veterans with HCV. He is a motivational speaker and the author of "Live," a poem about his experience living with HCV (available upon request). Since 2007 he has worked as a volunteer for the Red Cross, which includes duties such as assessing client need, and directing them to the appropriate case manager. He informs

clients about Red Cross disaster services and trains volunteers. Since 2007 he has volunteered at the Parolee Department, providing information to veterans and services that are available to them upon request. During 2000–2003 he worked as a paratransit driver transporting the physically disabled. He worked as a referral counselor at the Tenderloin Self Help Center from 1998–1999, conducting one-on-one interviews with members of the community. He was a Youth Director at YMCA in Columbus, Ohio coaching soccer teams, and a Youth Counselor at the Boys and Girls club of America in Las Vegas, Nevada. He currently attends San Francisco City College and completed the Community Health Worker program with a 4.0 GPA. He also completed class work at Canada Community College and Coastline Community College. He is delighted to work with the San Francisco Mayor's Hepatitis C Task Force by addressing the needs of veterans and others with HCV.

LINETTE MARTINEZ
Prevention, Education, Awareness and Testing Committee Member
Linette Martinez, MD, is a diplomat of the American Board of Internal Medicine. She works for the SFDPH at the Tom Waddell Health Center where she works directly with homeless patients, providing primary and HIV care, including monolingual Latino and Transsexual minorities. She does medical outreach and work with day laborers in San Francisco. She is also an Assistant Clinical Professor at the UCSF School of Medicine. Dr. Martinez is the lead member for the revision team of the Tom Waddell's Protocols for Hormonal Reassignment of Gender, widely available on the internet. Her experience working with these specific populations brought her to be part of the advisory committee for the creation of the guidelines "HIV/AIDS & HOMELESSNESS, Recommendations for Clinical Practice and Public Policy," developed by The Bureau of Primary Health Care and The HIV/AIDS Bureau. She is a Board member of the Bay Area Physician for Human Rights organization that aims to improve the health of the LGBT community in the Bay Area. Besides her interest in the medical care of minorities, she is interested in global women's rights. She organized and is actively recruiting sponsors to help women victims of the war in the Democratic Republic of Congo.

ANDREW REYNOLDS
Chairperson Research and Surveillance Committee, Prevention, Education, Awareness and Testing Committee Member
Andrew Reynolds is the STD/HIV Program Coordinator for San Francisco City Clinic, STD Prevention and Control. He supervises the HIV counseling and testing program, the HIV post exposure prophylaxis program, and the HIV and syphilis partner services program. Additionally, Andrew does trainings, lectures and presentations on a wide range of topics of HIV, STDs, HCV, and harm reduction. He has presented on HIV and HCV-related topics at a variety of national and international conferences; and he is the co-author on several articles, posters, and presentations. He facilitates a HCV support group at Quan Yin Healing Arts Center, focusing on building a mind-body connection using mindfulness-based stress reduction, building coping skills, and meditation. Andrew is a San Francisco native, currently living in Oakland with his family.

CLAYTON ROBBINS
Care and Treatment Committee Member
Clayton has spent the last 12 years working in HIV advocacy, education, and treatment. His educational background in cultural anthropology informs his work designing, training, implementing, and evaluating behavioral interventions. Clayton's primary research interest is to investigate how biological, psychological, and social cofactors impact health outcomes of people with an HIV, HCV, cancer, or other disease diagnosis, as well as the aging. Clayton applies this research to the design and dissemination of effective self-management and health promotion programs for people of all walks of life to use in raising healthy children, preventing and managing illness, and promoting healthy aging. As the current Director of Program Development at Shanti in San Francisco, Clayton assists health departments, clinics, and agencies in New York City, Chicago, New Orleans, and across the country in implementing effective HIV self-management programming.

ROBIN ROTH
At Large Steering Committee Member, Prevention, Education, Awareness and Treatment Committee Member
Robin Roth is a Health Educator and tenured faculty member at City College of San Francisco in the Health Education Department and in Women's Studies. She is cofounder of CCSF's HIV/STI Prevention Education Certificate program and currently teaches the "Hepatitis ABCs" course, "Women's Health Issues" and "Health and Aging," and is director of the Elder Abuse Alert project. Having successfully undergone treatment for HCV, Robin is an advocate and activist for this issue. She is a member of CalHEP, Hep C United, and the Hepatitis C Support Project support group. Robin coauthored the meditation CD and book, "Self-Care for Hepatitis C" and the free meditation,"7 Minutes for Liver Health" at *www.hepCmeditations.org*. Other publications include Women's Health Engagement Calendar—2002 edition, 2000 edition—and coauthor of Safe Natural Remedies for Discomforts of Pregnancy, 1982, revised 1993, with translations into Spanish, Chinese, Vietnamese and Cambodian. As co-director of CCSF's Project SAFE, Robin produced Safer Sex Play shops & Fairs from 1991–2001, and was Faculty Advisor of the Safer Sex Club, and a member of CCSF's AIDS Advisory Board. Robin appears in 3 years of "Who's Who in American College Teachers." She received her Master's of Science in Health Education from SFSU and her BA in Biology from Antioch College, Yellow Springs, Ohio. Additional credentials include HCV Educator Certificate, Hepatitis C Support Project; STD Advisor/Educator Credential, Institute for the Advanced Study of Human Sexuality; AIDS Antibody Risk Assessment & Test Counselor, UCSF; Health Information Administration Credential, Seattle University.

JIM STILLWELL
Public Policy Committee Member
Jim Stillwell is the San Francisco County Alcohol and Drug Program Administrator for the SFDPH, and oversees the implementation and operation of the San Francisco's substance abuse prevention and treatment programs. Over the past 24 years Jim has had a role in projects including: Healthcare for the Homeless, development of the SFDPH policies to support needle exchange, implementation of medical detox, the Treatment On Demand Initiative to double San Francisco's treatment capacity, on-site HIV testing in substance abuse programs, office based opiate treatment, and creation of the methadone vans. A formerly homeless addict in recovery for 25 years, Jim has worked closely with thousands of individuals affected by hepatitis.

LAURA THOMAS
Steering Committee Member, Chairperson Prevention, Education, Awareness and Testing Committee
Laura Thomas is the Deputy State Director, San Francisco, of the Drug Policy Alliance, the nation's leading organization promoting alternatives to the war on drugs. She has over 20 years of experience in HIV and public health policy, along with a strong commitment to community advocacy, thoughtful policy analysis, and coalition building. She first became involved in AIDS activism with ACT UP in San Francisco. Recently she was a consultant specializing in HIV policy and planning, with clients ranging from the California State Office of AIDS to the National Association of People with AIDS. Before that she worked for Tenderloin Health and Continuum HIV Day Services, nonprofit health and social service providers serving a predominantly homeless population in San Francisco's Tenderloin neighborhood, and for the SFDPH. She currently serves as a Co-Chair of the San Francisco HIV Health Services Planning Council. She has been a syringe-exchange volunteer for more than 12 years, and has helped organize a successful 2007 symposium on safe injection facilities. Laura is a proud recipient of the AIDS Hero Award from the 2000 AIDS Candlelight Memorial. In her free time, she is a volunteer with the Golden Gate Raptor Observatory, and serves on the Boards of Directors for WORLD: Women Organized to Respond to Life-threatening Disease and for the Asian & Pacific Islander Wellness Center. She graduated from the University of California Berkeley in 1995 with a Master's in Public Health and a Master's in Public Policy, and holds a B.A. in English from Wesleyan University.

JORGE VIETO
Prevention, Education, Awareness and Testing Committee Member
A kink player since the age of twenty, 29 year old Jorge Vieto is an active member of the San Francisco's leather community. A fraternal member of The 15 Association, Jorge holds the title of San Francisco Leather Daddy's boy XXII, and is a member of San Francisco boys of Leather. He has been a guest speaker, panelist and demonstrator

with groups such as Leatherman's Discussion Group, Leather Alley, Aguilas, Gender Blast, and the Stop AIDS Project Leather Events action group. Additionally Jorge has written articles for NALA News and Bear Party Magazine, and is the current LGBT guest columnist for Kink-e-zine.com. Jorge currently works as the Leather Network Intervention coordinator for the STOP AIDS Project.

CARLA WILSON
Research and Surveillance Committee Member
Carla Wilson teaches, trains, and studies the ancient art of Asian Medicine in a modern context, including acupuncture, herbal medicine, nutrition, exercise, and research methodology. With 28 years of experience in the practice of Asian medicine and a Master's Degree in Health Education and Organizational Leadership, she has taught, studied, and presented on Chinese Medicine internationally. She is Director of Quan Yin Healing Arts, which sponsors a HCV Support Group and annual Acupuncturist HCV trainings. Licensed to practice acupuncture and Chinese Medicine in NY, HI, and FL, her primary focus and passion has been to integrate acupuncture and Asian Medicine into the public health care system, address disparities in health care, and ensure the right to health care for all. She has worked in HIV care and chronic viral illness since 1983, addressing addiction, multiple-diagnosed populations, and people with a history of incarceration, homelessness, trauma, and mental illness. Her leadership and governance expertise includes grant writing, fundraising, and fiscal management to promote and sustain health centers and educational program development. She has served on the boards of a variety of community-based organizations, is a commissioner for the Accreditation Commission for Acupuncture and Oriental Medicine, and sits on the Governance Committee for the American Public Health Association. She is a PhD student at California Institute of Integral Studies, where her dissertation explores the partnership between Eastern and Western medicine and the evolution of integrative health care, and a doctoral candidate at the American College of Traditional Chinese Medicine.

The following people also served on the San Francisco Hepatitis C Task Force for part of 2010:

Naomi Akers
Naomi Akers has worked with the San Francisco sex worker community since 1995, and was diagnosed with HCV in 1997; she has worked in a variety of sex work venues, both legal and illegal. Ms. Akers was a research associate for several prominent studies including the HOPE study, the Urban Health Study, and the UCSF UFO study. Since August 2006, she has been the Executive Director for the St. James Infirmary, a free medical clinic for sex workers where she has worked since 2002, and has been a client since 1999. She earned her Master's in Public Health degree from SFSU. Naomi's areas of interest center around harm reduction approaches, social justice, and health as a human right, particularly for Sex Workers and drug users. As part of her MPH studies and a project for Legal Services for Prisoners with Children, Naomi recently conducted an oral health assessment of pregnant prisoners at Valley State Prison for Women in Chowchilla, California; this contributed to the dismantling of the Department of Corrections requirements prohibiting women prisoners from entering community-based programs to live with their children. She completed a project assessing San Francisco's Exotic Dancers' health needs and an evaluation of podcast Social Media designed for independent Sex Workers with Internet access. Ms. Akers has been a long-time member of the San Francisco HIV Research & Vaccine Trials Network Community Advisory Group and a member of the UNAIDS Sex Worker Global Working Group. For more information or to download her work, please visit: *www.towtruckpanties.com* or *www.pimpsdownhosup.com*.

Alice Asher
Alice Asher, RN, MS, CNS, is a clinical nurse specialist with the UCSF UFO Study, a group of prospective cohort research studies of HCV, STDs and HIV for young (<30 years old) injection drug users (IDU) in San Francisco. As Project Director of UFO Presents!, her work focuses on providing HCV prevention education to young IDU. She has been working in the field of viral hepatitis since 2003 as a research assistant, project director, nurse, and treatment advocate. Her work as doctoral student in Community Health and International Nursing at UCSF focuses on HIV and HCV prevention among injection drug users in the Bay Area and sub-Saharan Africa.

Yvonne Frazier
Yvonne Frazier operates Yvonne Frazier Consulting in San Francisco. She specializes in grant writing and technical assistance for substance abuse, health, homeless, employment and training, gender specific, and reentry programs, with a focus on capacity building and infrastructure enhancements for nonprofit agencies. She is in recovery from alcoholism and drug dependence, and in 1995 learned she had HCV. Some of her recent projects include grants for a parolee reentry center, gender responsive treatment, and numerous transitional living facilities. Most of her organizational clients serve criminal justice linked clients (parolees or probationers). She worked in substance abuse administration for more than 30 years, as the Alcohol and Drug Services Administrator in San Mateo County for seven years, and at Community Substance Abuse Services in San Francisco in capacities that included Director of the San Francisco Target Cities Project, Associate Director of CSAS, Program Analyst, and Assistant Director of the Employee Assistance Program. Early in her career she was the founder and administrator of a substance abuse treatment program for women addicted to prescription drugs in Sacramento. She has received numerous awards including the Life Time Achievement Award from the Alcohol and Drug Program Administrators Association of California, and the Life Time Achievement Award from Strategies for Change. She co-published many articles in her role as principle administrator for a meth research and treatment project. She made a presentation about her experience as a liver patient and person living with HCV at the Infectious Disease and Substance Abuse Conference held in San Francisco in 2007.

Laura Guzmán
Laura Guzmán is Director of the Mission Neighborhood Resource Center (MNRC), a collaborative project of the Mission Neighborhood Health Center in the Mission district of San Francisco serving homeless adults living on the streets, shelters, and SRO hotels. Ms. Guzmán has 17 years of non-profit experience as a disability, health and income rights advocate on behalf of low-income Californians, including Latino immigrants, people living with HIV and HCV, drug users and sexual and gender minorities. Ms. Guzmán was born in Buenos Aires, Argentina, and holds a Juris Doctor degree from New College of California School of Law (1995) and a Bachelors in Linguistics from University of California at Berkeley (1992). In addition, Ms. Guzmán is a senior trainer for the Harm Reduction Training Institute of the Bay Area, and delivers workshops and technical assistance for government and community based organizations. She is Co-Chair of the Funding Committee of the San Francisco Local Homeless Coordinating Board, and is President of the Coalition on Homelessness' Board of Directors.

Jim Row, FNP
Jim Row is a Family Nurse Practitioner with the Kaiser-Permanente Medical Group in San Francisco. He works in the department of Gastroenterology and is responsible for managing the medical care of persons with HCV and HIV coinfection. He decided to become a Nurse Practitioner in the early 1980s when the HIV/AIDS epidemic was starting, and immediately began working with persons with HIV/AIDS. The first HIV/AIDS clinic in Alameda County was started by Don Domorrow, LVN, and Les Solomon, MD; in 1985 the clinic was expanding, and Mr. Row was invited to join the medical team as the first mid-level practitioner at Fairmont Hospital AIDS clinic in San Leandro, CA. Also during that time when it was realized that the incarcerated populations in California were not receiving adequate HIV-related medical care, he was again invited to join the first HIV-focused medical team at California Medical Facility in Vacaville, California.

Diana L. Sylvestre, MD
Diana L. Sylvestre, MD, is an Assistant Clinical Professor of Medicine at the UCSF, and Executive Director and Founder of O.A.S.I.S. (Organization to Achieve Solutions in Substance-Abuse), a non-profit organization located in Oakland, CA. A leading researcher in the field of HCV and addiction, she obtained her BS degree from the University of Florida and her MD from Harvard Medical School. She trained in Internal Medicine at the Brigham and Women's Hospital in Boston, MA, and underwent fellowship training in Biochemical Genetics at the Sloan Kettering Institute in New York, NY. She is a specialist in Internal Medicine and Addiction Medicine, and her research focusing on HCV access and outcomes contributed to the 2002 NIH Consensus Statement on Hepatitis C, which expanded access to care in marginalized persons with HCV. Her community-based clinic O.A.S.I.S. has collaborated widely with other Bay Area agencies to establish standards of care and improve HCV outcomes in the underserved.

San Francisco Adult HIV Confidential Case Report

(for patients ≥ 13 years of age at time of diagnosis)

Return completed form to state/local health department

25 Van Ness Ave., #500
San Francisco, CA 94102
Tel: 415-554-9050

EHARS _____ EHX _____ Incidence _____

Health Department Use Only

Date Received: __ __/__ __/__ __ __ __ (MM/DD/YYYY)		Document Source: A__ __. __ __. __ __ Document UID:	
New Investigation ♦ **Y**es ♦ **N**o ♦ **U**nk		Reporting Health Department State: **CA** City/County: **San Francisco**	State Patient Number
Report Medium [**1**] Field Visit [**2**] Mailed [**4**] Phone	Surveillance Method ♦ **A**ctive ♦ **F**ollow-up ♦ **U**nk ♦ **P**assive ♦ **R**eabstraction	Date Form Completed: __ __/__ __/__ __ __ __ (MM/DD/YYYY)	City/County Patient Number

Patient Identification and Address. These data will not be transmitted outside the state health department.

Patient's Name (Last, First, Middle)		Alias Name (Last, First, Middle)		
Address	City	County	State	ZIP Code
SSN: __ __ __- __ __ - __ __ __ __ Alias SSN: __ __ __- __ __ - __ __ __ __	Other ID: Lab report number: __ __ __ __ __ __ __ __ __ __ C&T Number: __ __ __ __ __ __ __ __ __ __ Medical Record Number:_____			

DEMOGRAPHIC INFORMATION

Dx Stat at Report [**1**] HIV [**2**] AIDS	Date of Birth (Mo/Day/Year) __ __ / __ __ / __ __ __ __ Alias DOB: __ __ / __ __ / __ __ __ __	Country of Birth ♦ US ♦ US Dep & Terr, specify_____ ♦ Other, specify _____ ♦ Unk	Vital Status [**1**] Alive [**2**] Dead

Sex at Birth ♦ **M**ale ♦ **F**emale	If TG, Gender ♦ **M◊F** ♦ **F◊M**	Ethnicity [**Y**] Hispanic [**N**] Not Hisp/Latino [**U**] Unk	Race (Check one or more): ♦ Am Ind/Alask Nat ♦ Native HI/Other PI ♦ White ♦ Black/Afr Am ♦ Asian ♦ Unk Extended Race: _____

Residence at HIV Diagnosis ♦ Same address as patient address

City_____ County_____ State/Country_____ Zip _____

FACILITY OF HIV DIAGNOSIS

Facility name

City **State**

Facility Setting (check one) :

♦ Public ♦ Private ♦ Federal ♦ Unk

Facility Type (check one):

o HIV Counseling and Testing site
o STD clinic
Outpatient Facility:
o Private physician o Adult HIV clinic
o Other clinic
♦ Other facility (specify):_____
o Unknown

PATIENT HISTORY

After 1977 & before first positive HIV antibody test or AIDS diagnosis	Yes	No	Unk
Sex with male	Y	N	U
Sex with female	Y	N	U
Injected nonprescription drugs	Y	N	U
Received clotting factor for hemophilia/coagulation disorder, specifically: **[1]**-Factor VIII **[2]**-Factor IX **[3]**-Other (Hemophilia A) (Hemophilia B) Specify:_____	Y	N	U
HETEROSEXUAL relations with any of the following:			
♣ Intravenous/injection drug user	Y	N	U
♣ Bisexual male	Y	N	U
♣ Person with hemophilia/coagulation disorder	Y	N	U
♣ Transfusion recipient with documented HIV infection	Y	N	U
♣ Transplant recipient with documented HIV infection	Y	N	U
♣ Person with AIDS or documented HIV infection, NIR	Y	N	U
Received transfusion of blood/blood components (not clotting factor) First: ____/____/_____ Last: ____/____/_____ Mo Day Year Mo Day Year	Y	N	U
Received transplant of tissue/organ alternative insemination	Y	N	U
Worked in a healthcare or clinical laboratory setting Specify occupation_____	Y	N	U

LAB DATA

	First		Collect Date			Last		Collect Date			First Positive Detection Test			
AB Test at Dx	(+)	mm	dd	yyyy		(-)	mm	dd	yyyy		Test Type (select one)	mm	dd	yyyy

H-1 IFA	**P**os				**N**eg				♦ P24 Antigen ♦ RNA PCR (Qual) ♦Culture ♦ Proviral DNA (Qual)	**P**os				
H-1 WB	**P**os				**N**eg									
Rapid	**P**os				**N**eg									
H EIA-1	**P**os				**N**eg									

Immunologic Lab tests:	T Count	Pct	mm	dd	yyyy
Most current T count					
1st <200/<14% T count					

If Lab tests are not documented, is diagnosis documented by physician? ♦ **Y**es ♦ **N**o ♦ **U**nk

If Yes, provide date of physician documentation: mm dd yyyy

First Detectable VL:

Test Type (select one)	VL	mm	dd	yyyy
♦ NASBA ♦ RT-PCR ♦ bDNA ♦Other				

Clinical Record Reviewed ♦ Yes ♦ **N**o

TREATMENT AND SERVICES REFERRALS

	Yes	No	Unk	N/A
Patient informed of his/her infection?	Y	N	U	
Patient's partners will be notified about HIV exposure and counseled by: [**1**]-Health Department [**2**]-Physician/Provider [**3**]-Patient [**9**]-Unknown				
Patient has been receiving or has received:				
♣ HIV related medical services	Y	N	U	
♣ Substance abuse treatment services	Y	N	U	N/A
♣ Anti-retroviral therapy	Y	N	U	
♣ PCP prophylaxis	Y	N	U	

Patient's primary source of health insurance at time of HIV diagnosis :

	Medicaid		Private insurance, unspecified
	Medicare		State funded, unspecified
	Other public funding		VA
	No health insurance		Unknown

HIV TESTING HISTORY

Source of HIV testing history is: o Patient Interview o Medical Record o Provider Report o Other:_____

Date Patient Reported Information: (month/day/year) ___ ___ /___ ___ / ___ ___ ___ ___

1. Have you ever received an HIV negative test result? *(Check answer in box below)*

   oYes, had previous HIV negative test oNever had an HIV negative test *(skip to question #4)* oRefused oDon't Know/Unknown

2. What month and year did you receive your last (most recent) HIV negative test? (mo/year) ___ ___ / ___ ___ ___ ___

3. Was your last HIV negative test conducted in San Francisco?

   oYes, it was in SF. List the name of site _____ oNo, it was outside of San Francisco oDon't Know/Unknown

4. Date of very first **HIV confirmed positive** test: (mo/year) ___ ___ / ___ ___ ___ ___ *(Record date of test, not of results)*

5. How many HIV negative tests did you get in the 2 years before first HIV confirmed positive?	_____
6. Reason you got tested for your first HIV positive test? Did you get tested because you	*Mark Yes, No or Unknown below*
♣ were concerned about possible exposure to HIV in past 6 months.	o Yes o No o Unk
♣ time for regular test (for example, every 6 months)	o Yes o No o Unk
♣ just checking to make sure negative	o Yes o No o Unk
♣ required to take test by court order, military or insurance	o Yes o No o Unk
♣ other reason, specify: _____	o Yes o No o Unk

Antiretroviral Therapy(ART) also known as Post-Exposure Prophylaxis or PEP is used to prevent or treat HIV or Hepatitis

7. Have you ever taken any antiretroviral medications to prevent or treat HIV or Hepatitis?

   o Yes o No(*End of Form*) o Refused o Don't Know/Unknown

7a. If Yes, list ART's used:	_____/ _____ /_____
7b. First date any ART's used: (mo/day/year)	___ ___ / ___ ___ / ___ ___ ___ ___
7c. Last date any ART's used: (mo/day/year)	___ ___ / ___ ___ / ___ ___ ___ ___

Name of person completing form:_____ Phone number: _____

INSTRUCTIONS FOR COMPLETION OF "HIV CONFIDENTIAL CASE REPORT FORM"

Complete all questions for which information is available.

Page 1

1) **Ethnicity**: Check one response for Hispanic or Not Hispanic. Hispanic persons are of Spanish origin, descent or culture, regardless of race.
2) **Race**: Check one or more.
3) **Country of birth**: Please complete this item, even if born in the United States.
4) **Patient History**: Please check "yes", "no", or "unk" for each category.
5) **Laboratory Data**: Please complete the entire section. HIV antibody test, first available viral load report and CD4 test. If the patient has a positive HIV antibody test but there is no laboratory slip available, please note this in the appropriate section.
6) **Treatment and services referrals**: Please complete the section to the best of your knowledge.

Page 2

7) **HIV Testing History**: Please complete all questions-see above. If you have any questions about this section of the form you may call Tony Buckman, at 415-554-9074.

This case report may be phoned in (415-703-7280), hand delivered or sent by <u>TRACEABLE</u> mail to:

Nyisha Underwood, MPH
Linkage to Care/Partner Services Coordinator
San Francisco Dept. of Public Health
AIDS Office, HIV Prevention Section
25 Van Ness, Ste. 500
San Francisco, CA 94102

If you have any questions concerning this form or HIV/AIDS reporting, please contact the Statistics and Epidemiology Section at 415-554-9050.

LEGAL AUTHORITY TO COLLECT INFORMATION AND ASSURANCES OF PATIENT CONFIDENTIALITY.

It is fully consistent with California law for medical center employees to cooperate with representatives of the Public Health Officer in reporting HIV/AIDS cases. Section 2643.5 of the California Health and Safety Code includes HIV as a reportable condition and further stipulates the health facilities "may establish administrative procedures to assure that reports are made to the local health department without duplication." The confidentiality of Medical Information Act (California Civil Code Section 56.10(b)(7) and 56.30(c) states that patient medical information may be disclosed without prior authorization when specifically required by law such as in compliance with communicable disease reporting requirements. Section 199.21(1) of the Health and Safety Code state the results of HIV tests may be included in medical records and may be disclosed to the Public Health Officer in accordance with the AIDS case reporting requirements. Patient information gathered by the AIDS Surveillance Branch is held in accordance with the AIDS Public Health Record Confidentiality Act (Section 199.42 Health and Safety Code).

REPORTABLE DISEASES AND CONDITIONS

City and County of San Francisco San Francisco Department of Public Health

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643 and §2800-2812 §2500(b).
Every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, must report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

WHO TO REPORT TO

REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO* COMMUNICABLE DISEASE CONTROL UNIT *UNLESS OTHERWISE INDICATED

COMMUNICABLE DISEASE CONTROL UNIT **PHONE: (415) 554-2830** **FAX: (415) 554-2848** M-F 8AM to 5PM For urgent reports after hours, follow the prompts to page the on-call MD	**AIDS OFFICE** **PHONE: (415) 554-9050**	**ANIMAL BITES (mammals only)** **PHONE: (415) 554-9422 FAX: (415) 864-2866**
	STD CLINIC **PHONE: (415) 487-5555 FAX: (415) 431-4628**	**ENVIRONMENTAL HEALTH SERVICES** **PHONE: (415) 252-3862 FAX: (415) 252-3818**
	TUBERCULOSIS CLINIC **PHONE: (415) 206-8524 FAX: (415) 206-4565**	

DISEASE OR CONDITION / URGENCY REPORTING REQUIREMENTS

URGENCY REPORTING KEY

▲ Report immediately by telephone 1 Report within one working day of identification 7 Report within seven calendar days by FAX, phone or mail

- 7 Acquired Immune Deficiency Syndrome (AIDS) *to AIDS Office*
- 7 Alzheimer's Diseases and Related Conditions
- 1 Amebiasis
- 7 Animal bites (mammals only) *to Animal Care and Control*
- ▲ Anthrax*
- ▲ Avian Influenza (human)
- 1 Babesiosis
- ▲ Botulism* (Infant, Foodborne, Wound)
- ▲ Brucellosis*
- 1 Campylobacteriosis
- 7 Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix)
- 7 Chancroid *to STD Clinic*
- 1 Chickenpox (only hospitalizations and deaths)
- 7 Chlamydial infections *to STD Clinic*
- ▲ Cholera
- ▲ Ciguatera Fish Poisoning
- 7 Coccidioidomycosis
- 1 Colorado Tick Fever
- 1 Conjunctivitis, Acute Infectious of the Newborn (specify etiology)
- 7 Creutzfeldt-Jakob Disease (CJD)
- 1 Cryptosporidiosis
- 7 Cysticercosis
- ▲ Dengue
- ▲ Diarrhea of the Newborn, outbreaks
- ▲ Diphtheria
- 7 Disorders Characterized by Lapses of Consciousness
- ▲ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- 7 Ehrlichiosis
- 1 Encephalitis, infectious (specify etiology)
- ▲ *Escherichia coli* shiga toxin producing (STEC) including *E. coli* O157
- ▲ Foodborne illness
- 7 Giardiasis
- 7 Gonococcal infections *to STD Clinic*
- 1 *Haemophilus influenzae* invasive disease (less than 15 years of age)
- ▲ Hantavirus infections
- ▲ Hemolytic Uremic Syndrome
- 7 Hepatitis, viral
- 1 Hepatitis A
- 7 Hepatitis B (specify acute case or chronic)
- 7 Hepatitis C (specify acute case or chronic)
- 7 Hepatitis D (Delta)
- 7 Hepatitis, other acute
- 7 Human Immunodeficiency Virus (HIV) *to AIDS Office*
- 7 Influenza deaths (less than 18 years of age)
- 7 Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
- 7 Legionellosis
- 7 Leprosy (Hansen Disease)
- 7 Leptospirosis
- 1 Listeriosis
- 7 Lyme Disease
- 7 Lymphogranuloma Venereum (LGV) *to STD Clinic*
- 1 Malaria
- 1 Measles (Rubeola)
- 1 Meningitis (specify etiology)
- ▲ Meningococcal infections
- 7 Mumps
- ▲ Paralytic Shellfish Poisoning
- 7 Pelvic Inflammatory Disease (PID) *to STD Clinic*
- 1 Pertussis (Whooping Cough)
- 7 Pesticide-related illness or injury (known or suspected cases) to *Environmental Health Services*
- ▲ Plague (human or animal)*
- 1 Poliomyelitis, Paralytic
- 1 Psittacosis
- 1 Q Fever
- ▲ Rabies (human or animal)
- 1 Relapsing Fever
- 7 Rheumatic Fever, Acute
- 7 Rocky Mountain Spotted Fever
- 7 Rubella (German Measles)
- 7 Rubella Congenital Syndrome
- 1 Salmonellosis (other than Typhoid Fever)
- ▲ Scombroid Fish Poisoning
- ▲ Severe Acute Respiratory Syndrome (SARS)
- ▲ Shiga toxin (detected in feces)
- 1 Shigellosis
- ▲ Smallpox (Variola)*
- ▲ *Staphylococcus aureus* infections, severe (ICU/death) in a previously healthy person
- 1 Streptococcal infections, outbreaks of any type and individual cases in food handlers and dairy workers only
- 1 Syphilis *to STD Clinic*
- 7 Taeniasis
- 7 Tetanus
- 7 Toxic Shock Syndrome
- 7 Toxoplasmosis
- 7 Transmissable Spongiform Encephalopathies (TSE)
- 1 Trichinosis
- 1 Tuberculosis *to Tuberculosis Clinic*
- ▲ Tularemia*
- 1 Typhoid Fever (cases and carriers)
- 7 Typhus Fever
- 1 *Vibrio* infections
- ▲ Viral Hemorrhagic Fevers* (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
- 1 Water-associated disease (e.g. Swimmer's Itch and Hot Tub Rash)
- 1 West Nile Virus
- ▲ Yellow Fever
- 1 Yersiniosis
- ▲ **ANY UNUSUAL DISEASES**
- ▲ **NEW DISEASE OR SYNDROME NOT PREVIOUSLY RECOGNIZED**
- ▲ **OUTBREAKS OF ANY DISEASE**

*Potential Bioterrorism Agents

Effective February 2008 / Revised 10/09

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name

Social Security Number ___ — ___ — ___

First Name/Middle Name (or initial)

Birth Date Month Day Year

Age

Address: Number, Street

Apt./Unit Number

City/Town

State

ZIP Code

Country of Birth

Area Code **Home Telephone**

Gender M F

Pregnant? Y N Unk

Estimated Delivery Date Month Day Year

Area Code **Work Telephone**

Patient's Occupation/Setting

❒ Food service ❒ Day care ❒ Correctional facility
❒ Health care ❒ School ❒ Other _____

Ethnicity (✓ one)

❒ Hispanic/Latino
❒ Non-Hispanic/Non-Latino

Race (✓ one)

❒ African-American/Black
❒ Asian/Pacific Islander **(✓ one)**
- ❒ Asian-Indian ❒ Japanese
- ❒ Cambodian ❒ Korean
- ❒ Chinese ❒ Laotian
- ❒ Filipino ❒ Samoan
- ❒ Guamanian ❒ Vietnamese
- ❒ Hawaiian ❒ Other_____

❒ Native American/Alaskan Native
❒ White: _____
❒ Other: _____

DATE OF ONSET Month Day Year

DATE DIAGNOSED Month Day Year

DATE OF DEATH Month Day Year

Reporting Health Care Provider

Reporting Health Care Facility

Address

City **State** **ZIP Code**

Telephone Number ( )

Fax ( )

Submitted by

Date Submitted (Month/Day/Year)

REPORT TO

Communicable Disease Control Unit
San Francisco Dept of Public Health
101 Grove Street, Room 408
San Francisco, CA 94102

PHONE: (415) 554-2830

FAX: (415) 554-2848

STD (Fax): (415) 431-4628
TB (Fax): (415) 206-4565
AIDS/HIV (PH): (415) 554-9050

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STD)

Syphilis

❒ Primary (lesion present)
❒ Secondary
❒ Early latent < 1 year
❒ Latent (unknown duration)
❒ Late latent > 1 year
❒ Late (tertiary)
❒ Congenital
❒ **Neurosyphilis**

Syphilis Test Results

❒ RPR Titer:_____
❒ VDRL Titer:_____
❒ FTA/MHA: ❒ Pos ❒ Neg
❒ CSF-VDRL: ❒ Pos ❒ Neg
❒ Other:_____

❒ **Chlamydia**
❒ **Gonorrhea**
❒ **Chancroid**
❒ PID

Site:
❒ Pharyngeal ❒ Cervical/Vaginal
❒ Rectal ❒ Urine
❒ Urethral ❒ Other:_____

Gender of Sex Partners last 12 months:
❒ Male ❒ Transgender (M to F)
❒ Female ❒ Transgender (F to M)
❒ Unknown ❒ Refused

STD TREATMENT INFORMATION

❒ **Treated** (Drugs, Dosage, Route):

Date Treatment Initiated Month Day Year

❒ **Untreated**
❒ Will treat
❒ Unable to contact patient
❒ Refused treatment
❒ Referred to: _____

VIRAL HEPATITIS

		Pos	Neg	Pend	Not Done
❒ **Hep A**	anti-HAV IgM	❒	❒	❒	❒
❒ **Hep B**	HBsAg	❒	❒	❒	❒
❒ **Acute**	anti-HBc	❒	❒	❒	❒
❒ **Chronic**	anti-HBc IgM	❒	❒	❒	❒
	anti-HBs	❒	❒	❒	❒
❒ **Hep C**	anti-HCV	❒	❒	❒	❒
❒ **Acute** ❒ **Chronic**	PCR-HCV	❒	❒	❒	❒
❒ **Hep D (Delta)**	anti-Delta	❒	❒	❒	❒
❒ **Other:** _____		❒	❒	❒	❒

Suspected Exposure Type

❒ Blood transfusion ❒ Other needle exposure ❒ Sexual contact ❒ Household contact
❒ Child care ❒ Other: _____

TUBERCULOSIS (TB)

Status

❒ **Active Disease**
- ❒ Confirmed
- ❒ Suspected

❒ **Infected, No Disease**
- ❒ Convertor
- ❒ Reactor

Site(s)

❒ Pulmonary
❒ Extra-Pulmonary
❒ Both

Mantoux TB Skin Test

Date Performed Month Day Year

❒ Pending
Results:_____ mm ❒ Not Done

Chest X-Ray Month Day Year

Date Performed

❒ Normal ❒ Pending ❒ Not done
❒ Cavitary ❒ Abnormal/Noncavitary

Bacteriology

Date Specimen Collected Month Day Year

Source _____

Smear: ❒ Pos ❒ Neg ❒ Pending ❒ Not done

Culture: ❒ Pos ❒ Neg ❒ Pending ❒ Not done

Other test(s) _____

TB TREATMENT INFORMATION

❒ **Current Treatment**
❒ INH ❒ RIF ❒ PZA
❒ EMB ❒ Other: _____

Date Treatment Initiated Month Day Year

❒ **Untreated**
❒ Will treat
❒ Unable to contact patient
❒ Refused treatment
❒ Referred to: _____

REMARKS

PM 110 (SF 02/10)

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