Attachment A
San Francisco Department of Public Health
RFA #15-10749

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
STD CONTROL BRANCH

APPLICATION COVER SHEET
February 1, 2016 through June 30, 2018

AGENCY NAME			
San Francisco Department of Public Health			
STREET ADDRESS			
25 Van Ness Suite 500			
CITY	COUNTY	STATE	ZIP CODE
San Francisco	San Francisco	CA	94102
TELEPHONE NUMBER	FAX NUMBER		FEDERAL TAX ID NUMBER
(415) 437-6200	(415) 431-7154		94-6000417

Person having day-to-day responsibility for the project:

NAME		TITLE
Katie Burk		SFDPH Viral Hepatitis Coordinator
ADDRESS	CITY	STATE, ZIP CODE
25 Van Ness Avenue Suite 500	San Francisco	CA 94102
TELEPHONE NUMBER	FAX NUMBER	EMAIL
(415) 437-6212	(415) 431-7154	katie.burk@sfdph.org

Official person signing for organization:

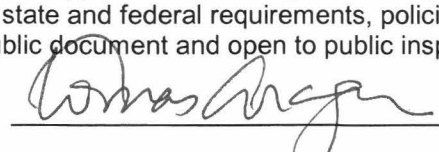
NAME		TITLE
Tomas Aragon		Director, Population Health Division
ADDRESS	CITY	STATE, ZIP CODE
101 Grove 3rd Floor	San Francisco	CA 94102
TELEPHONE NUMBER	FAX NUMBER	EMAIL
(415) 554-2898		tomas.aragon@sfdph.org

Financial Officer for organization:

NAME		TITLE
Greg Wagner		Chief Financial Officer
ADDRESS	CITY	STATE, ZIP CODE
101 Grove 3rd Floor	San Francisco	CA 94102
TELEPHONE NUMBER	FAX NUMBER	EMAIL
(415) 554-2900		greg.wagner@sfdph.org

AMOUNT REQUESTED $ 2,564,248	FUNDING PERIOD
	February 1, 2016 through June 30, 2018

The undersigned hereby affirms that the statements contained in the application package are true and complete to the best of the applicant's knowledge and accepts as a condition of a contract the obligation to comply with applicable state and federal requirements, policies, standards, and regulations. The undersigned recognizes that this is a public document and open to public inspection.

Signature:  Date: 12/8/15

Type Name and Title: Tomas Aragon, Director, Population Health Division

Table of Contents

California Department of Public Health
HCV Linkages to Care RFA 15-10749
Application Certification Checklist

Eligible Entity's Name: San Francisco Department of Public Health

Use this checklist to make certain your application package is complete. Enter an X for yes for each item provided and submit a copy of the completed checklist with your application. Applications that do not include all required elements listed in this RFA will be deemed non-responsive. Organize your application in the same order identified in this RFA.

Yes/No	Items Included in Application
☒ Yes ☐ No	Application Cover Sheet (**Attachment A**)
☒ Yes ☐ No	Table of Contents
☒ Yes ☐ No	Application Certification Checklist (**Attachment B**)
☒ Yes ☐ No	Program Summary
☒ Yes ☐ No	Statement of Need
☒ Yes ☐ No	Organizational Capacity
☒ Yes ☐ No	Copy of organizational chart
☒ Yes ☐ No	Organizational Capacity Assessment – Goal 2 **(Attachment C)**
☒ Yes ☐ No	Organizational Capacity Assessment – Goal 3 **(Attachment D)**
☐ Yes ☒ No	Copy of risk assessments used (if any)
☒ Yes ☐ No	Scope of Work **(Attachment E)**
☒ Yes ☐ No	Budget Justification **(Attachment F)**
☒ Yes ☐ No	Budget Detail **(Attachment G)**
☒ Yes ☐ No	Evaluation
☒ Yes ☐ No	Letters of support or memoranda of understanding (if any)
☐ Yes ☒ No	Subcontracting agreements (if any)
☐ Yes ☒ No	Evidence of non-profit status (if any)
☐ Yes ☒ No	One original and four (4) complete copies (if submitting application in-person or via mail)

I hereby certify that all the above required elements of my application, including the attachments and other appendices material, are attached and in the above order.

Authorized Signature: Tomás Aragón Date: 12/9/2015

Printed Name: Tomás Aragón

PROGRAM SUMMARY

San Francisco had the highest rate of newly reported hepatitis C (HCV) cases in California in 2011. Given our HCV epidemiology, the proposed program is specifically designed to reach people who inject drugs (PWIDs) in San Francisco – particularly African Americans – as those are the residents most likely to have undiagnosed HCV.

We are applying for both Goal 2 and Goal 3 of this RFA.

For Goal 2, we plan to build on existing partnerships between the San Francisco Department of Public Health (SFDPH), Glide, and the San Francisco AIDS Foundation (SFAF) to support implementation of the project. Most of SFDPH's support is in-kind, providing coordination, technical assistance, and structural support through policy development and increasing collaboration and resource leveraging where possible. A community agencies, Glide and SFAF will work in combination to bring HCV screening, education, and navigation services to PWID, in the locations where they are most likely to encounter high risk people who are not already engaged in HCV screening and care.

Starting in the first full year of the grant we expect to screen at least 1500 PWIDs per year for HCV, with about 450 people having a reactive screen, receiving a confirmatory result, and being supported in obtaining HCV care and treatment. In addition to those being screened, we expect to reach more than 15,000 people per year with outreach and education services related to HCV. To accomplish this, Glide will offer extended HCV testing hours and linkage services for clients who test positive. SFAF will increase HCV testing for clients in their syringe access locations and will develop a HCV Wellness drop-in at their 6th Street Harm Reduction Center. Our proposed staffing plan for Goal 2 includes 5.5 FTE HCV test counselors / navigators, 1.5 additional FTE of certified phlebotomists, a 0.5 FTE HCV data entry worker at SFDPH, and an additional 0.05 FTE of time for the staff psychologist at Glide to offer improved clinical supervision to HCV outreach, testing, and navigation staff. All other staff will work in-kind. Although SF does not currently use LEO for HIV or HCV services, we plan to begin using LEO to track all HCV testing and linkage data, if funded.

For Goal 3, we plan to work within the San Francisco Health Network (SFHN), SFDPH's safety net clinic system. The proposed program has three components: 1) To expand primary care HCV screening and treatment capacity by training providers at primary care clinics to improve competency for clinical management of HCV, implementing an e-Referral system for primary care providers to easily access clinical consultations for HCV care, and increasing HCV screening at methadone clinics. 2) To utilize primary care/methadone partnerships to increase screening and treatment, by pairing methadone clinics with nearby primary care clinics to facilitate linkage between both services, including directly observed therapy (DOT) at the methadone clinics for primary clinic patients living with HCV and also using methadone. 3) To increase screening and treatment among homeless populations by expanding the capacity of the SF Homeless Outreach Team to support the team's HCV treatment initiative. Starting in the first full year of the grant we expect to screen at least 1,000 people per year for HCV, with about 10% of them having a reactive screen, and receiving a confirmatory NAT result. In addition, we expect to link or re-engage at least 50 people in primary care, including care for their HCV. We anticipate that approximately 100 people will be able to access HCV treatment over the course of the grant, as a result of this funding.

Statement of Need

Hepatitis C is a critical problem in San Francisco; among California counties with >100,000 population, San Francisco (SF) had the highest rate of newly reported hepatitis C (HCV) cases in 2011.[1] From 2008 through 2011, 11,843 unique individuals with HCV positive lab results were reported to the San Francisco Department of Public Health (SFDPH), among a total population of 805,235. This number undoubtedly underestimates the prevalence of HCV in SF as testing was not routinely reported in California prior to 2008. In 2013, SFDPH received over 4,950 positive HCV laboratory reports on 3,205 individuals with confirmed past or present HCV infection, of whom 1,267 people were newly reported cases. SF has the highest rate of liver cancer in the entire United States, with much of it attributable to HCV.[2] In UCSF transplant centers – among the nation's busiest – approximately 50% of the 2,421 liver transplants performed since 1998 have been for HCV-related liver failure and/or cancer.[3] Based on the 2009 Nationwide Inpatient Sample data, 2.2% of U.S. and 5.4% of SF hospitalizations were for possible HCV-related conditions.[4] Furthermore, in 2013, 53 San Franciscans died from complications of end stage liver disease, with many of those deaths also related to HCV infection.[5]

Risk factors for HCV are not collected as part of the standard reporting form submitted to the SFDPH by laboratories and medical providers. However, since 2010, SFDPH has received CDC funding to conduct enhanced surveillance on newly reported cases of HCV; 20% are randomly selected for enhanced surveillance. A 1-page data collection form is sent to the health care provider who ordered the most recent positive HCV test to request patient locating information, race/ethnicity, primary language, reason the provider ordered the test, and risk factors; the provider is also informed that SFDPH will be contacting the patient. Approximately one month after contacting the provider, the patient is contacted by telephone and a public health interview is conducted. By directly contacting patients and faxing or mailing follow-up surveys to the providers, SFDPH is able to acquire information unavailable through routine public health reporting to better characterize the population of San Franciscans who are infected with HCV. Enhanced surveillance interviews of HCV cases found that injection drug use was the HCV risk factor most frequently reported by respondents.[6]

The proposed program is specifically designed to reach those who inject drugs in the City and County of San Francisco – particularly African Americans – as those are the residents most likely to have undiagnosed HCV infection in our city. According to National HIV Behavioral Surveillance (NHBS) data, there were between 18,000-25,000 people who inject drugs (PWIDs) in SF in 2012. Of those, 83% reported ever being tested for HCV, 53% reported testing positive, 20% ever received medications for HCV and 4% were cured of HCV.[7] NHBS findings from 2005-2012 demonstrate improved health insurance coverage for PWIDs in SF, which increased from 38% in 2005 to 83% in 2012, raising the possibility of effectively managing HCV in this disproportionately impacted population. Of the 3,205 people reported to SFDPH with an HCV positive test result in 2013, 69.1% were male, 65.1% were between the ages of 45-64, and 32.3% were African American,[8] despite the fact that African Americans are only 5.8% of total SF residents.[9]

Given these challenges, we see this funding as a great opportunity to unite and expand our efforts to improve drug user health, and improve our HCV screening and linkage navigation efforts in San Francisco. **Starting in the first full year of the grant we expect to screen at least 1500 PWIDs per year for HCV, with about 450 people having a reactive screen, receiving a confirmatory result, and being supported in obtaining HCV care and treatment. In addition to those being screened, we expect to reach more than 15,000 people per year with outreach and education services related to HCV.** These numbers were determined based on our current testing and outreach numbers at the participating agencies, our experience of demand for testing at sites where testing is not currently offered, and our projections of increased capacity once we hire the staff proposed here. In parallel, we are striving to increase provider capacity to clinically manage and treat HCV within our safety net primary care settings (see Goal 3 proposal), offering more possibilities for our community-based HCV screening agencies to successfully link clients to culturally competent care for their HCV.

This proposal seeks to bring together three organizations whose complementary assets lay the foundation for success. Glide, a community-based organization located in the Tenderloin brings deep cultural competency with and direct access to PWIDs in the highly HCV-impacted Tenderloin neighborhood, through existing syringe access and outreach efforts and has been a leader in HCV-related initiatives in the city. The San Francisco AIDS Foundation (SFAF), the lead agency for syringe access services in the city, has the trust of the thousands of PWIDs who access syringes via sites all over SF. SFDPH, the lead organization for this proposal, has a Viral Hepatitis Coordinator who is in a position to coordinate and align the services funded under this grant with the broader landscape of HCV efforts happening at SFDPH and in the city, keeping all eyes on the short-term goal of treatment access and the long-term vision of HCV elimination.

Through this program, Glide will offer extended HCV testing hours and linkage services for clients who test positive. Glide's HCV Services Program offers HIV and HCV testing, street outreach, syringe access services, and drug overdose prevention training. HCV Services also maintains a robust partnership with Tenderloin Health Services, a program of HealthRIGHT360 located on the sixth floor of Glide's building. The program's location is convenient for many clients, a significant portion of who use other Glide programs, such as the Daily Free Meals program. 53% of Glide clients using syringe access services in 2015 have been African American. Last year, Glide tested 522 people for HCV using the OraQuick HCV test, 77% of whom were PWIDs. A full 142 of those individuals (27.2%) tested HCV antibody positive, and 60 of them had a positive HCV RNA test and were referred to care. SFAF will increase HCV testing for clients in their syringe access locations and will develop a HCV Wellness drop-in at their 6th Street Harm Reduction Center. HCV Wellness drop-in clients will be offered a nonjudgmental space for building community through communal meals, accessing HIV and HCV screening, safer injection and vein care educational groups, overdose prevention trainings, and HCV treatment and adherence support groups by and for people who inject drugs. It will also feature frequent guest visits by HCV specialists and experts in the field. Last year, SFAF distributed more than 200,000 syringes *a month* to approximately 13,000 unduplicated people (31,627 duplicated contacts) with an emphasis on peer education and secondary distribution; thus far their HCV screening capacity has been limited, but the positivity rate for testing that *is* done hovers around 40%. Together these organizations have a broad reach to populations

with multiple cross-cutting vulnerabilities including drug use, homelessness and previous incarceration that render them vulnerable to HCV.

We determined the need for the proposed services through a series of ongoing citywide efforts, including those that are part of our SFDPH Drug User Health Initiative strategic planning, currently underway. These efforts include:

- A weekly HCV education and support group at a methadone clinic in the Tenderloin neighborhood, facilitated by the SFDPH Viral Hepatitis Coordinator. Recent topics have included people's understanding of drug injection and HCV transmission risk as well as the new HCV medications, and how this information can impact injection behavior.
- SFDPH has held 10 different focus groups with PWIDs and people who use drugs or alcohol without injecting, to discuss issues related to substance use, HCV, harm reduction, and access to care. These groups have been held with the support and participation of numerous SF-based community organizations or primary care clinics with strong connections to PWIDs, including two education-focused groups held in the SF County Jail in cooperation with Project Inform and Jail Health Services.
- SFDPH has also held focus groups to discuss HCV with community-based HIV testing coordinators, as well as other providers who work with PWIDs.
- Many key staff on this proposal are regular participants in a monthly case conferencing and education meeting at SFGH, for community-based HCV care providers citywide. This is a multi-disciplinary meeting attended by clinicians, pharmacists, community-based HCV screening staff, and administrators.
- SFDPH hosted a Hepatitis Planning Day in March, to conduct a visioning brainstorm and discuss concrete opportunities for intervention and set specific goals for improvement around hepatitis screening and care in San Francisco.

In addition, this past year Glide received funding from SFDPH to hold a series of focus groups to a) assess PWIDs knowledge levels around HCV and harm reduction, and b) test out social marketing messages and see if they resonated with PWIDs. This launched an agency-specific social marketing campaign (see Figure to right) featuring a series of messages, including "Living with Hep C? New Treatments Have Changed the Game," "Sharing Equipment Spreads Hep C: Come Get Sterile Stuff," and "We Can't Treat Hep C if We Don't Know We Have It." Materials will be distributed to PWIDs directly from Glide and other community organizations, and advertisements will be placed around the neighborhood and on public transportation. The campaign is also now in the process of being tailored and replicated in other agencies throughout the city, including SFAF, with money provided through the Mayor's office.

Organizational Capacity

The lead agency for this project is the SFDPH, an integrated health department with two major Divisions (see the attached *Organizational Chart*): the SF Health Network (SFHN) and the Population Health Division. Our mission is to protect and promote the health of all San Franciscans, and we are recognized as a public health leader, working closely with community organizations to implement innovative, effective, evidence-based strategies and enacting policies to build healthy, safe and equitable communities. SFDPH employs more than 12,000 staff in two major hospitals, 21 primary care clinics, 28 behavioral health sites, and more than 30 branches and sections. We have offices and services locations in every neighborhood in the City, and run a state-of-the-art trauma center and inpatient hospital (SF General Hospital). The **Population Health Division** is community and client-centered with branches that specialize in health protection, health promotion, and disease prevention and control, and work together in multi-disciplinary teams to address complex community health problems such as HIV and HCV. The Division has 520 staff, approximately 90 of whom are actively engaged in prevention, surveillance and research of blood-borne viruses. The **SFHN** is the city's only complete care system, including primary care, dentistry, emergency treatment, medical & surgical specialties, skilled nursing & rehabilitation, and behavioral health.

The direct services proposed in this grant will be provided by two community agencies. For over fifty years, **Glide** has worked toward its mission of creating a radically inclusive, just and loving community mobilized to alleviate suffering and break the cycles of poverty and marginalization. Building on the charitable efforts engendered by the formation in 1929 of Glide Memorial United Methodist Church, community members inaugurated Glide's social services programming in the 1960s in response to the crises faced by residents of SF's Tenderloin neighborhood. Today, Glide serves a diverse cross-section of homeless, low-income and marginalized populations with a suite of programs, including daily free meals, housing assistance, domestic violence counseling and abatement, substance abuse recovery, childcare, afterschool and summer programs for K-5, a family resource center, a drop-in legal clinic (in partnership with the Lawyers' Committee for Civil Rights), and on-site access to primary and mental health care (via Tenderloin Health Services, a program of HealthRIGHT 360). As a multi-service organization, Glide remains a life-changing gateway that models comprehensive care that embraces every individual with dignity and respect.

Glide is joined by the **San Francisco AIDS Foundation**, or SFAF. Since its inception as the Kaposi's Sarcoma Research and Education Foundation in 1982, SFAF has had a long history of successfully providing services to a variety of gay men and PWIDs in San Francisco. In those 32 years, SFAF has grown both physically, in the diversity of services provided, and in local, national, and international reputation. SFAF's mission is the radical reduction of new infections in San Francisco because they refuse to accept HIV as inevitable. SFAF runs HIV, HCV, and other health and wellness services in multiple locations citywide, including 13 sites offering 70 hours of syringe access each week through their lead role in the Syringe Access Collaborative (SAC), formed in 2010. The SAC is the citywide collaborative project of five community-based organizations that provide access to sterile syringes, injection & smoking supplies, and safer sex supplies to PWIDs in locations throughout the city. SFAF also runs the Stonewall Project, a state-certified outpatient drug treatment program started in 1997 as a harm

reduction program for gay men who use crystal meth; about 40% of Stonewall clients actively inject speed. SFAF also works with the Positive Health Program at San Francisco General Hospital to run two Centers of Excellence (CoEs): Access Hope and Black Health. Both CoEs provide primary medical care, psychiatry, substance use/abuse treatment, social work services, and case management – SFAF is specifically subcontracted to provide the case management services within these CoEs. SFAF also provides services through Magnet, a local, national, and international model for exceptional service provision for gay and bisexual men located in the Castro District.

SF already has a strong HCV-related program infrastructure. The SFDPH Viral Hepatitis Coordinator spent much of 2015 completing a comprehensive HCV-related needs assessment for SFDPH, and identified five strategic goals that serve as the basis for all HCV program planning and align with CDPH's Strategic plan to address Viral Hepatitis: 1) Increase HCV awareness in affected populations; 2) Increase community and clinic-based screening; 3) Implement a linkage-to-care program for individuals living with HCV who are currently out of care; 4) Increase primary care provider capacity to treat HCV; and 5) Increase patient access to curative therapies. SFDPH is making progress on each of these goals, and funding from Goals 2 and 3 of this RFA would greatly increase SFDPH's capacity to expand its work on our own goals 2 and 3.

Currently, HCV screening happens in SF through SFHN primary care clinics, the county jail, methadone programs, residential treatment programs, and other community-based sites, including syringe access programs, single room occupancy (SRO) hotels, and mobile testing – with much of this community-based testing done by Glide and SFAF. 5300 rapid HCV tests were conducted in SF last year.

Furthermore, SFHN has already initiated a set of processes to increase primary care physicians' capacity to treat HCV, thanks to a forward-thinking leadership team who has supported HCV-specific activities through SFHN infrastructure. Services just beginning through a $250,000 funding line in the Mayor's budget include:

- Capacity-building and data monitoring activities to support expansion of primary care-based HCV treatment, and assigned pharmacists to support physicians in selecting the correct regimens for their patients, and
- An e-Referral system, which will give SF the ability to capitalize on in-house HCV primary care expertise. This system will be available to all SFHN providers, and will be answered by the MD HCV specialist at Southeast Health Center.

It is important to note that SFDPH has an RFP currently out for our own HCV linkage program; local money has been set aside to ensure that funded agencies will support community-based organizations and SFHN clinics citywide to ensure HCV antibody-positive clients receive confirmatory NAT, help patients successfully attend medical appointments, assist them in ACA enrollment, and provide medical case management along with navigation support for opiate replacement therapy and syringe access. The mayor's funding to support this program is limited and SFDPH funding alone will be insufficient to meet the needs of vulnerable San Franciscans living with HCV; CDPH funding will enable a much broader reach for the linkage program.

Glide has multiple coordinated HCV screening and linkage strategies, and intentionally operates with a cross-training model. All staff are hired for their cultural competence and

experience with the populations that Glide services, including PWIDs and people who are homeless and marginally housed. Glide's HIV/HCV program currently has 5.2 FTE staff, each of whom conduct HIV and HCV outreach and provide HIV/HCV screening at Glide. Clients who test reactive during clinic hours can be walked upstairs to Tenderloin Health Services (a primary care clinic run by HealthRIGHT 360 on the 6th floor of the Glide building). This staffing is supplemented with about 14 skilled, peer volunteers conducting street outreach or supporting syringe access services at any given time, and 2 volunteers trained to provide HIV/HCV testing and counseling. Glide also has two phlebotomists, who are available to draw blood for confirmatory HCV NAT following a reactive OraQuick screening test; this staffing level means that blood can be immediately drawn for confirmatory testing around 75% of the time that HCV screening is conducted. Increasing the phlebotomy staffing to ensure 100% access to a phlebotomist during HCV screening shifts is a key goal of this proposal. HCV care is usually provided for Glide clients living with HCV through Tenderloin Health Services on-site. However, Glide staff support navigation to other primary care providers when desired; this capacity will increase with funding from this proposal. Importantly, Glide also offers more than 44 hours of syringe access services per week, serving 15,422 clients and distributing 644,438 clean syringes from Jan – Oct of 2015.

SFAF provides HCV testing using the OraQuick rapid HCV test, links clients with reactive results to SFAF sites offering confirmatory testing with certified phlebotomists, and has dedicated staff who support some of the hardest-to-link individuals in being successfully linked to care and obtaining treatment. Most SFAF programs already regularly distribute HCV educational materials to their clients as well as at street fairs and other city-wide events. To date, SFAF has worked at its syringe access sites with 70 clients interested in HCV linkage services, successfully linking 16 clients to HCV care, with 7 of them being cured of HCV. SFAF is in the process of developing a strategic plan to prioritize its HCV interventions and effectively integrate program activities at both its headquarters at 1035 Market Street and at Strut, SFAF's new Center for Health and Wellness soon to open in the Castro.

All community agencies track HCV testing information on the SFDPH HCV Screening form (see Appendix). Although SF does not currently use LEO for HIV or HCV services, **we plan to begin using LEO to track all HCV testing and linkage data, if funded through this proposal.** Taken together, these commitments by SFDPH, Glide, and SFAF help ensure long-term sustainability of any HCV-related procedures implemented with this funding.

In summary, the **SFDPH, Glide, and SFAF collaborative has exceptionally strong capacity in each of the following ten areas:** i) We have clearly shown leadership on community-based HCV screening and linkage to care through the outstanding work at Glide, known as one of the best programs in the country for people who are homeless and marginally housed, as well as those who inject drugs. SF has also demonstrated leadership addressing the needs of PWIDs in accessing medical care and support through the comprehensive Drug User Health Initiative, launched in 2015, its early adoption of comprehensive syringe access services, and its maintenance of low-barrier and immediate access to methadone and buprenorphine city-wide. ii) We have experience with PWIDs and relationships with community-based organizations including

our citywide harm reduction policy, first enacted in 2000 which explicitly outlines the SFDPH commitment to client-centered, harm reduction-based services for drug users. The work of Glide and SFAF in this area, which relies on the participation of peer models for consumer feedback and is described on the prior pages, are further evidence of this history. iii) We have experience working with non-traditional collaborators, including homeless services, substances use disorders treatment, syringe exchange programs, and HIV prevention and treatment. These are the very partners we have involved in this proposal – in fact, our working relationship with these entities is so longstanding that they no longer seem "non-traditional" to us! iv) Glide and SFAF work closely with Glide's affiliated clinic HealthRIGHT 360 and Mission Neighborhood Health Center both FQHCs, as well as numerous other SFHN HCV health care providers including Tom Waddell Health Center and the Positive Health Program at SFGH for those who are co-infected with HIV and HCV. These clinics are located in the neighborhoods with the highest proportion of PWIDs and have worked hard to earn the trust of PWIDs – with their success evidenced by their active patient populations. These providers have been pioneers of HIV and HCV treatment with vulnerable populations and their creative models of treatment engagement are national examples of excellence in clinical care. v) SFDPH routinely funds both Glide and SFAF for their work with HCV, HIV, and other health projects. All three entities have a strong relationship with the CDPH, and other state and local health departments, including LA, NYC, NY State, Seattle/King County, and more. We learned long ago that it is important to build from others' experiences and ideas, rather than working in silos, especially when it comes to marginalized patient populations. vi) We have extensive experience with coordinating a community-wide planning phase involving multiple community collaborators. Our work with the Mayor's HCV Task Force, the HIV Prevention Planning Council, and the San Francisco Health Improvement Partnership (SFHIP) are just a few examples of ongoing, successful efforts to bring community collaborators together to improve public health. vii) SF is one of the most well-researched, pioneering cities in the U.S. when it comes to public health. Our staff and researchers have launched multiple programs that have gone on to serve as evidence bases for work nationally, and even internationally, including at Glide and SFAF. We have been funded for dozens of CDC demonstration projects and have implemented hundreds of evidence-based programs in the fields of HIV, HCV, and more. viii) The SFDPH manages a multi-million dollar portfolio of HIV and HCV prevention, policy, surveillance, and research activities, as well as primary care navigation and retention, substance use treatment, and harm reduction services; responsibility for fiscal monitoring and oversight of government grants lies with a six member team based in the SFDPH Grants Unit and led by the Accounting Manager. The Accounting Manager establishes, evaluates and reviews fiscal procedures to ensure internal control and compliance and oversees and manages fiscal audits of Federal, State and private grants. ix) Our outstanding research staff participates in and leads national evaluation projects, at the same time we commit to using our local data for ongoing evaluation and continuous quality improvement. We concurrently manage evaluation activities for dozens of programmatic grants each year. Finally, x) SFDPH has a Public Information Officer who works with our community organizations and supports our community liaison, a staff position filled by a person with expertise at managing public relations with respect to PWID and HIV/HCV.

Our proposed staffing plan for this project includes:

Site	Position	FTE	Qualifications	Roles/Responsibilities	Hire date
Glide	HCV test counselor / Navigator (1.0 FTE will also be a phlebotomist)	3.5 FTE	Experienced with the SF System of Care for HIV and HCV. Certified as an HIV test counselor in CA; trained to use the OraQuick HCV rapid test; trained as a CHOW; 1.0 FTE will be a certified phlebotomist in the State of CA (or to be trained)	Work with other cross trained 5.2 FTE test counselors; Assist clients living with HCV to navigate to care and treatment; Conduct outreach/testing; Phone, text, email, reminders, home visits, office counseling, accompanies clients to appointments and general advocacy. Enter and maintain secure data; 1.0 FTE phlebotomist will draw blood for all confirmatory HCV NATs;	March 2016
	Staff psychologist	0.05 FTE	MSW and/or a licensed clinical psychologist	Provide regular clinical supervision for HCV program staff	Already hired
SFAF	HCV Navigator	2.0 FTE	Experienced with the SF System of Care for HIV and HCV. Certified as an HIV test counselor in CA; trained to use the OraQuick HCV rapid test	Assist clients living with HCV to navigate to care and treatment; Phone, text, email, reminders, home visits, office counseling, accompanies clients to appointments and general advocacy. Enters and maintains secure data	March 2016
	Phlebotomist	0.5 FTE	Certified phlebotomist in the State of CA	Draw blood for confirmatory HCV NAT	March 2016
SFDPH	HCV data entry worker	0.5 FTE	Data entry and analysis	Manage the data entry for all project activities, including via LEO	March 2016

This staffing plan will cover all of the increased testing and linkage activities proposed at Glide and SFAF, while SFDPH will have data management support and provide planning and coordination of the project in-kind. As with all our work, our effectiveness will depend on the skills and expertise of our project team to deliver technically sound, culturally competent guidance. Glide and SFAF both have a demonstrated commitment to hiring staff that reflect the populations being served, and both agencies have experience implementing peer education programs that will translate well to the HCV-specific programming described here. Peers will be utilized in the HCV client education and harm reduction groups at both agencies. For all project staff who will interact with clients and others during outreach, the ability to work well with PWIDs and other potentially challenging clients is an absolute requirement; staff without these competencies are sent to trainings or replaced.

The SFDPH Viral Hepatitis Coordinator will oversee the project and ensure training opportunities are available for staff by utilizing the resources of Project Inform, national viral hepatitis technical assistance groups, and SFDPH's Harm Reduction Training Institute, to be launched in early 2016. SFDPH and community partners are strongly committed to professional development; all staff must complete required online trainings each year, in addition to other training or learning opportunities.

As already described, this proposal builds on existing partnerships between SFDPH, Glide, and SFAF to support implementation of the project. Most of SFDPH's support is in-kind, providing coordination, technical assistance, and structural support through policy development and increasing collaboration and resource leveraging where possible. Glide and SFAF will work in combination to bring HCV screening, education, and navigation services to PWID, in the locations where they are most likely to encounter high risk people who are not already engaged in HCV screening and care.

Evaluation

Our evaluation plan for this project includes a combination of quantitative and qualitative methods to collect, organize, and report qualitative data for quarterly progress reports to CDPH/OVHP. Quantitative methods will include:

- Regular data extraction from LEO,
- Bi-annual client surveys at both Glide and SFAF, briefly surveying clients' knowledge of HCV transmission, treatment options, interest in treatment, and perceived barriers to treatment.

Qualitative methods will include two strategies:

- Three focus groups per year with clients at both Glide and SFAF (held independently at each site). These focus groups would include discussions around knowledge/self-efficacy for engaging in protective actions to prevent transmission, knowledge and perceived risk of re-infection after treatment and experience with HCV care provider(s) throughout the year.
- Annual qualitative interviews of project staff at Glide and SFAF, to determine what their interest in screening clients for HCV and referring those who test positive to treatment, and what they see the barriers to treatment to be.

All of the information gathered through these methods will be shared with project staff for purposes of continuous quality improvement, and also used to write quarterly progress reports to CDPH/OVHP as required. This will be managed by the SFDPH Viral Hepatitis Coordinator and the SFDPH Substance Use Program Liaison, both of whom will work in-kind for this grant. These SFDPH staff will organize the project, provide guidance and oversight to the participating organizations, plan and facilitate monthly meetings with all key project partners to understand program progress, strengths, and challenges, and summarize data and information learned throughout the project so that it can be easily shared with CDPH and others on a regular basis.

Our plan for quantitative data collection and management relies on the hiring of a 0.5 FTE data entry staffperson at SFDPH. This person will be responsible for receiving, reviewing, and data entering all community-based data related to HCV screening and linkage, using LEO. LEO forms will be completed by trained staff at each community-based site, then submitted to SFDPH on a monthly basis for data review and entry. The data entry staffperson will be responsible for all data quality assurance; s/he will conduct data quality reviews at least once per month and will work directly with field project staff to correct missing or problematic data quickly to improve data accuracy. **SFDPH is willing to use any of the data collection systems, measures, templates, and forms provided by CDPH/OVHP for data organization and reporting, upon request.**

We expect to have 3 main challenges in collecting and reporting the required data elements through this grant. First, converting to LEO will be a challenge for us in SF, because it is a new system that we have never used before. We recognize that this will require training all staff, then supporting them in collecting LEO-based data with quality and entering it appropriately. However, it will also require some thought on our end to adapt our existing systems to eliminate duplicate work while maintaining a comprehensive picture of our program. For example, our current HCV Screening Form, used by all community agencies offering rapid HCV screening, collects much of the

information that will be collected via LEO for this grant. However, it also collects contact information, data about attempts to contact clients who fail to return, and other notes about key supportive services provided to improve linkage and retention. Once this program begins, we will adapt this HCV Screening Form to include only the critical information not already captured by LEO, and will retrain staff in its use.

A second challenge in this grant involves determining the most appropriate balance between conducting blood draws for HCV NAT ourselves, and immediately linking clients to primary care for follow-up (including HCV NAT). While we intend to build the capacity to provide blood draws whenever possible following a reactive HCV screening test, we know from experience that many of the clients we will encounter will know that they are living with HCV, but will be very confused as to whether it was ever officially confirmed. While it will make sense to retest some of these people, in many cases it may make more sense to skip the screening and confirmatory blood draw and instead simply focus on re-engaging the client in care. We will continue to discuss ways to document this tension, the decisions that are made, and whether there are better ways to strike this balance as our program unfolds.

Finally, the third challenge involves our ability to describe barriers to care for our clients. While we are confident that we *know* the barriers our clients are facing, and take steps to address these barriers every day as part of the client-centered services we provide, we do not have a systematic way of tracking and reporting of these barriers for people with HCV. At SFAF, this can be partially addressed through adapting some of the barrier assessment and tracking systems from their HIV navigation program. However, Glide does not have the same funding from CDC to support this comprehensive program. SFDPH will assist the agencies in properly documenting these barriers by creating program-wide tracking forms based on those used by more experienced programs (e.g., New York City), and training and supporting agencies in their use.

One of SF's best strengths is its coordination and collaborative work between the SFDPH and community organizations, including shared use of data. Part of the role of the SFDPH Viral Hepatitis Coordinator is to ensure that community-based programs are properly documenting their activities for data entry; for this project she will train agencies in the use of LEO forms and will work with the SFDPH data entry staffperson to assure and improve quality of the data collection. Once high quality information is entered into LEO, it will make it easier to share data among collaborative partners. Client consent forms for procedures requiring confidentiality (e.g., testing or other activities where identifiable client data is collected and stored) are collected in writing at each encounter and are maintained at the site for review upon request. These consent forms include details about the information that will be shared with SFDPH or other community partners, and clients have the ability to ask questions about this data sharing before any information is collected. Similarly, signed Release of Information forms are collected from all clients who are linked to care (as long as they choose to sign) so that the community agencies can follow up with the clinic to which they were linked and share information. These forms are kept on site in locked files, available upon request. Finally, all collaborating partners in this grant will meet monthly to share successes, challenges, and work together to fine-tune the programs. While no confidential client information will be shared at these meetings without a client's written

permission, this will be a great opportunity for the project partners to learn from each other and work together to fine-tune the program.

SFDPH has an Integration Security and Confidentiality Guideline for the health jurisdiction, using CDC Data Security and Confidentiality Guidelines. All data collection, entry, management, submission, analysis, use, and dissemination procedures are consistent with these guidelines, and our data security and confidentiality policies conform with the NCHHSTP Data Security and Confidentiality Guidelines. We comply with all state and federal information systems and information processing security policies; our local procedures clearly describe required physical security attributes of all facilities; procedures for protecting, controlling, and handling data during performance of the project, including any development and testing activities; required limitations on employees with respect to the reproduction, transmission, or disclosure of data; physical storage procedures to protect data; procedures for the destruction of source documents and other contract-related waste material; and personnel security procedures. All agency personnel having access to identifiable and confidential information receive appropriate annual training and sign confidentiality pledges; this is in concordance with our 'Rules of Behavior' for persons who have access to data systems through this project. We complete an annual review and validation for all system user accounts to ensure compliance and continued need for access. **As our subcontractors, Glide and SFAF are bound by these same rules for data security and confidentiality; compliance with these rules is regularly overseen by their program manager.**

Attachment C: Organizational Capacity Supplemental Assessment Form— Goal 2: Hepatitis C Testing and Linkages to Care

Organizational Capacity			Number
Organization Name* **Glide Foundation**			
Reporting Period /Year** *(11/01/2014 – 10/30/2015)*			
Number non-clinical staff trained by CDPH/Office of AIDS or its agents to perform HCV rapid testing			**5.2**
Number of FTEs who perform on-site phlebotomy			**2.0**
Number of FTEs dedicated to HCV linkages to care			**1.0**
Number of FTEs dedicated to HCV education, outreach, support groups, and other services			**4.2**
Does your organization have a current Clinical Laboratory Improvements Act (CLIA) certificate of waiver to perform rapid HIV and/or HCV testing?			**☒Yes ☐ No**
Number of injection drug users (IDUs) served in any capacity in the past year			unknown
HCV Testing and Linkages to Care Services *(Please indicate the number of clients who have received the following services in the past reporting period / year, if known).**	**IDU**	**Non-IDU**	**Total**
Number of clients who *received* HCV antibody testing	**401**	**121**	**522**
➢ Number tested via HCV OraQuick	**401**	**121**	**522**
➢ Number tested via conventional testing (blood draw)	**0**	**0**	**0**
➢ Number tested via Home Access	**0**	**0**	**0**
Number of persons tested for HCV antibody who tested *negative*	**304**	**76**	**380**
➢ Number of persons who tested negative and received their results	**304**	**76**	**380**
➢ Number of persons who tested negative and received their results and were referred to a syringe services program	**304**	**0**	**304**
➢ Number of persons who tested negative and received their results and were referred to substance use services	**75**	**19**	**94**
Number of persons who tested HCV antibody *positive/reactive*	**136**	**6**	**142**
➢ Number of persons who tested HCV antibody positive/reactive and received their results	**136**	**6**	**142**
➢ Number of persons who tested HCV antibody positive/reactive and received their results and were referred to follow-up HCV ribonucleic acid (RNA) testing	**130**	**5**	**135**
➢ Number of persons referred for *on-site* HCV RNA testing	**67**	**3**	**70**
➢ Number of persons referred for *off-site* HCV RNA testing	**63**	**2**	**65**
➢ Number of persons who received HCV RNA testing (if known)	**67**	**3**	**70**
➢ Number of persons who received HCV RNA testing and had a positive HCV RNA test result (if known)	**58**	**2**	**60**
➢ Number of persons with a positive HCV RNA test result who were referred to care (if known)	**58**	**2**	**60**
➢ Number of persons with a positive HCV RNA test result who were referred to care and attended their first medical appointment (if known)	unknown	unknown	unknown

* Report data for the most recent year for which data are available and indicate start/end dates of the reporting year (for example, 07/01/2014 – 06/30/2015).

Attachment C: Organizational Capacity Supplemental Assessment Form— Goal 2: Hepatitis C Testing and Linkages to Care

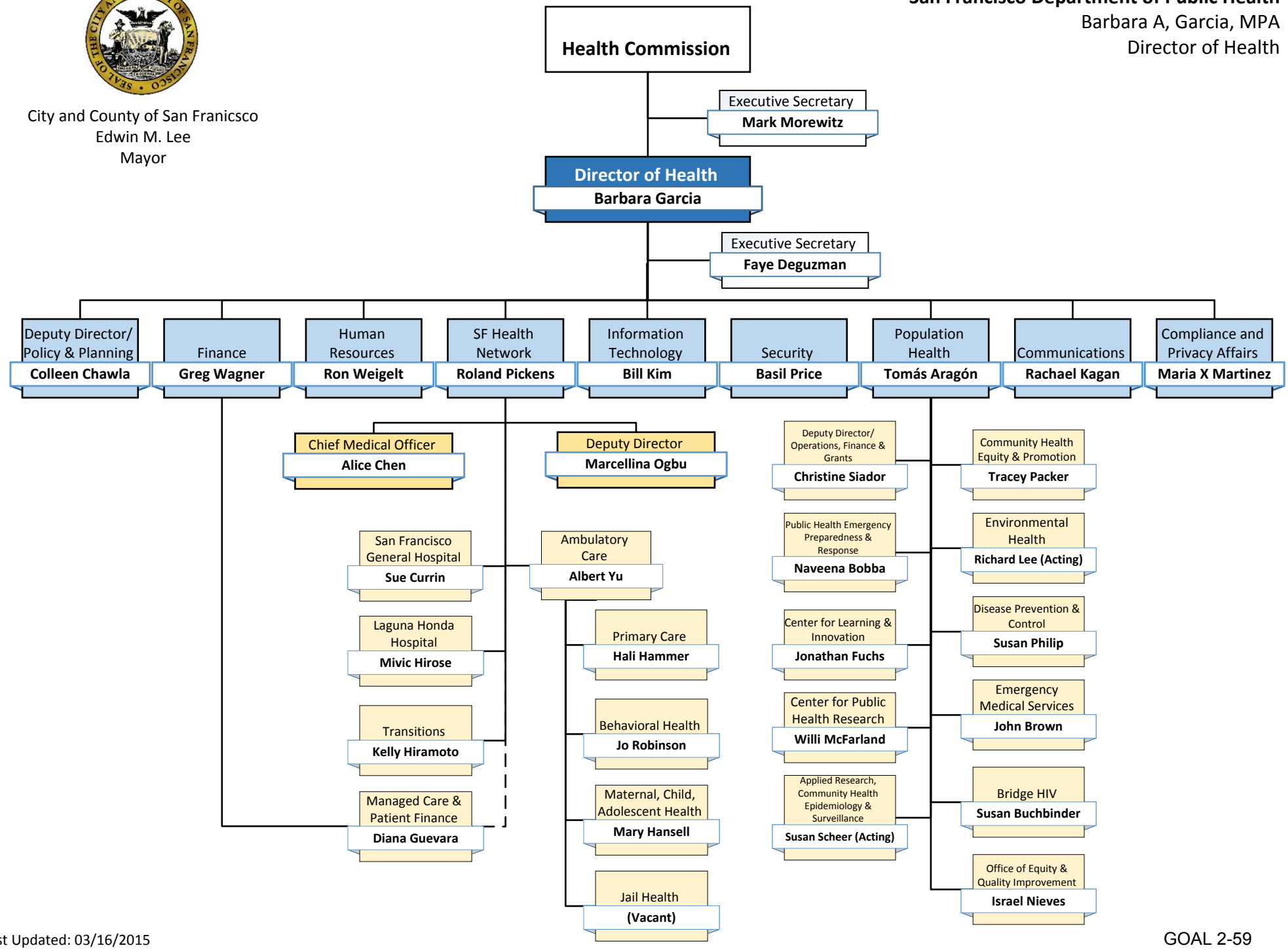
Organizational Capacity			Number
San Francisco AIDS Foundation			--
Reporting Period /Year** *(11/01/2014 – 10/31/2015)*			--
Number non-clinical staff trained by CDPH/Office of AIDS or its agents to perform HCV rapid testing			6
Number of FTEs who perform on-site phlebotomy			4
Number of FTEs dedicated to HCV linkages to care			0
Number of FTEs dedicated to HCV education, outreach, support groups, and other services			0
Does your organization have a current Clinical Laboratory Improvements Act (CLIA) certificate of waiver to perform rapid HIV and/or HCV testing?			☒Yes ☐ No
Number of injection drug users (IDUs) served in any capacity in the past year			12,000
HCV Testing and Linkages to Care Services *(Please indicate the number of clients who have received the following services in the past reporting period / year, if known).**	**IDU**	**Non-IDU**	**Total**
Number of clients who *received* HCV antibody testing			179
➢ Number tested via HCV OraQuick	115	64	179
➢ Number tested via conventional testing (blood draw)			0
➢ Number tested via Home Access			0
Number of persons tested for HCV antibody who tested *negative*	105	64	179
➢ Number of persons who tested negative and received their results	105	64	179
➢ Number of persons who tested negative and received their results and were referred to a syringe services program	105	0	105
➢ Number of persons who tested negative and received their results and were referred to substance use services	NA	NA	NA
Number of persons who tested HCV antibody *positive/reactive*	10	0	10
➢ Number of persons who tested HCV antibody positive/reactive and received their results	10	0	10
➢ Number of persons who tested HCV antibody positive/reactive and received their results and were referred to follow-up HCV ribonucleic acid (RNA) testing	10	0	10
➢ Number of persons referred for *on-site* HCV RNA testing	10	0	10
➢ Number of persons referred for *off-site* HCV RNA testing	0	0	0
➢ Number of persons who received HCV RNA testing (if known)	10	0	10
➢ Number of persons who received HCV RNA testing and had a positive HCV RNA test result (if known)	9	0	9
➢ Number of persons with a positive HCV RNA test result who were referred to care (if known)	9	0	9
➢ Number of persons with a positive HCV RNA test result who were referred to care and attended their first medical appointment (if known)	NA	NA	NA

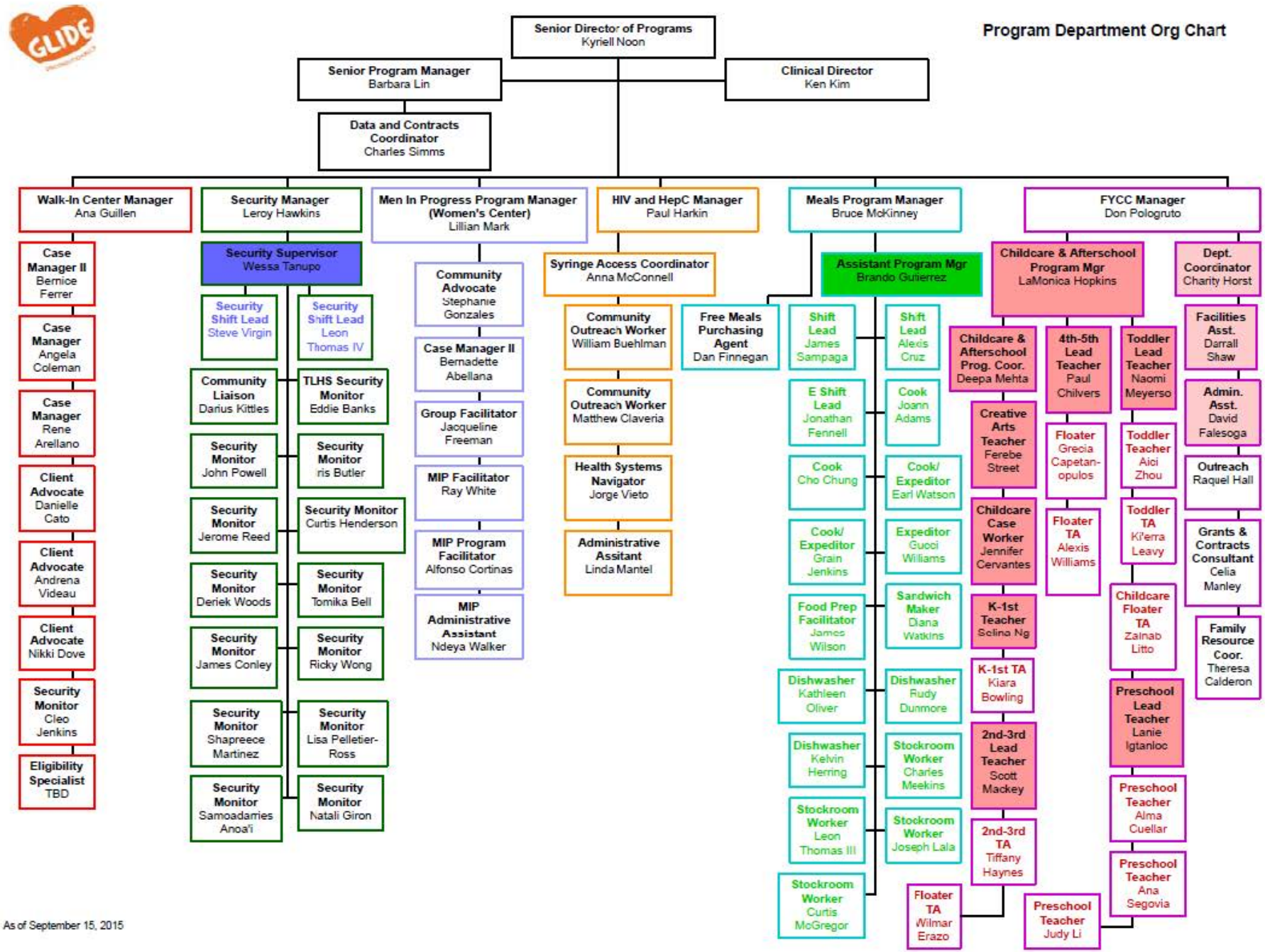
* Report data for the most recent year for which data are available and indicate start/end dates of the reporting year (for example, 07/01/2014 – 06/30/2015).

Exhibit A

City and County of San Franicsco
Edwin M. Lee
Mayor

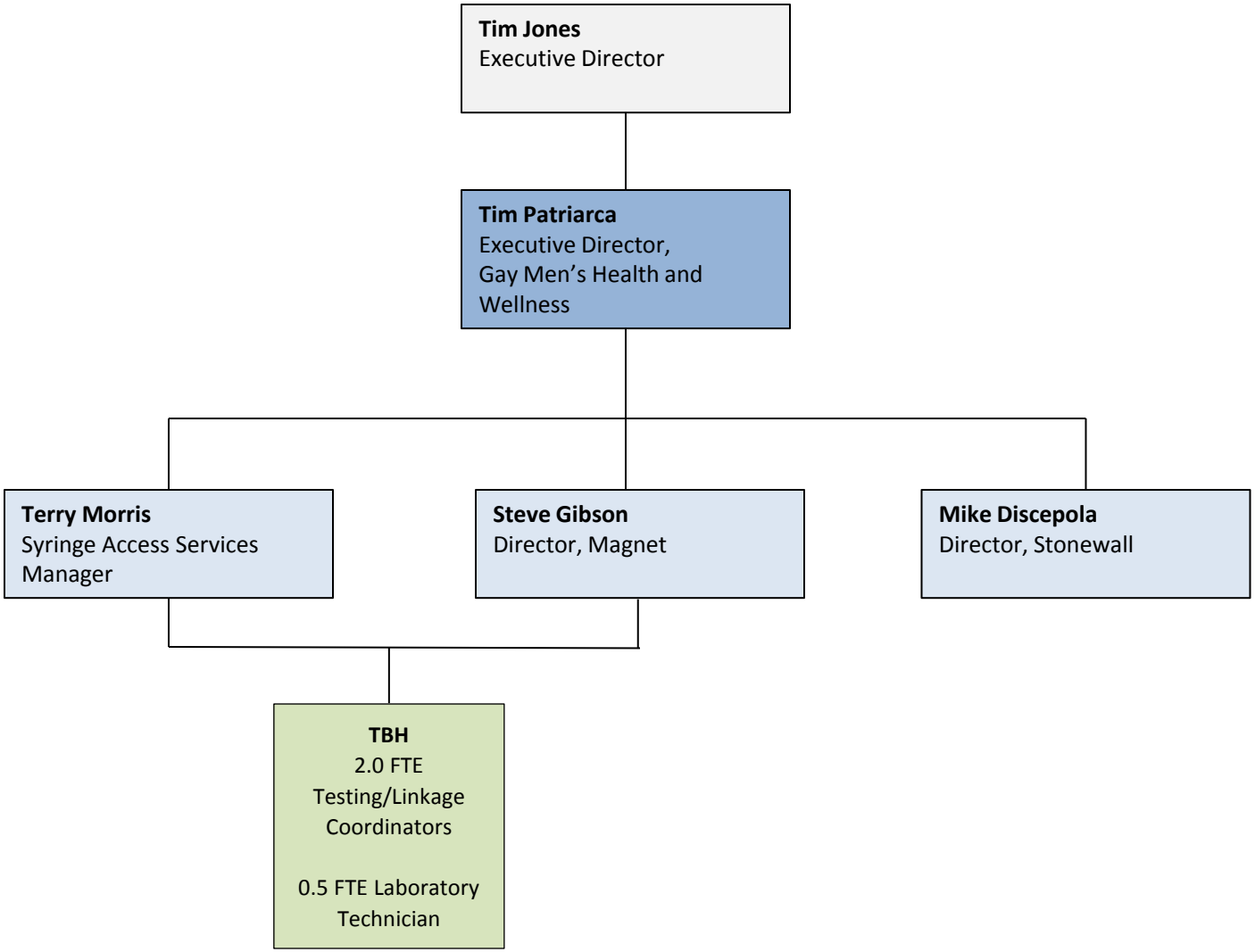
San Francisco Department of Public Health
Barbara A, Garcia, MPA
Director of Health




Program Department Org Chart
Senior Director of Programs
Kyriell Noon
Senior Program Manager
Barbara Lin
Clinical Director
Ken Kim
Data and Contracts Coordinator
Charles Simms
Walk-In Center Manager
Ana Guillen
Case Manager II
Bernice Ferrer
Case Manager
Angela Coleman
Case Manager
Rene Arellano
Client Advocate
Danielle Cato
Client Advocate
Andrena Videau
Client Advocate
Nikki Dove
Security Monitor
Cleo Jenkins
Eligibility Specialist
TBD
Security Manager
Leroy Hawkins
Security Supervisor
Wessa Tanupo
Security Shift Lead
Steve Virgin
Security Shift Lead
Leon Thomas IV
Community Liaison
Darius Kittles
TLHS Security Monitor
Eddie Banks
Security Monitor
John Powell
Security Monitor
ris Butler
Security Monitor
Jerome Reed
Security Monitor
Curtis Henderson
Security Monitor
Deriek Woods
Security Monitor
Tomika Bell
Security Monitor
James Conley
Security Monitor
Ricky Wong
Security Monitor
Shapreece Martinez
Security Monitor
Lisa Pelletier-Ross
Security Monitor
Samoadarries Anoa'i
Security Monitor
Natali Giron
Men In Progress Program Manager (Women's Center)
Lillian Mark
Community Advocate
Stephanie Gonzales
Case Manager II
Bernadette Abellana
Group Facilitator
Jacqueline Freeman
MIP Facilitator
Ray White
MIP Program Facilitator
Alfonso Cortinas
MIP Administrative Assistant
Ndeya Walker
HIV and HepC Manager
Paul Harkin
Syringe Access Coordinator
Anna McConnell
Community Outreach Worker
William Buehlman
Community Outreach Worker
Matthew Claveria
Health Systems Navigator
Jorge Vieto
Administrative Assitant
Linda Mantel
Meals Program Manager
Bruce McKinney
Free Meals Purchasing Agent
Dan Finnegan
Assistant Program Mgr
Brando Gutierrez
Shift Lead
James Sampaga
Shift Lead
Alexis Cruz
E Shift Lead
Jonathan Fennell
Cook
Joann Adams
Cook
Cho Chung
Cook/ Expeditor
Earl Watson
Cook/ Expeditor
Grain Jenkins
Expeditor
Gucci Williams
Food Prep Facilitator
James Wilson
Sandwich Maker
Diana Watkins
Dishwasher
Kathleen Oliver
Dishwasher
Rudy Dunmore
Dishwasher
Kelvin Herring
Stockroom Worker
Charles Meekins
Stockroom Worker
Leon Thomas III
Stockroom Worker
Joseph Lala
Stockroom Worker
Curtis McGregor
FYCC Manager
Don Pologruto
Childcare & Afterschool Program Mgr
LaMonica Hopkins
Childcare & Afterschool Prog. Coor.
Deepa Mehta
Creative Arts Teacher
Ferebe Street
Childcare Case Worker
Jennifer Cervantes
K-1st Teacher
Selina Ng
K-1st TA
Kiara Bowling
2nd-3rd Lead Teacher
Scott Mackey
2nd-3rd TA
Tiffany Haynes
Floater TA
Wilmar Erazo
4th-5th Lead Teacher
Paul Chilvers
Floater
Grecia Capetan-opulos
Floater TA
Alexis Williams
Preschool Teacher
Judy Li
Toddler Lead Teacher
Naomi Meyerso
Toddler Teacher
Aici Zhou
Toddler TA
Ki'erra Leavy
Childcare Floater TA
Zainab Litto
Preschool Lead Teacher
Lanie Igtanloc
Preschool Teacher
Alma Cuellar
Preschool Teacher
Ana Segovia
Dept. Coorcinator
Charity Horst
Facilities Asst.
Darrall Shaw
Admin. Asst.
David Falesoga
Outreach
Raquel Hall
Grants & Contracts Consultant
Celia Manley
Family Resource Coor.
Theresa Calderon
As of September 15, 2015

San Francisco AIDS Foundation
Client Services Organizational Chart

RFA 15-10749: Hepatitis C Testing and Linkages to Care Demonstration Project



Statement of Need

Hepatitis C is a critical problem in San Francisco (SF); among California counties with >100,000 population, SF had the highest rate of newly reported hepatitis C (HCV) cases in 2011.[1] From 2008 through 2011, 11,843 unique individuals with HCV positive lab results were reported to the San Francisco Department of Public Health (SFDPH), among a total population of 805,235. This number undoubtedly underestimates the prevalence of HCV in SF as testing was not routinely reported in California prior to 2008. In 2013, SFDPH received over 4,950 positive HCV laboratory reports on 3,205 individuals with confirmed past or present HCV infection, of whom 1,267 people were newly reported cases. SF has the highest rate of liver cancer in the entire United States, with much of it attributable to HCV.[2] In UCSF transplant centers – among the nation's busiest – approximately 50% of the 2,421 liver transplants performed since 1998 have been for HCV-related liver failure and/or cancer.[3] Based on the 2009 Nationwide Inpatient Sample data, 2.2% of U.S. and 5.4% of SF hospitalizations were for possible HCV-related conditions.[4] Furthermore, in 2013, 53 San Franciscans died from complications of end stage liver disease, with many of those deaths also related to HCV infection.[5]

Risk factors for HCV are not collected as part of the standard reporting form submitted to the SFDPH by laboratories and medical providers. However, since 2010, SFDPH has received CDC funding to conduct enhanced surveillance on newly reported cases of HCV; 20% are randomly selected for enhanced surveillance. A 1-page data collection form is sent to the health care provider who ordered the most recent positive HCV test to request patient locating information, race/ethnicity, primary language, reason the provider ordered the test, and risk factors; the provider is also informed that SFDPH will be contacting the patient. Approximately one month after contacting the provider, the patient is contacted by telephone and a public health interview is conducted. By directly contacting patients and faxing or mailing follow-up surveys to the providers, SFDPH is able to acquire information unavailable through routine public health reporting to better characterize the population of San Franciscans who are infected with HCV. Enhanced surveillance interviews of HCV cases found that injection drug use was the HCV risk factor most frequently reported by respondents.[6]

The proposed program is specifically designed to reach those who inject drugs in the City and County of San Francisco – particularly African Americans – as those are the residents most likely to have undiagnosed HCV infection in our city. According to National HIV Behavioral Surveillance (NHBS) data, there were between 18,000-25,000 people who inject drugs (PWIDs) in SF in 2012. Of those, 83% reported ever being tested for HCV, 53% reported testing positive, 20% ever received medications for HCV and 4% were cured of HCV.[7] NHBS findings from 2005-2012 demonstrate improved health insurance coverage for PWIDs in SF, which increased from 38% in 2005 to 83% in 2012, raising the possibility of effectively managing HCV in this disproportionately impacted population. Yet we know that even within the HCV population in SF, there are further disparities. Firstly, of the 3,205 people reported to SFDPH with a HCV positive test result in 2013, 69.1% were male, 65.1% were between the ages 45-64, and 32.3% were African American,[8] despite the fact that African Americans are only 5.8% of total SF residents.[9] Secondly, of the 1,267 newly reported HCV cases in 2013, 20.6% were from people with no reported zip code of residence,

many of which are likely to be homeless or marginally-housed and seen for care at clinics that are part of the San Francisco Health Network (SFHN), the primary care system for SFDPH. Another 17.1% of these newly reported cases in 2013 were from patients with residence zip codes matching the location of the SFHN clinics participating in this proposal. A small number of providers in the SFHN treat HCV within the primary care setting, but there are not currently enough providers with this specialty knowledge to directly meet the need for services, particularly those at the highest risk for sequelae of advanced disease who would most benefit from HCV curative treatments.

Given these challenges, we see this funding as a timely opportunity to unite and expand our efforts to improve drug user health, and improve the SFDPH's capacity to meet the needs of PWIDs living with HCV. **Starting in the first full year of the grant we expect to screen at least 1,000 people per year for HCV, with about 10% of them having a reactive screen, and receiving a confirmatory NAT result. In addition, we expect to link or re-engage at least 50 people in primary care, including care for their HCV. We anticipate that approximately 100 people will be able to access HCV treatment over the course of the grant, as a result of this funding.** These numbers was determined based on our projections of the number of eligible patients likely to be seen at each of the participating clinics each year, as well as our calculations of increased capacity to serve patients once we hire the staff proposed here. We have kept our treatment numbers conservative based on our existing experience with the prior authorization process from treating patients at other large SFHN clinics.

Through this proposal, the SFHN will ensure that we are not only increasing access to HCV treatment by increasing the number of providers who treat HCV, but also that we will deliver HCV treatment in innovative ways by locating HCV treatment interventions in primary care clinics, methadone programs, and through the work of the Homeless Outreach Team. We know from our vast experience working with vulnerable populations that it is important to utilize a variety of engagement mechanisms and locations to "meet people where they are at" in the spirit of harm reduction and client centered care. To that end, the proposed program includes three components:

Part 1: Expand primary care screening and treatment capacity. The SFHN primary care clinics provide care to an urban, largely poor, population, with public or no insurance, and a growing proportion with insurance accessed through the Affordable Care Act (ACA). By our conservative calculations, there are 1533 currently active patients in the SFHN system who are living with HCV, untreated, but eligible for treatment according to the new DHCS guidelines released in July of this year. That is 46% of the total number of SFHN patients living with chronic HCV (n=3355) – a group of patients with an opportunity for cure, if we are able to build capacity such that we can meet their needs.

Part 2: Utilize primary care/methadone partnerships to increase screening and treatment. To meet the goals of our proposal, Southeast Health Center (SEHC) will partner with Bayview Hunters Point Foundation (BVHPF), a methadone program in a highly HCV-impacted, predominantly African-American neighborhood, to offer directly observed therapy (DOT) and/or group treatment visits for SEHC patients who use BVHPF services. **SEHC** serves almost 4500 active patients per year. Of those, 56% are African American, 112 are homeless, 363 are PWID, and 69% are enrolled in Medi-Cal, with an additional 9% still uninsured. **BVHPF** is a methadone clinic across the street from SEHC

that has approximately 200 actively enrolled patients at any given time. BVHPF has a patient population that is 62% African American, 75% unemployed, and 66% male. Many BVHPF patients receive primary care at SEHC, making a partnership to support DOT of HCV treatment at BVHPF logical and highly impactful.

Similarly, the Opiate Treatment Outpatient Program (OTOP) at San Francisco General Hospital (SFGH) will offer DOT services for HCV primary care patients at three SFHN clinics: the SFGH Family Health Center (FHC), General Medicine Clinic (GMC), and Positive Health Program (PHP). (DOT for patients receiving primary care at PHP will be offered in-kind, as this is already funded through an existing grant.) **OTOP** is a narcotic treatment program that currently has 578 active patients, 35% of whom are African American. 70% of patients are currently unemployed, one third of whom are also disabled; more than half are homeless or marginally housed. 79% of OTOP patients have Medi-Cal, and an additional 19% are currently uninsured. **FHC** is the largest safety-net clinic in the SFDPH network, serving as the medical home to almost 12,000 patients. 269 of these patients have been identified as living with HCV – notably, 42% of those are women and 28% are African American. **GMC** is another large clinic, serving around 6,500 patients a year in more than 30,000 clinic visits. GMC patients are 51% female and 49% male, 52% ages 45-64, and 16% African American. 70% of GMC patients were enrolled in public insurance plans in FY13-14, with 2.4% identifying as homeless at enrollment. **PHP** provides primary medical care for nearly 3,000 people living with HIV, including screening, treatment, and advanced liver support for people who are co-infected with HIV and HCV.

Part 3: Increase screening and treatment among homeless populations. Finally, the Homeless Outreach Team (SFHOT) will initiate HCV treatment and support for highly vulnerable patients in its care. SFHOT works in small teams to outreach and provide care management to homeless individuals who have severe illnesses and are at high risk of death. Services are provided by teams with expertise in the complex issues that are barriers to stability for this population. The SFHOT has over 12,000 patient encounters per year, for approximately 4,000 homeless individuals, 30% of whom are African American. 40% of SFHOT patients are current or former PWID, 60% have severe mental illness, and 80% have current or recent substance use. Each year, approximately 90% are tested for HCV antibodies, with about 20% known to be living with chronic HCV.

We determined the need for the proposed services through:

- SFHN successes with a small number of clinicians treating vulnerable patients in primary care clinic settings, and SFHN leadership discussions about how to expand on that model to replicate success throughout the wider network.
- SFDPH has held 10 different focus groups with PWIDs and people who use drugs or alcohol without injecting, to discuss issues related to substance use, HCV, harm reduction, and access to care. This includes two education-focused groups held in the SF County Jail in cooperation with Project Inform and Jail Health Services.
- Many key staff on this proposal are regular participants in a monthly case conferencing and education meeting at SFGH, for community-based HCV care providers citywide. This is a multi-disciplinary meeting attended by clinicians, pharmacists, community-based HCV screening staff, and administrators.
- SFDPH hosted a Hepatitis Planning Day in March, to conduct a visioning brainstorm and discuss concrete opportunities for intervention around HCV in SF.

Organizational Capacity

The lead agency for this project is the SFDPH, an integrated health department with two major Divisions (see the attached *Organizational Chart*): the SFHN and the Population Health Division. Our mission is to protect and promote the health of all San Franciscans, and we are recognized as a public health leader, working closely with community organizations to implement innovative, effective, evidence-based strategies and enacting policies to build healthy, safe and equitable communities. SFDPH employs more than 12,000 staff in two major hospitals, 21 primary care clinics, 28 behavioral health sites, and more than 30 branches and sections. We have offices and services locations in every neighborhood in the City, and run a state-of-the-art trauma center and inpatient hospital (SF General Hospital). The **Population Health Division** is community and client-centered with branches that specialize in health protection, health promotion, and disease prevention and control, and work together in multi-disciplinary teams to address complex community health problems such as HIV and HCV. The Division has 520 staff, approximately 90 of whom are actively engaged in prevention, surveillance and research of blood-borne viruses. The **SFHN** is the city's only complete care system, providing primary care, dentistry, emergency & trauma treatment, medical & surgical specialties, diagnostic testing, skilled nursing & rehabilitation, and behavioral health.

SFDPH has significant expertise and experience engaging PWIDs across the continuum of prevention, substance abuse, and primary care and treatment services. Having learned many important lessons about harm reduction oriented, client-centered care during the worst years of the HIV crisis, SFDPH supports broad syringe access services and low-barrier access to methadone and buprenorphine through primary care and centralized methadone clinics. We also employ highly skilled clinicians who work to retain PWIDs in primary care and chronic disease management with impressive results.

SF already has a strong HCV-related program infrastructure. The SFDPH Viral Hepatitis Coordinator spent much of 2015 completing a comprehensive HCV-related needs assessment for SFDPH, and identified five strategic goals that serve as the basis for all HCV program planning and align with CDPH's Strategic plan to address Viral Hepatitis: 1) Increase HCV awareness in affected populations; 2) Increase community and clinic-based screening; 3) Implement a linkage-to-care program for individuals living with HCV who are currently out of care; 4) Increase primary care provider capacity to treat HCV; and 5) Increase patient access to curative therapies. SFDPH is making progress on each of these goals, and funding from Goals 2 and 3 of this RFA would greatly increase SFDPH's capacity to expand its work on our own goals 1 through 5.

Currently, HCV screening happens in SF through SFHN primary care clinics, the county jail, methadone programs, residential treatment programs, and other community-based sites, including syringe access programs, single room occupancy (SRO) hotels, and mobile testing. 5300 rapid HCV tests were conducted last year, with 1000 of those in methadone programs. Three SFHN primary care clinics (though not those included in this proposal) already provide embedded office-based outpatient therapy (OBOT), with both methadone and buprenorphine tracks and few exclusion criteria.

Furthermore, SFHN has already initiated a set of processes to increase primary care physicians' capacity to treat HCV, and additional funding will enable a broader reach of this model and a specialized focus on PWID. Current design models include:

- Centralized physicians and pharmacists identified to expand primary care treatment though a new e-Referral system available to all SFHN providers, which will give SF the ability to capitalize on in-house HCV primary care expertise. The e-Referral system will provide assistance and support to primary care providers in treatment readiness, regimen selection, and follow up for their patients.
- In January 2016, a half-day HCV treatment CME has been scheduled for pharmacists, nursing staff, and clinicians interested in treating HCV in the primary care setting. This training will be facilitated by primary care providers already regularly treating HCV, with the goal of having one or more prescribing primary care provider in every SFHN clinic to further decrease treatment barriers.
- A physician at SEHC hired with 10% special project time to help coordinate HCV care within the Bayview district, one of our neighborhoods with the highest HCV burden, and the highest proportion of African American residents.

Each of these processes is already funded and underway in SF thanks to a $250,000 line item from the Mayor's budget, but they are all in beginning stages of development. This CDPH funding would be used to expand and fully integrate existing efforts within the SFHN network, and enable a specialized focus on current and former drug injectors.

In addition to the work already beginning within SFHN, SF has been funded through a multi-city grant from the Patient-Centered Outcomes Research Institute (PCORI) to compare directly-observed therapy (DOT) for HCV treatment to navigation services for PWID who are co-infected with HCV and HIV. OTOP is funded through this grant, with all patients being seen at the PHP. While this is an already-funded program, we plan to use this CDPH funding to expand this model to include mono-infected patients, linking them to FHC and GMC for treatment instead of only for those co-infected patients that can be linked with PHP. Similar to the existing PCORI model, with this funding there will be a nurse embedded at OTOP to manage DOT services for patients managing their substance use through their program, and maintain regular communication with HCV treatment providers at the two new treating primary care clinics. Two additional studies recently funded include 1) The BYE-C study, awarded to the SF Substance Abuse Research Program by the National Institute of Health. This study will compare the effectiveness of treating HCV in a small number of active PWIDs via DOT five days a week through the research cohort versus weekly dispensing of HCV medication. The SFDPH Viral Hepatitis Coordinator will regularly consult with the Principal Investigator about the study's progress, to inform our own DOT programs, and 2) Curing HCV in Incarcerated Patients (CHIP) is a Gilead-funded demonstration pilot; SFDPH's Viral Hepatitis Coordinator is on the study's advisory board. CHIP will involve treating patients with HCV in the SF County jail and referring them to community clinics via navigators if they are released mid-treatment cycle.

Further, SFDPH has an RFP currently out for our own small HCV linkage program; local money has been set aside to ensure that whichever agencies are funded will support community-based organizations and SFHN clinics citywide to ensure HCV antibody-positive clients receive confirmatory NAT, help patients successfully attend medical appointments, assist them in ACA enrollment, and provide medical case management along with navigation support for opiate replacement therapy and syringe access.

Finally, SFDPH has spent the last year assessing its HCV needs and developing a strategic plan to implement needed interventions. This multi-pronged initiative involves

support and input from the Health Commission; in November of 2015 the HCV Initiative plans were presented to the Community and Public Health Committee of the Health Commission. This formal step requires SFDPH to set metrics that create a built-in accountability for progress and continuous quality improvement. For example, one of these metrics is that we will treat at least 5% of SFHN patients living with HCV in 2016, which represents at least 168 patients. This is critical, as a recently published study demonstrated that treating even 5% of prevalent infections in a city would result in substantially reduced HCV prevalence over time – cutting prevalence by more than 60% over 50 years compared to a scenario where only those with advanced liver disease are treated for HCV.[10] With this CDPH funding, SFHN will far exceed its 5% treatment goal. **Taken together, these citywide commitments help ensure long-term sustainability of any HCV-related procedures implemented through this CDPH funding.**

In keeping with trends in health care integration, our SFHN primary care clinics seek to improve routine screening and linkage by building it into existing work flows. As such, the clinics do not have siloed HCV outreach/linkage programs, but rather encourage and incentivize routine screening for all patients at risk of HCV including PWIDs and those in the birth cohort. Once patients are identified as HCV antibody positive, providers are expected to recall the patient, discuss results, and arrange for a confirmatory NAT through the clinic. For those with positive HCV viral load, some providers are experienced enough to initiate next steps of HCV evaluation including obtaining a HCV genotype, liver function panel, and imaging to assess fibrosis. However, most patients are currently referred to an off-site hepatologist for further management and treatment decisions. Currently, most of our primary care providers do not have sufficient training to provide comprehensive, longitudinal HCV treatment, which is a major part of the work proposed here. **Client outcomes are currently tracked per clinic** using Excel spreadsheets. However, registries of patients living with HCV can be generated using the i2iTracks system, described in more detail below.

SFDPH uses the EHR system *eClinical Works*. eClinical Works does have HL7 capabilities; our current version is HL7 2.3. However, this system contains no HCV-specific templates or prompts, and is not easily updated to include these or other customized items. SFGH continues to use the older EHR, the Invision Lifetime Clinical Record (LCR), as their primary medical record system for inpatients. Both of these systems function largely as a shared repository for clinical data. However, **SFDPH also uses the i2iTracks system for population health management and analytics.** This system interfaces with both eClinical Works and LCR. This is where meaningful data tracking is done, because it allows clinicians to pull lists of patients infected with HCV based on clinical tests such as HCV antibody positivity and detectable HCV viral load, and look at individual and population health level metrics. For example, required metrics including the numbers of patients screening HCV antibody positive who receive a confirmatory NAT are easily tracked. A current limitation of the system is the tracking of HCV genotype; however, we have a pending build request that should be met during the course of the project. Though there is not currently a field to track whether a patient is a PWID, any patient can be “tagged” for future reporting as part of a specific cohort. Through this mechanism, we will work with clinicians to tag PWID in the i2i system so that they can easily be recognized during the **highly feasible aggregate, organization-level, and/or client-level data extraction processes for this program.**

In summary, **SFDPH has high capacity in each of the following ten areas:** i) We have clearly shown leadership on access to HCV care and testing issues through our OBOT pilot work, our role in the PCORI HCV grant, CHIP, and BYE-C studies, and our existing infrastructure development. ii) We have experience with PWIDs and relationships with community organizations including more than 20 years of funding syringe access services. iii) We have experience working with non-traditional collaborators, including homeless services, substance use disorders treatment, syringe exchange programs, and HIV prevention and treatment agencies - these are the very partners we have involved in this proposal. iv) Our SFHN HCV health care providers are based in the community, and already have the trust of PWIDs, as evidenced by their active patient populations. v) SFDPH has a strong relationship with the CDPH and other state and local health departments, including LA, NYC, NY State, and Seattle/King County. We've learned that it is important to build from others' experiences, especially when it comes to marginalized patient populations. vi) We have extensive experience with coordinating community-wide planning involving multiple community collaborators. Our work with the Mayor's HCV Task Force, the HIV Prevention Planning Council, and the SF Health Improvement Partnership are just a few examples of ongoing efforts to bring community collaborators together to improve health. vii) Our staff and researchers have launched multiple programs that have gone on to serve as evidence bases for work nationally, and even internationally. We have been funded for dozens of CDC demonstration projects and have implemented hundreds of evidence-based programs in the fields of HIV, HCV, and more. viii) SFDPH manages a multi-million dollar portfolio of HIV and HCV prevention, policy, surveillance, and research activities; responsibility for fiscal monitoring and oversight of government grants lies with a six member team based in the SFDPH Grants Unit and led by the Accounting Manager, who establishes, evaluates and reviews fiscal procedures to ensure internal control and compliance and manages fiscal grant audits. ix) Our research staff participates in and leads national evaluation projects, at the same time we commit to using our local data for ongoing continuous quality improvement. We concurrently manage evaluation activities for dozens of programmatic grants each year. Finally, x) SFDPH has a Public Information Officer who supports our community liaison, a staff position filled by a person with expertise at managing public relations with respect to PWID and HIV/HCV. As SF is a high profile city with vast socioeconomic inequities, this is a very familiar task for us.

Our proposed staffing plan for this project includes:

Position	FTE	Qualifications	Roles/Responsibilities	Hire date
Project Coordinator/ Analyst	0.4 FTE + existing 0.6 FTE	BS/BA, experience with data collection and analysis, interest in viral infections and PWID	Non-clinical position to coordinate initiative activities, monitor data regarding HCV Ab and NAT testing, develop evaluation and quality improvement processes	January 2016
HCV Care Champion	0.1 FTE + existing 0.1 FTE	MD, leadership and education experience, HCV treatment experience	Will help manage and guide the overall project vision and progress; will offer supervision to clinicians/pharmacists; will develop and pilot a curriculum for residents to learn about treating HCV in primary care	Already hired
Primary Care-based HCV Treatment Champion	0.1 FTE + existing 0.1 FTE	MD, experience in HCV treatment, experience with substance-using patients	Review and respond to e-Referrals coming from all SFHN clinics, support SFHN trainings, offer on-site treatment at BVHPF for SEHC patients who are on methadone	Already hired

Centralized Pharmacist	0.1 FTE + existing 0.1 FTE	PharmD, experience in HCV and HIV treatment	Support regimen selection and treatment monitoring process for primary care providers in SFHN who are treating HCV	Already hired
Registered Nurse, SFGH	0.5 FTE	RN, experience with ORT and HCV treatment	Nursing support onsite at OTOP to support management of HCV medication DOT in collaboration with FHC and GFM	May 2016
Registered Nurse, SEHC	0.5 FTE	RN, experience with ORT and HCV treatment	Nursing support onsite at BVHP to support management of HCV medication DOT in collaboration with Southeast	May 2016
Community Health Worker	1.0 FTE	BS/BA, experience with PWID and homeless	Support for HCV treatment initiative for SFHOT patients	May 2016

Proposed staffing adequately supports the proposed project, as it supplements the existing infrastructure that supports the development of capacity to treat HCV among clinicians network-wide. This allows for broader and quicker expansion of this initiative, while providing extra support where it is needed to treat more vulnerable patients targeted in this funding opportunity. As with all our work, our effectiveness will depend on the skills and expertise of our project team to deliver technically sound, culturally competent guidance. Though peers will not be hired for service delivery in this program, we will continually assess our effectiveness in treating PWIDs not only through medical outcomes, but also through qualitative exploration of their experiences working with our providers (see evaluation for more information).

SFDPH is committed to hiring staff well-qualified to serve our target populations. SFHN hires staff with a strong understanding of urban poverty and related health outcomes, drug use, and homelessness, and we heavily recruit from UCSF residency programs that train their physicians in our clinics. Particularly for clinicians in SFHN clinics, the ability to work well with PWIDs and potentially challenging patients is an absolute requirement; staff without these competencies are trained or relocated to a different position. **Our HCV Care Champion will assume responsibility of overseeing new staff hired by this funding and ensuring their competence in working with our population**, as well as their approach's alignment with the vision and values of SFDPH. Bimonthly supervision provides opportunities to assess performance and project fit for each clinician. **SFDPH is strongly committed to professional development**; all staff complete required online trainings each year, in addition to other learning opportunities. This, along with our reputation as a cutting-edge, evidence-based health department has helped us to attract some of the best professionals in our field, including those with expertise in substance use and harm reduction.

As already described, within SFDPH, **a series of clinics with existing relationships will create new partnerships to implement this program as proposed.** This includes the formal linking of BVHPF with SEHC, as well as OTOP with FHC and GMC (in addition to its existing link with PHP). In both cases, the methadone provider of the collaborative unit (BVHPF and OTOP) will offer DOT for HCV treatment with the support of its partner health clinics. The partner health clinics (SEHC, FHC, GMC, and PHP) will refer patients in need of methadone or buprenorphine to the methadone providers, and will serve as the prescribing clinic for any people with HCV who seek regular opiate substitution therapy – including becoming a medical home for anyone who does not already have a regular primary care provider. This work will be supplemented by the efforts of the SFHOT to ensure focused care for homeless residents.

Exhibit B
Budget Detail and Payment Provisions

1. Invoicing and Payment

A. Upon completion of project activies as provided in Exhibit A Grant Application, and upon receipt and approval of the invoices, the State agrees to reimburse the Grantee for activities performed and expenditures incurred in accordance with the costs specified herein.

B. Invoices shall include the grant number and shall be submitted in duplicate not more frequently than monthly in arrears to:

Christine Johnson
California Department of Public Health
STD Control Branch
MS 7320
P.O. Box 997377
Sacramento, CA 95899-7377

C. Invoices shall:

1) Be prepared on Grantee letterhead. If invoices are not on produced letterhead invoices must be signed by an authorized official, employee, or agent certifying that the expenditures claimed represent activities performed and are in accordance with Exhibit A Grant Application under this grant.
2) Bear the Grantee's name as shown on the grant.
3) Identify the billing and/or performance period covered by the invoice.
4) Itemize costs for the billing period in the same or greater level of detail as indicated in this grant. Subject to the terms of this grant, reimbursement may only be sought for those costs and/or cost categories expressly identified as allowable and approved by CDPH.
5) A final undisputed invoice for the end of each fiscal year shall be submitted for payment no more than sixty (60) calendar days following the end of each fiscal year covered in this grant agreement, unless a later or alternate deadline is agreed to in writing by the CDPH Contract Manager.

2. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this agreement does not appropriate sufficient funds for the program, this agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Grantee or to furnish any other considerations under this agreement and Grantee shall not be obligated to fulfill any provisions of this agreement.

Exhibit B
Budget Detail and Payment Provisions

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this agreement with no liability occurring to the State, or offer an agreement amendment to Grantee to reflect the reduced amount.

3. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

4. Amounts Payable

A. The amounts payable under this Grant shall not exceed:

1) $456,000 for the budget period of 02/01/16 through 06/30/16.
2) $456,000 for the budget period of 07/01/16 through 06/30/17.
3) $456,000 for the budget period of 07/01/17 through 06/30/18.

B. Payment allocations shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are fulfilled and/or goods are received.

5. Timely Submission of Final Invoice

A. A final undisputed invoice shall be submitted for payment no more than sixty (60) calendar days following the expiration or termination date of this Grant, unless a later or alternate deadline is agreed to in writing by the program Grant Manager. Said invoice should be clearly marked “Final Invoice,” indicating that all payment obligations of the State under this Grant have ceased and that no further payments are due or outstanding.

B. The State may, at its discretion, choose not to honor any delinquent final invoice if the Grantee fails to obtain prior written State approval of an alternate final invoice submission deadline.

6. Travel and Per Diem Reimbursement

Any reimbursement for necessary travel and per diem shall be at the rates currently in effect as established by the California Department of Human Resources (CalHR).

Exhibit C

Standard Grant Conditions

1. **APPROVAL:** This grant is of no force or effect until signed by both parties and approved by the Department of General Services, if required. The Grantee may not commence performance until such approval has been obtained.

2. **AMENDMENT:** No amendment or variation of the terms of this grant shall be valid unless made in writing, signed by the parties, and approved as required. No oral understanding or agreement not incorporated in the grant is binding on any of the parties. In no case shall the Department materially alter the scope of the project set forth in Exhibit A.

3. **ASSIGNMENT:** This grant is not assignable by the Grantee, either in whole or in part, without the written consent of the Grant Manager in the form of a written amendment to the grant.

4. **AUDIT:** Grantee agrees that the Department, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to this grant. Grantee agrees to maintain such records for a possible audit for a minimum of three (3) years after final payment or completion of the project funded with this grant, unless a longer period of records retention is stipulated. Grantee agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Grantee agrees to include a similar right of the State to audit records and interview staff in any subcontract related to the project.

5. **CONFLICT OF INTEREST:** Grantee certifies that it is in compliance with all applicable state and/or federal conflict of interest laws.

6. **INDEMNIFICATION:** Grantee agrees to indemnify, defend, and save harmless the State, its officers, agents, and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the project, and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by Grantee in the performance of any activities related to the project.

7. **FISCAL MANAGEMENT SYSTEMS AND ACCOUNTING STANDARDS:** Grantee agrees that, at a minimum, its fiscal control and accounting procedures will be sufficient to permit tracing of all grant funds to a level of expenditure adequate to establish that such funds have not been used in violation of any applicable state or federal law, or the provisions of this grant. Grantee further agrees that it will maintain separate project accounts in accordance with generally accepted accounting principles.

Exhibit C

Standard Grant Conditions

8. **GOVERNING LAW:** This grant is governed by and shall be interpreted in accordance with the laws of the State of California.

9. **INCOME RESTRICTIONS:** Grantee agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Grantee under this grant shall be paid by the Grantee to the Department, to the extent that they are properly allocable to costs for which the Grantee has been reimbursed by the Department under this grant.

10. **INDEPENDENT GRANTEE:** Grantee, and its agents and employees of Grantee, in the performance of the project, shall act in an independent capacity and not as officers, employees, or agents of the Department.

11. **MEDIA EVENTS:** Grantee shall notify the Department's Grant Manager in writing at least twenty (20) working days before any public or media event publicizing the accomplishments and/or results of the project and provide the opportunity for attendance and participation by Department's representatives.

12. **NO THIRD-PARTY RIGHTS:** The Department and Grantee do not intend to create any rights or remedies for any third-party as a beneficiary of this grant or the project.

13. **NOTICE:** Grantee shall promptly notify the Department's Grant Manager in writing of any events, developments, or changes that could affect the completion of the project or the budget approved for this grant.

14. **PROFESSIONALS:** Grantee agrees that only licensed professionals will be used to perform services under this grant where such services are called for.

15. **RECORDS:** Grantee certifies that it will maintain project accounts in accordance with generally accepted accounting principles. Grantee further certifies that it will comply with the following conditions for a grant award as set forth in the Request for Applications (Exhibit D) and the Grant Application (Exhibit A).

    - Establish an official file for the project which shall adequately document all significant actions relative to the project;
    - Establish separate accounts which will adequately and accurately depict all amounts received and expended on this project, including all grant funds received under this grant;
    - Establish separate accounts which will adequately depict all income received which is attributable to the project, especially including any income attributable to grant funds disbursed under this grant;
    - Establish an accounting system which will adequately depict final total costs of the project, including both direct and indirect costs; and

Exhibit C

Standard Grant Conditions

- Establish such accounts and maintain such records as may be necessary for the state to fulfill federal reporting requirements, including any and all reporting requirements under federal tax statutes or regulations.

16. **RELATED LITIGATION:** Under no circumstances may Grantee use funds from any disbursement under this grant to pay for costs associated with any litigation between the Grantee and the Department.

17. **RIGHTS IN DATA:** Grantee and the Department agree that all data, plans, drawings, specifications, reports, computer programs, operating manuals, notes, and other written or graphic work submitted under Exhibit A in the performance of the project funded by this grant shall be in the public domain. Grantee may disclose, disseminate, and use in whole or in part, any final form, data, and information received, collected, and developed under this project, subject to appropriate acknowledgment of credits to the Department for financial support. Grantee shall not utilize the materials submitted to the Department (except data) for any profit making venture or sell or grant rights to a third-party who intends to do so. The Department has the right to use submitted data for all governmental purposes.

18. **VENUE:** The Department and Grantee agree that any action arising out of this grant shall be filed and maintained in the Superior Court, County of Sacramento, California. Grantee waives any existing sovereign immunity for the purposes of this grant, if applicable.

Exhibit A
Scope of Work

Goal 1: Using Surveillance to Improve Hepatitis C Virus (HCV) Outcomes

Description: Increase the proportion of clients with a reactive hepatitis C antibody test who receives follow-up HCV nucleic acid testing (NAT) and appropriate clinical management.

☐ Participating in Using Surveillance to Improve HCV Outcomes ☒ Not participating in Using Surveillance to Improve HCV Outcomes

The Grantee implementing Goal 1 (Using Surveillance to Improve HCV Outcomes) is responsible for completing the activities that have been selected by the placement of an "X" in the check box under Goal 1. A number of these activities are mandatory requirements for funding, indicated with an "X". Other activities are optional, based upon local program need and resources. Please indicate which of these additional activities your organization will pursue by placing an "X" in the appropriate check box.

Activities	Performance Indicators/Deliverables	Reporting Timeline
Measurable Objective: I. Identify clients reported through public health surveillance with a positive anti-HCV test, but no HCV NAT result and request the ordering provider requests HCV NAT.		
☒ A. Select a sample of living clients reported through public health surveillance with a positive HCV antibody test result but no HCV NAT result for provider follow-up. **(Required Activity)**	A. Number and percentage of clients reported through public health surveillance with a positive anti-HCV test result and no known HCV NAT result selected for follow-up.	Monthly [e.g., in the California Reportable Disease Information Exchange (CalREDIE)].
☒ B. Contact the provider who ordered the anti-HCV test to determine whether HCV NAT has been conducted, request that HCV NAT be ordered if not previously conducted and if indicated, and to conduct follow-up, as needed. **(Required Activity)**	B. Provider fax-back forms completed and entered.	Monthly (e.g., in CalREDIE).
☒ C. Ensure HCV NAT is conducted if indicated (e.g., by monitoring incoming paper and/ or electronic laboratory reports and by contacting the ordering provider as needed). **(Required Activity)**	C. Percent of clients reported through public health surveillance (e.g., in CalREDIE) with a positive anti-HCV test result known to have received HCV NAT.	Monthly (e.g., in CalREDIE).

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
Optional: **Place a checkmark in the box only if Grantee plans to participate in optional activities.**		
☐ D. For clients with a positive HCV NAT result, determine whether the client is in care and has received appropriate clinical management and/or treatment.	D. Number of clients with positive HCV NAT who receive the following key clinical management services, if indicated: Hepatitis A and Hepatitis B vaccination (or testing for immunity); HCV genotype testing; liver disease staging (including using non-invasive methods); HCV treatment.	Monthly (e.g., in CalREDIE).

SOW Narrative: *Briefly describe the specific methods and approaches that will be used to complete the activities selected for this objective. Briefly describe the anticipated scope of the proposed activities and a projected timeline, including the approximate beginning and ending month and year for each major activity.*

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
Measurable Objective: II. Partner with ordering providers to identify and address policy and system barriers to ensure all clients with a positive HCV antibody test receives follow-up HCV NAT.		
☒ A. Identify ordering providers with a high volume of clients reported through public health surveillance with a reactive anti-HCV test but no known HCV NAT result. **(Required Activity)**	A. Number of high volume providers identified for follow-up.	Quarterly for each fiscal year
☒ B. Convene ordering providers, medical directors, laboratory representatives, administrators, and/or other health systems leaders to assess policy and systems barriers to completing HCV NAT following a positive anti-HCV test (and, if HCV NAT positive, recommended hepatitis C clinical management services) and to identify potential policy and systems-level solutions for addressing barriers. **(Required Activity)**	B. Number of partners convened and outcome of convening, including potential policy solutions identified.	Quarterly for each fiscal year
☒ C. Explore the feasibility of implementing at least one policy or systems-level solution for ensuring that clients with a positive anti-HCV result receive follow-up HCV NAT and, if HCV NAT positive, recommend hepatitis C clinical management services. **(Required Activity)**	C. Number of policy solutions for which feasibility has been assessed and the results of the feasibility assessment.	Quarterly for each fiscal year
Optional: **Place a checkmark in the box only if Grantee plans to participate in optional activities.** ☐ D. Implement at least one policy or systems-level solution for assuring all clients with a positive anti-HCV test receive HCV NAT.	D. Number of policy solutions implemented and description of results.	Quarterly for each fiscal year
☐ E. Participate in task forces, work groups, and/or partnerships with health plans, community health centers (CHCs), community-based organizations (CBOs), hepatitis C	E. Number and type of activities conducted with task forces, work groups, and/or partnerships and outcomes of activities.	(Quarterly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
specialists, laboratories, pharmacies, and/or other partners to identify and leverage resources for improving hepatitis C screening, diagnosis, and linkages to care for vulnerable and underserved clients in designated jurisdictions.		

SOW Narrative: *Briefly describe the specific methods and approaches that will be used to complete the activities selected for this objective. Briefly describe the anticipated scope of the proposed activities and a projected timeline, including the approximate beginning and ending month and year for each major activity.*

Total Cost to Implement Goal 1:

- **Year 1:** $0
- **Year 2:** $0
- **Year 3:** $0

Exhibit A
Scope of Work

Goal 2: Hepatitis C Testing and Linkage to Care (LTC)

Description: Increase local health jurisdictions (LHJs) and community-based organizations (CBOs) capacity for and delivery of hepatitis C screening, testing, and linkages to care services to vulnerable and underserved clients at high risk for hepatitis C.

☒ Participating in Hepatitis C Testing and LTC ☐ Not participating in Hepatitis C Testing and LTC

The Grantee implementing Goal 2 (Hepatitis C Testing and Linkage to Care (LTC)) is responsible for completing the activities that have been selected by the placement of an "X" in the check box under Goal 2. A number of these activities are mandatory requirements for funding, indicated with an "X". Other activities are optional, based upon local program need and resources. Please indicate which of these additional activities your organization will pursue by placing an "X" in the appropriate check box.

Activities	Performance Indicators/Deliverables	Reporting Timeline
Measurable Objective: I. Provide outreach and hepatitis C screening, testing, and active linkages to care for vulnerable and underserved clients at high risk for hepatitis C infection.		
☒ A. Promote hepatitis C screening, testing, and linkages to care among clients living with and at high risk for hepatitis C, by educating clients about recent changes in hepatitis C treatment. **(Required Activity)** • *Glide has been a leader with a social marketing campaign to this effect; with in-kind money this campaign is being expanded to the San Francisco AIDS Foundation (SFAF) and other community organizations that serve people who inject drugs (PWIDs) in community-based HCV screening efforts.* • *Staff at Glide are regularly provided training about updated treatment information via HCV-specific training offered through a collaboration of SFDPH and Project Inform, and supported to provide information about these changes to their clients in every client encounter.* • *Glide will implement monthly harm reduction support; HCV will be a key topic of focus.*	A. Description of hepatitis C screening, testing, and linkage to care promotion activities among clients living with and at high risk for hepatitis C, including by educating clients about recent changes in hepatitis C treatment. • *The San Francisco Department of Public Health (SFDPH) Viral Hepatitis Coordinator will convene and facilitate monthly meetings with Glide leadership, as well as any agencies funded through the SFDPH HCV Linkage RFP. At these meetings the agencies will be responsible for reporting their education-related activities as collected on projects logs, and the SFDPH Coordinator will be responsible for collecting this information and summarizing it for quarterly reporting to CDPH.*	Quarterly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
☒ B. Conduct outreach to clients at high risk for hepatitis C who are unaware of their hepatitis C infection status, including clients with a positive anti-HCV test who never received HCV NAT and other clients at risk who did not receive follow-up services. **(Required Activity)** • *Glide currently does street outreach 3 days a week, for a total of 8 hours a week with 5.2 full-time equivalent (FTE) of staff who provide outreach. With funding from this proposal, that will increase to 12 hours a week over 4 days, during which clients will receive HCV education, linkage to HCV screening, and referrals to other services. With this proposal, Glide will be able to reach 8,000 more people a year through outreach, bringing their street outreach contacts to a total of 27,000 a year.*	B. Description of outreach activities to clients at high risk for hepatitis C who are unaware of their hepatitis C infection status, including clients with a positive anti-HCV test who never received HCV NAT and other clients at risk who did not receive follow-up services. • *Glide tracks all syringe access services, street outreach services, and overdose prevention trainings in Excel spreadsheets. All human immunodeficiency virus (HIV)/HCV testing is tracked in EvaluationWeb with reports compiled each month for DPH and other partners.* • *The SFDPH Coordinator will be responsible for collecting this information and summarizing it for quarterly reporting to CDPH.*	Quarterly for each fiscal year
☒ C. Assess risk factors to identify clients at high risk for hepatitis C who should be offered HCV or integrated HIV/HCV screening. **(Required Activity)** • *Potential clients of Glide are regularly assessed for current or former injection drug use or other high risk for HCV. A screening form is used that prompts staff and volunteers to assess risk and offer testing as appropriate (see Appendix).*	C. Client-level risk factor data for persons tested for HCV. • *Answers to questions on HCV screening forms are routinely send to SFDPH and data entered into the ISHTR data system.*	Monthly for each fiscal year
☒ D. Provide anti-HCV screening and client-centered results disclosure for clients at high risk for hepatitis C. **(Required Activity)** • *Glide will hire 2.0 FTE test counselors (cross-trained as HCV Navigators, including 1.0 FTE also cross-trained as a phlebotomist), who will assist Glide in expanding and routinizing their current HCV screening program and increasing their number of HCV tests to 700 per year. Glide currently tests in their main*	D. Number of clients tested for anti-HCV (injection drug user (IDU) vs. non-IDU); number who test positive; number who test negative • *All HCV tests are currently tracked on a standardized form within all community organizations funded by SFDPH, and submitted to SFDPH for data entry. Forms will be collected by test counselors at the community sites, and sent to SFDPH for data entry with the data entry staff person funded through this grant.*	Monthly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
building, at all syringe access shifts, and at venue-based testing including street fairs, shelters, and the drop-in at the SF Drug User's Union.		
☒ E. Offer clients with ongoing hepatitis C risk behaviors referrals to HCV prevention resources, such as syringe access services and substance use disorder treatment. **(Required Activity)** • *Glide operates syringe access sites through the San Francisco Syringe Access Collaborative. Information about these services is already readily available and is actively promoted at every client encounter where current injection drug use is reported or suspected.* • *Clients of Glide can also be referred to the Office Based Opioid Treatment (OBOT) Buprenorphine Induction Clinic at 1080 Howard Street for same-day buprenorphine treatment.*	E. Number of clients who report injecting drugs within the past 12 months who are referred to syringe access and/or substance use disorder treatment services. • *If funded, this information will be tracked and data entered per CDPH protocols.*	Monthly for each fiscal year [in Local Evaluation Online (LEO)]
☒ F. For clients with a positive anti-HCV test result, request and, where obtained, verify complete client contact information and permission to contact clients for follow-up. **(Required Activity)** • *All community-based agencies that test for HCV in San Francisco use a standardized screening form (see Appendix); this form is designed specifically to collect multiple forms of contact information and is completed every time a client undergoes a HCV screening test.*	F. Completed client tracking logs available upon request. • *This information is tracked via the San Francisco HCV Screening form and submitted to SFDPH for review and data entry. If funded, we will adapt the screening form to reduce redundancy but retain critical pieces such as the contact information data collection.*	Quarterly for each fiscal year
☒ G. Ensure clients with a reactive anti-HCV test result receive HCV NAT through: a) on-site, same day venipuncture; b) partnership with a private or public health laboratory that offers NAT; and/or c) active linkages to a primary care site that offers HCV NAT. **(Required Activity)** • *Glide will hire and train at least a 0.5 FTE*	G. Number of clients (IDU vs. non-IDU) with a positive anti-HCV test result who received HCV ribonucleic acid (RNA) testing (on-site vs. off-site). • *If funded, this information will be tracked and data entered into per CDPH protocols.*	Monthly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
phlebotomist so that on-site, same day venipuncture is available 100% of the time HCV screening is offered.		
☒ H. Ensure clients tested for HCV NAT receive their NAT results. **(Required Activity)** • *If a client who has blood drawn for an HCV NAT doesn't return for their results at their scheduled appointment, by SFDPH policy the agency must make at least 3 attempts to contact the client in the two weeks following the missed appointment, and document this. With this grant there will be capacity for the HCV Linkage Team to do further intensive follow-up to ensure results disclosure.*	H. Number of clients (IDU vs. non-IDU) tested for HCV RNA who receives their results. • *If funded, this information will be tracked and data entered into ISHTR per CDPH protocols.*	Monthly for each fiscal year
☒ I. Ensure clients with a positive NAT attend their first medical appointment. **(Required Activity)** • *With the funding through this grant, Glide will hire 2.0 FTE HCV Navigators, in addition to a Senior Navigator/Case Manager to assist with treatment access at Glide. A Navigator will be available at all screening shifts at Glide, in which case an appointment can be made for the next day and a warm handoff arranged.*	I. Number of clients (IDU vs. non-IDU) with a positive HCV RNA test result who attend their first medical appointment. • *If funded, this information will be tracked and data entered per CDPH protocols.*	Monthly for each fiscal year
☒ J. Provide active linkages to care for any client who is HIV positive according to established HIV linkage to care protocols and document linkage. **(Required Activity)** • *All patients who are HIV positive and not already engaged in HIV care will be actively linked to the Positive Health Program (PHP) at the San Francisco General Hospital (SFGH) via warm handoff or navigation through the SFDPH HIV Linkage, Integration, Navigation, and Comprehensive Services (LINCS) program if needed.*	J. Summary of linkages to care activities for HCV testing clients who test HIV positive. • *If funded, this information will be tracked and data entered per CDPH protocols.*	Quarterly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
Optional: **Place a checkmark in the box only if Grantee plans to participate in optional activities.**		
☒ K. Assist clients with obtaining identification. • *Glide already has procedures to assist clients with obtaining identification, and HCV program staff will link clients to the case manager to assist with this as needed.*	K. Completed client tracking logs available upon request. • *Glide will maintain client tracking logs regarding identification support, which will be available upon request.*	Quarterly for each fiscal year
☒ L. Assist clients with enrolling in health coverage. • *Individuals who need assistance enrolling in health coverage in order to seek HCV care will be immediately linked to an eligibility counselor at the clinic at which the client wishes to seek care.*	L. Completed client tracking logs available upon request. • *Glide will maintain client tracking logs regarding linkages to health coverage enrollment, which will be available upon request.*	Quarterly for each fiscal year
☒ M. Provide transportation, accompaniment, and/or other support to assist clients in attending appointments. • *Glide regularly uses bus tokens and cab vouchers to help clients attend medical appointments, which will continue during this grant.* • *With this funding, Glide will also have the staffing to accompany clients to appointments, either dropping them off with bus tokens to get home, or accompanying them into the appointment to serve as a health advocate, upon client request.*	M. Completed client tracking logs available upon request. • *Glide will maintain client tracking logs regarding transportation support distributed and appointment accompaniment, which will be available upon request.*	Quarterly for each fiscal year
☒ N. Collaborate with health care providers after linking client to care to monitor client outcomes and support retention in care. • *Once navigation support has increased through this proposal, Glide will routinely obtain signed Release of Information forms from any willing clients who are navigating to HCV care, and then follow up with either the primary care clinician or the clinic medical case manager.*	N. Completed client tracking logs available upon request. • *Glide will maintain client tracking logs regarding check-ins and follow-up actions taken with healthcare providers, which will be available upon request. Additionally, at the monthly project team meetings the agencies will be responsible for reporting on their progress in this activity, and the SFDPH Coordinator will be*	Quarterly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
• *The Glide navigators will be a resource for the clinic, so that when a patient misses an appointment, the clinic can reach out to the agency navigator for follow-up.*	*responsible for collecting this information and summarizing it for quarterly reporting to CDPH.*	

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

SOW Narrative: *Briefly describe the specific methods and approaches that will be used to complete the activities selected for this objective. Briefly describe the anticipated scope of the proposed activities and a projected timeline, including the approximate beginning and ending month and year for each major activity.*

One of the most significant strengths of our collaborative proposal is the existing work to coordinate high-quality and integrated HCV outreach, screening, and linkage-to-care for San Franciscans. The SFDPH's Viral Hepatitis Coordinator serves on multiple action-oriented local and national HCV task forces and HCV provider meeting groups, all geared toward making sure that PWIDs and others at risk for or infected with HCV can learn their status and access high-quality care. Glide has co-located their HCV services with HIV services, overdose prevention training, Naloxone provision, and syringe access. Their "one-stop shop" model actually brings the shop to the client, allowing for multiple points of entry both at Glide and out in the community, where a PWID can access HCV testing and education, HIV testing and education, clean syringes and equipment, and life-saving Naloxone.

Under this proposal, SFDPH will supplement its already high capacity for coordination by increasing staffing for HCV-related data entry, which will help shift the burden from community agencies to the health department while increasing data quality and use. Glide will add 2.0 FTE of new staff cross-trained as HCV outreach specialists, test counselors/test technicians, and navigators. One of those staff (1.0 FTE) will be trained as a phlebotomist to ensure 100% of clients with anti-HCV reactive results receive a confirmatory HCV NAT. They will also increase the FTE of a staff psychologist to assist HCV/HIV outreach, testing, and linkage staff through open-door clinical supervision. By April 2016, Glide will have been able to expand their hours and venues for HCV screening to be on track to conduct 700 HCV tests per year, on top of its current capacity.

Activity A. Promote hepatitis C screening, testing, and linkages to care among clients living with and at high risk for hepatitis C, by educating clients about recent changes in hepatitis C treatment.

As people who have worked hard to identify and educate PWID living with HCV for years when treatment was debilitating and ineffective, it is exciting to be working in a time when Medi-Cal is prioritizing treatment for PWIDs, and people can be cured with 12 weeks of treatment that has few side-effects and a remarkable rate of success. In San Francisco, we recognize that with our existing robust syringe access and opiate replacement therapy (ORT) programs, now that effective HCV treatment is available we finally have a chance to make a real difference in chronic HCV prevalence if we work to scale up the number of patients accessing this treatment, as the work of Vickerman and colleagues has shown.[10] We know that treatment is prevention, and are committed to helping PWID in our city realize that HCV and liver damage is not inevitable – now is the time to prevent, screen, and treat.

Staff at Glide receives regular in-service training about treatment changes, and are trained and supported to provide information about these changes to their clients in every client encounter.

Additionally, through a series of focus groups funded by SFDPH and organized by Glide, the information learned was recently used to put together a social marketing campaign intended to increase understanding of HCV treatment options for PWIDs (see image to right). SFAF is one of the community organizations funded to tailor the campaign to their own agency, and begin promoting this information similar to Glide's efforts. These posters and campaign messages will serve as prompts to start conversations about HCV prevention, screening, and treatment.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

Through this proposal, Glide plans to implement some monthly harm reduction support groups for PWIDs, particularly in relation to HIV and HCV. In addition to information about how to prevent transmission to others and avoid re-infection after HCV treatment, one of the main learning objectives in these groups will be to convey updated information about HCV treatment and the advantages of screening and linking to care for people living with HCV.

Task	Anticipated client reach	Begin month	End month
Continue to promote HCV "new treatments have changed the game" social marketing campaign	>1000	March 2016	Dec 2017
Continue updating HCV outreach workers and test counselors about new HCV treatment (in-kind)	n/a	March 2016	June 2018
Implement weekly harm reduction and HCV treatment education support groups for PWID at Glide	12 per year	March 2016	June 2018

Activity B. Conduct outreach to clients at high risk for hepatitis C who are unaware of their hepatitis C infection status, including clients with a positive anti-HCV test who never received HCV NAT and other clients at risk who did not receive follow-up services.

Glide staff currently do street outreach 3 days a week (2 afternoon shifts and 2 late-night shifts), focusing on roving around street corners in the Tenderloin where PWID and people who use other substances congregate. The outreach team currently reaches 23,000 people per year during these shifts. The outreach team includes two highly credible community health outreach workers (CHOWs) who are connected with the Tenderloin and PWIDs; they distribute harm reduction supplies and give health promotion information to those they encounter. In addition to the CHOWs, the outreach team includes a health systems navigator/phlebotomist and a community peer volunteer. The team also offers on-the-spot Naloxone training. The program manager is a regular participant in street outreach, with 15 years' experience in HIV prevention in the Tenderloin. For PWID who claim to already know they are living with HCV, outreach staff are able to talk with them about whether they have ever had a confirmatory HCV NAT, what their current care status is, and whether they are aware of the new treatments and interested in being supported to access this treatment. Linkages to follow-up services are then made as appropriate. For those who are at high risk for HCV infection but are not sure of their status, the outreach workers emphasize that "new treatments have changed the game," and it is very important to be screened and linked to HCV care and treatment if positive. Frequently, the outreach team can provide "walk-back" support to facilitate a same-day test at Glide. According to internal Glide data, a high proportion of the people who come to Glide for HCV/HIV testing are recruited through this outreach. With this funding, Glide will hire 2 more people to participate in outreach (2.0 FTE), which will allow for at least 6 more hours of outreach per week, expanding outreach to a minimum of 4 days per week.

In addition to active street outreach, Glide provides information and education about HCV through other means, including outreach to single room occupancy (SRO) hotels in the Tenderloin at least once a week to do a talk for residents during pre-scheduled community meetings, communal meals, or other naturally occurring events. At these events staff and trained peer volunteers do HIV/HCV outreach, education, screening, and linkages, as well as overdose prevention trainings and events. Glide staff also provide information and education about HCV wellness during a bi-monthly program collaboration with Glide Meals on its famous "Thursday Fried Chicken Day." On this day around 1,000 people come from all around San Francisco to use the Glide meals program for lunch. Glide counselors mingle with the diners and talk about safer injection and HCV wellness while promoting HIV and HCV testing – if clients wish to test, they are walked back to a ground floor private counseling room for testing. An average of 15 people decides to test for HIV/HCV during these "Fried Chicken" outreach days.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

With funding through CDPH, Glide will also implement some harm reduction support groups These will draw PWIDs in through the provision of food, a friendly environment, and the promise of accurate information delivered in a non-judgmental format. While there, they will receive the same resources that are routinely distributed through street outreach.

Task	Anticipated client reach	Begin month	End month
Expand Glide street outreach shifts to provide HCV education and referrals	8,000 additional per year	March 2016	June 2018
Implement harm reduction and HCV treatment education support groups for PWID at Glide	12 per year	Feb 2016	June 2018

Activity C. Assess risk factors to identify clients at high risk for hepatitis C who should be offered HCV or integrated HIV/HCV screening.
During outreach activities (both street outreach shifts and during the provision of other services for Glide clients), potential clients are regularly assessed for risk factors related to HCV. The vast majority of Glide clients have risk for both HCV and HIV (unless they already know they are positive), which is why Glide typically offers integrated HIV/HCV screening at every client test session.

At both of these community sites, a screening form is used that prompts staff and volunteers to assess risk and offer testing as appropriate, using the questions shown below. (See Appendix.) This type of screening will continue within this program.

1. Have/Are you *(check all that apply)*:
- ☐ Ever used intranasal drugs
- ☐ Ever injected drugs
- ☐ Ever smoked crack or methamphetamine
- ☐ Trans Females
- ☐ MSM in PrEP demo (Magnet/SFCC only)

IF "YES" TO ANY OF ABOVE – continue:

2. Have you ever tested for hepatitis C?
- ☐ Yes *(If yes go to Q 3)*
- ☐ No
- ☐ Don't Know

3. What was the result?
- ☐ Don't Know – ***Offer Hepatitis C Test***
- ☐ Negative – ***Offer Hepatitis C Test***
- ☐ Positive ↓
  - ☐ Don't know– ***Offer Hepatitis C Test***
  - ☐ No – ***Offer Hepatitis C Test***
  - ☐ Yes → **What was the result?**
    - ☐ Don't Know– ***Offer Hepatitis C Test***
    - ☐ Negative– ***Offer Hepatitis C Test***
    - ☐ Positive– ***Refer Client to Care Provider***

Task	Anticipated client reach	Begin month	End month
Screen clients for HCV screening appropriateness during street outreach shifts	400 per year	Feb 2016	June 2018
Assess HCV risk factors for all clients who present to Glide for HIV testing	5,000 per year	Feb 2016	June 2018

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

Activity D. Provide anti-HCV screening and client-centered results disclosure for clients at high risk for hepatitis C.
Funding through this proposal will allow Glide to dramatically increase their HCV screening numbers. Glide currently offers screening using the OraQuick HCV rapid test on the 5th floor of Glide, at all their syringe access shifts, and at venue-based testing shifts including at SRO hotels, street fairs including Folsom Street Fair, Dore Alley, and Juneteenth, select homeless shelters including St. Boniface, the drop-in space at the San Francisco Drug User's Union, and the Parolee Project at 111 Taylor Street. They also often test during the Glide meal programs – one of the most well-used services run by the Glide Foundation. Screening during Glide mealtimes is particularly interesting, because the food lines at Glide are infamously long, filled with people who are largely homeless and at high risk for HCV. Glide staff creatively incentivize their HIV/HCV testing by recruiting interested individuals from the line with the promise of a free pass back to the front of the line once their test is complete. However, other than the testing shifts on the 5th floor, HIV/HCV testing at Glide is currently ad-hoc, scheduled in these other creative venues when possible and not on a consistent basis. By increasing the 5.2 FTE of outreach and testing staff to 7.2 FTE with funding from this project, Glide will be able to expand and routinize this testing work, raising their number of HCV screenings by an additional 700 tests per year. In addition to more consistent testing, Glide will consider adding testing as part of the Homeless Youth Alliance services, more shelters and drug treatment programs, and Hospitality House, a supportive, safe space for people in the Tenderloin. A phlebotomist and HCV navigator will be available at *all* times HCV screening is offered via Glide.

Task	Anticipated client reach	Begin month	End month
Provide HCV screening concurrently with HIV testing at Glide and various community venues	700	April 2016	June 2018

Activity E. Offer clients with ongoing hepatitis C risk behaviors referrals to HCV prevention resources, such as syringe access services and substance use disorder treatment.
In San Francisco, any providers that work with people at high risk for HCV, particularly PWIDs and others who use substances, are very familiar and supportive of San Francisco syringe access services. San Francisco has a long and strong history of providing these services. Through the Syringe Access Collaborative – managed by SFAF and including Glide – community providers around the city work together to offer a comprehensive network of syringe access sites 7 days a week, in varied times and locations. Information about the Syringe Access Collaborative services is already readily available and frequently shared at all locations Glide and SFAF provide services, as well as at other health clinics and community sites. Referrals to these services are extremely common and we expect this to continue throughout this grant.

Additionally, PWID in San Francisco are fortunate to have wide and low-barrier access to buprenorphine and methadone, including same-day treatment initiation if desired. In most cases, this is facilitated through the OBOT Buprenorphine Induction Clinic located at 1080 Howard Street. At this site, any PWID can walk in and begin treatment with buprenorphine that same day. This is the only model in the country where pharmacists are the primary agents involved in assessing dosing and treatment progress for OBOT, and has been an extremely successful program with new referrals made each week from primary care clinics and other community providers. In addition to buprenorphine, methadone, residential substance use disorder treatment facilities, and other more traditional forms of substance use disorder treatment, San Francisco is fortunate to have multiple harm reduction programs, including San Francisco AIDS Foundation's Stonewall Project, which offers substance use counseling and support groups for men who have sex with men (MSM) who use speed. Like with syringe access services, we expect referrals to each of these resources to continue throughout this grant.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

Task	Anticipated client reach	Begin month	End month
Referrals to syringe access services	4,000 per year	Feb 2016	June 2018
Referrals to substance use disorder treatment options	400 per year	Feb 2016	June 2018

Activity F. For clients with a positive anti-HCV test result, request and, where obtained, verify complete client contact information and permission to contact clients for follow-up.
All community-based agencies that test for HCV in San Francisco use a standardized screening form (see Appendix). The front of the form is used for all clients, recording demographics, risk factors, and the initial anti-HCV screening result. Whenever the result of the rapid screening test is reactive, the person filling out the form is required to fill out the back of the form. The back of the form is designed specifically to collect multiple forms of client contact information, so that if the client does not return for their confirmatory results, they have a better chance of being contacted. These forms are held by the agencies until at least 3 attempts to contact the client have been made in the 2 weeks after a missed appointment. At this point they are submitted to SFDPH for data entry – though if this proposal is funded, they will also be able to be referred to the HCV Linkage Team for more advanced follow-up (see Activity H).

Task	Anticipated client reach	Begin month	End month
Completion of the HCV screening form following every reactive rapid HCV test	250 per year	Feb 2016	June 2018

Activity G. Ensure clients with a reactive anti-HCV test result receive HCV NAT through: a) on-site, same day venipuncture; b) partnership with a private or public health laboratory that offers NAT; and/or c) active linkages to a primary care site that offers HCV NAT.
Currently, about 75% of the time that Glide offers HCV screening, a phlebotomist is present to offer on-site, same-day venipuncture, sent that day to the SFDPH Microbiology Lab for processing. The other 25% of the time, a return appointment is made for a time when a phlebotomist is present at Glide – that same day or the next day. With funding from this grant, Glide will ensure that one person (1.0 FTE) of the 2.0 FTE of HCV Testers/Navigators hired will be trained as a phlebotomist, bringing Glide's phlebotomy staff to a total of 3 and allowing Glide to offer on-site, same day venipuncture 100% of the time that screening is available.

Task	Anticipated client reach	Begin month	End month
Train the newly-hired HCV outreach worker/tester at Glide so they are a certified phlebotomist	n/a	May 2016	June 2016
Ensure that all clients receiving a reactive HCV screening test receive a confirmatory HCV NAT	250 per year	June 2016	June 2018

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

Activity H. Ensure clients tested for HCV NAT receive their NAT results.
If a client who has blood drawn for an HCV NAT doesn't return for their results at their scheduled appointment, by SFDPH policy the agency must make at least 3 attempts to contact the client in the two weeks following the missed appointment. These attempts must be documented on the HCV screening form, including the date of the attempt and any notes, including the method of the attempt and the outcome. If the agency is unable to contact the client after 3 attempts, they are expected to close the case and submit the form to SFDPH, usually with more detailed notes about the case written at the bottom of the form (see Appendix). If funded, more comprehensive attempts to find and link clients to services will be possible, such as home or shelter visits. This case is officially closed and the form is data entered into the local ISHTR data system. However, with funding from this grant there will be capacity for the HCV Linkage Team to do further intensive follow-up to ensure disclosure of the results.

Task	Anticipated client reach	Begin month	End month
Have a counselor available to disclose NAT results at the time of a client's appointment	160 per year	April 2016	June 2018
Attempt to contact "no-show" clients at least 3 times after a missed appointment	40 per year	April 2016	June 2018

Activity I. Ensure clients with a positive NAT attend their first medical appointment.
With the funding through this grant, Glide will have 2.0 FTE staff trained as HCV Navigators, in addition to a Senior Navigator/Case Manager to assist with treatment access at Glide. A Navigator will be available at all screening shifts at Glide.

Until now, San Francisco has only been able to officially support passive linkage for HCV – essentially, making a referral and then hoping someone goes, following up with them at subsequent encounters when possible. Some staff members at Glide have been doing more intensive linkage work on their own, but this has never been funded so the services have been wholly insufficient to meet the needs of more vulnerable and disorganized clients. However, with more HCV-specific funding to create an active linkage program for HCV, we will be able to build more meaningful relationships with treating providers, more medical case management, and more active linkage and follow-up than has ever been possible before.

Glide typically refers HIV/HCV co-infected clients to the primary care providers at the Positive Health Program at San Francisco General Hospital, which specializes in primary care for people living with HIV and has providers quite skilled in managing HCV infection. For those who are mono-infected with HCV, Glide refers most people to the on-site Tenderloin Health Services and Tom Waddell Health Center, a part of the San Francisco Health Network (SFHN). Glide first assesses people's current engagement in care, and then discusses the client's needs, including where they hang out, where they live, what other conditions they have, and what clinic makes most sense for them as their medical home. Warm handoffs to known providers are used whenever possible, but sometimes linkages are made to lesser known providers who appear to be a better fit for a particular client. Glide has the capacity to assist clients with transportation and – with the funds from this grant – will be able to accompany clients to their first appointment and even attend the visit with the client's permission, to serve as their advocate when desired (see Activity M). Additionally, Glide will offer $10 incentives for any client who attends each of their first three HCV medical appointments, to encourage the establishment of healthy habits and ultimately retention. However, oftentimes it is a matter of repeatedly checking in with clients during their long wait for their first appointment, or the appointment at which they are scheduled to begin treatment. Reminding clients when an appointment is coming up and helping them not lose faith in the bureaucratic processes of care and treatment, as well as keeping them engaged by helping them to connect with support groups, mental health services, and other psychosocial services is a key role of these community organizations and their navigators.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

Lastly, the SFDPH released an HCV Linkage RFP in December, to be funded in February 2016. This funding is focused on establishing an HCV Linkage Team for the city, modeled on the concept of the successful SFDPH HIV LINCS Program (Linkage, Integration, Navigation, and Comprehensive Services). However, the initial funding for this program is small, and will be insufficient to meet the need for HCV linkage in San Francisco. Funding for Navigation from this grant for our two largest HCV testing community agencies (as well as our SFHN primary care clinics through our Goal 3 proposal) will go a long way in helping us meet the total need. To maximize the use of funds, the SFDPH Coordinator will assure the alignment of city and state-funded linkage services with the Viral Hepatitis Strategic plans for CDPH and SFDPH.

Task	Anticipated client reach	Begin month	End month
Link to care any Glide clients living with HCV and not already in primary care	40 per year	April 2016	June 2018
Provide incentives for Glide clients who attend 3 HCV medical appointments in a row	15 per year	April 2016	June 2018

Activity J. Provide active linkages to care for any client who is HIV positive according to established HIV linkage to care protocols and document linkage.
Unlike in other cities throughout the U.S, in San Francisco almost all of our residents with known HIV infection are engaged in HIV specialty care. We have a very robust linkage and retention program known as Linkage, Integration, Navigation, and Comprehensive Services (LINCS); clinicians know that if they have patients who have not returned for care at the expected time, they can call LINCS for free assistance in finding that patient and providing the support they need to return to care. Community agencies know they can call on the LINCS team to help them find clients who have been lost to follow-up and help ensure they are retained in care. We also have a large number of talented HIV clinicians with strong skills for managing HIV/HCV co-infection with their patients when needed.

As a result of our strong HIV linkage and retention successes in San Francisco, we expect that this activity will be most relevant when patients with HCV are newly diagnosed with HIV, or are found to have fallen out of care for their HIV as a result of significant life challenges. In these cases, patients who are HIV positive will be actively linked to the PHP or another HIV specialty provider via warm handoff from Glide Navigators, or navigation through the SFDPH LINCS program if needed. The LINCS program enrolled 116 clients living with HIV in 2012-2013, and relinked 73% of them to HIV care, with 64% of those achieving HIV viral suppression at 12 months after engagement with LINCS.[16]

Task	Anticipated client reach	Begin month	End month
Connection of co-infected patients not already in care with HIV linkage folks	5 per year	Feb 2016	June 2018
Linkage and ongoing retention for co-infected patients in HIV care	4-5 per year	Feb 2016	June 2018

Activity K. Assist clients with obtaining identification.
Glide already has procedures to assist clients with obtaining identification, as loss of identification is common in this target population and identification is required in order for people to access medical care. At Glide, a client identified as needing medication can go to the ground floor walk-in center and meet with a case manager who specializes in this support. The case manager works with the client to get a temporary ID, then help them complete paperwork and navigate the

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

process to obtain an official ID from the DMV.

Glide was recently funded through a Google Challenge Grant to create a web-based system called "Home in the Cloud," where homeless clients can store images of their legal identification and other important documents through a secure cloud-based web program, and if they lose their identification they can print a new copy easily. The start date of this project is likely in the next year, and once launched this will be another resource available to Glide clients.

Task	Anticipated client reach	Begin month	End month
Link clients with case managers/navigators to get an ID in order to access medical care	40 per year	Feb 2016	June 2018

Activity L. Assist clients with enrolling in health coverage.
Anyone identified through this grant as living with HCV or at high risk for HCV and not already enrolled in health coverage will be assisted with enrolling in health coverage. Depending on eligibility, uninsured clients in San Francisco can be enrolled in Medi-Cal, Medicare, or Healthy San Francisco. Healthy San Francisco is a local program designed to make health care services available and affordable for patients who are unable to secure health coverage elsewhere (e.g., are undocumented), or choose to pay a penalty rather than enroll in a Covered California plan, as long as they make less than $54,000 a year. In these cases, individuals can be enrolled, supplied with a Healthy San Francisco identification card, and linked to a medical home within the San Francisco Health Network where they will receive all primary care services.

It is fairly common that established patients experience lapses in insurance and also require support from the eligibility worker to re-enroll. This is particularly true of clients of Glide, since they often have no mailing address and/or are unfamiliar or uncomfortable with bureaucratic steps to renew and maintain coverage.

Individuals who need assistance in enrolling in health coverage in order to seek HCV care will be immediately linked to an eligibility counselor at the clinic at which the client wishes to seek care. SFGH outpatient clinics, including the Positive Health Program, and most large primary care clinics (including Tom Waddell Health Center, Mission Neighborhood Health Center, and Tenderloin Health Services) have an eligibility worker on-site who can see new patients the same-day for eligibility screening and enrollment support. For any instances where a patient needs to make an appointment to meet with an eligibility worker at a different place or time – for instance, when they are connecting with outreach services during a late-night shift, a HCV Navigator from Glide will be available to support that linkage (for example, by physically walking them to the new location, or arranging for transportation and accompaniment when needed).

When a new patient – or an established patient whose existing coverage has lapsed - meets with the eligibility worker, that worker will screen them to determine the most suitable coverage options, and then assist them with completing the necessary paperwork and securing the required documentation in order to be enrolled. Once the application has been submitted, patients are classified as "pending approval." For Healthy San Francisco enrollees, they can receive care the same day even if premiums have not yet been paid. For patients who meet the Medi-Cal guidelines, applications can take 1-6 weeks to process. While eligibility workers thoroughly screen and are usually clear on whether approval will be granted or not, the patient is informed that if they choose to receive care before the approval is received from the state, they will receive a bill for services if for some reason the application is declined. Depending on the urgency of care needed, some patients will choose to wait, while others will proceed with care and hope that the approval will come through. For any patient who chooses to wait for Medi-Cal approval, the HCV Navigator will be put on standby to help ensure that they return for care once the approval has been processed.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

Task	Anticipated client reach	Begin month	End month
Link clients to eligibility workers at an FQHC who can assist with health coverage enrollment	100 per year	Feb 2016	June 2018

Activity M. Provide transportation, accompaniment, and/or other support to assist clients in attending appointments.
Glide regularly uses bus tokens and cab vouchers to support clients in attending medical appointments, and this will continue during the course of this grant. However, with funding from this grant both agencies will *also* have the staffing to both keep them engaged before and between medical appointments, and to accompany clients to appointments, either dropping them off with bus tokens to get home, or accompanying them into the appointment to serve as a health advocate, upon client request. This is a core part of care navigation, especially for clients with minimal resources and chaotic lives. Yet our experience has shown that with encouragement and some hand-holding to stay organized and manage the bureaucracy, most clients do quite well with following treatment regimens or other clinician recommendations for HCV care.

Task	Anticipated client reach	Begin month	End month
Support clients to attend medical appointments through transportation vouchers	72 per year	Feb 2016	June 2018
Accompany clients to appointments, whether advocating in the appointment or not	28 per year	April 2016	June 2018

Activity N. Collaborate with health care providers after linking client to care to monitor client outcomes and support retention in care.
Once navigation support has increased through this proposal, both Glide and SFAF will routinely obtain signed Release of Information forms from willing clients who are navigating to HCV care, and then follow up with either the primary care clinician or the clinic medical case manager. We have found that building good relationships with providers who excel in HCV care and treatment is one of the best ways to ensure that clients link to and are retained in care. This happens in a few ways: 1) Glide navigation staff call clients to remind them that an appointment is coming up, then ask permission to follow up to see how it went. Knowing that there will be accountability for attending the appointment – and that someone cares enough to call back – is a powerful way to motivate follow-through. 2) The community-based navigator becomes a resource for the clinic, so that when a patient misses an appointment, the clinic medical case manager or primary care clinician recognizes this and knows to reach out to the HCV Navigator at Glide for follow-up. This type of symbiotic relationship allows multiple providers to work together to ensure that people living with HCV have the best chance of managing their condition well, and ultimately being cured.

Task	Anticipated client reach	Begin month	End month
Obtain release of information forms and follow-up at least once with the provider re retention	100 per year	April 2016	June 2018
Receive provider requests to find and try to re-engage clients who have fallen out of care	45 per year	April 2016	June 2018

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
Measurable Objective: II. Increase organizational capacity in non-healthcare settings to deliver HCV screening, testing, and linkages to care through training and quality assurance.		
☒ A. Dedicate at least one staff person (50 percent FTE or greater) to HCV linkages to care. **(Required Activity)** • *With funding from this grant we will add 2.0 FTE in staffing as HCV navigators.*	A. Number of staff (FTEs) dedicated to HCV linkages to care. • *Glide staffing records, in collaboration with their respective Human Resources teams. Staffing information will be collected and summarized for reporting by the SFDPH Viral Hepatitis Coordinator.*	Quarterly for each fiscal year
☒ B. ONLY IF PERFORMING HCV RAPID TESTING: Maintain a current Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver and HCV rapid testing quality assurance plan (HCV rapid tests may be added to an existing waiver at the time of annual waiver renewal). **(Required Activity)** • *Glide currently holds a CLIA certificate of waiver, with the OraQuick HCV rapid test registered on those certificates. They will continue to maintain those waivers as required.* • *Glide developed an HCV rapid testing quality assurance plan prior to the start of HCV rapid testing.*	B. Current CLIA certificate of waiver and HCV rapid testing quality assurance plan available upon request. • *These will be made available upon request to SFDPH or CDPH at any time.*	Quarterly for each fiscal year
☒ C. ONLY IF PERFORMING HCV RAPID TESTING: Ensure that staff performing HCV rapid testing are either: **(Required Activity)** a.) Trained by the CDPH/Office of AIDS or its agents in HCV rapid test kit proficiency and finger stick proficiency in accordance with Health and Safety Code Section 120917 or b.) Medical personnel who may administer the HCV rapid test as part of their regular scope of medical practice • *If not already trained, all staff will be trained by SFDPH staff acting as agents of the CDPH/Office of AIDS in HCV rapid test kit and*	C. Number of non-clinical staff (FTEs) trained by CDPH/Office of AIDS or its agents in HCV rapid test kit proficiency and finger stick proficiency. • *Training and ongoing certification of HCV rapid testers is tracked by SFDPH in a centrally maintained database managed by the SFDPH Substance Use Program Liaison, and will be made available to CDPH upon request.* • *Testing agencies use EvaluationWeb to document their screening tests and, therefore, the SFDPH is able to verify that tests are only being conducted by certified test technicians.*	Quarterly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
finger stick proficiency before performing HCV rapid testing.		
Optional: **Place a checkmark in the box only if Grantee plans to participate in optional activities.** ☒ D. Enroll one or more staff person in training to become certified as phlebotomists in order to conduct on-site blood draws for HCV RNA testing. **(Optional Activity)** • *Of the 2.0 FTE HCV Testers/Navigators added to staff through this grant, Glide will ensure that 1.0 FTE is trained in phlebotomy, particularly to work late-night shifts. This individual will be trained and certified according to California regulations for phlebotomy certification.*	D. Number of staff (FTEs) who perform on-site phlebotomy for HCV RNA testing. • *Agencies are responsible for tracking the phlebotomy licenses of their staff and volunteers; proof of active certification will be made available to CDPH upon request.*	Quarterly for each fiscal year

SOW Narrative: *Briefly describe the specific methods and approaches that will be used to complete the activities selected for this objective. Briefly describe the anticipated scope of the proposed activities and a projected timeline, including the approximate beginning and ending month and year for each major activity.*

Activity A. Dedicate at least one staff person (50 percent FTE or greater) to HCV linkages to care.
With funding from this grant we will add 2.0 FTE in staffing as HCV navigators, for a total of 2 positions dedicated to HCV linkages to care. This adds to the existing 1.0 FTE Senior Navigator/Case Manager who focuses on HCV treatment access. At Glide, these navigators and the other 5.2 FTE of staff who regularly do HCV outreach, screening, and linkage will also find support from an on-site staff psychologist, available for open-door individual support as well as group clinical supervision on a regular basis.

Task	Begin month	End month
Hiring, orientation, and training of new staff dedicated to HCV linkages to care	Mar 2016	June 2018
Increase in the staff psychologist hours at Glide to support increased clinical supervision	Mar 2016	June 2018

Activity B. Maintain a current Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver and HCV rapid testing quality assurance plan.
Glide has held a CLIA certificate of waiver since 2003, and added the OraQuick HCV rapid test to that certificate in 2013. Glide has worked with SFDPH and the California Lab Field Services every two years, as required, to renew this certificate. Glide also developed an HCV rapid testing quality assurance plan prior to the start of testing, in the same years that the OraQuick test was added to their CLIA certificate. HCV quality assurance and technical assistance in community-based programs is provided by the SFDPH Substance Use Program Liaison, who meets regularly with the agencies, reviews adherence to protocols, troubleshoots

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

challenges in the program, and verifies program compliance with regulations.

Task	Begin month	End month
Maintain existing CLIA certificates of waiver, including the OraQuick HCV rapid test	Feb 2016	June 2018
Review and update agency-specific HCV rapid testing quality assurance plans as needed	Feb 2016	June 2018

Activity C. Ensure that staff performing HCV rapid testing are either a) trained by the CDPH/Office of AIDS or its agents in HCV rapid test kit proficiency and finger stick proficiency in accordance with the Health and Safety Code Section 120917, or b) medical personnel who may administer the HCV rapid test as part of their regular scope of medical practice.
If they have not already been trained, all staff that will perform HCV rapid testing will be trained by SFDPH staff that act as agents of the CDPH/Office of AIDS in HCV rapid test kit proficiency and finger stick proficiency. The SFDPH offers this full-day training once per quarter, and will be sure that training is scheduled in San Francisco that will allow Glide staff to hire and train staff for this project without a long waiting period. All staff at Glide will complete the training (which includes HIV rapid test technician certification, HCV test technician certification, and finger stick proficiency) and will maintain active certification according to all CDPH/SFDPH rules, which includes annual competency assessment testing and performing a minimum number of HCV tests per year.

Task	Begin month	End month
Enroll all staff not already certified to perform HCV rapid testing in the SF version of the CDPH training program	Feb 2016	Apr 2016
Maintain active certification for all HCV testers according to CDPH and SFDPH rules	Feb 2016	June 2018

Activity D. Enroll one or more staff person in training to become certified as phlebotomists in order to conduct on-site blood draws for HCV RNA testing.
Glide will ensure that 1.0 FTE of the 2.0 FTE staff hired as HCV Testers/Navigators will be trained and serve as a phlebotomist, particularly on late-night shifts. This person will both be trained and certified according to California regulations for phlebotomy certification. This includes completion of 40-hour phlebotomy training from a school approved by California Lab Field Services, passing of a California State approved phlebotomy certification exam, and completion of at least 50 venipunctures and 10 skin punctures on the job (including a minimum of 40 hours on-the-job for a person with no prior phlebotomy experience). Glide staff get their practice at San Francisco City Clinic, a municipal STD clinic nearby that also has a high volume of venipuncture for testing. The HIV/HCV program managers at each agency will be responsible for tracking their staffs' phlebotomy certification and ensuring that they complete the required continuing education and submit renewal paperwork every two years.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline	
Task		**Begin month**	**End month**
Send new phlebotomy staff from each agency to a CA-approved phlebotomy training (40 hours) and exam		Mar 2016	May 2016
Support staff in completing the required clinical hours to obtain certification		Mar 2016	June 2016
Track staff phlebotomy certification and ensure they complete required continuing education and renewal paperwork		June 2016	June 2018

Activities	Performance Indicators/Deliverables	Reporting Timeline
Measurable Objective: III. Increase community-level capacity to deliver HCV screening, testing, and linkages to care to vulnerable and underserved clients at high risk for hepatitis C through partnerships.		
☒ A. Evaluate barriers to linkages to care among program clients. **(Required Activity)** • *The cross-training of Glide staff will be used as a foundation to enable them to "see the big picture" with clients, assess their barriers to care, and develop an individual plan to overcome those barriers.*	A. Description of barriers to linkages to care among program clients identified during HCV testing pilot project. • *Navigators at Glide will be responsible for compiling client-level information about barriers and action taken to overcome them. Barriers to be documented will include both those identified by the client (e.g., feeling judged by medical staff, transportation barriers) and those identified by the navigator (e.g., mental health issues, chaotic drug use).* • *This information will be documented on standard forms, still in development. To prepare for the activities described in this proposal, the SFDPH Viral Hepatitis Coordinator has reached out to other jurisdictions for these types of forms that could be adapted for use in San Francisco; these are in the process of being adapted and will be shared with the community agencies once ready.* • *The SFDPH Viral Hepatitis Coordinator will assume ultimate responsibility for gathering, summarizing, and reporting the information collected on these forms as required by this project (in-kind).*	Quarterly for each fiscal year

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline
☒ B. Develop and maintain partnerships with health plans, CHCs, CBOs, hepatitis C specialists, laboratories, pharmacies, and/or other partners to identify and leverage resources for improving hepatitis C screening, diagnosis, and linkages to care for vulnerable and underserved individuals. **(Required Activity)** • *The SFDPH Viral Hepatitis Coordinator will continue to actively participate in a variety of citywide entities focused on HCV, including the HCV Task Force, the HCV Provider's Meeting held monthly at SFGH, and the SFDPH Substance Use Leadership Team.* • *She will also continue her role coordinating HCV testing at substance use facilities including methadone programs, as well as overdose prevention services. She will continue her leadership role in the development and implementation of the SFDPH Drug User Health Initiative as well.* • *SFAF will continue building relationships with San Francisco pharmacies and pharmacists, working with them to find ways to improve the health and wellness of PWID who come to their pharmacies, especially to purchase and dispose of syringes, or access HCV medications.*	B. Number and type of activities conducted with new and existing partnerships, coalitions, task forces, and/or work groups and outcome of those partnerships in improving hepatitis C screening, diagnosis, and linkages to care for vulnerable and underserved individuals. • *The SFDPH Viral Hepatitis Coordinator will be responsible for collecting and documenting information about these collaborations, including through information gathered from partnering agencies at the monthly project meetings, and summarizing it for quarterly reporting to CDPH.*	Quarterly for each fiscal year

SOW Narrative: *Briefly describe the specific methods and approaches that will be used to complete the activities selected for this objective. Briefly describe the anticipated scope of the proposed activities and a projected timeline, including the approximate beginning and ending month and year for each major activity.*

Activity A. Evaluate barriers to linkages to care among program clients.
At Glide, the commitment to cross-train staff is the foundation for everything they do. This is not only more convenient for clients, who can receive any service – e.g., syringe exchange, HIV prevention information, HCV screening and confirmation if needed – at any encounter with a Glide staff person or volunteer. It is also a cost-effective way to build capacity among staff and ensure that they are well-versed in the needs of the target population, not in just one part of their lives. Given this, every staff person and volunteer who works on Glide's HIV/HCV services team is very knowledgeable about the barriers to care their clients face, and strategies to overcome those barriers. Examples of this include some obvious ones such as homelessness/displacement, mental illness, or chaotic substance use. But barriers also include lack of psychosocial support, internalized stigma or fear of stigmatization when seeking services, and a fatalistic approach to life: "I'm already going to die soon enough; I'm not worried about HCV." Sometimes the barriers are simple logistics (i.e. transportation) and sometimes concern for

Activities	Performance Indicators/Deliverables	Reporting Timeline

basic needs (such as food or even access to a clean needle for the next hit) prevents a client from taking the steps necessary to fully engage with medical care for their HCV. Glide staff speak about these types of issues with clients at every encounter, from outreach to screening. For those who test HCV positive, however, with this funding the Glide Navigator will be able to more formally work with clients to assess their needs. Glide is currently exploring the feasibility of utilizing the "Psychosocial Readiness Evaluation and Preparation for Hepatitis C (Prep-C)" tool.[17] This may be one way that Glide staff will assess and document barriers; these barriers will then be addressed in many of the same ways Glide has supported clients for years, though in more well-resourced and consistent ways. For example, they address fatalism through encouragement about the new treatments ("You can get the same treatment that cured Pamela Anderson's HCV, and you can get it for free!"); they address logistical concerns with transportation vouchers and similar; they address concerns about stigma by offering to physically go with them to appointments and serve as their advocate. It is this type of empowering work that has built Glide's reputation as an outstanding place for homeless people and PWIDs to access a range of life-saving and life-improving services.

Task	Anticipated client reach	Begin month	End month
Assessment of barriers to linkages to care among clients living with HCV at SFAF and Glide	200 per year	Apr 2016	June 2018
Development and execution of a plan for each client, to overcome barriers and link to care	158 per year	April 2016	June 2018

Activity B. Develop and maintain partnerships with health plans, CHCs, CBOs, hepatitis C specialists, laboratories, pharmacies, and/or other partners to identify and leverage resources for improving hepatitis C screening, diagnosis, and linkages to care for vulnerable and underserved individuals.
There are a number of ways that SFDPH and Glide work to develop and maintain partnerships that improve systems for HCV screening, diagnosis, and linkage to care for vulnerable and underserved individuals in San Francisco. In fact, this is the primary involvement of the SFDPH in HCV work, which – while critical to the overall proposal – is provided in-kind. In her policy and coordination role, the SFDPH Viral Hepatitis Coordinator is an active member of a variety of citywide entities focused on HCV, including the HCV Task Force, the SFDPH Substance Use Leadership Team, and the monthly HCV Provider's Meeting, held monthly at San Francisco General Hospital for information sharing and case conferencing among the city's HCV experts. She is also a leader in the SFDPH Drug User Health Initiative, which is building upon the Substance Use Work Group of the San Francisco HIV Prevention Planning Council. In 2014, this Work Group – co-chaired by the SFAF Director of Substance Health Services – released a series of recommendations designed to improve the engagement and access to services for people who use substances. One of these recommendations was that the SFDPH work to better "ensure that people who use alcohol and other substances have access to a system of care that is coordinated, cohesive, comprehensive, non-punitive and non-stigmatizing," including through the elimination of barriers to care and treatment for people with HCV. These same recommendations prompted an overhaul of the city's Harm Reduction Policy, which has been finalized and is currently awaiting endorsement from the San Francisco Health Commission. The SFDPH Viral Hepatitis Coordinator will also continue her role coordinating HCV testing at substance use facilities including methadone programs, promoting overdose prevention services, and ensuring that substance use providers and primary care providers throughout San Francisco are aware of advances in HCV and supportive of harm reduction strategies to improve the health of people living with HCV through facilitating trainings and presentations (see Goal 3 proposal). All of these efforts help to bring together partners from a variety of fields and venues in San Francisco, identifying and leveraging resources for improving HCV activities similar to those proposed here.

Exhibit A
Scope of Work

Activities	Performance Indicators/Deliverables	Reporting Timeline

In addition to the work of SFDPH, Glide also plays a role in the development and maintenance of these vital partnerships. Glide has staff that are on the San Francisco HIV Prevention Planning Council and who participate in the Substance Use Work Group mentioned above. These agencies help change norms and leverage resources through expanding HCV outreach and screening to more venues, developing relationships with clinics and specific providers through efforts to link and retain clients in HCV care, and demonstrating reliability as a resource for clinics and other community organizations looking to address HCV in their client/patient population.

Task	Begin month	End month
Continued membership of the SFDPH Viral Hepatitis Coordinator on various committees, task forces, and strategic planning groups, as applicable	Feb 2016	June 2018
Glide will grow as a leader and resource in SF for HCV screening, linkage, and treatment assistance	Feb 2016	June 2018

Total Cost to Implement Goal 2:

- **Year 1:** $228,000.00
- **Year 2:** $228,000.00
- **Year 3:** $228,000.00