END HEP C SF

ANNUAL EVALUATION REPORT

Year Eight - 2024

Report developed by: FACENTE CONSULTING
UNDERSTAND • IMPLEMENT • TELL YOUR STORY

Executive Summary

End Hep C SF (EHCSF) is a cross-sector initiative that utilizes evidence-based practices, harm reduction, community wisdom, and the creative leveraging of resources to work toward the elimination of hepatitis C virus (HCV) in San Francisco. Using a collective impact framework, EHCSF unites diverse stakeholders from various sectors to collaboratively develop and support HCV elimination strategies. This report evaluates EHCSF's 2024 efforts based on information obtained from EHCSF members and stakeholders, and data from EHCSF partner programs.

Key Findings in this Report

Collective Impact

EHCSF members shared that the initiative continues to do well in meeting the five conditions of collective impact, especially strong backbone support. However, EHCSF has experienced ongoing challenges in (a) data reporting and review and (b) engaging members consistently.

Results-based Accountability (RBA)

EHCSF tracks its progress using the RBA evaluation framework. RBA findings from 2024 demonstrate that the initiative has been very successful in ensuring progress in collaboration, education, and access to testing and treatment options. However, some measures indicate that efforts have not yet returned to pre-pandemic levels, and further discussion on how to address these gaps are warranted. In addition, delays in data have constrained opportunities for ongoing data-driven discussions and action planning.

Future Directions

Based on a poll conducted in the Fall of 2024, EHCSF should consider prioritizing:

- Building community leadership (working to increase opportunities and skills for leadership within EHCSF for those newly involved and for those with lived experience)
- Creating opportunities for collaborating to test innovative strategies for eliminating HCV
- Advocacy, including policy advocacy for HCV prevention and treatment, and other issues affecting the health of people experiencing homelessness and people who use drugs
- Funding agencies to supplement or enhance their HCV programs (such as expanded programming or sites)

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Table of Contents

Executive Summary **2**

Introduction **4**

History of End Hep C SF 4

End Hep C SF's Collective Impact Approach 4

Reflecting on End Hep C SF's 2024 Efforts 5

Part 1: Collective Impact **6**

Participation by EHCSF Members 6

Focus Group Feedback on Collective Impact Conditions 6

Part 2: Results-Based Accountability **9**

How does EHCSF use Results-Based Accountability? 9

Performance Measures: What are the impacts of EHCSF's programming? 10

Indicator Data: What impacts do we see citywide? 14

Part 3: Establishing Future Priorities **15**

Design of Stakeholder Poll 15

Poll Respondents 15

Ranking of EHCSF 2025 Priorities 16

Introduction

History of End Hep C SF

End Hep C SF (EHCSF) began in 2016, with the mission to support all San Franciscans living with and/or at risk for hepatitis C virus (HCV) to maximize their health and wellness. Now in its 8th year, EHCSF has successfully recruited 37 community partners into its membership, including community-based organizations, government agencies, clinical providers, and research institutions.

These community partners engage in one or more components of the initiative (Figure 1), including four workgroups, and a community navigation and advocacy program. A central Coordinating Committee supports collaboration across the initiative, and an Executive Advisory Committee serves as a steering committee for the initiative.

Figure 1. The End Hep C SF initiative includes four workgroups (green hexagons) and a community navigation and advocacy program (orange hexagon). A coordinating committee (center hexagon) and executive advisory committee (grey hexagon) organize and steer cross-initiative collaborations.

Together, EHCSF members apply a **collective impact framework** (described below) to work towards eliminating HCV in San Francisco.

End Hep C SF's Collective Impact Approach

Collective impact is a tool for addressing complex, deeply entrenched social problems through multi-agency and cross-sector collaboration. Figure 2 on the next page shows how the five conditions of collective impact show up in EHCSF's work.

Figure 2. EHCSF incorporates all five conditions of collective impact.

Condition	Description	How it works in EHCSF
Common Agenda	Partners have a shared understanding and joint approach.	EHCSF has a shared mission and vision—focused on eliminating HCV and maximizing health equity—that guides its efforts.
Shared Measurement	Success is measured and reported in an agreed upon manner.	EHCSF uses a process called Results-Based Accountability (RBA) to develop and review shared measures of impact.
Mutually Reinforcing Activities	Diverse stakeholders organize discrete, reciprocal activities.	EHCSF has four workgroups (Figure 1), each charged with making progress on complementary areas of the shared agenda.
Continuous Communication	Partners engage in frequent and structured communication.	EHCSF has an email listserv and most of its workgroups meet monthly. Communication is coordinated between workgroups through the Coordinating Committee.
Backbone Support	There is support through an independently funded staff.	EHCSF has dedicated paid staff and consultants that serve as the backbone support.

Reflecting on End Hep C SF's 2024 Efforts

This report explores EHCSF's use of the collective impact framework, progress toward shared RBA measures—including the story behind 2024 data—and the future directions desired by EHCSF stakeholders. This report was developed utilizing data from partner organizations, input from the EHCSF Coordinating Committee, findings from a stakeholder poll, and EHCSF meeting notes.

The findings from the 2024 evaluation process are organized into three parts:

- Part 1: Collective Impact – How well is EHCSF implementing this framework?
- Part 2: Results-Based Accountability – What is the status of EHCSF's data quality and results-based accountability measures?
- Part 3: Potential Future Directions – What should EHCSF prioritize in 2025?

Part 1: Collective Impact

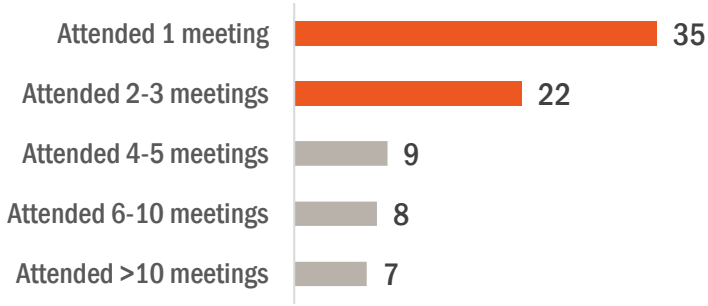
How well is EHCSF implementing a collective impact framework? This section of the report highlights data and findings related to the effectiveness of EHCSF's collective impact approach, including (i) the level of participation by EHCSF members, and (ii) focus group feedback on EHCSF's collective impact conditions.

Participation by EHCSF Members

In 2024, there were 81 unique participants at the 26 meetings across the four EHCSF workgroups and Coordinating Committee. These participants represented 15 agencies and at least 22 different programs. 44 participants only attended one workgroup while 37 attended more than one workgroup.

Of the 81 total participants, 43% (n=35) only attended one meeting in 2024 (Figure 3). 44 participants only attended a single workgroup[1], and of those, 79% only attended a single meeting of that workgroup. Figure 3 shows the breakdown for participation in meetings among the 81 participants.

Figure 3. Of the 81 participants who attended an EHCSF meeting in 2024, most attended 1-3 meetings.



Focus Group Feedback on Collective Impact Conditions

Four EHCSF Coordinating Committee members, including three backbone support staff, participated in a focus group on October 7, 2024. The focus group elicited feedback on collective impact conditions. Examples of feedback, which confirmed various discussion points discussed at workgroup meetings throughout the year, are shared below.

Common Agenda: One member shared that the big picture goal of HCV elimination is clear within EHCSF; however, they felt less clarity around the objectives leading to that goal. They also noted that measurable targets for EHCSF's work could be clearer, especially since data and surveillance reporting was delayed in 2024 (see details on next page).

[1] The CoRDS workgroup changed to an ad hoc meeting format in 2024. Some of those who only attended one meeting may have come to a CoRDS meeting on a topic of special interest to them but are not regular workgroup attendees.

Shared Measurement: Significant delays in data and surveillance reporting occurred in 2024, and participants expressed feeling that it was difficult to understand whether progress is being tracked and how it is being tracked. One participant stated that EHCSF has really struggled with obtaining the necessary treatment data to make data-driven decisions. This member did believe that this would likely change with negative RNA reporting in coming years, but that for now, this is a limitation. Changes made by SFDPH to data-reporting processes for funded agencies impacted the ability of work groups to regularly review and discuss Results-Based Accountability (RBA) performance measures, which had been occurring quarterly until 2024. The group suggested that it should be a priority to advocate for consistent and timely data presentations, which would require getting clear on what data are needed for shared decision-making, as well as what shifts would be needed for SFDPH to regularly collect and share community-based testing data in a timely way.

In Context: Impacts of Delays in Public Health Data Reporting

- In September 2019, the state of California changed Code of Regulations (Title 17 § 2505) such that negative results of reportable diseases must be reported when requested by the California Department of Public Health or the local health officer.
- At that time, San Francisco had already received negative results data for HCV from three entities. Although EHCSF heavily advocated for more data reporting, the San Francisco public health officer did not release a health order to require all entities to report this information.
- Shortly afterward, COVID-19 impacted all of these processes, and the push for voluntarily sharing negative results was put on hold.
- Over time, the practice of reporting negative results has shifted nationally, and as such, San Francisco has now received data on negative HCV RNA results for all major sites for 2024.

Mutually Reinforcing Activities: Focus group participants discussed the successful cross-workgroup attendance at the public, topic-specific meetings hosted by the Community Research and Data Stewardship (CoRDS) Workgroup, which was a new strategy employed in 2024 in lieu of regular workgroup meetings, which had been sparsely attended. Participants were also excited about the success of the quarterly joint Prevention, Treatment, and Linkage (PTL) Workgroup and Treatment Access (TA) Workgroup sessions, as meeting conjointly supported collaboration between groups. However, ongoing struggles with consistent attendance has made more widespread collaboration—organized through the Coordinating Committee—difficult to manage. Following staffing transitions, PTL was without co-leads for months. A lack of representation from PTL and TA in the focus group demonstrates this issue.

Continuous communication was not explicitly discussed among focus group participants, though they seemed to agree that EHCSF generally does well in ensuring communication between its backbone and members.

Backbone Support: Participants agreed that the EHCSF backbone support was strong and expressed appreciation for the financial support that EHCSF has garnered that makes backbone support possible.

Part 2: Results-Based Accountability

What is the status of EHCSF's data quality and Results-Based Accountability measures?
This section of the report highlights data and findings related to EHCSF's Results-Based Accountability (RBA) framework. EHCSF uses RBA to continuously monitor progress towards the initiative's goals (i.e. desired results), measure the impact of EHCSF efforts, document factors that may influence data trends, and make strategic steps toward improved HCV elimination.

How does EHCSF use Results-Based Accountability?

EHCSF uses the Results-Based Accountability (RBA) framework to create shared quantitative measures (a condition of collective impact; see Introduction) that guide evaluation, ongoing improvement, and accountability for city-wide progress toward HCV elimination.

30 organizations provide data for EHCSF's shared quantitative measures on a quarterly or annual basis, depending on the measure. These measures come in two forms:

(i) **performance measures**, which focus on outcomes directly linked to EHCSF's programming (such as uptake of community-based HCV testing), and

(ii) **indicators**, which focus on the citywide progress EHCSF hopes to see (such as the percentage of liver transplants in SF that take place among people with HCV).

These RBA metrics are intended to guide discussions in the PTL Workgroup on a regular basis, and they occasionally guide work of the Treatment Access and CoRDS Workgroups. In past years, measures were regularly reviewed and discussed to inform action planning. However, in 2024, RBA discussions were put on hold for two reasons. First, setting up SFDPH's new Health Access Points (HAPs) required time to build infrastructure for services and data collection. Second, subsequent lags in obtaining data—resulting from (a) complex data reporting forms that required both adaptation and training, as well as (b) complicated internal data sharing mechanisms between SFDPH Applied Research, Community Health Epidemiology and Surveillance Branch (ARCHES) and SFDPH Community Health Equity and Promotion (CHEP). Ultimately, data from quarter one of 2024 was not available for review until the Fall of 2024. Fortunately, timely data is continually improving as partners adjust to new data reporting protocols and commitments to advancing interagency data sharing capabilities come to fruition.

The remainder of this section contains a snapshot of relevant performance measures and indicators for 2024, along with the story behind the data. See our Clear Impact EHCSF Data Dashboard for the full list: **https://endhepcsf.org/evaluation-dashboard/**

Performance Measures: What are the impacts of EHCSF's programming?

The following six performance measures represent EHCSF program-level outcomes and correspond to priorities identified in EHCSF's 2023-2025 Strategic Plan:

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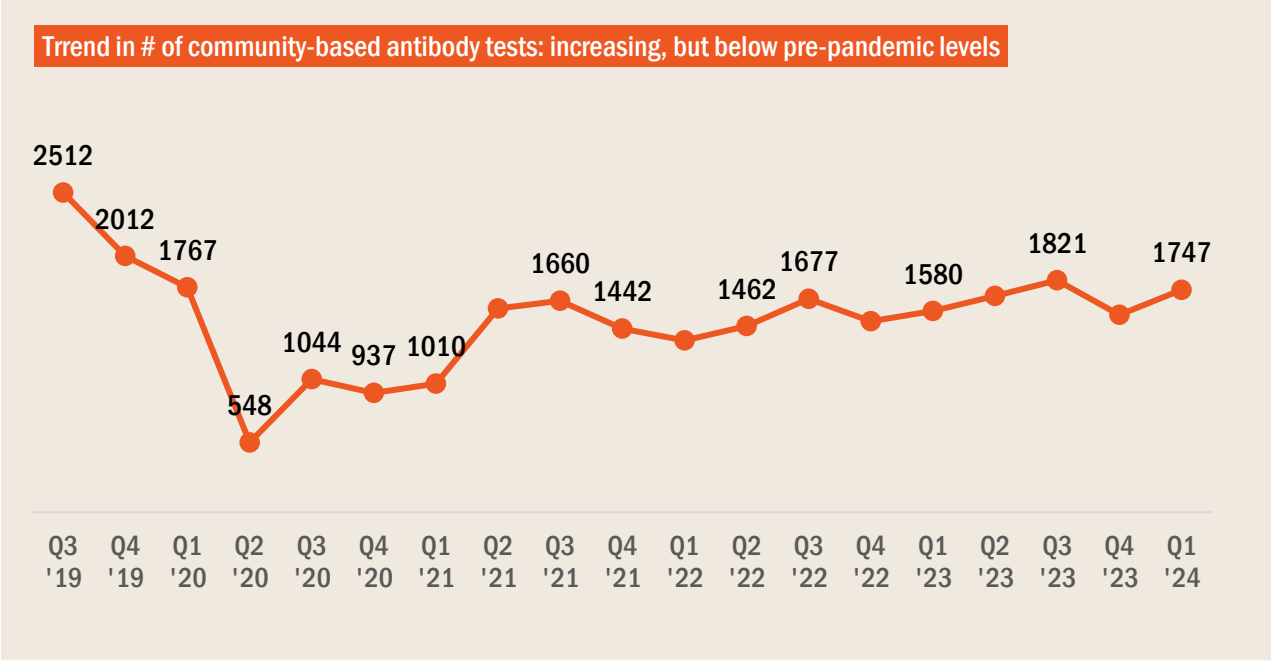
1. Strategic Priority: Increase the number of HCV antibody tests done in the community to a higher rate than we achieved pre-COVID.



Story behind the data: After a significant dip in quarter two of 2020 due to COVID-related shutdowns and service interruptions, community-based antibody testing has increased. However, testing numbers have yet to rise to pre-pandemic levels despite there being more organizations reporting community-based testing (six organizations, compared to three pre-COVID).

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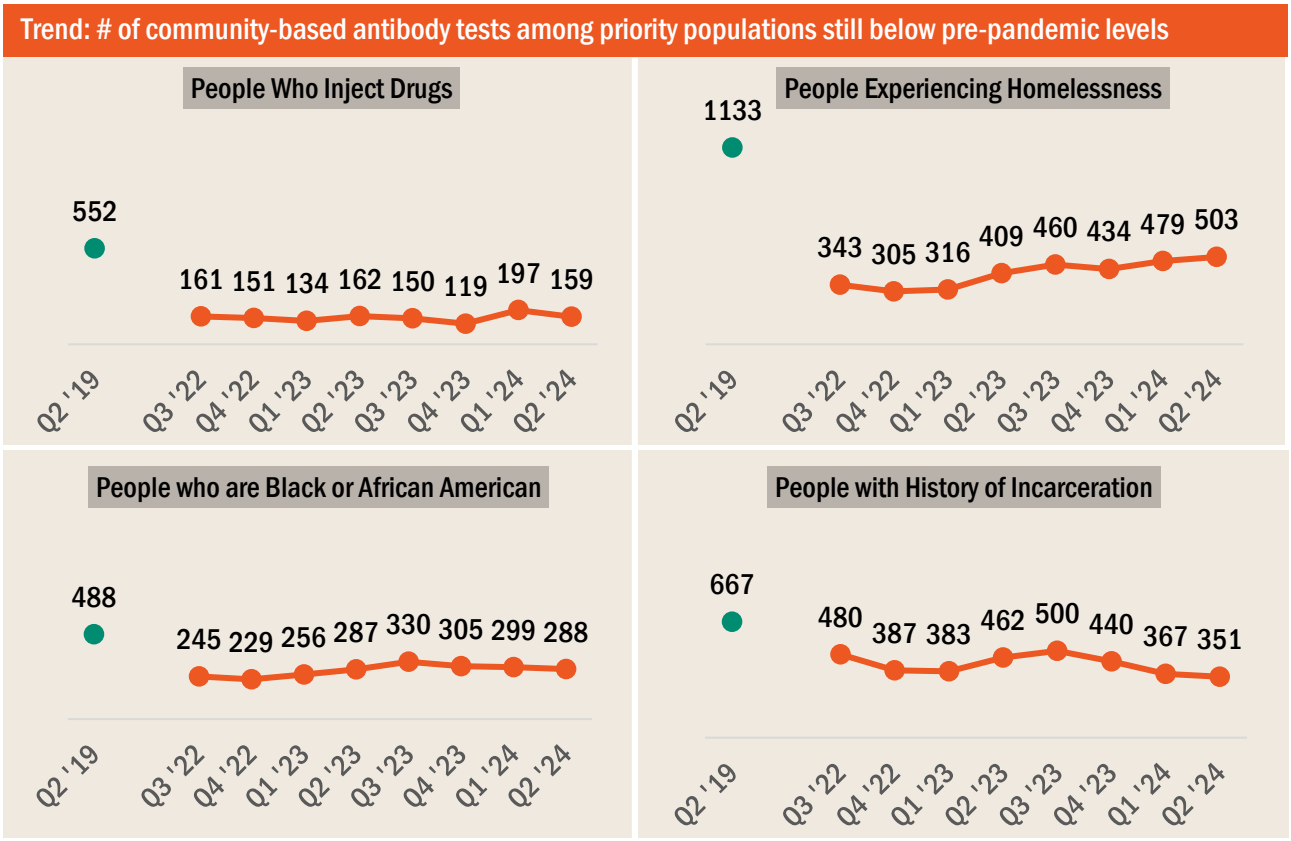
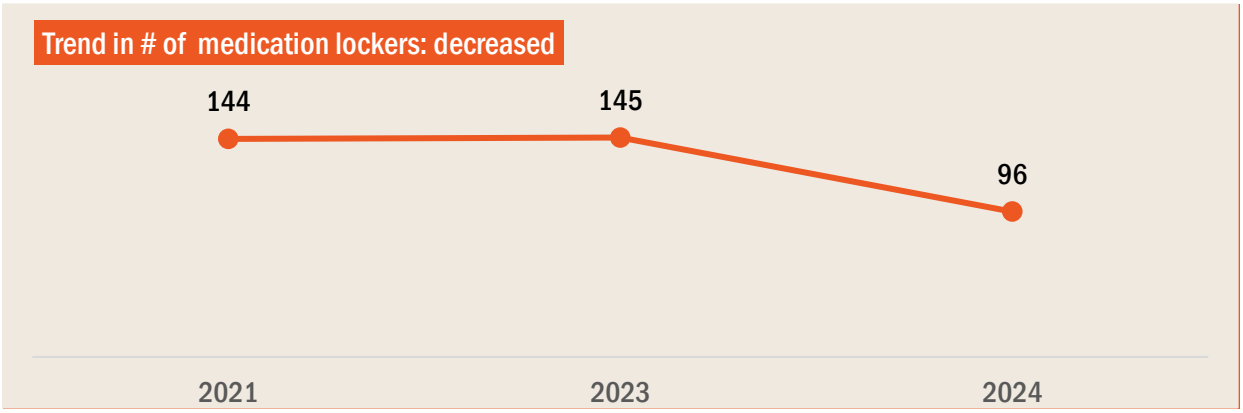
2. Strategic Priority: Maintain high rates of community-based antibody testing among people who inject drugs, people with a history of incarceration, people who are unhoused, and people who are Black or African American.



Story behind the data: EHCSF tracks performa nce measures among priority populations, including people who inject drugs, people expe riencing homelessness, people who are Black/African American, and people with a histc ry of incarceration. Despite EHCSF's efforts, community-based HCV antibody testing has ye to meet pre-pandemic levels for any of these priority populations. For example, in quarter 2 of 2019, 552 tests were conducted with people who inject drugs, but only 159 tests were conducted among this population in quarter 2 of 2024. As another example, the priority population that is currently receiving the most tests—people experiencing homelessness—had 503 tests in quarter 2 of 2024, compared to 1,133 tests in the same quarter in 2019. In discussion about these trends, PTL workgroup members identified increased challenges to engaging priority populations, including the closure of the Tenderloin Linkage Center, impacts of the Grants Pass ruling by the Supreme Court, and other local political challenges to harm reduction programs, including increased criminalization of homelessness and drug use in the Tenderloin and other neighborhoods. These challenges have made it difficult for community-based sites to increase testing to the desired rates for these priority populations, and will require additional discussion in 2025 to mitigate these barriers.

3. Strategic Priority: Increase the number of medication lockers available in various locations around the city[2].



Story behind the data: The number of available medication lockers in San Francisco decreased from 2023 to 2024. However, in lieu of medication lockers, several agencies have the option of weekly medication pick up or storage with staff only access. This service option preserves some sense of security for medication so that the potential for loss is minimized; however, autonomy and flexibility for people on treatment is also significantly reduced.

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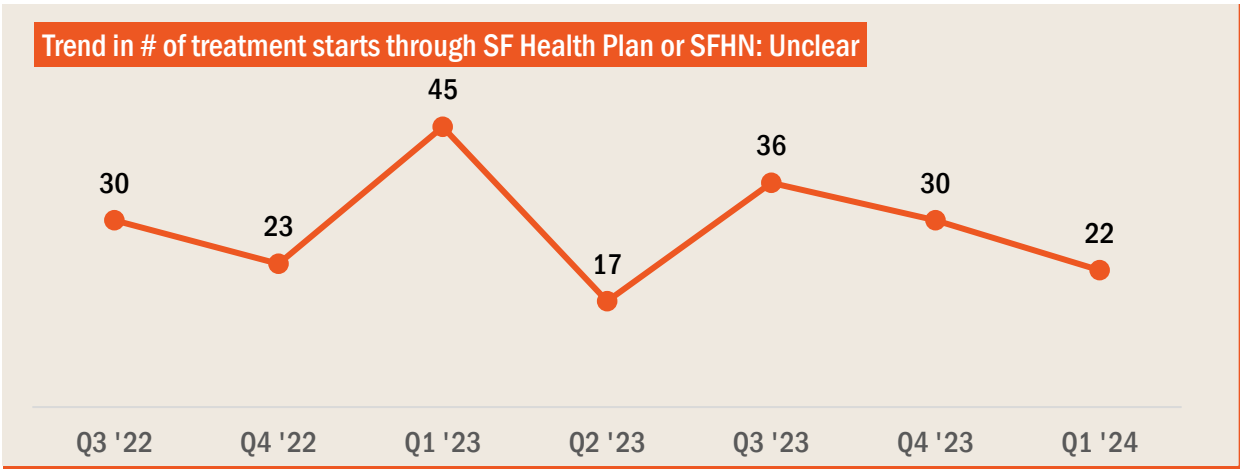
4. Strategic Priority: Increase the number of treatment starts through the San Francisco Health Plan and within the San Francisco Health Network (SFHN) as a whole.



Story behind the data: EHCSF has recently experienced challenges in obtaining timely San Francisco Health Plan data. In addition, data from quarter 1 of 2024 includes only 4 out of 7 programs. As such, it is difficult to determine progress on this measure. This reflects focus group feedback on how data and surveillance reporting issues limit the ability to drive decision-making with data and evaluation (see Part 1).

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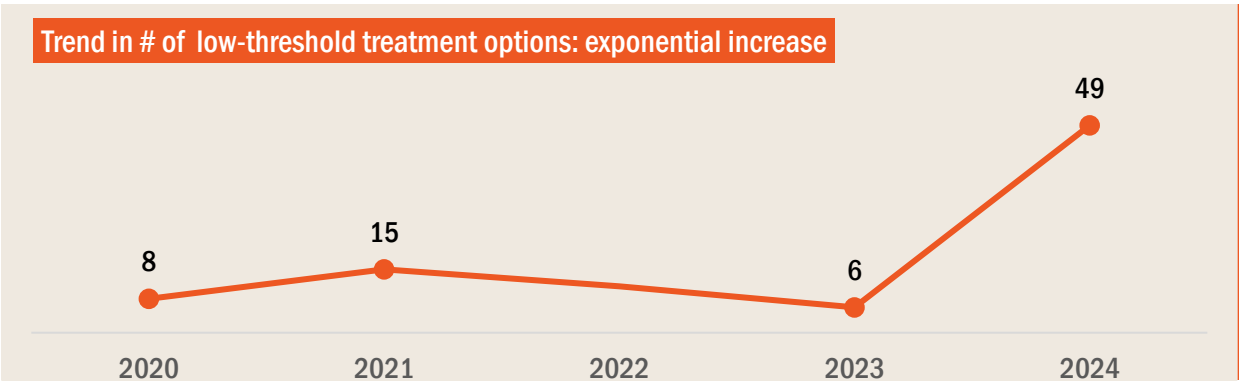
[2] No data was collected for this measure in 2022.

5. Strategic Priority: Increase the number of low-threshold treatment options in the city, above the 15 sites that were opened in 2021[3].



Story behind the data: Low-threshold treatment options in SF increased exponentially in 2024 mostly due to SFDPH data reporting including treatment options in 21 shelters. This measure counts the number of physical locations that offer low-threshold treatment options at non-clinical settings and can include vans, drop-in sites, navigation centers, or shelters.

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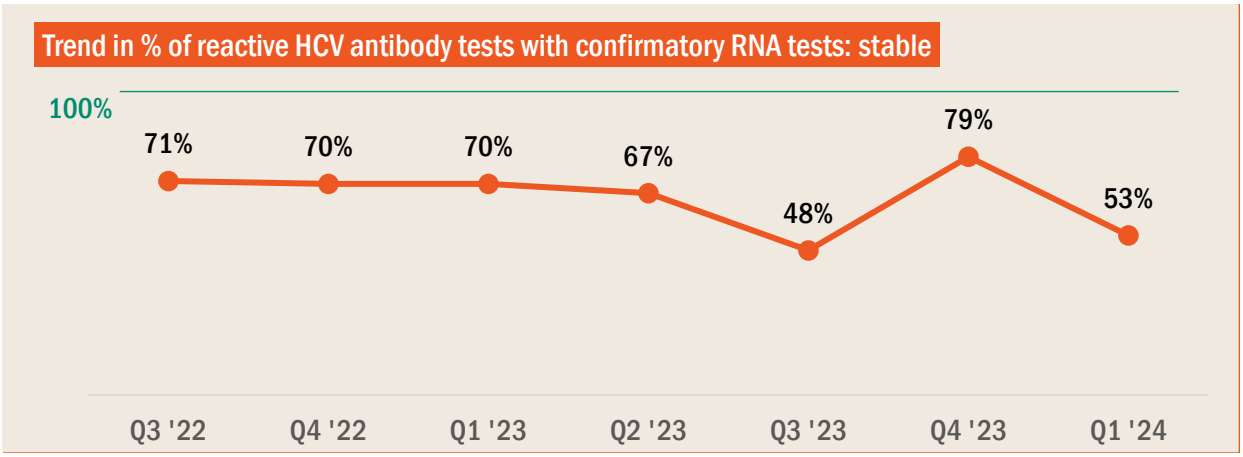
6. Strategic Priority: Approach pairing 100% of positive HCV antibody tests with confirmatory RNA testing, to align with CDC guidance[4].



Story behind the data: Since quarter 3 of 2022, the percentage of reactive HCV antibody tests with a confirmatory RNA test has been relatively stable. Notably, these more recent data show a much higher percentage compared to 2019 (quarter 1), when this measure was only 28%. This indicates an opportunity to enhance efforts to ensure individuals who receive an antibody test result are connected to organizations for linkage to RNA confirmatory testing.

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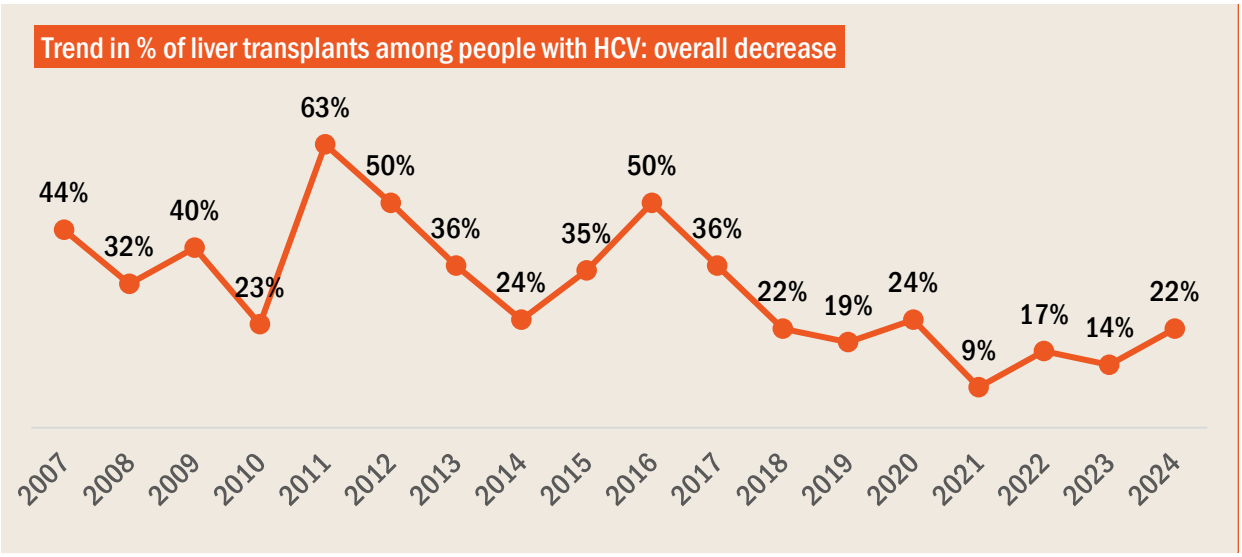
[3] No data was collected for this measure in 2022.

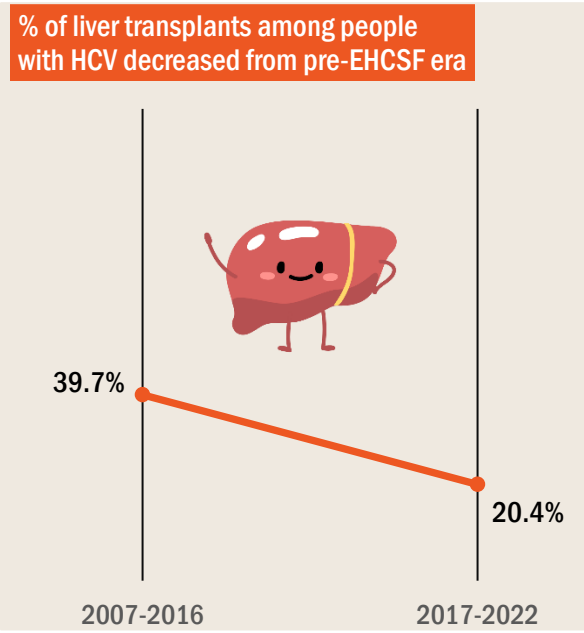
[4] https://www.cdc.gov/mmwr/volumes/72/wr/mm7228a2.htm

Indicator Data: What impacts do we see citywide?

The **percentage of liver transplants in San Francisco among people with HCV** is a city-level indicator that offers insights into EHCSF's impact on downstream HCV-related outcomes. For example, if EHCSF's work to improve treatment access is truly moving the needle on HCV outcomes, we would hope to see a continually smaller percentage of liver transplants among residents living with HCV because those individuals would all be connected to treatment, reducing the likelihood of liver transplant due to damage from HCV infection.



The number of liver transplants among people with HCV in San Francisco has substantially decreased over time for both people living with and without HCV. However, despite the similar decreases in overall liver transplants in both groups, the percentage of liver transplants on people with HCV has also decreased when comparing the period before and after EHCSF launched (average of 39.7% between 2007-2016, 20.4% between 2017-2022).



Part 3: Establishing Future Priorities

What should EHCSF prioritize in 2025? To answer this question, in October 2024 Facente Consulting conducted a 4-question poll about EHCSF stakeholders' preferred priorities. The poll was shared with EHCSF members via the email listserv, in a message that asked them to also share the poll with others in their network. This section summarizes the poll findings, which included 31 respondents.

Design of Stakeholder Poll

The poll asked about (i) the respondent's involvement in EHCSF, (ii) their role in the community, (iii) how they would rank nine possible priorities for EHCSF (Figure 4), and (iv) whether they wanted to share any additional priorities or comments.

Figure 4. List of potential EHCSF priorities that poll respondents were asked to rank in order of importance

- Marketing/Communications (ensuring people know about EHCSF)
- Building community leadership (working to increase opportunities and skills for leadership within the initiative for those who are newly involved and for those with lived experience)
- Building in more opportunities to use data to drive decision making
- Focusing on data and evaluation (improving the data dashboard on the website)
- Using and reporting SFDPH's HCV surveillance data in bigger ways for diverse audiences
- Funding pilot programs
- Funding agencies to supplement or enhance their HCV programs
- Advocacy including policy advocacy for HCV and other issues affecting the health of people experiencing homelessness and people who use drugs
- Creating opportunities for collaboration for testing innovative strategies for elimination

Poll Respondents

The 31 poll respondents included 10 clinicians, 2 community members, 5 frontline workers, 5 researchers, 5 people in another role not specified, 4 program management staff, and 2 community members (Figure 5). 65% of respondents currently engage in EHCSF, and 39% regularly attend a workgroup or meetings.

Figure 5. Clinicians contributed the most poll responses.

Ranking of EHCSF 2025 Priorities

Overall ranking of priorities

After ranking priorities overall (Fig. 5), three stood out as especially high or low priority:[5]

- **Building community leadership** was the ***highest ranked priority***, receiving the most #1 votes and just one last-place vote.
- **Creating opportunities for collaboration** was the ***second highest ranked priority*** receiving the second-most #1 votes.
- **Marketing and communications** fell to the ***bottom of the priority list***, receiving the most last-place votes.

The rank of other priorities was less clear depending on how consistently they were ranked. For example:

- Though only one person ranked **Advocacy, including policy advocacy for HCV and other issues** as #1, most people ranked it as #5 or higher, raising its overall ranking to #3.
- **Funding agencies to supplement or enhance their HCV programs** had the third-most #1 votes; however, many people also ranked this priority last, lowering its position to #4 overall.

When examining how priorities were ranked across members' roles (Figure 5, previous page), we observed no notable differences, especially given the relatively low numbers of respondents from most roles (Figure 5, previous page).

Figure 6. Overall ranking of 9 possible EHCSF priorities, according to poll respondents

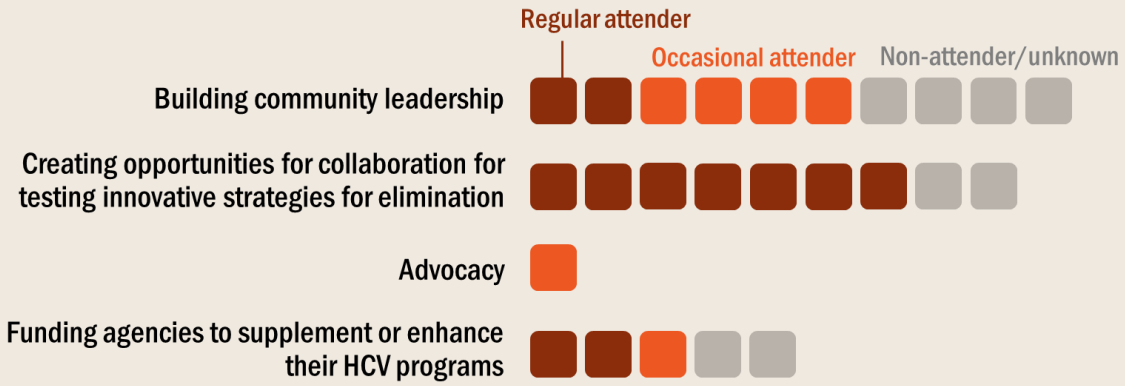
Rank	Priority
1	Building community leadership
2	Creating opportunities for collaboration for testing innovative strategies
3	Advocacy including policy advocacy for HCV and other issues
4	Funding agencies to supplement or enhance their HCV programs
5	Building in more opportunities to use data to drive decision making
6	Funding pilot programs
7	Focusing on data and evaluation (improving the data dashboard)
8	Using and reporting SFDPH's HCV surveillance data
9	Marketing/communications

[5] Each priority's ranks were weighted (e.g., rank of 1 = 1 point; rank of 2 = 2 points) across all respondents; then all priorities were re-ranked, starting from the priority with the fewest points.

Priority ranking by involvement in EHCSF

When considering the relationship between the top four ranked priorities and respondent meeting attendance, those who were regular meeting attenders more often chose "creating opportunities for collaboration for testing innovative strategies for elimination" as their #1 vote (Figure 7). While the total of 31 respondents was small, this may offer insights as to how general engagement in EHCSF promotes interest in the collaboration-focused priorities among members.

Figure 7. Regular meeting attenders more often ranked a priority about collaboration as their top priority. *Each box represents one stakeholder.*



- *Regular attender = attends a workgroup or multiple meetings per month*
- *Occasional attender = attends from time to time*
- *Non-attender/unknown = no longer attends, has not attended yet because is new, or attendance status unknown*

Additional insights on future EHCSF priorities

Respondents provided additional insights about possible EHCSF priorities via open-ended responses; examples are summarized below.

Building community leadership

Respondents recommended expanding the Community Navigator program and creating opportunities for position and compensation advancement for staff at community-based organizations. In addition, they recommended that the EHCSF conference be an annual event, offered at no cost to community members with lived experience.

Creating opportunities for collaboration for testing innovative strategies

Respondents shared several ideas for collaborations to increase access to HCV outreach, testing, and treatment. For example, one respondent recommended the development of more programs like the DeLIVER Care van, which provides a "test and treat" same-day model to key populations using telehealth. Respondents suggested that to best reach these key populations, programs can employ social networking strategies and other incentivized methods to engage people. Other recommendations included setting up new testing technology, like rapid confirmatory testing in high priority locations using Cepheid's newly available Xpert test for point of care viral load testing; integrating HCV testing and linkage to treatment in methadone and buprenorphine clinics; and expanding of HCV testing and treatment in jail settings.

Advocacy, including policy advocacy for HCV and other issues

One respondent commented that they would like to see EHCSF address funding for policy advocacy. They stated they would like to share activities and lessons learned between local elimination programs through quarterly or biannual meetings, which would have the added benefit of increasing community awareness of EHCSF and its activities.

Funding agencies to supplement or enhance their HCV programs

Respondents supported the idea of enhancing programs through funding and specified that funds would resource agencies that are still trying to recover their programming from COVID-related shifts and shutdowns. In addition, one respondent outlined two priorities for supplementing linkage programs. The first proposed priority is to champion a plan for better linking those newly diagnosed with HCV within the San Francisco Health Network (SFHN) to care. This idea included the suggestion of hiring someone who could work with each SFHN clinic to develop a workflow for that clinic to review the HCV registry and link untreated patients to treatment. The second proposed priority is to develop a feasible approach to data to care (citywide outreach to those living with untreated HCV).

Building in more opportunities for data-driven decision making

One respondent recommended continuing to advocate for enhanced data sharing practices, including for SFDPH to develop and share a citywide prevalence estimate to better understand progress in eliminating hepatitis C in San Francisco. Another respondent suggested using neighborhood and individual level data to design and implement treatment options.

Marketing/communications

One person noted that although it is important to have marketing and communications to ensure that people know about EHCSF, the key need under this priority was education on HCV prevention, testing, and treatment.