California Medical Leadership Forum for Public Health/Preventive Medicine
50th Meeting
March th, 2026, 8:00-9:30 am PST
MINUTES

This meeting used a Zoom account from CAPM with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes,) were attached to the email notice. All attendees except those participating by phone could enter information in "Chat." Web references for agenda topics were embedded in the agenda. **SPECIAL TOPIC FOR TODAY'S MEETING: HEPATITIS C, AND THERE IS ALSO A SPECIAL PRESENTATION FROM THE ADVOCACY GROUP AID ON THE HILL.**

Dr. Hattis began the meeting noting that the forum cast the widest net of any group when it comes to physicians and teachers of medicine teachers and medical students, staff of medical organizations, and of government departments that are interested in public health.
Regarding today's topic, Hepatitis C, he noted that we have curative medications, but it takes a few years for staffing, budgets, and organization of public health to adapt to a new model of care. Ron stated we have about 300,000 Californians estimated to have chronic hepatitis C and many of them do not know they're infected. The majority have not been treated. He noted we have a lot of public health professionals, but also some infectious disease and hepatology experts as well as some preventive medicine residents and our regular membership representation of medical schools, medical organizations, and departments. Ron requested that everybody log into the chat their name and what organization, school, or other affiliation along with email address and whether they want to be invited to future meetings.

Ron also announced that the next meeting in June would include an election of a new chair and he appointed a nominating committee. consisting of Sumed Mankar, our vice chair, Megan Ryan, who is in on the call from UC San Diego School of Public Health, and Jessica Nunez de Ibarra from CDPH. Those 3 individuals offer a wide representation, including MDs, DOs, Northern, Central, and Southern California, 2 genders, and different modes of practice, including federal, state and private sector. Ron hopes somebody will step up, noting a lot are capable and could do this.

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1) **Approval of Minutes:**
   Minutes from the prior meeting were reviewed and approved without objection. The special topic was "What's New in Nutrition," and there are slides are available if anyone is interested.

2) **Roll Call, Part 1**
   Due to large attendance, introductions were conducted primarily via chat. In addition to our usual representatives, guests were invited from CDPH, local health departments, correctional health, community organizations, and clinical settings across California. The

largest number of participants detected at one time by Zoom was 74, but only 67 could be accounted for. There were 16 regular representatives, 4 regular guests, and 47 special guests attending for the hepatitis C discussion.

Attendance and updates from both portions of roll call are included below. Regular representatives noted when joined by guests; guests noted only where present as only attendees from their schools:

ATTENDEES FROM ENTITIES THAT ARE REGULARLY REPRESENTED IN FORUM

California Academy of Preventive Medicine

1) Dr. Hattis, President, led the meeting.
2) Sumedh Mankar, DO, MPH Medical Director - Blue Shield of California, Promise Health Plan Sumedh.Mankar@Gmail.com Dr. Mankar, Vice President facilitated roll call.

State of California Surgeon General

1) Lauren Groves: Office of the California Surgeon General.

California Department of Public Health

1) Jessica Nunez de Ybarra, MD, MPH, FACPM, Community Health Medical Administrator, CDPH Office of Policy and Planning
2) Rachel "Ray" McLean, she/any, CA Dept. of Public Health, Office of STIs and HCV, Rachel.McLean@cdph.ca.gov Ray clarified in chat that re: Hep C testing funding, the first round of funding 22 local health jurisdictions were funded; 31 total in second round and to apply for in kind HCV antibody test kits, email CDPH.HEP@cdph.ca.gov
    a. Rachel also provided links to information: CDPH viral hepatitis information, see https://urldefense.com/v3/__https://cdph.ca.gov/ovhp__;!!HoV-yHU!pE4IJ0367Uwj9ES66Fufx_c3VrSLf5m_vp3mkWF-bZ-aSZsvwXF8TUZhSYVxHG2rOae94F1CQOiJw1tTQ5xGdAye$
    b. She noted that our state prisons also have an excellent dashboard with HCV screening and treatment data Dashboard - CCHCS
3) Carrie Jones, Program Director, CDPH Preventive Medicine Residency, carrie.jones@cdph.ca.gov (regular representative)
4) James Watt, CDPH. james.watt@cdph.ca.gov, Chief of the Center for Infectious Diseases
5) Kathleen Jacobson, Chief of Office of STIs and HCV, gave a presentation of current CDPH activities related to hepatitis C.

6) Linda S Lewis, DVM, MPVM CDPH, Office of AIDS linda.lewis@cdph.ca.gov
7) Lisa Bandong, Academic Partnerships Coordinator, CDPH (regular representative)
8) Nang Tin Maung, CDPH HCV epidemiology unit chief. Nang.tinmaung@cdph.ca.gov
9) Brady Johnson, MD, MPH (CDPH Preventive Medicine resident, asked if California has considered a subscription model for paying for Hep C treatment? He did med school in Louisiana and learned about how the state of Louisiana implemented a subscription model where they paid one flat rate for all Medicaid and incarcerated people in Louisiana to be able to get Hepatitis C treatment for a period of 5 years. During that time they saw greater than 500% increase in prescriptions filled for hepatitis C treatment. Jordan replied: they would defer to colleagues at CDPH about funding strategies the state has considered to fund treatment. To their knowledge, reimbursement of treatment has not limited elimination efforts in CA

California Medical Association

1) Alecia Sanchez, CMA

Medical Schools

Touro University

Traci Stevenson: Forum Secretary;

UCSF

George Rutherford, MD University of California, San Francisco george.rutherford@ucsf.edu

UC Irvine

Ariana Nelson

UC Riverside

Mark Wolfson

Stanford

Paul Kwo, MD, Stanford University, pkwo@stanford.edu Director of Hepatology Eleanor Levin MD, preventive cardiology, clinical prof Stanford (regular representative)

Loma Linda University

1) Sreyas Menon, Preventive Medicine Resident/Fellow at Loma Linda University. Currently rotating at San Bernardino County Department of Public Health, guest.
2) Abhishek Dharan, Preventive Medicine Resident at Loma Linda University. Currently rotating at San Bernardino County Department of Public Health. Also Chair of the California Medical Association Resident and Fellows Section. Email: adharan@llu.edu, guest.

UCLA

1) Kelly Chin, MPH student at UCLA, Intern at CDPH, Office of STIs and HCV, kelly.chin@cdph.ca.gov.
2) Priyanka Fernandes, UCLA Prev Med PD (regular representative)

University Southern California (USC)

1) Norah Terrault, MD, MPH. Norah.Terrault@med.usc.edu, hepatology
2) Jo Marie Reilly, Keck School of Medicine of USC , Dept pf Population and Public Health, jmreilly@med.usc.edu (regular representative)
3) Dr. Jeffrey Klausner, professor of medicine and population and public health at USC. Guest speaker today, see presentation on hepatitis C below.
4) Chrysovalantis Stafylis, MD, MPH, Dept. Population & Public Health Sciences, USC, Chrysovalantis.stafylis@med.usc.edu

Schools of Public Health

UC San Diego School of Public Health

Margaret Ryan, UC San Diego and Defense Health Agency (federal worker). margaret.ryan.md@gmail.com

UC Berkeley School of Public Health

Akhila Chilakala, PGY-3 IM/PM resident @ KPSF/UCSF, currently at UC Berkeley for MPH. akhila.chilakala@kp.org (guest)

GUESTS FROM ENTITIES NOT REGULARLY REPRESENTED IN FORUM (COMMENTS INCLUDED IF DID NOT PERTAIN TO TOPICS IN OTHER SECTIONS)

Organizations and Government Agencies:

Aid on the Hill

1) Ariella Bock, Aid on the Hill. ariella@aidonthehill.org See presentation by Ariella below. Ariella also shared a link in chat: https://urldefense.com/v3/__http://www.aidonthehill.org__;!!HoV-yHU!pE4IJ0367Uwj9ES66Fufx_c3VrSLf5m_vp3mkWF-bZ-aSZsvwXF8TUZhSYVxHG2rOae94F1CQOiJw1tTQ_TZDfY5$
2) Pkerndt@gmail.com (member of Aid on the Hill, and regular Forum guest)

California Dept. of Corrections and Rehabilitation, Correctional Health Care Services

1) Amy Krawiec, amy.krawiec@cdcr.ca.gov Amy shared that prevalence of untreated HCV statewide in CA prisons is 2.5%.
2) Heidi Bauer, Heidi.bauer@cdcr.ca.gov

California Hepatitis C Task Force

Bill Remak, CEO, California Hepatitis C Task Force, wmremak@pacbell.net

California Hepatitis Alliance

Jordan Akerley, End Hep C SF, California Hepatitis Alliance, jakerley@endhepcsf.org Jordan provided the following information in chat: For calendar invite to California Hepatitis Alliance (CalHEP) monthly meetings, please reach out at jakerley@endhepcsf.org or submit a request via the coalition's website. Meetings are monthly on the first Wednesday from 3:30-4:30 pm. Further discussions in chat included:

a. CalHEP co-chairs work with the End the Epidemics coalition to advocate for HCV budget priorities. ETE advocated for funding that has informed the HCV Prevention and Collaboration Funds, advocated against Gov Newsom's proposal to clawback funding allocated for the HCV Ab test kits, the POC test instruments. They're advocating for funding to support operator training for POC test instruments (required by HSC 120917)
b. Re: HCV dispensation, the Medi-Cal Rx Contract Drug List was updated 10/1/2025 to remove limits on dispensation of HCV medication. This enables providers to write for a full course of medication, support cure outcomes by eliminating the need for patients to make multiple trips to the pharmacy.

California Pharmacists Association

Sean Kim, PharmD, skim@cpha.com

California STI Control Association and Beyond AIDS Foundation

Gary Richwald, MD, MPH, former STI Director, LA County DHS, former President, California STI Control Association; President, Beyond AIDS Foundation

John Muir Health Concord

1) Alicia Antonio, Infection Preventionist. Alicia.antonio@johnmuirhealth.com
2) Joanna.mills@johnmuirhealth.com

Local Public Health Jurisdictions:

Alameda County

Catherine Toyooka, Alameda County, Director of Chronic Hepatitis. Catherine noted that they do not have county clinics and work with subcontractors. They host the statewide HCV Collab for LHJ staff who work with the CDPH HCV Allocations. She is the Director of Chronic Hepatitis and housed in the HIV/STI/ HCV Section, they take a syndemic approach..

Butte County

Jarett Beaudoin- Health Officer Butte County

Contra Costa County

Meera Sreenivasan, is the President of the California Association of Communicable Disease Controllers

County of Monterey

1) Bernard Fung, PHN, Monterey County, fungb@countyofmonterey.gov
2) Davithia Perry, County of Monterey Public Health Communicable Disease, perryd1@countyofmonterey.gov. They currently subcontract and refer hepatitis C patients for treatment.
3) Erika Turcotte, turcottee@countyofmonterey.gov, County of Monterey Public Health.

Del Norte County

Bonnie Brinegar, Del Norte County Public Health. bbrinegar@co.del-norte.ca.us

Fresno County Dept of Public Health

John Zweifler Medical Consultant Fresno County Dept of Public Health HCV in STI dept- not offering treatment currently. jzweifler@fresnocountyca.gov

Glenn County

Summer Burns, LVN II Glenn County Public Health

Los Angeles County

Carlos Velez, LA County dept of PH, cvelez@ph.lacounty.gov

Long Beach

1) Tania Trevino HIV/STI Surveillance. DIS. tania.trevino@longbeach.gov
2) Cliff Okada, MD MPH, Acting Health Officer, Long Beach Dept of Health
3) Emily Johnson (she/her): HIV/STI Surveillance Supervisor, City of Long Beach; Emily.Johnson@longbeach.gov

San Benardino County Department of Public Health

David Yleah, david.yleah@dph.sbcounty.gov

San Francisco Dept. Public Health

Stephanie Cohen, MD, MPH, SFDPH; Stephanie.cohen@sfdph.org

San Joaquin County

1) Maggie Park, San Joaquin County Health Officer
2) Jenny Malone Program San Joaquin County, Manager, Nursing TB/CD

Santa Clara County

1) Akanksha Vaidya, STI/HIV controller. Akanksha.vaidya@phd.sccgov.org. Dr. Vaidya is the President of the California STD and HIV Controllers Association.

Santa Barbara County

2) Adriana Almaguer, aalmaguer@sbcphd.org.

Stanislaus County

1) Thea Papasozomenos, Health Officer, Stanislaus County Public Health
2) Erin Gustafson: egustafson@schsa.org, Assistant Health Officer. HCV is housed under STI program; they refer pts for treatment.

Siskiyou County

1) Nellie Brasier, PHN. Siskiyou County Public Health; Communicable Disease. nbrasier@co.siskiyou.ca.us.

Tehama County

1) Timothy Peters, MD, PHD Tehama County, peterst@tchsa.net; Hepatitis C is managed by Timothy and PH nurses in their jurisdiction, then they refer for treatment
2) Yash Patel, Epidemiologist, Tehama County Health Services. Yash.patel@tchsa.ne

Tulare County Public Health

1) Sharon Minnick, Senior Epidemiologist, Tulare County Public Health, sminnick@tularecounty.ca.gov Sharon noted healthcare-associated (Hepatitis) can be much more common in other countries, so immigrants (even those living in the U.S. for decades) may have chronic Hep C without knowing and without other risk factors. She noted that Tulare is one of the counties that has never received any state money for hepatitis C.
2) Asma Tariq, M.D Health Officer, Tulare County atariq@tularecounty.ca.gov

Yolo County

Aimee Sisson, Yolo County Health Officer

3) Special Report: Aid on the Hill:

a. Ron introduced Ariella Bock as one of the co-founders of Aid on the Hill, a main advocacy group trying to restore U.S. international health aid since the destruction of USAID.
b. Ariella shared the link to their website and called out Peter Kurdt as one of their original founding members of Aid on the Hill.
c. Ariella described herself as a public health advisor at USAID, working on global health supply chain. At the end of January 2025, when USAID was closed, she and a group founded Aid on the Hill, which at this point now has about 600 members reaching over 6,000-7,000 people.
d. It is a professional association formed of current and former U.S. government officials and practitioners who worked both in the US and abroad to bring an advocacy voice to health policy and inform Congress both in Washington, D.C., and in our districts about what is happening and the implications.
e. She is happy to give more information about the organization and invites everyone to become a member and sign up for their newsletter.
f. A big thing they are focused on is an entire system of development and the need for returning funding to these programs.
g. They also are tracking staffing and expertise noting that when USAID was shut down, over 14,000 Americans working at USAID lost their jobs. And worldwide about 250,000 individuals both domestically and internationally to run these programs also lost their positions.
h. An area of focus remains funding noting that Congress restored about $50 billion to focus on international foreign assistance.

i. The big question is how is that money going to be spent? How does that money move from Congress, through the government, through the bureaucracy, into the hands of partners to be able to effectively provide the services that they are intended to.

j. This is a major concern. For example, PEPFAR, the President's Emergency Plan for AIDS Relief, which is one of the most successful programs that the U.S. government had ever initiated that provided funding for HIV (plus it was where Hepatitis C and sexually transmitted diseases programming sat) had focused on key populations.
    i. At the end of the fiscal year, they saw the government had close to $977 million remaining of unspent money which expired and returned back to the government.
    ii. The issue re why this money expired was that it couldn't actually be spent. The government had not enough people to actually spend it because they fired everybody and money could not be moved to programs.

k. With the $50 billion that has been now approved by Congress the question is how the government is able to move money from the government into the hands of partners.

l. When USAID collapsed so did all of the programs that supported these organizations. Within the government itself, there was contraction within the State Department, as USAID went from 14,000 staff to 7000 thus asking people to keep doing the work that 14,000 people did. She notes that there were absolutely issues and overlap but staffing is a big issue.

m. Ariella also noted that another issue is on a procurement level. In order to get funding and have partners, contracts need to be in place.

n. The concern is how are they going to provide oversight of the $50 billion. In regard to hepatitis C funding and PEPFAR funding, there is some money going out, Congress has approved it, but they are very concerned looking at the future and the landscape of what is happening.

o. This is where Aid on the Hill, comes in, and they encourage everyone to join and sign up for the newsletter.

p. Ron asked, what was the total budget before the collapse of USAID that the 50 billion is trying to replace. Ariella said that was a great question and that it was about 85% of the previous budget.

q. Ron also asked if is there was any indication the White House will actually spend that $50 billion?
    i. Ariella replied that is the big question and this is where the OMB and Russ Vaught have a conflict. She explained in the past, when Congress appropriated money, that money was automatically handed over by the by the Treasury to the departments that were funded, e.g., State Department, or CDC, according to what was approved by Congress.

ii. This government has a different interpretation, and they see the $50 billion as a maximum amount of money, rather than the minimum amount of money to spend.

4) **Special Topic: <u>Hepatitis C as a Public Health Opportunity</u>:**
Dr. Hattis introduced the guest speaker, Dr. Jeffrey Klausner, professor of medicine and population and public health at USC. Ron shared that Dr. Klausner has had a very interesting career including work in Zaire, Thailand, South Africa as well as San Francisco. Los Angeles, CDC and Harvard.
    a. Jeff noted there is lots of information about hepatitis C and he will highlight the problem in California noting that he has had a career back and forth between public health practice and academic medicine and research including program implementation and evaluation.
    b. Hepatitis C now is considered a leading cause of avoidable morbidity in the United States. The most common scenario is that people have asymptomatic infection, and that's why screening is so important. The US Preventive Services Task Force recommends at least one-time lifetime screening. It's a major cause of liver cancer, cirrhosis, failure, transplant, and death.
    c. There are more people with untreated hepatitis C in the United States and in California, anywhere from 2 to 4 times more people with hepatitis C than HIV. We've had a tremendous successful response to HIV, and we need to consider the same for hepatitis C.
    d. Transmission is blood-borne with the most common route of transmission currently through shared injection drug use. Paraphernalia, mother-child transmission can occur, although it's fairly rare. Sexual transmission does occur about 1-3% per year in discordant couples. It occurs in men who have sex with men with multiple partners. There have been case reports of transmission through tattooing and piercing, particularly in non-sterile facilities, and there have been cases of healthcare-associated transmission. Blood banks now test for hepatitis C, so, blood transfusion is no longer a major problem. There was an outbreak from a contaminated endoscope a few years ago at UCLA and needle stick remains a risk, although not very common. The groups at highest risk are persons who inject drugs, and incarcerated people.
    e. The state of California has had a very successful program for identifying and treating people who are incarcerated in the prison system. Persons who are experiencing homelessness, about 27% of persons living in Skid Row have been identified with prevalent infection. Historically, it was the baby boomer cohort, people born between 1945 and 65 who either acquired it through transfusion or through substance use.
    f. Dr. Klausner shared data from his PhD epidemiology student showing the number of newly reported hep C cases by age and sex in the United States in 2023. It excludes large states with a large number of cases, such as Arizona, Texas, Kentucky, North Carolina and Hawaii, but the two things to notice are the large

peak among 30 to 40-year-olds, which represents the second wave of the epidemic. Public Health officials thought they would be able to ride the baby boomer epidemic out as that cohort aged, but that has not been the case due to the second wave caused by the opiate crisis in the United States.

g. There is a 2 to 1 ratio of males versus females, which represents transmission through shared paraphernalia and injection drug use.
h. He shared a slide that looks at the number of newly reported Hep C cases that are hepatitis C RNA positive. He noted that measurable RNA in the bloodstream means that the blood of these individuals is infectious and can spread the virus to others, including family members, sexual contacts, and fellow drug users who share needles or paraphernalia.
i. From about 30,000 to 40,000 new cases estimated are reported in California a year. In more recent years, the numbers look lower, but that excludes two of our largest counties, San Diego and Los Angeles. The gaps in reporting and the uncertainty in reporting reflect just our limited surveillance and gaps in our surveillance and epidemiology programs.
j. The big news that everyone should be aware of is that hepatitis C is curable, and has been for more than 12 years. Treatment is two to three months of taking daily oral medication. Very safe and effective, and almost every study has shown a more than 95% success rate with 2 or 3 months of treatment. Treatment reduces complications, cancers, deaths, and saves money. There was a VA study that showed that cost savings of 7 to $9 billion were predicted, and this prevents expensive outcomes like liver transplant.
k. Under the leadership of Francis Collins, who was the former NIH director, and whose brother-in-law reportedly died due to hepatitis C, there was a big initiative and a lot of effort and discussion about a national hepatitis C elimination effort. There was a viral hepatitis National Strategic Plan. Unfortunately, under the current administration, this effort has essentially sunset. However, there continues to be an effort legislatively with the Senate bill called the Cure Hepatitis C Act of 2025 for new funding.
l. Drilling down back to LA County, Dr. Klausner stated he is at USC Keck and work with LA County Department of Public Health. He showed the estimate of the clearance cascade. The cascade, which was started in response to understand HIV, is a critical epidemiological tool for how we understand our gaps in our approach to certain infectious diseases, or any disease.
m. It's estimated about 70,000 of infected individuals in LA County that 82% have had viral testing, that 48% have infection. 48%, or over 27,000, have hepatitis C RNA positivity, but only 31% have been cured or cleared the infection.
n. This means that more than 2 in 3 individuals who are infected with hepatitis C have been untreated. And these untreated individuals have personal risk for medical consequences and can continue to spread infection.
o. Because it is a communicable disease, public health has the legal responsibility, and some may say the mandate to control the spread of communicable diseases.

p. Dr. Klausner discussed a project they started, called Hep C Project Connect. It's a partnership between USC and the Viral Hepatitis Unit of LA County, and the goal of this project, which was started in 2023, is to implement a linkage to Cure program, to increase treatment uptake for hepatitis C RNA-positive residents.
q. They use the project registry, which is based on mandatory reported cases, as mandated by the California Code of Regulations. Laboratories report a hepatitis C RNA result through the state system. It gets allocated to the county based on zip code and with that test result comes some case information. It is not complete case information which is an issue and makes it difficult. At the county, the data are processed, deduplicated, referenced with vital statistics. If someone has passed then it's removed from the data set, and then those are shared with the county board certified trained staff at USC who all have gone through different kind of checks to be certified county case managers. It is updated monthly but one limitation is that there are no jail-based test results and the contact information is incomplete.
r. The overall program notifies these reported case residents, educates them about hepatitis C, provides case management and linkage to treatment services, and then follows up to verify treatment. This is a pretty similar approach that's applied to HIV, syphilis and many other communicable diseases.
s. The first phase was a pilot program for about a year, and they received over 3,000 cases, were able to successfully notify about 20 to 25%. Two-thirds were untreated. We were able to link to a provider about 25% of those and document that about 58 initiated treatments. We learned from this pilot study that most, but not all, were aware of their hepatitis C result. About 1 out of 6 were not aware. These are people who were tested by a medical provider, HCV RNA positive, and never learn their test result.
t. This was not that dissimilar to when he took over the program in 1998 in San Francisco for HIV. They did not have a program to inform people of their HIV test result if they were positive. The idea was that it is up to the individual person to seek their test result. That changed with the advent of treatment and a different approach to HIV at the time. Most of the people they contacted were willing to pursue treatment. Most were insured either through public or private insurance, and they found that a treatment recommendation certainly encouraged people to visit a medical provider.
u. A barrier to treatment, categorized at a personal or system level, was that with most people it just was not a health priority. They were asymptomatic, they may have not heard about treatment that's curative, and it was not something that they were highly motivated to do.
v. Others reported some system-level barriers. There were medical providers who did not recommend treatment, take a watch-and-wait approach. Some people had challenges, identifying a specialist or some basic challenges, like lack of transportation to get to a medical provider.

w. A new version of hepatitis C Connect was started in April 2024, and this had additional linkages, such as a telehealth program in partnership with Walgreens, referrals to other LA County treatment providers, such as the AIDS Healthcare Foundation and Bienestar, which is a community-based organization that provides treatment services, particularly for Latino populations. And also with USC Street Medicine, which is a program that provides services to unhoused individuals, particularly in Skid Row in Los Angeles.
x. In this new phase they received over 8,000 cases, and were able to contact about 30% of those cases. Again, two-thirds had been untreated. About 80% did participate in the program, half were linked to a provider.
y. They were able to verify treatment to date of about half of those. The biggest challenge is contact success. They are only able to contact with the information that is provided through routine reporting about 29% of cases. That is a big gap and something that we as a public health community in California needs to address.
z. They did another study, trying to understand qualitative issues for barriers and facilitators to treatment from both medical providers, patient navigators, and community health workers, certainly socioeconomic factors and homelessness and substance use, mental health were substantial barriers. They know that there are major gaps in healthcare and access as well, but there were facilitators, so the simplification of care, one pill once a day for 90 days, or three pills once a day for 60 days make it easy for people to comply with care. When people understand that they can potentially infect family members, sex partners, needle-sharing partners, people do have a motivation to reduce transmission to people in their social network. They learned from this program that this type of public health outreach and notification linkage does work. It's feasible, it's acceptable, it provides an entry to healthcare. We can use available resources with rapid implementation and reduced programmatic costs.
aa. Their program has confirmed that students, particularly those in health sciences, are an important underutilized workforce that complements underfunded public health work.
bb. With any public health issue, the most important thing is political will and leadership, and that's what they’re trying to do today with the medical leadership group in California for public health. We need stronger surveillance and epidemiology reporting.
cc. In San Francisco in 1999, they started monthly reporting for HIV and STI’s which has continued for more than 25 years now and has been a critical tool to maintain awareness on HIV and STIs in that county. We need to address prior authorization barriers, as many private insurers in particular, still have substantial barriers to access to medication. Some require liver biopsy, which is no longer recommended by any of the professional groups.
dd. There is a bill called AB 1843, currently in session that will address some prior authorization barriers. He added that we need more state and county programs for

hepatitis C linkage to cure, we need to improve reporting. We also need to take advantage of these legislative initiatives that were successful and passed but may no have not been adequately monitored and enforced.

ee. SB 1152, which became effective in 2019, required hospitals prior to discharging a homeless patient to document they had been offered or referred for screening for infectious diseases, which in most areas include hepatitis C. And monitor and enforce AB 789, which became effective in 2022. It is a mandate of offering of hepatitis C testing in primary care, but more importantly, perhaps, is that law requires providers must directly offer or refer patients in California who test positive for further testing and medical management consistent with current treatment guidelines. He thinks that is a big piece that exists in the law, but is not really being implemented.

5) <u>Report from CDPH on Current State Hepatitis C Program</u>:

Next Ron called upon CDPH, Kathy Jacobson, to give a overview of the concept of what we're trying to develop as a state plan and how a group like this could help.

a. Kathy noted that she was asked to cover Hep C in California in 3 minutes, so she focused in on what funding has been allocated to Hep C in California.
b. Chronic Hep C cases in California decreased between 2020 and 2024 but this is a 'moderate' excitement because the vast majority of that decline, about 58%, is due to a decline in the amount of probable cases. Probable cases are defined based on whether or not we have Hep C RNA test results and they just started getting Hep C RNA negative test results in 2022. Based on that, they've been able to determine who may have been infected, but not cleared or cured, so that decreased substantially the number of probable cases in California. Some of the decline, about 18%, is due to a decrease in confirmed cases in California. Roughly 1 in 3 people with detectable hep C viral load tests results have evidence of cure, so this is where a lot of the work is, ensuring that those folks get treated and ultimately cured.
c. There is two different funding allocations for Hepatitis C prevention in collaboration, $4.5 million in ongoing funds that fund 21 local health jurisdictions. The current round of funds are for 2024/2025 through 27/28. It is roughly between $200,000 and $382,000 per local health jurisdiction that receives these funds. There was also a one-time $9 million investment spread over 4 years that is funding 10 local health jurisdictions for the same period of time. The local health departments that are funded are receiving anywhere from 201,000 to $288,000. Half of the funds that a local health department receives need to either go to a CBO or support a CBO in kind. For example, if a local health department is receiving $200,000 that means roughly 100,000 of that either needs to go to a CBO or half of the local health departments' efforts need to support that to support a CBO. She noted that those funds dwindle quickly.
d. Kathy showed a slide with the local health departments that are funded between those two different funding allocations, a total of 31 local health departments.

They determine funding using a formula based on case rates and equity. (Ron added that if a county doesn't have resourced to screen, they will appear to have low cases, which is a challenge)

e. The overarching goals of these funds include to ensure public health surveillance of hepatitis C. The next is efforts on testing, treatment, and linkage to care and the need for CBO partnerships to support the testing, treatment, and linkage to care.
f. In 2021, there was $1 million in state legislature funds allocated to Hep C antibody point-of-care testing for local health departments and CBOs. They can order these tests directly through the state's vendor. These point-of-care tests do require a CLIA waiver and one of the challenging things about point-of-care tests, is that there has historically been no mechanism to report them to the public health system when they are done out in the community. If they are done by a lab, the lab does the reporting, but when they are done in the community, there is no mechanism for reporting. That did change some during COVID, and some of those changes are trying to be implemented for other point-of-care CLIA wave tests that are done in the community,
g. The federal government has a thing called Simple Report that they're trying to get testing in and CDPH is also making efforts to allow for these point-of-care tests to be reported to CDPH directly.
h. In 2025, roughly 59 programs, including 15 local health jurisdictions, ordered these tests. She estimates that of this 1 million, roughly 80% of it has been spent to date, so there are still some additional tests available for application and ordering. Kathy answered a question confirming these are antibody tests not the RNA point of care testing. The funding was allocated in 2021 but sepia test was not available.
i. In 2022, California Legislature appropriated $15 million to CDPH to Emergency Department Hepatitis C, syphilis, and HIV testing, treatment and navigation to ongoing care. They contracted with Bridge to help get the funding out but their office, the Office of STIs and Hepatitis C, have been the implementation arm. Currently all 28 EDs are screening for hepatitis C, more than 80% of the EDs have automated their EMR ordering process so that they can order anywhere from 5 to 7 times more than if you relied purely on provider to do the ordering.
j. They are working through data but there is a lot of cleaning that needs to go on with that data to be able to report it. Data on a small subset of the emergency departments who tested over 50,000 individuals. There was a 6% antibody positivity, and they are continuing to gather that data to report on all 28 of those emergency departments. Funding to the emergency departments ends at the end of April of this year and it is quite an undertaking for EDs to implement routine screening. Urgent cares were not included in the funding requests, but the allocation did require that they cover the geographic and of volume of EDs including rural to urban EDs and any low volume to high-volume EDs. The EDs that were funded are spread across California.

k. Just in the last year California has appropriated an additional $1 million for RNA testing for in-kind support and CDPH released this announcement on February 17th. The application deadline is for March 31st and it is an opportunity for, local health departments, CBOs, emergency departments, et cetera, to apply for ta CLIA-waved RNA testing machine machine. They can also request testing equipment and cartridges. The deadline is March 31st and there will be a webinar on March 11th.
l. A few things CDPH has been working on include test-to-treat and put together a test-to-treat algorithm helping ED providers go from an antibody test to being able to start treatment right in the ED. They are also expanding this test-to-treat algorithm to be used by primary care providers.
m. CDPH also collaborated with DHCS to support the approval of Medi-Cal coverage of the full course of treatment at the time of prescription initiation.
n. They held a statewide primary care provider education on January 26th of this year. Dr. Terrault was the primary presenter and co-presented with Dr. Curtis Moore from CDPH. The also do monthly updates to local health departments and community providers related to hepatitis C. And have produced resources for local health departments for screening and treatment in unique populations including perinatal screening and correctional facilities.
o. She concluded that important overview there are a lot more ERs that are not funded. She noted that Rachel McLean said that AB 789, which required the primary care providers to offer screening for hep C, resulted in more testing, but not a whole lot more cases detected. Apparently, some are not accessing primary care, but they do get sick, go into emergency departments and urgent care.
p. Norah asked that with the new Cepheid opportunity, with point-of-care HCV RNA testing, if they were targeting specific groups. Kathy stated that as part of the eligibility criteria they we will use the volume of applicants to help determine where those tests go, along with both need and equity. Kathy also gave a shout out to Dr. Watt who provided a webinar on what the department was doing on vaccines.

6) <u>General Discussion on Hepatitis C, and Establishment of a Hepatitis C Team or Working Group</u>:

a. Ron pointed out that we had 74 people on the call at its peak, and he was humbled by the opportunity to chair this group of people who have extraordinary skill in various aspects of public health, liver diseases, infectious diseases, and requested that participants leave their information in chat. He then shared current simplified recommendations, (links are on the agenda) for documents on education and further background. He pointed out that in 2023 a combination of hepatologists and infectious disease specialists, the AASLD and the IDSA came up with guidelines that mentioned all of the many direct-acting antivirals that were developed. Currently, they recommend two drugs: The combination sofosbuvir and velpatasvir (Epclusa). Epclusa is one pill a day for 3 months, there is no

requirement with regard to food, and it can be given even with decompensated cirrhosis. In California, the generic form is automatically filled and for 12 weeks of treatment is about $8,000. The second drug, Mavyret, is a combination of glecaprevir and pibrentasvir. It is given for only 8 weeks but requires 3 pills a day, has to be given with food, has more side effects, and it is not indicated for decompensated cirrhosis. Some departments just teach their providers to use the EPCLUSA formula, even though it's an extra month because it's simple to use

b. Ron then referenced a document that included the workup listed as pre-treatment, stating that you need to have a positive RNA showing active infection because you can have hepatitis C antibody from a resolved case. The RNA test is usually a PCR. A pregnancy test is required because the FDA has not approved these drugs for pregnancy. There's a registry for them to determine whether they're toxic. He pointed out that this is an excellent guide from a hepatology and infectious disease perspective, but not from a public health perspective to start treatment as soon as possible so that patients don't get lost to follow up, spread it to other patients in the meantime, or have more advanced liver disease prior to getting on curative treatment.
c. Ron stated that he has written to Jeanne Marrazzo, who was Anthony Fauci's immediate successor at NIH but who is the new executive director of IDSA, the Infectious Disease Society of America, regarding guidelines on who can treat hepatitis C.
d. Ron shared that there has been pre-meeting discussion and interest regarding establishing a working group or consultation team under the aegis of this group. Ron announced that the co-chairs will be George Rutherford, with co-chair hepatologist from USC, Nora Terrault, both of whom were present on the call.
e. Norah noted that Rachel McLean put a link to the most revised version of the hep C treatment from AASLD IDSA in the chat and it emphasizes a minimalist approach where you really do need only the HCV RNA test up front and a good physical exam and history-taking, and then you can initiate treatment and get other tests thereafter. These guidelines will help simplify for non-specialist, primary care and frontier provider settings.
f. Paul Kuo from Stanford also concurred that the threshold for initiating therapy should be quite low.
g. George added that the 'endgame' of the committee Ron referenced (he invited Paul to join) is to develop a white paper that could be given to the CDPH or agencies about hepatitis C elimination in California adding that this is a Sisyphean task because we don't have closed borders with the other states. He stated we've done this before for tuberculosis in the 1980s, and more recently for chlamydia control, when Gail Boland was in charge of the state STD control program. The committee has a role to see if we can get funding for a larger strategic effort that would be much more comprehensive that would involve legislation, regulation, new public health programming, CME, etc. This may already exist, but the

question is, is what else needs to happen, can this be done comprehensively in a way that can be measured in the absence of federal leadership in public health.

h. Jordan Akerley, Strategic Director at NTEP CSF, co-chair of the California Hepatitis Alliance put s information in the chat and reported they are an informal coalition that convenes both community-based organizations or NGOs as well as county public health staff. They are delighted to have partners from CDPH, both from the immunization branch covering hepatitis B and folks from Dr. Jacobson's branch covering Hep C to help to increase awareness, share resources, and facilitate conversation across counties. This is a space where we can get together, not just with the county side or the local health jurisdictions and the state bringing community together. Nep CSF is co-sponsoring the legislation, AB1843 and highlights he can do that Big A advocacy, and the investment is in partnerships with folks across the spectrum to ensure that we understand community need and provider perspectives about the opportunities, gaps, and where we need to focus strategically.
i. Ron introduced Bill Remak to let people know that there has been a hep C task force for many years, and Bill is the contact for that.
j. Ron asked Akhila Chilakala, UCSF Preventive Medicine resident, to give example of what students and residents can do to help local health departments. Akila is working with Catherine Toyooka in Alameda County, and they are looking at a community clinic and their Hep C care cascade to see how patients have been able to achieve SVR and if they're reaching SVR at higher rates than national rates.
k. Ron noted Audrey Chavez runs a needle and syringe exchange program for the Bakersfield AIDS project pointing out the harm reduction portion of prevention. And, that pharmacies are able to dispense for sale syringes and needles without prescription and can be a resource for the 21 counties that do not have syringe exchange programs.
l. Sean Kang was introduced and is a pharmacist who works for the California Pharmacist Association. His job at the association is point-of-care testing and can also provide Hep C treatments. There are challenges particularly on reimbursement. They have reached out to DHCS how expensive the drug is and how the dispensing fee is about the $10. If you have about $25,000 medications to dispense but do not dispense them, then that is a financial burden on the pharmacy side. So, operation-wise, it doesn't make sense.
m. In San Francisco a group of pharmacists were trained to be consultants to the prescribers about hep C meds, an important part of the whole system of getting more patients in treatment. Similar to meds distributed on Skid Row, there is also work with the San Francisco County Health for those working on Mission Street. There are models but we need a stable model to work with. Starting a patient on treatment instantly is not practical because of the cost and it may take a couple of days before they can be picked up and this may require some follow-up. Some patients may not show up and get their meds, but otherwise it would be non-

economical for the average pharmacist. With HIV though, there are specialty pharmacies that attract a large number of HIV patients and make money and keep things in stock. He does not know if there are any specialty Hep C pharmacies at the present time, but that is a treatment model that allows a pharmacy to stock yet not lose money. Problem comes with the consolidation of the powers and the PBMs. There is no transparent definition on specialty drugs and often it is through mail order pharmacies. HIV and Hep C population are the most vulnerable and adherence is the key. If anyone has questions, they were invited to reach out. but I know we don't have enough time to discuss everything, so please feel free to reach out.

n. Ron introduced Dr. Akanksha Vaidya from Santa Clara County who is President of the STI and HIV Controllers. He asked about the variety of models of care in the local jurisdictions in terms of where Hep C is assigned and whether it is separate from hep B. A lot of hep C programs have been folded into local STI programs. Hep B, because of the immunization component, at least in their county, is still with communicable disease separate from STIs and HIV), but for Hep B partner services are extremely important as is perinatal immunization. Screening ultrasound for hepatoma is more of a problem so we may need to share staff in larger departments and not pigeonhole each of these diseases in a separate place.
o. Ron asked Mira Srivanasan if Hep B is usually under communicable disease control rather than STI, HIV who responded that she thinks it depends on how resource are used in the county.
p. Ron noted that there are multiple models and that Aileen Low is in charge of clinics in San Bernardino County. They have found a creative way to treat Hep C. They run a primary care system of clinics and taught their primary care providers to be the hep C treaters as this became a primary care problem.
q. Dr. Krawiec from California Corrections discussed the role of the correctional facilities in screening for Hepatitis C. Since 2017, they treated over 40,000 cases of hepatitis C with 10 providers. The team has been very stable, they treat as much as they can, and go to Project ECHO and get help from Dr. Jenny Price when they need assistance. They also have Loma Linda University Health as a resource, and are trying to work with Stanford when have difficult cases. It was noted that Norah Terrault headed Project Echo at UCSF, training primary care providers to be hep C treaters. She said that the Project ECHO model is well established and a hub and spoke model of training primary care and that Jenny does a fantastic job. In the early days the focus was on rural California, but now it is really any setting in which primary care wants to become a treater.

7) **Wrap up and Next Meeting**

a. Ron stated at the next meeting there will be an election for chair and a follow-up report from the team that George and Norah will be leading. He also proposed that we encourage the development of a single Website with links to the most

reliable health guidelines for both providers and patients, for multiple diseases and health and wellness topics.

b. Ron offered to stay late for any of the 51 people still on the call who would like to give personal introductions and tell what they're doing. Informal discussion continued. The meeting was finally concluded with 20 still online but considerably past the scheduled end.

Submitted by Traci Stevenson, Secretary
with wording taken from video recording, chat, and slides, and minor editing by Ron Hattis.
Approved at meeting of June 9, 2026.