Hep B United

SUMMIT REPORT

2-4 DECEMBER 2020

STANDING UP FOR HEPATITIS B: CREATIVE COLLABORATIONS TO AMPLIFY AWARENESS, ACCESS, AND EQUITY

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INTRODUCTION AND SUMMIT GOALS

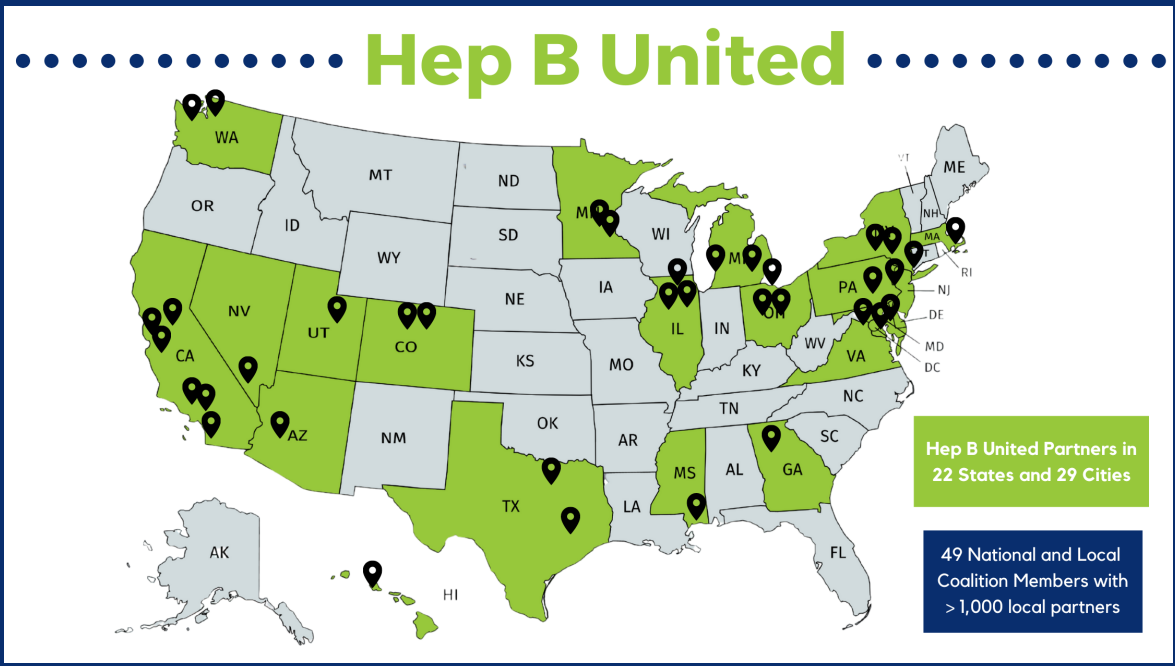
The 8th Annual *Hep B United National Summit* was the first of its kind held entirely virtually and took place from December 2-4, 2020, with participation from over 220 individuals from across the United States. The *Hep B United (HBU) National Summit* is the largest convening of hepatitis B leaders from community coalitions, national organizations, individuals and family members affected by hepatitis B, federal partners, and public health agencies across the United States. The Summit serves as a coalition-strengthening opportunity for partners to engage at multiple levels, in order to share experiences and best practices for hepatitis B education, screening, research, linkage to care, and outreach. In addition, the Summit features collaboration and networking opportunities among coalition partners. Each annual Summit advances our movement to address the public health concern that is hepatitis B, reflect on past successes and challenges, and plan for the future.

OUR GOALS

Awareness: Raise the profile of hepatitis B and liver cancer as urgent public health priorities.

Prevention: Increase hepatitis B testing and vaccination, particularly among Asian Americans, Pacific Islanders, and other high-risk communities.

Intervention: Improve access to care and treatment for individuals living with hepatitis B to prevent end-stage liver disease and liver cancer.



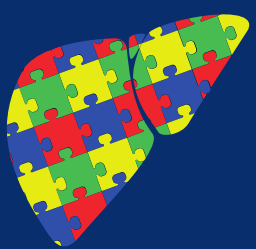
THE STATE OF HEP B UNITED

Hep B United was established by the Hepatitis B Foundation (HBF), in partnership with the Association of Asian Pacific Community Health Organizations (AAPCHO) in 2012, to meet the need for enhanced hepatitis B programs and advocacy in the U.S. HBU members represent 49 local coalitions working to reduce hepatitis B-related health disparities in 29 cities, 22 states and the District of Columbia. Since HBU was established, community partners have conducted over 72,000 educational sessions, screened over 37,500 high-risk individuals, and participated in dozens of media and advocacy events, regionally and nationally. A major contributor to this success is the *Know Hepatitis B Campaign*, a national, multilingual Centers for Disease Control and Prevention (CDC) communications campaign, to improve awareness and knowledge about HBV, and promote HBV testing. The campaign is co-branded with HBU. It provides tools and multi-platform resources for local coalitions, and represents a successful, ongoing partnership between HBU and the CDC.

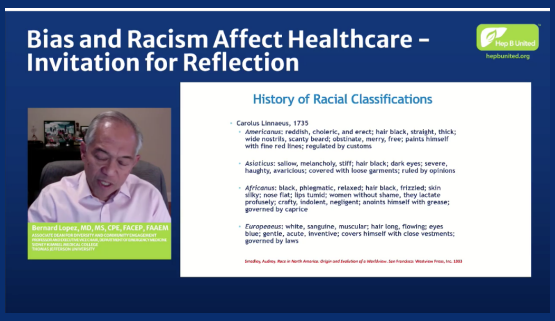
HEPATITIS B® FOUNDATION
CELEBRATING 30 YEARS TOGETHER

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

KNOW HEPATITIS B™



BIAS AND RACISM AFFECT HEALTHCARE: INVITATION FOR REFLECTION



Featured Speaker: *Dr. Bernard Lopez*
Associate Dean of Diversity and Community Engagement
Thomas Jefferson University
Philadelphia, PA

Moderator: *Chioma Nnaji, MPH, MEd*
Program Director
Multicultural AIDS Coalition
Boston, MA

This session was the first of two on bias and racism in healthcare. One recurring theme of 2020 was the persistent magnification of glaring racial inequities that exist in everyday life for Black Americans and people of color. COVID-19 has shone a particularly harsh light on these realities. We know that bias and racism operate at many levels. Racism in America is not new. The impacts of racism on health, including HBV treatment and outcomes, is not new.

This talk included a definition of bias and an overview of the unconscious bias that is built into us as human beings, in order to protect us from harm. Bias manifests itself everywhere from the hiring process to doctor-patient relationships. EVERYONE has biases - it is an effect of being human. Everything that we see and experience goes through the lens through which we view the world - which has been shaped by our own backgrounds and experiences. We all both experience and perform microaggressions. which are brief and commonplace indignities that communicate hostility toward marginalized groups. Microaggressions are the active forms of our unconscious biases.

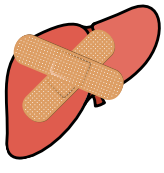
This talk also explored the origins of race, dating back to the 18th century. Racism is a system of structuring opportunity and assigning value based on one's socially ascribed category (e.g. race). A characteristic of racism is that its effects can persist in governmental and institutional policies in the absence of individual actors who are explicitly racially prejudiced. In medicine, we tend to focus on physical and individual factors. When we do that, we do not look out at the bigger determinants of health - the social determinants. Age, sex, and hereditary factors represent only 20% of an individual. In reality, there are another 80% of factors that go into the individual, and this is where racism has its biggest effect.

The question and answer and comment period from this session discussed how Asian Americans in particular have endured racism throughout COVID, the need for greater solidarity among different groups in anti-racist work, and the facts that we are individuals first and that this is a lifelong process that will often be painful and we need to be patient with each other. Takeaways: Speak up, find an ally, disaggregate data!

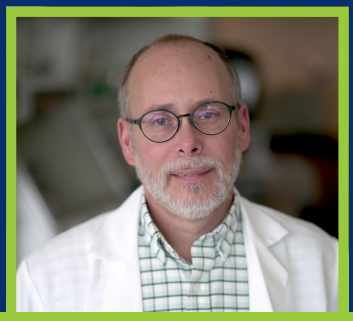
WHAT HAPPENED TO THE CURE FOR HEPATITIS B?

In the past 10 years there has been increased interest in hepatitis B research, both nationally and globally. In the US alone, NIH spending on hepatitis B research has almost doubled. Much has been achieved with current hepatitis B medications, including routine suppression of HBV DNA and greatly reduced risk of premature death from liver cancer in those on long-term treatment with controlled viral DNA levels. The current treatments do have limitations: Not everyone is eligible for or benefits from treatment, and the current medications work with only two modalities - nucleotide (nucleoside) analogues target the same viral stage, and all interferons stimulate the same set of cellular response.

There is hope in terms of the direction of future research. The number of medication candidates to treat chronic hepatitis B has increased fourfold over the past 10 years. Moreover, the current candidates in clinical trials work with different modalities, attacking the virus from various pathways, and it is clear now that combination therapy would be the more likely success. The good news is that the current candidates in the pipeline are inclusive to the broad spectrum of hepatitis B patients and therefore, the notion that those who have been on treatment may not be eligible for the potential new therapies is inaccurate. Another important revelation that has been recently discovered is that cccDNA (covalently closed circular-DNA) has a much shorter half-life than previously believed. This means that shorter treatment duration is possible. Obstacles still remain, however, in that drug development is difficult, time-consuming, and expensive. Additionally, the definition of hepatitis B cure needs clarification. Both Dr. Block and Dr. Tavis have agreed that the complete cure, which entails complete elimination of viral DNA material from the body, is almost not attainable with current knowledge and technology. Most researchers agree that functional cure seems to be the more feasible option. Functional cure means finite duration of treatment, no disease progression, no detectable HBV DNA in the blood, and sustained viral suppression – meaning immune control of residual cccDNA. Takeaway messages are to keep the advocacy going and maintain innovation and investment.



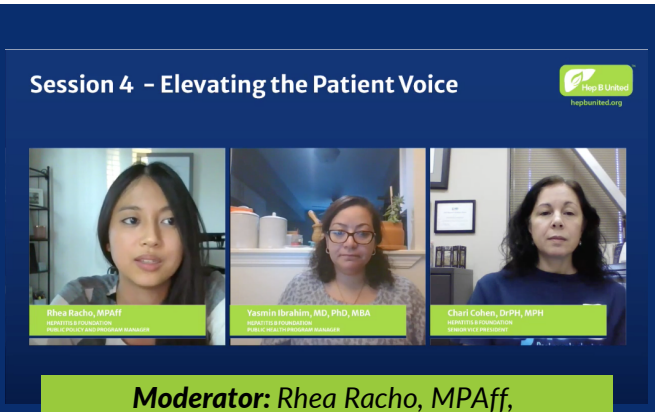
Moderator: *Chari Cohen, DrPH, MPH*
Senior Vice President, Hepatitis B Foundation
Co-Chair, Hep B United



Featured Speaker: *John Tavis, PhD*
Professor of Molecular Virology
Director of the Institute for Drug & Biotherapeutic Innovation
St. Louis University School of Medicine

Featured Speaker: *Timothy Block, PhD*
President and Co-Founder
Hepatitis B Foundation &
Baruch S. Blumberg Institute

ELEVATING THE PATIENT VOICE & #JUSTB STORYTELLER PANEL



Moderator: *Rhea Racho, MPAff,*
Public Policy and Program Manager
Hepatitis B Foundation
Featured Speakers:
Yasmin Ibrahim, MD, PhD, MBA
Public Health Program Manager
Hepatitis B Foundation &
Chari Cohen, DrPH, MPH
Senior Vice President
Hepatitis B Foundation

Co-Moderators: *Rhea Racho & Wendy*
Featured Storytellers:
Alice, Joe, DeWayne

Day 1 concluded with an inspiring and meaningful session focused on the importance of the voices and stories of those living with hepatitis B and their family members, and how crucial this is in turning the spotlight on HBV, particularly in terms of recognition and funding. This session was presented in two parts. The first included an overview of the #justB storytelling program, including outreach and promotion efforts and story-telling workshops. This was followed by a discussion of the results and data collected from the Externally Led Patient-Focused Drug Development meeting hosted in partnership between HBF and the U.S. Food and Drug Administration in June of 2020, as well as the results of surveys and interviews conducted directly with people living with hepatitis B worldwide. The data captured from these activities indicates the profound emotional and physical impacts of hepatitis B and sheds light upon the deeper meaning of an HBV diagnosis. Feelings of isolation and fatigue were those most commonly reported. Other reported concerns included accessing care from knowledgeable doctors, affordable medication, and management of the disease. Experiences of stigma and discrimination, and fears about disease progression into cirrhosis, liver cancer, or liver failure were also emerging themes from patient conversations. Public awareness and education desperately need to be improved, as well as access to and affordability of care both in the US and around the world.

The second part of this session consisted of a #justB Storyteller panel. The panelists shared their experiences of living with hepatitis B, including how it has affected their lives, and their hopes for a future cure. These hopes included the abandonment of interferon as a treatment, and more accurate information about hepatitis B and clinical trials, particularly for those with less access to and comfort with technology. Many thanks to all for their courage in sharing their stories and contributing to hepatitis B advocacy and elimination!

FEDERAL UPDATES ON HEPATITIS B

Moderator:
Nancy Steinfurth, MPA
Former Executive Director
Liver Health Connection

Featured Speaker:
Carol Jimenez, JD
Deputy Director for Strategic Initiatives, US DHHS, Office of Infectious Disease & HIV/AIDS Policy

Featured Speaker:
Jessica Fung Deerin, MPH
Epidemiologist
US DHHS, Office of Infectious Disease & HIV/AIDS Policy

Featured Speaker:
Carolyn Wester, MD, MPH
Director
CDC Division of Viral Hepatitis

The opening session of Day 2 provided an overview of progress made toward hepatitis B elimination at the federal level, including at the CDC Division of Viral Hepatitis and the Department of Health and Human Services Office of Infectious Disease and HIV/AIDS Policy. Up first was the HHS presentation focused on the unveiling of the *Viral Hepatitis National Strategic Plan: Roadmap to Elimination 2021-2025*. For the first time, the U.S. has signed on to elimination goals which align with those of WHO and the National Academies of Sciences, Engineering, and Medicine. The roadmap includes the integration of HHS' National Strategic Plans for Viral Hepatitis, HIV, STIs, and Vaccines, which shine a light on stigma, discrimination, and social determinants of health and the central role they play in the persistence of viral hepatitis, HIV, substance use disorders, and sexually transmitted infections.

The new plan stratifies priority populations by disease incidence, prevalence, and mortality to help narrow the focus and guide organizations on where to concentrate resources and effort to have the greatest impact. The plan will have 5- and 10-year targets and the core indicators include reducing acute HBV infections (with a particular focus on PWID), increasing birth dose rates, increasing the proportion of people aware of their infection (with a focus on AAPI communities), and reducing HBV-related deaths (particularly among AAPI and non-Hispanic black communities). The primary stated goals are to:

- prevent new viral hepatitis infections (through culturally competent and community-led education, increased vaccine uptake, and venturing into community spaces);
- improve health outcomes for people with viral hepatitis (through increased testing and linkage to care, reduced price and insurance barriers, expanded capacity of the public health and provider workforce, and more advanced diagnostics and therapeutics);
- reduce viral hepatitis-related disparities and health inequities (through reducing stigma and discrimination, decreasing disparities in knowledge and information, addressing social determinants of health, and practicing whole-person healthcare - HBU can play a significant role in this);
- improve surveillance and data usage (through establishing national capacity for this, improving reporting, sharing and use of clinical data, and developing and implementing quality improvement practices in the HBV continuum of care); and
- coordinate efforts among partners and stakeholders (through greater accountability among federal stakeholders, collaboration, and cross-disciplinary funding, services, and communication).

Partners are encouraged to continue to provide evidence on what elimination strategies are working to HHS and to email Jessica Deerin to be added to the map of existing projects.

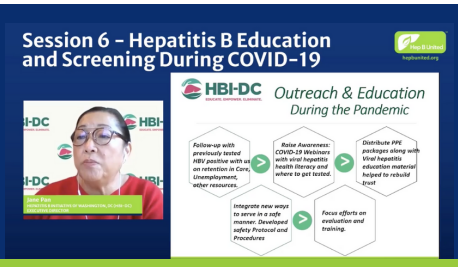
FEDERAL UPDATES ON HEPATITIS B (CONT.)

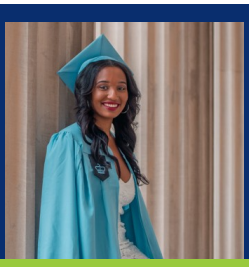
The second half of the presentation was focused on the work of the CDC. Dr. Wester began by reiterating that the funding for viral hepatitis remains at $39 million. The core indicators of CDC's viral hepatitis strategic plan are the same as those of the HHS plan outlined above. There was a reduction in acute HBV cases from 1980-2018, which aligned with the implementation of key recommendations. Pediatric vaccination rates, once achieved, remained stable and at or above the Healthy People (HP) 2020 target of 90% for nearly 20 years. Birth dose vaccination rates for hepatitis B are still below the HP 2020 target, but progress is being made. Acute hepatitis B infection is on the path to elimination in people younger than 29 years of age in the US: Rates of new infections among people in their 20s dropped from 4.0 to less than 1.0. Increasing rates among susceptible adults in their 40s, 50s, and 60s can be attributed primarily to injection drug use. There is still a long way to go to achieve universal hepatitis B vaccine coverage among adults in the US. The current hepatitis B vaccination recommendations are risk-based. Universal vaccination of adults will be presented before ACIP for a decision in 2021.

The recommendations for screening/testing and vaccines are made by two entirely different groups and are often not coordinated. Only about a third of people living with HBV in the U.S. are aware of their infection. Proposed updates to the CDC's 2008 Hepatitis B Testing Guidelines include one-time universal screening of adults, adding three additional risk groups (STIs, HCV, and incarceration), and updating serology recommendations. These new guidelines are expected to be published in 2022. In 2019, the HHS Office of Minority Health allocated $2.9 million in annual funding to support comprehensive hepatitis B prevention programs around the country, in collaboration with CDC and other key partners. Many initiatives have been undertaken to increase hepatitis B awareness and education, including the Know Hepatitis B campaign; the Viral Hepatitis Networking, Education, and Training program, awarded to coalitions focused on educational outreach and testing and to institutions to provide free online training resources for healthcare providers; and the National Viral Hepatitis Education, Awareness, and Capacity Building for Communities and Providers program, which will announce a request for proposals in March of 2021.

The questions at the conclusion of this session were related to funding, which for HHS depends on Congress and with which a clear roadmap and targets could help tremendously. The CDC plan will also need additional investment, but a lot of initiatives are already underway and can continue with current funding. CDC's plan is also funded by a variety of other divisions and through other federal agencies. Coordination and leveraging of resources are essential. The new Administration will be very helpful. Quest and LabCorp's analysis of U.S. hepatitis B blood panel data can be very useful to understand testing rates at the jurisdictional level and build cascades of care, in the absence of national surveillance. Pay-for-performance and quality measures are good ways to incentivize doctors to test for HBV infection. The Department (HHS) as a whole is working on initiatives to increase vaccination rates (in response to concern that vaccination rates have decreased due to COVID) - these include catch-up vaccinations for children, as well as incorporating HBV vaccination for adults into screening and prevention for other illnesses. There was strong encouragement for hepatitis B advocates at the local and community levels to keep the lines of communication open with federal partners and to make this a truly collective and supportive effort. Many thanks to Carol, Jessica, and Dr. Wester for their leadership in achieving hepatitis B elimination at the federal level!

HEPATITIS B EDUCATION AND SCREENING DURING COVID-19





Featured Speakers:

Jane Pan,
Executive Director
Hepatitis B Initiative of Washington DC

Halimatou Konte, MD
Health Program Director
African Services Committee

Danait Yemane, MPH
Hepatitis B Project Coordinator
African Services Committee

Y-Uyen Le Nguyen, MD
Hepatitis B Program Director
Charles B. Wang Community Health Center

Dung Hua, MHA
Program Manager
Vietnamese American Cancer Foundation

Session 6 of the Summit focused on the diverse and dynamic ways in which community organizations around the country continue to deliver high-quality hepatitis services, in the midst of the global pandemic. Panelists addressed patient engagement and communication, community safety, and creative initiatives to ensure efforts toward raising awareness about hepatitis B prevention and treatment continued uninterrupted. The session was moderated by *Catherine Freeland, MPH, Public Health Program Director at the Hepatitis B Foundation.*

Some of the strategies that were discussed in this session included outreach and education sessions using virtual platforms (Zoom), as well as contactless lab testing, as used in Philadelphia. Ms. Pan discussed tactics used by HBI-DC, namely outreach via emails and phone calls; contactless distribution of educational materials and PPE; follow-up with previously tested HBV+ persons regarding retention in care, employment, etc.; and multilingual webinars about COVID awareness, viral hepatitis health literacy, and free testing for COVID and hepatitis. Other actions that were taken included increased social media presence, a greater focus on evaluation and training, and application for and receipt of a HOPE grant to distribute PPE and educational materials, which allowed for the distribution of 1500 PPE kits and the creation of 1-page flyers on COVID and hepatitis. Partnerships were established with clinics who see hepatitis B patients and a hybrid screening model was developed using telehealth. Over 60 people were screened in this manner. In-person screenings resumed in October 2020 with special precautions taken - 78 people were screened at two different events. From January to October 2020, 1550 people were screened and 97% were linked to care. 135 vaccines were administered from July to September 2020 with help from provider offices.

VACF has adopted similar approaches, as Ms. Hua shared in her presentation. She spoke in detail about the digital divide that exists, mainly in the senior Vietnamese immigrant community, that is rooted in inequities that are themselves based in economics, usability, and empowerment. Outreach strategies have included community check-ins and needs assessments, distribution of emergency care packages, including hepatitis B and COVID educational materials, virtual workshops for households, and drive-through educational events. Since April 2020, VACF has been able to reach more than 3000 families.

In her presentation, Dr. Nguyen spoke about the development of protocol for disinfection and social distancing at her New York City community health center, the risks and strain posed by COVID-19, particularly in terms of testing and screening delays, the risks of patients running out of medication, and the more frequent reliance on telemedicine. Tactics for dealing with the pandemic have included one-on-one telephone education about hepatitis B and encouragement of testing for household contacts, moving bloodwork to locations near patients' homes, offering hep B testing at COVID testing events, creating 1-page flyers in English and Chinese to promote screening at the clinic, and collaborating with other Asian American organizations to conduct screening events. A live radio feature with hepatitis B education will be coming in the future.

Ms. Yemane from African Services Committee discussed similar strategies in her presentation, including following up with clients on health status and basic needs, and hosting screening events upon reopening with safety protocols and PPE. From July-December 2020, 75 people were screened for hepatitis B and C. Following the presentations, questions were asked about how to allay community fears about in-person testing during COVID, to which the response was to ensure adherence to all CDC guidelines, and to provide advanced registration, answers to questions, ample PPE, and crowd control. Another question was asked about how to bridge the digital divide - strategies for this included conducting phone outreach and providing testing and educational materials at other community events (such as food distribution) to make everything as equitable as possible. Thanks to all for sharing how you continued services during this difficult time!

INTEGRATING HEPATITIS B INTO STATE AND LOCAL VIRAL HEPATITIS ELIMINATION PLANNING

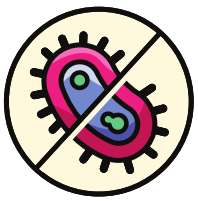
The first of two breakout sessions, this informative panel offered many valuable insights into the different approaches being undertaken to ensure that hepatitis B receives the attention and priority it deserves.

In Hawaii, a premium is placed on including all affected communities in the state plan - ensuring that voices and stories are included as data - in order to lend context to the lived experiences of viral hepatitis, and to make certain that the core values of social justice and equity in everything are reflected throughout the plan. A low threshold of engagement and flexibility are crucial. The four arms of the plan include awareness, access, advocacy, and using data for decision-making.

Similarly, in Pennsylvania, a high priority is also placed on including those with lived experience of hepatitis B in the planning process. Hepatitis B was elevated to the same level of priority as hepatitis C right from the beginning. During the plan design, four working groups focused on prevention, diagnosis, treatment, and surveillance. It was ensured that these state-level working groups were inter-agency to increase the level of buy-in from state leadership and to open discussion about funding strategies. The care cascade continues to be monitored and will inform future planning.

Equivalent strategies were undertaken in New York City, which received funding from the City Council and formed a multi-sectoral stakeholder group to improve health outcomes, decrease mortality, and improve diagnosis, care, and treatment.

At the national level, efforts have been made to encourage any state constructing an elimination plan to include both hepatitis B and C. Important guidelines to remember include the incorporation of harm reduction into vaccination, testing and linkage to care efforts; not politicizing elimination planning; and undertaking plan design and implementation using the lens of systemic racism and health disparities. Enhanced surveillance, integration of services, and coordinated efforts at all levels are critical to reach elimination goals and advocate for increased funding. Important takeaways are to create a two-way relationship with legislators, use data, and lead with tools and resources that are already available. This is a winnable battle!



Moderator: *Catherine Freeland, MPH*
Public Health Program Director
Hepatitis B Foundation

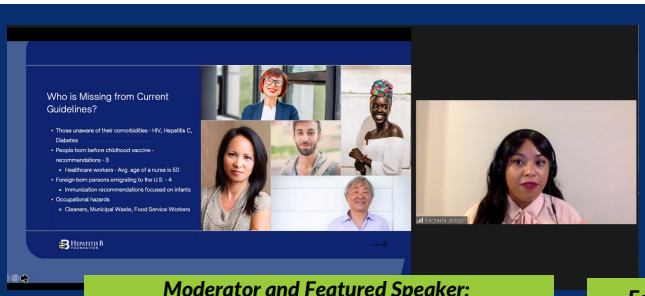
Featured Speaker:
Boatemaa Ntiri-Reid, JD, MPH
Director of Hepatitis, NASTAD

Featured Speaker: *Lauren Orkis, DrPH*
Viral Hepatitis Prevention Coordinator
Pennsylvania DOH

Featured Speaker: *Jessie Schwartz, RN, MPH*
Director of Viral Hepatitis Program
NYC DOH

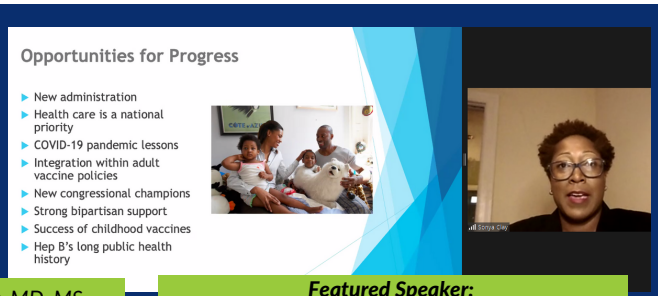
Featured Speaker: *Thaddeus Pham*
Viral Hepatitis Prevention Coordinator
Hawaii DOH
Co-Director, Hep Free Hawaii

THE PATH TO UNIVERSAL ADULT HEPATITIS B VACCINATION



Moderator and Featured Speaker:
Michaela Jackson, MS
Prevention Policy Manager
Hepatitis B Foundation

Featured Speaker: *Chia Wang, MD, MS*
Infectious Disease Physician & Medical Director, Antimicrobial Stewardship Committee, Virginia Mason Medical Center & Clinical Associate Professor of Medicine, University of Washington



Featured Speaker:
Sonya Clay
Government Relations Consultant
Vaccinate Your Family

The second breakout session of the Summit provided an engaging discussion of adult hepatitis B vaccination efforts in the US. In their presentations, Ms. Jackson and Ms. Clay offered an overview of the state of adult hepatitis B vaccination in the US, including current barriers. The present guidelines for adult vaccination are risk-based and complicated, leading to many population groups being either not included in the recommendations, or unaware of their risk profile. The number of people lacking sufficient insurance coverage in this country remains high and poses a barrier to hepatitis B vaccination, as well as to healthcare access in general. Challenges related to the 317 program, which covers several vaccine programs, also make universal vaccination difficult, as the program is not standardized across states and is frequently underfunded. Barriers also exist in terms of logistics (prescription requirement in some states and transportation/storage/stocking issues), diluted and inconsistent messages from different healthcare providers, a lack of awareness among policy makers, and vaccine hesitancy among adults. The effects of COVID-19 have suspended or reduced many hepatitis outreach programs that provide vaccines. Health disparities have become wider and more pronounced over the last year.

Now is an opportune time to work toward achieving universal adult vaccine recommendations: In 2020, CDC announced that hepatitis B is a winnable battle; the Division of Viral Hepatitis 2025 Strategic Plan calls for expanding hepatitis B vaccination recommendation; there is an anticipated focus on public health by the new administration; and several new Congressional and Senate champions with healthcare backgrounds have taken office. This interest has been amplified by the emergence of the COVID-19 vaccine, which could be an opportunity to open communication channels about adult vaccination against hepatitis B and other infectious diseases. Increased federal interest in addressing health disparities and chronic disease management can also play a significant role in this fight. There is also strong bipartisan support for vaccination, shown in the number of new immunization bills that were introduced only in the past few years and in progress made to provide proper and consistent coverage for vaccines through Medicaid and Medicare. Maternal health and prenatal care, which is always an important Congressional issue, is a good avenue through which to incorporate universal vaccine coverage, as well as maternal screening.

This session concluded with Dr. Wang sharing her experience of running the HIT-B Project: Reducing Hepatitis B Disparities through Health Information Technology at the International Community Health Services Clinic in Seattle, WA. ICHS is a Federally Qualified Health Center serving mainly low-income individuals, people of color, and immigrants from around the world, with more than half covered by Medicaid. There exists a high prevalence of hepatitis B at this clinic. The HIT-B Project aimed at assessing the effectiveness of electronic health records (EHRs) in improving hepatitis B screening and vaccination rates in a community health center setting. The intervention was comprised of two main parts: The Provider Dashboard, to which hepatitis B screening and vaccination were added, and the Huddle Sheet, a patient-specific paper sheet, which is submitted to the primary care physician before each care session to note important dates for tests or vaccine doses. Hepatitis B was added to that sheet. The most important challenge the project faced was identifying the right target population. The team leveraged the power of the EHR to pinpoint the clinic population that came from highly endemic countries. As a result of this project, the clinic population was almost twice as likely to get screened for hepatitis B and three times as likely to receive hepatitis B vaccines following the implementation of the intervention. This project has shown that engaging front line staff and integrating any intervention directly within the workflow ensures provider compliance and sustainability.

The biggest takeaways from this session were that proper communication and engagement with stakeholders (policy makers and healthcare providers), forming the right coalition, and raising awareness make a great difference and are important now more than ever to support hepatitis B screening and vaccination. Thank you to the speakers for their important insights & guidance for moving forward!

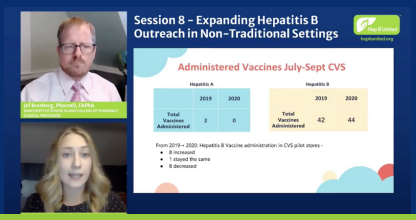
EXPANDING HEPATITIS B OUTREACH TO NON-TRADITIONAL SETTINGS

Day 3 of the Summit began with a highly engaging session representing a diversity of perspectives. The session started with Dr. Bratberg and Ms. Falleni presenting about an initiative to expand hepatitis A and B vaccination coverage for persons who inject drugs in the community pharmacy setting. The presentation highlighted the role of pharmacists as an under-utilized resource in the health care community and the most visible health professionals. Community pharmacies have the ability to leverage on-site vaccinations, as they are recognized as immunizers, and deliver harm reduction to high-risk populations. Additionally, they are equitably located to provide care to all communities. Barriers to hepatitis A and B vaccine administration largely involved stocking specific doses. In Rhode Island, hepatitis A and B vaccines are free of charge to opioid treatment programs, and universal vaccine purchase and distribution systems enroll all state providers, including community pharmacies. The presenters launched a pilot program in which they focused on a postcard intervention and custom websites with simplified language translated into English and Spanish about hepatitis A and B vaccines. From 2019-2020, hepatitis B vaccine administration at CVS pilot stores showed increases at 8 sites, 1 site whose rates stayed the same, and decreases at another 8 sites. In terms of next steps for this project, the successful aspects of the intervention revolved around the passive marketing intervention, supplemental educational materials, onboarding packets and phone calls, data collection and patient decision-making responsibility. Areas that need additional attention moving forward are patient follow-up, communication methods, onboarding protocol, COVID-19 considerations, store selection, and combination promotion for dual vaccination of hepatitis A and B.

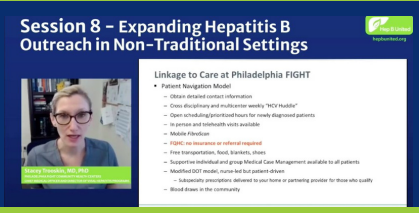
The second presentation was delivered by Dr. Jessop, who spoke about the continued need to try to reach "hard-to-reach" communities. Many of the barriers that exist within our traditional health care settings inhibit access to hepatitis B health care. These are related to health literacy, time away from work, and childcare, among other factors. The concept of primary prevention is key to addressing hepatitis B, and improving awareness, education, prevention of exposures, and immunizations located where people are is crucial. Immunizations should be located at drop-in centers, drug treatment centers, syringe exchange programs, and cultural centers or places where multilingual services are located, to which people would return to complete the vaccination. The importance of judgment-free screening was also emphasized as essential for identifying those who are living with hepatitis B, as was better language support.

This session concluded with a presentation from Dr. Trooskin, who highlighted lessons learned from HCV that could be translated into expanding access for HBV services. We need to be thinking about models of care that bring care to the community at a variety of locations, including community health centers, churches, pharmacies, etc. Additionally, task shifting should occur for hepatitis B management from the specialist to many different providers that can also dispense treatment, including PAs and NPs for example. More expanded testing capacity is also in order. There are a variety of settings that can also distribute medication and can utilize a model of embedded care, including syringe service programs, treatment centers, and correctional facilities. A model of patient navigation can significantly increase outreach to patients and reduce loss to follow up. The takeaways from unconventional settings and practices are many and we are fortunate to have had this informative and insightful session!

Moderator: *Daniel J. Ventricelli, PharmD, MPH*
Assistant Professor of Clinical Pharmacy
Philadelphia College of Pharmacy,
University of the Sciences



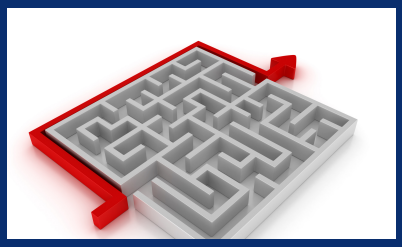
Featured Speakers: *Jef Bratberg, PharmD, FAPhA*
Clinical Professor &
Alyssa Falleni, Student Pharmacist
University of Rhode Island, College of Pharmacy



Featured Speaker: *Stacey Trooskin, MD, PhD*
Chief Medical Officer &
Director of Viral Hepatitis Programs
Philadelphia FIGHT Community Health Centers

Featured Speaker: *Amy Jessop, PhD, MPH*
Director, HepTREC
Associate Professor of Public Health,
Western Michigan University

BIAS AND RACISM CREATE SIGNIFICANT DISPARITIES IN HEALTHCARE - WHAT WILL YOU DO ABOUT IT?


Chioma Nnaji and Dr. Bernard Lopez returned for the final session of the Summit, which entailed a deeper exploration into individual biases and how these might manifest themselves in lives and work. The session began with a video on unconscious bias that detailed how our brains are designed to present us with a view of the world that is based on prior assumptions and biases that have been solidified over time, despite how we would like to believe the contrary. This occurs, for example, with visual biases that are the reason for optical illusions. Our biases allow us to filter incoming information and process data very quickly and are integral to our survival. The brain processes information in a way that makes us see things not as they are, but as they are most useful to us. Unconscious biases are present when processing information about the people around us, forming "social illusions" such as tribalism ("us" vs. "them"), fundamental attribution error, and confirmation bias. Our world today is much more diverse and cooperative than that of our ancestors, who relied on tribalism to survive. Our brains have not caught up to our present-day society. Fortunately for us, our brains are elastic and able to change. Some biases can quickly be changed or unlearned once we are conscious or aware of them; others may take much more time and effort. Just as we learn through repetition, we can also unlearn in the same way. Instead of reacting to our biases with shame or resignation once we become aware of them, “Be fascinated with your biases, be enthralled, be excited when one of them is revealed to you, because once you’ve learned to recognize them, then you can work at dismantling them.” We have less opportunity to change if we are afraid of or uncomfortable with our biases when they emerge.

This video was followed by everyone's participation in the Implicit Association Test, which investigates thoughts and feelings that exist outside of conscious awareness and control. This test is meant to raise awareness of unconscious bias; it is not a measure of bias or prejudice. In some ways, it is measuring how we are conditioned. A discussion of results followed this test, which was in turn followed by a review of earlier material. The concepts of structural and systemic racism were reviewed, including how these touch upon healthcare and are apparent in many of the health disparities we see today, including access to healthcare, experiences of discrimination, and increased exposure to traditional stressors like unemployment and pollution. COVID-19 has exposed and magnified already existing health disparities in Black and other minority communities. Race-based healthcare is structural racism within healthcare and medicine. A NEJM article that came out in July calls into question the use of race-based corrections and calculations that are used in medicine. Race medicine allows for the ignorance of the social (and predominant) causes (determinants) of disease.

Following the presentation was discussion about specific incidents of structural racism witnessed by Summit participants. Topics ranged from lack of language interpretation and misdiagnosis and mistreatment to assumptions made about entire groups of people and perpetuation of harmful stereotypes. Next was a conversation about actions that can be taken on an individual level to dismantle structural racism, which include modeling, changing hiring practices, speaking up, advocacy, education, and policy change. Inclusion of different voices, language access, workforce and leadership development for more people of color, integrating bias training, and mandating equity metrics in pay-for-performance models were also mentioned. Other more broad-scale action suggestions included seeking out interracial relationships and experiences, as well as valid information on race and racism, and joining or forming community or professional groups that work on behalf of multiculturalism, diversity, and antiracism. It is important to remember that becoming anti-racist is a lifelong learning process that involves repeated introspection, self-reflection, and change. It is vitally important to make sure we are working on all the issues discussed during these sessions in order to ensure that we achieve health equity for all those we serve.

Congratulations to all Hep B Champions!

Chioma Nnaji

Joe Balestreri

CHIPO NYC

David Urick

Asian Health Coalition

Amy Tang

Richard So

Bright Ansah

Farma Pene

And to our Federal Champion...

Corinna Dan

CONCLUSION

Despite the virtual nature of the Summit, Hep B United coalition members greatly enjoyed the opportunity to network with individuals from across the country - including partners from the community, state, and federal levels - and to share best practices and experiences during the 2020 National Summit. Going forward, coalition members will continue to build upon lessons learned from the Summit, as they return to their communities and continue to work toward our collective goal of eliminating hepatitis B in the United States.

Thanks to the Sponsors of the 2020 Hep B United National Summit

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