Summit for the elimination of hepatitis B and hepatitis C as a public health threat in the United States

ATLANTA, GEORGIA, USA
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Objectives

• To review the goals in the report of the National Academies of Science, Engineering and Medicine for the elimination of hepatitis B and hepatitis C in the US and the recommended actions to achieve those goals
• To highlight the strategies for prevention, testing, care and treatment needed for elimination, in particular those to overcome health disparities among marginalized and underserved populations
• To review current efforts to eliminate viral hepatitis, their capacity needs and best practices for development of elimination programs at local and State levels
• To foster collaboration between stakeholders in the elimination of hepatitis B and hepatitis C in the US
Chronology

- 1980s: hepatitis B vaccine and discovery of hepatitis C virus – the silent epidemics grow
- 2007: recognition that in US deaths from viral hepatitis exceeded those from HIV for first time
- 2010: IOM issued report on hepatitis and liver cancer: a national strategy for prevention and control of hepatitis B and C
- 2010s: licensing and introduction of first DAAs for treatment of hepatitis C
- 2015: UNGA adopted 2030 Agenda for Sustainable Development which includes a target (3.2): “By 2030 … combat viral hepatitis”
- 2016: WHA adopted global health sector strategy on viral hepatitis 2016-2021, with the target of elimination as a major public health threat by 2030.
- 2016: National Academies’ report on eliminating hepatitis B and C as a public health problem in US
National strategy for eliminating viral hepatitis

- The 2016 report concluded that elimination is feasible but would take considerable will and resources
- The strategy issued in March 2017 aims to eliminate viral hepatitis as a US public health problem by 2030, setting out appropriate goals and a path to achieving those goals. The US is the first country to have this sort of roadmap
- It responds to a real public health problem, many societal and individual facets of which were described at the Summit; it addresses health disparities and provides goals and specific actions with a timeline and numerical targets based on commissioned models of elimination of hepatitis B and C
- It identifies roles for diverse partners, including government at different levels, institutions (including CDC), clinical care organizations (including the VA and haemodialysis centers), professional bodies (such as AASLD, IDSA and NCI), voluntary organizations (e.g. American Cancer Society), academia, the pharmaceutical industry, coalitions, communities, and patients and their advocates
- It highlights what is possible with commitment and resources
It follows the five strategic directions of WHO’s global health sector strategy for viral hepatitis:
- public health information, essential interventions, service delivery, financing and research

The report contains 13 specific recommendations for different stakeholders, including greater attention to serious barriers, greater awareness (public and professional), a radical proposal for financing, and (a key recommendation) a coordination office at the highest level of federal government.

The strategy is aligned with CDC’s viral hepatitis elimination priorities. The HHS supports and shares the vision of elimination and is discussing alignment with the existing national action plan (https://www.hhs.gov/hepatitis/blog/2017/03/28/report-charts-course-to-elimination-of-hepatitis-b-and-c-in-us.html), but implementation of plans depends on capacity and resources.

Even before the strategy was issued, several major events had taken place: e.g. the Cherokee Nation Health Service’s HCV Elimination Programme, the commitment by a coalition of governmental and nongovernmental partners in the State of New Mexico to eliminate hepatitis C, New York State’s appointment of a Hepatitis C Task Force, San Francisco’s steps towards becoming the first hepatitis-free city, the provision of HBV vaccine and HCV testing in Health Departments in Tennessee, and the commitment by the State of Louisiana to eliminate hepatitis C.
Issues and needs

• Great political will be needed for elimination of viral hepatitis which, with public health generally, must remain politically a non-partisan issue; the national opioid addiction crisis is also bringing hepatitis C to the attention of politicians
• Current uncertainties about health policies and Government funding are confusing and disquieting but are focusing minds
• Transmission of viral hepatitis is avoidable and preventable; we have the tools and knowledge to reverse current trends in viral hepatitis but no single model applies: a multipronged approach is cost-effective (for HCV actions include medication-assisted treatment and harm reduction measures such as syringe services programs). Expanding or leveraging services can be done but needs federal and State commitment to reach the levels of access needed to be effective
• There was consensus that all infected people should be identified and treated; state models can help local authorities determine the number of people to be treated to reach targets. Treatment costs (real and perceived) are still high, but so are the costs of inaction
• Attention needs to be focused on immigrants and refugees of African origin, as well as Asians and Pacific islanders, owing to high prevalence rates in the countries they came from
Issues and needs (continued)

• PWIDs are to be found not only in cities but in rural areas, and are often hard to reach and face great difficulties in accessing care and services; incarcerated populations, mostly PWIDs, contribute over 80% of HCV transmission epidemics, but only 1% is being treated

• Needs include:
  – coordination at all levels, and prioritization
  – identification of the most effective interventions
  – decisive and quick actions (even though changing medical practice can take years), all based on better baseline data and better reporting, sharing and analysis of data
  – better diagnostics, including rapid point-of-care tests
  – better access to care, including overcoming language and other barriers
  – increased awareness of viral hepatitis (public and professional, including law-enforcement agencies - the war on drugs concept reduces the ability to provide public health services and prevention)
  – coping with immigrants and refugees, often transient communities
  – improved education of health care providers
  – reduction and elimination of discrimination and stigmatization, including the use by health professionals of non-stigmatizing language, and recognition of different forms of stigmatization; providers should not be judgemental
Issues and needs (continued)

- Hepatitis B and C are different viruses and cause different diseases, necessitating different responses; epidemics are dynamic with differing drivers and local characteristics (including cultural); need to focus on the drivers of epidemics (for instance, ignoring incarcerated populations will severely reduce chances of elimination). Good dynamic transmission models needed to determine appropriate interventions. Co-infections, including HIV, are a major issue – possible focus for Ryan White-type program.

- Hepatitis B: test HBsAg-positive pregnant women for viremia and administer antiviral treatment to those with a high viral load in the third trimester; improve coverage of birth dose of vaccine; find a curative treatment – meanwhile cope with lifelong suppressive therapy; agree on when to start therapy; population affected is disproportionately foreign born.

- Hepatitis C: many non-medically justifiable restrictions are placed on access to treatment in health plans and need to be removed (the VA has already done so); testing and screening need to be enhanced and focus needs to be on PWIDs to reduce HCV incidence, particularly in non-urban settings.

- Studies suggest syringe services have not had as significant an impact on HCV incidence in the US as elsewhere, probably reflecting the limited access and the strategies employed (e.g., 1 for 1 exchange); harm reduction plus HCV testing and treatment are most effective in preventing HCV with needle-exchange programs an entry point for care.
Best practices and success factors

- Valuable international and national blueprints and guidelines are available, e.g. on prices, costs, affordability and access to hepatitis C treatments including generics; on screening, care and treatment of patients with chronic hepatitis; on strategic information and modelling (several modelling studies used already); education programs; and linkage to care and treatment (B and C)
- In the US, CDC has regularly issued recommendations for HBV vaccination and is updating its guidance for HBsAg-positive pregnant women, infants and adults
- Robust Australian approach to making treatment available to all infected people, with tough negotiations with pharmaceutical industry to agree a cost of treatment acceptable to the Government; also example of programmes to build the evidence base for elimination
- Through Project ECHO rural primary care clinicians deliver hepatitis C care that is as safe and effective as that given in a university clinic; it is more successful than telemedicine and has been replicated throughout the world successfully, with collaborating networks and replicating hubs. Other approaches beyond specialist providers include videoconferencing and clinical video telehealth
- The work of the non-profit KPMAS health plan on care in an integrated health system is exemplary and needs building on
Best practices and success factors (continued)

- Numerous examples of city-level and community-based programs: Chicago, Massachusetts, Minneapolis (on East African immigrants and refugees), New York City (on care coordination and perinatal HBV transmission), Philadelphia, San Francisco, Seattle and Hep B Moms programs
- Outreach, mobile service delivery and co-locating service delivery programs are valuable, as are on-site treatment programs, particularly for equitable access to care of marginalized populations
- Community engagement, participation and ownership are vital to success – the movement to eliminate HCV started in the community. Harnessing community activism and engaging all stakeholders has been fostered through the creation of steering committees. Elimination can be driven at the health system, community and state levels as well as the national level. All efforts will be aided by continued community mobilization. Partnerships (including multi-sectoral) and leadership are also crucial
- US has strong and engaged communities, good research facilities, strong pharmaceutical industry (some with corporate social responsibility programmes, e.g. prevalence estimates and independent medical education), and sources of funding in public (e.g. SAMSHA) and private sectors
- The value of CDC’s convening role and its various initiatives e.g. surveillance, cascade of care
The way forward

- Press for creation of an overarching coordination office; elaborate action plans with numerical targets and goals that include universal testing for HCV and bringing more people with chronic hepatitis B and C into care and treatment; recognize that costs of medicines can be pushed down
- New partnerships, including government, need to be forged, and champions identified; political will and leadership must be sought; the message that public health is a non-partisan issue must continue to be stressed at the political level
- Enhance surveillance, including data on liver cancer, and improve data gathering, electronic records and registries, and analysis; value of multiple sources of data
- Expand coverage of hepatitis B vaccination of adults (and assess strategy) and of birth dose
- Overcome challenges to screening for HBV and barriers to access to health care, including focus on immigrant communities
- Improve outreach to and contact with underserved populations (e.g. PWIDs in rural communities and incarcerated subjects) through innovative strategies for service delivery and consultation
The way forward (continued)

- For HCV, remove non-medically justified restrictions on access to treatment and determine most cost-effective ways to reach targets; shape strategy to take treatment outside primary care, broadening participation in service delivery – from the use of peer educators and navigators to treatment by pharmacists and nurse-led programmes
- Achieving WHO’s 2030 targets for diagnosis, care and treatment for chronic hepatitis B would be highly cost-effective (according to models)
- Resolve issues around continuum of care and lifelong treatment of chronic hepatitis B
- Stiffen negotiations on prices, explore use of generics, and review utility of government policies (e.g. the Omnibus Budget Reconciliation Act 1990 and the 1498 Authority) while pressing for rapid development and regulatory approval of new antivirals for both hepatitis B and C
- Expand and build on innovative solutions, including linkage to care model
- Use care cascade to inform program activities and evaluate impact
Conclusion

• The Summit gave a ringing endorsement to the national strategy for elimination of hepatitis B and C as a public health problem in the US, seeing it as a rallying point for a wide and diverse cast of actors; its recommendations prompted vigorous debate but were uniformly accepted.

• Participants acknowledged and outlined the numerous constraints and challenges, but were enthusiastic about the prospects for achieving the ambitious targets, recognizing the need to monitor performance and progress.

• Times of uncertainty pose dangers but also offer the chance to capitalize on accumulated experience, today’s potential and the unfolding opportunities.

• Participants saw the potential for finding common ground, collaborating and innovating.

• The US is recognized as a can-do, will-do society. It has already shown, in Alaskan natives, that hepatitis B virus infection can be eliminated in neonates and children under 5. The challenge now is to convert the aspiration of elimination of hepatitis B and hepatitis C at the national level into reality.