National Task Force on Hepatitis B

www.hepbtaskforce.org

Meeting Notes

Date: Wednesday, March 1, 2023 (every 1st Wednesday of the month)
Time: 3PM ET / 2PM CT / 1PM MT / 12PM PT / 10 AM Hawaii
Email: administrator@hepbtaskforce.org

Zoom Meeting registration link: https://us02web.zoom.us/j/81055483671?pwd=YjdPN2RybE03eGpwdVJCZWpSWFJ5Zz09

Attendance (at or after 3:05PM) are as follows:

Executive Board Members (Officers):

☐ **Co-Chair: Carol Brosgart, MD** (San Francisco, CA)
☒ **Co-Chair: Richard So, MPH,** Executive Director, SF Hep B Free – Bay Area (San Francisco, CA)
☒ **Secretary: Catherine Freeland, MPH**, Public Health Program Director, Hepatitis B Foundation (Doylestown, PA)
☒ **Administrator** (and notetaker)**: Amy Trang, PhD, MEd,** Founder and CEO, Social Capital Solutions (Northern VA)

Regional Directors:

☒ **Northeast Regional Director: Dr. Ponni Perumalswami, MD,** Associate Professor, University of Michigan and Director of the Liver Clinic VA Ann Arbor Healthcare System (Ann Arbor, MI)
☐ **Southeast Regional Director: Vacant**
☐ **North Central Regional Director: Vacant**
☐ **South Central Regional Director: Tzu-Hao "Howard" Lee, MD,** Assistant Professor, Baylor College of Medicine (Houston, TX)
☒ **Western Regional Director: Thaddeus Pham,** Viral Hepatitis Prevention Coordinator, Hawaii State Department of Health (Honolulu, HI)

Student Representation

☒ **APAMSA students**

Board Advisors:

☒ Richard Andrews, MD, MPH, Board Advisor (Houston, TX)
☐ Moon Chen, PHD, MPH, Board Advisor; one of the original founders of the Task Force in 1997 (UC Davis; Sacramento, CA)
☐ Chari Cohen, DrPH, MPH, Board Advisor (Hep B Foundation; Doylestown, PA)
☒ Robert Gish, MD, Board Advisor (Robert G. Gish Consultants; San Diego, CA)
☐ Lu-yu Hwang, MD, Board Advisory (Department of Epidemiology, University of Texas HSC; Houston, TX)
☐ Karen Jiobu, Board Advisor (Asian American Community Services; Columbus, OH)
☐ Amy Tang, MD, Board Advisor (North East Medical Services; San Francisco, CA)

General Members (open to all on listserv; please excuse any typos)**: Total Number of attendees: 17**

- ✓ Jacki Chen, Ph.D. (New Jersey)
- ✓ Jane Park, APAMSA (Southern, CA)
- ✓ Lizette Gutierrez, Baylor St. Luke's Medical Center (Houston, TX)
- ✓ Julia Freimund, University of Washington School of Medicine (Seattle, WA)
- ✓ Irene Ma, Health Program Coordinator, MAHA (Chicago, IL)
- ✓ Priyanka Kundu, Health Planning Specialist and Hepatitis B Coordinator, Santa Clara County Health Department (CA)
- ✓ Binh Tran, PharmD, APHF and Hep B Free LA (Los Angeles, CA)
- ✓ Julie Yoshimachi, MD, Charles B Wang Community Health Center (New York, NY)
- ✓ Stephanie Campbell, Medical Affairs, Dynavax
- ✓ Dung Hua, VACF (Fountain Valley, CA)

Note: There may be some members missing from this list of attendees; please excuse any omission.

Agenda:

1) Welcome Task Force members
2) Note any changes to previous meeting's notes
3) Highlights from APASL
4) Project updates:
    a. HBV universal vaccination guidance promotion among providers
    b. HBV ECHO program
    c. HBV workforce development projects
    d. HBV elimination plan best practices among state Viral Hepatitis Coordinators
    e. HBV work group on updating screening guidance
    f. Upcoming trainings or resources
5) Action Plan discussion: Next steps?
6) Regional Updates (all Regional Directors)
    a. Nominations for Officers and Regional Directors
7) Other items (all members)

Meeting format:

- strategic discussions and resource sharing to assist members with their local work

Notes:

1) Welcome: Introduction / Roll Call of Officers and Regional Directors (Amy Trang)
    a) Opening remarks made by Richard So and Catherine Freeland
    b) Recognize any new members on the call: see list of attendees above
2) Note any changes to previous meeting's notes:
    a) Amy Trang made a statement about the Secretary / Treasurer position. There was a misunderstanding on term limits and representation from Hepatitis B Foundation. Amy Trang discussed this with Dr. Chari Cohen to clarify the position(s) and representation. Therefore, Catherine Freeland will continue to serve in the Secretary / Treasurer role. We thank Dr. Yasmin Ibrahim for assisting during the time requested.
3) Highlights from APASL (Dr. Robert Gish and Dr. Jacki Chen)
    a) A variety of topics were covered with a focus on the Taiwan experience on viral hepatitis elimination.
    b) It's expected that video links may be available; we'll share when it's available.
    c) Dr. Jacki Chen organized an evening banquet event that was patient-oriented with some entertainment. There were about 40 people that comprised of patients, doctors, professionals from NGOs, and industry.
    d) Patients made lots of personal statements; they were insightful.
    e) The topics discussed in the symposium and conference included lots of research on hepatitis B and C.
    f) There were also treatment guidelines from China that were shared; we'll include them at the end of these notes for others to review.
    g) Another key takeaways is also learning from Taiwan on their vaccination efforts and methodology that has already been disseminated relatively widely.

h) Dr. Jacki Chen also shared concerns for a specific patient who is having trouble getting treatment; details of the discussion are not provided in these notes, but were discussed among task force members. This is in reference to the following editorial published in *Hepatology Communications* journal: https://journals.lww.com/hepcomm/Fulltext/2023/03010/The_truth_of_the_matter__will_immune_tolerant.15.aspx

4) Project Updates

a) HBV universal vaccination guidance promotion among providers

i) We'll start planning this with universal screening promotion at the next Task Force meeting in April.

b) HBV ECHO program (Lizette Gutierrez and Catherine Freeland)

i) Due to spring break schedules, the April ECHO sessions in Texas will be canceled; sessions will resume in May. More resources from Common Spirit will be coming in to help market the ECHO program, i.e., having more opportunities to engage hospitals to be more involved in the existing viral hepatitis ECHO program. This will help with recruiting more program participants as well. There's already a big elimination initiative within the organization. Also, Delta is also being incorporated into the discussion.

ii) In the East Coast ECHO program last week, Dr. Joe Lim presented on management, which was really great and they had a person with lived experience share their experience with heavy management; it was a really unique perspective and helpful to bring that into the conversation. About 40 participants attended. Delta will also be incorporated in the April session.

c) HBV workforce development project

i) APAMSA is continuing to promote through their newsletter opportunities on how members can connect to and work with Task Force members. Jane Park also offered to work with APAMSA members to share the universal screening guidelines once their published, especially medical students who may already be working with providers in private clinics or larger health systems.

d) HBV elimination plan best practices among state Viral Hepatitis Coordinators

i) Resource to HepElimiNation. to get the current report cards for each state; no new updates for hepatitis B. There were new updates for hepatitis C and Medicaid.

e) HBV work group on updating screening guidance

i) Catherine Freeland shared updates on screening guidelines by CDC; we're expecting it to be published March 9th in the MMWR.

f) Upcoming trainings or resources

i) Dr. Andrews asked Dr. Gish about the "5x5x5" document that he had sent out earlier in the week. This was something that Dr. Gish helped put together, i.e., the first 5 were his recommendations. The document can also be found at the end of these meetings notes.

ii) Julia Freimund shared: https://cdc.train.org/cdctrain/welcome, and e-learning management platform offered by CDC. They have more than 2 million registered learners on the site and you can post free (or content that people have to pay for) on this site. The University of Washington has all four of their curricula on there and in May for Hepatitis Awareness Month, they will be featuring "Hepatitis B Online" with the new look of the universal screening recommendations. That information is expected to go out to more than 600,000 newsletter subscribers; the last time they pushed something out for The University of Washington, there were more than 300,000 impressions.

(1) http://www.phf.org/programs/TRAIN/Pages/How_to_Become_a_TRAIN_Course_Provider.aspx

(2) hepatitis B courses are already on TRAIN: https://www.train.org/cdctrain/search?type=course&query=%22Hepatitis%20B%22

iii) In preparation for May's Hepatitis Awareness Month, Richard So also reminded everyone about the ethnic media channels to tap into. In California in particular, Richard offered to help connect members to some media channels that have offered to promote PSAs on hepatitis B resources.

5) Action Plan discussion: Next steps?

a) Starting in April, we'll start discussing strategic directions for the National Task Force on Hepatitis B and how to achieve elimination by 2030 (7 more years); this will include the universal screening and vaccination campaign.

6) Positions still available for nominations:

a) Regional Directors:

i) North Central Region (formerly the North Midwest Region; it's "Central" now based on time zone): still available for nominations.

ii) Mid-Atlantic Region + Southeast Region (combined position): still available for nominations.

b) Please continue to nominate and self-nominate to fill these positions.

i) Submit a short bio and headshot photo to share

ii) Email: administrator@hepbtaskforce.org

iii) More information about the roles and responsibilities of these volunteer positions can be found: https://hepbtaskforce.org/our-coalition/governing-structure

c) It's a great opportunity for anyone looking for larger networking and support for their local programs / project initiatives on hepatitis B; the Task Force helps you connect to resources

7) Regional Updates

a) Student Representative: (Jane Park)
See updates in the workforce development section above.

b) Western Region (Thaddeus Pham):

i) In Hawaii:

(1) 1) Mortality Report https://www.hepfreehawaii.org/news/hep-b-mortality-in-hi-data is now available for public access. Friendly reminder to other colleagues in their state to look into the CDC wonder data to prepare your reports. There are also posts at:

(a) HRSB website: https://health.hawaii.gov/harmreduction/new-hep-b-mortality-article/

(b) Hep Free Hawai'i website: https://www.hepfreehawaii.org/news/hep-b-mortality-in-hi-data

(2) Currently working on the "gold card" proposal to eliminate barriers to access medication for hepatitis B patients; on-going so updates will be provided as things progress.

(3) For next time's discussion U=U campaign or awareness of Hepatitis B; this is something that Dr. Su Wang had shared with Thaddeus.

ii) Binh Tran attended the APASL meeting virtually and emailed her thoughts (see end of notes).

iii) Richard So shared that SF Hep B Free Bay Area will be partnering with NEMS to submit a proposal for the CA state grant and offer service in Northern San Mateo County. Looking to hear back in July if funding was approved. Currently outreaching in Chinese and newspaper and radio as well as Filippino newspaper and radio. Facebook podcasts are becoming popular among these communities. The outreach campaign will start in March and go through June to include May's Asian Pacific Islander heritage month. The campaign

will include physicians and a retail pharmacy vaccination company. Also, activities will be more like fun lunch and learn with arts and crafts and subtle health information to make the target audience feel more comfortable and engaged.

iv) Dung Hua shared that VACF has officially changed its name from Vietnamese American Cancer Foundation to Vital Access Care Foundation with a new logo. The acronym is still the same since that's what the local community knows them as; they still serve the Vietnamese community, but are also expanding to other populations. They have also been partnering with the pharmacies to serve the community. They are also partnering with a new organization to serve the population focusing on the LGBTQIA community to address prevention and behavior health. They will be hosting a one-stop shop event with health fair and other resources for food and housing.

c) North Central Region (vacant):
   i) Irene Ma from MAHA in Chicago shared that they are expanding health screening events; they are doing 2 events per month now and are still working with many organizations in Chicago, such as Northwestern Medicine and Loyola UIC Health to provide screenings and vaccinations for hepatitis A and B every month. They are primarily using WeChat to reach out the all the Asian communities; this is the most popular form of communication among Asians in Chinatown. They are also working in the suburbs as well like in Naperville and Aurora.

d) South Central Region (Dr. Howard Lee):
   i) Dr. Richard Andrews will be teaching family doctors in West Virginia on March 24th about hepatitis B at their state's annual AAFP meeting. West Virginia has among the highest acute hepatitis B rates in the country.

e) Northeast Region (Dr. Ponni Perumalswami):
   i) In Michigan, Dr. Ponni started a pilot grant project to engage stakeholders to understand the determinants around viral hepatitis B and C testing and liver cancer and linkage to care.
      (1) The premise of the project came from previous work that Dr. Ponni had done in New York City where they had health workers lead viral hepatitis, liver cancer, outreach model.
      (2) Michigan is geographically very different as well as the communities that they represent. Therefore, her cancer center is looking to better understand what influences; what barriers; what really facilities people getting testing for viral hepatitis. If they have viral hepatitis, then liver cancer is also explored.
      (3) They are looking into a multi-level approach, which has included a focus group with some external stakeholders from the Michigan State Department of Human and Health and services that represent Michigan's Medicaid center viral hepatitis section.
      (4) They are also interviewing 3 Michigan Asian American communities, i.e., Bangladeshi, Burmese, and Chinese to understand their thoughts of the big problem.
      (5) The final piece of this project will be to survey actual people from the community to understand what influences help seeking behaviors.
      (6) This would also include a community advisory panel for each community to create conduits for two-way communication between academic and community partners and adapt a community and community health worker lead for viral hepatitis and liver cancer outreach program.
   ii) Dr. Julie Yoshimachi from the Charles B Wang Health Center shared that they are reviewing the NY viral hepatitis elimination plan and discussing how to implement parts of those plans.

f) Southeast Region (vacant): nothing reported.

Meeting adjourned at 4:00PM Eastern Time.

8) Other items: (not discussed in the meeting)

- Next Hep B Task Force Zoom meeting date: **Wednesday, April 5, 2023 at 3PM Eastern Time** /2PM Central/ 1PM Mountain/ 12PM Pacific / 10 AM Hawaii (1st Wednesday of each month).
    - Other dates in 2023: May 3, September 6, October 4, and December 6
    - No meetings in June, July, August, and November; activities will continue to be shared via email

- Suggestions for the next agenda:
    - Start planning strategically for universal vaccination and screening campaign.
    - Projects and resource updates and discussions:
        - Focus on members' projects, provider education resources, and funding opportunities to share
    - Review nominations for 2 vacant Regional Director positions for the next 2-years (if any)

- The National Task Force on Hepatitis B is a volunteer-based national coalition and is independent from the state and local Task Forces or coalitions. Everyone is welcome to join the National Task Force on Hepatitis B by registering through our website. Newsletter - The National Task Force on Hepatitis B (hepbtaskforce.org). Promotion of the National Task Force on Hepatitis B is primarily through "word-of-mouth" and personal communication.

Upcoming HBV ECHO sessions: Free CME

Gulf Coast (Texas Heart Institute with Baylor St. Luke Medical Center): Project ECHO Interest Form (bcm.edu)

- Every 2nd and 4th Monday of the month
- 12:00PM to 1:00PM Central Time
- To register: Project ECHO Interest Form (bcm.edu)

East Coast (Hep B United Philadelphia): Hepatitis B ECHO Meeting Registration - Zoom

- Every 4th Thursday of the month
- 12:00PM – 1:00PM Eastern Time
- To register: Meeting Registration - Zoom

Other ECHO programs with HBV:

- The University of Washington Project ECHO Viral Hepatitis meets every Tuesday, 12 – 1:30 PM Pacific Time.
- To discuss if this ECHO program would be a good fit or if other training or consult options would better suit your interests/schedules, please email Pam Landinez, landinez@uw.edu.
- The sessions are geared towards individuals in the state of Washington and focus on hepatitis B or C is driven by the program participants.

Upcoming international HBV conferences:

- The 18th International Symposium of Viral Hepatitis and Liver Diseases (ISVHLD) Global Hepatitis Summit 2023
    - Paris, France
    - April 25 – 28, 2023
    - Registration link: Global Hepatitis Summit 2023 |Home (global-hepatitis.com)
- The European Association for the Study of the Liver (EASL) 2023
    - Vienna, Austria
    - June 21 – 24, 2023
    - Registration link: EASL Congress 2023 | 21-24 June 2023 | Vienna, Austria
- American Association for the Study of Liver Diseases (AASLD) Liver Meeting 2023
    - Boston, MA
    - November 10 – 14, 2023
    - No Registration link yet

Items shared via email:

1) Dr. Binh Tran attended the APASL Meeting virtually. The last session on 2/18/23 was very helpful, discussing on impact of mental health issues in the context of Hepatitis B presented by Dr. Chari. Dr. Gish also moderated an excellent discussion on Liver cancer, Hep B cure and Access. Here's her summary:

APASL JOINT SYMPOSIUM
Taipei 2023

The Asian Pacific Association for the Study of the Liver (APASL) Symposium was organized in conjunction with World Hepatitis Alliance and the Coalition to Eradicate Viral Hepatitis in Asia Pacific (CEVHAP) in Taipei, Taiwan on February 19, 2023

This is the first time I attended the virtual symposium, which brought many speakers and moderators from Asian countries, Australia and the U.S. on the theme: **"Responding to the Social, Cultural and Economic Impacts of Viral Hepatitis".**

The Symposium was very interesting as leaders and hepatologists presented in panel discussions on:

1. Paradigm Shifts in Stigma and Discrimination with a video on Lived experiences of stigma and discrimination (Dr. Lien Tran et al), a World Hepatitis Alliance white paper: The Impact of Stigma and Discrimination Affecting People with Hepatitis B: a Policy Response (Cary James, CEO, WHA)

2. Mental Health – Support and Tools for People living with Hepatitis.
Craig Kramer, former Mental Health Ambassador, presented the Keynote Address: Hepatitis and the Global Mental Health Crisis: what each of us can do for ourselves, our families and our communities.
Dr. Chari Cohen, President of Hepatitis B Foundation, presented on "Higher rates of depression and anxiety experienced by people with hepatitis – why?".

3. Innovation in Liver cancer, Hepatitis B Cure Science and Implications for Access, moderated by Dr. Robert Gish & Cary James.
Panel members spoke on Liver Cancer Diagnosis – what it means for patients according to where they live: comparing patient access to testing, therapy and care: Malaysia (Dr. Rosmawati Mohamed), Australia, and Viet Nam (Dr. Hang Dao, President of the Global Vietnamese Young Scholars Association).

At the close of the symposium, Dr. Shuichiro Shiina, President of APASL 2024 invited all to participate in the event in Kyoto next year!

2) Email shared by Dr. Robert Gish:

Dear Colleagues,

We are collecting comments on the 5x5x5 proposal below.

I would appreciate your comments and also have a look at the new Chinese guidelines attached.

Thank you
ROBERT G Gish MD
1 858 229 9865

The 5 x 5 x 5 Message

Reasons to treat HBV - 5 pillars:

1. Stigma/Discrimination
2. QOL/extrahepatic diseases
3. Infectivity
4. CLD Cirrhosis Prevention
5. HCC prevention

How to manage HBV - Follow the 5-Line Guideline

1. Test all for HBV with the HBV triple panel
2. Vaccinate all for HBV who are triple panel negative
3. Link all HBsAg+ patient to HBV DNA NAT testing and Delta Antibody screening
4. All HBV DNA + patients are stated on Nuc therapy
5. Stage all patients and decide on HBV surveillance

5 key messages about HBV

1. HBV therapy is not lifelong, there are many new therapies in the pipeline that can lead to functional cure, HBsAg loss and HBV DNA(-)
2. There are no "healthy" carriers, treatment results in improvement in the components of the 5 pillars
3. We always need more "research", but we have the research data now to take action now to implement the 5-line guideline
4. Delta testing should be provided to all HBV + patients, D is for Deadly
5. The only way forward to HBV elimination is to follow the 5-line guidelines, the current guidelines are too complex and lead to non-testing, non-treatment and non-vaccinations

5 Final Comments

1. Hepatitis B elimination will only occur when the human rights of all people with hepatitis B are respected.
2. Testing and diagnosis must be to the sole benefit of the person being tested.
3. Testing is to be only done by authorized health services.
4. Every person with hepatitis B needs to receive accurate and accessible information about their diagnosis.
5. Every diagnosis needs to be accompanied by a referral to treatment services, testing of family members and vaccination when required

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NOTE: Include the following attachments:

1) China HBV screening guidelines
2) Hawaii infographics

33 recommendations to see first! "Guidelines for the Prevention and Treatment of Chronic Hepatitis B (2022 Edition)" read the version in advance!

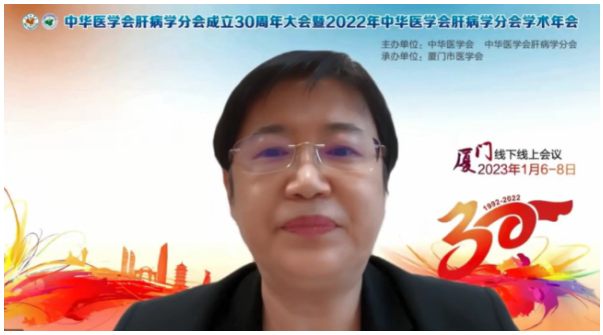
2023-01-09 Author: Tribune Small Tower Information

The revision of the 2022 editions of "Guidelines for the Prevention and Treatment of Chronic Hepatitis B" and "Guidelines for the Prevention and Treatment of Hepatitis C" is nearing completion. In order to help clinicians make reasonable decisions in the diagnosis, treatment and prevention of viral hepatitis, "China Medical Tribune" sincerely invites clinicians to give us feedback on problems or confusion encountered in clinical practice. , Top experts in the infection field provide targeted answers to questions!

Click the button to submit a question

From January 6 to 8, 2023, the "30th Anniversary Conference of the Chinese Medical Association Hepatology Branch and the 2022 Academic Year of the Chinese Medical Association Hepatology Branch" were hosted by the Chinese Medical Association and the Chinese Medical Association Hepatology Branch, and undertaken by Xiamen Medical Association. Meeting" was held in Xiamen in a combination of offline and online.

On January 6, Professor You Hong from Beijing Friendship Hospital Affiliated to Capital Medical University introduced the key points of the update of the "Guidelines for the Prevention and Treatment of Chronic Hepatitis B (2022 Edition)" at the meeting for soliciting opinions on the guidelines for the prevention and treatment of hepatitis B. This article extracts the key points of the guide to share.



Professor You Hong

Prevention - MTCT (HBsAg-negative mothers)

Recommendation 1 : Newborns of HBsAg-negative mothers should be inoculated with 10 μg recombinant yeast hepatitis B vaccine as soon as possible within 12 hours after birth, and the second and third doses of hepatitis B vaccine should be inoculated at 1 and 6 months respectively (A1). Critically ill neonates, such as ultra-low birth weight infants (<1000g), severe birth defects, severe asphyxia, respiratory distress syndrome, etc., should receive the first dose of hepatitis B vaccine as soon as possible after their vital signs are stable (A1).

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Prevention - MTCT (HBsAg positive or unknown mother)

Recommendation 2 : Newborns of HBsAg-positive or unknown mothers should be injected with a dose of 100 IU HBIG as soon as possible within 12 hours after birth, and 10 μg of recombinant yeast hepatitis B vaccine should be inoculated at different parts at the same time. The second and third doses of hepatitis B vaccine (A1) were administered at 1 and 6 months, respectively. It is recommended that children born to HBsAg-positive or unknown mothers be tested for HBsAg and anti-HBs 1 to 2 months after the third dose of hepatitis B vaccine. If HBsAg is negative and anti-HBs<10 mIU/ml, three doses of hepatitis B vaccine can be vaccinated according to the 0, 1, and 6-month immunization schedule; if HBsAg is positive, it is immunization failure and should be monitored regularly (A1).

Recommendation 3 : Premature infants and low birth weight infants (<2500g) with HBsAg-positive or unknown mothers should also receive the first dose of hepatitis B vaccine and HBIG as soon as possible within 12 hours after birth. After premature infants or low birth weight infants reach the age of 1 month, they will complete 3 doses of hepatitis B vaccine immunization according to the procedure of 0, 1, and 6 months (A1).

Prevention - Newborn (Breastfeeding)

Recommendation 4 : After newborns have been vaccinated with hepatitis B vaccine and HBIG within 12 hours of birth, they can accept breastfeeding by HBsAg-positive mothers (B1).

Prevention - Children (catch-up vaccines)

Recommendation 5 : For children who have not been vaccinated or have not completed the full course of hepatitis B vaccine immunization, revaccination should be carried out in time. The interval between the first dose and the second dose should be ≥ 28 days, and the interval between the second dose and the third dose should be ≥ 60 days (A1).

Prevention - Adults (Catch-up Vaccination)

Recommendation 6 : For adults who are immunocompromised or unresponsive, the vaccination dose (such as 60 μg) and the number of doses should be increased; for those who do not respond to the 3-dose immunization program, one more dose of 60 μg or three doses of 20 μg hepatitis B vaccine can be inoculated , and detect serum anti-HBs 1 to 2 months after the second hepatitis B vaccination. If there is still no response, another injection of 60 μg recombinant yeast hepatitis B vaccine (A1) can be inoculated.

Prevention - Accidental Exposure

Recommendation 7 : People who are accidentally exposed to HBV can be treated in the following ways.

1. Gently squeeze around the wound to drain the blood from the wound, then rinse the wound with isotonic saline, and then treat it with disinfectant (A1).

2. HBV DNA and HBsAg should be tested immediately, and rechecked after 3 to 6 months (A1).

3. Those who have been vaccinated against hepatitis B and are known to be anti-HBs positive (anti-HBs ≥ 10 mIU/ml) may not be treated. If you have never been vaccinated against hepatitis B, or if you have been vaccinated against hepatitis B, but the anti-HBs is less than 10 mIU/ml or the anti-HBs level is unknown, you should immediately inject HBIG 200~400IU, and at the same time inoculate 1 injection at different parts Hepatitis B vaccine (20μg), the second and third doses of hepatitis B vaccine (20ug) were administered 1 month and 6 months later, respectively (A1).

Prevention - Screening (HBsAg)

Recommendation 8 : HBsAg/anti-HBc and anti-HBs screening should be carried out when health checkups or medical treatment are not involved in nursery admission, enrollment and employment, and HBsAg screening should be carried out for the general population, especially for human immunity. HIV-infected persons, men who have sex with men, intravenous drug addicts, sexual partners and family contacts of HBV-infected persons, persons receiving immunosuppressants or antineoplastic drugs, anti-hepatitis C virus (HCV) drug therapy, etc. , and pregnant women, women of childbearing age, and women who are trying to conceive (B1).

Laboratory tests - screening (high sensitivity HBV DNA)

Recommendation 9 : For HBsAg-positive patients, including CHB patients receiving antiviral therapy, HBV DNA detection methods with high sensitivity and a large linear range of detection should be used as much as possible (the lower limit of quantitation is 10-20 IU/ml) (A1).

Indications for antiviral therapy

Recommendation 10 : For those with positive serum HBV DNA, persistent abnormalities in ALT (>ULN) and excluding other causes, antiviral treatment is recommended (B1).

Indications for Antiviral Therapy—Risk of Disease Progression

Recommendation 11 : For those with positive serum HBV DNA, regardless of the level of ALT, as long as one of the following conditions is met, antiviral treatment is recommended:

(1) Family history of hepatitis B cirrhosis or HCC (B1);

(2) Age > 30 years old (B1);

(3) Non-invasive indicators or liver histological examination, suggesting that there is obvious inflammation (G≥2) or fibrosis (F≥2) in the liver (B1):

(4) HBV-related extrahepatic manifestations (such as HBV-related glomerulonephritis, etc.) (B1).

Indications for antiviral therapy—liver cirrhosis

Recommendation 12 : Antiviral therapy is recommended for patients with compensated hepatitis B cirrhosis who are serum HBV DNA positive and HBsAg positive decompensated hepatitis B cirrhosis (A1).

Treatment – HBeAg-positive CHB

Recommendation 13 : NA (ETV, TDF, TAF or TMF) is the first choice for HBeAg-positive CHB patients (A1). Most patients require long-term medication. If you want to stop the drug due to various reasons, after 1 year of treatment, HBV DNA is lower than the detection limit, ALT returns to normal, and HBeAg seroconversion, and then consolidated treatment for at least 3 years (recheck every 6 months) remains unchanged, and If HBsAg is <200 IU/ml, you can try to stop the drug, but you should be closely monitored, and prolonging the course of treatment can reduce recurrence (B1).

Treatment - HBeAg positive CHB (interferon)

Recommendation 14 : HBeAg-positive CHB patients can also be treated with Peg-IFN-α. At 24 weeks of treatment, if HBV DNA decreases <2 log 10^4 IU/ml and HBsAg quantification >2×10^3 IU/ml, it is recommended to discontinue Peg-

IFN-α therapy and switch to NAs therapy (A1). The course of treatment for patients with effective Peg-IFN-a is 48 weeks, and the course of treatment can be extended according to the needs of the disease, but should not exceed 96 weeks (B1).

Treatment – HBeAg-negative CHB

Recommendation 15 : NA (ETV, TDF, TAF or TMF) is the first choice for HBeAg-negative CHB patients (A1). It is recommended that if HBsAg disappears and/ or anti-HBs appears, and HBV DNA is undetectable, if it is still undetectable after 6 months of consolidation therapy, the drug can be discontinued for follow-up (B1).

Treatment – HBeAg-negative CHB (interferon)

Recommendation 16 : PegIFN-α antiviral therapy can also be used for HBeAg-negative CHB patients. At 12 weeks of treatment, if the decrease in HBV DNA is <2 lg IU/ml, or the quantitative decrease in HBsAg is <1 lg IU/ml, it is recommended to discontinue PegIFN-a treatment and switch to NA treatment (B1). The effective course of treatment for patients is 48 weeks, and the course of treatment can be extended according to the needs of the disease, but it should not exceed 96 weeks (B1)

Treatment - interferon (predominant population)

Recommendation 17 : In some eligible patients, such as: HBV DNA<quantitative detection limit after NA treatment, HBeAg negative conversion, and HBsAg<1500 IU/ml, the addition of Peg-IFN-α therapy can be considered according to the patient's wishes , in pursuit of clinical cure.

After 24 weeks of treatment, if HBsAg<200 IU/ml or decrease >1 $\log_{10}$ IU/ml, it is recommended to continue NA combined with Peg-IFN-α therapy for 48-96 weeks; after 24 weeks of treatment, if HBsAg is still ≥200 IU/ml ml, consider discontinuing Peg-IFN-α and continue NA treatment (B2).

Treatment - compensated cirrhosis

Recommendation 18 : For patients with compensated hepatitis B cirrhosis, long-term antiviral therapy with ETV, TDF, and TAF is recommended, or Peg-IFN-α therapy, but related adverse reactions should be closely monitored (A1).

Treatment - decompensated cirrhosis

Recommendation 19 : For patients with decompensated hepatitis B cirrhosis, long-term treatment with ETV or TDF is recommended, Peg-IFN-α treatment is prohibited (A1), and TAF treatment can be used if necessary (B1).

Special populations - suboptimal responders and low viremia (CHB)

Recommendation 20 : For CHB patients treated with ETV, TDF, TAF or TMF for 48 weeks, if HBV DNA can still be detected (HBV DNA > 20 IU/ml), after excluding compliance and detection errors, NA treatment can be adjusted (using ETV Those who use TDF or TAF should switch to ETV, or the two drugs should be used in combination) (B1). It can also be combined with Peg-IFN-α therapy (B1).

Special populations—poor responders (cirrhosis)

Recommendation 21 : Patients with hepatitis B cirrhosis should be treated with ETV, TDF or TAF for 24 weeks. If HBV DNA can still be detected (>20 IU/ml), after excluding compliance and detection errors, it is recommended to adjust NA

treatment (using ETV Those who were treated with TDF or TAF were switched to ETV, or the two drugs were used in combination) (C2).

Special Populations - Chemotherapy and Targeted Immunization

Recommendation 22 : All patients receiving chemotherapy, targeted drugs, and immunosuppressants should be routinely screened for HBsAg, anti-HBc, and/ or HBV DNA before starting treatment (A1). For HBsAg and/ or HBV DNA-positive patients, ETV, TDF, or TAF antiviral therapy can be used at least one week before starting chemotherapy, targeted drugs, and immunosuppressant therapy (A1). For HBsAg-negative, anti-HBc-positive patients, if B cell monoclonal antibodies are used or hematopoietic stem cell transplantation is performed, or patients with advanced liver fibrosis/cirrhosis, ETV, TDF or TAF antiviral therapy is recommended (B1).

Special population - pregnancy (primary treatment)

Recommendation 23 : When patients with chronic HBV infection plan to become pregnant in the near future, or have antiviral indications during pregnancy, TDF can be used after full communication and informed consent (B1). If necessary (such as combined with renal insufficiency), TAF treatment can be considered (B2).

Special Populations - Pregnancy (Under Treatment)

Recommendation 24 : For patients with unintended pregnancy during antiviral therapy, if TDF is used, it is recommended to continue the pregnancy; if ETV is used, the pregnancy may not be terminated, and it is recommended to switch to TDF (B1). If interferon therapy is used, it is recommended to fully inform the pregnant woman and her family of the risks so that they can decide whether to continue the pregnancy. If the pregnancy continues, TDF should be used instead (C2).

Special populations - pregnancy (middle and late stages) in full communication

Recommendation 25 : For HBV DNA quantitative >2×10^{5} IU/ml in the middle and late stages of pregnancy , TDF antiviral therapy can be started at the 24th to 28th week of pregnancy on the basis of full communication and informed consent (A1). It is recommended that mothers with HBeAg-positive chronic HBV infection (immune tolerance period) may consider stopping the drug immediately or within 1-3 months after delivery. After drug withdrawal, liver biochemistry and HBV DNA and other indicators should be detected at least every 3 months until 6 months after delivery, and antiviral treatment should be started immediately if hepatitis activity occurs (A2). HBeAg-positive or negative CHB mothers can continue treatment after delivery on the basis of full communication and informed consent. Breastfeeding is not a contraindication to TDF therapy (C2).

Special populations - children (progressive stage)

Recommendation **26** : For children with advanced liver disease or cirrhosis, antiviral treatment should be given in a timely manner regardless of age, but the safety and drug resistance of long-term treatment should be considered. Ordinary interferon-α treatment can be considered for children 1 year old and above, ETV or TDF can be used for children 2 years old and above, Peg-IFN-α-2a can be used for children 5 years old and above, TAF treatment can be used for children 12 years old and above (A1).

Special population - children (immune tolerance period)

Recommendation 27 : Children in the immune tolerance stage (ALT<ULN) need to undergo liver histological evaluation, and children with liver histological grade G≥1 should receive antiviral treatment (B1); For children in the tolerance period,

antiviral therapy can be considered even if there is no evidence of liver histology. The use of antiviral drugs and regimens refer to children with advanced CHB. It is necessary to fully communicate with the guardian to obtain informed consent before starting treatment (C1).

Special populations - chronic kidney disease, renal insufficiency

Recommendation 28 : For patients with chronic kidney disease, renal insufficiency, or patients receiving renal replacement therapy, ETV or TAF is recommended as the first-line anti-HBV drug, and ADV or TDF is not recommended (B1). For CHB patients with high risk of renal function damage, changes in renal function should be monitored during the application of any NA antiviral. When patients who have been treated with ADV or TDF develop renal or bone disease or are at high risk, it is recommended to switch to ETV or TAF (B1).

Special populations - HBV and HCV co-infection

Recommendation 29 : When HCV and HBV co-infected patients are treated with DAA for HCV, if HBsAg is positive, NA treatment should be given to prevent HBV reactivation. After 12 weeks of DAA treatment, NA treatment can be stopped (B2); - During the application of DAA in HBc-positive patients, HBV DNA and HBsAg quantification should be closely monitored. If HBsAg becomes positive, NA treatment is recommended (B2).

Special populations - HBV and HIV co-infection

Recommendation 30 : For patients co-infected with HBV and HIV, it is recommended to choose an antiviral drug combination that is effective against both HIV and HBV, and choose two drugs with anti-HBV activity at the same time (A1).

Special Populations - Liver Failure

Recommendation 31 : For patients with HBV-related acute, subacute, acute-on-chronic, and chronic liver failure, antiviral therapy with ETV, TDF, or TAF is recommended if HBsAg is positive (A1).

Special Populations - HCC

Recommendation 32 : For patients with HBV-related HCC, if HBsAg is positive, antiviral therapy with ETV, TDF or TAF is recommended (A1).

Special Populations - Liver Transplantation

Recommendation 33: For patients undergoing liver transplantation due to HBV-related infection, if HBsAg is positive, it is recommended to start antiviral therapy with ETV, TDF or TAF before liver transplantation (A1).

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MORTALITY IN HAWAIʻI:

HEPATITIS B AND LIVER CANCER IN THE PAST 20 YEARS

In February 2023, the Hawaiʻi Department of Health released *Hawaiʻi Hepatitis B Mortality and Liver Cancer*, the first such report ever developed in the state. Below are the main report findings that demonstrate the importance of hepatitis elimination, in alignment with Hep Free 2030. See the back for a referral letter to get tested for hepatitis B.

HIGHER RATES

of Hepatitis B Deaths (2000-2020)

3 TIMES HIGHER IN HAWAIʻI

In 2019, Hep B mortality rate for Hawaiʻi was **1.17 deaths per 100,000**, compared to 0.42 per 100,000 for the United States.

MALE RESIDENTS IN HAWAIʻI

Hep B mortality rates for male residents in Hawaii were **up to 1.7 times state average** from 2000 to 2020.

API RESIDENTS IN HAWAIʻI

Hep B mortality rates for Asian and Pacific Islander (API) residents were **up to 1.4 times state average** from 2000 to 2020.

Higher rates of liver cancer mortality were also found when comparing Hawaiʻi to the United States.

In Hawaii, higher rates were found among male and/or API residents as well.

The full report contains more detailed information including tables and graphs as well as recommendations for improving data capacity to eliminate hepatitis B and related liver cancer in Hawaii. To read the full report, go to https://health.hawaii.gov/harmreduction/new-hep-b-mortality-article/ or www.hepfreehawaii.org.

Dear Healthcare Provider,

I would like to get tested for the hepatitis B virus because I may be at risk. I know that hepatitis B virus infection may not have immediate symptoms and that it can lead to liver cancer, even without cirrhosis or fibrosis (liver scarring).

I know that treatments can now manage the virus, if I have it. I also know that I can get protection through vaccines, so I would like to know my status.

Please screen me using the simple blood tests below:

Hepatitis B Surface Antibody Test (HBsAb)
This will show if I already have protection against hepatitis B.

Hepatitis B Surface Antigen Test (HBsAg)
This will show if I have chronic (long-term) hepatitis B.

Hepatitis B Core Antibody Test (HBcAb Total)
This will show if I have had previous exposure to hepatitis B.

If all tests are negative, please vaccinate me so that I can be protected against hepatitis B.

Here are some possible billing codes to use:

ICD-10 Codes	
Z20.5	Contact with suspected exposure to viral hepatitis
Z00.00	Routine medical examination of adult; Encounter for lab as part of general medical exam
Z11.59	Encounter for screening for other viral disease

CPT Codes	
86706	Hepatitis B surface antibody (HBsAb)
87340	Hepatitis B surface antigen (HBsAg)
86704	Hepatitis B core antibody, total (Anti-HBc)

If you want more information, you can find provider resources at www.hepfreehawaii.org.

Mahalo for helping me stay healthy and free of hepatitis B and liver cancer!

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HepFree HAWAI'I

MORE THAN 10 YEARS TOGETHER