Jonathan Mermin, MD, MPH
Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027

Dear Dr. Mermin,

We are writing on behalf of the 35 community health centers, including 29 Federally Qualified Health Centers that are a part of the Association of Asian Pacific Community Health Organizations (AAPCHO). We would like to express our great disappointment in not including goals related to hepatitis B virus (HBV) infection in the draft NCHHSTP plan. We appreciate the development of this plan and its relationship to other national plans, including the National Prevention Strategy and National HIV/AIDS Strategy. However, we do not believe that the Center's plan includes the need to address hepatitis B in at-risk populations, and is, therefore, not in alignment with the HHS Viral Hepatitis Action Plan (VHAP), as it does not include goals, indicators, or strategies for reducing morbidity and mortality associated with chronic hepatitis B infection.

In response to the request for review of the proposed NCHHSTP Strategic Plan through 2020, below are our comments:

In ***Goal 4.1***, the plan states that rates of HBV have been reduced, and alludes to the fact that incidence of HBV has not increased. Although incidence of acute HBV has decreased over the past two decades, chronic HBV infection rates have not decreased, signifying there has been little to no progress in addressing this increase. We would like to see "Reduction of the incidence of chronic HBV in the U.S." included within the listed indicators. NCHHSTP would be remiss to not include an HBV measure as one of its indicators.

For ***Goal 4.2***, the omission of hepatitis B measures in morbidity and mortality indicators must be rectified, as this signifies a lack of concern about the estimated 1.4 – 2.0 million affected Americans and those at increased risk for hepatitis B infection. In the U.S., less than 25% of people with chronic HBV know of their infection, and an estimated 4,000 people die annually of HBV-related disease. Because of the chronic HBV disease statistics, which are likely underestimates, the following should be added as indicators:

- *Proportion of persons with hepatitis B who are aware of their infection*
- *Mortality from hepatitis B-related liver disease, liver failure and hepatocellular carcinoma*

Although we appreciate the inclusion of HBV in ***Goal 4.3***, at-risk populations---people of Asian, Pacific Islander, or African descent, should be included in the indicators. These populations are disproportionately impacted and represent over 50% of chronic HBV infection found in the U.S. In order to ensure alignment with guidelines noted by the CDC, USPSTF, and VHAP, we propose an additional indicator to state:

- *Chronic HBV infections among high-risk foreign-born populations and their children*

In the ***Key Strategies*** section, when highlighting data points for program improvement (***Strategy 5.1***), it should be stated that data are needed to help to inform awareness of HBV infection generally, the prevalence of HBV in high risk communities, the limited number of people with HBV who enter care and treatment, and HBV-related mortality.

In ***Strategy 5.2***, when discussing gaps in critical knowledge, it should be acknowledged that the development of rapid testing for HBV should be prioritized since those at greatest risk often have the least access to appropriate healthcare services. Additionally, prevention strategies with regards to reducing racial and ethnic disparities in HBV need to be discussed with key public health agencies, healthcare providers, community leaders, and policy decision-makers.

For ***Strategy 5.3***, we commend the inclusion of the objective to "Utilize economic and health services to create [a] business case for public and private payers and employers to include the provision of critical preventive services in health plan coverage" as well as the provisions included to work with State Medicaid agencies, other payers, and increasing awareness in at-risk populations. We are concerned about the implementation of the USPSTF recommendations for hepatitis B screening among private and public payers, and believe that this research, business case development, collaboration, and education would greatly help many individuals at-risk for HBV. We appreciate the inclusion of the point for community-based organizations and health departments to work more closely with FQHCs, as the health care climate post-ACA is constantly evolving. Additionally, we support the proposed dialogue between CDC, HRSA, and CMS to develop clinical decision support tools to be used in a number of different electronic medical record systems.

Finally, in ***Strategy 5.4***, we want the Center to acknowledge the significant overlap that exists in the risk groups for TB and for chronic HBV infection, which include foreign-born individuals and refugees---this is a perfect opportunity for program collaboration and service integration (PCSI). Not vaccinating individuals within the National TB Program presents a missed opportunity to prevent potential HBV infection in these high-risk groups. We encourage the inclusion of HBV vaccination for all people in the U.S. identified as having TB infection, who are enrolled in directly observed therapy.

Although we appreciate the opportunity to comment on the NCCHSTP strategic plan, we are deeply distressed that the problem of hepatitis B has been significantly overlooked in the plan . We strongly believe that the Center's priorities should address the gaps and challenges in hepatitis B surveillance, screening and linkage to care if this public health threat is to be controlled, and eliminated, as outlined in the VHAP. We welcome the opportunity to discuss our concerns and comments further. If you have any questions or concerns, please contact AAPCHO's Senior Policy Analyst, Isha Weerasinghe (iweerasinghe@aapcho.org).

Thank you,

Jeffrey Caballero
Executive Director