



March 11, 2019

Tammy R. Beckham, DVM, PhD
Director, Office of HIV/AIDS and Infectious Disease Policy
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
330 C Street SW, Room L001
Washington, DC 20024

Re: Request for Information (RFI) - Improving Efficiency, Effectiveness, Coordination, and Accountability of HIV and Viral Hepatitis Prevention, Care, and Treatment Programs

Dear Dr. Beckham,

On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO), we appreciate the opportunity to provide recommendations for the development of the updated National Viral Hepatitis Action Plan. AAPCHO is a national not-for-profit association of 32 community-based health care organizations, 28 of which are Federally Qualified Health Centers, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the United States, its territories, and freely associated states. AAPCHO members serve over 500,000 patients annually, providing comprehensive primary health care, including hepatitis B services, for our patients and communities.

Many of our health centers serve populations that are at increased risk for hepatitis B and provide a range of hepatitis B services, including screening, vaccination, linkage to care, and initiatives that raise awareness of and education about hepatitis B. Our members also provide linguistically accessible, culturally appropriate, and financially affordable health care services to communities with high concentrations of medically underserved Asian Americans, Native Hawaiians and Pacific Islanders.

Viral hepatitis continues to be a serious public health threat affecting millions in the United States. It is critical that we continue to work towards collective national goals and strategies in order to measure our progress and achieve the 2030 viral hepatitis elimination goals established by the World Health Organization (WHO) and supported by the National Academies of Sciences, Engineering, and Medicine (NASEM) recommendations.

We currently have the tools to eliminate hepatitis B and C, including highly effective hepatitis B vaccines and hepatitis C curative treatments, and strongly believe that the U.S. government should commit to the elimination of viral hepatitis by 2030 or sooner. In the next iteration of the National Viral Hepatitis Action Plan, we recommend that the goals and strategies are aligned with the WHO and NASEM elimination goals and focus on achieving 2030 targets for elimination of hepatitis B and C.

To achieve hepatitis B elimination in the U.S., we strongly believe that it is important to develop a robust strategy to increase adult hepatitis B vaccination and maintain high levels of infant and childhood hepatitis B vaccination in the U.S. In the updated National Viral Hepatitis Action Plan, we would like to have hepatitis B vaccination highlighted as one of the primary methods of hepatitis B prevention, as

there should not be a single new case of hepatitis B when we have safe and highly effective 2 and 3 dose hepatitis B vaccines, yet only 25% of adults are vaccinated against hepatitis B¹.

This emphasis on adult hepatitis B vaccination is particularly important within the opioid epidemic, where we have seen sharp regional increases in acute hepatitis B in states such as Maine, where according to Maine's Centers for Disease Control and Prevention's 2017 state report, acute hepatitis B increased by 729% from 2015-2017 in Maine, with 53% of those newly diagnosed with acute hepatitis B reporting injection drug use and an average age of 42 years at the time of diagnosis, in contrast with the average age of 33 years seen for new hepatitis C cases in Maine during the same time period². This suggests the significant rise in hepatitis B cases in Maine is due to low adult hepatitis B vaccination rates in the setting of the opioid epidemic, since only adults born in the U.S. under the age of 25 were routinely vaccinated against hepatitis B at birth and in early childhood, causing the majority of adults over the age of 25-30 to be susceptible to hepatitis B infection, as they would likely not have been vaccinated, resulting in a higher average age of adults newly diagnosed with hepatitis B compared to hepatitis C in the setting of the opioid epidemic in Maine. In addition, among the individuals newly diagnosed with hepatitis B in Maine from 2015-2017, 15% were baby boomers, 32% were incarcerated, and 55% of those diagnosed with acute hepatitis B required hospitalization.

Examples in states such as Maine highlight the importance of emphasizing adult hepatitis B vaccination within the National Viral Hepatitis Action Plan, and we hope that a strong emphasis on adult hepatitis B vaccination, including a recommendation for universal adult hepatitis B vaccination in the same way that childhood hepatitis B vaccination is already universally recommended in the U.S., will be included as a primary strategy in the prevention of hepatitis B, so that we may achieve hepatitis B elimination in the U.S. and prevent the serious associated health consequences of chronic hepatitis B, including liver cancer, cirrhosis, and liver failure.

Further, we encourage that any strategies developed to test for, prevent, and treat hepatitis C, also addresses hepatitis B vaccination, prevention, testing, and linkage to care, particularly within the opioid epidemic.

Additionally, we offer the following recommendations for your consideration toward the development of the next iteration of the National Viral Hepatitis Action Plan (NVHAP).

(1b) What components of the NVHAP do you think should be maintained? What changes should be made to the NVHAP? This may include changes to the structure, goals, and indicators, key areas of focus and/or populations, and annual reporting processes by federal agencies. This may also include areas of the current strategy that should be scaled back or areas of the current strategy that should be expanded or scaled up.

¹ National Foundation for Infectious Diseases. NFID Call to Action: Preventing Hepatitis B in US Adults through Increased Vaccination Rates among At-Risk Groups, 2018. Available at: <http://www.nfid.org/hep-b-cta>. Accessed March 11, 2019.

² Maine Center for Disease Control and Prevention. Acute Hepatitis B Maine Surveillance Report 2017. Available at: <http://www.maine.gov/tools/whatsnew/attach.php?id=806225&an=1>. Accessed March 11, 2019.

- **Goal 1: Achieve universal Hepatitis B vaccination for all adults, not just vulnerable adults.**
In order to achieve hepatitis B elimination in the U.S., we need to increase adult hepatitis B vaccination coverage and develop specific strategies and initiatives to achieve universal adult hepatitis B vaccination, in the same way that childhood hepatitis B vaccination is already recommended. The recent rise in acute hepatitis B infection rates as a consequence of the opioid crisis, as noted above, reveals significant gaps in hepatitis B testing and vaccination, since less than 25% of adults age 19 and older are vaccinated against hepatitis B³. In addition, newly infected young women may be unaware of their hepatitis B infection and may infect their children with hepatitis B via perinatal mother to child transmission, subsequently causing these infants to be at significantly higher risk of developing chronic hepatitis B infection, early onset liver failure, and liver cancer.

New hepatitis B infections related to injection drug use are particularly prevalent among adults aged 30 to 49 who were not vaccinated as children⁴. We, therefore, recommend building capacity and support for community programs that provide support services for people who inject drugs to also provide hepatitis B vaccination to those susceptible to infection, in coordination with hepatitis B and C testing.

Furthermore, with the availability of a new, two-dose hepatitis B vaccine, there is opportunity to improve coverage and prevent transmission in high risk and hard to reach populations including the homeless, people who inject drugs, people with diabetes, and people living with HIV. We believe that adult hepatitis B vaccination should be achieved using the vaccine with the greatest completion rate and/or efficacy shown in the population in which it is administered, including the consideration of using the newer two-dose hepatitis B vaccine in patients who may be difficult to follow for extended periods of time or who are older adults with diabetes.

We would recommend the development of a “National Adult Hepatitis B Vaccination” campaign to increase awareness of the availability of the adult hepatitis B vaccine among healthcare providers, as well as among the general public, particularly in the setting of the opioid epidemic where states such as Maine have seen a rise of 729% in newly diagnosed hepatitis B cases from 2015-2017², in order to effectively increase adult hepatitis B vaccination and make significant progress toward ending hepatitis B transmission.

- **Goal 2: Reduce deaths and improve the health of people living with viral hepatitis and Goal 3: Reduce viral hepatitis health disparities.**
We recommend changing “reduce” for both of these goals to “goals 2: eliminate deaths and improve the health of people living with viral hepatitis” and “goal 3: eliminate viral hepatitis health disparities.” We recommend focusing the National Viral Hepatitis Action Plan on viral hepatitis

³ Centers for Disease Control and Prevention. Vaccination coverage among adults in the United States, National Health Interview Survey, 2016. Available at: www.cdc.gov/vaccines/imzmanagers/coverage/adultvaxview/pubs-resources/NHIS-2016.html. Accessed March 11, 2019.

⁴ Harris AM, Iqbal K, Schillie S, et al. Increases in Acute Hepatitis B Virus Infections — Kentucky, Tennessee, and West Virginia, 2006–2013. *MMWR Morb Mortal Wkly Rep.* 2016;65(3):47-50. doi:10.15585/mmwr.mm6503a2

elimination to align with global elimination goals, including those set by the World Health Organization.

- **Scale up and improve efficiency and effectiveness of strategies to increase hepatitis B screening and provider capacity to treat hepatitis B.**

As potential key strategies to scale up for **goal 2: reduce deaths and improve the health of people living with viral hepatitis**, we recommend the following activities to support strategy:

2.1 – build the capacity of the health care workforce to diagnose viral hepatitis and provide care and treatment to persons infected with viral hepatitis and strategy 2.2 – identify persons infected with viral hepatitis early in the course of their disease:

1) Develop a “Know Your Status” campaign to ensure that those susceptible to hepatitis B infection receive vaccination, in addition to education on hepatitis B reactivation for those with prior infection, and linkage to care for those with current infection. When screening for hepatitis B as per current CDC guidelines, the recommended tests are HBsAg (Hepatitis B surface antigen), Anti-HBs (Hepatitis B surface antibody), and Anti-HBc (Hepatitis B core antibody), and we support developing materials to ensure that providers test individuals for hepatitis B using all three of these tests. Those who have recovered from a past hepatitis B infection will test positive for both Anti-HBs and Anti-HBc – and it is important that these individuals are counselled to be aware of their risk for reactivation with immune suppression (and associated with initiation of Direct Acting Antiviral treatment for hepatitis C). Additionally, a subset of the population will test positive for Anti-HBc alone (isolated Anti-HBc). These individuals need further testing to assess their current hepatitis B infection status, as they could be chronically infected. 2) We recommend training front-line providers, e.g. primary care providers, to not only screen and vaccinate for hepatitis B but to manage and treat uncomplicated chronic hepatitis B in the primary care setting. Further, we recommend training for primary care providers regarding the follow up necessary for hepatocellular carcinoma (HCC) surveillance for those with chronic hepatitis B in which HCC surveillance is necessary per current clinical guidelines. We also encourage the incorporation of HCC surveillance recommendations for at-risk populations in primary care preventive health guidelines.

- **Add African immigrant communities as a priority population and include an objective within goal 3 to address health disparities impacting African Immigrant communities.** African immigrants living in the U.S. are disproportionately and increasingly affected by hepatitis B with infection rates upwards of 8-10%, rivaling that of Asian American and Pacific Islander populations^{5,6,7,8,9,10}. Sub-

⁵ J Immigr Minor Health. 2011 Apr;13(2):333-44. doi: 10.1007/s10903-009-9243-x. Epub 2009 Apr 4.

⁶ Yoo, G. J., Fang, T., Zola, J., & Dariotis, W. M. (2012). Destigmatizing hepatitis B in the Asian American community: Lessons learned from the San Francisco hep B free campaign. *Journal of Cancer Education*, 27(1), 138-144.

⁷ Chandrasekar, E., Song, S., Johnson, M., Harris, A. M., Kaufman, G. I., Freedman, D., et al. (2016). A novel strategy to increase identification of African-born people with chronic hepatitis B virus infection in the Chicago metropolitan area, 2012-2014. *Preventing Chronic Disease*, 13, E118.

⁸ Edberg, M., Cleary, S., & Vyas, A. (2011). A trajectory model for understanding and assessing health disparities in Immigrant/Refugee communities. *Journal of Immigrant and Minority Health*, 13(3), 576-584.

⁹ Kowdley, K. V., Wang, C. C., Welch, S., Roberts, H., & Brosgart, C. L. (2012). Prevalence of chronic hepatitis B among foreign-born persons living in the united states by country of origin. *Hepatology*, 56(2), 422-433.

¹⁰ Ugwu C, Varkey P, Bagniewski S, Lesnick T. (2008). Sero-epidemiology of hepatitis B among new refugees to Minnesota. *Immigr Minor Health*, 10(5):469-74.

Saharan Africa is known to have some of the highest rates of hepatitis B worldwide, and African immigrants are estimated to comprise 29% of chronic hepatitis B patients living in the U.S., highlighting the need to prioritize and address hepatitis B in this population^{11,12}. Although CDC recommends all immigrants living in the U.S. be screened for hepatitis B, this group continues to represent an unaddressed disparity and faces unique barriers to testing, vaccination and care. While data and interventions have thus far mainly encompassed Asian American and Pacific Islander populations, tailored and culturally-appropriate interventions are needed to address the unique barriers African immigrants face.

In order to reduce viral hepatitis disparities, education and community engagement efforts should expand to prioritize African immigrants and include collaborations with African community-based organizations to foster increased awareness, testing and linkage to care in African immigrant communities. African immigrants represent nearly one third of chronic hepatitis B infections in the U.S. but lack prioritization and subsequent community resources to address this burden, making these capacity-building initiatives important in reducing disparities and premature deaths.

- **Add liver cancer to NVHAP goals to improve awareness and screening for hepatocellular carcinoma (HCC).**

In the U.S., liver cancer is on the rise and has now become the fastest increasing cause of cancer-related deaths¹³. The CDC reports that viral hepatitis is attributable to 65% of new liver cancer cases¹⁴. Studies have also shown that liver cancer-related deaths are highest among people living with chronic hepatitis B and C¹⁵. Due to lack of surveillance for hepatitis B and C, many viral hepatitis cases go undiagnosed until they progress to cirrhosis, liver failure, and/or liver cancer. Screening high-risk groups and those with viral hepatitis can prevent liver cancer, lead to early detection, and may help to reduce early deaths from liver cancer. In addition, improved awareness about the link between viral hepatitis and liver cancer in the community and improving primary care provider awareness of the clinical guidelines for HCC surveillance for at-risk individuals with chronic hepatitis B and C is necessary to reduce deaths from liver cancer among at-risk populations.

- **Goal 4: Coordinate, monitor, and report on implementation of viral hepatitis activities.**

We support strategies to increase communication and improve coordination of viral hepatitis activities. We recommend developing and including indicators for goal 4 in order to effectively measure our progress.

¹¹ Centers for Disease Control and Prevention. (2008). Recommendations for routine testing and follow-up for chronic hepatitis B virus (HBV) infection. Retrieved February/25 from <https://www.cdc.gov/hepatitis/hbv/pdfs/chronichepbtestingflwup.pdf>

¹² Kim WR, Benson JT, Therneau TM, Torgerson HA, Yawn BP, Melton LJ 3d. Changing epidemiology of hepatitis B in a U.S. community. *Hepatology* 2004;39(3):811–6. <https://www.ncbi.nlm.nih.gov/pubmed/22105832>

¹³ American Association for Cancer Research. (2018). Why Is Liver Cancer on the Rise?. Retrieved from <https://blog.aacr.org/liver-cancer-rising/>

¹⁴ Centers for Disease Control and Prevention. (2016). CDC Fact Sheet: Viral Hepatitis and Liver Cancer (pp. 1-2). CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

¹⁵ American Liver Foundation. (2016). Liver Cancer on the Rise. Retrieved from <https://liverfoundation.org/liver-cancer-rise/>

(2b) Specific recommendations you think will improve the efficiency, effectiveness, accountability, and impact of the national response to viral hepatitis.

- **Develop specific strategies and activities to combat viral hepatitis-related discrimination.**

We strongly support maintaining goals and strategies related to decreasing viral hepatitis-related stigma and discrimination and emphasizing federal legal protections for persons living with viral hepatitis. In the next iteration of the National Viral Hepatitis Action Plan, we recommend developing specific activities to support strategies within goals 1 and 2, as there is an opportunity to achieve discrimination-related goals by scaling up collective efforts to actively address discrimination. Unfortunately, hepatitis B-related discrimination still occurs, especially within academic and employment settings, and often goes underreported. We must continue to increase awareness about federal legal protections and take action to ensure individuals living with viral hepatitis have equitable opportunity to pursue successful careers and have improved health outcomes and quality of life. We recommend adding as a strategy under goal 1, working together, with federal input and partnership, to address discrimination at health care schools, hospitals and institutions, treatment facilities, and in the military.

In particular, we recommend ending instances of institutional discrimination against those with hepatitis B, such as the discrimination against students living with chronic hepatitis B that has prevented these students from enrolling or continuing education in health professional schools due to their hepatitis B status. Instances of institutional discrimination against individuals with chronic hepatitis B perpetuate stigma in communities regarding hepatitis B and will make individuals less likely to seek hepatitis B testing and treatment, so a concerted effort must be made to eliminate hepatitis B-related institutional discrimination in all settings. Federal partners play a significant role in leading and convening community stakeholders and increasing public awareness about viral hepatitis-related discrimination.

- **Increase awareness about hepatitis B and the opioid epidemic and improve integration of hepatitis B testing and vaccination within harm reduction programs.** People who inject drugs are at a high risk of contracting hepatitis B infection through blood-borne transmission, sharing contaminated needles and drug use paraphernalia. About 20% of new hepatitis B infections occur among people who inject drugs, mainly through sharing of contaminated injection equipment and unprotected sexual contact. Previous studies have found that over 80% of people who inject drugs who have been injecting for longer than 10 years are infected with hepatitis B¹⁶.

State surveillance reports reveal a recent nationwide increase in acute hepatitis B and C infection, with the largest increases occurring east of the Mississippi river, especially in Maine and in Appalachia, that is directly related to the current opioid crisis^{2,17}. In an analysis of the National

¹⁶ Seal KH, Edlin BR, Ochoa KC, Tulskey JP, Moss AR, Hahn JA. Risk of hepatitis B infection among young injection drug users in San Francisco: Opportunities for intervention. *West J Med.* 2000;172(1):16-20. doi:10.1136/ewjm.172.1.16.

¹⁷ Patel A, Tohme R, Ward JW, et al. Emerging Epidemic of Hepatitis C Virus Infections Among Young Nonurban Persons Who Inject Drugs in the United States, 2006–2012. *Clin Infect Dis.* 2014;59(10):1411-1419. doi:10.1093/cid/ciu643.

Notifiable Diseases Surveillance System (NNDSS) from 2006-2013, the CDC assessed the incidence of acute hepatitis B infection in three Appalachian states (Kentucky, Tennessee, and West Virginia), noting an increase of 114% among non-Hispanic whites aged 30-39 years among individuals who reported injection drug use¹⁸. The state of Maine saw a 729% increase in new acute hepatitis B cases from 2015-2017, while North Carolina saw a 56% increase from 2014-2016 and Southeastern Massachusetts saw a 78% increase in new acute HBV cases in 2017^{19,20}. Aside from CDC surveillance data capturing newly diagnosed hepatitis B infections, there is limited data and few community-based serology studies on the risk of hepatitis B infection in people who inject drugs across the U.S. There is a need within the National Viral Hepatitis Action Plan to incorporate hepatitis B and comprehensive harm reduction strategies to include hepatitis B testing and vaccination in settings such as medication assisted treatment centers (MAT) and syringe service programs. Additionally, prevention strategies should incorporate awareness surrounding hepatitis B vaccination to prevent infection and transmission within this high-risk population.

- **Promote universal hepatitis B screening.**

We believe in order to achieve hepatitis B elimination goals, we must move beyond targeted screening to universal hepatitis B screening in order to close the major gaps in identifying all undiagnosed cases. A recent study of hepatitis B, hepatitis C, and HIV infections among patients newly diagnosed with cancer found that 6.5% of patients tested positive for previous hepatitis B infection; many of the patients had no known risk factors for infection, underscoring the need for universal hepatitis B testing²¹. Furthermore, targeted or risk-based hepatitis B screening strategies are being implemented primarily through community-based settings by smaller and often under-resourced organizations and clinics. While this approach reaches high-risk individuals, it has been challenging to reach a majority of high-risk populations. Additionally, targeted screening is difficult to implement in hospitals and health care systems where there is little provider awareness and incentive. Electronic clinical decision support technology, which can assist providers in identifying high-risk patients, is extremely challenging to integrate. For example, electronic health records currently do not capture country of birth, which is one of the major factors for those at high risk for hepatitis B infection. Risk-based screening guidelines that are based on country of birth and stigmatized risk behaviors (such as injection drug use or sexual activity) are difficult to implement within health care systems in the U.S. Risk-based testing for hepatitis B puts great burden on clinicians, who are typically unaware of the risks, are unsure of who to test, and too overburdened in primary care settings to learn the intricacies of who to test.

¹⁸ Harris AM, Iqbal K, Schillie S, et al. Increases in Acute Hepatitis B Virus Infections — Kentucky, Tennessee, and West Virginia, 2006–2013. *MMWR Morb Mortal Wkly Rep.* 2016;65(3):47-50. doi:10.15585/mmwr.mm6503a2.

¹⁹ Hepatitis - Disease Surveillance Epidemiology Program - MeCDC; DHHS Maine.

<https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/hepatitis/index.shtml>. Accessed February 21, 2019.

²⁰ NCDHHS: Hepatitis B, C on Rise in N.C.; Health Officials Encourage Precautions, Testing.

<https://www.ncdhhs.gov/news/press-releases/hepatitis-b-c-rise-nc-health-officials-encourage-precautions-testing>. Accessed February 20, 2019.

²¹ Ramsey SD et al. *JAMA Oncol.* 2019 Jan 17. doi: 10.1001/jamaoncol.2018.6437.

(3b) What specific actions should the federal government and others take to improve the coordination of funding and delivery of viral hepatitis services?

- **Improve coordination of funding and delivery of viral hepatitis services.** We would like to see greater coordination and communication among federal partners. For example, viral hepatitis prevention, surveillance, and response efforts within the CDC fall under both the National Center for Immunization and Respiratory Diseases (NCIRD) and the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). CDC should work to improve collaboration and coordination across these centers by including guidance in upcoming funding opportunity announcements that encourages collaboration of resources among state immunization and infectious disease prevention programs. As another example, in federal efforts to prevent perinatal hepatitis B transmission, there is opportunity to collaborate across systems to ensure individuals who are at risk for and impacted by hepatitis B are monitored and treated appropriately across the lifespan. Due to gaps in prevention activities, which include identification and case management of infected pregnant women and their infants, an estimated 800-1,200 infants are infected with hepatitis B each year. Although limited, data suggests that the majority of hepatitis B-infected pregnant women are not referred to medical management; a recent publication found only 21% of women had peripartum hepatitis B specialist follow-up care²². This is a missed opportunity for preventing perinatal hepatitis B transmission and liver disease progression for hepatitis B-infected women. The federal government should therefore provide funding and stronger guidance for state and local health departments to coordinate on perinatal hepatitis B prevention projects and to share surveillance data to proactively link hepatitis B positive pregnant women and their household contacts into testing, vaccination, and care services, if needed.
- **Increase transparency and communication.** We would also like to see more transparency and communication from federal agencies to viral hepatitis community stakeholders. This would include regular reporting around federal funding streams related to viral hepatitis services to help stakeholders track what is being done at the federal level. Additionally, federal agencies should provide stronger guidance to state and local health departments and provide more opportunities for communication at the health department level to ensure that the delivery of viral hepatitis services is better coordinated, streamlined, and efficient. Stronger guidance and increased funding from the federal level for state and local health departments to test new strategies and scale-up evidence-based strategies would also help improve the delivery of services across the country and help address racial, ethnic, and geographic health disparities.

(4b) What monitoring and evaluation strategies would further improve viral hepatitis prevention, care, and treatment?

- **Prioritize development of a national surveillance system for chronic hepatitis B.** Gaps in viral hepatitis data and lack of a robust coordinated surveillance system in the U.S. persists. Prioritizing and building a local and national infrastructure is integral to stopping the spread of viral hepatitis and monitoring progress to successfully end the epidemic. The National Viral Hepatitis Action Plan

²² Chang MS, Wharam JF, Zhang F, et al. Peripartum maternal hepatitis B care in a US nationwide data set [published online August 24, 2018]. *J Clin Gastroenterol*. doi: 10.1097/MCG.000000000000112



highlights current state-by-state estimates or state epidemiological profiles for hepatitis C, which develops a baseline and will enable us to measure impact, but we cannot do the same for hepatitis B. We recommend improving hepatitis B surveillance by not only tracking those who are HBsAg positive, but also those who screen susceptible to hepatitis B and those with prior hepatitis B infection.

- **Develop quality measures for hepatitis B.** The healthcare effectiveness data and information set (HEDIS) currently includes only measures related to hepatitis B immunization, but we need quality indicators for hepatitis B testing. We recommend additional specific strategies under Goal 2, strategy 2, the establishment and monitoring of quality measures to increase provider awareness about hepatitis B testing.

Thank you again for this opportunity to provide input on the next iteration of the National Viral Hepatitis Action Plan. There is great momentum and effective tools to eliminate viral hepatitis in the U.S. and we look forward to working with federal and community partners to end the hepatitis B and C epidemics through expanded adult hepatitis B vaccination, continued childhood hepatitis B vaccination, and hepatitis B and C screening, prevention, treatment, and linkage to care. Please do not hesitate to contact Adam Carbullido (acarbullido@aapcho.org) with any questions or to request additional information.

Sincerely,

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Association of Asian Pacific Community Health Organizations

Adam P. Carbullido
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