

WEBINAR VIDEO TRANSCRIPT
National Viral Hepatitis Action Plan,
Priority Populations Webinar (Part 1)

14 September 2017

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RICHARD WOLITSKI: Everybody, this is Rich Wolitski. I'm the director of the Office of HIV/AIDS and Infectious Disease Policy here in the Department of Health and Human Services. Welcome to our webinar today on priority populations, the National Viral Hepatitis Action Plan. And I'm joined today by a number of guests. The first I want to introduce, Corinna Dan, who's going to be co-moderating today's session with me. Corinna, why don't you say hi to folks?

CORINNA DAN: Welcome, everybody. We're really excited about the webinar that we've got going today. I'm Corinna Dan from the office of HIV/AIDS and Infectious Disease Policy.

RICHARD WOLITSKI: And what do you do there, Corinna?

CORINNA DAN: I'm the viral hepatitis policy advisor. So my job is to implement and coordinate the National Viral Hepatitis Action Plan with our federal stakeholders, as well as with all of our community out there joining us, hopefully, today.

RICHARD WOLITSKI: Thanks, Corinna. And we will introduce our guest in the middle of us in just one moment. For additional information, we really want to encourage you to go to our viral hepatitis website, which is at hhs.gov/hepatitis. It's got a good set of basic information about viral hepatitis, as well as updates under the blog section where Corinna, myself, and other folks here in the office and across HHS from CDC, from NAH, from SAMHSA, HRSA, other agencies are contributing information to keep you up to date about what's going on related to viral hepatitis.

So what are we going to do today? So this is the welcome. We're going to have remarks from one of our new leaders here in the office, the assistant secretary for health. Dr. Lin will be speaking to us momentarily. And spend a little bit of time giving some background on where we are with the epidemic and the National Viral Hepatitis Action Plan.

And then we're going to hear from a partner organization, The Hepatitis C Mentor and Support Group, and a number of speakers who will be talking about a number of the 11 priority populations that are identified as part of the action plan. Talk about some common themes and opportunities, and then we'll take time for questions. I know we do bad in these webinars about having enough time for questions and try to move through it, so Corinna saying go faster, go faster, mentally.

But let's go ahead and start with our first presentation. This is really one of our newest members in OASH. This is Dr. Matthew Lin. He was recently appointed by the Trump administration to serve as deputy assistant secretary for minority health, and in that role, he is in charge of the Office for Minority Health here in the office of secretary. He's an orthopedic surgeon by training. He spent most of his professional career working in a community primarily comprised of minority people. He has served on the board of directors of Alhambra Hospital and Garfield Medical Center.

And, for the past two decades, which I find really amazing, he's been involved in disaster relief effort. And he has been a part of the response to the 2015 earthquake in Nepal, the 2010 earthquake in Haiti, the 2005 tsunami in Sri Lanka, and the Hurricane Katrina response, also in 2005. So 2005 was a bit easier for you, it sounds like.

He has his medical degree from Taipei Medical University and he's completed residencies in Baltimore at Medstar Union Memorial Hospital and Johns Hopkins, as well. He's received a multitude of different awards and has also served as vice mayor and a city councilman of San Marino, California, which is located in Los Angeles, California, where I grew up. So Dr. Lin, welcome. It's a pleasure to have you here today.

MATTHEW Y.C. LIN: Thank you, Richard. Hi, everyone. This is Dr. Matthew Lin. I'm very pleased to have the opportunity to talk to you today about the opportunity, important, to reduce the health disparity in reaching the goal of the National Viral Hepatitis Action Plan.

Viral hepatitis disproportionately impacts many populations. And as many as one in 12 Asian Americans are living with hepatitis B viral infections. I did a screening in Los Angeles every year. My memory is about every 14 to 15 Asians screened in 100 screenings have Hepatitis B, but they don't even know it. And many don't even know that they are infected.

And Hepatitis C virus related death rate in the American Indians and Alaska Natives communities is more than double of the national rate. The African-American community accounts for 11% of the US population but over 25% of people living with HCV.

National Viral Hepatitis Action Plan. We have highlighted 11 priority populations that are listed over here. From the baby boomers group to the pregnant women. And on the action plan, we have to detect and to avoid and eliminate the hepatitis infection.

We have four goals. I just mentioned the third goal is to reduce the viral hepatitis health disparities. And those are important for someone to realize the disease is there, so you can get an early detection and work towards prevention. And right now, the treatment program is so good that we could really cure or prevent the disease to cause a lesser or no mortality rate. Those are the stuff I have in mind.

I see a lot of patients all over this section of our population. 50% of those patients do not know they have Hepatitis. That is a difficulty in our society. I hope, maybe in the year 2020 or 2030,

the Hepatitis viral will be eliminated from the American community. Thank you so much for your listening. Thank you.

RICHARD WOLITSKI: It's been a pleasure. And I have to say to everybody out there that the Office for Minority Health has been a great partner to us and has been really with us side by side in development of action items and goals for the current action plan. And we're looking forward to you being right there with us as you work to develop the next action plan, which is happening before too long.

CORINNA DAN: I really appreciate you--

MATTHEW Y.C. LIN: Thank you so much.

CORINNA DAN: --coming out.

RICHARD WOLITSKI: And we are going to move on to our next stop, aren't we, Corinna?

CORINNA DAN: We are. Moving along, since we have a lot to cover today.

RICHARD WOLITSKI: Yes.

CORINNA DAN: So I think many people who've joined us today are aware that millions of Americans are living with chronic viral hepatitis. About 850,000 chronically infected with Hepatitis B, and about 3.5 million chronically infected with Hepatitis C. What we see in terms of Hepatitis C, there are so many, but about 75% were born between 1945 and 1965, and many of those individuals were exposed when they were young kids. They may not even realize that they had been exposed through routine medical procedures.

What we see, also, now in the United States is new infections that are happening among young people who inject drugs. The problem with chronic viral hepatitis is that it leads to an increased risk for serious liver disease, liver cancer and death. Half of those people, as Dr. Lin said, don't even know they are infected. And, importantly, unlike many other health problems, we have incredible tools to prevent, to diagnose, and to treat Hepatitis B and Hepatitis C.

Today, we're going to talk about six of the 11 priority populations. But, as Dr. Lin said, we have 11 priority populations and, really, they range-- they're coming from all kinds of places, from all walks of life, from all areas of the country. And socioeconomically, geographically, we've got a real range. So that's, on the one hand, a challenge. And maybe on the other hand, we have opportunities, as well.

RICHARD WOLITSKI: And I think when we look at this, you can see, really, the diversity of the groups that are affected. And it really is staggering how many different groups are affected by Hepatitis B and C.

CORINNA DAN: Agreed. Quick status report. Here, we are losing ground in the fight against new hepatitis infections. What we're seeing with hepatitis B is that progress on prevention is really stalled. Some states have seen sharp increases, the 2015 surveillance reports of Tennessee and Ohio having really the sharpest increases. And it's interesting, because some states really have a lot of increase, some states actually went down a little bit, and some states were unchanged. So it really varies a lot, but the fact is that we were making terrific progress in preventing new hep B infections and that progress has stalled.

RICHARD WOLITSKI: And what Corinna's going to talk about a little bit later is what we're seeing is the increases are in those areas that are hardest hit by the opioid epidemic. And that's really the driving factor behind B and C and what's going on today.

CORINNA DAN: Right. The other piece of our puzzle with hepatitis B and C. Hepatitis C has seen about a 300% increase in new infections. So that line is going pretty much consistently up. Nine states in the 2015 surveillance report accounted for half of all new infections. We know that there are some states that are experiencing a lot of new infections. Overall, about 20 states saw increases. But there were some states that seem to be flat. They're not really seeing as much of an increase. And again, to your point, many of the states seeing increases are really bearing the brunt of the opioid epidemic.

Because so many people are chronically infected, we're seeing deaths due to hepatitis C increasing. Chronic hepatitis C now kills more Americans than all 60 other reportable infectious diseases combined. And they reached an all-time high in 2014. And so we're hopeful that our work to use the tools that we have can start to change that statistic.

RICHARD WOLITSKI: And important to remember, all of those people can be cured.

CORINNA DAN: Thank you. As Rich said, we're going to look a little bit more at the states that are most impacted. Talking about perinatal hepatitis B and perinatal hepatitis C, they're very different in a lot of ways. But what we're seeing with perinatal hepatitis C is that, again, our efforts have stalled. We would like to really get to the point at which we've eliminated perinatal hepatitis C transmission. But for the last almost decade here, we've got a pretty flat number with almost a thousand infants infected every year in the United States. And those are, as you say, preventable infections.

Rates of hepatitis C, when we talk about perinatal C, the rates of hepatitis C infection among pregnant women have increased. We had two states that took leadership on this, Kentucky and Tennessee. Both are reporting a steep increase among the women in their state. This is very concerning, because their infants are then, potentially, being exposed and potentially infected with hepatitis C. And the map there that was published in the MMWR shows you where the epicenter is, or where the states that are hardest hit are. And if you want more information, the CDC's got a great MMWR on that.

What we're seeing with the opioid epidemic is really concerning. Many communities have really been decimated. I heard some horrifying statistics about West Virginia, with something on the order of 40% of children in one county hardest hit out in foster care, because of deaths, because of incarceration of parents. The fact is that, related to the opioid epidemic, heroin use has more than doubled. Deaths due to drug overdose have increased over 300%. There's been an increase in heroin use and overdose deaths overall.

And when we look a little more closely at hepatitis C, we're seeing that most of the young people who are being diagnosed with hep C started using oral opiates, transitioned to injecting, are using heroin as well or pushing heroin. And overall, about 26% of the new hepatitis C infections and 68% of the new hepatitis C cases the CDC detected in 2014 were associated with injection drug use. So with that, I'm going to--

RICHARD WOLITSKI: Turn back to me.

CORINNA DAN: --turn it back to Richard.

RICHARD WOLITSKI: 11 priority populations. Say we want to focus on roughly half of them. And we're going to put some of the population burden and struggle and challenges that we're going to talk about today in some context.

So overall, if you look at 3.5 million people living with hepatitis C in the US, that's about 1% of the population. About one out of 100 people. Keep that in mind as we go through some of these other statistics.

Veterans. 6.2% of veterans in one study have chronic hepatitis C. That's six times the national average. Look among the homeless people, rates of hepatitis C infection could be as high as 50% in some communities. And about a third of people with chronic hepatitis C have been incarcerated, in jail or prison, at some point in time.

For people living with HIV, we see about 20% of them are coinfecting-- Oh, I said hepatitis C instead of HIV. So about 20% of people living with HIV are coinfecting with hepatitis C. One in five. And gay and bisexual and other men who have sex with men account for about 20% of new hepatitis C infections. And about 26%, about a quarter to a half, of people who inject drugs have chronic hepatitis C virus infection. Dr. Lin summed this up beautifully at the start of the webinar. We have a lot of disparities. And that's either going to be the subject of our next webinar, which we're going to plug the end of this one.

About 2.8% of baby boomers born between 1945 and '65 are estimated to have chronic hepatitis C. As Corinna said, in large part probably because of being infected when they went to the doctor and were exposed to contaminated medical equipment. In 2014, American Indians had the highest rates of new hepatitis C infections, highest rates of hepatitis C death. We look at African Americans in the US. Highest rates of new hepatitis B infections, second highest rates of hepatitis C infections, and the second highest rate of hepatitis B and C related deaths.

Asian Americans account for about 5% of the US population, but they represent more than half of chronic hepatitis B virus infections and they have the highest Hepatitis B related death rate. And pregnant women, we've talked about them a little bit already. But the concern there is not only their health, which we're very worried about, but the potential for transmitting hepatitis B and C to their infant as well. A major public health problem.

And this is all just really sad, because they're all preventable. We have effective tools. We have effective vaccinations for hepatitis A and B. We have accurate tests that can screen for hepatitis B. They can diagnose chronic infection long before symptoms appear. And we have hepatitis B treatment that can suppress the virus and allow people to stay healthy for years and years. Hepatitis C-- accurate tests, diagnose the infection early. And with hepatitis C, what's amazing now is that we can cure the infection in almost all cases.

So even though we have the tools, we don't have the ability to use them in all cases. We're seeing increases in infection rather than movement towards our goal of elimination. We have the opioid epidemic. That's the driving factor. That's the thing that's changed the direction of where we were going in hepatitis prevention. We know that comprehensive approaches to fighting viral hepatitis have great potential to prevent new infections and, most importantly, save lives.

But there are critical gaps in our response. Prevention messages are not reaching the people. People are not being screened and tested for viral hepatitis. Many people with viral hepatitis, even if they know it, are not able to access the effective treatment that would prevent disease progression and onward transmission of infection. And lastly, we know that we do not have complete surveillance data, because some states are not able to collect this information on new cases and death in a comprehensive manner. So that's background of the [? epi. ?] Get your [? epi ?] 101 refresher right there.

Now I'm going to say a few words about our hepatitis action plan for 2017 to 2020. This was released earlier this year, right at the start of this year. And it really is the foundation for a response. It's a battle plan for our nation's response. It provides a strategic framework that can be used to support state and local governments and organizations across multiple sectors to develop their own plan for how they're going to combat viral hepatitis in their community. It sets goals for the nation, priorities and measurable targets. It describes recommended actions, and I think, importantly, it's a way to hold us accountable at the federal level as well as the state and local level and to promote transparency, because we report results and progress on these indicators each and every year.

And as I said before, it's a national plan, but it's meant to be used by all of you. Go to the website and download a copy of the plan, as well a number of other useful documents and tools to help you when you're planning an implementation activity. So we heard about goal number three, which is reducing viral hepatitis disparities. Let's touch on the other three goals real quickly.

Number one, prevent new infections. Number two, reduce deaths and improve the health of people living with viral hepatitis. And goal three, as you heard from Dr. Lin, reduce health disparities related to viral hepatitis. And goal four, this is about improving the coordination, monitoring, and reporting and how we do our viral hepatitis actions. So that's the big picture of the four goals. And if we do these activities that support the goals, we'll achieve our goals. What it's going to do is it's going to put us on the path to achieving this vision that we have for the future, where the US will be a place where new viral hepatitis infections have been eliminated, where all people with chronic hepatitis B and C infections know their status, and everyone with chronic hepatitis B and C have access to high quality health care and curative treatment that are free from stigma and from discrimination. And we're going to touch a little bit on what a challenge stigma and discrimination really so are when it comes to viral hepatitis.

CORINNA DAN: I just want to say about that vision, when we were developing the action plan, we heard from stakeholders across the country, some of the folks on the webinar, I'm sure, that encouraged us to really be bold, to think bolder. And I hope that that vision really helps other people to understand what we're trying to accomplish with the action plan and what some planning can actually accomplish. So I hope that others are taking on that charge and know that some local jurisdictions have started making their plan and encourage others to do the same.

Speaking of our partners across the country, I want to thank Ronni Marks from The Hepatitis C Mentor and Support Group and give her just a couple of minutes to say a couple of words. When I started thinking about the task of organizing a webinar on the priority populations, there are 11 priority populations, it was overwhelming to me. And I thought, well, that's a little bit nuts. And I was talking to Ronni. She said, "We can do this, Corinna." So Ronni, if you're on, can you join us for a couple minutes?

RONNI MARKS: I will, thank you so much for inviting me to be part of this important webinar. I founded The Hepatitis C Mentor and Support Group to address a lack of education and support services for patients and providers nationwide. We provide these services to our programs and trainings, the Hepatitis C Education and Support Group Assistance Program. And the health care providers support an education program.

I am a hepatitis C patient and advocate since 1996, when I was first diagnosed, and happy to say I'm one of the lucky ones who is now cured. My travels across the country have enabled me to work with diverse patient populations and learn how they live with this disease and handle it. It is important we hear these personal stories and widely share this information, in order to better understand the different challenges these patients face. What I find that they all have in common is resilience. And in many cases, after being cured, patients want it pay it forward by helping others. Thank you.

CORINNA DAN: Wonderful, Ronni. Well, you're certainly paying it forward again and again with all of your work. And I know your organization has expanded lately. You're getting involved in some new areas, like helping to support communities to set up needle exchanges and

importantly, also, helping to build capacity in health care providers, as well as among people affected with hepatitis.

RICHARD WOLITSKI: I'm going to jump in there real quickly and say, Ronni, thank you for your assistance with this webinar. Thank you for your beautiful and concise remarks. I have to say, if there's something that gets Corinna Dan overwhelmed and feel like she can't manage it, that means it's huge. That taught me a lot about who you are, Ronni, that you were able to come in here and make it [INAUDIBLE]. Thank you again, Ronni. We appreciate your help and you being here today.

CORINNA DAN: Yeah. All right. So I highlighted the group that we're going to be talking with and about today in red. So there's a reddish color there, trying to keep with our color theme for the action plan. And I think Rich said it really well earlier. Achieving our 2020 goals will not be possible unless we understand and focus our efforts on the groups that are most affected with hepatitis B and hepatitis C. So this webinar is one way that we are working to increase engagement and awareness about the populations and the challenges and opportunities to work with those groups. So it is my pleasure.

RICHARD WOLITSKI: It is our pleasure.

CORINNA DAN: Our pleasure to talk with these six individuals who have joined us today. Actually, I think there's five total, but six including Ronni. And the first gentleman who is a veteran. You know that veterans have higher rates of hepatitis C infection than the general public. As I said earlier, in one study, hepatitis C prevalence was about 6%. So six time higher than we see it in the general public. Importantly, the Department of Veterans Affairs has recognized this. They've put a lot of work into understanding what the veterans affected need. And we've got support from our Members of Congress, who have enabled the VA to develop effective systems of care, because it really takes a system to treat that many people with hepatitis C.

RICHARD WOLITSKI: And it has held them accountable for the result and accountability for the research that they received. Before we jump in, I really want to say that six times the number of infections compared to everybody else. That's awful. And when you think about what our veterans have sacrificed, what they've given up for this country, what they've experienced as they go to war, or serve in times we're not at war, it's tremendous what they've done for the country.

And oftentimes they come back either physically wounded or emotionally scarred. And as a result, they have higher rates of substance use, higher rates of mental health problems, and we know that leads to higher rates of homelessness and a whole host of health-related challenges that our veterans face. It's shameful that this is what's current in the US today, but it's good to know that Congress and the VA have stepped up to make things right, at least when it comes to hepatitis C infections. So congrats to them.

CORINNA DAN: And to help us understand a little bit more about that experience, Knute Neihoff has agreed to join us today. He is a Vietnam veteran who was successfully cured of his hepatitis C infection. Thank you, sir, for your service. He has an important story to share about his experience with hepatitis C. Knute?

KNUTE NEIHOFF: Hi, everyone. First of all, thank you for allowing me also to participate and contribute to sending out this message that there's a cure. I left Vietnam in 1970 and was a combat medic for 20 months there. And I wasn't really diagnosed with post-traumatic stress until 1999, not knowing what all the stuff that was happening to me was during that whole time. But when my brother told me to go to the VA and get checked out, I went. They determined I had definitely severe PTSD, and that was in 1999.

Five years later, I got a letter from the VA saying that, because of my age group and because I was a medic, that I would have a possibility to have hep C. I'd heard of hep C, never knew really what it was. Went in, I got tested, I had it. In that time frame, I'd studied it and I was going, my god, here's another bomb in my head. So at that time, I could not get any cure, because interferon would interfere with my PTSD meds and so forth. Then in 2014, I got a call from the VA and they said they had a program. It's a 90-day program, and I go in and I take a pill. There will be some side effects and so forth, but the cure rate has been a little over 90%.

And by the way, I want to thank the VA from the bottom of my heart for how they've taken care of me and how I have witnessed how they have taken care of other veterans in all aspects of stuff. My liver, my mental, everything. Especially to Elizabeth McGuire, who has done a thing on a video to promote, and then the liver team in San Francisco. I can't say enough about their support.

And that's really what this is about. It's about support from them. It's about support from myself getting out to people who need recovery, who need the help.

And I took the pills for 90 days, and in between, I got a blood test. And they said, hey, Knute, you're 50% less liver enzymes, F4, F3s, whatever it was, and I went, wow. Then on February the 4th, 2015, I went in for my last day, and I had the results. And they said I was 100% cured.

There's no words to explain how I felt. I'm choking up now, because it was like I told Ronni, that it was like a black cloud that evaporated immediately out of my head. Not only did it signal that I'm going to be not worried about dying soon, which I could anyway, but I'm not from hep C, but just the whole thing about life. How important we all-- how important and how lucky we are to have life so we can contribute, to be part of our family.

I'm a grandpa now. Been married 42 years. I got four grandkids. Walking out of that VA with that being cured, I saw things clearer. My head was spinning with happiness. Colors were more vibrant. My determination was stronger, to be stronger. And I'm committed to helping anyone I can to overcome this disease. So thank you for this whole committee. Thank you to the government for helping me so I can help others. Thanks.

RICHARD WOLITSKI: Thank you. And thank you, first of all, for your service. Thank you for your inspirational story and everything that you're doing for your community and for other people who are struggling with hepatitis C infection. And I think your story, for me, just kind of reminds us why it's important to do this webinar. Because normally we talk about data, statistics, and numbers and graphs and figures, and it's really all about people at the end of the day. And too often we don't get to hear about people's experiences and what they're going through. And you've helped make a little piece of the experience a little more real for all of us. Thank you.

CORINNA DAN: Thank you, Knute.

KNUTE NEIHOFF: Never give up hope.

RICHARD WOLITSKI: No, don't.

CORINNA DAN: Thank you, that's an excellent, excellent message. We are excited today to talk a little bit about homeless individuals and the impact of hepatitis C on that group. Homeless individuals face a lot of challenges, including health care and health care access challenges. And hepatitis C rates, as we discussed earlier, as many as half of people who are homeless have chronic hepatitis C. And I think that we just haven't developed the tools that we need to help this population as much as we could.

However, it seems to me that the folks that are going to talk about it today, Kailyn Koh and Earl Batte, have been doing some really excellent work that's going to help all of us understand. I did just want to reflect that, in talking with the folks that are here joining us today and on the next webinar, I heard stories of people who were very close to losing their home, were not able to stay in an apartment or a place to live, maybe lived out of their car for a little while. And I think many people are in a position where they're just one or two paychecks away from being homeless. So it's not uncommon for people to be in a unstable housing situation or to become homeless, at least temporarily, and sometimes long-term.

So it is an important population. They face a lot of challenges. And I'm really, really happy, I want to welcome Kailyn Koh. I think she'll probably kick this off from the Los Angeles Christian Health Centers, their Midnight Mission CLINIC, where she works as a care coordinator. Kailyn, are you there?

KAILYN KOH: Yeah. Thank you guys for having us. So my role in treatment is kind of diverse, because with hep C and particularly with the homeless individual, each person's case can just vary so much. So sometimes they need help with figuring out next steps to get labs done. Some aren't sure if treatment is even something they want. And all of them need monitoring during treatment. So for each patient, you're really trying to meet them where they are and to show them what their next step is.

And so Shannon Fernando, our associate clinical director, is running a program in our Midnight Mission Clinic in which people living at the mission trying to recover from substance abuse and

homelessness can be treated for hepatitis C but with some of those extra barriers out of the way. For homeless individuals, even having a place to store their medicine can be a challenge. But this setup addresses many of those issues in a really unique way.

Patients are living in the same place that they're being treated. So they have some extra stability. They have a safe place to live. And they have the benefit of only having to take a flight of stairs down to come to the clinic.

One barrier I have seen, though, stems from the clinical presentation of hep C. Since it's possible to go for years without any symptoms or pain, it is often lower on the list of priorities for both the health care providers and for the patients that we're seeing. And this is especially true for the homeless population, where our patients tend to have really long medical problems lists. Without serious symptoms, hep C can go, for the most part, ignored, even though the virus is silently destroying the patient's liver, and even though hep C can be life threatening.

I recently saw a patient who told me, thank you for coming in to speak with me today, I totally would've forgotten that I had hep C when I came in to see the doctor today. But he just told me how much he wanted the treatment and how the treatment was going to be part of his recovery, how he considered hep C treatment part of his recovery from drug use. So I think that's one thing that is so significant about hep C treatment. It's the fact that it can give these patients hope, not only for a future in which they're free of just the virus, but also hope for a different future, period.

There are so many patients for whom treatment becomes a source of motivation and a source of empowerment to change their lives. Or they see it as part of a life change that they're already making for sobriety or for something else. I think that's a really special thing about hep C treatment. It can save someone's life, not only so that they can live longer, but it also gives them a chance to have a completely different future.

And one more thing I will say is just how much that I love working with hep C patients. I think it's really important to know that they're a group of people who really want to be cured, and they really want to move forward in their lives. They're not getting treated just because they're in pain all the time and they just want the pain to go away. They could have ignored a disease that doesn't give them any pain, but instead they're really thinking about the kind of future and the kind of health that they want to have. And that really shows in their treatment and the way that they really make an effort to make things happen and make their treatment a success. That's really something that's exciting to watch and something that's exciting to be a part of. It's just amazing to be part of these patients' lives in that way. And

I have with me one of our patients, Earl Batte, who wanted to say something too. So, Earl.

EARL BATTE: Yes, my name's Earl Batte and I thank you for the opportunity to share a little bit about me. I consider hep C an extremely, extremely dangerous virus. I'm not sure how many

years that it was in my body, but I had no symptoms. And that was part of the major problem, because I didn't have any symptoms that deterred me at all.

And when I found out about the treatment, I was hesitant about it, because it wasn't on my priority list. I had received treatment before with interferon and ribavirin, and the side effects were so horrific, it scared me into not wanting to get the treatment. And part of the problem with that was there wasn't any symptoms of the hepatitis C virus, so I was really hesitant about receiving treatment. I did go through the treatment with ribavirin and interferon and it didn't have an effect. It was not effective.

Thank god I did run to Shannon and the Christian Health Center at the Midnight Mission, because with six or seven years, I thought the hep C virus was out of my body. And when the thoroughness of Shannon and the participants here at the Christian Health Center at Midnight Mission let me know the virus is still active in my system, it really scared me.

When I thought I was cured of the hep C virus, it was uplifting to me. It gave me a new lease on life. I could have relationships. I didn't have to worry about my life being short. And then to find out that the virus was still active in my system was really depressing. I went through a period of depression all along while I was getting a thorough examination and having labs done and blood work done to determine what type of treatment would be administered to me. And it wasn't guaranteed at that.

But the staff here fought for me and got my medicine approved. And so far, after having lab work saying that the virus is out of my system is like a relief. It's like a million-ton rock being lifted off me. It helps me focus on the future and what I want to do with myself, because in the back of your mind, there's always that thought that your life can be shortened by a virus that you have. Or you could be crippled, you could be laid up, or some type of other effect because of the hep C virus.

It's such a scary thing, because there's no symptoms and no indication that your body is really deteriorating and you will have eventually a serious, serious problem that would be life threatening to you. So I want to give all the props in the world to having had been diagnosed with the hep C and receiving treatment. Thank you.

RICHARD WOLITSKI: Earl and Kailyn, thank you so much for being here today. And I think that oftentimes, when we look at people who are homeless and people who inject drugs, people who are in any way different from us, a lot of times we're going to other them. And we think of them as not equal, as different, and sometimes, unfortunately, look down on them. I think you've demonstrated that we shouldn't be doing that.

In my own work with HIV and hepatitis, I've come across people from all different walks of life that if I didn't do this work, I probably would not have had the privilege of knowing. We know people who are homeless and take their medication for hepatitis or HIV and do really well and have lots of attributes and strength to build upon. And so a lot of times, it's really just giving

them the opportunity to have the space, the skills, and the time to do the stuff that they need to do to make things right in their own life. Thank you for being--

KAILYN KOH: Thank you so much for doing this webinar. I think it's so important just to raise awareness, because it is something that goes under the radar so often. So thank you both.

RICHARD WOLITSKI: And to you as well. Have a good one.

CORINNA DAN: Thanks so much. All right. Moving on. I think we're going to talk a little bit about people in correctional facilities. I was amazed when I first got into the field of hepatitis to learn that an estimated one in three people with chronic hepatitis B had been through a jail or prison. It made me want to go work in jails and prisons, because I'm dedicated to this work. It made me realize that that was one of the places where public health care providers and others needed to focus efforts, because there's such great need among people who are incarcerated.

RICHARD WOLITSKI: Actually, years and years ago, and I can't even tell you how many years ago it was now, I was part of a study called Project Start that did HIV and viral hepatitis STD prevention for young men being released from prison. And as part of that experience, one of the things I really took away from it was this idea that people who are in prison are somehow walled off from our communities and they're just put away, gone forever, just how false that was. I think when we think about people who are incarcerated, we have to really think of them as people who are community members. Parents, uncles, aunts, sons and daughters, friends. They're part of our community and almost all of them are going to return to the community at some point in time. Often, after not too much time. We can't forget about them, and the health of people who are incarcerated is a part of community health as well.

CORINNA DAN: Thank you. Absolutely. So with us here today is Matthew Akiyama, assistant professor of medicine and attending physician, primarily at Montefiore Medical Center. But he's here to share today about his work in jail on hepatitis B. Matthew?

MATTHEW AKIYAMA: Thanks, Corinna. Hi, everyone. As Corinna mentioned, my name is Matthew Akiyama. I'm assistant professor of medicine at Montefiore and Albert Einstein College of Medicine. I really want to thank the organizers for the invitation and opportunity to speak on this important topic and the patients who have spoken thus far. Knute, Earl, and Kailyn as well. It's been really incredible to hear your stories.

So hep C incarceration, as Corinna was mentioning, and Rich as well, is a large topic to cover in five minutes. But I'll try to take on some of the more major challenges and highlight some of the key issues. And I'll close with some voices from patients in the criminal justice system who we would love to have joined us today.

I'm going to focus on hepatitis C, since this is the area I have more experience with in the correctional setting. But many of the same concepts apply to hepatitis B, as well. As I'm sure everyone on the webinar is aware, due to policies of mass incarceration in the last four

decades, there has been a large rise in individuals with substance use disorders in the criminal justice system.

Due to the interrelationship with substance use disorders, hepatitis C prevalence estimates range from 10% to 40%, depending on the setting. This represents what Merrill Singer, an anthropologist at University of Connecticut, described as endemic of hepatitis C and substance use disorders, as well as HIV and other communicable illnesses, and I would argue incarceration, as well. I think it makes sense to frame the issues in terms of the care cascade within the continuum of the community and criminal justice system for patients living with hepatitis C.

So the first step in the care continuum is testing, and for the last several years, national guidelines have recommended testing for individuals with criminal justice association. The Federal Bureau of Prisons followed suit in October of last year and also made the recommendation for universal opt-out screening in their guidelines, but uptake has lagged in these recommendations, and challenges still remain, in part because of cost and personnel. There's always personnel for pre- and post-test counseling. And all of the steps involved with testing, particularly components involving follow up require work and collaboration with the Department of Corrections to ensure patients are able to come to clinic to receive their test results and post-test counseling.

For the sake of time, I won't discuss confirmatory testing, but needless to say, this is something that needs to occur for patients to be aware of their chronic infection. Add the time delay of several days at minimum and more often weeks to months before counseling can be done per patient to confirm their diagnosis. This is particularly challenging in the jail setting, where length of stay often do not permit communication of test results. Until one-step testing options are available, this will remain the challenge.

Moving on to treatment in the cascade, we need to think of treatment broadly in terms of treatment in correctional settings versus linkage to an engagement in care in the community. Though in reality, there's often overlap in terms of patients coming into the correctional setting on treatment and vice versa. As for treatment in the correctional setting, cost is clearly a key barrier. Part of the challenge is that costs are dependent on state budgets, and while payment structures are too complicated to discuss in detail here, the majority of patients in the correctional setting are going untreated currently.

This is being overcome in certain settings with creative pricing and payment structures. Also, there is now an even newer generation of therapies available, which might help drive down costs and hopefully expand access to treatment. While cost is clearly a major factor here, we need to also be thinking about issues like workforce capacity expansion, telementoring, and other models of care to expand delivery in correctional settings.

If treatment can be accomplished in corrections, linkage to care for treatment in the community is essential. But there are many barriers for former detainees following re-entry,

and these range from financial, including poverty, to re-activation of their health insurance following re-entry, distrust of the medical system, readiness for treatment, ongoing or relapse back to substance use disorders, among others. Some of these barriers can be mitigated by working in collaboration with community-based organizations to maximize engagement in care on re-entry into the community, as well as treatment of active substance use disorders, both in corrections and in the transition to the community.

Interventions at the governmental level also show promise. For example, the New York State Department of Health began finalizing a waiver in April, 2016, with CMS, in which a request was made to enable the state to use Medicaid funding to pay for coordination and services 30 days prior to release. So common themes that emerge are partnering with CBOs, but also with DOC and lobbying for policy changes in order to ensure the care cascade is as seamless as possible and the transition from the community to the correctional setting and back again.

And to finish off, I wanted to bring in some voices of individuals with hepatitis C in the New York City jail system. One 40-year-old gentleman said, when I hit the street and have my freedom again, I want to have that part of my life done with, referring to jail drug use and his hep-c infection. This is a young man's game. I plan on changing my whole life around. I might even relocate. Another woman said, I'm on a new road. I'm not interested in going backward. These are some of the voices of individuals who are ready to be treated but still have difficulty accessing treatment in the correctional system. As previously stated, many have difficulty with linkage to and engagement and treatment upon re-entry into the community, making this a priority population for additional intervention. With all that, I'll pass it on to the next speaker.

CORINNA DAN: Thank you, Matthew. Really great to hear about the good work going on in New York. I believe that there are other Departments of Correction that are working on hepatitis B and hepatitis C. I hope that we can continue to highlight those beyond today and in the future with our work here.

RICHARD WOLITSKI: It's part of our job to not only call attention to the problem and the challenges, but really to shine a light on the successful programs and activities that are out there. So we love hearing when people are doing good work and making a difference. Let us know. I just wanted to add real quickly, Corinna, we didn't talk about this, but I'm going to take director's prerogative.

CORINNA DAN: Go for it.

RICHARD WOLITSKI: Want to encourage people, if there are any comments or suggestions that you want to give to us about future webinars, things you're interested in, things when you hear more about, or any feedback you want to provide to us, you can go ahead and use the chat function. Type in any notes to us there. And all that get saved and we'll be able to print it out and read it after the webinar.

CORINNA DAN: Great. All right. So we actually have a speaker now who has the experience of more than just one, as so many people do-- I mean, we try to put people into certain categories and sometimes it doesn't work that well.

RICHARD WOLITSKI: Yeah, our funding comes categorically in one narrow stream. And so often, it can get in the way of really providing patient-centered care that addresses the needs of the whole person. We're hearing today, these 11 priority populations, there's a lot of overlap in them. And people fall in multiple categories. People with HIV also get hepatitis. There's a lot of stuff out there in the world.

CORINNA DAN: I just wanted to get a little preview here in terms of men who have sex with men. Nearly one fifth of all new hepatitis B infections occur in men who have sex with men. We're also seeing a concerning trend of increasing hepatitis B infection among men who have sex with men, especially men who have sex with men who are living with HIV. Among people with HIV, like you said, it's so interrelated. We've got one in five people living with HIV have hepatitis C. About one in 10 people living with HIV have hepatitis B.

And so we got a really great speaker who has experience in both-- has experienced it all, at this point.

RICHARD WOLITSKI: And Nicholas, before we jump to you, just one thing to underscore with what Corinna's comments alluded to is that one of the big concerns for gay men living with HIV is potential risk of sexual transmission of hepatitis C, because the combination of having preexisting HIV infection appears to make it easier for hepatitis C to be transmitted sexually.

CORINNA DAN: But of course, some people with HIV also inject drugs, also have a range of experiences and potentially other risk factors as well.

[INTERPOSING VOICES]

RICHARD WOLITSKI: Nicholas, we want to hear your story and your perspective. Thanks for joining us today.

CORINNA DAN: Just want to ask if you're able to share your personal story about hepatitis B with us.

NICHOLAS MUNOZ: So I've been HIV positive for the last 22 years, and probably around 15 years ago-- and for the most part, I have always been pretty healthy. About 15 years ago, one day, I got really sick. And the funny thing is these symptoms were all too familiar to me, because I had my eyes turn yellow, I had pretty dark urine and abdominal pain. And the reason why is because I had hepatitis A at the age of 10, and then hepatitis B at the age of 19. And I just couldn't believe that I was going to have another episode of hepatitis.

I saw, for the most part, always the same doctor, who happened to be an infectious disease and also a GI and liver specialist. But the funny thing is, we never, ever talked about hepatitis C. We never talk about the chances for me to get infected with hepatitis C. So basically, I thought that once I was clear of hepatitis B many, many years ago, I was never going to get hepatitis ever, ever again.

But here I was, having the same symptoms all over again. Which is absolutely horrible. One thing that I have to point out is that the doctor told me, at that point, he said to me something I will never forget. He says, don't worry about it. It's a very benign disease. It doesn't hurt. And he was very wrong about it, because it actually turned out to be a horrible disease. A horrible disease.

So the years went by, and I didn't have-- well, we cannot try to figure out how I contracted hepatitis C. We think that it was because I was having unprotected sex with other male partners. So far, what I've been hearing from other people who have the experience of sharing hepatitis C, in my group, in the gay community, we don't have the heroin epidemic, but we have the methamphetamine epidemic. And I'm pretty sure that by using methamphetamine, that leads you into having these unprotected sex situations, and you engage in very risky sexual behavior.

So we really think that it was either by the unprotected sex behavior or perhaps sharing a crystal meth pipe could also have been the case. But anyway, many years went by. Probably about 15 years went by that I didn't have any symptoms, any problems, until one day about two years ago.

I woke up and I was so severely fatigued. I had absolutely no energy. And there's a difference between being tired and being fatigued. Being tired, you still can do things. Being fatigued, you cannot. I was so exhausted and I didn't know the reason why, so I went to see my doctor and we did a FibroSURE test to see the level of fibrosis in my liver. And about two or three weeks later, I get the results, and they were devastating. I was reaching the F3, F4. I was more close to the F4, which is very close to cirrhosis stage. So I honestly thought that I was going to die. Because I didn't have \$100,000 to pay for the treatment. The new treatments were available, the new pills were available, but I didn't have the money. I didn't have the resources to pay for these treatments.

And the thing is, my doctor at Parkland Hospital, which is the county hospital, he and the hep C doctor, they both told me that they were not going to treat me there, that I needed to have cirrhosis in order to get treated. So I didn't know what I was going to do or if I had any options.

What kept me going was my faith. I pray God for guidance. I pray God to show me who I needed to talk to and the questions I needed to ask, because that was a closed door. They told me flat-out, we're not going to treat you. We can't treat you until you get cirrhosis. Why are we going to treat someone with cirrhosis? Because it's irreversible at that point. It's irreversible. And why not treat people whose lives can be saved?

So I knew that a former doctor of mine was working at AHF Dallas AIDS Care Health Foundation. Dr. Elizabeth Race. And I went and talked to her and told her my situation. In the meantime, my health was getting worse and worse every day. Less energy, I was nauseated and having severe fatigue. So things were not improving. Things are not getting better.

So as soon as I tell her my story, she said without thinking twice, we're going to try patient assistance with Gilead, and I'm going to treat you with Harvoni. I was actually her first patient that she was going to treat with Harvoni. So only two-- it probably has to do with the fact that my liver fibrosis was pretty advanced. I was like knocking on the door of the cirrhosis stage. So we downloaded the application. Filled it out and faxed it. Within four hours, I got a phone call from Gilead to let me know that my application got approved.

CORINNA DAN: Wonderful.

NICHOLAS MUNOZ: A week later, I got the first bottle of Harvoni. In the meantime, like I was saying a minute ago, my health kept getting worse and worse and worse. I was not only at that point dealing with fatigue, but also I was dealing with extreme depression, anxiety, and the stress. I was dealing with thinking that I was going to lose my apartment, that I was so sick, well, of course I couldn't work. That I was going to lose my apartment and I was going to end up sick on the street, homeless.

RICHARD WOLITSKI: Nicholas, I want to jump in here and I want to ask you the question that I know of everybody wants to know.

NICHOLAS MUNOZ: Yes, please.

RICHARD WOLITSKI: Did you end up successfully completing your treatment and get cured?

NICHOLAS MUNOZ: Absolutely. I completed my treatment on November 25, 2015. After a month later, after I started treatment, I got undetectable. I have remained undetectable until today. I actually, two years later, probably a month ago, we had another viral load. It came back undetectable. I feel better than ever. I have a great amount of energy. I have gone to work. My life is back to normal. And I can not only put the hepatitis C behind, but also my drug problem. So life is good.

RICHARD WOLITSKI: Nicholas, that is so amazing to hear. This is just a wonderful story. And thank you so much.

NICHOLAS MUNOZ: I just want to say one thing before I go. There's help out there. For those who think that it's the end of the road, that there's no help, that, perhaps, money. This time, it was not an obstacle. So there's help out there, just keep-- I had to become my own advocate. I have to fight for my life and fight for myself.

And I want to say one more thing. I want to thank Andrew Reynolds and Ronni Marks, because during the worse days of the treatment and being sick and everything, in the Dallas-Fort Worth area, there was absolutely no support group. Nobody to talk to. Nobody that can relate to me and say a few words of help. Somehow, I opened a magazine, and I saw an article of Andrew Reynolds', an article that he wrote, and that led me to meet Ronni Marks. And without them and Dr. Elizabeth Race at AHF Dallas, I couldn't be here talking to you guys. So I hope my story helps others.

RICHARD WOLITSKI: I'm sure it does, Nicholas. Thank you again for sharing it, and thank you for really recognizing some of the important people. Another shout out to Ronni. I also just want to real quickly acknowledge that Dr. Laura Cheever, who heads the HIV/AIDS Bureau at HRSA, has really been making it a priority to ensure that people who are coinfecting with HIV and Hepatitis C are able to access treatment for HPV. And they're developing plans for, really, how they're going to be able to treat everyone who is coinfecting.

CORINNA DAN: One other thing. Kind of a theme, almost, in what we're talking about today is the opioid epidemic and the impact of the opioid epidemic on numbers of hepatitis C infections and numbers of hepatitis B infections. Primarily most of that is being driven by an increase in people who are injecting drugs. Lot of folks who might've started using oral opioids or intranasal heroin or other drugs transition into injecting, putting themselves at great risk, causing other harm. But in particular, hepatitis C is being driven, these days in our country, by injecting drug use.

RICHARD WOLITSKI: And unfortunately, a lot of communities around the country, they didn't have comprehensive syringe services programs in place that would have helped to mitigate the effects of the expansion of the opioid epidemic in those communities. And so we're seeing, fortunately, in part because of Congress' approval of the process were accepting some jurisdictions with public health emergencies that allowed them to use federal funding, some service program, or even aspects of syringe service programs, are really making a difference.

And we're seeing these programs pop up and grow in more and more communities and getting support from leaders all across the political spectrum. Some of whom you might not have expected to be as supportive and knowledgeable as they now are about the important effects of medications with the treatment, syringe service programs, et cetera, et cetera, et cetera.

CORINNA DAN: And I just want to put out there that we've seen that increase in new hepatitis C infections at least since 2010. And I've worked closely with people at the state level for at least that long and have heard their concern over the years. And I think one thing that we all need to be thinking about is the education and the prevention that we need to put in place in order to turn that epidemic around.

Because of the way we're going, we're on a trajectory to have even higher rates next year, when CDC looks at their 2016 surveillance numbers. I'm very, very concerned. And I know that it's not always easy to find individuals who have the experience of injecting to share their story.

And it can be really challenging, especially if you're working in public health, to find people that are willing to share those perspectives.

But then sometimes, the most important voices that we want to hear are the people who are impacted themselves, who have that experience. And so I really want to thank Sara for joining us here today, and I'm grateful that Sara is going to share her story with us. Are you here on the line, Sara?

SARA ALESE: I am. This is so exciting. This is so exciting, because where I come from, I didn't know that so many people actually do care. And this is extremely important for me to be involved in this. I've never been involved in something like this.

Just a little bit about me. I contracted hepatitis C when I was about 21 years old. I was with this guy. I was using his syringes and they were dirty. I remember thinking, there's just a stigma that comes with injection drug use. You're going to contract hepatitis C. My liver was failing, all my organs are failing. Finally get through all that, getting better, and as I'm being discharged, they're like, oh yeah, and by the way, you have hepatitis C. And I remember my heart just dropping into my stomach. And I remember wanting to use that as an excuse to use. There's all kinds of emotions that went along with it.

My dad, also, is a veteran who contracted hepatitis C in the military, and I just knew how it affected him. But I went to the gastroenterologist. I don't think they educated me correctly, because I went the next nine years thinking that I was hep C positive. I treated myself and everybody else as if I was hep C positive. I had tattoo artists for seven years, so I was really good with bloodborne pathogens and knowing how not to transmit. I was clean. I had babies. I thought I had hepatitis C, took precautions, was real careful with nursing.

I went out and used, I relapsed. And for two years, I used dirty syringes. And that's part of what I hate hearing, and I hate telling people that about myself. But nobody's talking about it, and it's so real. It's not that I wanted to do that, it's that I couldn't stop doing that. And to know that somebody is infected and to use their syringe, because I'm infected as well, that's just not OK.

So I got clean again, and in 2014, I called the health department. And I was like, why don't we have a syringe exchange here in Knoxville? And they're like, well, you're the first person that's called. And from there, I got a fire in my heart.

Since then, I volunteered with a liberal nonprofit called Positively Living. They work with HIV-positive people, and they had these tests that I could do confirmations. Because not all these people were positive. Not all these people have a virus, and they're putting themselves in situations which could ultimately lead to co-infection.

And I worked a job. What ended up happening is that I now work for Positively Living. I'm their HPV prevention coordinator. My heart is in these rural areas. If you guys look at the map here

in Tennessee, all those areas are what I cover. And there's nobody covering them. The health departments are just now getting to where they're able to confirm.

We're just now being able to get into those areas. Because I went to Claiborne County and I was like, what do I do? How do I get to these people? All there are trees. I thought, OK, probation offices. I got a hold of community corrections. And then there's other programs that I volunteered with just building this program where I'm reaching into these areas, to these people, and letting them know about the disease and educating them, and then testing them. But then, the most important part, because I can't get any further, is getting them to help me. Please, will you put this flyer up, which has all the information and risk factors or whatever? Will you put it in a laundromat? Will you tell your friends?

Because I care. And then they feel like they're helping. What I'm having trouble with is asking them to care. I'm having trouble having cabs to get these areas. But I have a lot of people who want to help, and it's really a beautiful thing to be able to be a part of this and to just keep working hard. I mean, I get really, really tired, but I know that if I just keep doing this, more people are going to have access to care. And they're going to get to see there are other people who care.

The doctors never even informed me when I was pregnant that I didn't have a viral. There's something disconnected right there, and we need to work on that, especially. I went to the homeless shelter, just asking them, what can I do? Here I am, this is what's gone on with me, what can I do? And they're like, go under that bridge, because they're not allowed in here. And they're so grateful that somebody cares just a little bit. And that little fire that lights up, that's what starts to grow.

And then they become sitting in my shoes. They want to be doing what I'm doing, instead of putting a needle in their arm every day. That's not what they wanted to do. It's really a messed up situation and I could go on and on, but I'm really grateful to be a part of this. I just got an email yesterday for an application for a syringe exchange program here in Knoxville. So we're working hard.

CORINNA DAN: Paying it forward. Thank you so much, Sara. Amazing. That is such a wonderful story and wonderful work that I think you're really looking for where the needs are, there in Knoxville.

RICHARD WOLITSKI: And Sara, I just want to jump in real quickly and say thank you as well. Some things I took away from your short story was how important it is for people to have hope, believe that they can have a better future. And without that, people aren't motivated to change anything. And by getting involved, setting up the syringe service program, really making that stuff happen, it's amazing. It shows the power of what individuals can do. It shows that when we get out there, and we actually do stuff, we make change happen, we feel better about ourselves as well. I mean, these have all been really incredibly inspirational stories.

Sara, thank you so much for being here and the work you do each and every day. What have we got next, Corinna?

CORINNA DAN: One of the things that I thought would be important to reflect back, because you heard individual stories, but maybe not-- I thought it would be helpful in some way maybe to try to pull out some of the themes and synthesize. Get maybe a couple of things that people might want to take away from--

RICHARD WOLITSKI: OK, go for it.

CORINNA DAN: --from this webinar.

RICHARD WOLITSKI: Let's hear it.

CORINNA DAN: Well, the one thing that struck me, I had a real good chance to talk with each one of the prisoners. One thing that struck me along the way is just hepatitis C is a physical disease. We can test for it. It causes physical damage in the liver and sometimes in other parts of the body.

But the psychological effect. Knute talked about the psychological effect. Earl talked about the psychological effect. I think almost everybody touched on the psychological effect of having hepatitis C, of some of the other things that put them at risk for having hepatitis C. I think that struck me as something that I haven't heard as much before I started talking with you.

I also heard the frustration of patients who want to access health care, or maybe were given a partial diagnosis or bad information, or, Knute's point and Earl's, the old treatments, maybe, were hard to take. Or they had a health problem that wouldn't let them take those treatments. And that frustration with medicine in general, when it feels like you can't do something, or maybe you don't qualify or something.

RICHARD WOLITSKI: And we put so much of our faith, so much of our trust, in our health care providers. And the vast majority of them are just really excellent and do such a good job, but, unfortunately, they're not all the time. Sometimes mistakes get made. Sometimes labs mix up information. Or sometimes, somebody just doesn't know the latest science. I think it underscores the importance of, one, people who are affected by infections like viral hepatitis doing some research on their own on the internet, and second opinions can be really important sometimes.

CORINNA DAN: The last patient perspective that I heard was really around stigma and information. And people being considered for treatment but having to apply or go through more steps to try to get treatment, or even, sometimes, having a doctor say, I can't treat you right now. For whatever reason that is. Really, I think it's impactful for people and makes them feel much more like they're being discriminated against. Sometimes, I think that that's very true. It's certainly a very real experience for a lot of patients.

Some of the things that I heard that really help, love to hear the stories about patients or people who get through their hepatitis to one extent or another and just really get a passion for hepatitis. I have to say, I learned about hepatitis. I got a passion for hepatitis. It's an easy thing to happen, but we need more people. We need to grow our army. We need to grow the attentive people, the groups of people that are working on hepatitis in the United States. We don't have the number that we need to really get all the work that needs to get done.

RICHARD WOLITSKI: So Corinna has this list of things that she thought about a little bit ahead of time. And she's really that smart. She can do this off the top of her head. All right, I'm going to say a few things about my themes.

A couple themes, for me, one, it shows really what strength and power and persistence, dedication, all kinds of great things, that people who are affected by viral hepatitis, people who are homeless, people who are injection drug users, et cetera, et cetera, that we all have within us. And if we can tap into that and leverage it, we can do great things. The last thing I'm going to reflect on, we got 10, 12 minutes left and we can get to at least a couple of questions. Just us talking on and on and on.

I spent a lot of my work in HIV over my career, and been somebody who is living with HIV since 1994, and I just see again and again a lot of parallels. Not everything is the same, but there are often these themes. And they come up again and again between HIV and viral hepatitis.

And we see, like Corinna said, the stigma. We see over time how you have treatments that aren't that good, and then what happens when you get treatment that is really effective and what a difference it makes. And how it takes some time for the costs to come down a little bit, hopefully, even more than they have come down now, for the course of treatment in the case of hepatitis C, we're hopeful, to continue to get shorter. And that you learn a lot of important lessons along the way. They can come from both science and from health care providers and from lived experiences of people whose lives have been affected by these diseases. So it's this collective knowledge that really moves us forward.

CORINNA DAN: So we're going to go ahead and look at some of those questions that you all have been sending in. We are looking at questions, so don't be shy. Tell us what questions you have. Is that the end, or--

[INTERPOSING VOICES]

RICHARD WOLITSKI: Glancing over them, and a number of questions are about the availability of slides recording from the webinar. Where and when will people be able to get those?

CORINNA DAN: So we will work as quickly as we can. I would estimate that in about two weeks, we could have a new blog post up that will have links to the archived webinar recording. We also have a transcript that goes with that so you can read quickly through and just get to the good part. I think you can maybe fast-forward through, too.

Those will be available and for people who are registered on the webinar today, we will send you a message with those links. So you don't have to haunt our website of course, you can always come to hhs.gov/hepatitis and catch up on the latest. But if you don't have time to do that, you will get an email telling you when that webinar archive is available.

RICHARD WOLITSKI: And you mentioned, Corinna, it's going to be communicated in a blog. Where might people on the webinar find that blog?

CORINNA DAN: On hhs.gov/hepatitis/blog, but if you go to the hepatitis page, scroll down a bit and you'll see the list of recent blogs there.

RICHARD WOLITSKI: Some of these questions don't even fit on the screen that we can look at. So, Corinna, what do you want to tackle first?

CORINNA DAN: They're really long. So one question that we got was about-- we got, actually, several questions about rapid testing, and rapid testing for hepatitis B, rapid testing for hepatitis C.

The hepatitis B testing question, I think, is pretty easy. I am not aware of any rapid hepatitis B tests currently being considered in the United States. There are tests that are available outside the US. I will continue to let our colleagues at FDA know that there is a need, or that people in the field are asking about it. But I think that it's the manufacturers that have to make the decision to try and get a new test approved in the United States. And so I would encourage you, if you work with a testing or diagnostic company, to ask them about their plan, because in our office, we don't make that. But if there were one, we would love to work with the manufacturer to let other people know about it once it became available for hepatitis B.

For hepatitis C, there are some rapid tests available. I think there's more than one. But the question was, would it help with screening for special populations if accurate, less expensive rapid diagnostic tests were available?

RICHARD WOLITSKI: The answer to that is yes, absolutely.

CORINNA DAN: Absolutely. We would love to see a more accurate test for hepatitis C available in the field. Unfortunately, I'm not aware of any right now, but there is some movement in the hepatitis C diagnostic phase. All right. So curious to learn if there's been any effort to screen the [? birth ?] cohort. Absolutely. So I want to answer that we, because of time constraints and because of limited attention span, we had to break up the webinars and do some special populations in one webinar, and others in another. So we'll be talking about baby boomers and-

RICHARD WOLITSKI: People of color, racial, ethnic minorities.

CORINNA DAN: --all of the other groups that we didn't cover today on our webinar on Thursday, September 28, at 3:00 p.m. Eastern. Just like today, only in two weeks.

RICHARD WOLITSKI: Lots of great work going on. You know what, I wish we had scheduled this for another 30 minutes, another hour. I know we can keep on going. But we got people dropping off the numbers. And for the few of you, the brave, the strong who are still on there, we want to thank you for staying with us and remind you that on September 28, we're going to pick up part 2 of our priority populations webinar. And we're going to be talking about--

CORINNA DAN: Baby boomers, people born 1945 to 1965, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, African-Americans, and pregnant women. And we'll be talking about pregnant women both in the context of hepatitis B as well as hepatitis C.

RICHARD WOLITSKI: We know that we did a sucky job again at being able to get to people's questions. We've got a long list of questions in the queue. And what we're going to do is follow up on our commitment to email people who had left questions. We'll send you a response from us. And again, I just want to tell you that a number of these questions, I can see that the answers to them are already on the website. So if you've got some questions, and you haven't checked out the website, make sure that you go to www.hhs.gov/hepatitis. So I think that's all I've got to say. Corinna, any last words?

CORINNA DAN: I want to thank one more time, give a shout out to Ronni Marks and thank all of the speakers. This was made by the patients and the providers who joined us here today.

RICHARD WOLITSKI: You are our heroes. You're an inspiration. We thank you. Couple other quick shout outs to MayaTech, for their support, to Victor, for his contributions, and to the CDC that really is responsible for getting us all this data that we've presented on the front end of this. They did tremendous work with not a whole lot of people. We really appreciate the support and this community that works together to make a difference. Thanks so much, everybody. Hope to see you on the 28th. Bye-bye.

CORINNA DAN: Thanks. Bye-bye.