

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



CMEO Podcast Transcript

Kris Kowdley:

Hello, I'm Kris Kowdley on behalf of CME Outfitters. I would like to welcome and thank you for joining us for episode four of the four-part CMEO cast series on best practices to improve screening and treatment of hepatitis B virus. Today's episode is titled *Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community*. This activity is brought to you by CME Outfitters, an award-winning accredited provider of continuing education for clinicians worldwide. So, as I mentioned, my name is Kris Kowdley. I'm director of the liver Institute, Northwest in Seattle, and clinical professor at the Elson S. Floyd College of Medicine at Washington State University in Washington State. I'm delighted to be joined today by my colleague, Anthony Martinez. Tony is an associate professor of medicine at the Jacobs School of Medicine University at Buffalo, medical director of hepatology at Erie County Medical Center in Buffalo, New York. Welcome, Tony.

Anthony Martinez:

Thanks Kris. Thanks for having me.

Kris Kowdley:

So to frame today's episode, let's start by reviewing our learning objective, which is to provide culturally appropriate counseling and support services to patients to ensure understanding of their disease and promote retention and care. And I can tell you from personal experience, having a practice in Seattle for almost 27 years now, we have many patients who hail from the Pacific Rim and also parts of Africa and are effected by hepatitis B and getting patients who are in some somewhat insular communities and being culturally sensitive and being able to reach those patients in terms of getting them motivated to be screened and linked to care is critically important given the burden of chronic hepatitis B in the U S largely affecting persons who may be foreign born. So Tony let's begin with a quick overview of HPV by the numbers and the key gaps that we as clinicians need to fill.

Anthony Martinez:

Yeah. So I think when you think about hepatitis B, sometimes you don't think about some of these numbers, how many people this actually affects in the U S and we're talking about 2 million people. And a quarter of these people actually die prematurely as a result of the hepatitis B and the downstream consequences such as cirrhosis and liver cancer. And the problem I think with Hep B is that it's frequently asymptomatic. It's a lot like hepatitis C, you don't have symptoms. And it has what we call a long natural history. Meaning by the time you develop symptoms or having any problems, it may be 20 or 30 years down the line.

I think the thing that makes me the most nervous though, about Hep B is that despite such a high prevalence, 2 million people who have it only about a third of patients are even aware of their Hep B status, less than 30% of people have actually even been treated for it. And there's been studies where they've gone back and they've looked at commercially insured patients, and only one in five people who've been diagnosed, which is a diagnosis rate of like 18%. So it really makes you nervous when you start to see some of these numbers, how vast this problem is, but how few people have actually, one are aware of it and two have been treated for it.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Kris Kowdley:

Yeah, those are great points. Now we've known for some time that certain patients may be from high endemic or high endemicity areas where the prevalence of chronic hepatitis B is more than 8%. But there are other populations or special populations if you will, particular groups that are increased risk for HPV, that we may not always be thinking about. So can you tell us a little bit more about who is at risk today?

Anthony Martinez:

Yeah. We can break this down into six big groups. So these six groups that we're talking about are foreign born Asian Pacific Islanders. So the prevalence ranges around 10% in that group, Africa born black populations, again, it's about 10%, individuals who are incarcerated have a whole host of risk factors for acquiring Hep B. The prevalence ranges there as high as 4%, people who inject drugs are very high risk group, the prevalence is kind of rangy there. It's anywhere between three and a half to 20%. The data's kind of all over the place. Another really important group is men who have sex with men. We have some solid data there that the prevalence is higher, somewhere around 3%. And finally, our refugee population. Hep V is endemic to a lot of areas where people immigrate from. So those are the six big groups that we really need to focus more on.

Kris Kowdley:

Well, that's very interesting, particularly, I think you would not necessarily identify incarcerated persons or refugees, but of course, once you point that out, it becomes quite apparent. And you might wonder whether if those individuals are past a certain age before universal vaccination and are in increased risk environments, how that would bode for transmission. Now you've identified several key groups target for screening, but as I alluded to earlier, it's not just the stigmatization that might be an issue, there are some interesting and challenging cultural and other structural barriers that clinicians might encounter for screening, treatment and follow up care. Can you tell us a little bit about what these barriers might be so we can start to think about breaking them down?

Anthony Martinez:

Yeah, sure. We'd like to break these things into three big buckets and we have barriers that exist at the patient level, the provider level, and also the systemic level. So let's begin with the patients. A lot of times is a lack of disease state knowledge. So what we're talking about is patients aren't sure how is hepatitis B transmitted? What are the risk factors? How do I get it? Is there a treatment? Am I able to get treatment for it? Is it curable? Is it manageable? So there's this sort of lack of awareness. We know that among patients with Hep B, those individuals who are more likely to be aware of their status and some of the information around hepatitis B tend to be U.S. born, married patients with some college education or higher, but that's kind of a minority group of those individuals with Hep B.

So there's a lot of lack of education around it. And that same issue pertains to providers. Hepatitis B is one of these disease states that you probably see with your fellows. I see it with mine all the time. They're intimidated by it. There's so many tests. Who do we test? How do we test? How do we interpret the certain things that come back in the panel? Who is exposed versus immune? Who's at risk here? So there's also some variance in guidelines for providers. You have the big organizations like ASOV and Eazel and the World Health Organization. And each of these groups has nuances in their guidelines for screening, and who to treat, and when to treat them. And a lot of times there's this overlap in some of the labs that come back, the patients might meet criteria in one thing, but not a couple of other aspects that might be in the algorithms from these groups.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Anthony Martinez:

So there's still a lot of confusion among providers. And then finally there's systemic based barriers. So in a lot of areas, particularly rural areas, there may be lack of specialist availability, they don't have ready access to either infectious disease specialists or GI hepatologists who are comfortable with managing Hep B, there's significant language and transportation barriers for patients. Oftentimes patients get referred to a specialty clinic and they don't make that first touch, they don't make that first appointment to be evaluated for their hepatitis. And usually the reason is that the system is hard to navigate. It's hard to schedule, it's hard to get to the clinic due to transportation, and we've pointed out who some of these groups are, these six high-risk groups. And a lot of times those are vulnerable groups of patients where the system becomes very complex. So I think that this is kind of a good way to look at it from kind of a 10,000 foot perspective, why these barriers exist and what these barriers are.

Kris Kowdley:

Yeah, no, that's a great summary. And I think of a patient, for example, we have a substantial that highlights many of your issues. We have a substantial community of Burmese refugees, and several of them are populations that are refugees who are fleeing various types of violence and other types of problems. And because they speak unusual languages, sometimes it's actually hard to get an interpreter for some of the languages that they speak and they're traumatized because they're refugees, they're socio-economically vulnerable, and just getting them to the clinic and managing to figure out how to get them tested and, cancer surveillance, it's a real challenge. I think it really takes a concerted multidisciplinary effort. Now you mentioned that foreign born and Asian Pacific Islanders and Africa born black populations are among high-risk groups. Tell us a little bit more about how HPV impacts these populations.

Anthony Martinez:

Yeah. So, this becomes important when you think about how the world has shrunk. People move all around the country, all around the world. It's very fluid. The movements of humans nowadays. And in Africa, the prevalence of Hep B is around 9%. And there's almost 200,000 men and women with Hep B who have immigrated from Africa to the US. So when you kind of break this down, it's about one in 10 African born individuals in the US who have hepatitis B. That's a lot of people. That's a significant number. And it's important to point out that the number one cause of cancer death of men in Africa is directly related to hepatitis B. When you look at Asian Pacific Islanders, there's probably, I told you this, 2 million people in the US that have hepatitis B, but more than 50% of Americans who have it are made up of Asian and Pacific Islanders.

And again, it's the number one cause of liver cancer in Asian Americans. And we're talking about one in 12 Asian-Americans who have Hep B. These are large groups of people. I mean, this is something that it needs to be on our radar, whether we're primary care physicians or family health providers. But I think it's important that we emphasize we need to be screening these people, especially when we have these individuals that we're getting on the translator phone. The example you pointed out, I had a very similar case the other day. We have a large refugee population here in Buffalo, and my patient was also Burmese speaking. And it was interesting. He'd had numerous labs over the course of a year. And when we looked at some of his old records, he had a formulation of tenofovir that had been prescribed to him.

And through the translator line, he was saying, "Yeah I always taking it. And then they told me to stop taking it." And his viral load is elevated. And when we were looking at things, we said, "It doesn't make sense. Like his virus was never undetectable." And it took probably an hour and a half with the translator and us, and communicating with his pharmacy to figure out that he was actually told to stop his cholesterol medicine, but he was taking the cholesterol medicine and he had stopped the tenofovir.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



So this is a great example of how this guy had gone almost a year, he had probably five touches with healthcare services and the whole time he's viremic, he has advanced fibrosis, and it took that amount of effort to not only translate, but to really understand where did he go to get his medications? Getting down into asking the questions differently. When you take your pills? How many pills do you take a day? What does the pill look like? But it takes a lot to do this the right way with some of these populations for sure.

Kris Kowdley:

Yeah. No, that's, that's a fantastic anecdote and congratulations to you. You probably saved that patient's life. Increasingly medication reconciliation is done as sort of a hand waving gesture by medical assistants. And of course we have the curse of Epic or not to blame just Epic, other large EMRs, where errors get transferred from one note to the next note, to the next note. And I always find it remarkable every time I talk to a patient myself and go over their, "current medication lists". And it's correct only about 30% of the time. So, really great point.

So what special considerations should clinicians make when addressing hepatitis B in immigrant populations? And I think this is a really good point because you just taught us that one in 10 individuals from Sub-Saharan Africa who are black and one in 12 persons from Southeast Asia have chronic hepatitis B. And of course, these communities tend to live together and they tend to cluster in populations where they have other people of similar backgrounds. So they come where they have people that they know or related to. So if a physician is practicing in those communities, it's likely that they're going to see a lot more than one or two patients. So really key to understand what should clinicians be doing and how should they be approaching this, especially if we are not of the same background.

Anthony Martinez:

Yeah. I think that this is a key part of medical education that I don't think at least here in the US we do a good enough job with. I tell my fellows and the residents all the time, you have to know your place. And what I mean by that is, you have to understand your community. You have to understand the needs of that community, how they live, what affects them, and this gets down into it's more than just understanding, this is how you screened for hepatitis B, or this is how you treat it. You have to understand what are the cultural and societal barriers that will, your knowledge is only so good if you can't deliver it to the street, it's useless. So you have to understand these issues of stigma within not just immigrants, but any of these vulnerable populations, do they have access to care?

We need more culturally relevant health information. I told you, in both providers and patients, there were deficiencies in knowledge about prevention, and screening, and treatment. And it's more than just translating things into a language that that patient may speak. It really has to be tailored to what their needs are. And that often is more profound than just speaking the same language. And how we deliver this education is important. In a lot of these communities, patients, and these community members, they have closer relationships with, for example, community health workers, or religious leaders in their community.

It may not be the primary care or provider or whoever the provider may be, may not be the individual who's the most effective relaying this health information. So I think it's really important to understand the community demographic and I always say you have to meet patients where they are. And so you can't take a one size fits all approach. It's just not going to work. If you want to disseminate this knowledge and treatment into the population to reduce the global disease burden, you really have to tailor it to the individuals who are affected by it.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Kris Kowdley:

No, those are really, really great points, and good guidelines and tips. One of the things that we found to be very effective in Seattle, where we have, as I said, a lot of patients from the Pacific Rim is the children of the patients are frequently very energized. And they are much more Americanized, much more comfortable, they're frequently serving as the interpreter. And the parents tend to be somewhat more reticent, tend not to be as communicative. And we'll see the white coat as a position of authority and will not ask questions. And so, the children, which are sometimes teenagers, sometimes adults, are the ones that are pushing the parents to seek treatment. So, getting the family members who are obviously all involved in the care is also really important.

Now you mentioned people who inject drugs are also a high risk group. What are the key issues, as well as the missed opportunities in this group? And here, I'm really eager to hear your insights because you are so passionate and committed to treating our vulnerable PWID population, that is People Who Inject Drugs in the context of treating hepatitis C and are making a major impact in Hepatitis C elimination in your area and nationally and internationally through your influence. I'm curious to hear what your perspectives are on Hep B as an international leader in this area?

Anthony Martinez:

Yeah. This is a group that is especially concerning to me. I think what makes me nervous here is the prevalence estimates. And there are so wide ranging, somewhere between three and a half and 20%. There's meta analyses that have looked at this, that suggests it might be somewhere around 9%. In the US we think it's somewhere around five. This is an important group. And I don't like that wide variance in our knowledge, it shows that there's a huge gap here that we really don't know where we stand with Hep B among PWIDs. This is a group of patients who we've done an amazing job with hepatitis C. And provider and PWID patients have been indoctrinated to screening for Hep C, getting treated for Hep C, but I feel like we've really missed the boat with Hep B screening.

And some of this comes to light when you look at, for those of you out there who are familiar with treating Hep C, you know that all the medications available have this black box warning to check for prior Hep B exposure, but then we have some new simplified guidelines that in those guidelines, actually just suggest that we check for Hep B surface antigen. So only suggesting that we look for chronicity and not necessarily exposure. But then we have this discordance with the box warning. So I would argue in this population that we need to do both, and we need to assess three things. We need to look for chronicity prior exposure, but also the immune status. There's a huge discordance among PWID patients between their verbalized assessment of having ever been immunized, and then there's zero positivity or negative negativity.

It often doesn't add up a lot of times, they say, "Yeah, I got the shots." Or I got one of the shots out of a three or something. They think they've been immunized, but maybe not. So I think that we've had a lot of missed opportunities here. We definitely need to do a better job in terms of how we look at Hep B. And I think that we could start with... And obviously it goes back to screening the initial workup, ensuring that if these patients aren't immunized or immune, that we improve immunization rates. I think we can do that if we combine these efforts into programs that offer medically assisted therapy or opioid substitution therapy.

So bringing this into the prisons and substance use sites, I think is important. Conversion to the two dose vaccination series, I think could be very beneficial. In the old days we had the three series shot, where you got it a month later, and then six months down the line. Most of the time patients don't get that third shot. So I think if you have the opportunity to bring it down to a full immunization within a two month period, I think that would definitely improve the state of things. But I think there's still a lot of big gaps in the PWID population.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Kris Kowdley:

What do you think are ways we can maybe improve this education? Many are aware of HCV as you mentioned, given the recent push, hepatitis B education remains inadequate. And this is obviously what we're doing here, is great for providers. Do you think there's a role for other ways of trying to do outreach? I cannot imagine that the vulnerable population we're trying to reach here, the PWID population is listening to podcasts regarding hepatitis B, so.

Anthony Martinez:

Yeah, I think that we can educate both on the provider and patient base level. So, we can educate addiction medicine providers who may be in this new emerging group of people who are treating Hep C to provide immunization, we've done a great job to educate patients about Hep C and how it's transmitted. I don't think it's that big a lift to incorporate Hep B into that narrative. I don't think it would take a whole lot to let patients know. We do this all the time in my clinic where we assess everybody at baseline for hepatitis A and B immunity. And at the follow-up visit, we tell them, "Look, you're immune to hepatitis A, we're going to treat your hepatitis C, and I can protect you from hepatitis B. I give you a couple of shots." And they don't like shots, but really nobody at the end of the day refuses it. So I think we can do better to incorporate it into our management of Hep C, and also our education regarding Hep C for both the patients and providers alike.

Kris Kowdley:

Yeah, that's an excellent point. There's so much convergence and momentum, and I think most of us have now gotten on the train that you and others have been driving and leading about the opportunity to treat the PWID population for Hep C. And as you point out, we're checking their hepatitis B status because we want to know if they're going to be potentially at risk for a flare, if you go on a DAA, but maybe the follow-up piece of to say, "Okay, if they're not immune, then maybe it is an opportunity for vaccination is not remembered." And that would be a great way to sort of tie this up. What should clinicians know about addressing hepatitis B in men who have sex with men?

Anthony Martinez:

Yeah, I think here it's important to point out that there's about a 19% incidents of past or current infection among MSM patients. So this is a really important group of patients that also similar to PWID, they have a poor concordance between their self-reported and serological measures of vaccination. We see that same discordance. So I think here we can probably do better again with immunization, with screening this group of patients, MSM patients who may be engaged in PrEP programs. This is obviously something that's already happening that they're being checked for hep B. At baseline they're being immunized is required. But I think if we use better educational strategies and better communication to provide accurate information and take a participatory approach. And this pertains to all of these different groups. Specific to MSM though, I think that we could also coordinate screening and educational events with existing community-based events.

Pride does a great job, for example, with various events throughout the year. Here in Buffalo, we have these amazing gay bingo events and different kind of things like that, that I could see a five minute educational bullet happening at... Listen, this is a thing that's out there that you can be protected against if you haven't been checked for it. When you're getting your other routine labs done, maybe this is something that you talked to your provider about. So again, I think we've missed some opportunities here, especially on the screening and immunization fronts.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Kris Kowdley:

Yeah. And you may already know this, but it just occurred to me as you were talking, and your points are all really great about maybe combining hepatitis B awareness and vaccination as a point of care for those patients that are on PrEP. For example, they come in, they have to get seen, they have to get prescribed, they have to get tested for HIV if they are candidates for PrEP. And that would be another great intervention. So maybe a little a whisper to the CME Outfitter team to maybe think about combining something like this with an HIV prevention podcast just occurred to me. Linkage to care is an important component of long-term management. And for a lot of the reasons we've already mentioned, we still have a lot of work to do in terms of improving the rates of linkage to care and treatment. What are your thoughts on this? There's been a stubborn problem because of the insular nature of some of the communities that live with hepatitis B, you must have some interesting insights and ideas.

Anthony Martinez:

Well, I mean, again, this is concerning when you look at some of the data over maybe a five or six year period. The uptake in screening or diagnosis of Hep B it's not huge. It's increased slightly, but it's obviously nowhere near where we need it to be. I mean, we were talking before. Only about a third of patients know their status, commercially insured patients, the diagnosis rate is only 18%. So we clearly have to do better. And I think that educational events like this, where providers are listening, it may trigger, "Hey, you know, I'm seeing somebody who falls within one of these groups, one of these high risk groups, I need to screen them for Hep B." Linkage to care and treatment is actually sort of been flat. Linkage it's been relatively flat. It's not improved a whole lot.

And I think that, that probably at least during this period of time that it was looked at in 2009 to 15. And I think a lot of that is probably attributable to those three big barriers that we talked about in these educational gaps. Initiation of antiviral therapy has actually sloped down a little bit. And again, that's concerning. I think it falls back to education. Providers are typically the ones who are initiating treatment in these patients. And I think that sometimes there's confusion as to when to treat, and who to treat, how to do it. So I think that really it's education, education, education, and maybe piggy-backing some of these disease states on each other, and converging Hep C and HIV and hepatitis B and PrEP, for example. But I think there's a ton of work to be done. I mean, these numbers that we've seen are not where we need to.

Kris Kowdley:

Yeah. You know I was really impressed by the drop-off in the number of patients treated. And you wonder, this is a public health issue and it should be a public health concern, it should be advocated by non-profits, by educational institutions, by governmental institutions, by NGOs. But unfortunately, sometimes a lot of the disease awareness type of information and education seems to coincide with the availability or introduction of a new therapeutic agent in the marketplace. And as laudable as it is what biopharmaceutical companies often do in terms of contributing to general education, not just directed towards their products, it needs to be a societal responsibility, it needs to be at universities, it needs to be in public hospitals and public health departments.

And of course, a chronic underfunding is always a challenge. But I really appreciate your thoughts on that. The prevalence in immigrants and ethnic minorities and numerous barriers to healthcare access have been associated with serious health disparities, including HPV. And one of the challenges in these populations is getting connected with people who can serve in a role of being an intermediary between the patient and the provider, who may or may not speak the same language, let alone identify with the culture. What role can community health centers play to improve engagement of individuals with hepatitis B in long-term care.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Anthony Martinez:

Well, look, these community health centers, this is the tip of the spear, right? I mean, this is where the majority of these Tyrus groups receive primary medical care or some sort of medical care. And I really feel like these centers can serve as sort of the nucleus to coordinate stakeholders. And we've had some success utilizing this ideology with hepatitis C. They work really well to integrate community health workers. I can think of a few in my own community here in Buffalo, that integrate with the religious members of the community, they provide health fairs, they have flexible appointments, and they do a ton of outreach where they actually go to the patient, there is health fairs and educational events. So I can visualize utilizing the community health centers more to help us to really break into this problem of Hep B.

They can also provide easy access to immunization. One of the things that I think I would love to see is to mimic one program that we've utilized for a long time with Hep C, where we've identified these sort of champions within the community health centers. So it can be any provider type. It can be a NP, PA, a physician, whatever the case may be. And what we've done over the past few years is, we've identified these individuals who kind of want to take on this role and we've as specialists train them in how to manage hepatitis C, for example, how to do the baseline workup, how to treat, and then we sort of serve as the mentor and also is the backup for questions and anything that may come up.

And I feel like we could do a... We're talking about the same number of people. Hepatitis C affects about two and a half million Americans and hepatitis B affects about 2 million. So, we're talking about in equal numbers, one thing is curable, one thing currently is manageable, but both are treatable. And I feel like if we could identify these champions, these viral hepatitis champions, for example, within community health centers, that we could really make a lot of inroads in terms of screening and see increased rates of treatment initiation.

Kris Kowdley:

It's an excellent point. Certainly some of the most passionate advocates for Hep C treatment that I've encountered over the years are people who work in these community health centers or FQHCs or other types of environments or opioid agonist programs. And frequently they're in recovery themselves. They're very passionate and identify with the patient population and it goes both ways. And, and similarly, I think in hepatitis B, we can be culturally sensitive. Some of the most passionate advocates come from the community, but have enough medical sophistication to be able to translate, interpret, and sort of make it relatable. So really great observations and insights. So Tony clearly clinicians and community health centers should work together to improve the prevention, detection and long-term management of hepatitis B. But what evidence is there to demonstrate that an inclusive strategy such as this to screen and treat or vaccinate in high-risk groups can provide benefit?

Anthony Martinez:

Well, yeah. I mean, I think that to really put a dent in this, we need to do three things kind of in combination. So improve screening, improve treatment initiation, and then improve immunization. So, we're testing, treating and preventing. I think those are the three big pillars that are required to get your arms around any type of viral disease like this. So we know that utilizing these types of strategies has both long-term and short-term effects. So when we talk about the short-term effects, what we're talking about is development of acute hepatitis B or fulminant hepatitis B and even possibly liver failure. And then the longer term repercussions that we see is, improvements within all of these high risk groups of long-term outcomes. So, if we screen and identify early and we initiate treatment, we can prevent the development of fibrosis and potentially cirrhosis, need for transplant, development of HCC. So, utilizing all three of these things at our disposal has both long and short-term effects.

Longterm Management of HPV, Meeting the Culturally Diverse Needs of Your Patient Community



Kris Kowdley:

Tony, thank you for providing us with a great discussion on Meeting the Culturally Diverse Needs of Patients Living with Hepatitis B. I'm willing to wager that this will have a record number of downloads. So let's close with our smart goals that is specific, measurable, attainable, relevant, and timely goals. These are what we hope healthcare providers listening today will take away from this podcast. Routinely screen, the six high risk groups for chronic hepatitis B infection for any hepatitis B infection, incorporate cultural sensitivities, including language barriers and stigma when discussing hepatitis B with patients.

And these can be deeply ingrained because of the fact that some families have multiple generations affected and employed CHC and outreach, community health centers and outreach to optimize retention and long-term care. To collect CME and CE credit for this activity, please click on the link identified here to complete the post test and evaluation online. Thank you for joining us today for episode four of our four-part CMEO cast series. To view additional episodes on Community Based Efforts to Improve Screening and Treatment of hepatitis B virus, please visit [CME outfitters.com](http://CMEoutfitters.com) where the content is second to none. And thank you again for participating and thank you for providing the best care for your patients.