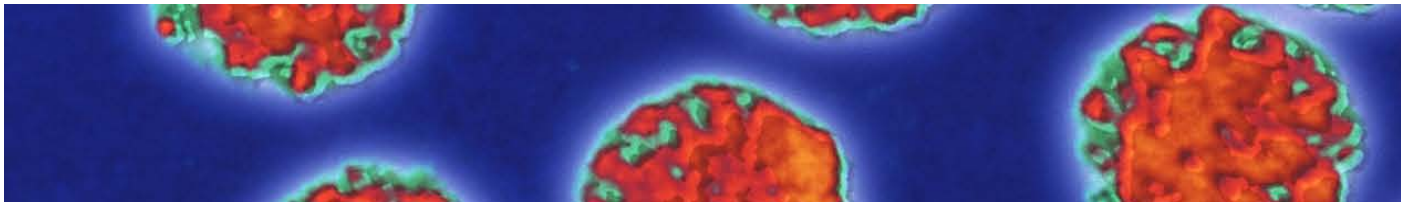


Hepatitis B Think Tank



Report

Sydney 18 July 2010



ashm
Viral Hepatitis Education Program

Funding for the Think Tank was provided to ASHM by the Commonwealth Department of Health and Ageing as part of the ASHM Viral Hepatitis Program Grant for 2009-2010, as an initiative to support the introduction of the 1st National Hepatitis B Strategy.

Format and function of this report

The Hepatitis B Think Tank was an initiative of ASHM funded by DoHA, as part of the 2009-2010 ASHM annual contract. The planning was assisted by a small group comprising the majority of panel chairs. It was conceptualised as an activity to help shepherd in the new National Hepatitis B National Strategy and to complement the more formal jurisdictional Implementation Plan. To that end, it was seen as a step in a process.

All effort was made to maximise participation and the collection of information to contribute to this report:

- on the delivery of content on the day through:
 - 20 speakers, speaking on different issues, across
 - four panels; each facilitated by
 - two chairpersons, taking written and verbal questions and comments from the floor.
- in the lead up to the day:
 - invitees were encouraged to suggest further participants and speakers;
 - were made aware of the panel speakers and their topics;
 - were provided with background on the speakers; and
 - were invited to submit questions or issues for review by panel chairs.
- through maximising input from participants through:
 - written questions;
 - verbal questions and responses;
 - evaluation and response form circulated on the day which gave the:
 - opportunity to include additional comments, including alternative speakers, issues and topics;
 - highlight key take home messages; and
 - issues for consideration in the report.
 - The evaluation form was also circulated via survey monkey after the event, in an attempt to further increase participation.

It was not possible, nor the intention in the time provided, to develop a series of recommendations from the Think Tank. Rather it was thought reasonable to prepare this report which attempts to:

- reflect and synthesise the discussion on the day and subsequently;
- make the source material available for closer scrutiny by others; and
- propose a range of actions to respond to the issues raised.

Whether and how the issues raised and options for action are prioritised needs to be subject to further consideration by stakeholders. This report has been prepared for all participants and those unable to attend and importantly, for the MACBBVS and BBVSS in its development of implementation plans for the National Strategies.

It must be remembered that the Think Tank set out to explore issues relating to engagement, information availability, research needs and workforce issues. It was not a clinical guidelines or treatment consensus meeting. Such a meeting may need to come later once some of these more fundamental issues have been addressed.

Please note:

- A number of resources referred to in the contents are only available electronically
- The full transcript of the day will be available, via the website in early August
- The preliminary report was presented to BBVSS 2 July 2010
- The Executive Summary is an assessment of the important issues coming from the Think Tank. Different agencies and individuals may have different priorities and foci in working in the hepatitis B area.
- The report is provided with the degree of detail and raw source material so that stakeholders can review in detail the discussions of the day and put this information to best use.

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ASHM would like to sincerely thank all participants for their valuable contribution.

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Appendices Set 1 – relate to the proceedings

- a. [Powerpoint slides attached](#)
- b. Presentations (Transcript) will uploaded when available
- c. Panel discussion (Transcript) will uploaded when available
- d. [Evaluation report summary](#)
- e. [Evaluation report with complete participant responses](#)

Appendices Set 2 – relate to contacts, participants and resources

- a. [Attendees](#)
- b. [Invitees](#)
- c. Report recipients
 - i. [People to get the report \(suggested before the day\)](#)
 - ii. [People to get the report \(suggested on the day\)](#)
- d. [Media contacts](#)
- e. [Posters exhibited](#)
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Executive Summary

The focus of this Think Tank was on engagement - trying to get a better and broader understanding of the issues of acute and chronic hepatitis B and workforce issues. It was not designed to address clinical guidelines or access to treatment. These issues may be the focus of a future similar meeting.

Three key areas emerged from discussions at the ASHM Hepatitis B Think Tank:

- Increasing the coverage of vaccination. This will need to rely on the prompt listing and identification of existing functional and effective strategies and include:
 - Antenatal (and maternal) screening and vaccination;
 - Household contacts of people with CHB, and
 - Systematic vaccination of priority adult populations.
- Establishing practical models of care which allow for the identification, monitoring and referral of people with CHB; and
- Appropriate workforce development (which must precede or be rolled out in tandem with the above), which provides appropriate information on and facilitates prevention, vaccination, diagnosis, treatment and care.

Users of this report are encouraged to consider the extent to which these priorities can be addressed within their organisation. It is unlikely that any organisation will cover each of these issues. Nor is it likely that these issues will precisely match the priority of any given organisation. These should be seen as broader priorities across the hepatitis B landscape.

Epidemiology and Opening Session

Two major issues were raised in the epidemiology session.

Hepatitis B is overwhelmingly a disease affecting Aboriginal and Torres Strait Islander Australians (predominantly in remote areas) and people born outside Australia (who are mainly infected vertically or as young children). The burden of chronic infection and greatest risk of advanced liver disease is among these groups.

Acute infection, which can be averted by vaccination, comprises only a small fraction of disease burden. Efforts should be taken to expand vaccination programs, particularly among household contacts of those with hepatitis B, people who inject drugs, prisoners and gay men. Notwithstanding, the vast majority of hepatitis B acquired by adults within Australia will be cleared. Priority should be given to increasing vaccination uptake in those most at risk. Some additional research on factors which predict or facilitate chronic infection would assist in the targeting of vaccination programs.

A number of options described in the following sections relied on the epidemiological data presented in this session.

Expanding participation in the dialogue

A number of suggestions were made to broaden the participation in this and other panel sessions, many of which related to people or organisations invited to attend, who, for a range of reasons, were unable to attend on the day. The complete lists can be found in the appendices.

Panel 1: Engagement

There was a general feeling that the level of community and health care worker **understanding about hepatitis B** is quite low and that there is a considerable degree of confusion. This relates to confusion about terms within hepatitis B, confusion between various types of hepatitis A, B and C and therefore by extrapolation, confusion about transmission, management and treatment. It became apparent there was a lack of a common language around hepatitis B and a lack of a shared understanding.

The notion of **health literacy** was introduced and this related to health in general as well as specifically to hepatitis B. While CALD organisations exist hepatitis B may not be a particular issue, or distinguished as 'special'.

A need for **cultural competency** training for those working with Aboriginal and Torres Strait Islander communities and CALD communities was identified. Cultural competency was seen as particularly important for agencies new to dealing with Aboriginal and Torres Strait Islander and CALD groups.

It was suggested that cultural competency has three dimensions:

- Individual – that is, the skill of individual HCWs in engaging individual clients;
- Population – the capacity of the agency to access the affected community; and
- Agency – the capacity of the agency to reflect on its own practices and accessibility.

Health literacy was explored as a concept - not just as a simple translation, but as a more active engagement. Interaction with leaders, elders and community opinion leader was raised in written comments as well.

There was a need to better know those communities most at risk. There was also a need for **improved data collection** on ethnicity and Aboriginal and Torres Strait Islander status in routine data collection. It may be possible to get this from surveillance data and encourage better data collection. It was noted that CDNA had recently supported the development of a National Surveillance and Monitoring Plan and that this is being overseen by NSW Health (nationally, on behalf of BBVSS).

The National Hepatitis B, Hepatitis C, HIV, Sexually Transmissible Infections, and Aboriginal and Torres Strait Islander BBV and Sexually Transmissible Infections Strategies 2010 – 2013 establish the framework and directions for national efforts to respond to the transmission and morbidity of these conditions. The Strategies have been endorsed by Australia's Federal and State and Territory Health Ministers and include objectives and indicators against which progress can be measured.

The Australian Health Ministers' Advisory Council (AHMAC) has endorsed a proposal for the development of a *National Surveillance and Monitoring Plan* to identify mechanisms for assessing progress and performance against the indicators of the Strategies. The development of the Plan is being overseen by the Communicable Diseases Network Australia in partnership with the Blood-Borne Viruses and STIs Sub-Committee of the Australian Population Health Development Principal Committee, both of which report to AHMAC. NSW will lead the development of the Plan on behalf of CDNA, with a view to completion in mid 2011.

While the concept of **consumer** might be useful, some people with hepatitis B were seen as pre-consumers as they were not in contact with the health system. At the same time, some sub-populations with HBV were seen to be going to doctors, particularly from within their communities. The issue appeared to be the connection between access to health care and HBV issues actually being part of that health care and there was a general feeling that there needed to be an elevated concern placed upon HBV so that doctors might engage opportunistically with their patients, and patients encouraged to raise HBV with their health care providers.

There was, however, agreement there needed to be a better exploration of **potential partners** than was provided in the panel. So along with identified priority groups of Aboriginal and Torres Strait Islander and CALD peoples, the addition of vulnerable groups was suggested, including:

- Persons with CHB;
- Contacts of people with CHB; and
- People who inject drugs.

While it was agreed that people from CALD backgrounds and Aboriginal and Torres Strait Islander people experience health inequities, there was no evidence presented that this was because of hepatitis B. Considerable attempt had been made in the formation of the panels to include a speaker from a Human Rights or Antidiscrimination perspective, however this was not possible due to competing demands.

The reason for trying to include this perspective was to explore “how to afford a given condition importance within a community, without inadvertently stigmatising those affected.” It was noted that the response to hepatitis B can draw from the response to HIV/AIDS, where targeting has been used to communicate directly to affected communities without generating stigma and discrimination in the wider community.

There was some tension between focusing on new communities and working with existing agencies and priority populations. There was a need to focus on what can be done now as well as looking for longer term solutions.

The panel discussion focused on the identification of priority points for engagement. These fell into three main categories:

- Times in peoples lives (such as recently arriving migrants; other access points such as entry to or change in school, work or prison);
- Community wide interventions, including the use of ethnic or community radio in language. Given high prevalence, up to 10% in some communities, this was seen as an imperative. It was also pointed out by a number of migrant community representatives that programs in language don't stigmatise as they are not understood by people outside the community; and
- The role of health care providers and programs like “Quality Use of Medicines” and the role of pharma support (though the role of pharma received very mixed support). Given the noted poor understanding among health care providers, health care worker education should be a precursor to broader programs or campaigns so that health care workers do not themselves become sources of discrimination as was reported in the C-Change research into hepatitis C discrimination of 2001.

There were some suggestions for clinical service pilots but these were not pursued in detail. It would be useful to collate a list of pilot projects and existing services such that an analysis could be done on their feasibility and transferability. Simply sharing these experiences would be useful.

Some options for consideration:

- Listing and the quick identification of potential partners*. This may in part be done as a function of the list of stakeholders generated from the Think Tank;

* this phrase has been used to describe what some people referred to as mapping, but which for the purpose of moving the strategy along is viewed as a much more active and simplistic process of identifying those activities which are being done, those which could be transferable and those which might readily fill gaps in our national hepatitis B response. It was pointed out that such an approach has been adopted in a number of jurisdictions as they approach the development of local implementation plans against the strategies.

- Listing and the prompt identification of existing services, nationally. This matrix would provide insight into who is doing what and provide a yardstick against which to measure the success and transferability of initiatives;
- Listing and the quick identification of potential health care worker education opportunities. These would include opportunities for influencing new partners and also further developing existing programs; and
- Development of simple, yet comprehensive definitions of and information about hepatitis B which can be used quite universally to reduce confusion, particularly between types of hepatitis.

Panel 2: Chronic Infection and Secondary Prevention

This panel focused on some of the potential **points of entry to access people with chronic hepatitis B**. This contact was seen as an opportunity for secondary prevention with affected individuals and primary prevention with their contacts.

Key points arising from the discussion were:

- While immigration was seen as a potential point for identifying CHB and vaccinating those not infected, including family members and household contacts of infected individual, this was not seen a simple process, as:
 - There was a level of concern about where the responsibility for this lay and the capacity for follow-up; and
 - A number of the written comments referred to post-settlement services and whether these could be used in the delivery of these services.
- Again, there was tension about the language used to describe hepatitis B and while it was said that hepatitis B is not a BBV, what it appears was meant was that hepatitis B should not be put in the mix with diseases which are seen to be transmitted through sexual contact and/or drug injecting (because these conditions are stigmatised within some communities, while having hepatitis B may not be subject to such stigma);

- Antenatal care and follow-up with infected mothers was seen as an important entry point to care and prevention. The role of general practitioners in delivering this support was noted;
- A compelling argument was put for effective-community wide vaccination for remote aboriginal people and improved access to treatment services. Infection rates, the potential for vertical transmission, poor access to diagnostics and poor health outcomes were given as evidence to support such an initiative. Approximately 30 – 35,000 Aboriginal people live in the Northern Territory and the majority of these people live in remote settings; and
- A range of mechanisms were suggested which might facilitate these interventions and as with the previous panel, the need for a better understanding of interventions nationally was apparent.

There was some tension between the focus on **vaccination versus follow-up monitoring** or people living with CHB. It is unlikely this tension will resolve without a better understanding of national vaccination coverage and the most effective prioritisation of vaccination.

It was apparent from the epidemiology presentation in the opening session and the panel discussion that **the burden of chronic hepatitis B in the foreseeable future will overwhelmingly be from those already infected**; many of those with chronic infection in Australia now and in the future will have acquired hepatitis B prior to their arrival in Australia. There appeared to be a level of exasperation in the audience and in the written responses about how Australia best addresses this issue. In particular, whether it would be appropriate for Australia to direct resources toward supporting, or in some other way influencing, the rollout of hepatitis B immunisation programs within the region.

Successive HIV strategies have made reference to Australia's position within a global epidemic. Australia has been signatory to a number of international covenants relating to HIV. Yet the three Hepatitis C Strategies and the first Hepatitis B Strategy are silent on these issues. Given the World Health Assembly has recently passed the resolution on hepatitis B & C, this may provide some stewardship to organisations exploring how they can influence hepatitis B policy regionally. It may also contribute to greater efforts for regional collaboration and shared experiences for learning associated with the Australasian Viral Hepatitis Conference.

Getting a better understanding of which Aboriginal and Torres Strait Islander people are currently vaccinated and where **catch-up programs** are required could identify a number of priority areas for action within a relatively small, finite and vulnerable population group.

The role of general practitioners and community practitioners, including nurses, was emphasised. There was discussion about the capacity for GPs to do **contact tracing** (CT) and the associated barriers. It was noted that GPs may assume that CT will be done by public health units, owing to their collection of notification data. It was felt that, while GPs may be well placed to do CT, they do not routinely do it. While a number of people pushed for the increased role of GPs in HBV, this is likely to need

to be attached to some incentive, such as being able to provide vaccination to close contacts and/or patients found to be unprotected. Increasing the role of HBV vaccination as part of a travel medicine package may be useful, directing costs to a more financially able population.

The discussion around sexual (BBV) versus perinatal transmission was highly charged. It was repackaged later as “**making hepatitis B a family issue**” which was more acceptable (though this may have remained distasteful to some participants). This seems like a complex issue which needs some consideration from a social and behavioural research perspective as outlined below:

- The perceived potential for stigma among communities with high HBV prevalence may be in the eye of the health care provider. It was suggested that in some communities HBV is just seen as “there” and not an issue. This apparent lack of stigma should not be equated with an appropriate self management of hepatitis B;
- There was some concern expressed that over “socialising” as opposed to the “medicalising” of HBV could result in the development of stigma and/or the attraction of discriminatory behaviour if HBV moves from a common, family-wide occurrence within a community, to a condition associated with stigmatised behaviours, such as injection drug use or sexually transmitted infections; and
- It is clear that there are some considerable concerns from within some of the health professions about HBV being associated with infectiousness or groups identified with infectiousness. This translated into concern about an HBV strategy coming from a BBV perspective, rather than some other place. There was no evidence however, that the origin of the strategy was, or would be widely recognised in the community.

From the discussion on the day, the evaluations and subsequent feedback, this appears to be an area with little available data. It would be disadvantageous if any efforts to improve the health outcomes of people with CHB had the adverse effect of:

- Creating stigma within a community toward people with CHB;
- Associating CHB with conditions which are stigmatised, and/or
- Reducing access to services for people with CHB.

While it is not suggested that this will happen, the discussions about cultural competency (and the greater need for this within the existing health workforce) and health literacy (within communities affected by HBV) mean that could be an unintentional consequence of action which should be guarded against.

At the same time the considerable experience among the health, community and research sector in dealing with communicable disease should not be lost, and efforts to reduce stigma where it is found to exist need to be further explored.

There were some parallels drawn between HBV and HCV. It was suggested that an ethnographic response to diagnosis and treatment may provide insights into how different groups deal with these issues. At the same time it was pointed out that grouping HCV and HBV together under the one **viral hepatitis tag may not be helpful** and may cause confusion for patients, consumers and those seeking education or to whom education is directed.

It was noted that the discussion had predominantly focused on improving diagnosis and vaccination coverage and that limited attention had been given to developing appropriate models of care and patient pathways to support regular monitoring of those with chronic hepatitis B. This is a critical issue for reducing the morbidity and mortality associated with hepatitis B and is a high priority within the Strategy. However the development of such clinical models was not the primary function of this initial Think Tank.

Some options for consideration:

While a public health response was called for, there needs to be a better understanding of how vaccination might be increased through traditional, non-public health methods such as:

- HBV as a standard travel vaccination for all residents leaving Australia;
- Logical work and accommodation related vaccination (for people at risk and if acutely infected at risk of infecting);
- Work related and sponsored vaccination; and
- Reviewing the cost implications of significantly increasing the purchase of vaccine. Would the cost go down?

An HBV registry was suggested by a number of people and the HBV registry in NZ is often referred to as an option. While this is mooted as good, it does not have as high a coverage as is sometimes assumed. The coverage was considerably less than was set as a target, worked best in one area, and covered a much smaller population and a land area (part of the North Island, which is less than that of Tasmania). Some consideration of feasibility would be useful. For example, could such a strategy be attempted in remote indigenous populations and/or WA where there are unique patient records? A discussion of this issue would be useful via BBVSS.

Clarification of the agencies best suited to take on HBV issues of a prevention, testing, diagnosing, monitoring and treatment nature is needed. Clearly there are some within government who are more interested in each of these issues. Existing community and professional organisations have interests in some or all of these areas. But the most significant population-based organisations which may have a role to play are largely outside the current BBVSS/MACBBVS scope (i.e. NACCHO, FECCA, multicultural health, ethnic medical organisations). BBVSS would benefit from a considered discussion as to how these agencies can best be engaged. Increasing the engagement of primary care in prevention and monitoring seems feasible and could fit within existing programs and may also be better accommodated under the proposed health reforms, but there is insufficient detail about the nature, scope and reach of reforms to explore this option much further at

this stage. BBVSS may be well placed to monitor these changes and act as a conduit for information exchange between commonwealth initiatives, states and territories and other potential partners including professional organisations and education providers.

Panel 3: Prevention

There was some feeling that this panel replicated some of the issues from the National Strategy discussions, but this was a broader audience. It is hopeful that similar discussions will continue to happen into the future and that we can continue to include new stakeholders at every opportunity. As with the previous panels, suggested additional speakers and people/organisations who should receive the report are noted in the appendices.

It was suggested that stigma can be reduced by investment in broad-based programs to reduce discrimination, but there was no evidence presented about where stigma was most experienced. Stigma appeared to be of greatest concern to health care providers. Again this issue may need to be referenced back to communities. Cultural and social research will be needed to address these issues. Individuals experiencing discrimination because of injection drug use are likely to be further stigmatised by the promotion of hepatitis B as a virus associated with injecting drug use.

Perhaps the most glaring issue for discussion in this panel was that different communities engage in different ways. The need to engage with communities rather than individuals was a particular emphasis in the feedback. There was again some concern that this panel concentrated overly on vaccination, however this is the primary domestic prevention strategy available.

The major take-home message from this panel was to get a better picture of what could be done within various communities to make the most difference. The notion of “**low-hanging fruit**” was coined by a number of speakers as a metaphor for interventions or **actions which could make an impact most readily**. This relates directly to the need to map those activities which are currently being done and those which might be feasible in the immediate, short and long term.

The balance between the focus on monitoring and treating those chronically infected and vaccination could have become acrimonious in this panel, but there appeared to be a balance between the two issues.

Some options for consideration:

- Research on vaccine failures were seen as important, however the overwhelming priority arising from this panel discussion was to determine the reach and nature of vaccination nationally, and augmentation of this with information about what is working in terms of costs and benefits. This relates directly to the mapping exercises described above;
- Again, the need for the differential impact of stigma in HCV and HBV was discussed and raised in the written material. There is a real fear that dialogue may break down between various stakeholders because of differences in language and understanding. What was seen as a passionate plea for treatment by some was seen as an off-hand comment by others. There is a real need in this area to bring stakeholders to the table for collaborative strategising. This may require compromise from all sides;
- Irrespective of compelling arguments about the minimal population benefits of domestic vaccination as compared to the implications of existing CHB, there was a strong support for continued vaccination programs within Australia, with a priority on those populations in whom greatest acquisition of CHB is likely. The low uptake of contact tracing among GPs suggests that time of diagnosis support may be useful; and
- There was a general feeling that there needs to be an increase, and perhaps a constantly evolving body of research in newly arriving communities.

Panel 4: Workforce

A number of issues were raised in this panel which had been raised previously. The attempt here was to try and synthesise these issues:

The relationship “hub and spoke” was referred to - also that of hospital-based centres, “big clinics” or “supa-clinics” as foci for treatment. Tertiary facilities as well as GP based clinics were all seen to play a role.

The contribution of pharma was again raised. There was on the one hand a recognition that pharma had provided and would continue to provide to a lot of support, but that this would largely be dictated by commercial criteria and smaller research or educational initiatives. It would not and should not provide a broad-based response or the backbone to a public health response to hepatitis B.

It was pointed out that 40% of GP care is in chronic disease management and HBV should be seen in this context. But the issue raised here was that there is a conflict because GPs cannot access treatment. In order to achieve the goals and objectives of the Strategy, it was suggested it will be necessary to better elaborate a model of care for hepatitis B with clear roles for the variety of health care providers,

developing models of care that support monitoring and improved access to treatment, including exploring the intersection between pathology/notification processes, the potential of Medical Director (and similar doctor desk-top software) to prompt recalls, developing referral algorithms and supporting GPs with management plans. It was thought this should be informed by a detailed understanding of the implications of the National Health and Hospitals reform process.

Cost effectiveness between GP and nurse-provided care was discussed. An interesting analysis of the barriers to nurse-provided care in General Practice was provided. This tempered some of the enthusiasm for potential nurse-led solutions which may appear possible under health reform. While these initiatives were welcomed there was recognition they would not be universal or quick.

Guidelines were recognised as necessary for assisting all levels of workforce responding to HBV. The CARPA manual was put up as a model. A number of models were put forward to increase the participation of GPs and other in HBV care.

Some options for consideration:

- There needs to be a solid consideration of the workforce initiatives which might be feasible in this area, particularly in the context of workforce reform. While this is a changing environment, opportunities will become available which will need to be considered. Again, the need for identifying available remedies and services appears to be the first piece of work to be undertaken; and
- Clinical issues were largely outside the scope of this Think Tank. It was proposed in the discussion at the end of this panel that one or more multidisciplinary centres be established in a number of state capitals to provide comprehensive diagnosis, monitoring and treatment to people with HBV. While this suggestion was given some support from the participants it was pointed out that such recommendations were not the purpose of the Think Tank and while the recommendation could be included in the report, it could not be considered a resolution for the meeting.

Summation – priorities from final session & evaluations

- Identifying and maintaining a primary vaccination program, identifying the holes in this and developing (and prioritising) strategies to address these.
- Focusing on chronic hepatitis B through identifying priority populations and strategies which may be working and could be generalised, including those which rely on public health responses and those which do not.

- Examining health literacy (not just in hepatitis B) and looking for opportunities where health literacy can be discussed, taught and researched if it is to become a concept within health service delivery.
- Identifying the following research priorities:
 - New migrant communities;
 - Similarities and differences between HCV and HBV;
 - Patient and community experience of stigma;
 - Patient and community experience of discrimination;
 - Exploration of the issue or concept of “family business” with communities;
 - Patient and community perceptions and conceptions of hepatitis B;
 - Better understanding of patient responses to treatment and living with CHB;
 - Translational research;
 - Working with untraditional partners to develop research questions and conduct research into Immigration and Corrections, etc; and
 - Feasibility studies including modelling and economic analyses.
- Looking at incentives for engagement (not just financial):
 - Vaccination; and
 - Vaccination of family members.
- Reducing the discord between health and medical sectors BBV/STI/perinatal.
- Cultural competency, opportunities could be built into relevant conferences and other activities nationally and at a state and territory level.
- The extent to which the CDNA data project can resolve the missing data issues needs to be explored. BBVSS would do well to set aside a session or hold a special session on data-related issues and in particular, on how different data collection activities can communicate: This could involve consideration of concepts such as:
 - Mass/community wide vaccination;
 - vaccination and monitoring of CHB;
 - CHB registry; and
 - models for care coordination for follow-up of patients with CHB.
- There needs to be a constructive discussion about the allocation of costs and a greater emphasis placed on putting CHB on the agenda of the health and health research sector. It is not sufficient to simply absorb HBV in existing BBV and STI structure and the need to greater explore and engage potential partners is crucial.
- The role of nurses and the expanding role of nurses in the health reform agenda may provide opportunities and is an area which needs to be closely monitored.

- Greater role for GPs in the delivery of care.

As noted at the outset, a call was made to recommend the establishment of one or more HBV specific clinical centres in areas of high need. While there was some considerable support for such a recommendation, the Think Tank explicitly did not set out to establish clinical priorities. The recommendation is thus noted formally on the record, but should be referred to a subsequent clinically-focused meeting.

Three areas emerged as key issues:

- Increasing the coverage of vaccination. This will need to rely on the prompt listing and identification of existing functional and effective strategies and include:
 - Antenatal (and maternal) screening and vaccination;
 - Household contacts of people with CHB; and
 - Systematic vaccination of priority adult populations.
- Establishing practical models of care which allow for the identification, monitoring and referral of people with CHB; and
- Appropriate workforce development (which must precede or be rolled out in tandem with the above) which provides appropriate information on and facilitates prevention, vaccination, diagnosis, treatment and care.

Next steps

This Think Tank was an initiative of ASHM for the benefit for the hepatitis B community the BBVSS and MACBBVS. The executive summary was finalised following consideration at BBVSS on 2 July 2010. Each agency and jurisdiction will have access to the material and the information contained therein, including the lists of potential partners research and resources to use as they see fit. ASHM will in the first instance attempt to make sure all those people identified at the Think Tank as potential recipients of the report have access to it

ASHM will use the information and experience from the Think Tank to assist it in planning its work in hepatitis B. In the immediate term this will involve:

- Providing focus for a workshop on hepatitis B to be held immediately before the Viral Hepatitis Conference in Melbourne in September 2010. This workshop will focus on developing a shared understanding of hepatitis B with those health care providers, CALD, Aboriginal and Torres Strait Islander organisations, media and other stakeholders who are new to hepatitis B;
- Furthering opportunities for expanding the research base to help inform the response to hepatitis B in Australia; and
- Further developing its education and information services in hepatitis B for health care workers.