CDC Director Dr. Robert Redfield

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Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping the health care of the future.

This week, we acknowledge December 1st World AIDS Day. We're revisiting a conversation earlier this year with Dr. Robert Redfield. He's a Director of the CDC and a renowned AIDS researcher. He discusses the CDC's commitment to bringing an end to the HIV AIDS epidemic within a decade and he also talks about research breakthroughs and advancement in treatment and preventing further infection through PrEP.

Lori Robertson also checks in, Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain, separating the fake from the facts, and we end with a bright idea that's improving health and well-being in everyday lives.

If you have comments please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to Podcast. You can also hear us by asking Alexa to play the program Conversations on Health Care.

Now stay tuned for our interview with CDC Director Dr. Robert Redfield on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Robert Redfield, Director of CDC, the Centers for Disease Control and Prevention. Dr. Redfield was Founding Director of the Department of Retroviral Research in the U.S. Army Medical Corps and co-founded the University of Maryland's Institute for Human Virology serving as chief of infectious diseases. He's also Vice Chair of Medicine at the University of Maryland School of Medicine. Dr. Redfield has advised the National Institute of Health on HIV. Dr. Redfield earned his bachelor's of science and his medical degree from Georgetown.

Dr. Redfield, welcome to Conversations on Health Care.

Dr. Redfield: Thank you very much, Mark.

Mark Masselli: You know, you're known as one of the world's leading experts and researchers working on the HIV AIDS epidemic and you carry that expertise to your current role as Director of the CDC and your agency is recently part of President Trump's really bold initiatives. We just got to get a shout out, ending the HIV epidemic plan for America. It seeks to reduce the number of new HIV infections by 90% within a decade.

I wonder if you could just tell our listeners about who's involved in the

effort and how you're planning to tackle this complicated challenge?

Dr. Redfield: Well, this really is a once in a generation opportunity. As you know, President Trump and the State of the Union highlighted this initiative to be able to bring an end to the HIV epidemic over the next decade, with the goal of reducing new infections by 90%, over the next 10 years.

Under the leadership of Secretary Azar, really all of the agencies within HHS, the CDC, HRSA, The Indian Health Service and NIH have really come together to put together this plan. When we looked at the new infections that were occurring in the United States between 2016 and ’17, we were all surprised to find out that more than 50% of the new infections, there's about 40,000 new infections a year, 50% of them were in only 48 jurisdictions, the District of Columbia and San Juan, out of the more than 3,000 jurisdictions in the country, so it was a very geographically focused outbreak.

When we looked even closer at the demographics of it, most of the new infections that are occurring in the United States are actually in African-American men who have sex with men or Latino men who have sex with men of those that are between the age of 25 and 34, so it's very demographically focused, so we have a very focused strategy initially to target these geographic areas and these demographic groups to have four key strategies diagnosed, you know about 15% of the people in our country with HIV infection still haven't been diagnosed.

Prior to this initiative, it turns out that almost 50% of them one in every two has been infected for at least three years, probably 70% of people that were infected diagnosed last year, actually have seen a healthcare facility the year before, but not been diagnosed. One of the areas is to really enhance diagnosis and try to re-instill in the health system a fervor for diagnosis.

To treat people that have HIV infection, we now know that it's pretty straightforward now how to treat with the new antiretrovirals that we have. They’re highly successful, unlike the earlier drugs where we struggled with resistance. If we can get people to viral loads that are undetectable, not only does that mean that the disease won't progress in them, it also means that they're not capable of transmitting the infection to somebody else. The phrase it's been used as you equals you, undetectable means that you're uninfectious to somebody else.

The ability to protect, that is prevent, new infection acquisition. Today, now we also have what we call pre-exposure prophylaxis using medication itself and individuals at risk for HIV that will prevent them even if they're exposed by method known to transmit HIV, they will

not become someone with HIV. Combine that with other comprehensive prevention strategies, particularly, say syringe programs.

Then finally, we have a fourth pillar, which is to respond when we do see hotspots that we can rapidly identify them and help the local public health community be able to respond in a way to prevent expanded transmission.

We're seeing that in a number of counties because of the comorbidity with the drug use epidemic that we have. That's really, really the plan that we fully intend to succeed, so that by the year 2030, the epidemic is, we know it will no longer be here.

The purest definition of that is to bring the new infections down to less than one in 100,000 Americans. Obviously, the goal is to go as few new infections as possible, but the epidemic would then be over.

Margaret Flinter: Well, Dr. Redfield, I think it's always worth saying this epidemic has taken 700,000 American lives since the early ’80s and 1.1 million Americans living with the disease.

I'm not sure that everyone understands this idea of how effective the drug regimens have become and getting people's viral loads down to undetectable levels. This advent of the PrEP drug protocol to protect non-infected people from being infected, so maybe just a little more about that for our listeners.

Dr. Redfield: It's really been exciting, you know, having been in this field really since the early ’80s to see the progress that science has provided and to see that go from no really therapeutic options to see then different early options, where we could prolong survival, but many people still develop drug resistance and treatment failed.

I can remember back in the ’90s, some of my patients were taking, you know, 30, 40 pills a day. Today, there's multiple regimens where you can take one pill or two pills a day.

The current regimens really are as close to, and I like to use the term bulletproof. These are very, very highly effective drugs now that are available to treat HIV infection and most individuals can really take them and most individuals with HIV infection today can anticipate to live a near normal lives.

If you're 20 years old today and you get HIV infection, today it would project you to live somewhere between 74 and 75 years of age. The therapy really is highly effective and the ability to get viral loads to the undetectable level is now the rule.

Not only does that change the disease progression in the individual,

but some of the real exciting data, is it really now definitively shows that if your viruses are undetectable by the current laboratory techniques, you really are not able to transmit this virus to somebody else, that means the treatments not only good for the individual's long-term health, treatment of people living with HIV is a major prevention strategy.

We could actually diagnose everybody, get everybody on treatment, get everybody's viral load undetectable that and of itself would end the HIV epidemic in America.

Mark Masselli: You know, Dr. Redfield, I was thinking about the strategy that you're going to have to employ. You were saying, you know, we've got to get people to enhance their diagnosis, but also have to have this fervor for people who want to treat this population and of course, you know, community health centers play a vital role in treating HIV and AIDS. Here in our own organization, we've had a lot of success and tell us how you will scale this program up nationally? How do you see the CDC and its partner agencies working at this local level?

Dr. Redfield: You know, and I've been very involved in the PEPFAR program from the beginning where we had really to go into sub-Saharan Africa and the Caribbean. Actually, we had to figure out not just how to provide treatment; we really didn't have a health infrastructure.

The beauty of this initiative is we're looking at multiple different health capacities in this nation and much of which made this so doable was the fact that there's 12,000 community health centers throughout the United States and many of them in these jurisdictions that we're discussing right now, so that the potential to expand the capacity by bringing in HRSA's programs for those individual at risk for HIV infection, that is the community health centers and get them engaged to help diagnosis and then those individuals that have diagnosed HIV infection that is the Ryan White Program, it really, you know, was sitting there that it's there.

The execution plans for this initiative are going to be developed by each jurisdiction, because what we're trying to do here is to figure out how does the health system now engage a component of individuals that are either at risk or living with HIV? How do we engage them effectively into the health system and we would argue that community health centers as well as community groups themselves are going to be the key stewards of understanding how we do this, as I said, by the community, for the community and the community. The community health centers are going to play a very, very, very important role.

Margaret Flinter: Dr. Redfield that prompts me to say we've had, I think, a little over 20 years Mark of stumbles and falls, evolving a model of highly effective

care and treatment for our patients with HIV and along the way, other challenges emerged hepatitis C, arrived on the horizon. Ultimately, we now have medication that actually cures hepatitis C, you've dedicated some of your formidable decades of research to the quest for a vaccine for HIV too and this has proved daunting for everyone in the field. Is the quest for a vaccine for HIV still on that list or are we really looking at preventing new cases and effective treatment of the ones that develop?

Dr. Redfield: Well, Margaret for the United States to be able to actually end the HIV epidemic, we have the tools, diagnose and treatment, developing viral loads that are undetectable and comprehensive evidence based prevention strategies, including perhaps unsafe syringe programs, those tools can bring an end to the HIV epidemic in the United States.

I can say for the world to bring an end to the HIV epidemic, we're going to need to have an HIV preventive vaccine. I've always said that when you look at trying to end -- eradicate an infectious disease, whether it's smallpox or polio, the key to that is having a vaccine. We've eradicated smallpox, we're on the verge of eradicating polio, last year we only had 33 cases in the whole world. To bring in a true global end to this epidemic, it is going to require an HIV vaccine and I'm confident that science will continue and eventually succeed in developing the scientific understanding that's required to develop an efficacious prevented HIV vaccine; but I can tell you as a young doctor who was at the bedside of a 27 year old individual that was dying of HIV infection and say in 1984 no one predicted that would become a lifelong treatable disease.

Yet, I would say one thing I always have had strong confidence in, is the power of science. I always had confidence that science would find solutions.

I started my, some of my early work in ’99 B hepatitis, who would have ever believed that we'd actually be able to cure that. We need to continue to invest significantly in the development of an HIV vaccine, but we should not wait for the HIV vaccine to bring an end to the AIDS epidemic in America.

Mark Masselli: We're speaking today with Dr. Robert Redfield, Director of the Center for Disease Control and Prevention. I want to pull together two things, one, the power of science and then vaccines. We're in this incredible throes of something that none of us would have imagined just a couple of years ago, this dramatic resurgence of preventable diseases like mumps, measles and chickenpox.

There's an anti-vaccination movement that just simply doesn't accept the science. Many families across the country are intentionally choosing not to vaccinate their children and that's obviously causing a

public health crisis in many communities.

I wonder if you could talk about this "anti-vax" movement. I was thinking, as you were talking earlier about, hey, we've mapped out where the bolus of this population is. What do we have on the data about the anti-vax population, if you're going to try to target them, this is a group of people that can be identified, what's the CDC doing to try to find common ground with people who simply can be bright and talented and educated and for some reason, they're off the track on, on this particular issue. How are you handling it?

Dr. Redfield: Well, this is really a very, very important question Mark and particularly very timely now. You know, the WHO this year actually listed for the first time vaccine hesitancy as one of the 10 greatest global health threats for the world.

Nothing saddens me more than to see the power of science left on the shelf. When you think some of us, I remember, polio. I remember measles. I remember a number of these diseases, pertussis and diphtheria. The challenge that many of the younger parents have today is they don't remember polio. They don't remember measles. This is one of the reasons I've asked the grandparents to get involved and maybe help in understand, you know, they may see certain issues with vaccines, and they don't understand the true horror, that these diseases, that these vaccines now prevent.

When I look at the reasons for people not taking advantage of vaccines, you know, I think it's important to stress that 94, 95% of parents vaccinate their children; but unfortunately, there are a number of people that have chosen to not accept vaccination. Some obviously for medical reasons, but others, less so, either religious or in some states now just philosophically, they don't agree with having a vaccine.

We have great data on what the state vaccination rates are, but within that state, there may be schools or communities or pockets where the vaccination rates are very, very poor, and that's what you're seeing, for example, in the state of Washington with the recent measles outbreak, although the State of Washington is very good overall childhood vaccination rates and I've actually seen some data from some schools where the vaccination rates are under 30% and some different jurisdictions along the United States. I do think there's an advantage to get a better handle on exactly what the regional vaccination rates are so that there can be more targeted intervention.

The ultimate goal is to get individuals to embrace vaccination as a critical tool to protect themselves, to protect their families, to protect the communities. I think there are really four groups that need to be reached.

The first is the anti-vax group, which is I think a very small group and I do think will be very difficult to reach. It's important that we can negate their message and this is why I've said very clearly in the recent New York Times, I bet that I did, vaccination does not cause autism period. Vaccines are safe period. The diseases that they prevent are not safe. They're complicated, and they can cause significant morbidity and mortality.

Now, when you look at the people that don't get vaccinated, it turns out some of them are misinformed, because the anti-vaxers do have significant information that's available on social media. People have different editorial systems now in how they get the information and so there's significant disinformation and we need to try to counter that and CDC has a site that I encourage people to go to cdc.gov/vaccines. We have a parent portal they can get in and get a lot of questions answered.

Secondly, I think they need to sit down with their healthcare professionals and have a dialogue and healthcare professionals have to take the time to listen to them, and listen to their misinformation and not ridicule it, but take them through and try to let them understand how they're misinformed.

Now, many more people that aren't vaccinated, they don't want to do something that might harm their child. They hear all this stuff, you know, that maybe the vaccine can do this and they're just -- that paralyzes them from making the proactive decision.

Again, healthcare professionals have got to step up and not just say, do you want to get the vaccine and the parent says no, and then they say, okay, why don't we have your next appointment in six weeks? No, they're going to say, wait a minute, why don't you want the vaccine?

Margaret Flinter: Dr. Redfield, thank you so much for that. We'd been speaking today with Dr. Robert Redfield, Director of the Centers for Disease Control and Prevention. Learn more about his work by going to cdc.gov or this particular effort by going to HIV.gov.

Dr. Redfield, we thank you for your very important scientific work, your commitment, and your quest to support the health of the public. Thank you for joining us on Conversations on Health Care today.

Dr. Redfield: Thank you, Mark and Margaret.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award winning journalist and Managing

Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics.

Lori, what have you got for us this week?

Lori Robertson: The measles outbreak in the United States and around the world has sparked misinformation on social media. One false Facebook meme blamed illegal immigration from South America, but the virus was eliminated across both North and South America in 2016. The recent outbreak is due largely to inadequate vaccination rates in some communities.

Measles was eliminated in the United States in 2000 and as mentioned from the entire North America and South America continents six years later. Elimination means cases can still occur, but that the disease hasn't been continuously spread for a year or more.

Recently, the virus has been brought into the U.S. by people who have traveled to places where there is an outbreak or where the disease is still common, such as parts of Europe, Africa, Asia and the Pacific according to the Centers for Disease Control and Prevention.

From those travelers, the disease can then spread in U.S. communities that have unvaccinated people. The pan-American Health Organization said the measles outbreak in New York City, which started in 2018 and spread in the Orthodox Jewish community was brought on by travelers who had been in Israel, where a large outbreak is occurring.

The CDC has said, this year marks the largest number of measles cases since the disease was eliminated in the U.S. and it said misinformation about vaccine was “a significant factor contributing to the outbreak.”

Similarly, the Executive Director of UNICEF and the Director General of the World Health Organization issued a joint statement that cited online misinformation about vaccine safety as a contributing factor in the rising number of measles cases in high and middle income countries.

Some major social platforms have recently taken steps to curb this spread of misinformation. Facebook announced in March that it would reduce the visibility of vaccine misinformation. YouTube said in February that it would prevent users who promote vaccine misinformation from running ads.

That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and as a project of the Annenberg Public Policy

Center at the University of Pennsylvania.

If you have a fact that you'd like checked, e-mail us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. One in five Americans will suffer a diagnosable mental health condition in a given year, and most often don't seek treatment.

For those with serious mental health conditions the consequences can be devastating, loss of job or home or even early death. Seeing a rise in mobile apps aimed at behavioral health entering the marketplace, the University of Washington researcher Dror Ben-Zeev thought a comparative effective analysis study would be a good idea.

Dror Ben-Zeev: Having a head-to head-comparison between a mobile health intervention for People with Serious Mental Illness called FOCUS and more traditional clinic based group intervention called WRAP or Wellness Recovery Action Planning.

The study really gets at some of the core differences between mobile health and clinic based care. The second thing we wanted to see is after people complete care, what are their subjective ratings of their experience and treatment? Are they satisfied with both interventions? Are there differences? 90% of the individuals who were randomized into the mobile health arm actually went on to meet a mobile health specialist to describe the app to them and train them how to use it and use the intervention app that's assigned to them at least once. Whereas in the clinic based arm, we saw that only 58% of the participants assigned to that clinic based intervention ever made it in for a single session.

Mark Masselli: Both groups of patients saw roughly equal results from their completed treatment, but the mobile group was more likely to engage in therapy.

Ben-Zeev says this suggests that mobile therapies may provide a useful tool for clinicians having trouble getting those with serious mental health issues to engage with the clinical interventions.

Dror Ben-Zeev: We know that the very existence of a group can be quite helpful; but for others, the interaction is anxiety provoking.

Mark Masselli: A targeted mobile app aimed at facilitating access to clinical care for those experiencing serious mental illness symptoms, improving access to intervention for behavioral health needs. Now that's a bright idea.

CDC Director Dr. Robert Redfield

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace in Health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts.

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