NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
MFP LUNCH & LEARN: HIV CONFIRMATION
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>> Welcome, everyone. My name is Tracy and I am the professional development coordinator for the Money Follows the Person project, and I want to thank everyone for being here today and joining us for our webinar. Just a couple of brief housekeeping items before we get started, everyone is muted for today so if you have questions or need assistance, go ahead and enter it into your chat question box and I will be monitoring that as we go along. A copy of the PowerPoint will be provided after the conclusion of today's webinar and I will e-mail that out once we are done. And we will also be sending out a survey to kind of get your feedback on future webinars that you might be interested in.

So, at this time I would like to go ahead and introduce our presenter. Today we have Fran DeShazo-Mock with us and she was the medical case management program coordinator for Cape Fear Valley Health system for 20 years. She coordinated care and services for HIV patients within Cape Fear Valley's six hospital health system and throughout their infectious disease clinic valley infectious disease care since it began in 2001. Fran has managed HIV management programs within a four-county area beginning back in 1994. And she has held numerous committee and volunteer positions at local, regional and state levels. She contributed to HIV policy writing and grant writing for several local and state agencies. And as a previous training consultant for HIV care program, she trained hundreds of HIV case managers and currently works in a consultant role for the Fayetteville area. Her educational background is a Bachelor of Social Work from Minot State University and a Master of Social Work degree with a minor in Medical Social Work and a concentration in Program Management from East Carolina University. She is also a licensed clinical social worker in a nationally certified social work case manager.

So, at this time I would like to welcome Fran and I will turn it over to you.

>> Okay, hi, everybody! I'm super excited to be here today. And I want -- before I talk about the objectives, I wanted to make it clear that this webinar and the PowerPoint is a little bit wordy. There is a lot of information in it. I wanted it to be used as a resource tool, not just as an educational experience. The objectives for today are to review key points concerning the North Carolina HIV disclosure and testing laws. As of January 2018, there have been some major changes. Also, the difference between what I consider community HIV case management versus HIV medical case management which you would find inside of a clinical setting. Also, there is going to be a lot of resource

education. Hopefully it's at your fingertips when you get this and you will be able to use it in your everyday work. Also, at the very end we will talk a little bit about stigma and discrimination and what you can do working with HIV patients to help remove that.

The wonderful thing is that over the last 30-35 years there is a tremendous amount of work and improvement on HIV care and right now there is very, very little distinguished difference between someone who is living with HIV and general population as long as life expectancy goes. That has a lot to do with the miraculous medications that we have available.

I thought I would start with some of the North Carolina statistics. I know a lot of people are interested in what's going on here in the state and on the national level for North Carolina. Great news is that most counties have a declining AIDS rate. But please know that there is a difference between the declining AIDS rate and new HIV diagnosis. Last year we had no babies born with HIV. That's wonderful news. People between the age of 20 and 29 years old had the highest rates of newly diagnosed HIV comprising 41% of the newly diagnosed population. And when you think about the 28 and 29-year-olds you have to remember that this is a generation that has grown up with HIV. And now they know that there are medications and treatments and HIV is not as scary to the younger population as it is to those who are much older.

Now among race and ethnicity and gender groups, black African-Americans represent 64% of all adult and adolescent infections. And when we look at that, we are looking that is 45 per 100,000 adult and adolescent populations. That's 45 people out of 100,000. The highest rate was among adult adolescent black African-American men. And then if you break it down even more, for adults and adolescents means anybody over the age of 13, from newly diagnosed with HIV in 2017, men who reported sex with men which is MSM accounted for 64% of all cases. Heterosexual transmission risk was 29%. Injection drug use is 3%. And then you have men who have sex with men who are also injecting drug users at 2.4% and these are the stats for 2017. And this all comes from the 2017 HIV STD hepatitis surveillance report which was actually updated I believe in December of 2018. So, they do try to keep those statistics updated on a quarterly basis.

Now, North Carolina statistics continued. As of December 31, 2017, the number of people living with HIV who reside in North Carolina was 35,045. That includes those who were initially diagnosed in another state. When someone moves to North Carolina and they are HIV positive and they enroll in HIV care, they get a visit from a DIS worker, disease intervention specialist if they are not already in the North Carolina data base. North Carolina has a data base of everybody who has tested HIV positive. That's the law. So even though they have been -- may have been counted in California, they also get counted in North Carolina as well. In 2017, we had 1,310 new HIV diagnosis reported. And actually, this was a slight decrease from 2016 where we had 1,399 adults and adolescents who were newly diagnosed. And again, the website is down here. If you are interested in any of the other sexually transmitted diseases, hepatitis, all of that information, every group, sub group is available to you at this website.

Now unfortunately for North Carolina, we are still struggling as far as number of HIV diagnosis. In 2017, we were number 6 in the nation. And a lot of people kind of question why that happens. We are in the south. We don't have the resources that a lot of the bigger states have. Education is lacking. Access to resources can be an issue. But if you notice there is Florida, California, Texas, New York, Georgia, all of these other states that are on this list have huge urban areas. North Carolina our biggest urban area is Charlotte but it still is not anywhere near the size of the other states.

I thought what I would do is I would take you through what the process is beginning with HIV testing, getting linked with a clinic, getting linked with a case manager and then some of the issues that the patients run into. HIV testing can happen with your medical provider. Actually, all medical providers should be including HIV testing in their general lab unless a patient -- [inaudible]. So, when you go in for your annual physical, your medical provider should be telling you they will be testing you for HIV. If they don't ask you, I would ask to see if they were testing you. It should be a normal test that is run now. The E.R., local emergency rooms, also do HIV testing and of course if you are admitted to the hospital, if there is an indication that an HIV test needs to be done, they will do it. They will inform you first. Then the second place for HIV testing is the health department. It's an -- if an individual feels like they were exposed to HIV, they can go to their local health department and get free testing. And then the other way HIV testing happens is when you get a visit from a disease intervention specialist. Disease intervention specialist, their whole job is to track down individuals who have some type of trackable disease or illness that needs to be monitored. So, when it comes to HIV, if a disease intervention specialist comes to talk to you, that means that you had sexual contact with someone over the last 12 months who has had exposure to HIV. And the disease intervention specialist or through the health department it is a difficult job. They do a great job, but it is -- they are the face of getting a patient into the door for HIV care. And I thought I would include the regional offices or the DIS workers that the state is broken into regions. We have ten regions. Where I'm from, Cumberland County, region 5. Our DSDIS workers are pretty awesome. I worked with them pretty closely especially in the hospital.

One of the -- I wanted to talk a little bit about what happens when a DIS worker comes out and notifies an individual that they either have HIV or they have been exposed to HIV and need to be tested. When someone is notified that they have HIV, the DIS worker goes over what we call control measures. And these are basically the law that North Carolina puts out there and what the expectations are for someone who is living with the virus. In 2018, in January 2018, there was a big change in the control measures. We have -- if you see here it says the person diagnosed with HIV infection shall refrain from sexual intercourse unless condoms are used except when the person living with HIV is in HIV care, adherent with the treatment plan of the attending physician and has been virally suppressed for at least six months at the time of sexual intercourse. And then it goes on to talk about if your partner is on HIV pre-exposure prophylaxis. Remember, I will talk about those in-depth. That first piece there where it talks about if a person is on treatment, which is HIV medication, and they are virally suppressed for at least six months, virally suppressed means that they basically you are unable to detect HIV in a person's system. So, the levels are so low it's like the HIV is sleeping and it's not causing any damage and it's not replicating.

One of the reasons North Carolina did this was to reduce the stigma related to HIV. If a person is taking their medications every single day and their virus is suppressed. They cannot give HIV to someone else. So, they no longer have to inform their partners of their HIV status if they are enrolled in care and if they are virally suppressed. But what that also means is that person has to go to their doctor every three months and be tested to ensure that their viral load stays undetectable.

Now when we talk about prep, what we are talking about is a medication called Truvada. If a person who is highly sexually active or if you are in a relationship with someone and you do not want to use a condom, we always recommend condoms, always, always, and if you do not want to use a condom, you can use prep which reduces HIV transmission by like 90%. If you are an IV drug user it reduces it by 70%.

Now I have the entire control measures listed so you can read it, but one of the questions that I get asked most has to do with partners and spouses. And this is where that is addressed. It's addressed from the point of view of the physician, but it really can be anybody who is involved in that person's care, the nurse, the social worker, the case manager. And basically, we can encourage the individual who has tested HIV positive to tell their partner on their own. If they choose not to, we get the name of the partner and then the disease intervention specialist will inform that individual that they have been exposed to HIV and need to be tested. We cannot go and tell anyone of anybody's status. That absolutely is against all HIPPA.

Now the disease intervention specialist, the DIS worker, is usually the gate keeper in a lot of situations unless someone is in the hospital and if they are in the hospital they can be referred to the HIV case management team or the HIV medical case manager who is actually in a clinic. But about 12 years ago the state of North Carolina kind of changed how they did HIV case management. Outpatient HIV case management became more of a short-term kind of goal-oriented service to get individuals enrolled in medical care. It's a Medicaid only program, and the idea is that within two months you would be able, as a case manager, you would be able to get them linked to medical care. After two months you would need a physician's order in order to continue providing HIV case management. Not a lot of agencies in my area are doing the outpatient HIV case management. It's a Medicaid only program. So those patients who are self-pay don't get this type of care, however, when the state moved further away from outpatient HIV case management, they moved towards HIV medical case management. And basically, that someone, a case manager, social worker, who is actually part of the medical team in the clinic and it includes a holistic approach and linkages to all kinds of services and emphasis on education and getting them enrolled in treatment and making sure they are coming to their appointments on a regular basis.

Now some clinics are private. Some clinics are what we call Ryan White funded clinics. All patients have access to HIV medical case management case managers if it's a Ryan White clinic and then most -- in fact, I want to say basically all of the major health systems, IV clinic have a case manager associated with them and also the health centers here in North Carolina all have case managers or social workers who are doing HIV medical case management associated with them.

Now the goals of HIV case management are to improve access to a wide range of appropriate services. That would be mental health, substance abuse. That would be your basic needs. Housing, accessing to medications is one of the biggest ones that we work with. We want to promote continuity of care. We want to educate that individual so their health status and level of functioning is very high and then the overall reason for HIV case management is to contain the cost of care. And HIV case management is really no different than the other case management models that are out there. You're always assessing -- you always have a plan. You are always looking for resources. You are always coordinating, monitoring and reassessing. Now if you are following someone in the clinic under medical case management, you are not going to discharge that patient unless they move out of town or there is a death. Discharge it happens quite a bit with the community based HIV case management.

Now you heard me mention Ryan White versus private clinic. Ryan White is federal funding that came out in the early 90s when it was really, really difficult to get medical care for people who were living with HIV and dying of AIDS. We have several, several Ryan White clinics across the state. It's a huge program with a rich amount of resources. Ryan White clinics treat all patients regardless of their ability to pay. That doesn't mean it will be free, but they would use a sliding fee scale, and they will help access medications, support groups. If you needed dental care, if you needed eye care, basically anything that a patient needs they would have the best resources for.

Now a private clinic, not every private clinic has a social worker, not every patient is going to need a social worker. But when you are talking with a patient about where the best fit for that patient would be, the number one priority is its patient choice. The patient may want to see a doctor that doesn't have resources that you feel like would be a better fit for them, but they have that option of choice.

Now based on self-pay status versus insurance, a lot of the major health systems have some type of patient financial assistance. So for instance if a patient were at Cape Fear Valley, for example, and they just met one of the infectious disease doctors here and our infectious disease doctors are fabulous here, and they want to stay with that doctor, the chances are very good that -- and the doctor is connected to Cape Fear that we can help enroll them in some type of assistance to help for cost of labs and that visit. A lot of the health systems their clinics, their primary clinics as well have this as well. They do have a program that will help self-pay patients.

The need for psychosocial resources -- when a patient is talking about where they want to go for care. It's a good idea for you to be a sounding board for what their needs may be. If they are homeless or if they are having issues with transportation, it might be a good idea to kind of give them all of the options and what resources every clinic has available so that they can make the best decision possible. As far as finding out what clinics are in your area, you can call the health department and in particular talk to one of the DIS workers, or you can contact the regional dogwood network in your area and they can tell you which clinics are available. I also have several slides that -- with the Ryan White network and their contact information so you have that.

I want to talk a little bit about what Ryan White is so you get a better feel for it. So, Ryan White program has different funding parts based on the different needs across the state. Part A, there is only one place in North Carolina that gets Part A funding. That's for your bigger metropolitan areas and that would be the Mecklenburg Charlotte area. Part B is the biggest program under Ryan White. And Part B funds the HIV clinics that are in the area. It also funds the HIV medication assistance program. And we are talking about millions of dollars here in North Carolina. And then we also have Part C. Part C is for back in the day when we couldn't get primary care providers to see patients, Part C covers that. So, it's more of a comprehensive primary health care that an HIV patient can have access to. And a lot of our health centers have Part C attached to them. This is super, super helpful for individuals who are either underinsured or do not have insurance. And then Part D is specific to family centered primary and specialty care for women and infants, children and youth living with HIV. So, you will find that I think Chapel Hill has a Part D grant. You will find a lot of the health centers are also going to have Part D grants.

Part F has to do with supporting provider training, technical assistance for case managers. It also has to do with funding innovative projects that help with prevention and care. And what falls under that would be the special project of national significance. In North Carolina we always have these programs funded. These are your support groups for women. These are your projects focus on transgender issues. Young black gay males. Fantastic work. The project really does great work.

Also, the AIDS education training centers program. We have ours in North Carolina and the education programs aren't free. They are very inexpensive. And it also funds our dental programs. We have -- and I believe it's Wake Forest and Chapel Hill that have the dental program. It still is fairly difficult to find dentists that will treat patients with HIV. And especially with the expense of the dental care that a lot of HIV patients need. The dental programs have been very important. And then we have one minority AIDS initiative and that's in Charlotte. And that focuses on improving access to care and health outcomes for disproportionately affected minority population including black African-American populations.

Now there is a lot going on in these next slides. This is for information so wherever you are in the state you have access to every single Ryan White resource out there. And I wanted to bring your attention, you might see the acronym HOPWA under services provided. HOPWA is housing opportunity for people with AIDS. And I'm not going to spend a whole lot of time on that. Every network chooses how to spend their HOPWA dollars a little differently. So, if you have a patient who is HIV positive and they are having some housing issues, you can call that network administrator directly and ask them how to go about getting them assistance. Now we will tell you that financial assistance and programs available are very limited because again they have chosen to sink the majority of their money into medical care and accessing medications. And like I said, they are all here. I uploaded everything -- I uploaded everything for you guys so you would have it.

When someone picks a clinic and they come in for their initial visit, we talk about a lot of things. One of the things that we really focus on is the fact that the CDC recommends that everyone who tested positive be offered medication and I call it highly active retro viral therapy and we call it HART for short. And the -- HART for short. The sooner that you start therapy, the longer that your health will stay either maintained or will increase. So, you have the possible benefits are decreased severity of acute disease which is a fancy way of saying that your viral loads, your system isn't compromised so much that you end up with an AIDS diagnosis. You have lower viral starting point which means that the HIV is not progressing in your body and not destroying cells so your immune system stays pretty healthy. Reduced rate of mutation. That has to do with medication and if you are on your meds and you gotten 95% compliance with those medications, HIV is not going to mutate those cells and destroy them. And that is really what we are looking at. We are looking at trying to keep our healthy cells so that we can fight off infections. Also, that goes along with preserving immune function. And then it lowers your risk of HIV transmission which we already talked about. If you are taking your medication every single day, and it can be just one pill now, you lower the risk of giving HIV to someone else. Which no one -- I haven't met -- I haven't met anybody in my 25-year career who has ever willingly wanted to give HIV to anybody else. So, it's incredibly important that they stay on their medications.

When you are seeing your HIV medical case manager for the first time, it can be very intense for the patient. They have a lot of fears and they have a lot of questions that have to do with accessing medical care. The two questions that I get the most have to do with am I going to die? And also, how am I going to afford these medications? We spend a lot of time educating patients on how far we've come as far as medications go. And the fact that individual can live a very, very long life. They don't get to build the inner relationship again. They have trust issues. It's an opportunity to really build -- start to build rapport with that patient and talk with them about the fact that life is different. It's not over. And you also have the ability to assess what are the emerging needs at that point. What referral will need to be given. Whether it's mental health or whether it's just basic live everyday living types of things. Or if they need a referral for substance use. We send a -- we spend a lot of time addressing their fears and their issues. Even if they don't ask questions, we talk a lot. And they don't always remember everything from their first visit, but they will remember something.

Right now, we have 46 HIV medications that are available. 46. That's amazing. If you look at the little picture that I have up here, you see the pill count in the 90s and then the pill count for today. Now I have to say the pill that they are showing you for today is pretty small. Most of the one-pill-a-day medications that are available are the size of a multi-vitamin. But they have three or four HIV medications in one pill. You take it once a day. I mean, it's amazing. It's amazing what they have been able to do in the last 35 years.

When we talk about adherence factors, some of the positives that we've got going is the medications, we've gone a lot to once daily dosing. I will say that not everybody can do the one-day dosing. We have patients who have been living with HIV for 30 years. It's tough to take medicine every day and if your body has basically become immune to that medication, you may have to take two or three different meds a day. Most of the patients are able to take once daily dosing which is very helpful. That pill is large and that's one of the -- if you aren't good at taking pills, it takes a lot of practice sometimes to get those pills down. But they are the size of a multi-vitamin. The medications are getting better as far as side effects. They have good tolerability. The older you are, the -- it appears more responsible you are taking medications. We have to work super hard with our young people to get them to understand the importance of coming to the doctor and taking medications. With that being said, we don't force patients to take HIV medications. It's really an individual -- HIV is very unique and individual to each person and that's the way that it needs to be approached. If I have an 18-year-old in my office, they may not be ready for meds and I'm not going to make them take a pill that they might take once a week and then they would destroy their opportunity of having that pill as an option in a year when they are ready to take pills. Now that being said, if someone has AIDS and they are in a position where they are fighting off an opportunistic infection which is a type of illness that individuals with suppressed immune systems get, then they may not have a choice but to start meds. It's always up to the patient as to whether or not they take them.

Also, what helps is a multi-disciplinary care team approach. That's when you have your doctor, your social worker, case manager and you have a nurse and are all on your team and are working with you to help you take the medications as you should and help you come up with ideas on what to do. If you are not a great pill taker which I can relate to, trust is incredibly important, not just with the provider but also the social worker and the nurse. The more they trust you the more they are going to listen to what you are trying to share with them as far as education and living a long life and if they would take -- just give the medication a chance. It would change their life. Education is super important. Like I said, the pill can be large.

The cost for the monthly medications average between $2,000 to $4,000. Very rarely that's an issue. We have enough resources for patients regardless if they have private insurance or not to where we can access medications for them. Again, compliance with these meds need to be at 95% for them to be effective. And like I just said, HART is now more accessible than ever. There is absolutely no reason why a patient should not have access to HIV medications.

And this is one of the big reasons why, HMAP. Stands for the HIV Medical Assistance Program. Right now, there are approximately 8,500 patients enrolled in this program. There are sub programs under this program. So, if you have Medicaid or if you have private insurance through your employer, you do not qualify for HMAP. Otherwise if you are on an ACA insurance program, if you have Medicare Part D or if you are uninsured, you potentially qualify for HMAP. And the gross income is at the 3% level of the federal poverty level which is I think if I remember right that's about $37,000 for one person.

And I will -- actually I will go back. I have included on the bottom the website for HMAP. The staff at HMAP have really put in a tremendous amount of time on the resources available on that page, and it's not just for people living with HIV. It is questions about Medicare. It's questions about disability. Accessing all kinds of different medications. A lot times our HIV patients as they grow older it's not just HIV they are dealing with. They are dealing with heart failure, they are dealing with diabetes. And I will say HMAP, their medication list -- there is at least -- probably over 100 medications that an individual can access. And they are not just HIV meds. They are medications for depression. There are diabetic meds and their blood pressure meds and there is all kinds of medications that an individual will be able to access. Again, if you go to their website -- I mean, they work really, really hard on developing a great resource web page for the community.

PrEP, we talked a little bit about PrEP. It's a pre-exposure prophylaxis. A daily medication, it's Truvada that can reduce your chance of getting HIV by 90%, injecting drug users by 70%. Most infectious disease clinics do follow individuals who want to be on PrEP. That means they are not HIV positive but they go in for regular every three months visit for lab tests and refills and monitoring just to make sure that everything is going well. There is help to pay for PrEP. It's covered under Medicaid and most health insurance if you have private insurance, there is a co-pay card available to assist with out of pocket expenses.

Now I didn't want to -- with men, HIV in general affects men and women differently. And it's interesting because Truvada, one of the medications for PrEP shows that. For men, Truvada it takes ten days for the Truvada to start to work. For women it takes 20 days for Truvada to start to work and that's taking the Truvada every day.

I wanted to talk a little bit about PEP. PEP is the post exposure prophylaxis and basically these are your emergency situations where you have needle sticks or you have sexual assault. And it's not meant to be an ongoing kind of prophylaxis way of dealing with not getting HIV. I wanted to say is if you are ever in a position where you were -- ever stuck by a needle or there was a sexual assault, go to your local emergency room or if you know you have come in contact, not necessarily sexually but we had police officers who have had blood exposure. Go to your local emergency room and they have PEP protocol. What that is, is you basically start on a particular HIV medication regimen within 72 hours of the exposure and are on it for 28 days. It's very effective for the prevention of HIV. I will say nothing is ever 100% but it's pretty close. And it's again for emergency use only. And the really encourage an individual to be monitored by a physician. It doesn't have to be infectious disease physician. It can be your primary care physician, but these medications can affect your liver so there is monitoring that they will want to check your labs while you are on the medication.

One of the other questions I get asked about a lot is so my -- is HIV will they qualify for SSI or disability? And that's going to be a no. Being HIV positive does not guarantee Social Security benefits nor does it guarantee Medicaid coverage. With the amazing medications that are out there, even someone who has reached the AIDS status, once they start medication, their body can actually build itself back up to where they have the ability to either continue to work or go back to work. So, it's a lot more difficult than it used to be to get any type of benefit for someone who is living with HIV. If someone is on disability and they want to go back to work, refer them to the transition program that SSDI has or SSI has or vocational rehab. They have been really great about sending them back to school or helping them learn a trade.

And I did want to talk about the Duke Health Justice Clinic. I have used them so many times over the years. They help patients who would like power of attorney, living will, wills in general. They work with families with kids. If they want a guardian for their child if something were to happen, they help with those types of situations. But they also moved into discrimination and worked a lot with trying to remove stigma with patients. So, if someone loses their job and it's directly related to them being HIV positive, the Duke Health Justice Clinic can step in and help. It's run by third year law students, but it's monitored by two law professors who are fantastic. They also work closely with insurance issues. Very closely I should say with insurance issues. So, if you have someone you are working with and their insurance company is not covering their medications or they are not allowing for alternative options, I would definitely the Duke Health Justice Clinic a call and their information has been included and also their website.

Just wanted to talk briefly about HIV stigma and discrimination. We have come a long, long way as far as HIV stigma and discrimination goes, but we still have a long way to go. HIV related stigma refers to negative beliefs, feelings and attitudes towards people living with HIV, their families and even the people who work with them like us. A lot of people would say still say I can't believe you work with people who are living with HIV and my response is I love it. They are absolutely the most wonderful people. The more you can normalize the situation the less the stigma will be attached to it. HIV discrimination refers to the unfair and unjust treatment of someone based on their real or perceived HIV status. You can think someone has HIV. You cannot tell by looking at somebody if they are living with HIV. You just can't. Discrimination can refer to those who care for people with HIV. Their families. And if you have a patient who is running into discrimination issues, again, I would refer you to the Duke Health Justice Clinic.

Discrimination stigma also related to myths or pre-existing biases against certain groups, sexual behavior or fears of illness or death.

What can you do to reduce stigma and discrimination? Know the facts. Educate yourself. Study. Understand what's going on here in North Carolina and then the United States when it comes to HIV. Be aware of your attitudes and behaviors. That is so important. People living with HIV are extra sensitive and they can feel how you present to them. And you want to be as open and normal with them as possible. You want to choose your words carefully. Think before you speak and just remember that is a human being who is sitting across from you. Educate others. Be open. Any time that you have an opportunity to correct someone who has misinformation, do it. Focus on the positives. We don't know how long HIV patients will live these days. We know they can have families. We know they can have healthy children. We know they can work and go to college. We know they can live healthy and happy lives. And the ultimate thing is to treat people with dignity and respect. That goes a long way when you are dealing with someone who has had such a huge life change. The way you interact with them, whether it's asking if you can give them a hug. Whether it's listening to their stories. Whether it's linking them with resources, all of that helps to reduce the stigma attached to HIV.

Then the last thing is that one day I would love to say I used to have HIV. I don't know I will see a cure in my lifetime but I know it will happen. And with that, that is the end of my presentation. If anybody has any questions, I would be happy to answer them.

>> Thank you so much. I do have a couple of questions that have come in. And the first one is if somebody is going into an E.R. or admitted to a hospital, how does the hospital know whether or not a person needs to be tested? What are the deciding factors? And if they do decide to test, can the person decline the test?

>> Well, I'm a social worker. I'm not a medical provider. But I will tell you there are things that they look for like dramatic weight loss. They look for thrush in your mouth. If someone is running a fever and they can't figure out why, they may want to test. And everyone has the right to decline an HIV test. They don't have to do it. Except for a newborn baby. I should clarify that. When it comes to babies, if a mother -- if there is no evidence that a mother has been tested for HIV during pregnancy, that baby will be tested when it's born.

>> Great. Thank you. The next question is: Whether or not our Medicaid beneficiaries assigned to a clinic or can they choose between a Ryan White clinic or a private clinic.

>> They can choose between a Ryan White clinic or private clinic. You are assigned a primary care and not assigned a specialist. They have a right to choose their infectious disease specialist in their clinics.

>> The next question is, is PrEP only for injecting drug users and is it something that can be given to adolescents?

>> PrEP is for everyone. And, yes, to adolescents. It is an option for adolescents.

>> And the last question -- actually another one just came in. So, let me ask this one and then I will come to the one that just came in. So, if a person has AIDS, can they decline to take medications? And if so, is there any negative impact or penalties for that person?

>> Yes. It happens all the time where we have patients who actually are in the end stages of AIDS who decline to take medication. All we can do is support them and educate them. And there is not a penalty for that, no.

>> And then the question that came in just a moment ago is a clarification point. In your presentation you mentioned that the PrEP products against HIV are around 90% during high risk sexual behavior but this person's provider had mentioned that it's closer to 100% for patients who take it as prescribed. Do you have any kind of new updates or literature that a person can go to get more information on this?

>> I would go to the CDC website to get more information. And I will tell you there is -- depending on the data that you utilize, it's between 90 -- I wouldn't say it's actually 100%. It's pretty close. It's pretty close. 90% is the lower end. I did not want to give 100% because 90% is what I got from the Center for Disease Control.

>> Next question is, is PrEP fully covered by Medicaid?

>> Well you use your co-pay but, yes. So whatever co-pay is $6, it would be $6 under Medicaid.

>> Great. All right, so it looks like that is the last of the questions. So, I will go ahead and cut it off at this point, and I want to thank you so much for your time today and your willingness to present on the topic. You had some great information, and I will make sure that everybody gets the presentation that you provided with all of the additional links and information. And for anybody who has additional questions, if you want to send them to me or put them into the survey that I will be sending out, that would be great and we can work on getting those answered for you. But at this time thank you so much, Fran. I appreciate you being with us today. And thank you to everybody on the call.

>> Thank you.

>> Have a great day, everybody. Bye.