Education on Protocols and Procedures Applicable to HIV Counseling, Testing, Reporting, and Partner Notification

Presenter: Marye Bernard, DNP, FNP-BC, AAHIVM

It is my pleasure to introduce today's presenter, Doctor Marye Bernard. Doctor Bernard is a three time graduate of the University of Tennessee Health Science center where she received a BSN, MSN and a doctorate in nursing practice. Doctor Bernard has provided primary care, women's health and acute care for nearly 30 years. She is well known for her affectionate provision of care to all people, regardless of age, race, gender, sexual orientation or disease state. She is a renowned national speaker with many pharmaceutical companies providing knowledge across the United States.

Doctor Bernard is the recipient of many awards and even has an award that's given annually, named in her honor. She is an educator with years of experience as an adjunct assistant professor at the University of Tennessee Health Science center. She has served as a clinical preceptor to many of the Mid South's nurse practitioner students and takes great pride in those who she has mentored. Doctor Bernard's focus of concern is based on wellness and prevention of disease. Her philosophy and provision of care is to take care of each individual patient thoroughly and completely as if they are the most important person in the world.

Without further ado, I am going to turn it over to Doctor Marye Bernard. Thank you. Thank you very much. Thank you Doctor Matthews for that nice introduction. I'm excited to bring this topic, the education on protocols and procedures applicable to HIV counseling, testing, reporting and partner notification.

HIV has been an area that's been near and dear to me for many, many years and so it's with my pleasure that I talk about it. I do want to give one disclaimer, however, and that you probably already can see, is that I'm technically bad, real bad. So if I make a mistake, just bear with me. I promise I will correct it. So we'll just kind of jump right in.

And first of all, let you know my disclosures. I do receive an honorarium for presenting this course. There is a lot of diversity, equity and inclusion involved. We try to make sure that this course is

applicable to all groups of all backgrounds and that there's differences. If there are differences between populations, we make sure that we do note them.

There are a few limitations and risks. You know, HIV, back in the day was really, really rough. Really, really rough. People died and suffered and had a lot of things going on with them. But over the years, what we've seen is an evolution in the assessment and care of HIV, which makes taking care of people living with HIV a lot easier.

Although some of the newer cases are horrific, like the cases of the past, but the demographics, they continue to change. Certain people in certain areas are at increased risk for HIV acquisition. And so therefore, we're going to highlight the importance of testing, because initiating a provider client relationship through counseling and support is the essence of the relationship. And when you're working with people living with HIV, you're going to be working with them for a long, long time because it is a chronic illness without a cure. But certainly we know how to take care of it.

So as we take care of people living with HIV and AIDS, we do practice cultural humility and we try to understand the effectiveness of a good assessment for HIV, knowing that it is the basis of what we do. So after this course, you should be able to identify various types of HIV testing. You should be able to explain HIV AIDS provider and patient reporting protocols and partner notification requirements, and you should be able to describe the best practices for HIV counseling. So let's talk about this thing. Where is it?

Why are we even concerned? It has a global impact. Globally, there are 39 million people worldwide who are HIV positive, and some of them have progressed on to AIDS. Of this number, surprisingly, 20 million are women. And that's a number that can be alarming when you think about it.

But if you think about places like sub saharan Africa and places where women get into healthcare quicker than men, then it makes sense. And there's 17.4 million men and a total of 1.6 million children who are less than 15 years old worldwide living with HIV. And we're seeing rising cases in eastern Europe and in the eastern Mediterranean. But it just goes into hand with what we're wanting. We have decided, as a part of ending the epidemic, that the 90 90 90 approach is something that we need.

We want that by 2030, the year 2030, 90% of all people know their HIV status, know whether they're HIV positive or not, and that 90% are in care linked to services, because we certainly know how to treat HIV now and we know how to treat it well. And that 90% of, of the people who are in care are undetectable. As you'll hear over and over again, we want clients to be undetectable because we know if they're undetectable, they cannot transmit this virus. That's where we get you, equals you. Undetectable means untransmittable.

So the 90 90 90 approach is worldwide, and it's what we're doing to make sure that we get more people aware of their HIV status. Now, although we know a lot about HIV and we know how to treat it and all of that, there's still new infections occurring every year. The demographics of new infections that we have reflective through the year 2022 are quite alarming. If you look at that, more than 1.3 million people were newly diagnosed in 2022. That's pretty impressive indeed.

Now, if we look at the United States in North America, we had 58,000 new cases. But when you compare that to even Latin America, twice as many, or even western and central Africa, again, almost three times as many. But when you look at sub saharan Africa, almost ten times as many new cases, which says to me, a focus needs to be put there. But even more alarming to me than that is if you look at the Asia and Pacific islands, that's a very, very, very small landfill, but they had 300,000 new cases in 2022. What that clearly says to me and to other people who are affected with this virus or dealing with it, is that we've got to do something to stop the new infections.

Just because we know how to treat it doesn't mean that we should get infected. Now, we still know that the epidemiology is something to talk about. It's still a major global public health concern. It's still a global public health concern, and we have at least 40,000 people who have passed from this virus globally. Now, again, we know how to treat it.

We know how to test for it. So we've got to stop getting new cases. And of the people who we know who were infected in 2022, two thirds of them were in the african region. Two thirds of the 39 million, 25 million. And then when you look at in America, the majority of the cases are in the african american community.

So this is something that people with african heritage should be very concerned about and should be very busy at helping us in this epidemic. Now, in 2022, over half a million people died from HIV related causes of the people who, you know, even with the people who were diagnosed. So it's kind of like you're getting people in, you're getting people out, you're getting people in, you're getting people out. And that's got to stop. When we look at the.

That 86% of people knew their status and 76% were on medications, and 71%, 71% had suppressed viral loads. So we know that people who are HIV positive and who are aware of their status continue to cause new cases, but we are learning to suppress. But keep in mind that we want the 90, 90, 90. We want 90% of people to know their status. We want 90% of the people that are on medications, that are positive to be on medications, and we want 90% of those people to be suppressed.

And that's where 90, 90, 90 comes in. Now, we have identified certain groups that are more likely to get HIV than others. One group is young women and adolescent girls. Why do we say that? We say that because, first of all, the body is not fully developed, and the cervix, the mouth of the womb, has to be fully developed.

Well, in young adolescent girls, it has not truly developed. So that's an easy point of entry for this virus. We know that men who have sex with men are at more risk of having HIV or acquiring HIV, and it's because of the sexual practices of anal sex. With anal sex, the risk is there because, first of all, the blood vessels in the anus are very, very, very close to the surface, and then there's trauma occurring with insertion. And so that makes the men that are receptive partners who are receiving more at risk for getting HIV than other people, transgender, the same way, because a lot of transgender women are at higher risk, but they don't always have the highest numbers.

A while back, we didn't worry so much about IV drug abuse because it had died down. But now we're seeing more and more people who are injecting more drugs. They're not just injecting heroin, they're injecting meth, they're injecting crack, they're injecting pills, they're injecting a lot of things. So IV drug abuse has increased as a risk factor, again, for HIV acquisition. Now, it's unfortunate, but it's true that prisoners are also more likely to acquire HIV.

Why? The same reasons. Trauma. And once you have trauma, you have blood, and once you have blood, you have a point of entry. Same thing for sex workers and people with multiple partners and those who refuse to use condoms.

It's the constant opportunity there for trauma, for exposure, for you to have sex with someone who's HIV positive. So, again, we're still seeing a lot of HIV, and we have identified many, many people who are at higher risk at this point. Are there any questions about what we've covered so far?

No. No questions in the chat. Okay. Seeing that there are none, let's talk about other things that put you at higher risk. One is having another sexually transmitted infection, and you would say, why?

Well, syphilis, herpes, chlamydia, gonorrhea, all of these cause inflammation. They all cause for the normal mucosa to be. To be infected or to be affected by the STI. Once there's a point of entry. Take,

say, herpes.

There's a sore there. There's a painful ulcer there. Once HIV infected, semen or vaginal fluids get in there, that is a point of entry, and you get HIV the same way you get other STI's. So that increases the importance. Now, I have young folks who, they don't mind getting gonorrhea, chlamydia.

They don't mind getting BV. Some of them don't even mind getting syphilis, but they do mind getting HIV, but they keep forgetting that you get them the same way. And if you can protect yourself from these things, you can protect yourself from HIV as well. We know that people who use drugs and alcohol sometimes are not at their wisest or best to make decisions. Sometimes people who've had too much to drink or gotten too high, they'll do things that they normally wouldn't do and a lot of risky things.

That's a major concern. We try to teach our young folks about using drugs and alcohol to stay away from those things so that they don't get themselves in trouble unintentionally. Now, receiving unsafe injections, like, I think in Jackson, Mississippi, there was someone doing injections in the buttocks for buttock implants and transfusions. Well, ever since 1995, we have not really worried about blood transfusions because all the blood is screened on collection and screened again before it's infused. So we're not worried about that.

But blood transfusions used to be a major form of transmission. But tissue transplant, tissue transplantation and medical procedures can also cause problems if the equipment is unsterile or not new. Now, there are a lot of people who are getting home tattoos. Everybody knows how to do a tattoo now, but are they using new needles? Are they using clean equipment?

That's important, and that's why it's so much safer if you're going to get a tattoo or you're going to have a piercing, to go to a reputable shop that's been inspected and has licensed. Now, experiencing accidental needle sticks, that can be scary. I remember for early in my career, I was working as my first

job, and I went in a room and I gathered up all the blankets and sheets from the bed. I was going to make the bed real pretty and have the room looking real neat so that the client's family, when they came, the client would look good. Well, as I gathered up all those sheets there, somebody had left a needle in there, and the needle went straight through my hand.

Well, that was a terrible, terrible experience for me. Because I had to get tested for hepatitis, I had to get tested for HIV. But back then, I also had to get what they called gamma globulin shots, which hurt. Now we do post exposure prophylaxis with medicines. But back then, I had to get those big heavy duty shots.

And I'll tell you, it was the one thing that made me very, very careful for the rest of my career, I've never had a needle stick again. But it was not fun waiting on those results to see if I indeed had caused myself any problems. So when we get to the counseling part of it, it is the core, it is what makes things work. It is the basis of holistic model of what we're going to do. Because when we talk to our clients and when we work with our clients, we're establishing a relationship.

And again, this relationship is long lived. It's very important that it's an honest and gentle relationship. You know, I try to make sure that when I meet people, that I let them know that they can be themselves around me and that they can be who be, say, do whatever they need to. And that I'm very accepting because already a lot of clients are already stuck with stigma, and they're already upset, they're already nervous, they're already scared, they're already worried about rejection. So it's important that we take these counseling opportunities and make sure that we integrate it into their care in a way that is helpful to them and to you.

So we have two aims. When we're talking about HIV, we want to prevent further transmission. That's first and foremost. We've got to stop the spread of this virus. And then we want to make sure that those who are infected or affected have the support and services that they need.

In case you didn't know, there are lots of services out there for people living with HIV. To the point, in some states, like New York, people have faked having HIV just to receive some of the benefits that are out there. So when we begin our counseling, y'all, we do a lot. We do a little counseling before the test is done. You know, you want to know what risk factors the person has had.

And I'm very gentle and slow to ask too many questions because I want them to tell me what they want me to know. And so you ask questions or you make statements like, tell me. Tell me why you are interested in getting tested today. What will it mean to you if the test is negative? What will it mean to you if the test is positive?

What things do you think put you at increased risk. What things do you think you've done that help you be safer? Are you aware of any places to go for your healthcare? Did you know that you could be treated? Those are the type of things that you want to talk to before the test is done, to assure the client that regardless of the results, the results can be handled.

Now, we also want to talk to the client after the test. If it's negative, then I want to talk to them about the things that they can do to remain negative. I remember my son had an exposure once, and he came to the office to be tested, and I remember he was so nervous. He said that was the longest 20 minutes of his entire life. But after his test, one of the counselors got with him and made sure he understood how he had put himself at risk and how he could not put himself at risk in the future.

They did counseling on how to properly use a condom, how to properly use a dental dam, how to get tested first before you engage in sexual activity with people. That's one of the things we're asking young folks to do before you start having sex with Tom, Dick, or Harry or Susie, Ann and Joan. Why don't you both go get a quick test? It only takes 1520 minutes, and then you have an idea of whether or not you're in trouble. The thing is, if you're negative, I want you to stay negative.

Now, for those who are positive, I want to link them to services. I want them to know that there are people out there who can take care of their virus like they want it to be taken care of. I want them to know that it's not a death sentence, they're not going to die. And we totally know how to take care of people living with HIV. As a matter of fact, it's easier to take care of HIV than it is diabetes and hypertension.

And I explain how, but also make sure they know how not to transmit this virus to someone else. And the main thing I do is link them to services and get them on medicines. The trend is toward rapid start. When you find out someone's HIV positive, we want to have them on medicine within seven days maximum, preferably the same day of the diagnosis. We want to put them on medicines the same day.

And because we want them to become undetectable, because if they're undetectable, they can't transmit this virus to anyone else. And so after the diagnosis has been made, you then want to talk about other things, resources, families, support, you know, who can you tell? What will they say? Will they support you. Those things are important because still to this day, there are families who reject their loved ones when they find out they're HIV positive because they haven't taken the time to find out what is a risk factor and what is not.

Living with someone is not a risk factor. Having sex with someone is shaking hands with someone or hugging someone with HIV is not a risk factor. But sharing a needle with someone who's HIV positive or cocaine straw it is. So again, once we do this, counsel, we want to make sure that the patient has hope. Now, I don't do very much bereavement counseling anymore, but back in the day, we used to sit down and plan funerals and, you know, decide who was going to say what, who was going to get the dog and who was going to get the mink coat, etc.

Etcetera. Well, we rarely do bereavement counseling anymore because the only people who are dying from HIV and AIDS in the United States are those who want to. Because medicines are readily available in some other countries. It's not as available as it is in United States, in Europe, but we definitely have it. There are hotline counselors.

There are volunteers who answer the phone for people who are HIV positive. These counselors are able to answer your basic questions and find and also link you to care. Now, when a person has been diagnosed and has not gotten into care, we look for them and we try to get them in care. We try to put them in a position or in a place of care that best fit their needs. I'm in private practice, so some of my clients would not go to the health department, would not go to the public clinics, but they'll come here because it's private and there's no stigma attached.

And again, we make sure that there's psychological support for that patient and everyone involved. We do have support groups in Memphis, Tennessee. There's lots of support. There's daycare, there's aid service organizations, there's counseling, there's housing. We have a lot of things, and most big cities do, too.

It's just a matter of knowing who those people are and where the services are. But counseling afterwards is important. But a big, big, big component of HIV counseling includes making sure that there's a good understanding about HIV. Before I jump into this, I'll pause again. Are there any questions?

Okay. No, not yet. Okay. Seeing that there are none, we'll keep it moving. So what do we talk about when we talk about HIV and AIDS?

What are some of the things that are important? Well, the first thing. I want them to understand that it's a retrovirus. Most viruses don't reach back what this one does. It is the virus that causes aids.

HIV stands for the human. And I'm going to repeat human. I'm going to repeat human immunodeficiency virus. It's not the ape deficiency virus. It's not the cat, the dog.

It's human. And our immune systems are not made like any other immune system. So that is why we're not worried about cross contamination from feline AIDS to human AIDS, because the immune system is different. HIV, the human immunodeficiency virus, is the virus that causes AIDS, and it does so by slowly and effectively destroying the immune system. It stops the immune system from taking care of itself, as, for example, if I get a cold, my immune system is normal.

I may sneeze a couple of days, cough, even have a runny nose, but my immune system is healthy, and it's going to make those antibodies to fight that cold off. Well, someone who doesn't have an immune system may not be able to fight off something as simple as a cold. Now, how do you get HIV? Well, you know, it's funny because people are afraid to touch folks who have HIV, but they'll go to church and hug everybody at church. They'll say, I don't want to eat her food, she's got HIV.

But then you go to the restaurant. My patients work at the restaurants, in the grocery stores. They'll say, I don't want anybody with HIV touching me. Well, my patients, they do hair and nails and everything else. They're everyday people.

So it's a, we need to make sure people truly understand how do you get HIV? And the most common way people get HIV is through sex. The riskier the sex, the most likely you are to get HIV positive. Now, anal sex has been identified as the most risky form of sex for HIV acquisition. There's a national trend with young people on anal sex.

We've got to educate them on the dangers of anal sex. In HIV acquisition, blood is the other way. But now I want to make sure that it is understood that blood by itself is not the problem. It's got to have a

point of entry is, for example, when the iv drug user has blood in that needle and puncture you to inject drugs in you, that's the point of entry. If you take a handful, let's just say a couple of HIV infected blood, and you just put it on somebody's skin, the skin is intact, there's no abrasions there's nothing's going to happen.

There's no point of entry. It's got to have a point of entry. And remember the mucosa, like the inside of the mouth, the inside of the anus, the inside of the vagina, all of those places are easier to cause trauma than anywhere else. Now, we've seen a lot of shared cocaine straws, and everybody doing tattoos with the same needle. That's also ways of getting a HIV.

You know, I've got patients who have done so many drugs in their nose that they don't have a middle section, they don't have the septum. And so when they share a cocaine straw with somebody, there's blood there, and so you don't see the blood, it's microscopic. Then you get the straw and you get you a little cocaine, and you snip the cocaine and their blood because your nose is excoriated as well, there's the point of entry. So we have to be careful of making sure that there is no point of entry. Since 1997, we haven't had many perinatal transmissions.

Women just don't have HIV positive babies anymore. At the Geneva conference of 1997, it was discovered that if a woman takes medicines while she's pregnant and during labor and delivery, it is very unlikely that she'll deliver an HIV positive basis. So we know that women who are HIV positive can have normal, healthy and happy babies. They can do just like anyone else. So we, again, we don't see much perinatal transmission.

And when we do, it frustrates me because that tells me that that woman was not in prenatal care, because during prenatal care, the woman is assessed for HIV at least three times. Now, there's some labs that we have to watch. These labs tell us the story. The first one is to see cd four count. That measures the immune system.

That tells me how healthy a person is. And I want their cd four count, or their t hepper count, whichever they want to call it, to be as high as possible. I like to like in your cd four cells, to like little soldiers. How many soldiers do you have to fight for you? And when I measure the viral load, the other important land, I'm measuring the amount of HIV in the blood.

Pertain cc of blood per five drops. And so when I tell someone that their viral load is 100,000, I am not talking about the body circumference altogether. I'm talking about every cc of their blood. I'm talking about them having 100,000 then. So of course I want the viral load to be as low as possible, to be undetectable, because, once again, undetectable means untransmittable.

That means that you cannot give this virus to anyone else. But we even have more important lab that is fairly new to us. It's called resistance testing. These tests will allow me to use your blood to explore the medications that are available and let me know which ones I can and cannot use based on the mutations that the HIV has transformed into. So when I do resistance testing on someone and get my results and start them on medication, I know without a shadow of a doubt that the medicines are going to work.

For example, a genius might come back and show me that your hiv looks like this. Well, I'm going to find a medication that looks just like this as well and put you on it. But if you don't take it properly or miss dosages, then your virus starts changing, and maybe it'll look like. Like this, but my medicine still looked like this. So that's how we get resistance.

Your virus has changed and no longer fits the mode I needed to do. So, with resistance testing, I can tell which medications you can and cannot use. Again, this is the only exact science out there, because I know that when I start your medicines, they're going to work. I know that they're going to lower your viral load. I know that by lowering your viral load, that's going to allow your cd four cells to increase,

thereby increasing your immune system.

And so with having treatment available, having the labs I need, having the resistance testing, I can decide with my client what's the best medication for them. We have several choices of pills, and most of the medicines are single tablets. Very few people on more than one medicine. And I can assure you, if they're on a lot of, it's probably because they didn't do a good job of taking their medicines, and they now have some resistance. So for that reason, we have to make sure that people take their medicines the way they're prescribed.

And again, the medicines by mouth, the pills, they're taken every day. Every day. Anytime you miss a dose, you miss, you give your virus an opportunity to change, to do something different. Now, the newer classes of medications are really, really potent. They work really, really good.

As a matter of fact, these medicines are so good that some of them have been made into injectables. Long acting injectables is what we call it. And the one that we use most is cabenuva. It's a drug that lasts several months. You get your first injection.

A month later, you get another injection. Then after that, every two months for there. From then on, you get an injection for your medicines. And what patients like about this is that they're not, they're not told with having to take medicines every day. They're not burdened by having to pack medicines when they're out of town.

They're not worried about people seeing what they need or what they have in their medicine cabinet. But either form is you have to pick what's best for the person. For me, with my schedule, the injectables would not work. I just don't have time to go to the doctor every other month. So I would prefer the pills, but there are other people who would prefer not to take a pill every day.

And so the long acting injectables are really good for them. I also use long acting injectables on people like homeless people who don't have anywhere to store medicines, people who are forgetful young folks who don't want to be burdened with a pill every day for people who just aren't that good at staying on track, that's who I use the injectables on. But I have to make sure that they're the type of client that will come back for a proper assessment, because my goal, again, is you equals you. That they're undetectable, so that they are unable to transmit this virus to anyone. So I like to go over the life cycle of HIV, if you allow me to.

And I'm going to use my pointer here. So HIV itself, it's a retrovirus. One of the things about HIV that's different from other viruses, it has its own genetic makeup. It comes already ready. That's its one strand genetic makeup.

And if you'll notice that it's got on the outer core little receptors, because the first thing that HIV has to do is attach itself to one of the receptor sites on the cd four cell. That's the first thing. And yes, we have medications that can stop it from attaching. Yes, we do. But if we don't stop it, it takes this single strain of rna and does a reverse transcriptase, in end, double the double strand.

Now it is DNA, so the rna becomes DNA. And so, you know, DNA represents an identity. So we have medicines that work right here to stop that reverse transcriptase, we can treat it right here, too. Well, if we don't stop their reverse transcriptase, what happens is this new cell, with its new structure, integrates itself into the core of the cd four cell, thereby destroying the cd four cells. It has literally hijacked it and taken over.

And now this is no longer a cell that can help us, but now it's an HIV infected cell that's not going to do anything good for us at all. So once it has destroyed that cell protease, an enzyme comes and help it chop itself back up so that it can escape the cell and leave the cell and go and mature so it can get another cd. Four cell. And yes, we have medicines to work right here. And you'll say, well, if you got

medicines to stop with the attachment, you've got medicines to stop with the fusions, you got medicines to stop with the reverse transcriptase, you got medicines to stop with the integrase, you got medicines that are stopped with the protease.

Which ones do you use? Well, research has shown us that different combinations work different. You would think, if I can keep this virus out of the cell, that's the best way. But no, this virus is smart. Even when we keep it from fusing correctly, still some of it gets there.

We've learned that the best place to fight this virus is at the integrated spot where it's the newest classes of medications right here. And in the parts of, um. Excuse me again, you guys. And in the parts of reverse transcriptase, that's the best place to fight it. So if that sounded complex, let me tell you about this a little different, and I'm going to use a personal story.

My mother has a sister. Ain't Betty. Ain't Betty is a junkie lady. She always has cats and everything. She comes to our house and she parks in my mom's parking space, perfectly parked.

Then she brings all her junk into the house, including all her little nasty cats, and then they take over the house. They destroy it. Now it's no longer a house fit to live in. Then she gathers her stuff, her cats in her junk, and then she goes over to my sister's house and do the same thing over and over again. So in the long run, there's nothing safe and sacred there.

That CD for sale is destroyed, and my mom's sister has torn up our house and is going somewhere else. Are there any questions about the life cycle of HIV? No. Okay. No questions.

Okay. Well, I'm gonna have to think either I'm doing a really good job, or I'm boring you all to death. I want to think that I'm doing a good job, so I'm gonna smile. All right, I. All right.

So, as a social worker, case manager, engaging with patients with HIV, it's important to discuss the cd four count. We do want patients to know what their cd four count is. How healthy are you? I want them to know how much virus they have, what is your viral load. Also engage in what medicines do they take and if they are able to get those medications or not.

And I can assure you any HIV spot will know how to help you get medications. Do you take a mess prescribed? I've had patients to not take their medicines on the weekend or not take their medicines when they're partying. Well, I tell them it's important that you take them every day regardless of what you're doing, because a part of the intake, you ask so many questions of a person, their lifestyle, their habits, and so forth, that you select a regimen based on what they'll tell you that's best for them. I had a patient once who did not take his medicines over the weekend because it was his birthday, and he said he didn't want to mess up because he wanted to drink alcohol.

And I reminded him that when I did his intake, I asked him about alcohol, and he told me he drank. And I explained to him that when I selected his medicines, I took that into consideration, that he did not have to note take his medicines because he was drinking. That was a part of the plan that we had come up with. I want to know if people have any side effects from medications, because side effects can be a game changer, but for some people, side effects can be tolerated. I started taking care of this young lady in 1998, and at the time, she.

Ooh, when her folks brought her in, she was so sick. She's very thin, skin and bones, a lot of thrush, lot of things going on with her. And at the time, the most popular regimen was a drug called Kaletra that had to be boosted and some other drugs, at least three drugs. Well, these drugs, old as they are now, they got her better. She gained her weight back.

The thrush went away. Her immune system enhanced now, but the medicine calls her to have chronic diarrhea. So she adapted. She started wearing a pad in her underwear every day and just going to the

bathroom and just knowing that she was going to have diarrhea, even when the diarrhea caused her potassium to get low. She says, fine, I can handle that.

Well, as medicines evolved and tried to get her on newer medicine, she didn't want to change. She didn't want to change because she was sure that that old regimen worked. She was not sure about the new regimen. So we tried a couple of times to change her, and she just would not let us. It got to the point where I was just simply embarrassed to put my name on her prescriptions.

They were that antiquated, you know, from 1998. So I told her, I says, honey, I'm not going to be able to refill these medicines with my name on them. I says, last time I did, the pharmacist called me and asked me, did I make a mistake? I said, so we're going to have to either do something new or I'm going to have to find your provider who doesn't mind writing these prescriptions. So she went along with me and let me put her on a singleton tablet.

When I brought her back in, she looked so good. She had gained a few pounds. And she said to me, I can't believe you let me have diarrhea all these years. And you knew that this medicine will work. And I carefully reminded her that I tried.

She was the one that would not allow me to change her medicine. She was willing to put up with the side effects, but I think that it's important to address the side effects because I know that I cannot do side effects, especially for a long time. I want to make sure that all the clients can get the medicines that they need and to know what, what can we do to help? Sometimes you listening to a client or helping them figure out how to say something to another provider is the best thing that you can do for them, because, again, there are psychosocial issues involved with being HIV. Be positive.

As a matter of fact, we do have to keep it concerned that for a lot of people, just getting the news that your HIV positive can be so shocking, a lot of people start thinking that they're going to die, that they're

not going to make it. So some people start these self damaging behaviors, but we assure people that we do know how to treat HIV. And again, it's easy to take care of HIV than it is many other chronic illnesses. One of my dear, dear friends lives with HIV, and when they were diagnosed 30 years ago, one of their spiritual leaders said to them, you should start saving money. You should try to save $100 at least a month.

Well, my friend, not thinking that they would live long enough to benefit, it, did not start saving. Instead started spending and having a good time. Well, my friend is still paying the debt from having that good time, and they're still here and they didn't save, and they wish they had it, but they thought they were going to die and they saw no point in it. But we have to make sure clients understand that HIV and death are not equivalent. My oldest patient is 84 years old, and they do very, very well.

They have no problem. I have more problems with her and her diabetes in a sweet potato pie that I do. Anything else, that's my biggest trouble with her is getting her not to eat sweet potato pie and things that she likes. But there's also fear and anxiety. People don't know what's going to happen to them.

How you going to treat me? You know, because they've sat around with the family, they've heard what you say, they know what you think about people living with HIV. So they're not going to tell you because you've already made it clear your feelings. People are worried about being rejected. They're worrying about people not loving them.

They're worried about even being able to be in relationships. Some women will stay in abusive HIV relationships because they think that they have no other choice but to date somebody who's HIV positive or someone who already knows their status. Now, sometimes patients are scared to tell their partners. Well, in the state of Tennessee, you have to tell. So letting other folks know dealing with the new diagnosis is really hard.

A lot of patients will tell you. They remember found out day. That's what they call it. The day I found out. Found out day is very, very memorable for a lot of people.

But again, those fears, those anxieties, those shocks, we have to help them understand that it's nothing that we worry about or anything that we fear. But a lot of patients with HIV will suffer from depression. You know, they have to adjust knowing that this is a chronic illness, that we don't have a cure. But I remind them I don't have a cure for hypertension, diabetes, seizures, a lot of stuff. But I certainly know how to treat them, and I know how to treat HIV better than I know how to treat those other things.

So not having a cure is not significant as long as we know how to control. Now, a lot of people, because of the HIV and other life strategies, will have really bad mental illnesses and other health problems. Again, it's all about giving a client hope, letting them know that in today's day, they can live a normal, healthy life. They can have a job, they can go to school, they can have children, they can be in relationships. They can do it all.

Now, if treatment fails, that's a whole nother conversation because that means they didn't take the medicine. So that means that we've got to do something different about their treatment because the medicines work, and they work well if taken as ordered. Now, there are some people who are mad. They stop getting infected. They try to spend a lot of time trying to figure out who infected them.

A lot of times, they cannot figure it out. A lot of times, they think that they have to go into isolation and live this super strict life that they've got to, you know, beef and super was it super vigilant of their health and super this and super that. It is not like that. They have to take medicines every day or get a shot every two months. They won't.

If they take it the way it's prescribed, they will become undetectable. Because I told you, I do resistance testing, and I know without a shadow of a doubt it's going to work. And I know they'll become

undetectable. And I know that means that they will not be able to transmit it. And it also means that their lifestyle and what they're doing in their lives will not change.

Today, I take care of all kinds of people. Judges, teachers, police officers, business owners, little everybody, my best friend, everybody. But we also have to deal with some patients and the guilt that they have as they see having HIV as punishment sometimes for being gay. Young lady, last week I worked with, she felt guilty because of how mean she's been to people living with HIV. She says, she said some really, really, really mean things about people living with HIV have been low down to people have thrown away dishes and things that they've touched, you know, and so now she feels awfully guilty and feels like this is her punishment for the way she treated other people.

And I gently remind her that she's HIV positive because she had sex, unprotected sex, with someone who's living with HIV, and that she did not have sex with God. So it's not a punishment for God. So, you know, again, comforting people and making them feel good about themselves is very important. It's equally important to involve the partner and the family as necessary. A lot of moms will come in with their children worried to death about, oh, will they live?

Will they die? What's going to happen to little Johnny? We assure them that if little Johnny takes his medicine, little Johnny will be fine. Now, testing is very important. Testing is very important.

The only way we'll know for sure is if a person is tested for HIV. It is. We want to test people. We want people to know their status, because 40% of new diagnosis are transmitted by people who didn't even know that they were positive. So when we give you numbers, about people being HIV positive and about the statuses and the numbers we have.

Now keep in mind that does not include everybody, because again, 40% people don't know that they're HIV positive. Now the center for Disease Control says that we should test everybody at least once

between the ages of 13 and 64, and they should get tested more frequently if they're at higher risk. We test annually and at the request of a client, I've got some people who come in every other month for HIV tests. Well, post test counseling to me is very important with them, because if we were successful with the post test counseling and teaching them about prevention, they wouldn't continue to come and ask for an HIV test. Now sometimes people will play games.

They'll know that they're HIV positive and will not tell their partner, but will go with their partner to get tested so they both, quote, can find out at the same time. You know, again, it's really only fair to give a person a chance to decide and to be involved in your care if you're going to be their partner. If my partner were HIV positive, I would want to just make sure that they took their medicines every day so they would not infect me with HIV. Now a lot of people think that as they get older, that they're at less risk for HIV is completely not true, especially for women, because as women change, our bodies change, and as we make less and less estrogen, our vaginas are drier, thereby making it more easy for excoriation and trauma to occur during. So for my older women, I teach them about Ky jelly and things to do to keep the trauma down.

And again, we recommend that anybody who's pregnant gets tested for HIV several times, because if they are positive, they can get on medications and during the pregnancy and during labor and delivery and not have an HIV positive baby. Now there's lots of different types of tests, and it always depends on the institution and what their monies are like. But a lot of people do antibody tests, and they do antibody tests because antibodies are like little soldiers. After your body's been exposed to HIV or other things, it makes these little soldiers call antibodies. Now, we see a lot of rapid tests that are antibody tests, the fingerstick, the oral quick, the whole blood.

These tests usually require less than 30 minutes to run. And, you know, there's lots of these tests available, and a lot of people are certified to do HIV testing. Over 15 of these tests are approved by the

FDA. And this rapid test can tell if a person's been infected or exposed to HIV 18 to 90 days after exposure testing is the epitome of us doing something about this virus because we've got to know our status so we'll know what we need to do. There's so many people who won't get tested because they think they're not at risk.

Those people make me very, very, very nervous because those are my young professionals, people who make a lot of money, live in big houses, drive fancy cars. Unfortunately, HIV doesn't respect that. HIV doesn't care. So I do encourage people to engage in the community tests and events. If you can get an HIV test, then please do so.

But once you get a negative, do everything you can to remain negative. Then the second type of tests are the antigen antibody tests. Now antigens are a little different. They're proteins that trigger the immune system to fight. So you got these little antibodies, they're soldiers, they're saying, hey, somebody's been here, let's gear up.

And then the antigen say, yeah, let's fight these people. And so you have the antigen antibodies together and that is a test that's just as well. There are some rapid antigen antibody tests. They're a little bit more expensive, but they are very good because they detect within ten days, sometimes up to three months. So that's very important.

And again, the lab tests that are done, they're done at health fairs, they're done in offices, they're done at church affairs, they're done in all sorts of places. But these tests do require confirmation, both the antibody and the antigen. And antibody tests, they do require confirmation because you can have a false positive antibody test. Rarely is there a false antigen antibody test, but there is such thing as a false antibody test. Someone who I love very dearly tested had a positive antibody test, scared him to death.

And so of course we did what we said. We started this person on medicines right away and began to do the confirmatory test to make sure. Well, it turns out that the confirmatory tests on this person were negative. They did not have HIV, but they had been exposed. So they were very, very glad to exchange their HIV medications in for some prevention medicine that we call PrEP.

Pre exposure exposure prophylaxis. They were very, very glad too. And that's another thing that we've got to make sure our young people know about is pre exposure prophylaxis. Now the nucleic acid test, the NAT test, these are the ones that are best. They look for the antigen, the P 24 antigen.

If that antigen is there, HIV is there, you can rest assured it detects HIV anywhere from ten to 33 days after exposure. But it's a very, very expensive test. It's not one that I would do just for routine screening. It's one that we do when we're trying to confirm or make some quick decisions. But again, there's many types of tests.

As a matter of fact, you can go to Walgreens and get a test yourself. You can call different agencies around town, like friends for all and sister reach. They will send a self test to you. The CDC was sending self tests. I'm not sure if they still are, but it's important that everybody, everybody knows their HIV status.

So the last test that we are going to talk about is the enzyme immunoassay. Now, this one is the most reliable. It tests for HIV and it checks for HIV two, and it's the most cost effective one that we have. And again, it's because of these antibodies that are produced by the immune system that when you're exposed to viruses like HIV, it tells the body to get ready and to fight along with the antigens. And I'll just stop right here and just make sure there are no questions about HIV testing and which testing is best.

No questions at this time. Okay. All right. Well, we're moving right along. Okay.

So there are some laws that are very important in different states have different laws. Starting in 1982, all AIDS had to be reported. Starting in 1992, all HIV has to be reported. So if a person tests positive at any site where there's lab, it goes to the state health department. Now, we do know that there are some cases in private offices where that information is not shared.

But the law is that if a person test positive, is it supposed to go through the health department? And again, it's so we can keep up with the numbers. The state wants to know how they were infected, what is their age, where do they live, things like that. Because we do know that certain groups are impacted by HIV at different rates and levels than other people. Now, the state, they just have your name, Mary Bernard lives here.

Da, da, da. They remove all that personal information, but they keep the statistics that are important. Black female, ages between 50 and 65, that will be in there. So that when we get our statistics back and we're able to talk about these things, we know who has the problem and where the money needs to go. For example, a while back, most of our cases, most of them were in men who have sex with men.

So there are lots of programs developed to address this population so that the efforts would be towards men who have sex with men. Now, once this information is gathered, it is sent to the CDC. But the CDC does not share this information with anybody. Instead, it holds it in a reporting storage system called ehars. And that is where all your information is.

So, for example, if a patient lives in Tennessee and they're positive, according to the Tennessee code annotated act 1214 0102, all medical lab results must be reported to the Tennessee Department of Health within one week. And what that means. They want to know what the viral load was. They want to know what the cd count was. They want to know any tropism or any HIV related tests that I've done.

They want to make sure that it is logged in. The demographics, again, is so important because there we know where the risk is. Like now we know the risk is in people of color. We know that. We know that two thirds of the cases are in african descended countries.

And then we know in the United States that of that, the numbers left, that most of the cases are in African Americans. So the efforts to end the epidemic are placed there because that's where the problem is. We also look at acquisition risk. How did you get it? Like, right now, we know that there's lots of iv drug abuse.

So there's needle exchange programs and places to go where you can wash your needles and get things that you need to protect yourself. We give out kids safe, safer drug kits with the sponges and the things that people need to keep from getting blood from someone else on themselves. That's just the bottom line. And then, of course, we want to know how they're treated. Which drugs are most used, which ones are least used?

Are they using the injectables? Are they using the pills? If so, which regimens and which ones are better tolerated? Which ones do people like? And so that information is important for us to know so we know what to make available to the people out there.

We have to fax this information to the local health department. Prior to medical records, electronic medical records, the health department personnel would come over and manually go through the charts to try to see who was infected, what was their risk factor, what was their zip code, did they go for medications or not? You know, those type of things would happen, and they would make sure that they reviewed the charts in detail. You can also email this information or contact the Tennessee Department of Health via telephone for those in Tennessee, for those in other states, same thing. You just have to contact your department of Health and get that information to these people.

All right, so we've talked about a lot of stuff. A lot of stuff that we're not through yet, but we're getting to the home stretch. And again, if there's anybody who has a question at any point, just let me know. All right, let me back it up. So.

So we do have one question. Okay, great. If you want to answer it before partner assisted. Yes. Okay.

So do. Do we know why certain populations are more prone to contracting HIV more than others? Oh, boy. That's a million dollar question. Yes.

Okay. So there's a lot of things. Social drivers of health are one. We used to call those social determinants of health, but social drivers of health are one thing, and one of the biggest ones is education and lack thereof. Unfortunately, a lot of people get their best information off TikTok and Instagram, and sometimes it's not actually correct.

We also know that there are certain behaviors that are associated with HIV acquisition. And we know that from our sociology backgrounds, that the advanced childhood experiences cause people, especially child sexual abuse causes some people to have different sexual behaviors that are riskier than others and which puts them in a position to be more likely to get HIV. We know poverty is a driver. You know, there are people who have sex for money, and the people who are having sex for money are more likely to get HIV than others. We know that certain neighborhoods take, here in Memphis, there are certain neighborhoods that are inundated with HIV.

So if you live in that neighborhood, you're more likely to get HIV because you're more likely to indulge in that neighborhood. As we've had the problem with the schools, we know that if we've got a problem with one school, we know we're going to have an HIV problem because the young people indulge and engage with each other. But if you're asking if there's anything genetic or anything like that. Not that we know of, but we do know the social drivers of health are huge. That and substance abuse, substance

use.

People who are addicted severely will do just about anything for the drugs that they desire, including trading their bodies for drugs. I hope that answers the question.

Thank you. Okay. All right, so when a person tests positive for HIV, it has to be reported. It has, the partner needs to be notified. And it's different ways that the partner can be notified.

It can be passive HIV partner notification. And that's when a trained person help them, encourage them to disclose their status with their sex partners and drug partners to do it by themselves. They give them tips, they give them ways of doing it, and sometimes even role play and help them tell someone they're HIV positive. It's a hard thing to do. Then we have assisted partner notification where trained specialists, after exposure will help the person notify the people who are they've been involved with in an anonymous way.

They won't know. They'll say something like, Mary Bernard, you've had sex or been exposed to HIV, either through drugs or sex, and it would be good for you to get tested. And when people get that type of notice, for some people, for me, I would know who my contact was. But for some people, they don't know who those people are. But once they, you know, you get the people notified, you do offer them a way of getting into care themselves as well.

Now, some people even engage in what we call contract referrals. These people enter into a contract with a trained person who agrees to disclose their status for them and agrees to help their partner to get into a testing situation within a certain time frame. And they do offer this testing for that person who's been exposed. Again, contract referral are most likely done by health departments and agencies of such. But again, it's a way to tell people without telling them yourself.

Sometimes the providers themselves will tell a partner that their HIV, that they've been exposed to HIV and that they need testing. And sometimes there's multiple ways of doing it. It doesn't really matter how a person is told, but a person deserves to know that they're living with HIV because we know that untreated HIV can attack the body, it can attack the brain, the heart, the kidneys, the lungs. And so rather than allow a person's body to be deteriorated without them even knowing why, it is best to tell. And in the state of Tennessee, it's a mandate.

You have to tell. You cannot just not tell somebody and continue to have sex with people knowing your HIV positive. The U equals you has been a good and a bad thing because you equals you. Undetectable means untreated, transmittable. Some people have taken that to being that if I don't have any virus in my body, then I don't have to tell nobody that I'm HIV positive because I can't transmit this virus.

Well, that's not true. You still are supposed to give people the opportunity to decide. Being undetectable does not give you the right, nothing to expose your status. People deserve to know whether or not they want to engage in sex with someone who's HIV positive. Again, it doesn't matter whether you do it or somebody coaches you to do it, you and the coach or somebody paid or institution, it doesn't matter as long as a person notifies the partner before sex that they're HIV part of their HIV positive.

Now, we do know that all of the states have some laws governing the reporting of HIV. Some are stricter than others. But in New York, they don't have a criminal statute explicitly for addressing the exposure. So in New York, if you're aware you're living with HIV and you don't tell somebody, you might get a misdemeanor. If you have sex with a another person, you might get a misdemeanor, but you probably won't get in a lot of trouble.

But New York laws to me are a little antiquated. And I'll tell you what I mean by that. They say that they may be guilty of a misdemeanor if they have sex with another person, period. Not if you tell them or not.

So according to how this law looks, it almost looks like if you're HIV positive and you have sex, you're going to get in trouble.

Trouble. But the felony laws that have been used against people living with HIV in New York, they've been prosecuted under general criminal laws and can be subjected to indefinite civil commitment. You know, they can get in a lot of trouble and they're aware that they're living with this infectious disease and don't tell another person. But again, New York is funny to me because it says may be guilty if they have sex with another person, not if they have a sex and not disclose. I think the disclosure is the most important thing that we can do to help prevent the spread, because I have patients to come in with their partners.

They're curious. They're curious. You know, I love this girl, I love this guy, but he's HIV positive. What do I need to do? And it's always my pleasure to tell them, make sure that they take their medicines and make sure they take it correctly because they will become undetectable and they will not be able to transmit this virus to you or to anybody else.

But again, New York is different, but in Tennessee, we've got specific criminal statutes and sentences enhancements. You know, people who live with HIV or hepatitis can be charged with a felony for engaging in sex without disclosure. Their status. The whole thing is disclosing your status. They may be criminally prosecuted if they share needles, knowing that they have these infectious diseases, they can't donate blood or organs or tissues, semen, none of those things.

If they have hepatitis B, C or HIV, and again, that can cause a person to get a felony. But all of these things are tested before they're collected and before they're used. Persons who are engaging in sex work, they can be charged with a felony. And it's just recently, just very, very recently, that we've said that you cannot. Well, for folks with aggravated prostitution in the past, that they were criminally prosecuted and went on the sex registry for Life, things have changed since then.

They still get in trouble, but it's not like it was.

Although some people consider HIV an aggravating factor, the sentencing, let's just say somebody gets raped and, you know, you have HIV and you rape somebody, you know, that's an aggravating factor. That's the type of thing that can get a person in a lot, a lot of trouble. They can get in trouble for exposing another person unwillingly. And again, there is such thing as criminal HIV exposure or aggravated prostitution, and that prior to May 17, 2023, that would have got a person on the sex offender registry for life. But on May 17, 2023, Governor Bill Lee signed a law that removed criminal HIV exposure from the list of offenders that require sex offender registry.

Which is a good thing, because when you think about it, if you're on the registry, you can't live so close to a school, you can't live so close to a church. You can't do this and you can't do that. What it does, it drives people who are living with HIV underground. It drives them underground where they can't be seen or heard. It also keeps them from allowing people to test them and put their status out there, because if you know my business and you tell others, then I'm affected by it.

So again, in Tennessee, it is a law, you must tell somebody, you can be charged with a felony, but you're not on the registry for life. Now, in North Dakota, they do have a specific criminal statutes for HIV. And it tells you if a felony, it is a felony for a person not to disclose their status before sex. That's what most people say before sex. So you don't have to disclose your status to everybody you meet, only those you're going to have sex with.

And it's a felony for a person living with HIV not to disclose their status or to share needles with someone knowing that they have been, that they are HIV positive. So again, people living with HIV who expose other people can get in trouble and have been in trouble. I'm not sure how strict it is nowadays, but back in the day, it was really, really, really strict about people who did not tell. They got in a lot of

trouble. Whole lot of trouble.

So in California, there is no statue at all that criminalizes HIV transmission or exposure. However, the sentence may be worse if for people who are living with HIV who committed underlying sexual assault crimes. Like, again, like I said, rape or molestation, you know that you're HIV positive and you didn't disclose and you committed rape or some of these other crimes, it can be a thing that caused your sentence to be much, much worse. So people who live with HIV do tend to have more sentences for sex crimes. And I think as they should, I think that's only fair.

And people living with infectious, communicable conditions, they can be charged with misdemeanor for a specific intent to transmit. If they're trying to transmit this virus to somebody, they can get in trouble. They can get in trouble. Now, before California's HIV criminal exposure laws were revised in 2017, people were occasionally convicted of HIV related exposure crimes under general criminal laws. Now, I don't know how much this is being enforced today with the other crimes that we have and so many ugly things that happened, but I do know it is a crime not to tell someone, not to let them know, and then to do things for them.

So, boy, we've talked about a whole lot of stuff, and so we're going to start pulling things together for you. In summary, HIV, it's the virus that causes the human immunodeficiency immunodeficiency virus syndrome. If untreated, it can progress to HIV. And AIDS means that the immune system has weakened to a cd four count, less than 200, meaning that the body is now vulnerable and able to catch diseases that ordinarily it would not be able to catch. So, again, it's important that people understand what HIV is.

Another thing I'd like to just put as a disclaimer here. Although we've written AIDS in several spots, we really don't use that language a whole lot anymore. We use HIV disease. And I'll tell you why. Back in the day, if your cd four cells were less than 200, that meant you were going to die.

Nowadays, if your cd four count is less than 200, it means you need some medication and some support so that you can do better. Now, people who are not on medications and who do not have control of their virus, let me say that again. For people who are not on medications and do not have consistent control of their virus, they can transmit HIV easily, easily, easily. If it's controlled, the risk of transmission is close to zero. U equals u.

But again, they can transmit this virus through their body fluids. And I'll tell you, let me just hit on breastfeeding here. Breastfeeding has been something that we've traditionally said, no, no, you can't do. But now there are some research projects in which women are being allowed to breastfeed, but the recommendations have not trickled down yet. But just know, know that it's probably coming.

All right? So I want to make sure you understand the language. Art, a r, t, and antiretroviral therapy, that's the use of medications. That's what we call the regimens, the medicines that we put together. Although we're using a lot of single tablet regimens, there are more than one pill in the medication.

It's not like we're just saying, here, take this one pill. It's a combination of medications that completes the regimen. And again, we call that art, antiretroviral viral therapy. And we use that effectively and know all the tricks to make an artwork. And we're able to design regimens for people individually based on their needs.

For me, I would need a very small pill with very few sides effects, especially nausea. I can't stand nausea. It reminds me of pregnancy or hangover, and I'm too old for both of those, so wouldn't want to fool with that. But finally, HIV medicines can eliminate the risk for transmission and for people, for women who do want to breastfeed through breast milk, we do know that there's a less than 1% consistency of virus in their blood. But again, it still has not been 100% recommended, although there are some studies out there that suggest that it won't be very, very much longer before women who have

babies will be able to breastfeed because they'll be undetectable.

Part of that problem was we only had tests to check for HIV in the blood. We didn't have tests to check for the amount of HIV in other parts of the body. So, excuse me, that's a big problem. So when patients take their combination of medicines, back in the day, we called it a cocktail. Now we just call it your regimen, and your patients take that one pill or several pills or their injection as prescribed.

And again, the medicines that we're using now have a long half life, so they're quite forgiving, if you will. So I'm not as concerned nowadays if a person misses appeal as I was back in the day when they did. Now some people have a higher risk of mental health illnesses when they are HIV positive. So again, being holistic, looking at the whole person, addressing all of their needs are very important. My last patient I saw before this, she is very depressed.

She lost a child and she's got some other health challenges. And she said to me, I just don't know how much longer I want to be here. Those are the type of things that you listen for and you interact on. Of course, I had a case manager to get with her. Of course we made some referrals.

Of course we took good care of her and made sure she didn't go home and commit suicide. But people living with HIV sometimes are so ashamed or so hurt or so disappointed that at that moment they would rather not live. But I remind myself that's just at that moment. Now, the enhanced HIV AIDS reporting system is a database for the CDC. And this is where all the information is stored, and it's where we keep track of everything.

And if we really want to know some answers, this is where we would go. But we do know that all 50 states have specific laws, excuse me, governing the reporting of HIV. There's something that has to be done in every state. And again, some states require that you report the borrowed loads and the city for counts. But in the state of Tennessee, you just have to report the case and the demographics that go

along with the case.

But again, reporting is important. So we've talked a lot. So I'd like to do a nice recap, if you will. Number one, HIV is a chronic illness. It's going to be here for a while, and people can live, and they do live.

Counseling and testing is very integral part of HIV care.

It's a very important part of HIV care. And it's important that the case manager, the social worker, the provider, whomever is the person who's going to be engaging with that client, understands HIV themselves, understand that it's a chronic illness that can be treated, that people can live, and that there are resources out there. Humility, grace, and the golden rule is very important. How would you want someone to treat you if you were sitting across that desk? Keeping in mind that there's lots of fear, lots of anger, lots of mental illnesses, that case manager, that social worker is going to be very, very important.

And probably the liaison between that provider and the patient, it's also going to be very, very important that the right report is done and that the right numbers are attended to. But most importantly, I think it's important that we offer hope that we let clients know who test positive for HIV, that they're doing fine. They will live. They will live well. They can live like anyone else.

And that they can be undetectable, which would make them untransmittable, which will make them a part of the solution. This is the last slide. I'll entertain any questions or concerns that you may have during this time. And I'll just share with you that in my close to 30 years of taking care of people living with HIV, I've developed a whole new family. It's people that I've met who I take care of, who I cherish, and, you know, it's just a great relationship.

When they see me, they're having. When I see them, I'm happy. And I've enjoyed these years of taking care of people living with HIV because you know what I figured out? They're just like me. They just have a different diagnosis.

Thank you. We do have some questions. Good. So first question being when working with minor patients, we know that children are or minors, I won't say children that minors do not necessarily, their parents are not privileged to their health information. I think starting at the age of twelve.

How do you handle a positive result when working with a minor as far as involving the parents or disclosing to the parents? Okay, well, I give a real talk, you know, we're going to need your parents insurance, sweetie, we don't need your parents insurance to pay for the medications and the business. Now for patients who are unemployed, you know, there are programs out there, but for a minor to be HIV positive, it the parent. We need the parent involved if we can. But now I do have one case of a young lady whose parents are not involved, but she's done everything she supposed to do to enlist herself into Ryan white services.

She's unemployed. She's able to prove that she doesn't have an income. She's able to prove that. So she gets her services free through the Ryan White program where we give her her medications and Ryan White foundation pays me to see her. But for the most part, we do want the parents involved if we can, you know.

Doctor Matthew, what if a client refuses? I'm sorry, let me go back and say one other thing, Doctor Matthews, is that when a child is infected with HIV, you know, to me it's a bigger issue than just HIV positive or nothing. Who is that child having sex with? Is there a CSA case? Is this child sexual abuse or was it something else?

Do I need to spend some time with education and trying to contact the contacts of the contact, you know, so it's a bigger issue than just parents being involved. I'm always concerned when very young people become HIV positive. Absolutely. What if a client refuses to consent to tell past and future partners about their status? Well, that's their choice.

If they refuse to tell someone and someone becomes infected and it's determined they knew, then it's a felony. They'll be in trouble, a whole lot of trouble, as a matter of fact, because that's criminal exposure. Now, there are some people who, again, take you, equals you, and don't tell anybody. You know, I've got clients who've told me. I don't tell them, I just take my medicine.

I remind them of the laws of Tennessee. If you're caught, you're going to be in trouble. You're going to get a criminal exposure case. So. But you can't make them do it, you know, and you certainly can't tell those people yourself because that's a HIPAA violation, you know?

Right. Are the partners of the client also eligible for counseling? Yes, absolutely. The partners of the clients are eligible for counseling at the same place that the patient was counseled at. As a matter of fact, after the testing is done, you do want to, you know, say, I'm positive.

My partner comes in, we want to counsel my partner, but we want to test my partner, too. And if my partner is positive, then we want to get my partner in the care right away. But if my partner is negative, we want to do everything we can to keep that person negative through education, through prophylaxis, condoms, dental dams, whatever they need to keep from someone else.

So, Doctor Bernard, can you speak a little bit about how these processes are handled for people that are incarcerated? Very good. Now, in the state of Tennessee, everybody's tested for HIV on their way. The reason is there were some lawsuits of some folks who came out of jail HIV positive who claimed that they got raped in jail. So the state has to report these people and they have to offer them

medicines.

There's different institutions around town that take care of the inmates.

The indigenous hospitals in most cities, like here at regional one, is responsible for the inmates and disclosures. There's none. The same thing. The same rules apply to them as applies to everyone else.

Okay. So the reporting is the same across the board for the prisoners as well as it is for people that are not incarcerated? Absolutely. Absolutely. The only difference with incarceration, Doctor Matthews, is that these, the inmates may not be privy to the newer and simpler medications.

Thank you for that clarification. I want to give members on this webinar one more minute to ask any questions that they may have. So I will give them, give a few seconds for them to type those questions in the chat box. And while we have you seen greater compliance with the new, simpler medications? I know there's lots of advertisements for them.

Absolutely. The side effects was one of the major barriers for people taking their medications continuously. Now, most of the pills are small, low side effect profile, easy to hide, easy to take, and so people are much more adherent than they've ever been before. People feel more hopeful than ever before. You know, with HIV, I can do one pill once a day.

I can hardly do that. For hypertension and diabetes, usually it takes more than one. And then I have to keep bringing you back to assess to see if it indeed is working. Whereas with HIV, I have a definitive test, I have the resistance testing that will allow me to pick that red, that I have no shadow of a doubt that will work for you. And patients knowing that their medicines will work for them is hopeful as well.

Because we went through the phases of I don't want to be a guinea pig, I don't want nobody run trying stuff on me. Now, we know, we know that people can live with HIV, we know we can treat them simply. We know that the medicines are less, less toxic than ever before. So the answer is yes. We see a lot of more adherence than we used to.

Awesome. Well, Doctor Bernard, we do not have any further questions. I would like to take this time to thank you for your time and your expertise, and thanks to everyone who participated in today's course. We look forward to your feedback on the course evaluations and hope to see you in future courses on continued.com. doctor Bernard, if you will please advance to the final slide.

Let's see here.

Is that it? That's it. Thank you all so much. Thank you all for attending. Please note that the exam will be available in your pending courses on our website 15 minutes following the completion of the course, you will have two attempts to earn a passing score and must take the exam within the next seven days.

Again, thank you, Doctor Bernard, for your time, your expertise. This concludes today's course. Have a great rest of the day. Thank you.