Clinical Education Initiative
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HIV, SUBSTANCE USE, AND SOCIAL JUSTICE

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[video transcript]

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Today's speaker Shani Wilson PAC. Shani Wilson is a board certified physician assistant who enjoys giving a voice to underserved communities are frequently sought after panelists. She uses her experience working in the FQHC for the last nine years to lecture and teach on the intersectionality of social justice and medicine, advocacy and service as a medical professional is very important to Shani . She was recently one of nine physician's assistants to be appointed to the American Academy of physician's assistants national commission to address equity within the PA profession and was also elected to serve as the first black president of the LGBTQ PA caucus, which currently has 800 members from across the US. Shani also works closely with local organizations that strongly advocate for LGBTQ rights and access. She currently is one of the CO directors of the Rochester black pride and recently received an award from the community led organization, the Jason Ward community advocacy award, which named after one of the founders of their local mocha Center, which was integral in caring for and mentoring queer youth. Shani also received also helpful recently served as the first chair of inaugural Rochester Police Accountability Board, its mission set by an overwhelming majority of Rochester voters in 2019 is to ensure public accountability and transparency over the powers exercised by sworn officers of the Rochester Police Department. Shani is also a new CEI champion for the western New York region. So thank you so much, Shani, for taking the time. And I'll let you take it from here.

01:53
All right. All right. Thank you so much, everyone. My I see, see some familiar faces, and or I see some familiar names. And some I don't know. So thanks for coming. You know, I think for a lot of us that work in care in New York State, you know, a lot of this that you're going to hear from me is not really new. But I think the thing that really kind of sticks out to me is I came out of Internal Medicine and into addiction medicine, and dealing or you are working with people with substance use issues. And so, you know, there is a lot of intersectionality between HIV and substance use and even how they're treated in society, right, or even in culture. And so that's why, you know, I really wanted to talk about this. So a lot of the times you'll hear me use kind of HIV and substance use interchangeably. And I hope that it can be demonstrated Why not that the diseases are the same, but that the way that they are treated, arguably in society is the same, right? Same same folks are usually disproportionately affected. Same folks are not able to get care consistently. So I'm hoping to be able to have those types of discussions today. Next slide, please. I do not have any disclosures to disclose. Next slide. So our learning objectives today is how shaman, stigma against persons living with HIV and or persons who use drugs undermines their progress, recognizing historical foundations of medical mistrust that directly

affect communities and describe its effect on individual healthcare behaviors, both overt and insidious. Identifying the political and societal tools that tools that impede progress of persons living with HIV, and or persons who use drugs, and discuss provider discomfort with patient sexual history taking and analyze common patient provider communication errors. Next slide. So, I know this is a really weird slide. But I thought it was super important to kind of talk about substance use and HIV, and a phenomenon called confluence, which is you see these two bodies of water that look very different. And when I thought about, you know, how we've treated HIV and substance use the history of both write history of HIV in the 80s, how we had disproportionately affected populations that, you know, really have had to fight hard for treatment, right, and now to actually mobilize their own communities in order to get adequate treatment, right, you know, ACT UP and other organizations that started in New York City or an across the, across the United States, providers and patients talking about their experiences with dealing with HIV and AIDS in the 80s. And even you know, those types of things. So, if you guys have seen pose, you've seen that in the very last episode only because I just watched it, which I highly recommend you do, if you haven't, that, you know, they took some really big risks when talking about ACE inhibitors and talking about like, are not ACE inhibitors, rather but protease inhibitors, and making sure that it could get out to the general public so that you get treated but the confluence really just talks about how to these two streams feeding each other can help or hurt an ecosystem. Right? And if you can see it, that, you know, the medical crisis that we have, you know, both things are amplified by, by racism, lack of access all the things that we just discussed. But as you can see that, you know, both kind of are meshing into each other, even though they look dramatically, drastically different. Next slide. So here's what we do know, you know, HIV and substance use disorder, you'll hear me refer to it for us as STD just because for you know, I don't want to see substance use disorder for the entire our drug use and addiction can hasten the progression of HIV, especially in the brain. We know that, like, you know, we have like clinical research indicates that drug use and addiction can increase viral load, accelerate disease, disease progression, worsen AIDS related mortality, even among patients who follow the correct regimes, we know that there is a high cost of treatment in an ad that can add to significant barrier, you know, they we talked about HIV medication costing in the hundreds of 1000s of dollars, right, when I was a starting clinician, people that I respected in an FQHC world, arguing on the phone with with providers, and then you know, really being afraid of having their patients come back, you know, time after time to you know, get treatment because either they left treatment or something happened and they would have to go again and fight on on the phone to try to get them treatment. We know that, like I said, we increase in HIV transmission, delayed diagnosis, delayed therapy, initiation and inconsistent, inconsistent adherence, when they're dealing with both HIV and substance use disorder. Substance use is also associated with higher rates of antiretroviral non adherence. We know that, that I'm sorry, excuse me, that we know that HIV, meth amphetamine and THC nicotine are found in some studies to suppress immune function, not surprising to all of you that are

usually dealing with these folks. Substance use also found to be a predictor of early death or age related death. Next slide. We know that there is various that cause inconsistency in treatment, I like to say inconsistency rather than none. Because, you know, and you can argue me down. So what I say usually argue me down, you can argue me down all you want. But a lot of times, we may see a lot of patients in treatment, we may not, but more than likely, you've got patients that you see, but they're inconsistent. They, you know, and, and they disappear for six to 12 months at a time and then just poof, out of nowhere, they'll just show up again. So what causes those inconsistent inconsistencies and treatment intersectional stigma, you know, intersectional stigma is, you know, the, the idea that we have a that these, these different disease states can amplify stigma. It causes gender sexuality, that affects gender, sexuality, and those that use drugs, and it's significantly real affects patient outcomes. You know, cultural stigma causes significant lapses in treatment and research, lack of financial resources, puglia's, public stigma or outing you've heard it in your visits, all of a sudden somebody comes to you in tears because or that they're like really struggling because somebody out to be on Facebook, we had sex once, all of a sudden, they found out through the community that I was HIV positive, then I'm sure you've had it happened, or maybe maybe not. But in some clinics, people outright accuse you of outing them in the community because they think that their medical information is not protected. We also talk about a lack of cultural understanding that and we'll talk about it later that we really, really beat people up for for struggling with disease states. Next slide. You know, it's an intersectional stigma is a concept that emerged to characterize convergence of multiple stigmatized identities within a person or group. And it really affects their health and well being, you know, we associated with worse health care outcomes, including depression and alcohol dependence used currently, two, researchers are really using it now to examine the effects of stigma and how it actually affects how our patients do. And example our, you know, example in complications and response to treatment and why patients disappear. You know, we are constantly as clinicians, people that work with people who use drugs or have HIV, you know, with our, you know, with our like super sleuth being like, why can't we get patients to stay in treatment? Why, why why? Well, there are a lot of reasons why, right? There's convergence. There's culture, there's a lot of different reasons. Next slide, please. As you can see a famous famous book, The Scarlet Letter, you know, we talked about the cultural impact Choice versus disease, right? Why can't you do it? I did it. Why can't you write we talk about religion. We talk about homophobia. We talk about disease. I don't think addiction is a disease, right? Even though we have you know, Samsa and other places that have actually now classified as a disease state. We know that it affects brains neurological processes, having sex as a toy Historical framing of addiction or infection with HIV is now you know, folks feel like they're criminals that deserve punishment rather than medical treatment. And also to you guys, you know, when I was growing up, and I'm sure you all remember, and I'm just for some reason, I just kept thinking of coming to America. And the part where Eddie Murphy was in the McDonald's, the McDonough MC, I forgot what it's called, but it was like the McDonald's

look alike. And the person who was obviously unhoused, and just unkempt, or at least I thought you're supposed to be portrayed as was like, you know, you know, completely like supposed to be cracked out, right? To use a really terrible term. And, and like, but that's that's how in certain cultures that these folks are portrayed, right. And they're portrayed in media that way as well. Next slide. Impact of shame. People dealing with shame, often boy relationships, vulnerability and community, they are prone to suppressing their emotions, they feel worthless, depressed and anxious, they're less likely to take healthy risks, they're less likely and more likely to relapse into problem behaviors. Also, too, I think that there's a lack of insight into their behaviors and why they're why they're a problem. Like, why is this problematic? And they'll just be like, kind of shaking their head and being like, but why you're like, Well, look, you're feeling shame. And all of the shame is now kind of amplifying how you feel, and it's keeping you away from your medical professional. Next slide.

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So But despite the many under of the established standing of, of HIV, decades, and substance use disorder now that is starting to come into the limelight, with the knowledge that addiction is a complex brain disorder, for instance, with many different components and public and justice, the public health care and justice systems still reflect the idea that if you succumb to drug use, then you are you have a moral weakness. And listen, it's even folks that have actually overcome substance use disorder issues, that you're a flawed character. It's an honestly I, you know, what I saw as a clinician as a, you know, when I was working in my career clinic that I worked in, in Rochester. I remember having talks with guys and people about like, what it was like in the 80s. And I couldn't understand, but it was like, for some reason in this was that folks that were lived through the AIDS crisis, couldn't understand how people get HIV today. And I remember being like, well, you know, somebody said something really racist to me, and they're like, Well, I don't really know how this is happening, you know, maybe they just need to stop having sex with people. And I just looked at the person I was like, did that, you know, did that stop you? Right? Didn't you want people to be, you know, kind to you as far as like, you know, having to have the freedom to do what you wanted to do. Right. So I wasn't sure if that was survivor's guilt or what that actually was, but but now we have like politicians that also weaponize substance use disorder and also weaponize HIV. You know, we've talked about HIV criminalization, making some easy trigger points, mobilize community and communities involved and voters. You've seen it in the last couple of years. But for instance, the George Floyd murder murder case was weaponized George Floyd's drug use in order to portray him as a criminal instead of a patient. You know, Floyd's girlfriend had testified that he became addicted to opioids through prescription painkillers, somebody gave him those, that was somebody with a license. And that because he stopped getting them, he had to obtain street drugs in order to make himself not get sick. And so when it comes, but listen, police officers were were, you know, being defended, but, you know, when somebody is killed by them, when

somebody is killed by a police officer, it's easier to portray them as dangerous as possible. Next slide. Okay, so healthcare providers also do shame, you know, and just not understanding provides substandard care to contribute to trust issues that from those that need help, which can result in serious physical complications. And that results in longer hospital stays inpatient treatment and outpatient treatment facilities. You know, example being you know, you have somebody with substance use disorder that has a really horrible cellulitis. I'm not going to the hospital, they're not going to take good care of me, and then they get, you know, then it just starts burrow into the muscles start to burrow into the bone, it becomes a horrible, then you're begging them to go to the hospital, and they literally have to be wheeled in and stay in the hospital for weeks on IV antibiotics. Right? I know you've all heard about it or seen it. It's a significant drain on the healthcare system from complicated and repeat hospital admissions, all that's going to cost money. economic costs of the opioid epidemic and 2017, for instance, was an estimated 1020 1 billion, including the cost of opioid use disorder estimated at 471 billion and the cost of fatal overdoses are estimated at 550 billion billions of dollars because we just don't know better. Next slide. So we do as much we can do much to reduce shame and stigma and of drug addiction, HIV. Once medical professionals, we as a society understand that addiction is not just a disease of the brain, but one that in the circuits that enable us to exert free will no longer the angels are able us to observe you will no longer function as it should. Their freewill is impaired, disrupt certain does drugs disrupt circuits, the person who is addicted, or using using drugs does not choose to be addicted. At a certain point, it is no longer a choice. And you're going to hear me talk about this in this discussion about when do we say to patients that there is responsibility but not blame? And I really, really liked that. Because when I was doing the research for this project, because, you know, really, you know, we want to practice harm reduction, but at a certain point, we're all burned out, right. But I think responsibility not blame is really helpful when thinking about how to treat people with substance use disorder and also HIV. people addicted people in my laboratory or people who use drugs will often say it's not even pleasurable anymore, I just can't control it. Or they'll say I had to take drugs because of the distress of not taking drugs, it's just too difficult to bear. Next slide. Gabor Ma Tei said in his wonderful book in the realm of hungry ghosts, being cut off from your own natural self compassion is one of the greatest impairments that we can suffer along with our ability to feel our own pain to grow, to grow our own hopes for healing, dignity and love. What we seems non adaptive and self harming in the presence was at some point in our lives. And what I had a patient tell me was one of the hardest ideas was to accept that I was worth saving, right? If you have people that are consistently being told by society, culture by their medical professionals, even remember, it can be you know, bias is not what you say what your mouths what you say, what your body that you know, they're not worth saving, then why should they be saved? I had a patient tell me recently that they had been an inpatient 22 times and finally got clean at the 23rd time, everybody's worth saving. Next slide. So this is my HIV, substance use and politics. We're going to start with the substance, social determinants of

health, you know, both substance use or sorry, social determinants of health, they and social substance use disorder a clear linkages between poor health and structural factors such as poverty, lack of opportunity, substandard living and working conditions. When we find that counties with the lowest levels of social capital, also have the highest overdose rates, which we'll talk about in this discussion, economic hardship. Social isolation, hopelessness are key reasons for drug use. If you have communities that don't have hope, right, or don't have consistent access, poverty and substance use reinforced by untreated mental health disorders, lack of stable housing, are correlated with substance use disorders in underserved communities. The increases of HIV infections also points to limited access to preventative measures, which we saw during the pandemic, and limited access to health care providers and testing sites. What do you do if your testing cycles to 5pm? What do you do if they're not open on Saturdays? What do you do if you can't get a hold of your provider? Right? Next slide. So I'm sure you've all seen this meme about the Spider Man's, you know, pointing at each other. I really like this. When we think about government, we think about health care. And we think about us that, you know, we're always pointing the always trying to examine something to try to fix it. And we're always pointing at each other to figure out who's to blame for it, right? You see this a lot in government when I worked for when I volunteered for the city of Rochester, that was something that I constantly would see. And just as a provider was just mystified by that we couldn't ever get a straight answer from anybody about why something was wrong. And it was always a commission or a committee or something, or else bla bla bla. And so we were always just super frustrated. And I'm sure that you know, this is on the Mac, the micro level at local government, but we're talking about macro level in federal government and culture. Next slide. So the first example I have for you is how and how this affects you know, how it's affected community is Scott County, Indiana, 2011 to 2013. And this is one of the poorest countries in Indiana, their average population was 20,000. The popular average income was $20,000. At the time, population was 4300. They had one medical provider in the entire county, or I think, yes, in the entire county or there's like a city in Indiana that had the worst HIV outbreak. There were no substance use treatment centers and little to no HIV testing available. What was happening at the time was planned parenthood. Pence was just Mike Pence was just elected as governor. And Planned Parenthood ran five rural clinics in Indiana. They also offered HIV testing and prevention, counseling for better health. The one in Scott County performed over abortion As women had to routinely travel 50 miles for joint health care, but politically, it made sense in order to, you know, get in good with the state, people who voted for him in order for them to try to shut them down. And so it became, you know, the the goal of the pence administration to shut down Planned Parenthood because of their abortion, the abortion issue, but meanwhile, you're shutting these down. They have very little, very little HV x's to begin with. So, you know, people were, you know, getting getting drugs, and pence. Even though we had medical professionals begging for him to stop people at the DOH level, he

waited 29 days before enacting a statewide emergency. But by this time, there are already 79 new cases of HIV positive patients and 235 people were affected by HIV in just two years.

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Next slide. So this is how guys I Pence was asked to declare an emergency, but he had a personal opposition to needle exchanges, which is what the DOH was begging for, because they can drone they can donate drug use, which is also misinformation. And just like not enough education, right, educate your politicians, Scott County was ideal for opiates use because these folks were found to be reusing needles when the Department of Health started doing some investigating, right? poverty caused also a spike in deaths in 2000 2001 to 2002 and then rose to 700 Bison by 2012. This is a really good example of how policy and politics affects health care outcomes. You know, even though he pence you know, we failed to act in response to increasingly urgent signs of the significant LGB outbreaks and deleted elimite implementation because of that reason. Next slide. So this is just a snapshot couple a couple years later, in 2015. There, I think Scott County was still dealing with HIV problems. But you know, when you kind of, like, blow it up into a macro level, you know, you know, 2015 had few related HIV diagnosis where 2015 were African American and more were Caucasian, you know, likely reflects the movement of the LGBT epidemic into places like Scott County, which was right, white, poor and rural areas, new diagnosed in 2015, tend to be much younger, which we saw that HIV and the IBD related HIV cases were under the age of 45. Okay, and 80% versus 80%, and 45 and older with the broader broader population. So we started to see that this at 45, and under started to start to balloon up. Next slide. So this is Monroe and Erie County 2020 to 2021. And I participated on a panel with the group of other medical professionals through CEI, actually, folks got together and said, Okay, during the pandemic, the very, very beginning of the pandemic, we're all trying to figure out what to do. We started seeing people started coming to the office and saying, I'm HIV positive or something's wrong, we started finding HIV positive patients, me myself, I had five HIV positive patients in a week. I'd never seen anything or even heard of anything like that before. So we were asked to participate. The preliminary data that came out in 2021, I'm going to take it from the slide that we used was Buffalo and Rochester regions had 41% new HIV positive cases in 2020 and 24% in Rochester, compared to the average for 2018 2019. From 2019 to 2020, we saw that also, gonorrhea cases in Erie County went up by 650 6% confirmed syphilis cases doubled in Erie County as well, during that timeframe. New Ibtihaj diagnosis continue to increase. Of course, most of the increase of HIV diagnosis were not as black, Hispanic black individuals ages 25 and younger, with a history of male and male sexual contact, which and also larger than expected HIV diagnoses for people that were trans experienced. Next slide. So buffalo zip codes are found to have the highest percentage of HIV cases, as you can see here, also the most concentrated areas of poverty, right, inconsistent access to healthcare. What happened when you're trying to figure out how to service people when the pandemic shut everything down? Well, it just exposed the safety

net, which we saw better like at a at a national level, which was the holes are too large people are going to people are falling through and it doesn't take a lot for that to happen. Health care interruptions were found to be the main culprit. There were 53 new new HIV diagnoses just in Erie County in 2020. Black individuals made 62% of those HIV diagnosis versus two versus the 46% that were statewide. Zip codes with 20% or higher poverty experienced a large decrease in diagnosis but but started rising again in 2020. This This decrease could be caused by an actual drop in transmission but really we saw guys that it was just a drop in testing They just didn't have access. Next slide, please. So we're gonna move now to medical mistrust. You know, again, asking the question Why Why don't our patients what's going on? Next slide. So, why medical mistrust happens? I'm sure if I open up thing, and I'm sure you all can tell me why, but long history of abuse in disadvantaged populations, seven to 10% of black Americans say they're unfairly treated by the healthcare system and 55% say they distrust it from generations of maltreatment, we find that medical providers are just not culturally proficient. I say proficient rather than competent, because competent means that you have some abilities or qualities, but actual proficiency means that you're well advanced in the art and occupation of what you're doing. So I'd like to see proficiency, racism and discrimination towards groups of marginalized people, and also medical gaslighting. Next slide. So I'm sure you've got heard the gaslighting I'm sure, maybe you've seen the movie, maybe not, but actually wasn't movie back in the day. It was starring these two folks. I actually had never seen the movie I've only seen it on like TV. But it comes from a movie where husband was trying to drive his wife insane by trying to convince her that she saw a light and a lamp that wasn't there. Implicit you know, we talked about implicit bias, negative evaluation from one group to another, activated by quickly and unknowingly seeing accused by skin color accent or fish or physical appearance. We know that marginalized patients are likely to experience gaslighting, when a medical professional dismisses somebody's symptoms or denies tests or treatments ultimately will lead to misdiagnosis. Clinical stressful clinical environment, right? You take a few are seeing 30 patients in a day you're running around all over the place, it's going to be easier to gaslight, somebody we talked about stressful plenty of character, time pressure, cognitive burden on the provider. And we know that implicit biases pay does play a role. Next slide. Discrimination in the medical setting of perceived discrimination, remember, doesn't even have to be actual discrimination. Right. But it's if it's perceived, you know, we learn from people learn from experiences, you know, my grandmother, when when I was my great grandmother, what I heard when we were growing up, was you know, we were from rural Alabama, you didn't go to the hospital until you were dying. You didn't go because you didn't know if you're gonna get out or not. And so, you know, think about that today. Fast forward to today, when a person has a bad experience at a clinicians office, and then you tell their family members and their family members tell their friends, this would happen to me, or and or avoidance to minimize interactions or drama and discrimination. I had a patient told me once that we sent her to get a rash diagnose, she was trans experienced. And the provider that saw her, you know, it was a was something we didn't

think it was anything, you know, that was significant, but it just wasn't responding to treatment. We had done all the necessary testing bloodwork, etc. And she told me that she went and that the provider wanted to see your genitals. And we weren't sure why it was like, what are they? Why did they say that? She's like, Well, they didn't even ask my sexual history. They just were like, Well, maybe it's on maybe that's there too. And she's like, well, it's not. And so it was it was very upsetting for her. It was very upsetting for us to hear. And so, but that's what I'm saying like we talk about, you know, traumatic experiences in the doctor's office and just unnecessary examination. Next slide. So we have racial bias in the EMR, this was taken during COVID. Then what happens was is on this actually in Chicago, Cook County, they started the group and researchers started looking for medical people that were treated in the EDS, they started doing an EHR word search that included non adherent, aggressive, agitated, angry in the EHR, combative, challenging, hysterical, exaggerate exaggerating, defensive. This findings from the study had 2.5 times the odds of those being described as one or more negative descriptors in the in the history, physical notes, the EHR, even adjustments were made to account for socio Demographic and Health characteristics. Next slide. So what happened was, is that they found that because of these word descriptors, that it potentially affected the perceptions and decisions of future providers when they saw it in the note, you scroll in and you see that they somebody had a negative encounter with the patient, you still need descriptors, it was more than likely that that patient was going to have a negative experience with the next provider. So as we talk about cutting pasting bias, negative script is written in the mission history and physical or may likely be copied into subsequent nodes communicating and amplifying bias. And so when you're on the floor, people cut and paste your cut and pasting bias. biases can be transmittable from one person to another, just like a pathogen. Next slide. So I wanted to include sexual history here just because we're talking about providers, making sure that they're comforting Well, that's one of the things we're commonly experiencing, especially within the queer sphere, Ved during the years and many patients, many providers call or just patients that just reported uncomfortable experiences. Next slide. So the five P's of sexual history. Remember, it's not just who you have sex with, but partners practices, protection from STDs. STIs pesters you from STDs, prevention and pregnancies, there are areas that you should be able to openly discuss. Next slide.

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Partners, Are you sexually active genders of past partners? How many partners have they had patients with multiple sex partners? Sis male patients or male identifying patients who have sex with men? Should be an additional question to assess their HIV risk and STI risk. If the patient has reports one partner, as this is casual, casual, long term partner, you know, I know you know, you know the words like is it a some time he thing like what is it? You know, how do you guys identify? If they're ambiguous about their identification? You have to ask more questions. Right? Because then they should be right. So they're like, Well, I don't know what it is, you

know, like, well, I Well, are you guys using protection because then it will lead to a better conversation. Right? The patient knows your partner's having sex with other people. If they don't know. Then there's another door to open be like, maybe you guys should be using protection. What do you How are you protecting yourself if you don't know what they're doing? Next slide, please. practices, what kind of sex are you having? For example, oral sex, vaginal sex, anal sex sharing of sex toys? Are you cleaning the toys? Right? Lots of times, you would see patients coming in with gonorrhea repeatedly didn't know how we were how we were getting that. But they're using the same toys. Were they Using a flashlight, which was a toy in order to help with oral sex? And they were sharing them or just like not cleaning them? And they end up with repeat STIs? How do you protect yourself against HIV and STDs? Remember, those that have anal sex? Are you the receptive or inserted partner? Do you use count condoms in those encounters? When do you are you? Have you ever received or gave no sex? Or do you have? Do you use condoms? When you have no sex? Or oral or vaginal sex? Rather? Do you use dental dams? Do you have oral sex? Sometimes, maybe never. Sometimes, maybe never. Next slide. We talked about that already. So just always dental dams. Some people don't even know what they are. If you don't know what they are, you know, you remember Google Images is your friend. Just be careful because you know, the filter. But you know, they can talk about dental dams and just how to make sure they're protected. Next slide. past history, so sometimes, but not always, when you have an STI, there should be itching, burning, dripping warts, some of that stuff. If they have health, what kind of you had? When did you have it? How were you treated? Have you been treated in the past? Sometimes it's like, you know, especially when it comes to anal health. We have a lot of inexperienced providers that don't really ask a lot of anal health questions. But when they would come to us, we would be we would see cauliflower, you know, cauliflower lesions. And we're like, Well, how long have they been here? And we would find that they were actually getting pelvic exams was some of them had pelvic exams, like a week before they saw us. Next slide, please. Prevention of pregnancy. Remember, not just this says identifying not just this identifying? Do you have any plans to have children or have more children? Do you or your partner feel that there's a need for contraception to avoid pregnancy? Do you want information on birth control? Do you know what it is? You know? Do you know how it works? A lot of times you know why don't want to take it well, why not? Well, because I don't know how it works? Well, here's how it works. You know, do you have questions or questions or concerns about pregnancy prevention? How do you prevent yourself from getting pregnant? Also to remember, you know, a lot of times in domestic violence situations, they may not feel like they can protect themselves. Next slide, please. So, that's why I'm saying like for intimate partner violence, you know, we've been able to get creative with how we talk to people, but you know, the do you feel safe in your home is not necessarily going to work for you. Right? Because everybody will have a yes, no question. But sometimes it's not a yes, no answer. And a lot of times I find and I'm sure you find as well, that it just takes just obviously getting to know you as a clinician and having established rapport, but also to just getting

creative with your questions. Do you feel sleep safe sleeping to your partner at night? Do you feel like you can leave your house? Are you hiding money around the house? Do you feel like your Do you feel financially secure? Are you working? Um, a lot of what I just encountered this yesterday, folks were I had a patient tell me she's been hiding money in her bookshelf, because she knows her partner will check there. Her partner has been checking her phone so she changes her password every time he checks it. You know, so it's just getting more creative with questioning. The next slide, please. Substance use screening. Do you have partners that inject drugs? Do you receive? Have you ever received or given money of your shelter? drugs or sex? Do you have any partners that have been incarcerated? Next slide. So, wanted to talk a lot about Chem sex because this is coming up more often. We talked about alcoholic drugs, do you have sex? Do you feel that you need to the you know, how do you participate, like how to use drugs when you have sex, if at all. As you can see, here, here's the picture during pride or other times popper use for those that do not know what poppers are, they are a they were a high blood pressure medication. But now they are used to lower inhibitions and to make orgasms feel stronger. Also, we know that they increase the risk of bleeding and so an increased risk of increased blood to the vault. Right. So we know that poppers and chem sex can possibly risk possibly increase the transmission of HIV. We also know that increasing syphilis date rape and sexual assault as well. Next slide. So this was a really interesting study out of Shenyang China, I was really surprised to see it only because not a lot of data is coming out of China that I know of, maybe, maybe it's just me, but especially since it's such a close, close was so close, but, you know, they studied poppers and studied from 2011 2013 was meant to charge HIV incidents, you know, they interviewed 40. So for new study, five sis men, they had, you know, interviews their proper use a third had engaged in condomless sex with multiple sexual partners. 10.5 of those interviewed had been concurrently tested for positive for syphilis. They'd also been using meth, but only in 2.5%. But they found though that in the study, that those that weren't zero converted to HIV, had been using poppers consistently or had at least been exposed or used at once, and had had syphilis, or had been using or had to engage in sexual risk behaviors, higher sexual high risk sexual behaviors, excuse me. Next slide. So here's just another way to see that, as you can see, you know, they had recruited some but really only foreigners 75% stayed on COPPA use was about 111 versus non, we saw that 16.7 16.2% 00 converted versus the 5.8%. Next slide, please. And just another way to see that as well, that we talked about cumulative HIV incidents, copper uses, as you can see, it's, it's exponential. Next slide, please. Okay, so how do we address patient outcomes? How do we talk about that, and I really love this one, because it's about, it's about kids of building a bigger boat. Next slide. And I'll explain why. So I'm sure you if you don't know if you've never seen Jaws before, this is when Roy Scheider Schneider takes like he, he's putting chum in the water. And then all of a sudden, like, you know, JAWS appears and he's like, Yo, we're gonna need a bigger boat. So you know, we're dealing with and remember, it wasn't until he got out there until he realized that he was going to need something more than he had, which is where we are. We're dealing with generations of

poverty, lack of access, children's chairman, social determinants of health, inconsistent or uninsured patients. So what are we going to do as providers? Right? How are we going to make sure that we're addressing that now that we know what's actually out there? I think that it's really just about making sure that we are culturally competent, and that we're making sure that patients are feeling heard. Next slide. So this is where cultural competence comes in. You know, we talk about making sure that our patients, they understand us versus and we understand them, we talk about, like, making sure that we are now that we know how to talk to them, right? That we have the necessary tools in order to understand what they're saying, right? That data and various parts of that, you know, culturally specific treatment also matters a lot and improves treatment access, utilization and outcomes. You know, cultural competence and the addiction or STD community really matters a lot. Just like in the queer community, it really enhances feelings of comfort, support and structure in the treatment environment. I you know, I like to talk about showing empathy rather than trauma, tourism. That's one of the things especially as you know, somebody that's black and as a sis female, during the, you know, George Floyd and during we know, when people being killed by police, it was easy for people to just like, bypass my feelings. It really wasn't empathetic. It was just like, kind of like taking a snapshot of people's pain and their angst and whatever. It was really upsetting. So that's why I like the trauma tourism because it gives the picture that it's like you're just kind of passing by Next slide.

40:02
So outreach based strategies also helps us build a bigger boat, right? We understand that like with both of these, both of these disease states, that community really is a central part of it, not us, we're not the central part of that conversation, the community is and the patient, we're the ones that give the tools in order to help. So outreach strategies have changed based on the needs of the communities, injection drug users, female sex partners, not identified gay men, were who have faced with men, high risk youth and residents in areas with high rates of sexually transmitted disease, many will not frequent health care facilities due to previous issues with racism, discrimination, transphobia, homophobia, right, many community members have started their own outreach programs in order to de stigmatize HIV testing and living with HIV, also to remember the substance use movement. Now harm reduction would not exist without the communities that were being affected by them. Right, we did not invent harm reduction, they did. So that is something else that came out of that. Next slide, please. So we talked about early in the lecture about responsibility, and not without blame, and recognizing that blame and social disapproval is also a part of our culture. And especially if you are, if you are a, if you are a person of color. I mean, that's a longer conversation. But I'm gonna be honest, you know, a lot of it is our culture, and our identity is so tied to our family. And, you know, it was our, you know, substance use disorder and HIV decimated the communities. And, you know, if you look at the 80s, and in, especially in New York City, you know, pastors people were looking to just

please help us, please get this done. But everybody was pointing the finger at each other trying to figure out what to do. But, you know, they were begging like Jesse Jackson folks going on TV, begging people, like begging the government for help. But, you know, the only person that was sensitive in the conversation was the person that was being affected. And they were, you know, being stigmatized, but the person that I mean, I think that really, the, the people that are responsible, or not the communities are being affected, but government. And, you know, the, that's why I like the Serenity Prayer because it, it centers the patient, but stops pointing the finger, right? You know, the Serenity Prayer, change what you can accept what you can't, you know, I think that, you know, there's, there's some things you can hold people accountable, but, you know, finger, you know, blaming people just doesn't work. And, you know, we've seen that time and time again, it works, it doesn't work for us, like, you know, it doesn't work for our kids, it doesn't work for our pets, right? When you're, you know, trying to get them to do a certain behavior, or you're using a physical or, you know, punishment or like emotional manipulation, it doesn't work. So we can, you know, help our patients with, with accountability without punishing them. And I know guys, listen, you know, especially as a provider, you're exhausted, I just want people to feel better. And it's really easy to just, like, take that out and be like, but you, I wish you would write. Next like, so this is where I believe advocacy comes in, you'll always hear me say this in every lecture that I give, because as being a clinician that's worked in government. You know, lawmakers predict how we treat patients, we must be able to recognize policies that contribute to current and inequities in access to HIV and STD treatment, relate to your colleagues that inequity is deeply rooted in our profession, use of the experiences to educate and enlighten, you know, advocate for community partnerships, peer guided programming, right? You know, a state of New York does a really great job with a with, with peer coordinators peer, we now have ways for peers to be able to get educated and how to reach out to the, to their, to their other peers. Right. When I worked at Anthony Jordan Health Center, the Hepatitis C program was a really great program, and a lot of those that have been previously treated for Hepatitis C, can people in program who saw it consistently saw it with people that are, you know, using substances, right? Only thing now is that we have to think about as clinicians is, is where it advocacy comes in is, how do we advocate on a macro level for our patients, especially those that are that are using substances. I know if you guys are vise fans if you guys watch vice at all, or if the vice TV, but one of the things is that we're now seeing people that use substances that are peers that are now falling back, or having issues with relaxing because they're just stressed out, because they just see so much and they don't really have a lot of help. They're just expected to keep seeing people but they're not getting what they need in order to maintain their own sobriety. You know, we have to recognize these these patterns and actually advocate make sure that they're changed, right. So and also to remember, you know, those that want to that those that are in peer peer guided programming, need to be able to be able to take care of themselves. We saw that also in the peer community as well. Making sure we have trans experience programming, making sure that we have trans

experienced trans experience people in the front, not in the back. You know, providers cannot continue to centralize themselves in conversations, we have to take a step back and let other people centralize themselves. You know, we recognize that, you know, these institutions, we didn't create them, but it's our job to help, you know, build build a better build a bigger boat. Okay. You know, that we know that there are community partnerships, you know, I hope that, you know, clinicians on this call or people that work with folks will consider, you know, testifying, I was able to testify at the state level, at, at the opioid use opioid thing was opioid, something opioid with less than at the state level. And it was really an enlightening experience, we had quizzes from all over the state that came. And we really talked about some of our strategies that we're using to treat our patients with substance use disorder, you know, really was intentional about intersectionality, when it came to, you know, people that have HIV substance use disorder, right. There are people that have been doing this for decades, like Gay Men's Health Crisis, you know, Trillium Health that was once AIDS Rochester, there are other people across the they've been doing this forever. But, you know, now, I think that, you know, what we need to continuously, in my opinion, need to be continuously pushing for is how are we going to be able to do our programming that is a little bit different towards peers? And how are we going to be able to make sure that people stay in program, and I believe it's community that makes them so like, you know, we have like in the latex ball in New York, right, that's been a that's been in existence since the 90s, I believe, or the 80s. So you know, we have programming that works, we need to just be able to study and push money towards those things, and state money, honestly, towards those things to make sure that they can actually get the funding that they need. Okay, so that is it for me. And I see that there is some there's some chatting that is going on. So I will go ahead and just start looking at it. And Shani , you can go ahead if you'd like to go through the chat. Yeah. So I just wanted to, to Nico James. I'm just going to read what she wrote. When we look at the statistics of black people in the majority proportional HIV and substance use disorder, health problems. In general, the biggest problem is racism. People tend to think that racism just means hate over hate. in Social Work, school at NYU, taking a class and racism was required in the white students are so uncomfortable that it was difficult to even get through the class for anyone. Interesting. If, if we're working it in HIV or mental illness, it's fine, but not racism. Interesting. If you as you stated, we go to doctors and hospitals and anywhere we are judged. The reaction to us is often masked and the providers ignoring us gaslighting, so that we think that we are the problem the way someone speaks, or their history or source of income. It's really racism, it's hard to talk about any of this without addressing the elephant in the room. I just went as a social worker speak to a white client very engaging than the next the next black client, she was looking around. What we need more black people, black providers and managers in the health and social work field. So I just have a very short story, but I don't know if anybody would like to write in the chat about their experiences. But when I was doing research for another project with this group, I there was a black clinician who was an orthopedist two, we talked about pain and about managing pain, right? We know

that there's a study out there that talks about how pain people are treated within the pain sphere if you're black or brown. And one of the things that she said was that she was really upset because her son had broken a bone and orthopedist had set the bone without any without any medication. And she said the look in her Sanai her son's eyes will she'll never forget it. And I and I don't even have kids, all I have is a cat. And I was just like, I was really like it. Like I could see it in my own mind's eye about how she was like, like the horror like the you know, being horrified as a clinician number one, and as a mother number two and as a black woman number three, right, being not able to even give her son the adequate treatment that he needed at the time. So just wondering if there's anybody that has anything else to add to that.

49:14
That's definitely something to think about. And yeah, please write in the chat. Anyone if you have any experiences or anything that you'd like to add Shani? I have a question. Possibly. I know you said prior that when you're, you know, you're seeing patients and, you know, you don't want to feel like you're talking at them. You want them to feel open and, you know, especially when you're doing a sexual history, that includes substance use screening, and then intimate partner violence. How do you feel that in communities of color sometimes don't want to openly admit they're doing drugs or they feel like they're going to be in Someone's going to arrest them if they feel like they're they don't want to tell people that they're doing drugs possibly. Is there any ways that you work with your patients in terms of the way that you ask questions in terms of injection drug use, because you don't know if you're screening someone for all of these things that could come back later and be HIV positive? And you don't know the route of how that happened was injection drug use was a sexual activity. If you could speak more to that?

50:29
Well, I think I think what I would say to that is that, you know, for me, I think that it just like with every clinician, it just comes with time, you know, the fold in that the fact of just like, what to Nikko was saying, which is that you still have to you, you know, racism is the first layer of everything that we deal with as people of color as black people. And so you just have to recognize that that's their, you know, even as a black clinician, there is no incentive for them to trust me whatsoever. And I don't expect that to happen. I only expect that, you know, when we have when we develop report, hopefully they'll tell me, look, if I see it something on the bloodwork, then I have to alert them as to what I see, right? If I see something that's like, if I if you know, but that's we talk about, like sexual history taking, that's why it has to be in depth. And that's why it has to be, you know, look, if somebody tells you that they're uncomfortable, they'll just, they'll just act uncomfortable. They'll tell you, you know, this is the Tick Tock generation, right, like everybody knows how to talk to each other now, for the somewhat and you can you understand body language pretty well. But, you know, the I think that I would just

say that, like I you know, I think I think that, as far as like, I think education is super important. But I think that report is most most more important and understand like, when you walk into a room, what you know, what the actual layers are, what you're dealing with is going to be, you know, I don't expect for people to tell me the truth or expect to feel comfortable telling you the truth. And that's why we have what we have in this country right now is that, you know, we just have so many layers to peel back. So that's one

51:55
answer to that. Thank you. We have in the chat, Megan row in saying yes, I learned of a study that surveyed medical students that reflected the stereotype about pain threshold for black people that still exists, and they put a link in the chat. So thank you, Meghan. Yep.

52:16
Yeah, I actually discussed that in this lecture, but I just skipped over it. But yeah, the lecture was the actual study, if you please look at it, because it's actually pretty horrible is only in 2016, to where it was two groups of medical students. One that was that were just medical students versus residents, they gave the same pain scenario. one black, one black person, one Hispanic person, let next person and one white person. And they all had the same clinic. You know, they broke up broke a large bone, like a long bone, like a you know, like a, like a tibia, I believe. Or a fibula, not sure which one but it wasn't like a, you know, like anything nuts. They asked the boat, same people about the pain regimen that they should receive, and about aftercare. And, you know, statistically white pert white folks that better treatment than both in both the Hispanic and the black folk. And I was just like, Yeah, yep, it's, um, it's uh, but again, you encounter that when you you know, when you're in the world, you countered that with your medicine. So, yeah.

53:23
We have a Oh, if you see the, in the chat Tyeisha noted, these stories happen far too often, I accompany clients to the clinic and keep a notepad out when clinicians think I'm taking notes on them, they treat the patient better. I've also been told from clients that they receive better treatment when I'm there opposed to them going alone?

53:45
Yeah, listen, the thing about being a black and brown person is that like, when it comes to like, I have most of my day is telling folks that are black and brown, how to deal with specialists, right? Orthopedics especially sorry, you know, like, Hey, this is what you say this what you do, make sure you take somebody if you don't speak, you know, very good English, if you are not, you know, English, don't your first language, take somebody that does take paper, you know, ask your questions, put them out on paper. And honestly, as a clinician that is had that done to

me, I really appreciate that because I can I can take a better note, they leave being feeling better and feeling more empowered, but like, it is, it is the it feels like you know, 1930s all over again, in a way where it's like, I'm having to do word of mouth in order to keep people safe. So

54:32
we have a question here against Meghan, who wrote in previously, if at all, how do you think these kinds of assumptions on pain intersect with how opioid use impacts communities? I would say

54:49
that, I guess I would just say access to opioids, I guess. I would just say pain assumptions, right? Like, you know, and I know that globally. Act. has to opioids has changed significantly? We all we've all seen that right. But, you know, I think that like, you know, just like the the ED doc that had a child that couldn't even get injectable pain medication where their son is, you know, leg was broken for God's sake. You know, I think that that's like, you know, I think that there's two there's two parts where you have like people that are in dire need of medical intervention that are not getting it, versus people that just like, you know, parts of the state of New York, where are you going to do his walk down the street? You can get a benzo scrip, right? Or, you know, you can just like you can get like 6060 percs, it's, it's something that's just like, it's just disproportionate how pain is interpreted by the person that's actually hearing it from somebody else. What's it and if you see what they look like, then according to the, you know, the study that was just shown to you, it is interpreted differently. And that's what I would say.

55:50
Great, thank you so much. But we do have a comment from Meg, and thank you for so much for the presentation. We're updating our educational materials for STD. And your presentation helped shed light on the important extra intersections and perspective looking forward to bringing these concepts to the forefront while making this educational material for our teams. Great. Thank you.

56:13
Thank you guys. Thank you so much for all that you do for New York State. You guys are amazing. Thank you for all you do,

56:19
guys. Thank you so much, Shani for presenting today.
[End Transcript]