**Whole Health Assessment**

FACULTY

Leo Moore, MD, MSHPM of Los Angeles County Department of Public Health, Los Angeles, CA

Quintin Robinson, MD of AbsoluteCARE Medical Center & Pharmacy, Atlanta, GA

Nathaniel Currie, DSW, LICSW in Private Practice and Consultation, New York, NY

HOST

Terrance Moore of NASTAD (National Alliance of State and Territorial AIDS Directors), Washington DC

**SHAWN CASE STUDY V-BLOG 1:**

*Another sleepless night – another nightmare…the same nightmare: back in the middle of that prayer circle, praying the gay away; preacher daddy making me tell about kissing Michael; the deacons shaking their fists, the mothers clutching their pearls…*

*“If you are filled with the homosexual spirit, beg God to free you.”*…*“The Good Book says a marriage is between a man and a woman”*…*“Homosexuality is a sin - just as adultery, fornication, drunkenness, gluttony, pride, laziness and ingratitude.”*

*Now that’s what I call Christian mingle…*

*“Pray and ask for forgiveness, Son.” …If only it were that simple…* *“Love the sinner, hate the sin.”?*

*But I AM the sin. I AM the abomination…a stain on the body of Christ. What I want doesn’t matter.* *My life doesn’t matter.*

*Please God, just let me sleep. I just need sleep. I don’t know how much more I can take.*

**TERRENCE:** Wow! I don't even know where to start. Does anybody want to j p in on this?

**LEO:** So, my heart goes out to Shawn. As a Black, gay, spiritual man from the South myself, I can definitely identify with the conflict he's experiencing: his growing love for men and the teachings that are being shared in church, and the conflict between the two of those.

**NATHANIEL:** Mm-hm. Yeah, absolutely. I think what compelled me, what moved me with Shawn's narrative is, you know, you really get a sense of this, you know, environmental discord and conflict --

**LEO:** Mm-hm.

**NATHANIEL:** -- and then this sort of conflict within his identity and sort of, you know, just the rejection of family and friends and environment and support, and how that sort of has manifested into this sort of explosion or implosion for him. Just this burden.

You could feel like the heaviness of the burden with this young man. And in a lot of young men that I see, it's similar, you know?

**TERRENCE:** And that's really why we're here. And the goal of His Health is to increase the capacity of providers to screen, to diagnose, to link and retain Black men who have sex -- sex with men in HIV clinical care.

So, far too long we have placed the sole responsibility on health on Black gay men and Black gay men themselves. And contrary to popular belief, far too many people believe that Black gay men don't in fact care about their health. We here know that that in fact is not true.

This Health module series is really about changing the narrative. And so, from NASTAD's perspective, we feel it takes a village: providers working also with Black gay men to increase the quality of health care in their lives.

In this module, we'll discuss mental health and Black MSM; engaging in sexual health conversations; a discussion about leading with pleasure. We'll talk about strategies for improving engagement, retention through viral suppression; understanding your patients and also the provider's role in implicit bias, and also discussing medical mistrust and addressing stigma.

Participants will learn the following. They'll be able to sort of identify factors affecting the mental health of this population; address some of the patient depression, anxiety, and posttraumatic disorder issues that are among this population; also, being able to discuss some factors around engagement, and so linkage, also retention among Black MSM. And implementing clinical health strategies from the provider perspective to increase Black MSM engagement. And finally, describing the impact of medical mistrust, and as I mentioned, bias and stigma in terms of young Black MSM and how that impacts their engagement and care.

NASTAD is actually asking providers such as you and others out there to really think about the whole person, beyond just their HIV status. And we know that Black gay men like Shawn want to be affirmed. And so, thank you, faculty, for joining us for this 2.0 module series.

**TERRENCE:** So, Nathaniel, tell me about the work that you do and how it impacts the mental health of men like Shawn.

**NATHANIEL:** Sure. So, I'm a clinical social worker and working with young people who experience emotional distress, mental health concerns and a whole host of other, psychosocial and social environmental issues.

I can bring that expertise here today and sort of look at the clip, the narrative here with Shawn and say this is a young man who is hurting. This is a young man who is struggling. This is a young man who even just from the short clip we can see is struggling with some depression, worry, irregular sleep patterns, just a whole host of concerns in his daily life.

And so, with my patients in practice, one of the other things I would do is really take them through a pretty brief assessment to look at the psychosocial factors and environmental factors. I'm going to look at other signs of discontent, other significant psychosocial stressors. Stressors look like whatever really is a particular stressor to a patient.

 I'm looking at home life, work life, school life, changes in social interaction. Is the patient, you know, interacting with peer groups the way they used to or has that decreased? Of course, I'm going to look at substance use and abuse, histories, any kind of history of abuse or neglect, as well as income and resources. We know poverty plays a big role in how people access resources.

 And lastly of course I want to look at support systems. So, what I say to my patients is, "What do your support systems look like? Family, friends, faith-based community? Are you a part of a community activity or a sports group? Who can you talk to? Can you identify someone, that you can talk to today?"

 And that really brings us to a pretty well-rounded assessment that is being mindful of the barriers to receiving behavioral health care for folks, including, low self-esteem, low sense of mastery, and low socioeconomic status.

Any kind of discrimination, violence, oppression,including, discrimination in dating and dating life, negative life events, and so on and so forth. Protective factors might look like, kinship and social supports. Who are people close to, and how do they support them? High self-esteem, high sense of mastery. Is there a skill or a talent or a job well done that really provides that protective factor for the patient?

**TERRENCE:** So, talking about mental health can be stigmatizing. So, what role can providers have in this discussion with their patients? Nathaniel, can you tell us a little more about that?

**NATHANIEL:** I love this part. I think that it is so important to recognize that our primary health physicians and providers in the community really stand at the forefront of assessing and engaging folks in mental health care. A lot of young men, particularly young Black men, never get a chance or -- or have a will to see a behavioral health professional, and so we recognize that those -- you know, those very small, very early conversations come from the primary care health office. And so, we are looking at providers to begin the assessment right in the exam room

**NATHANIEL:**  The US Preventative Service Task Force recommends screening for depression in general adult populations. Although they do not recommend a frequency. It's a good idea to incorporate behavioral health screenings into every face-to-face visit. I'll say that again and again. It's really important to have that embedded into just regular dialogue.

**TERRENCE:** So, this is great, Nathaniel. So, let's go a little bit deeper here. So, tell us a little bit about if I'm a provider, what are some of the tools that I can leverage.

**NATHANIEL:** There are some great tools, evidence-based tools, that providers can use right off the bat. They're easy to access. Uh, the PHQ-2, or PHQ-9, is an assessment tool that asks questions to gauge and assess depression.

The PHQ-2, two quick questions. If a patient scores higher than a four on the PHQ-2, then I'm going to recommend going further into the -- the full assessment, right, the PHQ-9, nine questions assessment. If they score lower than that, great. I'm going to move -- you know, the provider will move on to the rest of the session.

And the PHQ-9, what I love about it is it does take an opportunity to talk about suicidality, homicidality and self-harm. And so, if we're looking at depression, we also want to be mindful of suicide as a risk factor and then adding a few questions of our own. You know, just having some organic conversation with our patients and really go into detail. Have you thought of harming yourself or somebody else? Have you thought of taking your life or someone else's life? What does self-harm look like to you? Is it cutting, carving, biting, you know, huffing chemicals, extreme risk-taking? Are there any marks on your body right now in -- in a place I could see or not see while you're clothed?

You know, asking these kinds of questions and getting an idea if there needs to be a further full assessment with a behavioral health professional. Are we recommending connection to psychiatry? What other tools, what other resources does this patient need?

**TERRENCE:** So, the onus doesn't have to be on the provider to get at some of these deeper issues you're talking about.

**NATHANIEL:** Absolutely. The provider is flipping the switch for care, you know.And that's really what we're looking for here.

**TERRENCE:** So, what else are we seeing and what other opportunities, uh, should a provider sort of leverage. And where else should a provider's eye go**,** if you will?

**NATHANIEL:** Right. So, we just had this sort of idea of looking at depression. We also want to take an opportunity in the exam room to address anxiety. All right? Keeping in mind that there's, you know, healthy anxieties, and we want to kind of frame that for our patients, right? So, being nervous in the school play or talking in front of a large group, that's healthy anxiety, right?

But then there's maladaptive anxiety, right? So, the anxiety that interrupts activities of daily life, right. Like going to work, interacting socially, uh, changes in appetite, mood, and sleep patterns, right? And so, we're asking providers to use again a very simple tool, much like the PHQ-2, the GAD-2, right, the Generalized Anxiety Disorder assessment tool.

Two quick questions, again. If a patient scores four or higher on the GAD-2, I'm going to again recommend that we go further into the seven questions, the full GAD-7. If a patient is scoring high on that assessment tool, we're going to move them forward to a connection to a behavioral health professional.

We might want to ask a few other, you know, probing questions, though. What is this anxiety around? Do you feel safe at home? Do you feel safe in the community? A lot of anxiety comes from not feeling safe. So, we want to gauge the level of safety in the home and in the community for our patients.

**TERRENCE:** So again, I think this is an important point, just to amplify that providers don't have to be sole experts. They just need to be able to identify.

**NATHANIEL:** Just identify, just assess. We're not asking providers to diagnose mental health concerns or disorders. We're asking providers to get the ball rolling and get folks connected.

**TERRENCE:** Okay, Nathaniel. This is a lot of tools. So, what should providers prioritize or think about? Are there other things that they should consider?

**NATHANIEL:** I think right off the bat what comes to mind for me is again, PHQ-2, GAD-2, and really making it part of every exam visit for folks.

**TERRENCE:** And how do you do this in such a short visit?

**NATHANIEL:** It's practice. It's comfortability. It's confidence. In some medical systems, I've seen it embedded into electronic records. I've seen it written in intake forms. What I like about, you know, incorporating this into every visit is that we are starting to be able to create a documentation trail that allows us to assess mood and behavior over a continuum, and we can kind of start to measure and monitor how folk’s mood change, right?

So, if somebody's depression is elevated for a period of time, I'm starting to ask myself questions. You know, what's going on in the last eight months where suddenly depression is up, anxiety is up, and they're missing visits? You know, something must be going on. Let me do a deeper dive into this person.

**TERRENCE:** Longitudinal information actually makes it easier over time.

**NATHANIEL:** It really does.

**QUINTIN:** And another, where I practice, we actually have it embedded into our electronic health record. So, when they are doing their check-in, we kind of make it a normal process, so we tend to normalize and eventually destigmatize this evaluation for mental health to make it part of a routine.

**TERRENCE:** So how does PTSD and trauma play into all of this, Nathaniel? Can we talk a little bit about that for a moment?

**NATHANIEL:** I think we should. I think we should look at Shawn and his narrative and start to talk about some pretty obvious trauma that this young man has experienced and continues to experience.

So, for me as I'm, you know, observing, and assessing this, this narrative of this young man, I'm compelled to identify that there's this level of trauma in his familial unit. There is this pressure to conform to an identity that's not his own, right? So, there's sort of a traumatic sense of identity in being there.

There's a traumatic sense of rejection from the faith-based community that he's a part of, right? Then there's grieving the loss of that community. And to make matters worse, if you will, it's the support systems he has in his life, they would have been his family and his community faith-based organization and groups and stuff.

And so, with the loss of the support system and the rejection of the community and this conflict with identity, I see these multiple layers of -- of trauma. And we can look at trauma through a lens of multiple layers and how they sort of add up over time, right?

Now we have this young man who is traumatized in a variety of ways, and then maybe continues experiencing trauma through just general things in the environment, things in the media, interactions with peers, rejection or oppression in dating, right, or exploring sex and sexuality.

So, we have all these different types of trauma that Shawn is experiencing. And he comes into your office and we're asking questions about medicine and about behavioral health. And he's sitting with this trauma. I think it's really important to recognize that for Shawn.

I also think it's important that we recognize that not all trauma is PTSD. And PTSD doesn't necessarily indicate, you know, trauma. PTSD is a clinical diagnosis, based on criteria listed in *DSM-V*. Trauma is an experience, right?

PTSD can affect anyone who has experienced or witnessed any event where they thought that their life was in jeopardy or their life was in jeopardy. Trauma is easily defined as a deeply distressing or disturbing experience, right? So, when we're looking at trauma, it could be, you know, a car accident or, you know, rejection of a community, being ostracized, right?

 PTSD is more severe than that. It's a clinical diagnosis. And in terms of the population that we're working with, young Black men who have sex with men, uh, we want to talk about PTSD. We want to talk about trauma. We want to talk about PTSD because of higher risks of PTSD in young gay men.

We want to talk about it because of higher rates of childhood sexual abuse, intimate partner violence among Black men who have sex with men. And of course, we want to connect PTSD, trauma, psychosocial stressors to other serious sequelae, including depression, alcoholism, higher body mass index, higher cholesterol, asthma, diabetes, suicidality, so on and so forth. We're starting to kind of connect the dots here between what we experience, our emotional health, and how our body sort of manifests those symptoms.

 I think it's important to recognize how, you know, trauma appears in all of our lives really, through potentially exposure to abuse and violence, natural disasters, acts of war, descriptions of war. We see it in the media daily, right? Terrorism and hate crimes. I think about the shooting at Pulse nightclub, where young men of color, young gay men of color were, uh, murdered for their -- you know, owning their identity. Seeing that at home is enough to be triggered to a traumatic response, right?

**TERRENCE:** So, if I'm a provider, how do I assess?

**NATHANIEL:** That's a great question. I think again, getting back to some of our earlier dialogue around getting assessments down to the nitty-gritty. You know, there's not a lot of time in the provider office. We want to be able to assess thoroughly.

We can ask certain questions. And those questions would be "Have you ever experienced a life event where you felt like your life was threatened or was actually threatened?" Right? The second question: "How you -- have you ever experienced abuse, domestic violence, death of a loved one, or community violence?"

If someone's answering yes to either one of those or both, I'm going to ask a third question. "Since that event have you experienced change in sleeping or eating patterns, frequency of nightmares, flashbacks, disassociation, heightened worry, avoidance of people or places or things, changes in satisfaction from activities that you once liked?" So, on and so forth. I'm going to incorporate those quick questions in and see if there's a call for work, a call for referral, a call for further diagnosis.

The intent is not to have the primary care provider make a clinical diagnosis, right? We're asking folks to evaluate and assess and refer to a mental health specialist and really keep, you know, the whole health of the patient in mind.

**SHAWN CASE STUDY V-BLOG 2:**

*All the sleeping pills in the world won’t do me any good if I stay out all night.*

*The doctor thought I should see a therapist…. Not my speed, but I gotta share what’s going on inside with somebody.*

*And now I got to go the clinic… again. I can’t ignore this damn itching in my butt anymore,* *and I really can’t talk to anyone about it.  Not Mom.  She’s too busy pushing some girl at me. And not the guys – even though I think they would understand.  I can’t be the only one of us to have had this happen to.*

*Ugh – A couple hours of sleep would’ve helped -- but too late for that*.

*Sexcapades have their price.* *Off to judgment day*

**TERRENCE:** Again, this is a lot. Shawn is really struggling with sexual identity here. How do providers really work with someone who is struggling and grappling so much?

**LEO:** Thanks, Terrence. That's a great question. As Nathan mentioned, this patient is struggling with a conflict of identity. He's struggling with who he wants to be and who his mother and family want him to be. And it's really important for providers to think through all of those pieces to be able to offer comprehensive sexual health care to patients.

So, I think it's important for providers to view sexuality from three vantage points. Those vantage points are cultural, self-identity, and sexual behavior.

Cultural is defined as how the community or social environment labels one's sexuality. In Shawn's case, a great example of that would be if he had been told directly or indirectly that being gay makes him soft or feminine or would cause him to be ridiculed by peers, or in his case put in a prayer circle and prayed over for hours at a time.

And that can affect, uh, the way that he interacts with the health care system and also how he labels himself. He may reject completely the label of being called gay.

Self-identity is defined as how one identifies themselves in terms of sexual and romantic attraction. And people identify themselves many different ways. Black MSM may identify as straight, as gay, as bisexual, as same gender loving. Or they may not ascribe to a label at all

Self-identity is not nearly as important in our conversations with patients as sexual behaviors are. Sexual behavior is defined as who a patient actually engages in sexual intercourse with, which may look different than sexual labeling or owned sexual identity.

And it may look different, but it's extremely important for us to focus more on the sexual behavior than on sexual identity because we've seen in data and anecdotally that when we focus on sexual identity, we miss diagnoses. For example, if a patient tells us that they're straight, we may miss a diagnosis of rectal chlamydia or gonorrhea by not swabbing in that area. And we have a lot of data that we've shared about that in module 1, so I would encourage providers to check back in with module 1 for a quick refresher on this topic.

Moreover, it's really important for providers to recognize that it requires a narrative shift, this conversation between providers and patients about sexual health. We have to shift from focusing on disease prevention to pleasure and safety. Providers are more likely to gain rapport and obtain a more thorough sexual history by leading with questions about pleasure and safety.

There was a recent study that was done that showed that MSM complained about many different sexual complaints more than their straight counterparts. Some of those were oral dryness, lack of orgasm, in addition to other complaints. And so, one thing that that tells me is that providers need to be asking these questions to ensure that they're enhancing the pleasure that their patients are having and also empowering patients to take control of their sexual health and allowing them to make the best and most informed decisions for themselves.

It’s also, important to note that when providers ask these questions, or are open to conversations about sexual pleasure or lack thereof, they're able to really get a good sense of the behaviors that patients are engaging in. For example, if a patient tells me as a provider that they're having anal discomfort, then I'm able to kind of see that as maybe a possibility that they're engaging in rough anal sex or anal fisting. And then I can talk with them about ensuring that copious lube is being used to prevent those things from happening.

**TERRENCE:** Leo, you just laid out a lot. In the back of my mind, I'm thinking this is awkward content. As a provider, are there strategies to have conversations with Shawn or anyone else that might come into your clinic?

**LEO:** There are multiple best practices that providers can use for sexual health conversations. The first is to normalize sex. I often say to my patients, "Sex is normal. Sex should always be consensual and pleasurable." I make the point about consensual and pleasurable because we know that intimate partner violence occurs in Black MSM. I want to ensure that those men know that it's a standard that sex should always be consensual and pleasurable.

It's also important for providers to normalize sexual health conversations. These conversations can be jarring for patients if there's not a natural segue into this conversation. Just given that these are questions that are very private and personal, and patients may not be readily comfortable answering. So, I generally will say to my patient, "These are questions that I ask every patient.”

It’s also important to focus on sexual behaviors over sexual orientation as I've discussed. No judgment or blanket generalizations. Now, this piece is extremely important. I've seen it many times with patients who come back to my STD clinic where I work. After I’ve started them on PrEP and referred them to their primary care providers, they come back and say that their provider had said something like, "You should just use condoms. If you just used condoms, you'd be fine. You don't need this PrEP."

It's really damaging to relationships when we judge patients, and we also know that those judgments don't always lead to patients taking on our recommendations. So, we should avoid judgment or blanket generalizations.

We also need to get rid of any fear-based language. Fear-based language isn't needed for one reason, because a lot of Black MSM have heard and seen people in the community who have seroconverted, who've become HIV-positive. That language isn't needed in this community or is it ever needed. So, avoid fear-based language.

And last but not least, educating patients. We really want to educate patients on the diversity of the HIV and STD prevention portfolio. That includes in addition to condoms, PrEP, or pre-exposure prophylaxis. It also includes treatment as prevention, which is the process of an HIV-positive partner taking treatment to decrease their viral load to undetectable levels, thereby protecting their partner and increasing their own health outcomes.

When we talk about educating patients, we have to ensure that we are being patient-centered. That's a term that was coined by Snowden and colleagues a few years ago. It's really focused on having a conversation with patients about the risks and benefits of their sexual practices, and then allowing them to make the best decision for themselves. We have to remember patient autonomy. It's our role to educate patients and then allow them to make the best decisions for themselves.

If we have these open conversations, then we're really able to continue to put in those messages that are important sexual health prevention messages. Whereas if we do any of these other negative practices, like judgment or fear-based language, we risk not being able to have those conversations with patients.

**SHAWN CASE STUDY V-BLOG 3:**

*What do you call someone who got HIV in the ‘80s? A victim. What do you call someone who gets HIV in 2017? A fool.*

*I got Chlamydia AND HIV. Wish I could say I was surprised.*

*They said my viral load was 50,000 and CD4 count was 700.*  *I don’t know what that even means.* *Doctor says he wants to wait on treatment*.  *I don’t know what I should be doing*

*Thank God for Denise.  She said that is unacceptable – un-Christian even.* *She also said: “this is you and this is how God made you and it’s time to take care of you.”*

*She had me make another appointment and is going back with me.* *That’s my Good Judy!*

**TERRENCE:** All right, gentlemen. Shawn is now HIV-positive and so what are your observations about how we navigate Shawn through the HIV care continuum? So, let's start with you, Nathan.

**NATHANIEL:** Well, what I liked about that clip is, you know, first off, the support systems, right? We know people are thriving, are more connected to services, and have more positive outcomes when they have support systems, right?

So, despite the rejection from his family and the faith-based community, he has Denise, right? And Denise, who shares similar faith, is a support system for him, a guide, and willing to be there both physically but also emotionally. So, we see that support system, this newfound support system.

We also see a sort of alignment and building of trust with the HIV tester. Whereas there were missed opportunities by other providers to engage and develop a relationship with Shawn, this tester was able to align himself and build this trusting relationship that has Shawn interested in going back for more care or other types of care.

**TERRENCE:** Leo, you have observations on Shawn's predicament now?

**LEO:** Yeah. One thing I also noticed is that Shawn didn't know what his labs meant. And I think it’s important for our patients to know what their labs mean and to also ultimately know what the goal is for their care. So that he would know, for instance, that the viral load needs to come down to an undetectable level. So, he knows that he's on the same team with that provider and working towards that goal.

**TERRENCE:** Mm-hm. What are your observations?

**QUINTIN:** Well, one of the things that's pretty glaring to me is that when Shawn met with his HIV care provider, he actually decided to wait on therapy.

**TERRENCE:** Right, right.

**QUINTIN:** The thing is, you know, HIV treatment guidelines have been evolving over the -- you know, the duration of the epidemic. And where we are right now, according to the Department of Health and Human Services, the recommendation is for anyone who's HIV diagnosed is just to start antiretroviral therapy as soon as possible.

So, I think that's something that we can talk about, what that relationship between Shawn and his provider looks like. And we'll talk a little bit about that, later in the module. But I think that's definitely key in terms of the provider's recommendation really isn't in line with current guidelines.

**TERRENCE:** Right, right.

**QUINTIN:** So, as we talk about that, you know, we're talking about Shawn and just engaging, Black MSM in HIV care across the care continuum. We want to look at that process of linkage, engagement, and retention. We know that engagement in care actually begins at the testing site. Shawn and his tester had a great relationship that definitely points to how important that is.

We also know that linkage to care appears to be related to that whole counseling, testing, and referral practices, or CTR as we sometimes call it. A great example of kind of how this works and may not work is the Never End Care Project that looked at HIV linkage across five health departments. They specifically looked at a group of young people who were predominantly African-American males under the age of 30 who had to have been diagnosed with HIV within the last 90 days and had NOT had a cd4 count or viral load drawn within the 90 days after diagnosis.

They found that there were experiences of lack of empathy. The participants noted that there was insufficient or incorrect counseling. They weren't given the right information.

We also know that the method of referral actually had an important influence on their linkage outcomes. So, we talk about active referral versus a passive referral. Looking at the Never End Care Project, most of those referrals were passive referrals.

A passive referral really talks about you're at the HIV testing site, and you get your HIV result, and the tester tends to either just give you a telephone number, a card, a flyer, or "Go here for care."

Whereas looking at active referrals, an active referral is a great example of where the tester actually picks up a phone, calls a health care provider, and for the most part, most of those clients walk out with either a card with an appointment or at least the information of where to go.

**TERRENCE:** Some greater care.

**QUINTIN:** Something tangible for them. That's kind of what really is important to linkage. As we move forward and move Shawn through the HIV care continuum, it’s really important to focus on two definitions so we know what we're talking about.

According to the CDC guidelines, or recommendations, and in line with the 2020 measures for the National HIV/AIDS Strategy, linkage to care is defined as that person who's diagnosed with HIV being seen by a provider within 30 days of receiving their diagnosis. When we talk about engagement and/or retention, they're usually used interchangeably, what that means is that the HIV diagnosed person has had two or more cd4 counts and viral loads done at least three months apart. That they have actually seen a provider more than once and are engaged in care, and that repeat is the retention component.

We also know, as we talked -- as Nathan talked about earlier in terms of those factors that affect mental health, there are also some complex multilevel factors that affect a patients’ engagement in care.

Things like age, sex, race, and ethnicity are also important. But other things that are important are access to health insurance, transportation, the social support, self-efficacy and actually resiliency is actually really important. So, when we talk about self-resiliency, we're talking about the ability of someone to inherently navigate those barriers, essentially, you know, the resiliency of being able to bounce back. They've had a negative interaction, but they're able to move forward through that. So that's really important, specifically when we're talking about young Black MSM.

Relationships with the care and support providers are also important affecting how they're engaged in care, whether it's with the social worker, the testing person, the front office provider.

There are also other retention strategies that we actually need to talk about. Things that have been shown to help are the easing of structural barriers. So, we're talking about that availability of appointments, the availability of their provider, having adequate transportation to and from their doctor's appointments.

Social support is also a great strategy to look at retention in terms of looking at where they have social support from their peers, family, friends, whether it's an online social support group or an in-person social support group. Those things tend to improve retention where you have someone encouraging you along.

This creation of what we call a social infrastructure to support patients, specifically Black gay men, or twinning. When we look at the health care site, there's also this mirroring of support services that are also available at an AIDS service organization. Things like food, transportation, housing, social support, and behavioral health are all at least co-located at the health center or also with an ASO or AIDS service organization.

It doesn't necessarily mean that someone has to be physically present, but as the health care facility you have a really good relationship with one or two AIDS service organizations in your community where you can pick up a phone and say, "Hey, I have this person here. They've been couch-hopping for the last couple of days. What housing programs are you aware of that I can kind of link him to?"

**TERRENCE:** So, the goal is really seamless care.

**QUINTIN:** Exactly.

**TERRENCE:** Okay.

**QUINTIN:** And the other thing that can improve retention in the care are incentives. For most people the first thing that comes to mind when we're talking about incentives is something financial - in terms of giving them, you know, a gift card or a cash card or a voucher.

But there is also the idea of broadening this idea of what incentives are. So, yes, gift cards, food vouchers, grocery coupons, gas cards are all great, but other incentives can be some of these emotional or support services.

Something that I do with some of my patients who are definitely newly diagnosed, I like to see them on a monthly basis kind of just to touch base, make sure that everything's going okay. And as we are moving through, if they're doing well, we talk about their adherence. "So, you've taken most of your meds this week. Okay. What are your numbers looking like?" As they start to improve their care, I can start to spread out their office visits. Or I do just even little things of, you know, when I come into the exam room and I see them, we celebrate kind of what's happened.

**TERRENCE:** Yes.

**QUINTIN:** Especially those patients who've had difficulty when they get to that undetectable, I've given them just a hug, a sticker, things like that. Those incentives are actually important. So, it doesn't necessarily have to be financial.

And also, there's the social enablers, in terms of looking at those programs that involve peer navigators, retention specialists. All of those can actually help to keep, you know, patients like Shawn in care.

Another thing that we want to actually talk about as we move Shawn through each step in the HIV care continuum, is the provider wanting to delay therapy. You know, that prescription of antiretroviral therapy is necessary point to achieving viral suppression. So, we definitely have to talk about that.

And we have to talk about some of the protective factors that contribute to achieving viral suppression and adherence. We'll talk about some things specifically for Black MSM because that's a group that we actually really don't conveniently study. When we talk about protective factors, again, social support, resiliency comes back again.

Thinking about achieving viral suppression, how can we continue to motivate patients to remain virally suppressed? What are some things that we can do to kind of push them along and motivate them? Again, it goes back to that provider-patient relationship and also the relationship with other people in the staff.

Where I am in Atlanta, talking to our patients who are getting undetectable, I'll share that information with the pharmacist, who has a great relationship with the patient. So, the pharmacist then comes out and says, "Good job. You've done this. You know, you've been working really, really hard. You finally got here." You can actually use that ongoing motivation, not necessarily from the health care provider, but using those other support services that you have present.

What specific tools for adherence that have been proven to work? That's a very new area for study. We've looked at things that could potentially improve adherence in terms of looking at tools from electronic pill monitor- -- monitoring, pill bottles, telephone reminders, electronic pagers. One thing that I actually do with my patients is have them take out their smartphone in the office with me and, "What time do you take your medications?" And I have them set an alarm every day. And it doesn't necessarily have to say "Take meds" but it's like it can be any type of creative statement that they know what that means.

**TERRENCE:** Because they all have a phone.

**QUINTIN:** Yeah, exactly. They all have a phone. And sometimes I have to have them put it away when I'm seeing them in the exam room.

So again, when we're talking about that relationship and achieving viral suppression, it's very important that we have guidelines. There are things out there that help us make these decisions. Again, looking at Shawn and his interaction with his health care provider, we have to restate that the current DHHS guidelines really state that we should start antiretroviral therapy as soon as possible.

**TERRENCE:** Excellent. So, opportunities for both the patient and the provider.

**QUINTIN:** Right. And again, you know, to the last point, we know that providers play a significant and major role in retention to care. Appointment adherence in patients, that actually has been correlated with the patient's opinion that the practitioner actually listened to their concerns in terms of the patient comes in with their goals for the visit, but the provider has their goals. You have to figure out how to meet at least halfway within that 15 to 20-minute office period.

They found that appointment adherence actually improved when practitioners actually explained things in a way that individuals could understand, and used language and terms that they know what they mean. A lot of times we as health care professionals get so caught up in what we do that we find ourselves using these clinical terms that our patients really don't understand. But, you know, something as simple as understanding what top-bottom versatile means. In terms of talking about sexual activity, rimming, fisting, using that language and being comfortable as a provider, you can convey that comfort level to your patients.

The patient’s trust in their practitioner is very important, specifically in Black MSM in terms of they've kind of gone through this part of their developing identity, where they didn't share what their feelings were with other people, whether it's family or in Shawn's case his church. But if you're able to share that with your provider and build that trust in that relationship, that again improves their role in retention.

What negatively contributes to adherence, or at least to patients not staying engaged in care, is there are providers who don't answer questions or address doubts. You know, if you have a patient who says, "Well, why are you prescribing this medication as opposed to this medication?" and the provider's response is, "because this works," isn't really sufficient. You know --

**TERRENCE:** Yes.

**QUINTIN:** Young Black MSM and Black MSM, in general, actually want to be active participants in their health care, and we have to help providers understand that.

**TERRENCE:** So, Quintin, I actually appreciate you acknowledging the sort of deviation from the provider in terms of treatment. I'm really fixated on that, and so I'm wondering, Leo, if you can help sort of take this home on this point and what might be happening there?

**LEO:** So, as providers, we know that although the guideline says one thing, that there may be other circumstances that cause us to delay things. One reason for this might be that the patient needs help affording the medication and needs to be on a patient assistance program, so that had to be applied for that visit. Or maybe the patient is skeptical about starting medication at that time and wants to talk to a friend who's on treatment or do their own research on the medication before starting. But in some cases, it may actually be due to implicit bias as to why a patient is not started in alignment with guidelines.

**TERRENCE:** So, what is implicit bias?

**LEO:** So, implicit bias is defined as a bias in judgment and/or behavior that results from subtle cognitive processes, often operating at a level below conscious awareness and without intentional control.

A great example of that would be a provider subconsciously thinking Black gay men are less likely to adhere to their medication, or Black gay men are more likely to be lost to care. So, they make decisions based on those subconscious thoughts and beliefs.

There are multiple strategies to check your bias in real time. First, it's important for providers to recognize that we all have bias. Everyone has bias, and if we can recognize that we all have it, then we're more likely to check it in real time.

One strategy for that is consciously affirming our egalitarian goals and considering specific ways to implement them. So consciously affirming that we want every patient to receive equal care, that we want every patient to have positive health outcomes, and then finding specific ways to ensure that that happens.

For example, I would say that I want all of my patients to be started on HIV treatment as soon as possible, unless blank. And whatever those reasons are will be clearly defined, and then I adhere to that to ensure that every patient gets started as soon as possible.

It is important for providers to consider gut reactions to specific individuals or groups as potential indicators of implicit bias. You know, if I'm having a conversation with a patient and just the interaction is giving me pause or bothering me, then I really have to ask myself why is this bothering me in real time and try to work through that so that I'm able to offer the patient the best care possible.

Also, acknowledging and confronting, rather than suppressing uncomfortable feelings and thoughts. I think it's easy for myself and for many people to just try to block out a thought, or sweep it under the rug and move forward. But it's really important to acknowledge that that thought happened so that you can really drill down to why, and it kind of helps you to check your bias.

And it is important to consider the situation from the patient perspective. Providers must recognize that medical mistrust is real, and that it stems from actual events of experimentation and exploitation of Black bodies, from experimentation on slaves to the Tuskegee syphilis study, to the use of Henrietta Lacks' HeLa cells for breast cancer treatment.

This is real, and these are stories that Black MSM have seen in the media or heard about from family members. And sometimes that's brought into the interaction between patient and provider.

It is also important to note that racial injustices, such as police brutality and racist remarks can contribute to medical mistrust and that health care is considered a part of those barriers that keep Black MSM from achieving optimum health care. So, providers have to be able to distinguish themselves from those barriers and help patients overcome those barriers through a few ways.

One of those ways is to establish connections with patients. Real connections. One easy way to do that is to find one thing about a patient that you can identify with, that one thing that when that patient comes in it's your running joke or your running commentary with them.

I have patients who come in and they may say that they're from Atlanta, and I grew up in Atlanta, so I can ask them, "When's the last time you went home?" or things of that nature. So that that way you are establishing a connection, you're establishing familiarity with them.

It’s important to address issues of mistrust head-on when possible. So, when you feel that a patient is not taking a recommendation because they may be mistrustful, having a conversation about the fact that you understand that this may be an area where there could be mistrust, but this is the reason that I do this practice.

This takes you right into normalizing medical practices and procedures, which should be standard. So that you are talking to a patient directly about why you do a certain procedure or a certain practice. For instance, I do colonoscopies on all of my patients because it's recommended at the age of 50 or earlier if a patient has a family history of colon cancer. So, making it -- making it very clear that this is something you do for all patients.

And lastly, adapting a philosophy of full disclosure. So, as Quintin mentioned, it's really important that Black MSM feel completely engaged in their care. Black MSM want to be a part of the care decisions that are being made for them, and with them. It is the way that it should be. So, we want to make sure that we're doing that, and that's a great way to quell medical mistrust.

It's important for providers also to address stigma. First, to recognize stigma. Providers must recognize that there is stigma that their patients may be bringing into the decisions that they're making around their health care. So, there are HIV stigmas, and there are PrEP stigmas, and some stigmas that are combined for both.

There's stigma around disclosure, stigma around telling a person that you are HIV-positive and how they're going to react. Will that lead to violence? Will that lead to rejection? There's stigma around the vulnerability and rejection that you may have in sexual or romantic encounters. There are community perceptions, and those community perceptions can be community as a whole, can be in the Black community, can be in the gay community, or it can be all of those, given that being a Black MSM or a Black gay man is intersectional.

We have to recognize that in all of those areas or a combination of them, a person may be experiencing stigma, and that stigma can affect the way that they engage with the health care system and with providers.

For PrEP, there's a lot of stigma that patients pick up from providers. Lack of provider knowledge or providers having bias against the use of PrEP and preferring condoms and making judgments on patients, as I previously mentioned. And then there are community perceptions and misperceptions and misinformation about PrEP. There are community members who think that Truvada is only used for HIV treatment. So, if they went in the medicine cabinet of their partner or someone that they were dating and saw Truvada there, they would instantly think that the person is HIV-positive, which may not be true. They very well may be on PrEP to prevent HIV.

Lastly, creating partnerships with patients. We see that when patients feel as if you're on their team, and if you feel that they're on a team with you, then you're less likely to see them as oppositional, and less likely to allow bias to get in the way of the care that you're trying to give to them, because you're both working towards a goal together.

**TERRENCE:** So, gentlemen, we've covered a lot of information here today. And so, what are your final take-home messages? If I'm a provider having watched this module, what are the one or two things you'd want to hear from each of you around the topics that you discussed. Let's start with you, Nathan.

**NATHANIEL:** Certainly. I think for me the real message here is to, you know, take advantage of every face-to-face visit with a patient for an opportunity to engage them in dialogue, engage them in assessment around behavioral health and mental health concerns, and really incorporating that into practice through the life of the patient and provider relationship.

When I look around here at our panel, I think, "Wow! This is -- this is the Dream Team. This is integrated care right here at its finest.” We have behavioral health. We have primary care. We have infectious disease specialty. We have all these doctors here together working for, you know, patient well-being, patient health, and patient safety.

And I think that's really what the goal is in health care, right? So, I think overall that would be my message for our providers that are watching the segment.

**TERRENCE:** Let's go to you, Quintin.

**QUINTIN:** I think as we talk, or think about Shawn, as we kind of take him through the HIV care continuum with his diagnosis, I think, you know, the effect of transmission of accurate information is really important. Whether it's from the testing center and linkage to care about what to expect from that. From prescribing antiretroviral therapy with his doctor and understanding what that means, and making sure that he's actually getting really accurate and reliable information and it's transmitted in a way that he understands.

**TERRENCE:** Mm-hm. Finally, Leo.

**LEO:** So, I have two main wrap-up takeaways. The first one is that it's important for providers to lead with pleasure when having conversations with patients about their sexual health. If they lead with pleasure and employ some of the best practices that I mentioned, then they'll be able to deepen the patient-provider relationship and provide comprehensive health care to patients.

The second takeaway that I would mention is that there are many, many things that are happening in patient-provider relationships that aren't being said. There can be implicit bias on the side of the provider, and there can be medical mistrust and stigma on the side of the patient. So, it's really important for us to know that those things may be in the room, as well, and to be able to address them in real time.

**TERRENCE:** And as you say this, I just want to take us back to really why we're doing this as part of His Health. It really is about switching the narrative, and it's about bringing the patient and the provider together so that they can have a holistic relationship that really gets at what we're ultimately trying to do, which is to better the health outcomes of Black MSM. So, thank you all for joining us today.

**ALL:** Thank you.