

Black & LGBTQ+: At the intersection of race, sexual orientation & identity

On June 24, 2021, the Advisory Committee on LGBTQ Issues and Minority Affairs Section held a webinar featuring a panel of experts who shared information and insights about the health and well-being of Americans who identify as Black and LGBTQ+.

About the webinar: Black & LGBTQ+: At the Intersection of Race, Sexual Orientation, and Gender Identity

About 40% of LGBTQ+ adults in the United States are people of color, including 12% who identify as Black. A recent report by the Williams Institute offers demographic data and key indicators of well-being, including mental health, physical health, economic health and social and cultural experiences, for adults who self-identify as Black and LGBTQ+.

A senior scholar from the Williams Institute and a panel of physician experts share information and insights about the health and well-being of Americans who identify as Black and LGBTQ+.

Speakers

- LeAnne Roberts, MD, member, AMA Advisory Committee on LGBTQ Issues
- Bianca D. M. Wilson, PhD, Rabbi Zacky Senior Scholar of Public Policy at the Williams Institute
- Maya Green, MD, member, AMA Advisory Committee on LGBTQ Issues
- Christopher Harris, MD, FAAP, chair, American Academy of Pediatrics Section on LGBT Health and Wellness

Transcript

Dr. Roberts: On behalf of the American Medical Association and our Minority Affairs Section and Advisory Committee on LGBTQ Issues, welcome everybody and good evening. I'm Dr. LeAnne Roberts, a member of the AMA Advisory Committee on LGBTQ Issues, where I serve as the GLMA representative. And in the past, I've served as the Medical Student Section for the AMA. I practice obstetrics and gynecology in the quad cities, serving patients on the Illinois and Iowa border. I'm pleased to be joining you and our speakers today, as we explore the intersection of race, sexual orientation and gender identity, and what that means for the health and well-being of Americans who identify as both Black and LGBTQ. Our AMA strategic plan to embed racial justice and advance health equity sets forth a dedicated, coordinated and honest approach, and recognizing that getting to equity and justice means centering and integrating the voices and ideas of the historically marginalized, and leveraging change via relationships and networks, data and research, communication, education, and policy and advocacy.

Recognizing that we all come to equity and justice with potentially different life experiences and levels of understanding, our discussion this evening includes data and demographics, experiences and voices and openness and authenticity.

To lead our discussion, I'm pleased to introduce our panelists. Bianca Wilson, PhD, is the Rabbi Zacky Senior Scholar of Public Policy at the UCLA School of Law's Williams Institute. Dr. Wilson's research focuses primarily on system-involved LGBTQ youth, LGBT poverty and sexual health among queer women. In addition to multiple peer reviewed and institution published reports, she co-edited a special issue of the Journal of Lesbian Studies, that featured a multi-disciplinary collection of work on health and other topics from the perspectives of Black lesbians in the United States, Caribbean and South Africa.

Maya Green, MD, MPH, is a fellow member of the AMA Advisory Committee on LGBTQ Issues, and is the Howard Brown Health Regional Medical Director for communities on the South and West sides of Chicago. Dr. Green is a proud South side Chicagoan, a former private and public school educator, and a family medicine and HIV medicine specialist. Her client panels include pediatric and adolescent patients, adults who speak Spanish and American sign language, and people who experience substance use disorder. Dr. Green established the first COVID-19 testing centers on Chicago's South and West sides, and continues her COVID work in five citywide vaccination sites via a mobile unit. Dr. Green is the founder of HIV Real Talk and is a board member of the Chicago Task Force Prevention and Community Services, and the 5:30 Scholars Program.

Christopher Harris, MD, is a pediatric pulmonologist from Boston. Dr. Harris is a founding member and current chair of the American Academy of Pediatrics section on LGBT health and wellness, and has

been an active leader in the organization's clinical workforce and equity efforts. He is a past president of GLMA and was a member of the commission to end health care disparities. Dr. Harris is a long-time advocate for LGBTQ patients, parents and their families, working to advance legal recognition and support an end to illegal discrimination in adoption and foster care systems. Dr. Harris is actually wearing two hats tonight and doing some double duty. He actually is at an American Academy of Pediatrics Pride Month event that he is leading. So he will be kindly joining us when he is available for our discussion.

We'll be leading off with Dr. Wilson's presentation and follow with a panel discussion, including Dr. Green, Dr. Harris, Dr. Wilson, and of course your very own questions. Please submit your questions, thoughts, insights via the Q&A function on your Zoom panel. We'll be monitoring them and we'll share them with the panel for discussion. With that, I'll turn it over to Dr. Wilson.

Dr. Wilson: Hi. Good evening, everyone. Thank you, Dr. Roberts for the introduction, and for the AMA for the invitation to present to you all. I'm going to go ahead and share my screen, so you could see the PowerPoint. I guess someone let me know if that looks off, otherwise I will move ahead.

So I'm pleased to present today just a very brief overview of a report that we finished just this year on Black LGBT adults in the U.S. Again, I work at the Williams Institute, which is an LGBT law and public policy research center that really has kind of filled the role of providing demographics and other type of large-scale survey data often, but we also do some qualitative studies as well that help inform public policy discussions about the lives of sexual and gender minorities, and also just about the role of orientation, gender identity, and the law. So the Black LGBT Adults Report is really an updated report of a similar type of brief that we did now maybe eight or nine years ago, and brings in new data. And I completed it with my colleagues, Soon Kyu Choi and Christy Mallory. So just an overview, but obviously if anyone has questions about other elements of the report, happy to get into that as well.

One of the things we identified and here, we primarily use data from the Gallup Daily Tracking Poll across ... So pulled several years of data together. And from that, we get an estimate that there are approximately more than 1.2 million adults in the U.S. that identify as both Black and as LGBT. What I think is also striking about a map like this, showing where Black LGBT adults are, is that you see they're essentially where Black non-LGBT adults are. So this is a community, a population, that's dispersed across, distributed across the U.S., and largely is where other Black folks are. I think outside of like a slight trade-off maybe, between the South and the West coast, it's important for folks to remember that, when we start talking about LGBT folks, including Black LGBT folks in particular, we don't all of a sudden just start talking about New York, Chicago, and LA, and San Francisco, that really are talking about folks that are across the U.S.

So a little bit about the sample. Just who are Black LGBT folks in terms of our demographics? I mean, one thing to keep in mind is that this is a population that skews young, and that's the case for all LGBT groups, and it is no different among those who identify as Black. This is important to keep in mind that,

when we think about experiences with discrimination and reported rates around health and education, we have to keep these kind of overall population demographics in mind. Of course, when we actually review some of the health conditions, we do control for this element of what we know in terms of how the demographics are skewed.

In terms of education, we see that, while overall, it appears that LGBT and non-LGBT Black folks have similar rates of education, like say attaining a college degree, that's driven a little bit more by the similarity in rates between Black men for LGBT and non-LGBT. We do see among Black women, Black LGBTQ women, a lower college education rate compared to Black non-LGBT women. And I think this is an important context when we later talk about economic instability.

A little bit more about the demographics of the Black LGBTQ population. When we look at kind of where folks are living and what their living situations are and parenthood status, we actually see, again, some areas where there's similarities, but also some differences related to gender. So if I was just going to show you like an overall table of urbanicity, or whether or not people lived alone among Black LGBT people, I would be saying Black LGBT folks are more likely to be in urban areas. But here you see, that's really driven by the statistic for Black women. It's slightly higher to significant, even though it's slightly higher. And Black LGBTQ folks are more likely to live alone, but that's driven a little bit more by the rate among Black men, that black LGBT men are more likely to be living alone than Black non-LGBT men.

In terms of relationship status here, we see, and not surprisingly given we know about LGBT populations overall, that LGBT folks are more likely to not be partnered, less likely to be legally married than non-LGBT folks. And that was consistent across gender groups.

Now what's interesting, in terms of parenting status and whether or not folks have children, is that as a whole, Black LGBT folks appear to be less likely to be parents, less likely to have children in their home than non-LGBT folks. However, this is most driven by Black LGBT men. In fact, Black LGBT women have similar rates of parenting, 44 or 45%, as non-LGBT women. And that's also really important context when we move on to talk about economic instability and other types of vulnerabilities with regard to health and social status.

So getting to one major measure of economics stability here is whether or not folks are living with a low income. So what I mean by this, in this case, is that here, we're looking at the federal poverty line, but not just at the federal poverty line. This is actually the 200% federal poverty line. So generally when we talk about the federal poverty line, many of you, I know, know this, but just to recap, it's really a formula that looks at both how many folks are living in your home and how much income is coming into the home. The federal poverty line, what we call the 100% federal poverty line, is quite low. So here, this is an estimate of even well, who is at the 200% line? Which is about equivalent to four people living in a household making less than \$50,000. As you can imagine, that is still a very difficult level of income to live under and be supporting for people.

So we see here that Black LGBT folks, as a whole, are more likely to be living with low income compared to Black, non-LGBT people. And this is particularly heightened among women, but still the case among men. And I think this is significant in that, excuse me, that when two years ago, we published at the Williams Institute, my colleagues and I published an update on LGBT poverty overall. And there is a narrative that when you look at Black ... I'm sorry, when you look at gay and bisexual cisgender men, you don't see high poverty rates. But when we looked specifically at race, we do see that impact of LGBT status among Black men, and we see a higher poverty rate, that is the 40 versus 44%. While it may not seem like much, it is statistically significantly different.

So also an important context when talking about really Black LGBTQ folks, is that the intersection of multiple forms of social statuses that experience oppression are their experiences with discrimination. And here's just one way to measure that and think about that. We asked a question about, and this is not using the Gallup Daily Tracking Poll, but instead using a representative study of LGBT people through an NIH funding, we asked about whether or not they'd experienced discriminatory events. And here you'll see, this is not significantly different. And I think the similarities are important to point out, too, that at least at the level of it at least one discriminatory event, about 80% of Black folks, whether or not they're LGBT, report experiencing that. And I think that's an important context to consider.

When looking at physical health conditions, there are a few areas here where LGBTQ folks experience higher rates and others where they don't. In terms of asthma here, heart attacks, but that's driven by the rate among men, and cancer were reported at higher rates among Black LGBTQ folks compared to non-LGBT folks.

Also, an important measure of health is our mental health. When the sample was asked about their experiences with depression, we do see here significantly higher rates of reported depression among Black LGBTQ folks versus not. And this is regardless of gender.

So moving from health outcomes to health access, one kind of major indicator of health access is whether, and really brings in the economic stability component, is whether or not folks are recipients of Medicaid, meaning that they rely on a public benefit system in order to receive some level of health care. We do see that overall, Black LGBT folks are more significantly likely to be Medicaid recipients. And the reason I'm showing you this chart in particular is that, again, you see that while, say, Black men might not necessarily be more likely to ... Black LGBT men might not be more likely to be poor than Black LGBT women, the significance of being a parent, so also that men, Black LGBT men tend to not parent as much as Black LGBT women, yet for those who are parents, they are more likely to be Medicaid recipients compared to their non-LGBT counterparts. So basically, Black LGBT men who are parenting are experiencing this kind of combined health access and economic instability issue.

Also, mirroring that, a more straightforward measure of health access is whether or not folks are uninsured. Here, it's really Black LGBTQ women are the ones who report, at a higher rate, having no form of insurance, compared to Black, non-LGBT women.

And a final chart that I'll show you just for this quick overview is whether or not folks report having a regular health provider. Or here, I think the question was actually a private personal physician. What's interesting here is actually this interaction with gender, that while overall, Black LGBT people are less likely to report having a regular health provider, that's actually driven by women, and Black LGBT men are actually more likely to report having a provider.

So this is an overview of the highlights. Among Black adults, LGBT folks are similar in a lot of ways to those who are not LGBT, in terms of parenting status, education, overall health rating. I didn't show a chart here, but also reports of trouble with the police or the law, but different in several, more economic instability, a few areas of higher health issues, lower BMI, but more heart disease, asthma and cancer, and more likely to be uninsured and using Medicaid.

So I will stop there, since my goal was just to provide context for our excellent panel, and to hear how they reflect on many of these findings in practice.

Dr. Roberts: Bianca, thank you so much for sharing this important look at the complexity of intersectionality and the effects on health and well-being among Black LGBT-identified adults in the U.S. Your work really shines a light on the many layers of inequity that Black LGBT adults experience every day across our country. Our AMA equity efforts are rooted in the wisdom and expertise of communities and in shared learning available to us from evidence, knowledge and personal and professional experience. So let's hear from our panelists. Participants, please remember to submit any questions that you may have to our Q&A function. For our panelists that are here tonight, in your clinical experiences, how do you see the impact of some of the stigma and stress data showing up in the health issues of Black LGBTQ folks?

Dr. Green: Hi, I'll go ahead and take that one. Thank you, Dr. Wilson and Dr. Roberts. It shows up in a lot of ways that Dr. Wilson mentioned. But also, every time I see it, I see the context. So think about what was going on in the rooms when the country, the Constitution was written, right? We're here to talk about race, sexual orientation, gender identity. There was, in that room, signing things, one race, one sexual orientation, one gender. And everybody who has been chosen to lead this country since then, except one time, right, 46 times, because President Cleveland got voted in twice, but 46 times we have chosen one race, one identified sexual orientation, and one identified gender.

Now, while we know those things may not necessarily in a person's personal life, be true, we acknowledge, too, that in this country, we have been guided to oppress anything except for that one race, one sexual orientation, and one gender identity. So what that looks like when a patient walks in the room is, continued strategic forms of oppression, like poverty, like lack of access to care and things like that. That's how things that started centuries ago play out with my patients, even today. What it looks like is, if we're going to be honest and authentic about delivering health care, we have to insert equity all along a person's identity, gender, lifespan, the same way, every day when that person gets up, for centuries, right? We have in this country created a construct where the norm was one

thing and everything else was suppressed.

So that's the mental wellness of my patients, kind of supporting that, supporting even the thought that the person has, the right to life, liberty, and the pursuit of happiness. That is wellness, not just me writing a quick pill. That is what wellness looks like. Because remember, when that one race, one orientation, one gender wrote that they should have the right to life, liberty and the pursuit of happiness, that's exactly what that meant. It meant for that one race, one orientation, one gender, not life, liberty and the pursuit of happiness for all. So what it looks like delivering health care is working in that and encouraging someone to even believe that they also have the right, so that's where we start. I can go on and on about it, but I definitely want to make space for the other panelists, if they want to share.

Dr. Roberts: Dr. Wilson, did you have anything to add to that from the data perspective?

Dr. Wilson: When thinking about clinical practice, I mean, one of the things that stand out for me that I'm curious for those of you who are engaged in the day-to-day practice, but one of those data points that stood out for me is kind of that juxtaposition of, for Black LGBTQ women in particular, around whether or not they have a provider. I know from another report that we did recently, looking at LGBTQ women overall, and that was trans inclusive, again, their report being less likely to be accessing our LGBT health research centers.

And I'm just wondering if there's any connection around that, like if that's part of why I'm seeing this data point in one place showing less likely to have a regular provider, for example, compared to LGBTQ men. And then seeing similarly in the other, in our Women's Report, being less likely to go to LGBTQ centers in particular. And just wondering if, so thinking about that intersection around just practice and care. That's something that stands out for me that I'd be curious what you all thought, too.

Dr. Roberts: Sure. Well speaking of that ... Well, I was going to segue into a question specifically regarding LGBTQ women. Are there some concerns that are particularly impacting Black LGB women, whether they identify as cisgendered or transgendered, regarding some of the data points that we've seen?

Dr. Green: Definitely. And any other panelist, I can't see, so please chime in. Definitely. I mentioned mental wellness. And if you look, so let's just start, Dr. Wilson, with imagining what historically has happened to Black women. Because the issue is, layers on top of layers on top of layers of this franchisement and being overlooked and underserved, right? So let's just take off one layer, and this is an intersection of them, right, so let's just take off one layer and looking at what has happened to Black women in the medical industry historically.

And we can trace it all the way back to Henrietta Lacks, things that have been done. The book that we learned medicine from, Netter's Anatomy, let's talk, and look at the harm that has been done to the

bodies of Black people and Black women, and bring it all the way to, I usually use the example of Serena Williams going in the hospital saying, "I can't breathe. I'm in pain." And they're like, "No, you're not." and look at the literature out of, I think it's University of Virginia, health care providers literally believe Black women are in less pain than other people when they tell you they're in pain.

So now, imagine going into a health care space and saying, "Okay, I want to talk about all these things," just basic care, and then wanting to walk in liberation of your whole self, sexual orientation, gender identity, that kind of thing, that we haven't even broke the barrier on just basic health care and pain. And so look at the infant mortality rates, maternal, you know this, Dr. Roberts, is just not, we're just not there yet. And to speak to what happens when a center is LGBTQ-focused, a lot of the evolution of these centers came from the HIV-AIDS epidemic, which was geared, really initially, to serve non-Black gay men.

And so as we evolve, kind of look at the underlying, and that's why I brought up the structure in the country, as we evolve, we have to think about what our norms are here, right? As we knew that more African Americans were dying of HIV and less white people dying of HIV, or white gay men, the funding disappeared, the awareness disappeared, the normalization disappeared, a lot of things disappeared. But the health care center itself promotes this, and can continue to provide a certain standard of health care. And now I am not a man, I don't identify as gay, and I'm African American or Black. And so historically, just like we, again, I mentioned these sound like norms, and it seems when I bring up the Constitution and who was in the room, it seems disjointed, but literally every four years we say our norm, our leader, what we see, except for one time, so 40 out of 46 times. One time, we did something different. The same thing exists for the health care industry.

What I love is that slide that you showed, where more people are publicly identifying. You showed a slide where, hey, it's the youth. Well, I think there are factors also that play into that, where maybe the youth before were ... They were there. I don't think the number actually changed. The number of people who felt walking liberation to have that conversation has changed. So we're getting there. But yeah, I'll stop right there, because I see our other wonderful panelist joining us, and I definitely want to learn from everyone here.

Dr. Roberts: Sure. I do have one comment that you had brought up, Dr. Green regarding maternal mortality and maternal health. And the really big hot topic in the United States is birth equity and maternal mortality and morbidity amongst African American women. The interesting thing is, as an obstetrician gynecologist that I certainly have seen is, there really is a lack of data regarding information about women or individuals who identify as gay, lesbian, bisexual, transgender, that are choosing to conceive and give birth, and their experiences and layering that information as we're looking at birth equity in the African American community as a whole, and how important is to get that missing data point, so we can better serve our patients going forward.

I do want to give a shout out to our other panelist who has joined us. So we have, Chris is now here. And Chris, we did have a question regarding some of the data points that were brought up, as Dr. Wilson has discussed, these data points regarding demographics were mostly in adults. So we definitely wanted to get your input, Dr. Harris, regarding, how, if you and other pediatricians see similarities or differences among youth who identify as Black and LGBTQ, if you are aware of those?

Dr. Harris: Certainly, thank you so much. And again, I apologize for being late. It's June, it's Pride. I'm hosting another event for the American Academy of Pediatrics over there, on that computer, and coming over to this computer for this. So very glad to join and offer whatever insights that I might come up with.

I think one of the concerns for LGBTQ youth, especially those of color, relate to perhaps difficulty for many families accepting the sexual orientation or gender identity of their young person. And that can lead to significant problems in the family, in the home, leading to children becoming homeless, or having other significant social difficulties, again, that we know that can lead to adverse childhood experiences, and that can have many downstream consequences for life for the young person.

Dr. Wilson Am I okay to add to that?

Dr. Roberts: Of course.

Dr. Harris: Please.

Dr. Wilson: Yeah. I mean, I think it's really important that we bring up the issue of how LGBT youth are experiencing kind of that anti-LGBT bias in their homes and in the various settings that they're operating in. So it's interesting, like the report that I gave is a very much right now set up as Black LGBT versus not. So it's really about the impact of LGBT status, in many ways, enhance intersectionality in some ways. But there's really looking at what's going on relate to LGBTQ status. But when we think about youth, and there's a lot there that's really about race.

Like, some of the other stats related to Black LGBT youth is incarceration. Among youth who are incarcerated or in detention, over two-thirds are sexual minority girls. So among girls, over two-thirds are sexual minority. Eighty percent of them are youth of color. And the thing is, even though we can trace maybe the ways that it might be about LGBT status, they're actually, in many ways, also in line with an over-surveillance of Black and Brown communities and American Indian communities. And we see those similar high rates among foster youth, that again, yeah, LGBT youth are over-represented in foster care, somewhere between 20 and 30%. Most of them are youth of color, but LGBT status alone is not what's driving them into that system, because they come in before their LGBT-identified.

So I think it's like there's some really complicated ways to get at some of the issues of the way white supremacy is operating, that Dr. Green raised, that combines with what Dr. Harris was also saying, for

thinking about the experiences of our LGBT youth that are queer and of color.

Dr. Green: I think, too, in our society, there is a drive. So when we talked about one race, one sexual orientation, one gender identity that we hold as the status quo in this country, or the standard in this country, anything that's the other, we almost demonize, fear, and then we want to put in a certain place in control, even in ourselves, right, anything that's the other in ourselves.

So that strategic form of oppression shows also in social determinants of health, things like that, it comes out in so many ways because it's so ingrained in us. It's like certain things we're trained to do, you wake up in the morning, you brush your teeth, you do the things you do in that order. And it's the same way we are trained in this country, as a society, kind of to operate. So as that person may not identify as sexual orientation-wise, the over-policing, the over-monitoring people of a certain race, people of a certain gender, and people have a certain orientation, still goes on.

So one of the things I think Dr. Harris, we were talking about before you joined is, one of the things that's kind of the rainbow or the bright side of this is that, as there are more community organizations, as there are more policies that come out to support, as there are more local spaces to support these youth, that's why I think we're seeing that kind of slant, where more people, are being open and walking in liberation. Because remember, if we strategically oppressed a certain group of people, then people that may be existing in that lifestyle or that belief or that identity, they will not acknowledge who they are and they will not walk in liberation, for fear of becoming that other that you mentioned, Dr. Wilson.

Dr. Harris: And I certainly agree. One of the things that we, as pediatricians do is, we care for the child, but we also care for the family. And for a child, family support is key. And if there is any degree of friction, because parents don't accept the child's sexual orientation or gender identity, that can become very problematic. Because again, that is generally the spot that the first support should come from. And again, I think I have to acknowledge it, that because of the church, there are families that have significant problems accepting a child with a different sexual orientation or gender identity.

Dr. Green: Dr. Harris let's get into it. Did you see the look on the faces when you ... I said, "Oh, you want to be authentic today? Okay. It's our month. Let's do it. Okay. I love it." Everybody was like, "Oh, okay."

Yes, absolutely. And I also, if you look at any other space where historically religious organizations have put an other, because of their belief, it is exactly this pattern. So one of the things we had on the back-end, top-end having conversation is, this pattern of ostracizing even our family members, because they don't subscribe or they don't fit a certain pattern that we feel we have to present in community or present in our societies, it creates this big problem.

Look what happened during COVID. Our LGBTQ-identified youth had such a hard time, because before, they could go out and go to these safe places and spaces and spend time with their friends. When the lockdown came, they were like, "Oh, I'm going to shelter in place with my family." And the families began to say, "You cannot be here," even in the face of a disease that was killing our community. They were like, "You can't stay in our home. Our home, can't be a safe space for you, because of how you identify." So we've come a long way, and we have a lot of work to do.

Dr. Roberts: Now, speaking of mental health, what can we do as physicians to advocate for more mental health services amongst youth, to assist our younger patient population and their families as additional supports?

Dr. Harris: Mental health, for children and adolescents, is woefully, terribly under subscribed. I mean, we don't have enough child psychiatrists throughout the U.S. I talk to my general pediatrician colleagues who say that the waiting lists are months long to get children in, and it's only for children in crisis that they can finally get somebody seen, and that means through an emergency department, through a hospitalization. It's a terrible, terrible problem. And I think that we need to increase the number of training slots for child and adolescent psychiatrists. We need to ... increase the number of training slots for child psychologists, also social workers who see children and families. It is a tremendous, tremendous problem, and one that is going to require significant intervention from all of medicine and society to fix, I think.

Dr. Green: I agree Dr. Harris. And then, even for people listening to this call, if you looked at the access points, we talked about earlier, strategic forms of ... Sorry, Dr. Roberts. Were you going to say something? We talked about earlier, strategic forms of oppression. Now, wherever you are, in whatever city you live in, just do the little Google dot locator about all the mental health or mental wellness support access points in your city. Just hold it there. Now, take away every access point in your mind that doesn't serve children. You see how small ... Now, you're like, "Oh." Now map out, put that on top of the poverty, like the demographic, the racial demographic of where people live in your city. Okay, now I guarantee you, wherever you were, you realize that all the strong access points are usually in non-Black and Brown neighborhoods, right?

On top of that, we have to realize that the strong access points need to be increased, and we're not going to build out a bunch of wellness, mental wellness spaces overnight, hopefully we will build them out, but that means our providers, primary care providers, have to study, have to understand, and have to be prepared to walk in that space with that youth. That means, I daresay like Dr. Harris meant, our worship leaders that are going to be affirming to our communities have to be prepared to have those conversations in that youth. And honestly, in the Black family, our aunties, our cousins that know what's going on, but want to keep it their business, "I ain't going to say nothing. I'm just not." No, you have to advocate for your loved one. You know?

So have, like if they're young and they're youth, and they're the kid in the family, and then maybe they can't have such a strong ... the level of strength of conversations with the parent that you can, then maybe you need to step in there and have that conversation with the adult, your sister, your brother who's their parent. Step in the way. Have it. Be an advocate for it. So it's time for our community advocates to come out and realize that the schools, everywhere, if you're a touchpoint, you have to learn and educate yourself and become a stronger touchpoint. That's why I'm glad, Dr. Roberts, you're leading this discussion today and we're doing this today.

Dr. Roberts: Absolutely. This brings up a really important point regarding the fact that there are definitely possibilities, but limitations, in addressing the social determinants of health regarding this community. So what can and can't be done as part of practice? For example, we saw data points that Dr. Wilson brought up of Black gay men who are fathers, and they experience lower incomes and lack of insurance, and how that might impact their children that they're raising. I mean, what can we and can we not do, realistically in practice, to advocate for addressing these issues and social determinants of health?

Dr. Harris: I'm going to have to scoot out. Thank you so very much for allowing me to join this for a moment. And again, I hope that this is just the start of conversations that we have in organized medicine about these topics. So thank you.

Dr. Roberts: Thank you, Dr. Harris for coming.

Dr. Green: Thank you, Dr. Harris. Dr. Roberts, Dr. Wilson, is it okay if I go ahead and respond to that? Thank you so much. Dr. Roberts, I would say we have to realize, like I keep talking about this strategic form of oppression, right, that inequities and social determinants of health are strategic forms of oppression. If I have a grocery store, or if I have a great education resource, I could actually build it out, and the finances to do it, I can build it out in any part of the city I want it, right? And it's not by just coincidence that they're all in some area. We have to realize that addressing social determinants of health: education, access to nutrition, access to job equity, that's part of the wellness program for our communities. That is part of health care. Transfer of wealth is part of health care.

Because if we're going to talk about realistically addressing this, we have to really address the narrative of the life of the communities that these people are going back to. If we talk about, if we look at substance use and things like that, we talk about ... One of the things we always talk about is meth in the male gay population. And we say, "Oh, we have to stop it. We have to stop it. Some people can functionally use it." If you look at that map, people that are functionally using or functionally taking meth are in certain neighborhoods. And we're like, "Why can't everybody do it?" What is their narrative that they're going to go back to? Because some people use these things as a way of escape. We never change the narrative of this person, what the person is going back to, but we want a person to subscribe to our thoughts of what their life should be.

The things we can do to really be intentional about wellness is, do work in the social determinants of health, be more, just like every day, strategic forms of oppression, every day the system does its part, we of the community, every day, we can't get tired. We got to wake up every day and be equally as aggressive about dismantling the inequities that are LGBTQ Black population youth and others are experiencing.

Dr. Wilson: I mean, it's interesting. I mean, I love that Dr. Green went straight for the providers need to get fully involved in dismantling the system. I thought maybe I would just share something that's a little bit more about the interpersonal health care practice. So as a non-practitioner, all I have to offer here is really my own experience. I didn't plan to share this today, but this was so powerful to me that, last year, maybe three months into the pandemic and lockdown at home with three kids, my mom, and both me and my spouse working full time, and all of a sudden I'm cooking three of the meals every day. It was madness, right? And I was concerned like, "Okay, is my health going down?" I'm just anxious. Like, "What's happening?"

I spoke to my physician. So my primary physician is a Black cis, straight woman, that both me and my sister sought out. Like we drive farther to go see her. My sister found her. I said, "Okay, I'm going, too." I just want to put out there that there was something very powerful about knowing that, as a physician, she didn't have the power alone to deal with anti-lesbian bias, to deal with what it meant to be a Black woman working in a predominantly white LGBT space. But when she talked to me about my concerns related to health, she named all those things. And the power of that conversation, of saying, "Look, I know you deal with anti-fat bias, and I know that you don't want to come in. I know you force yourself to come in, knowing that people are only going to look at you in one way, as like a fat Black woman, and not pretend potentially having health. That's something that sits with you." She names those things. "I know what it means that you're at home with a woman for a spouse, and dealing with anti-lesbian bias."

So I put that out there because I actually found such a strength, that someone who tends to be so structurally and policy-oriented, there was something very powerful about that interpersonal connection, and willing to at least name those structural determinants that she might not individually be able to dismantle, but knew that it had meaning in my own health and health care.

So again, I didn't plan to share that, but I'm just putting that out there to the group, that when I think about all of us realize that we have a lane in this overall agenda, and we have a certain skillset, we do the best with what we can do with that skillset. And I thought that was a very meaningful way that she attempted to use her skillset in acknowledging that broader context, but still trying to deal with individual health. I just thought I'd throw that out there.

Dr. Roberts: I think those are really, really powerful points. But I do want to identify something that ... The two of you speak a little bit from a place of geographic privilege, in that the two of you are located in more LGBT-friendly communities, so to speak. Personally, where I'm at, it's a little less friendly in

my community than some of the things that you may have access to in Los Angeles or Chicago. For patients and individuals who are in places like the South, or the true Midwest, so to speak, where the public policy tends to be least supportive of both Black and LGBTQ people, how, in your view, can these public policy challenges be overcome? Specifically for Dr. Wilson, since you are spending time in it from a legal framework, and data collection, from that standpoint, where do you see us making some changes from a public policy perspective, and how can health care organizations really move the needle into a positive direction?

Dr. Wilson: Yeah, thank you for the question, Dr. Roberts. So you're right, and our data reflects that LGBT folks in rural spaces, for example, are more likely to be poor, are more likely to be dealing with, going back to Dr. Green and Harris's points earlier, dealing with religious-based organizations that don't serve them as well, and those are those in rural areas, regardless of whether or not they're Black. So we know that, that's an issue. And that's part of why, as much as at the Williams Institute, we try to aim to provide data that are state-by-state ... so that state-based groups can engage in their advocacy efforts.

It's the same reason why folks are saying you need to pass the Equality Act, or think about federal level policy solutions that do not allow a state cultural-dependent adoption of rights, essentially, for LGBT folks to be what protects them or does not protect them. So it's looking to some of the federal level actions, like the Equality Act, that provide opportunities to not be so dependent upon state or local-based cultures around who has rights and who does not. And when we know that the Bostock decision, last year's U.S. Supreme Court, decision created that at a federal level, but that's only in the employment context. So there are a lot of other settings that are missing, including health care. So I'll stop there and let Dr. Green, and you, if you have additional comments on that.

Dr. Green: No. Well, okay, I do. I liken it to when the pandemic hit, and everybody had to have social distance, and we're like, "Oh, it's a physical distance." And one of my friends who lives in a rural area was like, "Oh, welcome to my world." So yeah, we are sitting in privilege. And I was like, "Oh." Because you never think it's you when you talk about tearing down the powers, speaking truth to power, you never think that, "That means part of me, too." And so, one of the ways that ... And I remember asking her, I said, "Well, since the distance is an issue, and since that opportunity to gather ..." And that's one of the things in the, I've observed, at least in the spaces that I've been, all the way from, I live in Chicago, born, mostly raised in Chicago, I lived some years in Nigeria, but did my schooling in Alabama, in a rural place, not Birmingham, normal Alabama.

So that experience, I do remember how detached I felt until I got acclimated. And one of the things I would do is reach out and find other ways to connect with people. Even though when I was there, email was out, I found being able to write, being able to share spaces and now virtually, being able to do that and organize. And I remember saying to my friends who were in the city, "When you do something, try to do it statewide. Try not to detach from, 'Hey, I'm in Chicago, but you're rural, so I'm

going to set all these rules and make all these pathways in Chicago, and never think to make it Illinois-wise, because it doesn't apply to me.' Never forget about those that, we are connected through, and bound through our experience and struggle of being someone's other." And I think that's important to remember in all our policymaking and things like that. And I think that what, Dr. Wilson, thank you for doing.

Dr. Roberts: Just as a reminder for all the participants, since we are running low on our time here, if you have any final questions, to please submit them to the Q&A chat box. We do have a question for both Dr. Green and Dr. Wilson. "Despite a decline in new HIV infections across the board, Black gay and bisexual men, in addition to transgendered women, consistently account for the highest degree of new infection rates, given their percentage in the population. How can physicians and researchers improve confidence around PrEP for HIV among Black gay men and transgendered women, encourage treatment as prevention among HIV-positive patients, and urge more youth to test early and frequently to significantly decrease the new HIV transmissions and late-stage AIDS diagnosis among queers of color?"

Dr. Green: I think I'll start. Dr. Wilson, you can definitely mention anything I've left out. Two things. In COVID, people are saying, "Hey, now you can go in places maskless." Also, as a health care provider, but as a community member, make sure when I'm in that room with that patient, I am socially maskless. It's like, "Take the mask off," the fact that we're all sitting here, because someone in the time that we were born had sex without a condom, or unprotected. And that's just part of life. I breathe, I pee, I poop. I have sex. If humans didn't have sex, we would die off the face of the planet, okay? So it's just part of our nature, and take care of the whole person, and stop putting that provider mask on and being uncomfortable. Because if I'm uncomfortable with talking about it, certainly my patient is uncomfortable. And stop trying to streamline a patient into a certain lane, making it uncomfortable to talk about all the types of sex that we all enjoy.

The other thing is, make ways for people who are not yet ready. So if I'm saying, "Hey, I'm going to prescribe PrEP for gay men all the time," then men who may experience and love and sex with men that don't identify as gay, then think PrEP isn't for them. No, PrEP is for people who live and love. Testing is for people, HIV screening is for 13 to 65, and included all your stuff. If I'm going to screen you for diabetes, I need to be screening you for your sexual wellness, too. And stop putting labels on something that's part of our human culture and where we are, and it's just part of science. I hope I answered the question. Okay.

Dr. Wilson: Yeah, definitely. I mean, the only thing I would, excuse me, add to that is, excuse me, I was part of ... This is what happens. We're back out in the real world, I already have a cold. Colleagues of mine here at UCLA in social work and in the HIV Policy Center, we did a project, and intervention a couple years ago, that said if we're really talking about the fact that the HIV epidemic has followed Black gay and bisexual and other men who have sex with men, in ways it seems like all

over the world, again, be about a lot of these social determinants, experience with discrimination and poverty.

And so the intervention was really targeted at, let's talk about making sure health care providers are connected to legal services, so that when they're getting kicked out of their homes, when they're dealing with employment discrimination, kind of connecting to those social and legal services that are actually designed to have an impact on these social determinants, that physical health and mental health providers cannot necessarily directly do. But it was about getting them connected to that wraparound care, and not just within the HIV centers that have the wraparound care, but getting providers more broadly connected, so that some of those social determinants that probably best explain why we continue to see those rates among our Black gay and bisexual cis men and trans women, start addressing those things more directly.

Dr. Roberts: And I think, too, it's also really important for health care providers to do the work and figure out what types of patients they may have that would be candidates for PrEP therapy, getting comfortable administering PrEP therapy, and asking the questions that you need to ask to figure out if your patient is a candidate. I know in my own practice, I really had to take a look, because I was mostly prescribing PrEP therapy mostly for victims of sexual assault. But I really had to take a look and look back at a lot of my cases where I figured that there were people that I missed that would have been candidates for PrEP therapy, had I offered. And so it's really trying to get that mindset of looking at your patient population and being comfortable with having that discussion with them.

Someone from our audience has asked, "How would we go about finding pediatricians or any other health care providers that are open to medically transitioning individuals who identify as transgender, especially children or adolescents?" Because that is a huge barrier to care, I would assume in any location, but especially in more rural locations, and how to go about finding folks that may be prescribing PrEP therapy, as well, if you have any input.

Certainly I think that if, for this participant in the audience, certainly if you are looking and Googling to find gender-affirming care in blank city, so if you're in New York or Chicago or Miami, if you type in gender-affirming care, there's usually some pop-up of some individuals that may be providing gender-affirming care in your community. You can always probably check with your local LGBTQ center. Usually they are right on the pulse of things regarding who's providing care in your communities, if you're having difficulty finding practitioners that are providing gender-affirming care.

Dr. Green: And then, thank you, Dr. Roberts, I would also say social networks are good, right, whether they're virtual social networks, Facebook, things like that. You can look for gender-affirming care groups and then kind of tease it out from there. I would say, definitely call and make sure the clinic is there and things like that, if you go the social network thing. But in different communities, in different spaces, people know who can offer it. Now we have virtual access to it, things like that.

The other thing I really wanted to talk about is, when you think about, and I know we're over time, but I like to take the label, like the labels off of PrEP, like Dr. Roberts is doing, kudos to you. Because HIV is a virus that impacts the immune cells, I mean, the immune system of humans. It's not a gay or ... It doesn't have that label.

And every time we try to put certain labels on stuff, then it gets us every time. We tried to put labels on COVID, it got us. So being able to do what exactly what you did, Dr. Roberts, and say, "Hey, this access may be for everybody." And consistently, it's a journey. Our practice is a journey, right? In five years, in five months, I'm going to reevaluate something, and see how I can improve. So I just want to give kudos to you, Dr. Roberts for saying that. That was powerful.

Dr. Roberts: Yeah. Thank you. We were just notified that the American Academy of Pediatrics and Children's Hospital Association can also help identify gender care providers. So that's another great resource for that.

I do have one last question. I know we're a little over time, but if our panelists don't mind asking this, answer this one last question. So, "Based on your experiences and observations over the past year, what would you say is the most pressing challenge and most promising opportunity for the health and well-being of Black LGBTQ Americans?"

Dr. Green: Is it okay if I go first, Dr. Wilson? I think the greatest challenge is somehow thinking we've arrived. We've done a lot of work, yes. Kudos to that. As we say in my community, no shade to the work we've done. We've done a lot of work. We have miles, we have a long way to go. So thinking, "Hey, I can be on this and be a Black lesbian. And I'm on the AMA thing, we've arrived, people." No, we have not arrived. We have a lot more to do in order to reach, liberation is the goal, not the opportunity to sit here and state that I'm a same gender-loving African American woman. True liberation for everybody, rural, city in whatever walk of life, that is the goal, right? So we have a long way to go for that.

The other thing is, the greatest opportunity, the most promising opportunity, is what Dr. Wilson kind of touched on is, everybody, every ally, every community member, doing their part every day, get up and dismantle every day, in your own way. You don't have to get up and ... Get up and dismantle every day is our greatest opportunity, because together we can achieve much more than we can isolated.

Dr. Roberts: Dr. Wilson, I would like you to maybe integrate your answer into both these questions, because there's one really good question that just came through. "We use the umbrella term LGBTQ regularly and fluidly. However, those of us who are part of the T in the acronym frequently get lost in the data as it relates to race. And our plight is incredibly difficult compared to our cisgender peers. Was the Williams Institute able to differentiate between LGB and T in its data?" And I think maybe that can segue into some challenges, but potential promising opportunities and addressing transgender health data collection, and identifying ways to address social determinants of health for our

transgendered brothers and sisters.

Dr. Wilson: Yes, absolutely. Thank you for asking that question. I know I also glossed right over who the LGBT people were, how we measured it, but that could be a conversation for another day.

So in this study, the answer is no, that the data that we're using is in response to a one-item question that the Gallup Tracking Poll used, which just says, "Do you identify as LGBT?" And then, if they answered, yes, then that's who we're talking about here. Which is also why it's super limited when we talk about LGBT female versus male, because at the time they were asking this question, they didn't use our recommended way of doing that, which is... It was just asking the, "Are you male or female?" So when I say LGBT female, I actually don't exactly know, are those transwomen, are people looking at that and saying, "Oh, I think I know what you're trying to ask me. You're trying to ask me what I was assigned to birth." And they're not answering their current, their actual gender identity. So there are limitations in terms of how we talk about those data.

We do have within the CDC health surveillance system, and if you look at, if you're interested in this and looking at our LBQ women's report, I actually chose to move away from the Gallup data for that, for the reason that you're asking, which is, that's an opportunity to separate cis and trans women. Now, I intentionally did that study in a way that talked about women as women and was trans-inclusive. But I still present the data for cis and transwomen separately, for those who want to think about and look at the specific areas of vulnerability and risk that trans women experience that are different, and there are some areas where cis women are experiencing it at higher rates, as well.

So in that report, I have it divided out for those reasons to both say, "Let's just talk about women as a whole, but for those who want to think about kind of the role of gender identity, even among queer women, here are those data." So I hear you on that limitation. And in some reports, we are able to do that, depending on the dataset. And I think that is a great challenge and opportunity for where we need to continue just collecting better data to know, are we doing better?

Dr. Roberts: We are out of time, and this definitely was such an enlightening and important conversation that actually needs to continue to happen throughout various organizations and various social structures that we have, to better address the needs of our patients and our community.

Our sincerest thanks to Dr. Bianca Wilson, Dr. Maya Green and Dr. Chris Harrison. All of you who have participated in our webinar tonight, we want to continue to be bold, to advance our necessary path, to advance health equity, especially here at the American Medical Association. So again, thank you so much for coming. We really appreciate it. We definitely would like to keep this conversation going in the future. Take care, everybody. Stay safe, healthy and be well.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

988 Suicide & Crisis Lifeline

With an increased number of people reporting worsening mental health in recent years, it is imperative that people are aware of the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) telephone program.

People experiencing a suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress can call, chat or text 988, and speak to trained crisis counselors. The national hotline is available 24 hours a day, 7 days a week.

The previous National Suicide Prevention Lifeline phone number (1-800-273-8255) will continue to be operational and route calls to 988 indefinitely.