ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

[Additional Counsel on Signature Page]

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN JOSE DIVISION

SANTA CRUZ LESBIAN AND GAY COMMUNITY CENTER d/b/a THE DIVERSITY CENTER OF SANTA CRUZ; LOS ANGELES LGBT CENTER; AIDS FOUNDATION OF CHICAGO; B. BROWN CONSULTING, LLC; BRADBURY-SULLIVAN LGBT COMMUNITY CENTER; NO/AIDS TASK FORCE d/b/a CRESCENTCARE; SERVICES AND ADVOCACY FOR GLBT ELDERS; DR. WARD CARPENTER, *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States; U.S. DEPARTMENT OF LABOR; EUGENE SCALIA, in his official	Case No. 5:20-CV-07741-BLF **PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION AND MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: January 7, 2021 Hearing Time: 9:00 A.M. Trial Date: None Set

capacity as Secretary of Labor; CRAIG E. LEEN, in his official capacity as Director of the Office of Federal Contract Compliance Programs; OFFICE OF MANAGEMENT AND BUDGET; RUSSELL VOUGHT, in his official capacity as Director of the Office of Management and Budget; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF JUSTICE; WILLIAM PELHAM BARR, in his official capacity as United States Attorney General; U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT; BENJAMIN SOLOMON CARSON, SR., in his official capacity as Secretary of Housing and Urban Development; U.S. DEPARTMENT OF VETERANS AFFAIRS; ROBERT WILKIE, in his official capacity as Secretary of Veterans Affairs; NATIONAL ENDOWMENT FOR THE HUMANITIES; JON PARRISH PEEDE, in his official capacity as Chairman of the National Endowment for the Humanities; NATIONAL ENDOWMENT FOR THE ARTS; MARY ANNE CARTER, in her official capacity as Chairman of the National Endowment for the Arts,

Defendants.

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NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION

PLEASE TAKE NOTICE that on January 7, 2021, or as soon thereafter as they may be heard before Judge Freeman, Plaintiffs will hereby and do move pursuant to Rule 65 of the Federal Rules of Civil Procedure and Civil Local Rules 7-2 and 65-2 for a preliminary injunction prohibiting Defendants from enforcing Executive Order 13950 and implementing agency actions. Without an order from the Court, the Executive Action will continue to cause Plaintiffs irreparable harm. This motion is based on this notice; the Memorandum of Points and Authorities; the Declarations of Sharon Esther Papo for Santa Cruz Lesbian and Gay Community Center d/b/a The Diversity Center ("Papo Decl."), Aisha N. Davis for AIDS Foundation of Chicago ("Davis Decl."), John Peller for AIDS Foundation of Chicago ("Peller Decl."), Adrian Shanker for Bradbury-Sullivan LGBT Community Center ("Shanker Decl."), Bernadette Brown for B. Brown Consulting ("Brown Decl."), Darrel Cummings for Los Angeles LGBT Center ("Cummings Decl."), Alice Riener for NO/AIDS Task Force d/b/a CrescentCare ("Riener Decl."), Hilary Meyer for Service and Advocacy for GLBT Elders ("Meyer Decl."), and Dr. Ward Carpenter ("Carpenter Decl."); this Court's file; and any matters properly before the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

The First Amendment is the foundation of our country's freedom. Chief among its protections is the right to criticize the government, and even the Nation itself, for failing to live up to the ideals we espouse. This freedom to speak uncomfortable truths to power has been central to the various civil rights movements of the past century, exposing the Nation's shortcomings in order to push it forward in its treatment of racial minorities, women, and the LGBT community. Courts have long recognized that the government cannot silence its critics by labeling their speech "un-American," including even the burning of the flag. *See Texas v. Johnson,* 491 U.S. 397 (1989). Indeed, more generally, the government cannot discriminate against speech based on its content and viewpoint. Nor can the government leverage its spending powers in an effort to silence private speech.

Executive Order 13950 (the "Executive Order") violates these core principles. Executive Order 13950, 85 FR 60683 (Sept. 22, 2020). It silences speech that identifies and counter-acts the continuing stain of racism, sexism, and anti-LGBT bias in our society by labeling it, in the words of the Director of the Office of Management and Budget ("OMB"), "anti-American propaganda." *See* Off. of Mgmt. & Budget, Exec. Off. of the President, Memorandum for the Heads of Executive Departments and Agencies No. M-20-34, Training in the Federal Government (Sept. 4, 2020) [hereinafter "Memorandum M-20-34"]. The concepts of systemic racism and sexism, White privilege, and unconscious or implicit bias hold a mirror up to America and expose the ongoing pernicious effects of centuries of subjugation, discrimination, and criminalization of Black and Brown people, women, and LGBT people. Precisely because these truths make some listeners "feel discomfort, guilt, [or] anguish," the President has labeled them "divisive concepts" and silenced this protected speech. *See* Executive Order, Section 2(a).

Plaintiffs are non-profit organizations, a consultancy, and an individual for whom these concepts of systemic bias and privilege are critical to their ability to protect LGBT people from harm and serve clients who are LGBT or living with HIV. The LGBT community has endured centuries of discrimination through criminalization and medical persecution, including having their identities labeled "disorders." Fear of persecution and enforced silence contributed to the spread of HIV and hundreds of thousands of avoidable deaths. Many in the community have suffered even greater stigmatization due to the confluence of race and sex. To effectively serve their clients, protect LGBT people from harm, and help the LGBT community overcome this history of discrimination, Plaintiffs address and apply lessons from the study and analysis of systemic racism, sexism, anti-LGBT bias, White privilege, implicit bias, and intersectionality, as well as principles of cultural humility and from critical race theory, in diversity trainings that they provide to their own employees, to those of third-party clients, and as part of grant-funded work.

The Executive Order, and the steps already taken by Defendants to implement it, silences Plaintiffs' advocacy. It cuts Plaintiffs off from federal funding in the form of grants and contracts, and from providing diversity trainings to recipients of such grants and contracts, even when the

trainings are unrelated to the program that is the basis of the federal funding. This scheme infringes Plaintiffs' constitutional rights. Plaintiffs must censor their trainings, or cease them altogether, in the face of an Executive Order and vague administrative guidance that deliberately silence Plaintiffs' speech on account of its message. Plaintiffs are already experiencing harm, including self-censorship and client loss, resulting in irreparable injury.

Because the infringement on Plaintiffs' constitutional rights is clear, and their injuries irreparable, they are entitled to an injunction to stop Defendants' unconstitutional conduct. The public interest also favors Plaintiffs' unrestricted, undiluted speech, particularly in the context of an ongoing crisis for Black and Brown people involved with the justice system, and the COVID-19 pandemic, in which the communities that Plaintiffs and their clients serve comprise a disproportionate share of those affected. The government, by contrast, faces no harm if the Court enjoins the implementation and enforcement of the Executive Order during the pendency of this suit. A preliminary injunction is thus warranted not only to protect Plaintiffs, but to safeguard the public interest, and therefore the Court should issue such an injunction immediately.

STATEMENT OF FACTS

I. THE EXECUTIVE ORDER, ITS ROOTS, AND ITS IMPLEMENTATION

On September 4, 2020, Russell Vought, Director of the Office of Management and Budget, issued a Memorandum to the Heads of Executive Departments and Agencies on training in the federal government. *See* Memorandum M-20-34. It describes the use of millions in taxpayer dollars by federal agencies to fund what it labels "divisive, anti-American propaganda," and directs agencies to "identify any contracts or spending related to training on 'critical race theory,' 'white privilege,' or any other training that teaches or suggests either (1) that the United States is an inherently racist or evil country or (2) that any race or ethnicity is inherently racist or evil." *Id.* That same day, on Twitter, Director Vought announced that "[t]he days of taxpayer-funded indoctrination trainings that sow division and racism are over. Under the direction of [President Trump], we are directing agencies to halt critical race theory trainings immediately." Russell Vought (@RussVought45), TWITTER (Sept. 4, 2020, 7:57 PM),

https://twitter.com/RussVought45/status/1302033078848753665. The following day, President Trump announced on Twitter "[t]his [critical race theory] is a sickness that cannot be allowed to continue. Please report any sightings so we can quickly extinguish!" Donald J. Trump (@realDonaldTrump), TWITTER (Sept. 5, 2020, 7:52 AM), https://twitter.com/realDonaldTrump/status/1302212909808971776.

On September 22, 2020, President Trump issued Executive Order 13950 on Combating Race and Sex Stereotyping. Its stated purpose is to establish a United States policy against what it characterizes as "promot[ing] race or sex stereotyping or scapegoating" in the federal workforce, Uniformed Services, or federal grants. Executive Order, Sec. 1. It also prohibits federal contractors from "inculcat[ing]" those views in their own employees. *Id*. In effect, the Executive Order seeks to use the government's massive presence in all aspects of our society to censor specific speech that the President dislikes or finds inconvenient: speech about systemic racism, sexism, implicit bias, intersectionality, cultural humility, and other concepts that shed light on the realities of race and gender in the United States.

The Executive Order includes a range of restrictions and means of implementation regarding what it calls "divisive concepts." Section 2(a) of the Executive Order defines "divisive concepts" as "concepts that (1) one race or sex is inherently superior to another race or sex; (2) the United States is fundamentally racist or sexist; (3) an individual, by virtue of his or her race or sex, is inherently racist, sexist, or oppressive, whether consciously or unconsciously; (4) an individual should be discriminated against or receive adverse treatment solely or partly because of his or her race or sex; (5) members of one race or sex cannot and should not attempt to treat others without respect to race or sex; (6) an individual's moral character is necessarily determined by his or her race or sex; (7) an individual, by virtue of his or her race or sex, bears responsibility for actions committed in the past by other members of the same race or sex; (8) any individual should feel discomfort, guilt, anguish, or any other form of psychological distress on account of his or her race or sex; or (9) meritocracy or traits such as a hard work ethic are racist or sexist, or were created by a particular race to oppress another race. The term 'divisive concepts' also includes any other form

of race or sex stereotyping or any other form of race or sex scapegoating," which are defined in Sections 2(b) and 2(c) of the Executive Order. *See* Executive Order, Secs. 2(a), (b), (c).

In defining these prohibited ideas, the government intentionally lumps together concepts that have nothing to do with each other, in an attempt to delegitimize scientifically based criticism of systemic oppression—equating, for example, teaching racist theories that "one race or sex is inherently superior to another race or sex" with *exposing* such racism by exploring the "unconscious" biases Americans hold as a result of centuries of racism and discrimination. *See id*. In essence, the President seeks to gaslight Americans into believing that the very raising of awareness regarding systemic racism, implicit bias, and White privilege that is *necessary* to combat racism is itself racist.

Section 4 prohibits government contractors from using any workplace training for their employees that includes the "divisive concepts," and requires provisions in their contracts binding them to that commitment. *Id*., Sec. 4. This restriction applies even if the contracts at issue bear no relation to the prohibited trainings. Noncompliance may lead to contract termination or suspension, as well as ineligibility for future contracts that likewise might have nothing to do with implicit bias training. *Id*., Sec. 4(a)(3). Section 5 creates a similar prohibition for grant recipients, directing agencies to review their grants and identify programs for which they may condition grants on certification that funds will not be used to promote the "divisive concepts." *Id*., Sec. 5.

The Executive Order also establishes means of investigation and enforcement. Section 4(b) orders the Department of Labor's ("DOL") Office of Federal Contract Compliance Programs ("OFCCP") to establish a hotline and investigate complaints received regarding activities that violate the Executive Order. *See id*., Sec. 4(b). Section 8 directs the Attorney General to assess whether workplace trainings teaching the "divisive concepts" generate liability under the Civil Rights Act of 1964. *See id*., Sec. 8.

On September 28, 2020, Director Vought issued a second Memorandum, which, in furtherance of the Executive Order, requires federal agencies to determine how much they spend on diversity and inclusion programs, and review their trainings to determine whether they "teach,

advocate, or promote" the "divisive concepts." Off. of Mgmt. & Budget, Exec. Off. of the President, OMB M-20-37 (Sept. 28, 2020) [hereinafter "Memorandum M-20-37"]. Agencies that provide grants are directed to "look at all Federal grant and cooperative agreement programs, *not just those for the purposes of providing training*," and include conditions on awards that preclude the use of funds for promoting the "divisive concepts," even through research. *Id*. (emphasis added). Memorandum M-20-37 notes that reviews of training materials can be supplemented by a "broader keyword search" of agency financial data and procurements for terms including "'critical race theory,' 'white privilege,' 'intersectionality,' 'systemic racism,' 'positionality,' 'racial humility,' and 'unconscious bias.'" *Id*.

On October 7, 2020, OFCCP released guidance on the Executive Order in the form of frequently asked questions ("FAQs"). Executive Order 13950 – Combatting Race and Sex Stereotyping, Office of Federal Compliance Programs (Oct. 7, 2020), https://www.dol.gov/agencies/ofccp/faqs/executive-order-13950 [hereinafter the "DOL FAQs"]. The DOL FAQs restate the requirements of the Executive Order and its mandate prohibiting federal contractors from "inculcating race or sex stereotyping in their employees in workplace diversity and inclusion trainings." *Id*. Among the FAQs is "Does Executive Order 13950 prohibit unconscious bias or implicit bias training?" The response states: "Unconscious or implicit bias training is prohibited to the extent it teaches or implies that an individual, by virtue of his or her race, sex, and/or national origin, is racist, sexist, oppressive, or biased, whether consciously or unconsciously. Training is not prohibited if it is designed to inform workers, or foster discussion, about pre-conceptions, opinions, or stereotypes that people—regardless of their race or sex—may have regarding people who are different, which could influence a worker's conduct or speech and be perceived by others as offensive." *Id*.

In furtherance of the Executive Order, OFCCP established and publicized a "Complaint Hotline to Combat Race and Sex Stereotyping." *See id*. According to the DOL FAQs, "the hotline receives complaints via telephone at 202-343-2008 and via email at OFCCPComplaintHotline@dol.gov." *Id*. The agency's Division of Policy and Program

Development will monitor the hotline. *See 'Anti-American' Training Hotline Set Up for U.S. Contractors (2)*, BLOOMBERG LAW (Sept. 29, 2020), https://news.bloomberglaw.com/daily-labor-report/u-s-contractors-can-now-easily-report-anti-american-training. "Complaints requiring an investigation will be sent to the appropriate Regional and District Offices for review and handling." *Id*.

On October 22, 2020, OFCCP published a Request for Information ("RFI") in the Federal Register that "requests comments, information, and materials" from federal contractors, subcontractors, and their employees regarding workplace trainings involving "prohibited race or sex stereotyping or scapegoating." Request for Information; Race and Sex Stereotyping and Scapegoating, 85 Fed. Reg. 67, 375–78 (Oct. 22, 2020).

The Executive Order went into "effect[] immediately," with the exception of imposing mandatory terms on government contracts, which is set to go into effect on November 21, 2020. *See* Executive Order, Secs. 4(a), 9; DOL FAQs. Additionally, agencies are required to report to OMB by November 20, 2020, the grant programs for which they may impose the restrictive conditions set forth in Section 5 of the Executive Order. *See* Memorandum M-20-37.

II. DIVERSITY TRAININGS THAT ARE VITAL TO DELIVERING CARE AND PREVENTING HARM HAVE BEEN CHILLED BY THE EXECUTIVE ORDER.

Health care and service providers and consultants that provide diversity training, such as Plaintiffs, must explicitly acknowledge and address systemic racism, sexism, and structural anti-LGBT discrimination as part of their missions and their work. People of color, women, and LGBT people face significant health disparities and barriers to accessing care, including widespread discrimination, particularly those with more than one marginalized identity. People of color and LGBT people also face disparities in every aspect of the justice system. Plaintiff health care providers and HIV/AIDS service providers must explicitly acknowledge and confront the role of systemic racism, sexism, anti-LGBT bias, and implicit bias as a contributor to health disparities and inequities in order to combat those disparities and inequities, reach marginalized populations, and provide quality care, as their federally funded grants require. Cummings Decl. ¶ 9; Reiner

Decl. ¶¶ 7–32; Davis Decl. ¶¶ 12–14. Plaintiff LGBT Centers and Plaintiff SAGE must acknowledge and address these concepts as they provide critical services to vulnerable people, or train others to provide such services. Cummings Decl. ¶ 10; Papo Decl. ¶ 10; Shanker Decl. ¶¶ 10–12, 21; Meyer Decl. ¶¶ 12–13, 16–17. Plaintiff Brown Consulting incorporates these concepts in trainings of law enforcement and corrections officers. Brown Decl. ¶ 12.

In particular, implicit bias among health care workers shapes their behavior and produces differences in patient diagnoses, treatments, and outcomes. Carpenter Decl. ¶ 16; Riener Decl. ¶¶ 20, 22, 28. Some health disparities are inexplicable for any reason other than implicit bias on the part of health care providers. Carpenter Decl. ¶ 16. When patients experience discrimination in medical settings, whether because of explicit or implicit bias, medical mistrust between a patient and care provider increases, and patients stop or delay seeking care. Carpenter Decl. ¶ 14; Cummings Decl. ¶ 16; Riener Decl. ¶¶ 9, 22, 29; Meyer Decl. ¶ 17. In turn, patients' conditions remain untreated for a longer period of time—if they ever get treatment—causing more acute health conditions, and increasing the eventual cost of their care. Cummings Decl. ¶¶ 15–16; Riener Decl. ¶¶ 23–29. Some conditions can become incurable simply because of a delay in treatment. Carpenter Decl. ¶ 14.

To overcome medical mistrust, health care providers must acknowledge its roots. Black patients are acutely aware of past maltreatment of people of color in medical research and by medical institutions. Providers must also acknowledge and address the role of other forms of systemic racism, sexism, anti-LGBT bias, and the socioeconomic issues associated with poverty in patient health. Systemic racism, sexism, and anti-LGBT bias can limit access to health care, housing, HIV prevention education, and screenings. Identifying disparities and acknowledging their underlying causes is essential to informing testing and prevention efforts, and to improving health outcomes. Peller Decl. ¶ 8.

The need to address systemic racism and bias is even more acute in the context of the COVID-19 pandemic, in which marginalized communities have been among those hit hardest. Riener Decl. ¶¶ 11, 21, 30; Peller Decl. ¶ 9. There are stark racial disparities in rates of COVID-

19 cases and deaths. Merlin Chowkwanyun, Ph.D., M.P.H. & Adolph L. Reed, Jr., Ph.D., *Racial Health Disparities and Covid-19—Caution and Contex*t, 383 NEW ENG. J. MED. 201, 202 (2020), *available at* https://www.nejm.org/doi/full/10.1056/NEJMp2012910. These disparities can only properly be understood and addressed within the broader context of systemic discrimination. Riener Decl. ¶¶ 10–11. Additionally, to address these disparities, Plaintiffs must identify and combat implicit bias on the part of health care providers. Bias in medical settings during an epidemic of an infectious disease, such as HIV/AIDS or a pandemic such as COVID-19, places the entire population at greater risk because people who are disproportionately at risk for infection are less likely to seek or have access to testing, less likely to seek or have access to treatment, and less likely to provide information to contact tracers. Carpenter Decl. ¶¶ 17–19. This Executive Order "will chill outreach to communities of color and LGBTQ people, including targeted efforts to address medical mistrust and encourage use of a vaccine among such communities, and result in sicker patients and increased mortality from a global pandemic. People will not show up to the health care system, and the coronavirus will spread to people around them." Riener Decl. ¶ 30. Understanding systemic racism, discrimination, and bias is vital to protecting the public health. *See*, *e.g.*, Shanker Decl. ¶¶ 14, 16, 22; Carpenter Decl. ¶¶ 17–19; Davis Decl. ¶¶ 20–21.

Implicit bias in the context of law enforcement, policing, corrections, and the juvenile and criminal justice systems fuels glaring disparities for people of color and LGBT people, particularly those with more than one marginalized identity. The nation's juvenile and criminal justice systems reflect our unresolved legacy of racism. Black people face disproportionately high rates of discrimination, violence, arrests by law enforcement; elevated rates of incarceration; and harsher penalties than their White peers. Elizabeth Hinton, LeShae Henderson, & Cindy Reed, *An Unjust Burden: The Disparate Treatment of Black Americans in the Criminal Justice System*, Vera Instit. of Just. (May 2018), https://www.vera.org/downloads/publications/for-the-record-unjust-burden-racial-disparities.pdf; James Bell, *Repairing the Breach: A Brief History of Youth of Color in the Justice System*, W. Haywood Burns Instit., https://burnsinstitute.org/wp-content/uploads/2020/09/Repairing-the-Breach-BI_compressed.pdf. LGBT people, too, are

disproportionately incarcerated and face a heightened risk of sexual abuse committed by other inmates and staff. *See* Movement Advancement Project and Center for Am. Progress, *Unjust: How the Broken Criminal Justice System Fails LGBT People* (Feb. 2016), https://www.lgbtmap.org/file/lgbt-criminal-justice.pdf; Nat'l Prison Rape Elimination Comm'n Report 73 (June 2009), https://www.ncjrs.gov/pdffiles1/226680.pdf. One of the contributors to systemic discrimination in the justice system is implicit bias on the part of school administrators, members of law enforcement, and correctional staff, which Plaintiff Brown Consulting seeks to correct through trainings. Brown Decl. ¶ 16; and *see* Nat'l Juvenile Defender Center, *Annotated Bibliography: Implicit Racial Bias in the Criminal/Juvenile Justice System* (Oct. 2020), https://defendracialjustice.org/wp-content/uploads/toolkit-files/Confronting-Bias/Implicit-Racial-Bias-Studies-Annotated-Bibliography-Updated-October-2020.pdf. The lives of LGBT people of color are at risk if corrections staff and police officers do not understand the role systemic racism and implicit basis contribute to their over-representation in the justice system and heightened risk of victimization.

Plaintiffs already are experiencing the Executive Order's chilling effect. As declared by AFC, "AFC's program staff are concerned about funding streams for necessary work that discusses race and gender equity; additionally, our partner organizations with smaller budgets are concerned that even a hint of impropriety will devastate their budgets. Moreover, our community members view this Executive Order as an attack on all the progress that we have made towards ending the HIV epidemic. In the short time since the announcement of the Executive Order, we have already held meetings to discuss the ways that funding will have to be rerouted, just in case we are operating within the unclear boundaries of the Executive Order." Davis Decl. ¶ 18. Plaintiffs' staff are chilled from covering topics in trainings, or appearing on panels at conferences. Cummings Decl. ¶¶ 11, 12, 18; Papo Decl. ¶¶ 11–14. Entities such as those routinely trained by Plaintiffs have canceled or sought to excise content from trainings as a result of the Executive Order. *See*, *e.g.*, Shanker Decl. ¶ 20. Plaintiff SAGE had a scheduled webinar series canceled by a government entity that expressly pointed to the Executive Order as the reason. Meyer Dec. ¶ 14. Plaintiff

Bradbury-Sullivan Center expedited many of its planned trainings to ensure that as many as possible occur prior to the Executive Order's effective date "based on the confusion caused by the Executive Order" and its "fear about its prohibition on accurate discussions of systemic problems surrounding race and sex." Shanker Decl. ¶ 13. Plaintiff AFC lost thousands of dollars when the sponsor to a conference felt compelled to withdraw its financial support explicitly because of the Executive Order, forcing AFC to fill the gap. Davis Decl. ¶ 22. Plaintiff CrescentCare's legal services clients may no longer seek certain trainings as remedies in legal actions against defendants who are federal contractors or grantees. Riener Decl. ¶ 31. Plaintiff Brown Consulting edited critical content on white privilege and racism out of a curriculum for a third-party client. Brown Decl. ¶ 19.

The harms of barring this critical content are severe. Plaintiffs work every day to address the health disparities among LGBT people, Black and Brown people, and people with multiple minority identities; the systemic barriers and bias in health care, housing, and education based on race, sex, and LGBT status; the obstacles to accessing services and care for seniors stemming from lifetimes of accumulated discrimination, distrust, and isolation; and the violence and victimization experienced by Black and Brown LGBT and gender nonconforming children and adults at the hands of law enforcement. Their efforts to combat systemic racism, sexism, and anti-LGBT bias ensure that people have access to lifesaving health care, culturally competent social services, and equitable treatment in the justice system. Stopping Plaintiffs' work puts lives at risk.

ARGUMENT

"The purpose of a preliminary injunction is merely to preserve the relative positions of the parties until a trial on the merits can be held." *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). A plaintiff seeking a preliminary injunction must show "that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Regents of the Univ. of Calif. v. U.S. Dep't of Homeland Security*, 908 F.3d 476, 505 n.20 (9th Cir. 2018) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)). In applying this standard, "the

elements of the preliminary injunction test are balanced, so that a stronger showing of one element may offset a weaker showing of another." *Pimentel v. Dreyfus*, 670 F.3d 1096, 1105 (9th Cir. 2012) (internal quotation marks omitted).

The requirements for a preliminary injunction are met here. Plaintiffs are likely to succeed in proving that Executive Order 13950 is unlawful and unconstitutional, including that it violates the First Amendment of the U.S. Constitution because it unlawfully chills and discriminates against speech based on its content and viewpoint, and the Fifth Amendment of the U.S. Constitution because its vague and ambiguous language fails to provide Plaintiffs fair warning as to what speech falls within the Executive Order's prohibitions.

The irreparable injury is clear: the Executive Order acutely harms Plaintiffs' constitutional rights, organizational missions, and service efficacy. It chills speech critical to providing health care and social services to vulnerable constituencies during the COVID-19 pandemic, as well as to training others to provide such services effectively. In stark contrast, the government will not be harmed if the Court halts the Executive Order's implementation during merits briefing. And the public interest plainly favors preventing the Executive Order from taking immediate effect, in large part due to the importance of Plaintiffs' speech to the delivery of health care and essential social services to marginalized communities, the protection of the public health during the pandemic, and the security of children and adults interacting with law enforcement and corrections officers. Because Plaintiffs are located throughout the country and serve widely dispersed populations, and relief limited to Plaintiffs will not cure their harms, the Court should issue a nationwide injunction.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

A. Plaintiffs Are Likely to Succeed in Demonstrating that the Executive Order Violates the First Amendment.

The Executive Order impermissibly chills Plaintiffs from discussing systemic racism, sexism, implicit bias, intersectionality, critical race theory, and other related concepts. In particular, it chills this speech in the context of trainings that enable service providers to deliver life-saving care and social services to marginalized communities. It sweeps even more broadly

against certain stakeholders, such as grant recipients, who are forbidden to even "promote the concepts" prohibited by the government if the program in question benefits from federal funding.

There is "little question that vocational training is speech protected by the First Amendment." *Pac. Coast Horseshoeing Sch., Inc. v. Kirchmeyer*, 961 F.3d 1062, 1069 (9th Cir. 2020). Such speech "imparts a 'specific skill' or communicates advice derived from 'specialized knowledge.'" *Id*. (quoting *Holder v. Humanitarian Law Project*, 561 U.S. 1, 27 (2010)). "An individual's right to speak is implicated when information he or she possesses is subjected to 'restraints on the way in which the information might be used' or disseminated." *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 568 (2011) (quoting *Seattle Times Co. v. Rhinehart,* 467 U.S. 20, 32 (1984)). First Amendment protections also cover would-be recipients of vocational training. "[T]he Constitution protects [a] right to receive information and ideas[,]" and restrictions on this right constitute a cognizable First Amendment injury. *Kirchmeyer*, 961 F.3d at 1069 (quotation omitted). "This right to receive information naturally extends to educational settings." *Id*.

The Executive Order on its face restricts this protected speech based on its content and viewpoint, as it aims directly at a particular message—science-based approaches that expose the continuing effects of the Nation's history of discrimination on the basis of race, sexuality, and gender. As courts have stated, "'[v]iewpoint discrimination is an egregious form of content discrimination, and occurs when the specific motivating ideology or the opinion or perspective of the speaker is the *rationale* for the restriction [on speech].'" *Alpha Delta Chi-Delta Chapter v. Reed*, 648 F.3d 790, 800 (9th Cir. 2011) (quoting *Truth v. Kent Sch. Dist.*, 542 F.3d 634, 649–50 (9th Cir. 2008)). "A restriction on speech is unconstitutional if it is 'an effort to suppress expression merely because public officials oppose the speaker's view.'" *Id*. (quoting *Perry Educ. Ass'n v. Perry Local Educators' Ass'n,* 460 U.S. 37, 46 (1983)).

Here, the Executive Order precludes advocacy and trainings that rely on concepts the government deems offensive, including the idea that people "should feel discomfort, guilt, anguish, or any other form of psychological distress" on account of the privilege conferred on them by their race or sex. It mandates withholding federal funds from those who would otherwise

express, or engage others to express, the forbidden content and viewpoint. This includes funding for contractors and subcontractors that is *completely separate from* and *does not itself subsidize* the prohibited expression. But the government is not permitted to burden speech "because of disapproval of the ideas expressed." *R.A.V. v. City of St. Paul, Minn.*, 505 U.S. 377, 382 (1992) (citations omitted). Nor can it burden speech because it may cause listeners discomfort; "speech cannot be restricted simply because it is upsetting or arouses contempt. . . . '[T]he government may not prohibit the expression of an idea simply because society finds the idea itself offensive or disagreeable.'" *Snyder v. Phelps*, 562 U.S. 443, 458 (2011) (quoting *Johnson*, 491 U.S. at 414). The government's views on the merits, validity, and propriety of the concepts it seeks to outlaw are immaterial to the constitutional analysis.

Content-based regulation, including viewpoint discrimination, is subject to "the most exacting scrutiny," *Johnson*, 491 U.S. at 412 (citation omitted). Such enactments "are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Reed v. Town of Gilbert, Ariz.*, 576 U.S. 155, 163 (2015). "In the ordinary case it is all but dispositive to conclude that a law is content based and, in practice, viewpoint discriminatory." *Sorrell*, 564 U.S. at 571 (citation omitted).

Such is the case here, where the Executive Order offers no basis to counter the presumption against invalidity and withstand rigorous First Amendment scrutiny. The government's justification for its action—outlined in its stated Purpose for the Executive Order—is that the outlawed concepts derive from "a different vision of America" that the President deemed "rooted in [] pernicious and false belief[s]." Executive Order 13950, Sec. 1. In other words, the President denounced criticism of the Nation's shortcomings as a "destructive ideology . . . grounded in misrepresentations of our country's history and its role in the world" simply because the speech is inconsistent with the President's own political message. But silencing views with which the President disagrees is not a compelling governmental interest, even if characterized as a "malign ideology." *Id.* And even assuming counteracting racism is a compelling interest, the Executive Order does the opposite. In true Orwellian fashion, the Executive Order simply labels speech

designed to root out and expose even unconscious race and sex bias as instead "perpetuat[ing] racial stereotypes and division." *Id*. The Executive Order concludes that the prohibited trainings "undermine[] efficiency in Federal contracting" and "promote divisiveness" in a contractor's workplace. *Id*. But prohibiting diversity trainings is not necessary to achieve these stated interests—which are hardly compelling—and its vague language and broad sweep are not narrowly-tailored means of achieving them.

The Executive Order's chill is not only direct, but also magnified through leveraging federal spending. The Executive Order prohibits federal contractors from spending *any* money, including their own, even to *receive* trainings involving the outlawed concepts. The government's compulsion of intermediaries to censor trainings is equally as forbidden as its direct censorship. The government "may not induce, encourage or promote private persons to accomplish what it is constitutionally forbidden to accomplish." *Norwood v. Harrison*, 413 U.S. 455, 463, 465 (1973).

The government cannot leverage its spending powers "to regulate speech outside the contours" of the federal programs it funds. *Agency for Intern. Development v. Alliance for Open Society Intern., Inc.*, 570 U.S. 205, 214 (2013). Using its vast economic resources to stifle speech by conditioning federal contracts and grants on limits to expression outside of the government's programs is unconstitutional. The government cannot "demand[] that funding recipients adopt—as their own—the Government's view on an issue of public concern," as such a condition "by its very nature affects 'protected conduct outside the scope of [a] federally funded program.'" *Id*. at 218 (quoting *Rust v. Sullivan*, 500 U.S. 173, 197 (1991)). Further, even when a program is federally funded, "funding decision[s] cannot be aimed at the suppression of ideas thought inimical to the Government's own interest" if the expression at issue is private, rather than public. *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 548–49 (2001).

Here, the government is restricting speech based on viewpoint, and using its spending powers to do so. President Trump and his Administration have labeled trainings and grant-funded work "offensive" and "un-American" for calling attention to the lamentable extent to which the United States has failed to uphold the rights of minorities and marginalized communities. On that

basis, it determined that anyone who might view the prohibited concepts differently, and would share those views with others, should be precluded from receiving federal funding, even for purposes entirely unrelated to the speech at issue. There is no cognizable justification for the Executive Order's restrictions on speech and the harms that will ensue. The Executive Order restricts protected speech simply because the government disagrees with the content and viewpoint expressed. The First Amendment violation could not be more clear.

B. Plaintiffs Are Likely to Succeed in Demonstrating that the Executive Order Violates the Due Process Clause of the Fifth Amendment.

The Executive Order casts an especially broad chill on Plaintiffs' speech because its vague and ambiguous language fails to put Plaintiffs on notice of precisely what speech is subject to penalty. For example, it prohibits the promotion and teaching of concepts that people "should feel discomfort, guilt, anguish, or any other form of psychological distress" on account of their race or sex, which defines the prohibited conduct based on how a listener might react. Additionally, the FAQs published by OFCCP in an effort to clarify the Executive Order only sow more confusion. They provide that "[u]nconscious or implicit bias training is prohibited to the extent it teaches or implies that an individual, by virtue of his or her race, sex, and/or national origin, is racist, sexist, oppressive, or biased, whether consciously or unconsciously." *See* DOL FAQs. But such training *is* allowed "if it is designed to inform workers, or foster discussion, about pre-conceptions, opinions, or stereotypes that people—regardless of their race or sex—may have regarding people who are different, which could influence a worker's conduct or speech and be perceived by others as offensive." *Id*. The boundary between the two is impossible to assess, and the Executive Order offers no objective standard for agencies' enforcement. There are numerous other undefined terms and phrases whose meanings are key to understanding the scope of the Executive Order's prohibitions, including what it means to "inculcate" a concept in an employee, what activities qualify as a "workplace training," and what it means to suggest that the United States is "fundamentally" racist or sexist. *See* Executive Order 13950, Secs. 2(a)(2), 4(a)(1). These terms and phrases also create ambiguity and confusion.

"'It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined.'" *Hunt v. City of Los Angeles*, 638 F.3d 703, 712 (9th Cir. 2011) (quoting *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972)). A regulation may be void for vagueness if it "'abuts upon sensitive areas of basic First Amendment freedoms, operating to inhibit the exercise of those freedoms.'" *Id*. (quoting *Grayned*, 408 U.S. at 109) (parentheses and brackets omitted). In particular, "[t]here are three objections to vague policies in the First Amendment context. First, they trap the innocent by not providing fair warning. Second, they impermissibly delegate basic policy matters to low level officials for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, a vague policy discourages the exercise of first amendment freedoms." *Cohen v. San Bernardino Valley Coll.*, 92 F.3d 968, 972 (9th Cir. 1996). *See also CPR for Skid Row v. City of Los Angeles*, 779 F.3d 1098, 1103 (9th Cir. 2015) ("Uncertain meanings inevitably lead citizens to steer far wider of the unlawful zone than if the boundaries of the forbidden areas were clearly marked.") (quoting *Grayned*, 408 U.S. at 109). Where a restriction implicates First Amendment rights, "a 'more demanding' standard of scrutiny applies." *Hunt*, 638 F.3d at 712 (citing *Holder*, 561 U.S. at 28 (2010); *Maldonado v. Morales*, 556 F.3d 1037, 1045 (9th Cir. 2009)).

Plaintiffs are at a loss as to how to discern what they can and cannot say, at the risk of running afoul of the Executive Order. As they impart vital lessons about race, sexuality, and gender, they must now contend with the impossible (and counterproductive) task of determining whether their trainings and advocacy may invoke feelings of discomfort, guilt, and anguish. While the First Amendment does not permit the government to restrict speech "because it is upsetting" to the listener, *Snyder*, 562 U.S. at 458, it is an independent constitutional violation to specifically *define* the prohibition based on the listener's reaction, which necessarily means "[t]he line between allowable and prohibited [speech] is so murky, enforcement . . . poses a danger of arbitrary and discriminatory application." *Hunt*, 638 F.3d at 712. The FAQs only further complicate Plaintiffs' predicament: whether a diversity training is suitable to the government will be a fact-intensive, highly subjective inquiry that renders it impossible for Plaintiffs to know how to discuss these

issues in the context of providing vital services. DOL and other federal agencies are empowered to exercise enormous discretion in determining what speech is disqualifying. As a result, Plaintiffs will have to censor their speech or not speak at all to avoid potential penalty. *See Hunt*, 638 F.3d at 713 (A "lack of clarity may operate to inhibit the exercise of freedom of expression because individuals will not know whether the [enactment] allows their conduct, and may choose not to exercise their rights for fear of [the consequences].")

These situations are not hypothetical—they are already happening. Plaintiffs cannot discern whether they may discuss systemic racism or "which terms and ideas to avoid" when training law enforcement, Brown Decl. ¶ 19, 20; the causes of health disparities based on race when invited to participate on a panel about HIV, Cummings Decl. ¶ 12; or the intersectional roots of the modern movement for LGBT inclusion. Meyer Decl. ¶ 13; Shanker Decl. ¶ 23. The Executive Order and its implementing guidance are unconstitutionally vague and violate Plaintiffs' Due Process rights.

II. THE RULE WILL IRREPARABLY HARM PLAINTIFFS.

When, as here, an enactment likely to be held unconstitutional frustrates the core missions of organizational plaintiffs, courts recognize that the injury is irreparable and justifies a preliminary injunction. That is especially so when First Amendment rights are at stake, the deprivation of which by definition qualifies as irreparable. Here, Plaintiffs' speech is already being curtailed, and will continue to be, in a manner that frustrates Plaintiffs' core missions.

A. Courts Routinely Find that Infringement of Free Speech Itself Constitutes Irreparable Injury.

Infringement of Plaintiffs' speech itself constitutes irreparable harm warranting a preliminary injunction. "Irreparable harm is relatively easy to establish in a First Amendment case. A party seeking preliminary injunctive relief in a First Amendment context can establish irreparable injury . . . by demonstrating the existence of a colorable First Amendment claim." *CTIA - The Wireless Ass'n v. City of Berkeley, California*, 928 F.3d 832, 851 (9th Cir. 2019) (quotation omitted). *See also Goldie's Bookstore, Inc. v. Superior Court of State of Cal.*, 739 F.2d 466, 472

(9th Cir. 1984) ("[P]urposeful unconstitutional suppression of speech constitutes irreparable harm for preliminary injunction purposes."). "[T]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *CTIA*, 928 F.3d at 851 (quotation omitted).

Moreover, "even if the merits of the constitutional claim [are] not 'clearly established] at [the] early stage in the litigation, the fact that a case raises serious First Amendment questions compels a finding that there exists 'the potential for irreparable injury, or that at the very least the balance of hardships tips sharply in [a plaintiff's] favor.'" *Sammartano v. First Judicial District Court*, 303 F.3d 959, 973 (9th Cir. 2002) (quoting *Viacom Int'l, Inc. v. FCC,* 828 F.Supp. 741, 744 (N.D. Cal.1993)). Because "the harm claimed is a serious infringement on core expressive freedoms, a plaintiff is entitled to an injunction even on a lesser showing of meritoriousness." *Id.*

Plaintiffs' First Amendment claim is exceptionally strong, far surpassing the bar of a "lesser showing of meritoriousness." The First Amendment protects both Plaintiffs who wish to provide trainings on issues such as systemic racism, as well as would-be recipients of that training, like Plaintiff Dr. Carpenter. The Executive Order and implementing agency action constitute content and viewpoint discrimination by restricting advocacy and trainings that employ "divisive concepts" that the government disfavors. Plaintiffs' speech has been chilled because the Executive Order punishes them for discussing concepts related to systemic racism and implicit bias—concepts that are key to effectively reaching, treating, and protecting the communities they serve. And in the case of employees like Dr. Carpenter, they are unable to listen to speech that is vital to doing their jobs effectively. Accordingly, the infringement of speech by the Executive Order constitutes irreparable injury counseling in favor of a preliminary injunction.

B. The Rule Will Compromise Plaintiffs' Missions And Operations.

The Executive Order will frustrate Plaintiffs' core missions, which itself is irreparable harm. *See, e.g.*, *Valle del Sol Inc. v. Whiting*, 732 F.3d 1006, 1029 (9th Cir. 2013). *See also E. Bay Sanctuary Covenant v. Trump*, 354 F. Supp. 3d 1094, 1116 (N.D. Cal. 2018), *aff'd*, 950 F.3d 1242 (9th Cir. 2020) ("[T]he Organizations 'have established a likelihood of irreparable harm' based on

their showing of serious 'ongoing harms to their organizational missions.'") (quoting *Valle del Sol Inc.*, 732 F.3d 1006 at 1029). It will jeopardize Plaintiffs' ability to ensure that the individuals that they and their clients serve and protect receive high quality, compassionate, and culturally-competent care and services and are free from harm. The Executive Order forbids Plaintiffs from empowering their employees and those they train to understand the complexities around serving and working with marginalized and multiply-oppressed communities, such as racial minorities who are also LGBT.

The Executive Order directly frustrates the missions of Plaintiff health care providers and HIV/AIDS service providers to deliver high quality and culturally competent health care and services, and to perform grant-funded work addressing health disparities. Riener Decl. ¶¶ 11, 29; Cummings Decl. ¶¶ 3, 19. Plaintiff LGBT Centers and SAGE cannot effectuate their missions of protecting the LGBT community through trainings that explain the systemic challenges vulnerable people face. Shanker Decl. ¶ 22; Meyer Decl. ¶ 12. Plaintiff Brown Consulting cannot reduce disparities for people of color and LGBT people in the justice system if unable to address systemic racism, implicit bias, and intersectionality in trainings. Brown Dec. ¶¶ 17, 21. Plaintiffs, their employees, and their clients are sabotaged in their ability to serve their constituents. Riener Decl. ¶ 12; Shanker Decl. ¶ 21; Meyer Decl. ¶¶ 12–13, 16–17; Davis Decl. ¶¶ 19, 23. Plaintiffs are trusted for the comprehensive, fact-based services and training they provide and that trust will be harmed by self-censorship about the concepts deemed "divisive" by the Executive Order. Riener Decl. ¶ 12; Shanker Decl. ¶ 22; Meyer Decl. ¶¶ 16–17.

Moreover, without certainty in how to comply with the Executive Order and maintain their federal funding or federally funded clients, Plaintiffs' ability to budget, plan for the future, and secure the resources they need is compromised. Cummings Decl. ¶ 8 (Approximately 80% of LA LGBT Center's revenue consists of federal funding); Riener Decl. ¶ 7 (Approximately 70% of CrescentCare's revenue consists of federal funding); Shanker Decl. ¶ 7 (Approximately 33% of Bradbury-Sullivan's revenue consists of federal funding); Davis Decl. ¶ 10 (Approximately 79.2% of AFC's revenue consists of federal funding); Meyer Decl. ¶ 8 (A significant portion of SAGE's

revenue consists of federal funding). Courts have recognized that such existential business risks constitute irreparable harm. Where plaintiffs face "substantial loss of business and perhaps even bankruptcy, [this injury] sufficiently meets the standards for granting interim relief, for otherwise a favorable final judgment might well be useless." *Doran v. Salem Inn, Inc.*, 422 U.S. 922, 932 (1975). *See also Am. Passage Media Corp. v. Cass Commc'ns, Inc.*, 750 F.2d 1470, 1474 (9th Cir. 1985) ("The threat of being driven out of business is sufficient to establish irreparable harm.") (citing *Los Angeles Memorial Coliseum Comm'n v. National Football League,* 634 F.2d 1197, 1203 (9th Cir. 1980)); *Cnty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 537 (N.D. Cal. 2017) ("This budget uncertainty is also causing the Counties irreparable harm, and it will continue to do so absent an injunction. . . . Without clarification regarding the Order's scope or legality, the Counties will be obligated to take steps to mitigate the risk of losing millions of dollars in federal funding, which will include placing funds in reserve and making cuts to services. These mitigating steps will cause the Counties irreparable harm.") (citing *United States v. North Carolina*, 192 F.Supp.3d 620, 629 (M.D.N.C. 2016)). Here, organizations who continue to perform these necessary trainings stand to lose current funding, and be blacklisted from receipt of future federal funding—even if their government contracts have *nothing* to do with the training that the Executive Order prohibits.

III. THE BALANCE OF THE EQUITIES FAVORS PLAINTIFFS, AND AN INJUNCTION IS IN THE PUBLIC INTEREST.

The Court "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief," while paying "particular regard for the public consequences" of entering or withholding injunctive relief. *Winter*, 555 U.S. at 20, 24. When the government is the defendant, those inquiries merge, resulting in a balancing that turns on the public interest. *Nken v. Holder*, 556 U.S. 418, 435–36 (2009).

In addition to considering the demonstrated harm to the Plaintiffs, it is also in the public interest to permit Plaintiffs to continue to speak about the concepts that the Executive Order outlaws. The advocacy and training that the Executive Order prohibits facilitates the proper

delivery of health care and social services, something that the government ostensibly made no effort to consider. The communities Plaintiffs and their clients serve are often the most isolated from life-saving health care and social services, and vulnerable to abuse from law enforcement and other authorities. Without Plaintiffs' efforts to combat systemic racism, sexism, and anti-LGBT bias, more people will fall out of care, more will sicken, and more will face injustice at the hands of officials charged with protecting them.

The public interest in enjoining the Executive Order is even more apparent in the context of the COVID-19 pandemic, which has disproportionately impacted the communities that Plaintiffs and their clients serve. Cummings Decl. ¶ 5; Davis Decl. ¶¶ 20–21; Shanker Decl. ¶ 22; Riener Decl. ¶ 30; Meyer Decl. ¶ 18. Absent the trainings, marginalized people will fail to get tested, decline to take a vaccine when it becomes available, decline to participate in contact tracing, remain isolated, sicken, and even die. Davis Decl. ¶ 20; Riener Decl. ¶ 30; Meyer Decl. ¶ 18; Carpenter Decl. ¶¶ 17–19. "Proper staff training is one of the best ways" to reach and provide services to the population served by Plaintiff SAGE (LGBT older adults), who are particularly vulnerable to COVID-19 and the effects of isolation. Meyer Decl. ¶ 18. The secondary effects of providing training to engage with marginalized communities weigh even further in favor of a preliminary injunction. Shanker Decl. ¶ 14.

Plaintiffs also have demonstrated that the Executive Order infringes on their constitutional rights, which weighs in favor of awarding a preliminary injunction. *See Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights") (quoting *Sammartano*, 303 F.3d at 974). This harm outweighs any government interest in immediate enforcement of the Executive Order.

Meanwhile, it is plain from the Executive Order's stated Purpose that the government's proffered interests are merely a facade for its dislike of the "divisive concepts" and its desire to avoid hard truths regarding racism and bias. The government claims that the "divisive concepts" could promote inefficiency and "divisiveness in the workplace and distract from the pursuit of excellence and collaborative achievements in public administration." *See* Executive Order, Sec. 1.

Yet, in the same breath, the government makes clear that these interests are pretense: it labels these concepts a "malign ideology" that it believes "misrepresent[s] our country's history," presenting "a different vision of America" that is "rooted in [] pernicious and false belief[s]." *Id*. In other words, the government's purported justification is just a restatement of its hostility to the speech it finds inconvenient. If that justification cannot withstand First Amendment scrutiny, neither can it be given any weight in balancing the interests at issue. Moreover, even if the Court *did* credit these explanations, there is no basis to believe that the government would be harmed if implementation were delayed pending the outcome of this lawsuit.

There will be immediate harm to Plaintiffs and their clients if the Executive Order is implemented, and in turn immediate harm to the communities that Plaintiffs and their clients serve. These harms are magnified in the context of the COVID-19 pandemic, and will generate significant adverse public health consequences. In contrast, there is no credible harm to the government if the Executive Order is delayed. Consideration of the relevant factors favors freezing the status quo pending final resolution of Plaintiffs' claims.

IV. THE COURT SHOULD ENTER A NATIONWIDE INJUNCTION.

"[T]he scope of injunctive relief is dictated by the extent of the violation established, not by the geographical extent of the plaintiff." *E. Bay*, 909 F.3d at 1255 (quoting *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979)). There is "no general requirement that an injunction affect only the parties in the suit." *Regents of the Univ. of Cal.*, 908 F.3d at 511 (quoting *Bresgal v. Brock*, 843 F.2d 1163, 1169 (9th Cir. 1987)). Instead, "[a]n injunction may extend 'benefit or protection' to nonparties if such breadth is necessary to give prevailing parties the relief to which they are entitled." *E. Bay*, 909 F.3d at 1255 (internal quotation marks and citation omitted).

Nationwide relief is necessary to stop the significant harms described here. Plaintiffs are located throughout the country and serve widely dispersed populations. *See* Cummings Decl. ¶¶ 3–4; Papo Decl. ¶ 5; Meyer Decl. ¶¶ 3–4; Brown Decl. ¶¶ 1–2. Additionally, Plaintiffs will be deprived of complete relief if the injunction is limited to the parties because of the third parties that fund Plaintiffs or pay for trainings. Papo Decl. ¶¶ 6, 8–12; Shanker Decl. ¶ 20; Cummings

Decl. ¶ 8; Meyer Decl. ¶¶ 7–8, 11. An injunction limited to the parties will not prevent the harm Plaintiffs presented. *See California v. Azar*, 911 F.3d 558, 584 (9th Cir. 2018).

In particular, the work that Plaintiffs perform includes services provided pursuant to state, county, and local contracts and grants. If those public entities are required to comply with the Executive Order while Plaintiffs are not, the pass-through funding stream remains cut off. Similarly, Plaintiffs provide trainings to private third parties who receive federal funding, including contractors who would be forbidden from using any workplace training that they would otherwise offer through Plaintiffs, even if their relationship with the federal government has *nothing* to do with the trainings at issue. In both cases, the harms to the Plaintiffs and, more importantly, the communities that they and their clients serve and work to protect, would persist.

The Executive Order's harms have been, and will continue to be, deep and widespread, and are occurring across the country. An injunction limited to Plaintiffs will not remedy these harms. This Court can prevent these injuries by entering a nationwide preliminary injunction.

CONCLUSION

The Court should preliminarily enjoin implementation of the Executive Order.

Respectfully,

/s/ Anne Johnson Palmer

Dated this 16th of November, 2020.

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs

*Admitted *pro hac vice*

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF SHARON PAPO, LSCW, EXECUTIVE DIRECTOR OF THE DIVERSITY CENTER OF SANTA CRUZ, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Sharon Esther Papo, LCSW, hereby state as follows:

1. I am the Executive Director of the Santa Cruz Lesbian and Gay Community Center d/b/a The Diversity Center of Santa Cruz, a not-for-profit 501(c)(3) organization based in Santa Cruz, California, that provides a variety of services to members of the lesbian, gay, bisexual, transgender, queer, and questioning ("LGBTQ+") communities. Prior to serving as the Diversity Center's Executive Director, I was the Executive Director of 3rd Street Youth Center and Clinic, a multi-service health center in Bayview Hunters Point, San Francisco.

2. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies and their leadership from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

3. The Diversity Center was founded in 1989 as the Santa Cruz Lesbian and Gay Community Center. Over the years, the Diversity Center has grown in scope, budget, and staff, and now serves the lesbian, gay, bisexual, transgender, queer and questioning ("LGBTQ+") community of Santa Cruz County. The Diversity Center is the chief agency in the county promoting social justice, enhancing the health and well-being, and building a sense of community for LGBTQ+ people. Our committed staff members work with nearly 250 volunteers to produce community programs and events. We operate a welcoming community center with a lending library, cyber center, and many other resources. We also are the fiscal agent for several LGBTQ+ groups, giving them the benefits and protections of our non-profit status.

4. The Diversity Center receives pass-through federal funding through Santa Cruz County to provide outreach and services to prevent the sexual exploitation of LGBTQ+ teens. The Diversity Center's current contract for these services was issued September 16, 2020, for $25,000. The Diversity Center also participates in Medi-Cal Administrative Activities ("MMA") through Santa Cruz County.

5. While the Diversity Center's services are directed at Santa Cruz County residents, people from all over Northern California—from San Francisco to San Luis Obispo—benefit from our services and attend our events. Each year we reach approximately 8000 people through our service programs and educational events, and approximately 20,000 through our outreach. Our youth programs bring queer and questioning teens together to create safer schools, to support one another, to build future queer leaders, and to have fun. Our seniors programs improve the quality of life of LGBTQ+ folks over 60 through social and recreation activities. Our bilingual program for transitional adults ages 18-25, "Conexiones," builds community through social events, food, education, and robust communication. Our transgender and veterans programs offer information, support, activities, and resources.

6. Among our most important programming is the diversity training program we provide to diverse clients, including businesses and educational and health care institutions. We offer specialized bilingual trainings upon request, in addition to LGBTQ+ Aging Sensitivity trainings to local businesses and organizations so that they can improve how they serve LGBTQ+ seniors. We also operate a "Triangle Speakers" bureau that trains LGBTQ+ members of the public to be ambassadors, public speakers, and educators in the community. Our diversity trainers and Triangle Speakers reached 2800 participants during the last fiscal year through 93 trainings.

7. The Diversity Center also performs internal training of its staff, volunteers, and board members with a focus on race equity and inclusion.

8. The Diversity Center charges a fee for our external diversity trainings, which covers the initial consultation, training customization, preparation time, travel, set-up, staff support, delivery, and debriefing. We offer a reduced fee for local non-profit organizations. Our diversity trainings constitute a significant revenue line for the Diversity Center. Our diversity training revenue provides key funding for our youth program, including staffing. If we stopped providing

these trainings, or if our training revenue were reduced as a result of the impact of the Executive Order, it would impact our ability to provide lifeline resources for young people in our community.

9. Our one-hour trainings cover key concepts and language. Two-hour trainings include an overview of best practices, or a Triangle Speakers panel. Three-hour trainings cover all these topics, customized for individual audiences. The trainings aim to achieve 1) an understanding of the spectrum of gender and sexuality, key terminology, and inclusive language; 2) an increased awareness of myths and barriers for LGBTQ+ people in communities and workplaces; and 3) practical actions to embrace and celebrate diversity.

10. The Diversity Center's trainings often cover issues relating to systemic racism and intersectionality. For example, trainers discuss with participants the extraordinary level of physical and sexual violence experienced by Black and transgender women of color and the systemic sexism, racism, and transphobia that underlie this violence. Members of the Triangle Speakers bureau often speak about the role of structural racism, sexism, or anti-LGBT bias in shaping their lives.

11. Upon information and belief, the clients of the Diversity Center's training program include both federal contractors and grantees. The Diversity Center has trained a local sheriff's department, a child welfare agency, students and staff at research universities, and over 500 health care workers at major medical institutions.

12. I am concerned that an attendee at a training could call the DOL hotline and lodge a complaint simply because the attendee does not like the anti-racist message of a training, or because the attendee feels uncomfortable at learning hard truths. I am worried that such a complaint would risk the loss of the Diversity Center's federal pass-through funding. I also am concerned that clients in the community now are more reluctant to seek our trainings for their employees for fear of being deemed noncompliant with the Executive Order and losing their own federal funding.

Losing our federal funding and reducing our training revenue would cause significant harm to our budget, and would cause us to reduce our services.

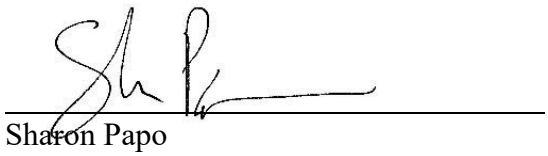
13. Additionally, if we are forced to reduce our trainings, or limit their content, we will negatively impact the community we serve and do harm to our mission. Our trainings are critical for many reasons. For-profit employers want to create a safe workplace for their employees and inviting environments for their customers. Our trainings also help decrease lawsuits, and reduce tensions within the workplace and our broader community. These employers seek us out because they understand that if they do not have the tools and knowledge we provide, they are not going to succeed as readily in meeting these goals. We help health care providers offer better, more culturally competent care, and universities provide a more welcoming climate for students. If we ceased providing these trainings, we would reduce the sense of security, safety, and belonging in the community that is so important for peoples' well-being.

14. Our services have become particularly important during the COVID-19 pandemic. Two therapists provide group therapy to address Coronavirus-induced stress. We provide food deliveries, and have created an emergency response fund that has given away many thousands of dollars to community members in economic distress. We support students through gender and sexuality alliances ("GSAs") in schools around the county, and we now have begun hosting a chat space online that is available around the clock to ensure that young people have support they need day and night. We also continue to offer regular programming around exercise, nutrition, queer history, and provide support groups that have taken on increased importance to people feeling isolated. We do not want to reduce any of these vital services, which are often lifelines to people in need.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 12, 2020

Respectfully submitted,



Sharon Papo

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice*.

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF AISHA N. DAVIS, ESQ., DIRECTOR OF POLICY FOR THE AIDS FOUNDATION OF CHICAGO, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Aisha N. Davis, hereby state as follows:

1. I am the Director of Policy for AIDS Foundation Chicago ("AFC"), a not-for-profit 501(c)(3) organization based in Chicago, Illinois, that mobilizes communities to create equity and justice for people living with and vulnerable to the human immunodeficiency virus ("HIV") or chronic conditions. I have served in this capacity since February 24, 2020.

2. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

3. AFC was incorporated November 13, 1985, as an Illinois not-for-profit corporation and began operations on May 1, 1986. AFC brings together service providers and funders to develop systems that meet the needs of people living with HIV or acquired immunodeficiency syndrome ("AIDS"). Since its inception, AFC has led both state and city-wide efforts to coordinate essential medical and support services for people living with HIV/AIDS.

4. AFC provides systems-level leadership to the Chicago area's HIV/AIDS sector by providing funding to and coordinating the activities of Chicago's regional case management system; distributing funding for permanent, supportive housing including rental and utility assistance; providing capacity building services to community organizations that provide high quality HIV/AIDS programming and services to communities and neighborhoods that have been historically under-served by medical services, especially HIV care services; and engaging in local, statewide, and federal policy advocacy to promote HIV/AIDS funding and services.

5. Preventing new cases of HIV is at the core of AFC's work—and it is at the core of Getting to Zero Illinois, which is a state-wide initiative to end the HIV epidemic in the state by 2030. AFC, in partnership with both the Illinois Department of Public Health ("IDPH") and the Chicago Department of Public Health ("CDPH"), coordinates the Getting to Zero Illinois project.

The guiding principles of Getting to Zero Illinois include eliminating stigma, dismantling systems that perpetuate white privilege, promoting cultural humility, prioritizing trauma prevention and trauma-informed care, and focusing on data to achieve outcomes.

6. Every day, AFC walks alongside almost 7,000 people living with or vulnerable to HIV who need support to achieve their health and life goals. This work includes intentionally focusing on the communities and populations that are disproportionately impacted by the HIV epidemic. In Chicago, and across the nation, the populations most impacted by the HIV epidemic include Black and Latinx communities. Currently, of all clients in our programs, 61.7% are Black, 17.1% are Latinx, and 2.1% identify as Indigenous, Asian, or multicultural. Additionally, 43% of our clients are gay or lesbian, 9% are bisexual, 3% are queer, and 3.1% are transgender, non-binary, or genderqueer. For many Black, Latinx, and Indigenous communities, HIV-specific preventative and treatment services are less accessible due to the systemic under-resourcing of minority communities and neighborhoods. Moreover, LGBTQ+ communities often face a lack of access to competent, comprehensive, and compassionate healthcare services; with trans, non-binary, and genderqueer community members sometimes encountering additional discrimination within LGBTQ+ centered spaces. Due to systemic racism, homophobia, transphobia, and misogyny, the HIV epidemic disproportionately impacts many of our priority communities. One of the most important ways to address and remedy systems and structures that have procedures or processes that disadvantage marginalized groups is by ensuring that we can train and educate service providers, community leaders, elected officials, and the public on these issues.

7. AFC is committed to prioritizing marginalized populations disproportionately impacted by social determinants that contribute to health disparities in HIV/ AIDS. HIV and chronic conditions disproportionately impact specific populations. As an organization that has been doing this work for 35 years, AFC recognizes that it will have the greatest impact on the HIV

epidemic by focusing our efforts on those most-impacted by HIV, based on epidemiological data and unmet need: young Black gay and bisexual men, transgender women of color, Black women living in high-incidence areas, and Latinx gay and bisexual men.

8. AFC is a federal grantee and subgrantee, and manages local, state, and federal funds for an array of HIV/AIDS-related services. By assisting government entities in planning, distributing, and monitoring service contracts, AFC helps develop provider expertise and promotes uniform and high-quality delivery of care across the region. AFC receives various forms of funding and grants from the CDPH, IDPH, and the U.S. Department of Health and Human Services ("HHS"); including, but not limited to, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, direct funding from the Centers for Disease Control and Prevention, discounts under the 340B Drug Discount Program, and Medicaid reimbursements.

9. Additionally, AFC participates in a rental subsidy program partially funded by the U.S. Department of Housing and Urban Development ("HUD"). Through federal grants from HUD's Housing Opportunities for Persons with AIDS ("HOPWA") program, AFC assists people who are chronically homeless in finding permanent housing, manages the delivery of HIV rental subsidies to low-income people with HIV and people living with chronic conditions, and convenes HIV housing advocates to both expand and improve the housing continuum.

10. Funding from HUD, HHS, and other federal grants account for a significant portion of AFC's revenue. In total, 79.2%—or $25.9 million —of AFC's funding originates from the federal government, which includes over $14 million for programs that require case management training through programming from HHS and HUD.

11. The federal funding AFC receives has given us the ability to connect people living with or vulnerable to HIV to safe and stable housing—which results in better health outcomes. Recently, in response to the COVID-19 pandemic and the subsequent economic downturn, AFC

was able to use HOPWA funding to help provide hotel and permanent housing opportunities to housing insecure individuals in the Chicagoland area. Through federal funding AFC received from CDPH, AFC was able to establish the HIV Resource "HUB." As of October 16, 2020, the HUB has dispensed more than $590,000 to cover COVID-19-related financial emergencies for more than 342 people living with and vulnerable to HIV in the Chicago eligible metropolitan area (which includes Cook County and the surrounding "collar counties"). The majority of the funds distributed cover people's rent to prevent eviction and homelessness; utilities; and food needs.

12. AFC's vision is that people living with HIV or chronic conditions will thrive, and there will be no new HIV cases. In working towards that purpose, AFC has identified and works to address systemic factors—including, racism, sexism, homelessness, poverty, and immigration status—that drive the HIV epidemic and inequities in health outcomes. The data we have available, both nationally, statewide, and in the city of Chicago paint a picture of multiple epidemics and pandemics disproportionately impacting Black, Latinx, and Indigenous communities. AFC's work must include discussions on the impacts of race, gender, sexual orientation, and income level on health outcomes.

13. Our clients are not just people living with or vulnerable to HIV—they are also members of predominantly Black and Latinx communities that are more likely to live in areas that are denied access to affordable and nutritious food, healthcare, and employment that provides living-wages. Furthermore, we must also acknowledge and address the barriers that our clients and communities face in accessing comprehensive health care. A Black transgender woman living with HIV in Chicago and enrolled in Medicaid is not only worried about her viral load and access to medication—she is also worried about employment discrimination, HIV criminalization, housing security, and access to gender-affirming care with culturally-aware and competent providers. Systemic racism limits access to comprehensive and equitable healthcare on the South

and West Sides of Chicago; systemic transphobia contributes to transgender, non-binary, and genderqueer people disproportionately experiencing unemployment and housing instability; and systemic misogyny drives the gender pay gap. All of these things are further intensified for multiply-oppressed people who live at the intersection of various marginalized identities. Without acknowledging and addressing all these factors, AFC cannot successfully achieve our mission and vision.

14. Everything AFC does needs to center "why?" Structural racism is at the heart of the disparities that AFC witnesses in HIV and one of the reasons "why" there are disparities driving the epidemic. Therefore, it is of the utmost importance that AFC's internal trainings, external federally funded trainings, and policy advocacy work all address structural racism—explicitly. AFC convenes and trains close to 130 case managers, across 35 agencies, to learn the latest in providing comprehensive case management services that empower people living with HIV. When training case managers, we include trainings that familiarize them with the current landscape of the HIV epidemic and include foundational information on how race and gender impact the way case managers execute their work with non-monolithic communities. Trainings cover a broad array of topics; including interpersonal cultural competency, trauma-informed care, financial literacy, effective communication with clients, HIV and aging, engaging with transgender clients, the impact of HIV on transgender populations, LGBTQ+ cultural competency, cultural competency and Black communities, and working with clients at risk for deportation.

15. The vagueness of the Executive Order has created an untenable situation; currently, AFC must determine whether we are able to effectively train case managers without fear of retaliation from the federal government. More than $14 million, including grants tied to Ryan White and HOPWA, of our funding requires case management training. AFC is now forced to decide whether to train case managers in a manner that best equips them to work effectively with

our clients or lose significant funding and grant opportunities. AFC cannot properly train case managers and fulfill our mission if we cannot discuss the systemic barriers that drive disparities in care and health outcomes for communities of color, LGBTQ+ communities, and people living with or vulnerable to HIV. There are so many ways of measuring AFC's success in our case management program, but we focus on the percentage of our clients whose HIV is virally suppressed. Among AFC's HIV case management clients, 85% of them have achieved viral suppression. That is an incredible testimony to the power of AFC's case management, and that case management cannot meet, let alone improve, on these numbers without being able to discuss the barriers to care that our clients face due to systemic forms of oppression.

16. Part of strengthening AFC and successfully ending the HIV epidemic includes recognizing our need to work toward ending racism and white supremacy. AFC will never achieve our mission—mobilizing communities to create equity and justice for people living with and vulnerable to the HIV or chronic conditions—without first recognizing and dismantling the racist core of the many systems AFC works within. These systems are part of the reason why HIV disproportionately impacts specific populations: young Black and Latinx gay men, transgender women of color, and Black women living in high-incidence areas. To start the conversation, AFC recognized that we need to look inward. AFC is providing trainings on implicit bias, systemic racism, and white supremacy culture to our staff. Trainings like these not only help our staff to better recognize how we can serve the most vulnerable and marginalized in our communities; but also highlights how these various forms of oppression impact each of us in the work we do. Our internal work has also led to including our priority populations in our strategic plan; centering our work on racial equity, diversity, and inclusion to achieve greater impact; and increasing resource development for under-resourced groups. With the Executive Order in place, our ability to train our staff to best fulfill our strategic plan is in jeopardy.

17. Nationally, as well as in Illinois and Chicago, the HIV epidemic disproportionately impacts gay and bisexual Black men and Black cisgender and transgender women more than people of other races and ethnicities. AFC leads Women Evolving, which supports transgender and cisgender women living with HIV who are returning to community from prison or jail. The program is funded entirely by HHS' Ryan White Program, through a Special Project of National Significance grant. Women Evolving is part of an initiative to develop innovative community collaborations that break down isolation and stigma for women of color living with HIV and helps connect participants to medical care, housing, and employment—which are critical services that case managers link their clients to in order to reduce recidivism. The motivation for the creation of the Women's Connection is in part rooted in the layered and intersecting ways that cisgender and transgender women of color are heavily impacted by HIV and were not being adequately supported in local planning or service delivery. Trainings provided to the case managers that work with this group of women focus on addressing multiple topics which include domestic violence, health care access, transgender cultural competency, and the impacts of systematic bias on multiply-oppressed people. Under the Executive Order, AFC would be prohibited from training case managers on these issues, which would result in undermining our ability to effectively serve our clients.

18. Since the announcement of the Executive Order, AFC has been concerned with the impact it will have on our existing projects and our communities. When we were first confronted with the relatively vague language of the Executive Order and the subsequent Office of Management and Budget ("OMB") memorandum, we began to discuss ways to continue our work both internally and externally. As an organization that has been in existence during the majority of the HIV epidemic, we are familiar with hardship, strife, and the harm that can be caused by federal administrations that prioritize profit and the status quo over the needs of people. Much

like in the past, we are dedicated to continuing this work; however, it would be dishonest to imply that there will not be significant harm caused by the Executive Order.

19. The Executive Order has already begun to have a chilling effect. AFC's program staff are concerned about funding streams for necessary work that discusses race and gender equity; additionally, our partner organizations with smaller budgets are concerned that even a hint of impropriety will devastate their budgets. Moreover, our community members view this Executive Order as an attack on all the progress that we have made towards ending the HIV epidemic. In the short time since the announcement of the Executive Order, we have already held meetings to discuss the ways that funding will have to be rerouted, just in case we are operating within the unclear boundaries of the Executive Order. We are putting words to centuries of systemic oppression that have driven the disparities we see in the HIV epidemic, housing insecurity contributes dramatically to shorter lifespans for Black, Latinx, and Indigenous communities. The Executive Order is an impediment on the road to progress and has left many organizations like AFC wondering how we are supposed to execute our missions without being able to reach our communities in a truly informed manner.

20. Now, AFC faces a new reality, COVID-19. Although this reality is one that we have never experienced, both here in Chicago and across the United States, one emerging trend is not novel—Black people and communities of color across the nation are being disproportionately impacted by COVID-19. In response to the pandemic, AFC pivoted our Resource HUB, a partnership with Center on Halsted, to focus on COVID response. As of September 1, 2020, 40.3% of the clients served through the HUB were Black and 31.3% were Latinx. With more than 70% of the people seeking services through the HUB identifying as Black or Latinx, it is imperative that our case managers are trained on cultural competency to best meet the needs of our clients. Part of this cultural competency training is based on decades of research. Having a case manager

that understands how a Black and/or Latinx person living with HIV is disproportionately impacted by COVID-19, and how these communities are also typically employed as first responders and essential workers enables a level of connection and care that is crucial to the work case managers do. However, our ability to provide comprehensive cultural competency trainings is now in question—creating an additional barrier for the majority of our clients who are best served when their case managers are trained to recognize and address the systemic oppression impacting our clients' lives.

21. In addition to the Resource HUB, AFC launched "Hotel to Home," a project using available hotels in the region to serve people living with HIV who are experiencing homelessness. The goal of Hotel to Home is to decrease the risk of contracting COVID-19 amongst unhoused people living with HIV by immediately moving them into hotels, and then quickly connecting them to permanent housing options. The project is funded by CDPH, HUD's HOPWA program, and through the CARES Act. Hotel to Home is just one way that AFC seeks to address social determinants that contribute to negative health outcomes—specifically, access to safe and stable housing. Statistics have shown us that stable housing not only improves mental health, it also eliminates barriers to care. At AFC, we know that funding for housing is funding for HIV because it provides safety and consistency to our clients and their families. The COVID-19 pandemic, further highlights how important this type of funding is. Now, more than ever, we must be able to use federal funding in a way that specifically meets the needs of our most marginalized and vulnerable clients. In our advocacy efforts during the pandemic, we have specifically called on local, state, and federal representatives to advocate for ongoing support and work that addresses the disparities and inequities in health outcomes for Black and Latinx communities.

22. As a direct result of the Executive Order, AFC has experienced a negative financial impact and is witnessing its chilling effect. In late October, AFC co-sponsored a free, two-day

conference entitled "Positive Change II - Dismantling Racism in the HIV Workplace" ("Positive Change"). The purpose of Positive Change was to both provide information to the HIV workforce and to reflect and strategize on the roles that leaders, communities, and our organizations play in perpetuating structural racism and white supremacy. Positive Change provided attendees with context on the lived experiences of diverse populations heavily impacted by HIV: Black and brown transwomen, gay men, and justice-involved populations. Participants gained insights into building and sustaining a culture of race equity and walked away with an understanding that we cannot get to zero and end the HIV epidemic without race equity. Unfortunately, in the time between the release of the Executive Order and right before Positive Change, our primary sponsor felt compelled by the Executive Order to pull close to $6,000 in federal funding. After the primary fiscal sponsor pulled funding, AFC scrambled to fill the gap and address direct costs associated with holding Positive Change.

23. Ultimately, the Executive Order is another barrier to health equity for communities that have long been pathologized as simply unhealthy. People living with HIV, Black, Indigenous, and Latinx people, and LGBTQ+ people face systemic and structural oppression that often lead to deadly outcomes. AFC was born out of a need to rectify these harms and address the needs of these communities by working with and for them. This work will continue because it must, but the Executive Order will negatively impact our best work. At AFC, we are dedicated to seeing the end of the HIV epidemic, and hope that the courts will recognize that this work must include conversations and trainings that specifically acknowledge and address the systems that oppress our community members because of their race, gender, and/or sexual orientation.

[*signature on next page*]

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated: November 13, 2020

Respectfully submitted,

DocuSigned by:
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Aisha N. Davis, Esp., Director of Policy

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice.*

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF JOHN PELLER, PRESIDENT AND CEO FOR THE AIDS FOUNDATION OF CHICAGO, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, John Peller, hereby state as follows:

1. I am the President and CEO for AIDS Foundation Chicago ("AFC"), a not-for-profit 501(c)(3) organization based in Chicago, Illinois, that mobilizes communities to create equity and justice for people living with and vulnerable to the human immunodeficiency virus ("HIV") or chronic conditions. I have served in this capacity since September 9th, 2014.

2. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

3. As a service organization working with and for people living with or vulnerable to HIV, we feel a responsibility to bring our collective knowledge about the HIV epidemic to bear in this current moment. In recognition of the harms we are still working to overcome, we want this knowledge to help avoid repeating mistakes of the past. In the early days, silence about HIV was the hallmark of the federal government's response to the epidemic. Today, the same federal government seeks to silence us yet again as we work to address one of the root causes of HIV – institutional and societal racism.

4. When AIDS entered the public consciousness in 1981, it was first identified as an ailment affecting gay, white men in New York and San Francisco. Although untrue, the virus was originally characterized as a "gay cancer" and then "gay-related immunodeficiency disorder" (or GRID) – pathologizing an entire community, and placing the blame of a public health crisis at the feet of a queer communities already facing discrimination and bigotry. For Haitian immigrants, injection drug users, and sex workers – communities who were also heavily impacted by AIDS – centering gay, white men meant overlooking these marginalized communities.

5. Due to systemic racism, homophobia, transphobia, and misogyny against the groups most affected by HIV—which included Black and Latinx women, transgender women, and Black

and Latinx gay men— health outcomes were dire. This discrimination was compounded by the structural inequities affecting these groups and as a result, the response to the HIV epidemic over the first decade was mostly apathy and silence. As fatalities grew in cities across the country, governments at all levels largely ignored the problem. It took over four years (until 1985) and the impending death of actor Rock Hudson before the President Ronald Reagan even mentioned AIDS in response to a reporter's direct question, and it took until 1987 before he gave a major address about it.

6. After watching their friends die around them in increasing numbers, while the government and public largely ignored the plague attacking their communities, activists formed the AIDS Coalition to Unleash Power (ACT UP) in New York City in March 1987. With the battle cry of "Silence=Death," ACT UP took to the streets with confrontational and controversial protest activities to bring attention to the ongoing public health crisis and the apathy about the deaths of thousands of their friends and partners.

7. As a movement, we will never be silent again. We know the consequences. We have seen the harm. We have suffered enough from apathy and silence. The work done by activists across the nation pushed the government to take real action to address the growing epidemic and undoubtedly saved thousands of lives in the process. We are still fighting the battle that they initiated in those dark years.

8. The HIV advocacy movement did not get everything right in that first decade, and we are still striving to do better. Many movement leaders did not acknowledge or address the significant impact HIV has, and continues to have, in Black communities, among Latinx people, and among transgender and cisgender women. The failure to recognize these disproportionate impacts and to address the biases and structural inequities that are at the root of them resulted in the HIV-related disparities for these groups that are still evident today. We know that we must

keep talking about them—we cannot be silent—because that is the only path to addressing these disparities and preventing more unnecessary deaths. Yet the Trump administration's executive order that is at the heart of this legal case is forcing us to be silent.

9. And, like the HIV epidemic has done for decades, the COVID-19 pandemic has once again exposed the health disparities that persist for Black, Indigenous, and Latinx communities in this country today. This new health crisis illustrates how the same disparities occur almost 40 years later. HIV advocates have a moral obligation to speak up, to declare the truth about the root causes of these inequities, and to do our part to overcome their effects in the context of this latest global pandemic. Yet Trump's executive order forces us to make an impossible choice. We could use our voice to combat these inequities by training our staff and community on racism and discrimination – or we can forfeit the federal funds that provide life-saving services for people living with and at higher risk for HIV. This choice is simply unacceptable.

10. We will not be silenced by our own government when silence equals death.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated: November 13, 2020

Respectfully submitted,

DocuSigned by:
John Peller
1AE52E5395C34FA...

John Peller, President and CEO

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice*.

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

**admitted pro hac vice*

[Additional Counsel on Signature Page]

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 5:20-CV-07741-BLF

DECLARATION OF ADRIAN SHANKER, EXECUTIVE DIRECTOR OF BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Adrian Shanker, hereby declare as follows:

1. I am the Founder and Executive Director of Bradbury-Sullivan LGBT Community Center ("Bradbury-Sullivan Center").

2. I assumed that role in 2014 when Pennsylvania Diversity Network restructured into Bradbury-Sullivan Center. I received a bachelor's degree from Muhlenberg College in Religion Studies and Political Science in 2009 and earned a Graduate Certificate in LGBT Health Policy & Practice from The George Washington University in 2017. I previously volunteered as Board President of Equality Pennsylvania, served on the Office of Health Equity Advisory Board for the Pennsylvania Department of Health, and co-chaired the community advisory committee for LGBT Healthlink, which was a CDC-funded national disparity network for LGBT tobacco and cancer disparity work.

3. Bradbury-Sullivan Center is a 501(c)(3) non-profit organization that is based in Allentown, Lehigh County, Pennsylvania, and incorporated in Pennsylvania. Bradbury-Sullivan Center is a comprehensive community center dedicated to advancing community and securing the health and well-being of the lesbian, gay, bisexual, and transgender (LGBT) people of the Greater Lehigh Valley, a historically under-served region of Pennsylvania for the LGBT community. Bradbury-Sullivan Center provides programs and services to thousands of community members throughout the year.

4. At Bradbury-Sullivan Center, in addition to staff management, board development, fundraising, and strategic planning, I oversee administration of data collection for the Pennsylvania LGBT Health Needs Assessment. With Health Programs employees at Bradbury-Sullivan Center, I also develop health promotion campaigns to make behavioral, clinical, and policy changes to improve LGBT health. With Training Institute employees, I oversee the content and impact of training we provide to educators, healthcare professionals, government agencies, and more. I

currently serve as LGBTQ subcommittee chair of the Pennsylvania Department of Health's COVID-19 Health Equity Response Team.

5. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

6. Bradbury-Sullivan Center's programs and services for the LGBT community include arts and culture, health promotion, youth programs, pride programs, and supportive services in addition to our Training Institute. Youth services include youth empowerment and HIV prevention in an every-day out-of-school program. Supportive services include providing non-judgmental HIV/STI testing, medical-marijuana enrollment assistance, and support groups, as well as hosting a free legal clinic. And Bradbury-Sullivan Center's Training Institute provides training to agencies throughout Pennsylvania to ensure LGBT inclusion as well as to address health care disparities and barriers to care.

7. Approximately one third of Bradbury-Sullivan Center's annual budget consists of federal funding, either directly or indirectly. This includes, for example, funding from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), National Endowment for the Humanities, and National Council on the Arts. Some of these funds are federal grants that are "pass-through" funds administered by state or local governments, such as the Pennsylvania Department of Health. Without such funding, we would not be able to provide many of the services we provide to our clients.

8. The Executive Order is of great concern to the Bradbury-Sullivan Center as it inhibits the ability of the Bradbury-Sullivan Center to fulfill its mission, to properly serve its community, and frustrates the very purposes for some of the grants the Bradbury-Sullivan Center receives.

9. For example, through the Pennsylvania Department of Health, the Bradbury-Sullivan Center has been incorporated into a five-year grant meant to address tobacco-use disparities funded by the CDC. For the first year of the grant, the Bradbury-Sullivan Center must provide training to contractors and subcontractors of the Pennsylvania Department of Health's Division of Tobacco Prevention and Control on promising practices and evidence-based strategies for addressing LGBT tobacco disparities in Pennsylvania.

10. Of course, health disparities cannot be addressed without a discussion and an understanding of the systemic issues around bias that lead to such disparities. This includes discussion of the social determinants of disparities based on race, sex, and LGBT status, including implicit bias and systemic racism, sex stereotyping, and related anti-LGBT discrimination. Accordingly, in its trainings, the Bradbury-Sullivan Center discusses disparities within the LGBT community, such as those based on race, gender, or age. It is impossible for us to properly conduct our trainings with a list of banned terms or concepts, such as "intersectionality," "unconscious bias," or "systemic racism," that are critical to understanding the causes of such disparities.

11. In addition, the Bradbury-Sullivan Center receives funding from the Network of the National Library of Medicine of the NIH specifically to conduct trainings of personnel at mental health outpatient clinics on promising practices for LGBT care and to conduct community outreach via public libraries to educate the public on breast cancer screenings, LGBT health disparities and barriers to care. The performance period for these two subawards end in April 2021. These trainings and community outreach events necessarily discuss health disparities within the LGBT community, such as those based on race and gender, and address their root causes. Health care providers cannot properly address health disparities without addressing the systemic problems that cause them.

12. Training health care professionals, and others, on implicit bias, systemic racism, sexism, and intersectionality helps health care professionals to provide better and more affirming care to their LGBT patients. Health care professionals more clearly understand the barriers to care, including barriers to disclosure of one's LGBT identity, and can then work to create inclusive and welcoming healthcare environments for their patients.

13. Based on the confusion caused by the Executive Order and our fear about its prohibition on accurate discussions of systemic problems surrounding race and sex, we have been forced to expedite many of our trainings and spend additional resources in making sure that some of these trainings occur prior to November 20, 2020.

14. The Bradbury-Sullivan Center also receives funding through the Pennsylvania Department of Health to train Pennsylvania's COVID-19 contact tracers regarding how to interview LGBT people, including how to ask questions related to sexual orientation and gender identity. Because of higher risk factors such as smoking, higher incidence of cancer and unsuppressed HIV, and decades of barriers to care that have caused many LGBT people to delay or avoid seeking healthcare when they are sick, LGBT people are uniquely vulnerable to COVID-19 and the worst effects of COVID-19. As such, the trainings for COVID-19 contact tracers include discussion of barriers to care that contact tracers may need to address in the course of their work. Upon information and belief, the Pennsylvania Department of Health receives federal funding for COVID-19 contact tracing.

15. Bradbury-Sullivan Center spends a significant amount of resources documenting health disparities in the LGBT community. Some of this work is documented in the Pennsylvania 2018 LGBT Health Needs Assessment that Bradbury-Sullivan Center helped conduct and can be found at https://tinyurl.com/2018PaLGBTHealthNeeds. The Bradbury-Sullivan Center is also working on the 2020 LGBT Health Needs Assessment, which is funded by the Pennsylvania

Department of Health. Upon information and belief, some of the funds being used for the 2020 LGBT Health Needs Assessment are federal in origin.

16. In order to properly understand the health needs of the LGBT community in Pennsylvania, we must gather and seek data to unearth health disparities. Accordingly, the Pennsylvania LGBT Health Needs Assessment asks questions about race and gender. Data gathered from that work confirmed that only about 17% of LGBT Pennsylvanians in 2018 had a provider whom they considered to be their personal physician. That means that in times of need, LGBT people are more likely to randomly select a health care provider with whom they do not have a relationship, putting them at increased risk of finding a provider who is not LGBT-welcoming. Data from 2018 also indicated that over 50% of LGB and 75% of the transgender community fear going to a health care provider due to negative past experiences directly related to the patients' sexual orientation or gender identities.

17. Bradbury-Sullivan Center's research into health disparities facing the LGBT community reveals that approximately one in four members of the community in our region experience a negative reaction from a health care provider when they come out as LGBT. More than half of respondents report fear of a negative reaction by a health care provider if they come out. Indeed, approximately three quarters of all transgender respondents fear such a negative reaction. Our research also identifies pervasive health disparities between LGBT people and the majority population with respect to tobacco use, cancer, HIV, obesity, mental health, access to care, and more, with LGBT people consistently experiencing worsened health outcomes. The same is true during the COVID-19 pandemic, where LGBT people are uniquely vulnerable to COVID-19. What is more, the needs assessment confirms intracommunity disparities, with LGBT people of color, transgender people, and women experiencing disparities that run even deeper than the rest of the LGBT population. Due to intersectional health challenges, these multiply

marginalized populations are doubly or triply impacted with systemic healthcare bias — biases due to sexism, racism, homophobia, and/or transphobia.

18. In order to fulfill our mission to advance the health and well-being of the LGBT community in Pennsylvania, and particularly in the Lehigh Valley, Bradbury-Sullivan Center through its Training Institute provides LGBT cultural competency training, training on barriers to care and health disparities, health care consumer panels, Art History from a Queer Perspective presentations, and policy development. Our trainings focus on helping to understand the best ways to avoid creating barriers to communication by understanding the best language to use, the cultural circumstances of this population, and the misunderstandings that may occur inadvertently. The trainings also explain that professionalism may require understanding that past disparities, barriers to care, and past negative experiences among marginalized populations require intentional efforts to create equity. These trainings represent a significant revenue line for a small organization like ours.

19. For example, our LGBT Cultural Competency Training includes current definitions and explanations of essential language that describe and engage the LGBT population. It details the sources of minority stress that contribute to barriers to care and health disparities. It focuses on current federal, state, and municipal laws, policies, requirements, and promising practices to have a positive impact on LGBT people. It outlines proven strategies that mitigate risk, discrimination, and self-harm. It explains that professionalism may require understanding that negative past experiences and the community's cultural history of bias and discrimination require additional efforts to create equity, and it includes information on steps that organizations may use to further approach equity. Finally, the training provides an understanding of intersectionality and the layered identities that cause some LGBT people to be multiply-marginalized. And the training

explains why "treating everyone the same" may not meet the needs of the LGBT community an organization serves.

20. Upon information and belief, many of the clients of Bradbury-Sullivan Center's training programs include both federal contractors and grantees. For example, Bradbury-Sullivan Center has provided recent trainings for staff at: school districts, such as the Allentown, Central York, Interior, Quakertown, Pennsridge, and Reading School Districts; university and colleges, such as Penn State University, Penn State College of Medicine, and Muhlenberg College; and state and local governmental agencies, such as the Pennsylvania Department of Health, Pennsylvania Housing Finance Agency, City of Allentown Health Bureau, and Erie County Department of Health. Each of these entities may now be more reluctant to seek, or even prohibited from seeking, our trainings for their employees for fear of being deemed noncompliant under the Executive Order and losing their federal funding. Indeed, I am personally aware of entities in Pennsylvania like those outlined above that have canceled or sought to excise content from diversity and inclusion trainings as a direct result of the Executive Order.

21. Bradbury-Sullivan Center is significantly funded through government grants, with many originating through Federal funding sources. Some of these grants are specifically intended to provide training to health care providers. If the Executive Order were to go into effect, it could have an immediate impact on existing grants, as well as on future grants, and on the ability of Bradbury-Sullivan Center to effectuate its mission. Training material cannot simply remove any acknowledgement of systemic racism, cultural humility, or implicit bias based on race, sex, or LGBT status, and an inability to offer training would limit the ability of the LGBT community served by Bradbury-Sullivan Center to receive affirming services and treatment from health care providers in Pennsylvania.

22. The Executive Order has a chilling effect on Bradbury-Sullivan Center, would negatively impact its finances, harms the organization's mission, and harms the community members served by Bradbury-Sullivan Center, many of whom are vulnerable and marginalized in multiple ways. Indeed, the harm caused by the Executive Order—and its chilling effect on Bradbury-Sullivan Center's work—may be particularly damaging in light of the COVID-19 crisis, which has increased social isolation, compounded pre-existing mental health issues, made people (especially young people and seniors) more vulnerable to abuse and exploitation, and caused a cascading economic crisis for many people. The LGBT community trusts Bradbury-Sullivan Center for the services and training it provides and that community trust would be harmed by self-censorship about systemic racism and sexism, not to mention the inability to train our staff about implicit bias, and the other concepts deemed "divisive" by the Executive Order.

23. What is more, the vague nature of the Executive Order itself is burdensome because it is so difficult to know what content will get us into trouble or get our training clients into trouble. We are worried that our staff could themselves, our organization, or our training clients into trouble simply because when they relate their personal narratives, they may make members of the audience uncomfortable during speaking engagements or media appearances, or they acknowledge the role that systemic racism, sexism, or implicit bias has had in shaping their experiences. The thought that an employee of a training client who simply doesn't want to attend the training could call the Department of Labor hotline to complain will having a chilling effect on our training clients ability to hire us for training, on our staff who provide training, and on the finances of our organization.

[*Signature in next page.*]

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 12th day of November, 2020.

DocuSigned by:
Adrian Shanker
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Adrian Shanker

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice*.

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF BERNADETTE E. BROWN, PROPRIETER OF B. BROWN CONSULTING, LLC, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Bernadette E. Brown, declare as follows:

1. I am the Founder and Sole Proprietor of B. Brown Consulting, LLC. ("Brown Consulting"). Brown Consulting is a Limited Liability Corporation ("LLC') that is based in Bloomfield Hills, Michigan and incorporated in Michigan.

2. Brown Consulting is a federal subcontractor, receiving pass-through federal funding through a subcontract with the National Prison Rape Elimination Act Resource Center ("The PRC"). The PRC is funded by the DOJ Bureau of Justice Assistance and operates via a cooperative agreement between the DOJ and nonprofit organization Impact Justice. I received and accepted a "no cost extension" to my existing subcontract for these services on September 23, 2020, which extended the contract term until October 31, 2021. Separate and in addition to my contract with the PRC, my consulting business provides training and consultation to other entities such as law enforcement, federal executive branch agencies, juvenile justice and other state and local agencies, and national and local nonprofits.

3. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

4. I received my A.B. in anthropology from Columbia University, where I was a Robert A. Quittmeyer Scholar and a member of the Dean's List. I received my J.D. from Boston University School of Law, where I was an Edward F. Hennessey Scholar. I am licensed to practice law in the state of New York.

5. I began my career as a public defender in New York City at the Neighborhood Defender Service of Harlem, an experience that emboldened my commitment to a just and equitable society. After leaving the public defense sector, I worked for a range of institutions and organizations promoting justice and equity, which included serving as a senior program specialist

for the National Council on Crime and Delinquency in California, as a policy director and lobbyist for Michigan's lesbian, gay, bisexual, transgender, and queer ("LGBTQ") equal rights organization, as the director of the Center for Sexual and Gender Diversity at Duke University, and as the deputy legislative director at the New York Civil Liberties Union.

6. I launched Brown Consulting in 2018 to work with partners across the spectrum to explore new strategies to end the cycles of incarceration. An equitable, inclusive and healthy society includes many participants. There are many systems in communities that intersect to support the well-being of community members. When there are gaps in these systems, it can result in fewer opportunities for some people, while providing an abundance of opportunity for other people. The most egregious of these gaps can create discrimination, harassment and a range of traumas that result in involvement with the juvenile and criminal justice systems. Consequently, Brown Consulting seeks to work with and within agencies, organizations, and institutions as a thought partner to prevent and remedy these inequities. Building on my prior work and life experience as a Black, bisexual, cisgender woman, one of my areas of expertise is examining how the intersections of sexual orientation, gender identity and gender expression ("SOGIE"), race, ethnicity, and sex can lead to a person's involvement with and experiences in, the juvenile justice and/or criminal justice systems.

7. As a consultant to the PRC and prior to my current contract, I developed the first lesbian, gay, bisexual, transgender, and intersex ("LGBTI") and gender nonconforming ("GNC") training curriculum for those seeking to become certified Prison Rape Elimination Act ("PREA") auditors (individuals who determine whether juvenile and adult detention facilities are compliant with the PREA standards) by the U.S. Department of Justice. PREA, a federal law passed by Congress and signed into law by President George W. Bush in 2003, recognized that youth and adults who are incarcerated face high rates of sexual harassment and sexual violence and explicitly

acknowledged that non-heterosexual juvenile residents and non-heterosexual and transgender adult inmates faces higher rates of sexual victimization than their heterosexual and cisgender peers. First, it is important to note that LGBT and questioning ("LGBTQ") people are overrepresented in the juvenile and criminal justice systems. Though the percentage of LGBQ youth in the U.S. population range from 7-10.5%,[1] approximately 20% of youth in the juvenile justice system identify as LGBQ and GNC, and 85% are youth of color. The disproportionality based on identity compared to the general population of youth is stark for girls where approximately 39.4% identified as LGB and additional 18.5% acknowledged attraction to those of the same sex. The incarceration rate for LGB adults is 1,882 per 100,000, more than *three* times that of the U.S. adult population. Once again, the percentages are higher for women: 35.7% of women in jails and 42.1% of women in prisons identify as lesbian or bisexual, or acknowledge engaging in same-sex sexual behavior. While 0.6% of adults in U.S. identify as transgender, 16% of transgender people report experiencing incarceration at some point during their life. Data compiled from the National Inmate Survey 2011-2012 by the Bureau of Justice Statistics ("BJS"), U.S. Department of Justice, stated that, "[i]nmates with the highest rates of sexual victimization are those who reported their sexual orientation as gay, lesbian, bisexual, or other." In prisons, 5.4% of non-heterosexual inmates reported experiencing sexual victimization by a staff member compared to 2.1% of heterosexual inmates. That figure rises to 12.2% for non-heterosexual inmates who experience sexual victimization by other inmates as compared to 1.2% of heterosexual inmates. These numbers are worse for transgender inmates. In prisons, 15.2% of transgender inmates report experiencing sexual victimization by staff, and 33.2% are victimized by other inmates. Youth in juvenile facilities are also at greater risk. Data compiled by BJS from the National Survey of Youth in

[1] Estimates in studies quantifying the number of LGBTQ youth in the general population vary depending on the terms both youth and researchers use in surveys, as well as the categories included, e.g. sexual orientation, gender identity, or gender expression.

Custody, 2012 uncovered that non-heterosexual youth reported a "substantially higher" sexual victimization rate (10.3%) by other youth as compared to heterosexual youth (1.5%).

8. Approximately 75-80% of Brown Consulting's annual income comes from my contract with the PRC. Without such funding, my income and livelihood would be severely impacted.

9. The work I perform as part of my contract with the PRC falls into two main categories. First, I conduct PREA auditor trainings which includes presenting material on LGBTI and GNC inmates, detainees and juvenile residents. This training focuses on obligations under PREA to ensure the safety of LGBTI and GNC youth and adults who are detained, incarcerated, or otherwise housed in secure settings within the juvenile and criminal justice systems. I also assist in the trainings for PREA auditors by facilitating small group discussions about general topics covered. These trainings generally, but not always, occur once a year.

10. The other portion of my contract with the PRC is to provide training and technical assistance (including policy and practice guidance) upon request, to adult and youth correctional and detention facility staff, including institutional leadership (wardens, chiefs, superintendents, commissioners, directors, etc.), corrections officers, medical and mental health providers, food service workers, maintenance staff, and other administrators. This work also includes representing the PRC at national conferences such as the American Jail Association and the American Probation and Parole Association.

11. The other work of Brown Consulting apart from the PRC contract involves developing and delivering training content tailored to the needs of nonprofits and state and local agencies whose staff works with populations who are over-represented in the juvenile or criminal justice systems or at risk of incarceration. I also consult with agencies seeking to establish nondiscrimination policies and implement procedures that prohibit discrimination and harassment

on the basis of protected classes such as gender, sexual orientation, gender identity, or gender expression (and noting if race, ethnicity, disability, or other protected classes are not included in existing policy), and incorporate best practices into their work.

12. The content of my trainings to nonprofits and state and local government entities depends on the needs of the entity requesting training or technical assistance, but usually consists of explanations of concepts and terminology related to SOGIE and appropriate use of terminology; discussions of the impact of the intersections of race and/or ethnicity and SOGIE in society and in the context of the juvenile and adult justice systems; addressing and combatting stereotypes around race; "coming out"; racism within the LGBTQ community; regional, racial and cultural differences regarding LGBTQI-related terminology; implicit bias and the role it plays in contributing to disproportionately high rates of harm by law enforcement, incarceration, increased surveillance, and negative interactions with justice professionals for Black and Brown people and Black and Brown LGBTQ and GNC youth and adults, in particular; white privilege; racism; sexism; heteronormativity and cisnormativity; societal gender expectations; and why gender pronouns are important.

13. The Executive Order is of great concern to me as it impacts my ability to provide trainings that I perform that are not part of a federal government contract or grant, that focus on subjects prohibited by the Executive Order, and that account for a significant proportion of my income.

14. Disparities in juvenile and adult justice systems, including policing, cannot be addressed without a discussion and an understanding of the systemic issues around bias that lead to such disparities. This includes discussion of systemic issues and bias that lead to racial- and gender-based disparities. Accordingly, in my trainings, I discuss disparities for people of color, particularly for Black people, including LGBTQ and GNC people. It is impossible for me to

conduct trainings given the nature of my work, and the clients who hire me to perform this work for them, if I have to do so with a list of banned terms and concepts, such as intersectionality, unconscious bias, or systemic racism, that are critical to understanding the causes of such disparities and the experiences of youth and adults interacting with justice systems, and essential to protecting them from harm if they are incarcerated or detained.

15. I am worried that I could get into trouble simply by relaying credible, accurate data and research findings, in addition to my personal narrative, and thereby making members of the audience uncomfortable. For example, at a recent PRC-funded training, I noticed two officers in the back of the room who were looking at their cell phones and typing constantly during my presentation. One officer (Officer A) used his phone more than the other one (Officer B). I wondered if they were paying attention, and/or communicating with each other. At the end of the training both officers approached me. Officer A thanked me for the training and explained that he was fact checking everything I said during the training, searching all of the research I cited to ensure my credibility. After determining I was credible, he said he was grateful that the agency selected a trainer who actually knew what they were talking about. (He stated that he's attended trainings where that was not the case.) In another training, an officer, a straight Black man, expressed appreciation that I discussed dispelling the myth that straight/heterosexual, cisgender, religious Black people are more anti-LGBTQ than anyone else. Discussing my own experience as a Black bisexual woman who grew up with a lesbian mom and my supportive Black family members, including an extremely religious grandmother, always underscores this point. I have also discussed the violence and incarceration that occurred in my family and my community in Detroit, how the country's racist drug policies contributed to the incarceration of many of my family members, and how this inspired me to do this work. While these participants were receptive and appreciative of my knowledge and expertise, and how my personal experience informs my work

and trainings, their feedback underscores how closely participants pay attention to the sources I use and to my own personal narrative. A participant who is paying equally close attention, and not receptive to the information I am presenting, could easily see the research I cite, which acknowledges the existence of systemic racism and implicit bias, or discussing my own experiences to illustrate systemic racism and implicit bias, as offensive. In the above scenario, if Officer A were recalcitrant, or worse, affirmatively anti-LGBTQI and/or consciously racist, instead of researching the citations, he could have pulled up the Department of Labor website and emailed a complaint before the training even concluded. And instantly my income and livelihood would have been at risk, and more importantly, valuable information that's required to protect the safety and well-being of vulnerable people who are incarcerated or detained would not be obtained.

16. Some of the data and research I share in my trainings demonstrate the disproportional representation of youth of color in the juvenile justice system, how systemic racism in school is often the first entryway into the juvenile justice system, and how heteronormativity contributes to girls who identify as non-heterosexual becoming targets for teachers, and then police officers, in addition to detention facility staff. These bad outcomes can be more pronounced for girls of color simply because they oftentimes tend to be first targeted by race. I also share research that demonstrates that girls in same-sex relationships are at least 8 times more likely to be arrested for statutory rape as compared to their male and straight peers, and incidents where the victim was white were much more likely to result in an arrest; Black GNC girls are more likely to be profiled as gang members or assumed to be in possession of drugs; and transgender and GNC youth of color are more likely to experience harassment as compared to white and gender conforming youth. A 2016 study of girls in California's juvenile justice system (in which Black, Latina and multiracial girls comprise 90% of the system) uncovered glaring differences between white, straight girls and lesbian, bisexual, or questioning ("LBQ") girls of color in the system. As compared to a white,

straight girl: a white, LBQ girl is 8 times more likely to enter the system; a Latina, LBQ girl is 15 times more likely to enter the system; a Black, LBQ girl is 71 times more likely to enter the system; and an LBQ girl with more than one racial or ethnic identity is 265 times more likely to enter the system.

17. These disparities result, in significant part, from systemic racism, sexism, and anti-LGBT bias. One of the contributors to systemic discrimination is the role of implicit bias on the part of school administrators, members of law enforcement, and correctional staff. Research has found, for example, that adult perception of black girls as less innocent and more adult-like than their white peers may contribute to harsher punishment by educators and school resource officers and that disparate police treatment of Black people stopped in groups may be driven by societal biases, such as stereotypes of threat and aggression even though no evidence suggests that Black groups are more likely to be engaged in illegal activity. As an example, at a juvenile facility in one jurisdiction where I was consulting (not PRC-funded), a Black gay girl who was GNC received a love letter from another Black gay girl who was gender conforming. The letter was typical of adolescent behavior and development and, had they not been in a juvenile facility, would've been viewed as such. The Black GNC girl, the recipient of the letter, was punished by being placed in isolation, overnight, with one staff member supervising her. The officer who meted out this punishment claimed that the GNC girl "enticed" the other girl to write the letter. This is an example of a Black girl, whose sexual orientation is deemed unacceptable, and whose gender expression is masculine, is automatically viewed as "aggressive" and "predatory," and therefore other girls must be protected from her. These trainings help officials who have disciplinary or punitive control over other peoples' lives to check and combat implicit bias in themselves in order to reduce harm to the populations they serve.

18. In my trainings, there are always corrections officers and other staff who absolutely do not appreciate this research and the commentary I provide. Many people completely divorce race and ethnicity from SOGIE (and while they are separate identities, they are profoundly linked within the justice context), and consequently are not prepared to address or discuss the intersections. I have read evaluations of my trainings in which officers have told me that I'm going to hell because of my sexual orientation, and that my son should be ashamed to have me as his mother (both of these were from non-PRC related trainings). This resistance to, and harassment of, me while conducting trainings also occurs outside of the youth and criminal justice context. I have conducted non-PRC contract trainings for social workers who could also file complaints. In my trainings there have been white social workers who do not appreciate that I highlight information about the racist underpinnings of the child welfare system in the U.S., particularly pronounced within Black and Indigenous communities. There have also been straight, cisgender social workers in trainings who have argued with me about respectful terminology for LGBTQI and GNC youth; there was one social worker who stated that her gay friend gave her permission to use outdated terms that are considered offensive by many in the LGBTQ community so she did not have to listen to what I said.

19. I am concerned about how the Executive Order might impact my non-PRC contracts. At present, I am currently working on a non-PRC contract with a nonprofit agency. I just completed the first draft of the curriculum and chose not to add material on white privilege and racism because of the Executive Order. Instead, I elected to wait until my meeting with the organization to ask them questions about including this material. I was also recently introduced to the police chief at a large police department who encouraged me to reach out to him to discuss community policing and the LGBTQ community. This occurred prior to the Executive Order. Now I am in the position of thinking about how to approach the police chief, and measuring what I

might say knowing that this department has received some federal funding in the past. Moreover, many police departments in the country receive federal funding and I am concerned that other future clients might shy away from engaging with me, knowing that I discuss white privilege, cisgender privilege, heteronormativity, and other subjects prohibited by the Executive Order. They may even peruse my website through the lens of the Executive Order and I may never receive the opportunity for an introductory meeting to explain my services. In addition to the above, I am also invited to present or be a guest lecturer at colleges and universities, many of which receive federal funding. Thus, I am very concerned that I may lose those opportunities as well.

20. I feel as a result of the Executive Order I have two choices: (1) choose to continue to do the right thing and risk losing my PRC contract in addition to non-PRC potential clients, or (2) censor my language in a manner that does not run afoul of the order. Given the order's broad scope, it would be difficult for me to determine which terms and ideas to avoid, especially given that my entire professional field is an offshoot of slavery in the U.S.

21. I am most profoundly concerned, however, for the youth, some as young as 10 (or even younger), and adults (or young people treated as adults when they are 16 or 17 or even younger) who are confined in our nation's detention centers, jails, prisons, lockups and community confinement facilities, especially LGBTQI or GNC youth and adults. They are among the most vulnerable members of our society and even more at risk when in custodial settings. And being disproportionately people of color and LGBTQI or GNC, most of them have already experienced trauma and harm associated with discrimination and bias on account of multiple aspects of their identities in their everyday lives. With high rates of unemployment, school bullying, depression, suicidal ideation, self-harm, and suicide among LGBTQ or GNC people in general, protecting them from harassment, victimization and isolation (specifically, the number of transgender people who are placed in solitary confinement because the correctional facility determined that's the only

way to keep them "safe") while incarcerated can literally be a matter of life and death. I think censoring myself will automatically result in less effective training, thereby placing the people I serve at more risk for all of the harms noted in this declaration.

22. A supportive environment where people who are detained or incarcerated are safe also keeps officers and other facility staff safe by reducing conflict and violence. After one of my trainings, a captain in a correctional facility told me that a transgender inmate in their care had repeatedly made complaints that staff refused to respect their identity and use their gender pronouns. There were constant disciplinary issues, complaints and incidents. The captain reported that after my training he worked with staff and trained them to treat the inmate with dignity and respect. When staff implemented the captain's orders, disciplinary events reduced dramatically. The captain stated that an important part of educating of his staff was emphasizing that their professional duties would be easier to fulfill and *they* would be safer if staff fostered a more inclusive and respectful environment. During another training at a juvenile facility, I had the opportunity to provide an educational session on SOGIE for the youth themselves. The young people were active participants. Several weeks after the training, the officer who organized the training contacted me and told me that many of the young people who attended the session became vocal advocates for treating LGBTQI and GNC youth with dignity and respect. When other people who are detained understand that everyone should be treated with humanity, it reduces the likelihood of bullying, harassment and violence. This also made the job easier for many staff members who were worried that they would meet with resistance when discussing this topic. Instead, many of the young people became ambassadors for the safety and well-being of all youth.

23. I worry that it will be impossible to address the underlying harms that are the reason for the existence of the contract I have with the PRC under the terms of the Executive Order, and will frustrate the entire purpose of PREA and the PRC's work as a critical program of the U.S.

Department of Justice, Bureau of Justice Assistance. And I also worry that other agencies and organizations, especially ones that receive federal funding, that want to receive the type of training and assistance my consulting business provides to help them address systemic racism and gender bias in their own work will no longer seek out this training. Or if they do, participants will utilize the hotline to shut down information they don't want to hear and, as collateral damage, end my business and eliminate my livelihood.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 13th day of November, 2020.

Bernadette E. Brown
Sole Proprietor
B. Brown Consulting, LLC.

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
* *admitted pro hac vice*.

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF ALICE RIENER, CHIEF OF STAFF FOR CRESCENTCARE, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Alice Riener, hereby state as follows:

1. I am the Chief of Staff for NO/AIDS Task Force d/b/a CrescentCare (hereinafter "CrescentCare") in New Orleans, Louisiana.

2. CrescentCare's mission is to offer comprehensive health and wellness services to the community, to advocate empowerment, to safeguard the rights and dignity of individuals, and to provide for an enlightened public. CrescentCare strives to lead in quality-driven health and wellness care, and to meet existing and emerging needs with active participation from the community we serve. CrescentCare provides high quality and culturally humble care to the entire New Orleans community. We are particularly focused on our Greater New Orleans neighbors who come from traditionally medically underserved communities: the service industry, the LGBTQ community, the uninsured and the underinsured, immigrants, and communities of color. We provide comprehensive health and wellness care with integrity, quality, respect, and compassion that is safe, effective, patient-centered, timely and efficient, equitable and evidence-based.

3. The NO/AIDS Task Force was founded in 1983 in response to the early devastating effects of the HIV epidemic in New Orleans. In the years following, we continued to expand our services in response to community need and the impact of the HIV epidemic on diverse populations. Throughout the 1990s and early 2000s, we added case management, mental health services, a meal delivery program and a community prevention and education project. In response to the community need for health care in post-Hurricane Katrina New Orleans, and the opportunities offered to organizations under the Affordable Care Act, we looked to expand our mission and services as a community health center. In 2013, we became a Federally Qualified Health Center (FQHC). During this transformation, we changed our name to CrescentCare and expanded our mission to provide comprehensive health and wellness services and advocate empowerment for the whole community. As we continue to evolve, we are committed to providing high quality,

humble and affordable health care and supportive services to the vulnerable in our community. Because we work holistically at the intersection of health and social determinants of health, we have also added a Legal Services program to our complement of services, which provides free legal assistance to people living with HIV and others throughout Louisiana. Our response to systematic racism, homophobia, biphobia, transphobia, anti-immigrant sentiment, and misogyny is to provide exceptional services and create a culture of humility, intersectionality, and inclusiveness for the entire community.

4. As Chief of Staff at CrescentCare, I am part of the senior leadership team, and provide management and administrative support for grants, conduct oversight of compliance and audit requirements, oversee the finance and revenue cycle departments, and guide the human resources aspect of CrescentCare. I lead strategic initiatives and numerous special projects. Along with our CEO, I staff the Board Executive Committee and steer Board education efforts, as well as track compliance and risk issues to report to the Board.

5. I submit this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

6. CrescentCare's client population is diverse. Forty-six percent (46%) are African American, 39% are White, and 10% are Hispanic. Over 77% are between the ages of 25-64, and 13% are between the ages of 19-24. Fifty-six percent (56%) are male and 44% are female; 3% are transgender. Twenty-three percent (23%) are lesbian or gay, 60% are straight, and 9% are bisexual. Almost half (48%) of our clients have incomes below 100 percent of the federal poverty level, and only 12% had incomes over 200 percent of the federal poverty level. Thirty-five percent (35%) of our patients are uninsured, and 36% are on Medicaid. Our client population experiences high rates of chronic medical conditions, homelessness, unstable housing, extensive trauma history, and

discrimination and stigmatization. Our clients come to CrescentCare from all across Louisiana and the Gulf South region to seek services in a safe and affirming environment.

7. As a health care, social services, housing, and legal services provider, CrescentCare receives various forms of federal funding directly and indirectly via federal programs, including but not limited to those authorized by the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 and the Housing Opportunities for People with AIDS ("HOPWA") program. These federal grants are administered by the Department of Health and Human Services ("HHS") and the Department of Housing and Urban Development ("HUD"). Some of these federal grants are "pass-through" funds administered by state or local governments. These grants and the programs that they facilitate, such as the 340B Drug Pricing Program (a federal program requiring drug manufacturers to provide outpatient drugs to eligible health care organizations at significantly reduced prices), account for approximately 70% of CrescentCare's income. Without such funding, we could not provide many of the services we now provide to our clients.

8. Embedded in the Deep South, our staff's understanding of the history and legacy of slavery, implicit bias, and the ongoing impact of systemic racism are imperative to our organization's ability to provide culturally competent care to our diverse population. Many of CrescentCare's grants necessitate an acknowledgement of and an effort to provide culturally competent care. Several of CrescentCare's grants require targeted outreach to minority populations. Such grants include our SAMHSA Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Population at High Risk for HIV/AIDS, which is focused on African Americans; our HRSA Ryan White Part F grant for Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who Have Sex with Men, and our PS17-1704 grant from the CDC for Comprehensive High-

Impact HIV Prevention for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color.

9. Cultural competency, including an acknowledgment of medical mistrust within communities of color and recognition of the ongoing impacts of structural racism, is an integral part of our delivery of care. CrescentCare's Ryan White grants for individuals living with HIV require documentation of patient demographics including race/ethnicity and also documentation of health outcomes disparities. CrescentCare's Ryan White Part A grant through the City of New Orleans requires detailed information on the racial/ethnic make-up of CrescentCare's Board of Trustees, staff, and patients. As a Federally Qualified Health Center, CrescentCare's HRSA Section 330 grant requires that at least 51% of CrescentCare's Board members are patients served by the health center and that patient members as a group reasonably represent the demographics of the patient population. The Section 330 grant also requires regular reporting on patient race and ethnicity through the annual Uniform Data Systems (UDS) report. To effectively serve diverse patients—including LGBTQ patients, transgender patients, and patients of color—CrescentCare's staff must be culturally competent and address mistrust of medical providers that frequently exists in these populations. CrescentCare also is required to have significant patient involvement and input on programs from patients that reflect the demographics of those served by those programs. With the COVID-19 pandemic, CrescentCare has received additional HRSA funding and Federal Communications Commission ("FCC") funding to test and help address COVID-19 disparities among the African American population, with special strategies such as home monitoring for blood pressure and providing telehealth devices to patients across the digital divide.

10. The Executive Order would significantly impact CrescentCare's ability to effectively implement and manage many of its federal grants. Some grants are explicitly designed and funded by the federal government to address minority populations and minority health

disparities, which cannot be effectively addressed without understanding its systemic causes. Not only are cultural competency and acknowledgement of the systemic causes of health disparities necessary for CrescentCare to fulfill its mission, cultural competency is also specifically referenced in a number of CrescentCare's grants and CrescentCare's staff must be able to competently provide services to meet the grant requirements. For example, the Health Center Program Site Visit protocol for the Section 330 FQHC grant requires us to provide evidence of training of front desk and clinical staff in cultural knowledge, attitudes, and beliefs of patient population. Our Ryan White Part A grant from the City of Baton Rouge requires us to provide yearly proof of cultural humility trainings for our staff. The Executive Order would require CrescentCare to secure other, non-federal funds to fulfill the requirements of these federal grants.

11. It is essential that CrescentCare continue to be able to train its own staff, including health care professionals, on matters relating to cultural competency and diversity. Specifically, it is absolutely necessary that our staff receive training on systemic racism, sexism and implicit bias as these concepts relate to health care disparities for the patients we serve. CrescentCare has often been awarded competitive grants—such as the Part F SPNS grant, the 1704 grant and the COVID grants—precisely because we have a demonstrated track record of engaging these marginalized communities and of improving health outcomes by providing access to care and services. Successful engagement of these communities is a direct result of the type of trainings that would be prohibited by the Executive Order. The COVID-19 pandemic has highlighted the health disparities our providers and staff contend with on a daily basis in working with the communities we serve. The COVID-19 data from Louisiana and New Orleans clearly shows that people of color have died from COVID-19 in disproportionate numbers.

12. Our stated goal with trainings and this work is to create a culture within our organization of reflection, insight, awareness, acceptance, kindness, and support for our staff so

that we can more effectively serve the community and achieve our mission. The purpose of this facilitated dialogue and the training is to provide a fact-based historical context, an understanding of historical trauma, and to enhance our staff's ability to assist the clients and communities we serve. The training is meant to make our staff more effective at the work of improving health outcomes. It is meant to ensure that all of our staff are approaching the care and services we provide with an understanding of the myriad of complex issues the clients face in navigating their day-to-day world. It is intended to improve the communication and understanding between staff and provide tools and vocabulary for navigating challenging conversations and topics.

13. The training we have provided in the past includes concepts such as cultural humility, identifying interpersonal and institutional bias, and internalized oppression. It explores ideas around implicit bias. For staff whose life experience have not exposed them to these concepts and frameworks, the purpose of the training is to deepen their empathy and broaden their understanding and their ability to connect with individuals we serve whose life experiences differ from their own. For staff whose life experiences mirror our patients and clients, the training is a way of validating their experiences and creating a shared language and understanding.

14. Moreover, trainings—whether internal or performed for client entities or members of the public—comprise only one part of CrescentCare's comprehensive approach to combating structural racism and its impact on patient health and well-being. We intentionally combat implicit bias and acknowledges structural racism as part of our mission through hiring staff from specific communities we serve. We prioritize outreach and advertising to communities of color independent of particular federal grants to encourage them to seek testing or treatment. We provide translators for patients with language barriers to ensure they can access services. We offer support groups for particular communities such as Black trans women.

15. CrescentCare helps ensure cultural competency throughout its organization and programs, as well as in the community, in a number of ways. For example, CrescentCare created a Transgender Advisory Committee (TAC) in 2017 which has collaborated with other organizations providing transgender-related services and hosted the first Community Forums on Transgender Health in New Orleans with over 50 participants with a focus on Creating Accountability in Healthcare. The TAC also created a training and presentation on "Prioritizing Trans-Feminine and Gender Non-Conforming Voices in Public Health" that was presented to 100 fellow public health workers, providers and organizers at the Philadelphia Transgender Wellness Conference. The TAC also developed best practices for transgender leadership skills and transgender care delivery. The TAC assisted with a trans-focused cultural competency training at University Medical Center and offered technical assistance to Unity's Rainbow Friends initiative which focused on reducing incidence of LGBTQ homelessness with an emphasis on transgender individuals.

16. In another example of CrescentCare's leadership on diversity, in 2018 it created a Black Leadership Advisory Committee (BLAC) to address diversity and to create solutions for health disparities for African Americans and lead cultural competency initiatives at CrescentCare. In addition, initial orientation for new employees includes in-depth discussion and dialogue about multicultural awareness, LGBTQ sensitivity training and customer service training needed to provide exemplary care and services to CrescentCare's patients. As additional needs are identified for cultural competency training as well as other training opportunities, in-services are designed in-house with content experts and offered to CrescentCare employees as appropriate in their respective departments.

17. Recent competency trainings include topics related to sensitivity toward Latino/a population, Black populations (Undoing Racism workshops provided by the People's Institute for

Survival and Beyond), LGBTQ community (Homophobia/Transphobia Awareness workshops provided by the Center for Excellence for Transgender Health and the California STD/HIV Prevention Training Center), homeless population, and individuals living with disabilities.

18. CrescentCare's office and clinic settings are designed to adhere to trauma-informed practices by offering safe, supportive and welcoming environments. Waiting rooms and other areas have safe zone signs, YMSM, MSM, lesbian, bisexual, transgender literature on safer sex and drug use harm reduction practices, condoms, and a non-discrimination employment policy that includes sexual orientation and gender identity/expression. CrescentCare is also a well-recognized leader in advocacy activities at the local, state, and national level. The National LGBT Healthcare Equality Index is administered by the Human Rights Campaign Foundation (HRC). CrescentCare has been designated a LGBTQ Healthcare Equality Leader each year 2016-2019. This nationally recognized designation is bestowed when an organization demonstrates their commitment to health equity by completing focused training on the LGBTQ populations, including mandatory training for organization leadership.

19. Given that most of CrescentCare's budget is comprised of iterations of federal funding, the Executive Order could cause significant concern and confusion among CrescentCare's staff and board members with the following types of potential negative outcomes:

a. The organization may not be able to renew certain grants or apply for additional federal funds that reference disparities if the organization is not allowed to ensure that staff are culturally competent to carry out strategies to reduce disparities among certain populations. This could have a significant negative effect on CrescentCare's ability to provide needed HIV services in the community and very adversely impacts its financial sustainability.

b. Staff and board members may be unable to participate in public awareness initiatives, conferences, media interviews, and other opportunities to educate the public about health care disparities. CrescentCare has been a regional and national leader in HIV care for people of color and the LGBTQ population for many years and the Executive Order could inhibit its participation and presentations at national conferences and in national and regional working groups.

c. CrescentCare's medical providers have done significant publication of research that includes disparity information. Ongoing interest by CrescentCare providers to conduct and publicize such research could also be jeopardized, given the routine use of federal funds for the underlying work.

d. Internal issues among staff members may develop if the organization is not able to provide diversity and equity training to ensure a cohesive and integrated organization.

20. If CrescentCare cannot provide rigorous training on implicit bias to its staff, its patients could suffer. Implicit bias based on race, sex, and LGBTQ status on the part of health care providers can harm the quality of patient care, patient and patient outcomes. The unexamined behavior might be subtle. It might manifest as a staff member being unconsciously more lenient to a White patient who is late for a medical appointment but requiring a Black patient who missed the bus to reschedule her appointment. Or it could manifest as a landlord who illegally changes the locks on a client or refuses to renew the lease after learning of the person's HIV status or because the client is a Black woman and the landlord believes he can get away with these behaviors without negative repercussions. This not only impacts this client's ability to store her medication, to make it to her job, and to care for her children, it also impacts her mental and physical wellbeing.

When she becomes homeless and losses her job, is arrested for sleeping on the street, or has her children taken away by the state, this further impacts her mental and physical health. When she is incarcerated because she cannot pay the exorbitant bond set by the judge and has no resources to access legal counsel, this impacts her physical and mental health. For many of our patients, the legacy of slavery and history of discrimination impacts every facet of their lives from their housing, access to education, employment, and health care.

21. The socioeconomic issues associated with poverty—including limited access to high-quality health care, housing, and HIV prevention education—directly and indirectly increase the risk for HIV infection and negative outcomes for COVID and affect the health of people living with and at risk for HIV and disproportionately impacts people of color. Stigma, fear, discrimination, and low perceived risk may prevent Black individuals from accessing HIV prevention and care services and the Executive Order would limit CrescentCare's ability to provide programs that address systemic racism issues and ensure staff are appropriately trained to implement them. CrescentCare has been the leading organization in Louisiana to advocate for the intersection of HIV advocacy and social/racial justice issues for many years. CrescentCare's Legal Services staff provides educational trainings for employers, stakeholders, and others on current laws related to HIV and expands the legal knowledge of the community and works to address racial/social injustice, stigma, and discrimination.

22. Providing medical, behavioral health, case management, or legal services to any patient must start from a relationship of trust. If there is not a relationship of trust, the patient or client may not share all of the pertinent information around risk factors with the doctor. For example, a young African American man may disclose only to a staff member that he trusts that he is having sex with both men and women and the number of sexual partners he has had over the past six months. As research and data demonstrate, this additional information directly correlates

to the level of the patient's risk for sexually transmitted infections, including HIV. He might only be willing to get tested regularly for STIs and access pre-exposure prophylaxis (PrEP) to prevent HIV after a staff member is able to successfully engage with him about his risk factors and connect him with someone to enroll him in insurance. He might only disclose the symptoms of depression and high blood pressure because he trusts his doctor. Cultural competency and mitigation of the effects of implicit bias are crucial components of developing that trust.

23. Medical advice, legal advice, or referrals for services that are not informed by the whole patient's experience are unlikely to address the full spectrum of a clients or patient's actual needs. A patient or client that perceives that their needs are not being met are unlikely to continue to engage in services and more likely to drop out of care and services. For example, a patient of trans experience that is misnamed and misgendered in our waiting room by our staff may decide to walk out of the clinic and never return. Alternatively, a patient that is called by their name and feels treated respectfully by our staff may stay in the waiting room, make their way back to our provider and finally receive access to much needed and long delayed medical care.

24. Workplace training concerning culturally competent care, including instruction with respect to systemic racism and implicit bias, is especially crucial for our staff given the vulnerability of our client population. Many if not most of the individuals in our very diverse patient population already face considerable stigma and discrimination – as people living with HIV, as sexual or gender minorities, and/or as people of color. Many of our patients also have behavioral health issues which can be compounded and aggravated by systemic racism. Training that provides a deeper understanding of history and context will enable staff to engage and keep patients and clients in care and services.

25. CrescentCare has provided services to thousands of clients who have experienced traumatic stigma and discrimination – based on their sexual orientation, gender identity, race, sex,

and/or other factors – in seeking from others the services CrescentCare provides. For example, a patient of trans experience came to us and related his previous health care experience. He had gone out of the country in an effort to receive gender affirming care, but the surgery was not successful. His previous doctor in New Orleans had called in other providers and students into his exam room and treated him, in his words, as a "freak." The idea of being treated as not fully human is a consistent theme we hear from our patients of trans experience in describing care they have received.

26. As a result of these experiences of discrimination in medical establishments, patients stop seeking care or their care is detrimentally delayed out of fear of repeated discrimination and denials of care. As a result, their conditions remain untreated for a much longer period of time, if they ever get treatment, resulting in much more acute conditions. For example, untreated high blood pressure due to negative experiences with the medical establishment may result in patients who must seek care in the emergency room, ultimately costing the health care system millions of dollars in unnecessary expenses while harming patients and public health. When medical staff fail to care for every patient in the best way that they can, putting patients' best interests at the center of medical care, medical mistrust is increased, care is delayed, and health care becomes more expensive and less effective. And with infectious diseases such as HIV, COVID-19, STIs, etc., lack of culturally competent care can place the entire population at large at risk for increased disease.

27. Reducing barriers to care across the board—from financial to transportation to the respect and understanding that staff exhibit towards patients—increases the likelihood that patients will remain engaged in care. Reducing these barriers to care requires an understanding of the social determinants of health, which public health officials agree include things like racism, misogyny,

homophobia and transphobia. We cannot reduce these barriers to care without an open dialogue with our staff, our Board and our community about them and the factors that create them.

28. Many health care providers and other staff harbor explicit or implicit biases against LGBTQ people and people living with HIV. Because of CrescentCare's workplace training requirements for health care workers in addition to legal requirements, health care facility nondiscrimination policies, and professional norms, bias is hopefully minimized. By undermining training requirements, and chilling employers, supervisors, and trainers from training staff about systemic racism and implicit bias, the Executive Order likely will result in more incidents of discrimination and greater harm to LGBTQ individuals, patients living with HIV, patients who are struggling with mental health or substance use issues, and especially patients of color, including the patients and clients who receive services from CrescentCare.

29. It is extremely difficult to provide effective care after patients have been rejected or discriminated against by other providers. The patients' level of trust at that point is so low that they expect to be mistreated, stereotyped, and discriminated against. This requires providers at CrescentCare to spend a significant amount of time trying to undo the damage (often cumulative, particularly with intersectional marginalized identities) of such care. Patients who have been discriminated against have lost complete trust in the system and in health care providers. The Executive Order has caused and will continue to cause additional discrimination against our patients at other facilities that will pause or cease cultural competency trainings for fear of losing their own federal contracts and grants. Health care providers at these other facilities will deny treatment to our patients or discriminate in other respects, either intentionally or unintentionally, simply because their employers are chilled from giving these health care workers explicit instructions and tools to combat implicit bias through training. As a result, our staff will need to assist in unpacking our patients' health care trauma so that our patients are able to engage in our

services and trust our health care providers in a meaningful way. When patients are discriminated against elsewhere, every patient contact at our facility will need to spend more time and resources assisting those patients, from front desk to triage staff. Discrimination creates added health stressors that damage the patient-physician relationship, resulting in inferior health outcomes for patients. It takes a long time to re-earn the trust for which patients hope, but are afraid, to give us. The Executive Order has and will continue to increase patient trauma, and in turn, increase the Center's workload, consume its resources and make it more difficult to provide patients with the care that they need.

30. The Executive Order is especially egregious and harmful during a pandemic like COVID-19 when patients most desperately need to know that they will have somewhere to go for nondiscriminatory health care should they contract the virus. During a pandemic, access to health care services is paramount. The Executive Order's prohibition on workplace trainings to address implicit bias and systemic racism, and its prohibition on the use of grant funds to "promote" such concepts invites discrimination and damages the public health during a crisis, particularly when communities of color face severe disparities with respect to morbidity and mortality. This Executive Order will chill outreach to communities of color and LGBTQ people, including targeted efforts to address medical mistrust and encourage use of a vaccine among such communities, and result in sicker patients and increased mortality from a global pandemic. People will not show up to the health care system, and the coronavirus will spread to people around them. We already have a problem with transgender people avoiding the emergency room when they need care out of fear of discrimination. After a person has been dismissed or disrespected by an emergency room provider they are not likely to go back even if it means they might die. This is the time when health care providers must make particular efforts to provide affirming and culturally competent care free of bias—whether explicit or implicit—in order to encourage people

to seek the health care they need—not only for a patient's own sake but for the sake of the public health generally. LGBTQ people and members of other marginalized communities otherwise may go untested, spread the virus further, and die at home, avoiding an emergency room out of fear of being subjected to such discrimination in their most vulnerable moments. The Executive Order multiplies this serious problem.

31. Finally, through its Legal Services program which is federally funded, CrescentCare engages in advocacy, outreach, education, and litigation to address discrimination (including in housing and access to health care), secure public benefits, protect rights to privacy, and assist with permanency/estate planning. We also provide civil legal aid to income eligible persons in Louisiana with legal issues involving matters related to or arising from their HIV status. Without the assistance of our Legal Services attorneys, unmet legal needs would negatively impact our clients' health. Many of our clients would face the loss of family, food, shelter, income, medical care as well as custody of children and personal safety. A typical tool to address the needs of our clients and the community we serve is to demand and secure trainings that address systemic issues and bias against people living with HIV as part of the resolution. Many of the defendants or respondents in these matters are themselves federal contractors who would be prohibited from agreeing to or providing these trainings as a result of the Executive Order. The Executive Order thus also inhibits CrescentCare's ability to secure legal resolution of its clients' problems in a manner that prevents the same discrimination from occurring in the future.

32. CrescentCare comes from two powerful legacies. The origin of the NO/AIDS Task Force organization was in response to the devastation of the AIDS epidemic. The legacy we intentionally joined when we became CrescentCare is that of community health centers, born out of the civil rights movement and the war on poverty and as a direct response to inequalities faced by African American sharecroppers in the Mississippi Delta. Over 35 years of service, our

organization has built trust with our community. With a grounding in these two legacies, CrescentCare stepped up in the wake of the COVID-19 pandemic and has provided over 7,000 tests out of two tents in the parking garage. Individuals from vulnerable communities came to us for testing because they did not trust the testing sites provided by the federal government. The highly infectious nature of the COVID-19 virus highlights the level of the interdependence of all of our health. Denying competent and effective health care to some members of our community endangers everyone. The Executive Order's suppression of concepts and ideas central to preventing discrimination against our patients and clients thwarts CrescentCare's mission and our ability to serve our community.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated: November 12, 2020

Respectfully submitted,

Alice Riener

Alice Riener, JD

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice.*

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF DARREL CUMMINGS, CHIEF OF STAFF OF THE LOS ANGELES LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Darrel Cummings, hereby state as follows:

1. I am the Chief of Staff of the Los Angeles LGBT Center ("the Center"), a not-for-profit 501(c)(3) organization based in Los Angeles, California, that provides a variety of services to members of the lesbian, gay, bisexual, and transgender ("LGBT") communities. I have served in this capacity since 2003, and also previously served as Chief of Staff from 1993 through 1999. More broadly, I have been an advocate on LGBT issues since 1979.

2. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies and their leadership from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

3. The Center was founded in 1969 and offers programs, services, and global advocacy that span four broad categories: health, social services and housing, culture and education, and leadership and advocacy. The mission of the Center is to fight bigotry and build a world where LGBT people thrive as healthy, equal, and complete members of society. Today the Center's more than 750 employees provide services for more LGBT people than any other organization in the world, with about 500,000 client visits per year.

4. As the largest provider of services to LGBT people in the world, many of the Center's patients tell us that they come to the Center seeking culturally competent health care due to being denied care or being discriminated against based on their real or perceived sexual orientation, gender identity, transgender status, and HIV status. The Center's client population is disproportionately low-income and experiences high rates of chronic physical and mental conditions, homelessness, unstable housing, trauma and discrimination, and stigmatization in health care services. Our client population is diverse with respect to race and class, and approximately a third of our patients self-report that they are non-White. Many of our clients come

to the Center from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

5. The Center has remained open for services throughout the COVID-19 health crisis, which has stretched the Center's resources thin. Communities of color have suffered disproportionately during the COVID-19 crisis with respect to both morbidity and mortality. Testing and contact tracing are key to effectively respond to this and other health pandemics. Yet, when patients fear discrimination, testing and contact tracing cannot be implemented effectively. There is no more important time than now for our clients to know that we are open for services and they will continue to receive affirming, nondiscriminatory care at the Center, especially the care necessary to treat life-threatening conditions.

6. The Center provides a wide spectrum of health care services, including, but not limited to, HIV treatment, testing, and prevention care, as well as treatment for gender dysphoria and mental health care. The Center has medical providers who specialize in the care of transgender patients and who provide a full range of primary care services in addition to hormone therapy, pre- and post-surgical care, and trans-sensitive pap smears, pelvic exams, and prostate exams. The Center's broad array of health care services are all under one roof, from counseling and therapy to pharmaceutical and nutrition needs.

7. The Center is one of the nation's largest and most experienced providers of LGBT health and mental health care. As a Federally Qualified Health Center, the Center is required to serve anyone on a nondiscriminatory basis who walks into its doors. We accept a variety of health insurance plans, including Medi-Cal (California's Medicaid program), Medicare, and most private insurance plans. We also provide services to uninsured individuals. We work with these individuals to help them access insurance through Covered California (California's Affordable Care Act "exchange"), and/or navigate other medical- and drug-assistance programs. Where

insurance is not available, our services are offered on a sliding-scale basis, based on ability to pay. We pride ourselves on providing leading-edge health care, regardless of individuals' ability to pay.

8. The Center is a federal contractor, subcontractor, grantee, and subgrantee. Approximately 80% of the Center's revenue arises from federal programs, including, but not limited to, a contract with the U.S. Department of Veterans Affairs; funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990; direct funding from the Centers for Disease Control and Prevention; discounts under the 340B Drug Pricing Program; grants under section 330 of the Public Health Service Act; grants from HRSA Bureau of Primary Health Care under which the Center is a Federally Qualified Health Center; and Medicaid and Medicare reimbursements. The Center also receives federal funding for research programs, and is currently a participant in multiple federally funded studies, including through the National Heart, Lung, and Blood Institute; National Institute of Allergy and Infectious Diseases; National Institute of Child Health and Human Development; the NIH; National Institute of Drug Abuse; and the Patient-Centered Outcomes Research Institute. The Center also receives federal funding to combat COVID-19 infections under the Coronavirus Aid, Relief, and Economic Security ("CARES") Act. Many of the Center's federally-funded grants require the Center to acknowledge, address, and combat systemic racism in health care services and public health programming. For example, the Center is a grantee of the Minority AIDS Initiative ("MAI"), part of the Ryan White HIV/AIDS Program. The MAI was established in 1999 to improve access to HIV care and health outcomes for disproportionately affected minority populations, including Black populations.

9. The Center works hard in numerous ways to identify and address disparities in access to health care and patient health inequities based on race, sex, and LGBT status. The Center trains its own staff to identify and acknowledge disparities in underlying health conditions, cultural and historical barriers to care, and to combat implicit bias that could interfere with patient-provider

interactions, the ability of patients to receive equitable access to care, and patient outcomes. Through these trainings, the Center acknowledges and addresses systemic racism and the role of implicit bias in contributing to health disparities, which is crucial to ensuring that the Center continues to provide the highest quality health care to patients without discrimination. Lack of such training would exacerbate health care disparities that people of color face in the broader health care environment—a directly contradictory outcome to the mandates of the Center's grants. Without addressing topics such as implicit bias and grappling with historical racism in the medical field, the Center cannot successfully fulfill the obligations of its federal funding. Such training is inherent in the work the Center has been funded to do. The staff time for many of the participants in these internal trainings is paid for under federal grants.

10. In addition to training its own staff on cultural competency, the Center performs external trainings as well. The Center has received federal funding to perform trainings of health care providers at other institutions, including a grant from the Office on Violence Against Women through the United States Department of Justice that is focused on prevention of intimate partner violence. The Center's Children Youth and Family Services group also conducts external trainings directed at cultural competency in working with LGBT foster youth. The Center receives no direct federal funding to perform these youth-focused trainings. Instead, the recipients of the training, including schools and the California Department of Child and Family Services, pay the Center for the trainings. Our Trans Wellness Center staff have performed cultural competency trainings at numerous workplaces. The Center's director of case management recently did a training for a national social work conference. Additionally, the Center's Transgender Economic Empowerment Group conducts external cultural competency trainings, although we generally do not receive payment for these particular trainings. Many of these trainings, if not all of them, contain explicit acknowledgement of systemic racism, and implicit bias with respect to race, sex, and LGBT status.

11. The staff at the Center who perform these internal and external trainings are now concerned that their programming and their presentations will be used as a justification for suspending or terminating the Center's federal funding from grants and contracts. Trainers must self-censor about matters relating to implicit bias and systemic racism or sex stereotyping, which are often central to the purpose of a particular training. Such self-censorship can defeat the purpose of the training and leaves the audience without the tools necessary to ensure nondiscriminatory services to vulnerable communities. Further, the breadth of the Executive Order is confusing and vague, which makes it impossible for trainers to figure out which concepts will be deemed too "divisive," and how they can avoid being found noncompliant.

12. Additionally, as a result of the Executive Order, Center staff members now feel chilled and concerned about participation in conferences, media interviews, and other opportunities to speak on behalf of the Center to educate the public. Each staff member must worry about what they are allowed to say about the Center's mission and the importance for LGBT people and people of color to have an affirming and nondiscriminatory environment in which to seek medical care and other services. The Executive Order's chilling effect causes staff members to censor themselves from discussing publicly the effects of implicit bias in contributing to disparities. For example, staff members have questioned how they can participate on a panel about HIV without discussing disparities with respect to race and sex, including structural obstacles to obtaining adequate care and treatment for members of these communities. Could participation on a panel at a medical conference be perceived as a training? What if a member of the community in the audience calls the Department of Labor hotline to complain? Could the Center lose funding pending an investigation?

13. Moreover, trainings—whether internal or performed for client entities or members of the public—comprise only one part of the Center's comprehensive approach to combating

structural racism and its impact on patient health and well-being. The Executive Order calls into question whether other substantive work performed by the Center could be interpreted as "promotion" of "divisive" concepts. For example, the Center employs "navigators," which is a term for frontline staff members who work as peers to members of vulnerable communities to counsel them, change behaviors, and bring people in to various types of care. A navigator's job is to reduce and eliminate any barriers that someone may have to accessing health care. Navigators receive internal and external trainings to learn how to work with clients in priority populations so that they can meet a person where the person is, and move the person from resistance to action. Navigators spend much of their time in the field helping people, and receive specialized training. They learn how to become a trusted source for people who often lack trust in health care providers, and then usher that trust into encouraging a client to visit a provider, see a therapist, or take medication. Some navigators work with high risk populations to help them access and remain on Pre-Exposure Prophylaxis (PrEP) as a form of HIV prevention. Others, such as opiate navigators, tackle substance abuse. Retention and care navigators work only with people living with HIV who have fallen out of care. A disproportionate number of these are people of color, and the reasons they have fallen out of care often relate to systemic racism. Some of the work performed by the Center's navigators is pursuant to a federally-funded grant that specifically funds outreach to gay Black or Latinx men about barriers to care. These navigators talk to people about discrimination in housing or employment and let them know about our services, and the ways in which we can help them. The Center employs social workers who help people with housing and food access. Once a client is housed, we can get the client to the Center provide the client with appropriate medication and other forms of health care. These navigators use critical race theory to inform their interventions to meet clients where they are, validate their experiences, and help them move

through their experiences to get them into a better place for their health. The time of the staff in the trainings is often covered by federal dollars.

14. The Center just opened a new location in South Los Angeles in order to serve the health needs of LGBT Black and Latinx communities. The Center also intends to engage in advertising to target young queer men of color in particular around PrEP and HIV prevention. The aim of such outreach is to build trust and community in the hope that such trust will be transferred to medical care and prevention services. The Center engages in other targeted initiatives as well. The Center's Trans Wellness Center focuses exclusively on care for transgender and non-binary clients. The Center has programs for monolingual Spanish speakers, programs on violence prevention with an emphasis on transgender women of color, programs providing post-incarceration linkages into services, and programs to assist sex workers in negotiating safety. Because of the structural challenges facing the population we serve, our staff must be able to address systemic racism, and be fluent in the concepts labeled "divisive" in the Executive Order, to overcome these barriers. It is part of the DNA of the job.

15. LGBT patients historically have faced significant barriers to accessing health care, including widespread discrimination based on LGBT status, which results in mistrust by LGBT people of health care providers, and reluctance on the part of LGBT patients to seeking care in the first place. A shocking number of LGBT patients fear going to a health care provider due to negative past experiences directly related to their sexual orientation, gender identity, or transgender status. The Center's providers have observed patients arriving at the Center with acute medical conditions that could have been avoided but-for the patients' reluctance to seek routine and necessary medical care for fear of discrimination and being turned away. For example, we have had clients arrive at the Center with Stage 4 ovarian cancer because they were afraid to seek routine pap smears.

16. For similar reasons, LGBT people are less likely to have a primary care provider whom they consider their personal doctor. That means that in times of need, LGBT people are more likely to randomly select a health care provider with whom they do not have a relationship, and they are at increased risk of finding a provider who is not LGBT-affirming. The Executive Order interferes with the Center's efforts to train health care providers in basic cultural competency and gender-affirming health care practices so that providers do not subject patients to the trauma and interference with doctor-patient trust that can result when a provider harbors pernicious sex-based stereotypes about LGBT people and related anti-LGBT bias—whether implicit or explicit. Once an LGBT patient experiences such discrimination, the patient will be far less likely to receive the health care treatment that they need because, after being discriminated against, they are unlikely to seek other care out of fear of repeated rejections. This delay has serious medical ramifications for clients and public health at large, and also results in increased costs to the Center and the health care system generally.

17. The Center's health care providers – particularly its counselors, psychiatrists and other behavioral-health staff – have treated many patients who have experienced traumatic stigma and discrimination based on sexual orientation, gender identity, transgender status, sex stereotypes, HIV status, and/or other factors. The stories that patients tell the Center's staff about their discriminatory experiences outside of the Center include:

a. One transgender patient was unable to find supportive mental-health housing due to discriminatory experiences based on gender identity, which led to the patient being homeless.

b. Another transgender patient, who developed profuse bleeding after surgery, was denied treatment at an emergency room where they were told by an emergency

room doctor: "what do you want me to do about it?" They arrived at the Center in distress three days later, having lost a significant amount of blood.

c. A transgender patient needed to have a pelvic exam. The Center referred him to a specialist who denied services to him because he was transgender.

d. Patients have stated that their physicians told them that they do not need HIV testing because they are not engaging in same-sex sexual relationships. Not only is that conclusion contrary to medical guidelines, but when patients refuted assumptions about their sexual relationships, they were met with disapproval.

e. Patients have expressed concern about traveling outside of Los Angeles for business because if they are ever in need of emergency medical assistance, they will not know where to go to ensure that they will receive nondiscriminatory, proper health care services.

f. One patient recalled that when her late partner was in the hospital, she was there most of the time to care for her. There was a nurse who treated them kindly and appropriately until the nurse heard them refer to each other by "Honey." The look on the nurse's face changed and she treated the couple "like trash" after that. The patient remarked that allowing health care employees (everyone from those working in food service and housekeeping to physicians and nurses) to express judgment or disapproval based on their religious or moral views when providing care to patients results in placing LGBT patients in a "lesser-than" category of patients.

g. Patients residing at assisted-living facilities have described discrimination and denials of care when their sexual orientation, gender identity, and HIV status were revealed. Patients who are transgender have described having to hide their gender

identity and transgender status once they are no longer able to care for themselves and are required to find assisted-living arrangements.

h. Patients have described being intentionally referred to by names and pronouns other than their preferred names while seeking health care services elsewhere. There is no valid medical reason to not refer to a patient by their name and pronouns, consistent with their gender identity.

i. A patient described being given his positive HIV results by way of his provider placing a lab printout on the counter then leaving for 10 minutes and letting the patient read it. The patient was not given any further information, and was instead told to go to our Center.

j. Patients have reported that their primary care physicians do not feel comfortable prescribing HIV preventatives, such as Truvada for PrEP, even when such medications are appropriate and should be provided according to current medical guidelines and standards of care. Patients also have reported that their physicians shame them for requesting PrEP medications and then deny them the medication, which is how they find their way to the Center. For example, when one patient asked his provider about Truvada, his physician questioned him as to why he needed it and proceeded to tell the patient that he would not need the medication if he were more careful. Another patient was denied PrEP altogether and lectured that he did not need PrEP unless he was having sex with sex workers.

k. Patients also have expressed reluctance to use their insurance for PrEP because they are afraid of having the drug documented on their insurance record. These patients fear that a history of using a medically necessary HIV preventative could be used against them in the future by making them targets for discrimination based on

sexual orientation, gender identity and/or transgender status, and HIV status, given the current political climate and discrimination in the health care context.

l. A significant number of patients come to the Center's Sexual Health and Education Program for testing and sexual education rather than their primary care physicians because they do not feel comfortable talking about their sexual histories and choices out of fear of being treated negatively, judgmentally, and with bias and discrimination.

m. Multiple patients have stated that they come to the Center to be tested for sexually transmitted infections because the Center does rectal and throat swabs instead of only urine tests. Not all health care providers do all three forms of testing even though three-site testing provides the most accurate results for testing and treating sexually transmitted infections. This is especially true for gay men. Someone could test negative for a sexually transmitted infection with a urine test, for example, but test positive with a rectal swab. Patients report that when they specifically asked their outside provider to do rectal swabs, they were judged. When patients are judged by their physicians and/or cannot be out to their physicians about their sexual orientation and/or gender identity out of fear of discrimination, LGBT patients cannot receive the health care services that they need, including prophylactic treatments, and may experience delays in medically necessary treatments, resulting in more acute, life-threatening conditions.

18. Many of the Center's patients and LGBT people in general have reported that they are not out to their other medical providers about their sexual orientation and/or gender identity out of fear of discrimination and denial of health care. When patients are unwilling to disclose their sexual orientation and/or gender identity to health care providers out of fear of discrimination and being

refused treatment, their mental and physical health is critically compromised. The Executive Order chills staff at the Center from training health care providers about the degree to which systemic discrimination causes LGBT patients to be closeted and reluctant to disclose their gender identities, sexual histories, or other information relevant to their treatment. For example, a provider's implicit bias, including assumptions about patients based on sex stereotypes and damaging systemic gender norms, can make patients reluctant to come out to the provider, depriving the patient of necessary preventative screenings and testing (including for cancer, HIV and other sexually transmitted infections). If Center employees cannot train health care providers on implicit bias based on sex stereotypes, health care for LGBT patients will suffer.

19. The Executive Order makes it difficult, if not impossible, for the Center to continue providing the same level of social, mental, and physical health care to its patients. The Center's mission includes addressing the need for equity in health care for all of the Center's patients and the LGBT community generally. This mission is frustrated by the Executive Orde.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 13, 2020

Respectfully submitted,

Darrel Cummings

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice.*

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF HILARY MEYER, CHIEF INNOVATION AND IMPACT OFFICER, SERVICES AND ADVOCACY FOR GLBT ELDERS, INC., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Hilary Meyer, hereby state as follows:

1. I am the Chief Innovation and Impact Officer for Services and Advocacy for GLBT Elders, Inc. (SAGE). I submit this Declaration in support of Plaintiffs' motion for a nationwide preliminary injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

2. I joined the SAGE staff in October 2010 and since have held the following titles: Director, National Resource Center on LGBT Aging; Director, National Programs; Director, Social Enterprise and National Projects, Chief Enterprise and Innovation Officer; and Chief Innovation and Impact Officer. Prior to SAGE, I was the Fair Courts Program Director at Lambda Legal and an Associate at Reitman Parsonnet, practicing labor and employment law in New Jersey. I earned my J.D. from Rutgers School of Law- Newark and B.A. from Colgate University. I am a member of the bar in both New York and New Jersey. At SAGE, as a member of the Executive Team, I contribute to the organization's strategic leadership and overall organizational health. I am directly responsible for building SAGE's strategic plan, and for overseeing many of SAGE's national public education and training efforts; SAGE's externally-facing diversity, equity and inclusion work; and, SAGE's evaluation and impact measurement efforts.

3. Founded in 1978, SAGE is the country's largest and oldest organization dedicated to improving the lives of LGBT older people. SAGE offers services and resources to LGBT older people and their caregivers with the mission of supporting LGBT older people in aging with respect and dignity. SAGE has over seventy staff members spread across the country to meet the needs of the nation's large and growing LGBT senior population.

4. SAGE is a 501(c)(3) non-profit organization headquartered in New York, where SAGE operates five senior centers and is building affordable LGBT-welcoming housing. Outside New York, SAGE works with affiliated chapters to provide programming and services to LGBT older

adults across the country, to connect LGBT older adults with community members to combat social isolation, to provide resources that support financial literacy and stability; and to create intergenerational connections through shared meal programs. SAGE also runs the LGBT Elder Hotline, providing crisis response services, support, and information about community resources, and launched a national LGBT housing initiative, helping builders develop LGBT friendly affordable senior housing and engaging in education and advocacy to combat housing discrimination. More broadly, SAGE is a leader in advocacy for LGBT elders at the national, state, and local levels, educating policy makers on LGBT and HIV aging issues and leading coalitions to ensure participation of diverse elders in policy conversations.

5. As SAGE's Chief Innovation and Impact Officer, I oversee many national projects, including SAGE's National Resource Center on LGBT Aging and SAGECare, SAGE's external training and consulting division. In this role, I directly supervise four full time employees and manage a department of eight full time employees and one independent administrative assistant; this department has overall responsibility for grant-funded deliverables in the areas of national public education, issue awareness, and building the competency of service providers across the country in serving LGBT older people.

6. SAGE founded the National Resource Center on LGBT Aging in 2010 to serve as the first national training and technical assistance center on LGBT aging. The goals of the National Resource Center are to provide educational instruction, help, and resources to support the over 7 million LGBT older adults age 65+ anticipated by 2030. Under its auspices, we launched a national LGBT aging cultural competency training program, working in conjunction with public health experts, local leaders in LGBT aging, and organizations specifically serving transgender seniors and LGBTQ elders of color. By the end of 2020, the Resource Center had trained over 21,000 professionals in all fifty states.

7. SAGE launched the SAGECare initiative in May of 2016. SAGECare is a cultural competency training program for skilled nursing facilities, health care organizations, assisted living communities, hospice and palliative care, long-term care communities, home health providers, and anyone providing services to older adults. Agencies and facilities that complete certain amounts of training are eligible for SAGECare credentials, which designate the facility or agency as welcoming, inclusive, and prepared to work with a diverse population of LGBT clients, family, and friends. SAGECare offers trainings for all levels of staff, administrators, and executives; provides personalized consulting on a broad range of topics related to LGBT aging; and conducts LGBT-inclusion audits of providers' policies and procedures. To date, SAGECare has trained over 105,000 people, and has credentialed over 525 providers in 48 states, including the agencies referenced in paragraph 6. SAGECare has created trainings in Spanish and Cantonese, and, particularly in the last year, has developed a suite of on-line training products.

8. SAGE receives various forms of federal funding directly and indirectly via federal programs, including but not limited to grants from the Department of Health and Human Services Administration for Community Living ("ACL"). SAGE receives ACL grant money directly, as well as via pass-through funding from the New York City Department for the Aging and other ACL-funded organizations. Aside from ACL funding, SAGE also contracts with state and local entities receiving federal funding, including the Pennsylvania Department of Military and Veterans Affairs and the Indiana Veteran's Home; serves as an independent contractor for a Workforce Investment Organization funded by the New York State Department of Health pursuant to a Medicaid waiver; and has worked with the Pennsylvania Health Care Association on grant projects funded by Civil Monetary Penalties imposed by the Centers for Medicare and Medicaid Services ("CMS"). These various funding streams account for a significant portion of SAGE's budget, including my work and the services that I, and those that I supervise, provide. Without such

funding, SAGE could not fully carry out our work to ensure culturally competent care for LGBT older adults.

9. Since 2010, SAGE has received over $4 million in grants from ACL, nearly $3 million of which has gone directly to fund the National Resource Center on LGBT Aging. These ACL grants are aimed at strengthening the aging and disability networks through emphasis on diversity and cultural competency. Specifically, ACL funds the National Resource Center on LGBT Aging to "educate mainstream aging services organizations about the existence and special needs of LGBT elders, sensitize LGBT organizations to the existence and special needs of older adults, and educate LGBT individuals about the importance of planning ahead for future long-term care needs." SAGE has also received approximately $1.2 million each year since 2012 in pass-through ACL funding under contracts with the New York City Department for the Aging to support SAGE's direct services work.

10. The current grant SAGE receives to support the National Resource Center on LGBT Aging is entitled, "Strengthening Aging Services for Minority Populations Through Technical Assistance, Resource Development, and Program Coordination." ACL described the purpose of this funding opportunity as carrying out the directive of the Older Americans Act to take particular note of, and prioritize serving, older adults and their caregivers "who are in greatest economic and social need" and who may face increased challenges in accessing culturally appropriate and responsive services due to their racial or ethnic background, limited English proficiency, sexual orientation, or gender identity. This particular funding opportunity sought to expand ACL's support for national organizations developing and implementing technical assistance and support activities to serve African American, Latinx, Asian and Pacific Islander, Native American, and LGBTQ seniors. It acknowledged that "[w]ith the expected growth in the older adult population and the increases in minority populations among them, it is ever more critical that the networks of

support to whom these individuals turn for assistance have the capacity to affirmatively support them in culturally appropriate ways." We received $215,144 for the first year of the grant, which runs from August 2020 through July 2023, and additional awards of $220,999 have been recommended for each of the next two years. Under this grant, SAGE provides support to other ACL-funded organizations in reaching the most vulnerable older members of the community, many of whom are LGBT and also racial or ethnic minorities. This support includes training and technical assistance, such as webinar presentations to ACL-funded State Units on Aging, Area Agencies on Aging, and subcontractors. The work required by the grant also includes collaborating with ACL-funded Technical Assistance and Resource Centers serving African American, Latinx, Asian and Pacific Islander, and Native American older adults to create resources, webinars, and presentations, as well as to work together on promoting and disseminating a jointly created best practices guide for serving diverse elders.

11. SAGECare is a fee-for-service social enterprise program, meaning clients either pay SAGE directly for our training and consulting services, or we offer free-of-charge training and consulting to clients if SAGE can subsidize the training through the ACL-funded National Resource Center on LGBT Aging. Our SAGECare clients represent a mix of for profit and not-for-profit service providers; government-funded federal, state and local entities; and academic institutions. Direct client-to-SAGE payments from state and federal agencies and entities that receive government funding, including from CMS Civil Monetary Penalties, Medicaid funding for state designated Workforce Investment Organizations, and the Department of Veterans Affairs, from January 2019 through today account for $158,205. SAGECare training and consulting revenue from July 2016–June 2020 totaled approximately $1.5 million.

12. SAGE understands that LGBT older people are a diverse group, and that providing high-quality person-centered care for all older people requires understanding the intersection

between sexual orientation, gender identity and expression, and other aspects of human identity such as race and ethnicity. This commitment to intersectionality means that we collaborate closely with the ACL-funded Minority and Aging Technical Assistance and Resource Centers (TARCs) which include MPH Salud, National Caucus & Center on Black Aging, National Asian Pacific Center on Aging, and National Indian Council on Aging. This intersectional approach is central to both SAGE's mission and the purposes of our ACL grant. We support ACL-funded organizations in reaching the most vulnerable older members of our communities, many of whom are LGBT and also racial or ethnic minorities. Two of the most impactful ways we support ACL-funded organizations in reaching these elders is through training and technical assistance. These trainings include webinar presentations to ACL-funded State Units on Aging, Area Agencies on Aging and subcontractors. From 2015-2020, 11,219 employees from 745 ACL-funded organizations participated in the webinars, and SAGE managed over 500 requests for expert technical assistance coming through the National Resource Center on LGBT Aging. At the request of these ACL-funded organizations, we have translated some of our materials on LGBT cultural competency into languages other than English. During 2015-2020, 23 resources were translated into Mandarin, Vietnamese, and Spanish, reflecting the need for training and technical assistance materials that link LGBT cultural competency with diversity and inclusion. Since July 2019, our webinar series has a 73% attendance rate, which is well above industry standards and further demonstrates that ACL-funded organizations see the necessity of intersectional LGBT-cultural competency in executing on their organizational priorities and serving our most vulnerable older adults. As required through the ACL grant funding, and consistent with the National Resource Center on LGBT Aging and SAGE's commitment to diversity and equity, the National Resource Center on LGBT Aging will continue to work closely with the Minority and Aging TARC organizations as well as other ACL resource centers and nonprofits with a focus on intersectionality that will bring

a deeper racial, ethnic and disability lens to our training and education work. Because our ACL grant requires precisely this type of intersectional approach, we worry that it is will be among those targeted in the agency review process prompted by the Executive Order. If ACL were to condition our receipt of funding on our certifying that we would not include information about systemic racism, sexism, or anti-LGBT bias in our public education efforts, we could not fulfill the purpose or requirements of the grant at all. Even assuming we were able to re-write and re-record all of our training and other educational products – an undertaking that would come at great financial expense and staff time that could otherwise be directed toward advancing our organization's mission of improving the lives of all LGBT older people – the end result would be content that will be less impactful, less effective, and less valuable to our learners and would not further the grant's purpose of ensuring that older minority populations have networks available "to affirmatively support them in culturally appropriate ways."

13. Our goal is to make sure that all LGBT older people are treated equitably, with respect, and are provided with the resources they need so they are able to thrive. This requires that staff of agencies and facilities serving seniors understand the unique perspective, experiences, and concerns of this population. Staff who have the skills to provide excellent services to LGBT older people have often taken the time to become familiar with LGBT history, interrogated their own personal viewpoints, and considered how their actions can impact an LGBT older person. We accomplish this by training staff on both the systematic structural problems of racisms, homophobia, biphobia, and transphobia – as well as the ways that those structural problems manifest in individual behaviors through discriminatory actions, micro aggressions, and implicit bias. None of our work is intended to blame individual people for their beliefs; instead, we seek to empower staff to treat all of their constituents equitably. We take this approach of combining macro and micro considerations and an intersectional lens for the pedagogic reasons outlined

above, and also in recognition of the fact that efforts to advance LGBT inclusion have been intersectional from the start. The Stonewall Riots, often seen as the beginning of the modern LGBT rights moment in the United States, was led by LGBT people of color who tied their experience as LGBT people to their experiences as people of color. The Executive Order threatens our ability to make use of these foundational concepts, and without a clear sense of what is and is not permissible, we are completely unable to execute on our goals of providing tested, necessary, impactful interventions that are in high demand. At a bare minimum, it is clear that our existing trainings include terms that the OMB's keyword search would flag, and we worry that our efforts to ensure that our trainings fully address the systemic racism, sexism, and anti-LGBT bias experienced by LGBT older adults over the course of their lives will jeopardize our ability to provide trainings to federally funded entities.

14. The Executive Order has already directly interfered with our training work. SAGE's Senior Director of National Projects was scheduled to participate in a webinar series focused on supporting the needs of diverse populations of older veterans. The webinar series was part of the Veterans Administration's Geriatric Scholars Program, a project funded through the Veterans Health Administration Offices of Rural Health, Patient Care Services, and Geriatrics and Extended Care. The Geriatric Scholars Program provides continuing education and professional development on geriatric topics to care providers throughout the Veterans Health Administration to improve the quality of care received by older veterans across the country. The webinar series was to focus on gerodiversity -- or multicultural aging issues -- to address and raise awareness about equity, diversity, and inclusion issues among aging veterans. SAGE had accepted the invitation to participate, both to provide SAGE's particular perspective and content to the training and as a way of generating future training opportunities. Specifically pointing to the Executive Order and the two related OMB memos, the Office of Rural Health instructed that the webinar

series could not be held as scheduled. SAGE worries that many more government agencies, or entities that receive government funding, will do the same, undermining SAGE's ability to carry out its mission of ensuring culturally competent care for LGBT seniors. Our trainings are in high-demand from government and federally-funded agencies, and we fear that they will also stop all training work as a result of this Executive Order, causing us to lose both important funding and valuable time to reach vulnerable LGBT older people during this pandemic.

15. We are also concerned that our trainings will be reported on the Department of Labor's hotline as violating the Executive Order. The purpose of our training program is to give staff the concrete skills and information they need to reach the vulnerable population of LGBT older people. While the overwhelming response to our training is positive, as demonstrated by our evaluation data, there have certainly been individuals who have participated in our trainings who are upset by the content and react poorly to being trained on how to be more inclusive. We have received feedback complaining that addressing aspects of LGBT identity itself is a matter of "an infinitesimal group seek[ing] to leverage countercultural mores upon the majority," a perspective that echoes the Executive Order's suppression of content addressing race- or sex-related privilege because of the distress or guilt it might cause someone to experience. We worry that individuals who object to the content of our trainings, including regarding the lifetime of discrimination experienced by diverse LGBT seniors, would report our trainings as violating the Executive Order, or that clients will simply decide to cancel all diversity and inclusion training to not risk any negative reports.

16. In addition to our external trainings, SAGE also takes seriously the need to do internal trainings for SAGE's staff and board to address issues of systemic racism, sexism, and anti-LGBT bias. Part of our efficacy as cultural competency trainers is SAGE's credibility and good name in the field. We are a trusted partner and subject matter expert, and maintaining that reputation

requires that we put in place the same best practices and trainings that we request of other organizations. Our work, at all levels, is informed by an intersectional approach that takes seriously the legacy of racism in this country, as well as our responsibility to make a positive change in the world. It is this perspective that allows us to attract and retain a diverse workforce, discover and attend to the needs of our constituents, and develop the board credibility we need to advance our mission across our diverse constituency. In short, we cannot do our jobs, and we cannot support our clients in doing theirs, if we do not have a well-trained staff conversant in the concepts banned in this order.

17. An intersectional approach to understanding the identities of LGBT seniors is critical to ensuring that aging service providers recognize seniors' distinct experiences with stress, health, and identity connected to their sexual orientation, race or ethnicity, and sex that cannot be fully captured by considering each of these aspects of their identities separately. LGBT seniors are significantly more likely to need aging services and facilities as they are often financially vulnerable, have less access to informal care networks, and experience isolation and loneliness at higher levels when compared to non-LGBT older adults. They are twice as likely to be single and live alone and four times less likely to have children. They may be estranged from their families of origin as a result of systemic anti-LGBT bias, and face particular challenges navigating governmental assistance and medical programs, including barriers relating to race, sex, and LGBT status. LGBT older adults have faced lifetimes of systemic discrimination on account of their sex, sexual orientation, and transgender status, and this discrimination is compounded by systemic racism. The impact of exposure to both interpersonal and structural discrimination creates health disparities and increases distrust of service providers. Despite the increased need for services, fear of discrimination on the bases of sex, LGBT status, and race at the hands of health care and aging service providers and facilities prevent LGBT seniors from seeking the care and services they truly

need. SAGE's research has found that 40% of lesbian, gay, and bisexual older people and 65% of transgender older people have serious fears about being able to access safe healthcare as they age. These fears are even greater for African American and Latinx LGBT older adults. The trainings SAGE provides are designed to overcome that fear, in addition to directly addressing the implicit bias providers may have against LGBT people, and particularly LGBT people of color, that affect both the quality and appropriateness of their care. Unless aging service providers have the know-how to do proactive outreach, these seniors will stay in the closet and stay out of services for fear of being harmed.

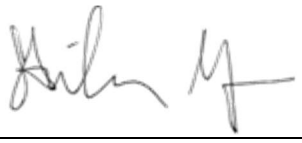
18. The vulnerabilities faced by LGBT older adults are exacerbated in the midst of the COVID pandemic. Fear of discrimination at the hands of care providers makes LGBT seniors more likely to delay getting treatment and less likely to disclose their sexual orientations or gender identities to care providers. They may also face challenges in explaining to care providers who their loved ones are because they are more likely to rely on "chosen" family, rather than their families of origin from whom they may be estranged, and those support networks do not have the same legal recognition. Maintaining contact with loved ones can be essential to a senior's physical and mental wellness, including because loved ones may hold key information about the senior's health history, and when care providers do not understand an LGBT senior's support network, their care will suffer. We also know that much of the isolation and fear experienced by LGBT older people has been exacerbated by the COVID-19 pandemic. Many LGBT people live alone, may be isolated, and for many of the pandemic is also raising memories of the HIV/AIDS epidemic. In the face of this pandemic, LGBT people as well as long-term survivors of the HIV/AIDS epidemic need access to affirming services, and proper staff training is one of the best ways to create those services and reach these elders.

19. This Executive Order harms LGBT older adults in at least two ways. First, it stops those who provide care to our most vulnerable seniors from getting the information and skills they need to reach this population. Instead of empowering staff to reach vulnerable seniors, this Executive Order makes it more difficult for these professionals to do their jobs. Second, it sends a message to LGBT people, especially LGBT people of color, that their needs, personal histories, and experiences are not important, inherently create conflict, and ought to be banned from discussion. At this moment of crises and reckoning in our country, the last thing we should do is silence entire swaths of our population from telling their stories and getting the resources and supports they deserve. This Executive Order sends a clear message of exclusion and prioritizes the comfort of some Americans over the lives and health of others.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated: November 12, 2020

Respectfully submitted,



Hilary Meyer

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice*.

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

**admitted pro hac vice*
[Additional Counsel on Signature Page]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

THE DIVERSITY CENTER OF SANTA CRUZ, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 5:20-CV-07741-BLF **DECLARATION OF DR. WARD CARPENTER, MD, CO-DIRECTOR OF HEALTH SERVICES, LOS ANGELES LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Ward Carpenter, MD, hereby state as follows:

1. I am the Co-Director of Health Services for the Los Angeles LGBT Center (LA LGBT Center), where I was formerly the Associate Chief Medical Officer as well as the Director of Primary and Transgender Care. I received my medical degree from the Robert Wood Johnson Medical School and had my residency at St. Vincent's Hospital Manhattan. I am board-certified in Internal Medicine and I hold certification in HIV Medicine. I am licensed to practice in the state of California. At the LA LGBT Center, I oversee all operations of the Federally Qualified Health Center ("FQHC"), including personnel, finances, clinical programs (mental health, psychiatry, primary care, HIV care, transgender health, substance abuse, and sexual health), nursing, case management, quality, risk management, and clinical research. I also maintain a panel of patients for whom I provide direct care.

2. I submit this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent defendant agencies from enforcing Executive Order No. 13950, titled "Combating Race and Sex Stereotyping" (the "Executive Order").

3. As the Co-Director of Health Services, I oversee the health care of over 32,000 current patients who come to the LA LGBT Center for their care; I personally provide care to a panel of 200 patients. All of my patients identify as LGBT, and approximately 30% of my patients are people living with HIV. Our patient population is diverse with respect to race and class, and approximately a third of our patients self-report that they are non-White. Our patient population is also disproportionately low-income and experiences high rates of chronic medical conditions, homelessness, unstable housing, extensive trauma history, and discrimination and stigmatization in health care services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

4. I provide a wide spectrum of health care services, including, but not limited to, HIV treatment, testing and prevention; STD testing, treatment and prevention; general primary care with an LGBT focus; and comprehensive transgender care. I have worked in this field of medicine continuously since 2004 and have personally cared for over 4,000 people in that time. I have worked in two FQHCs, in New York and Los Angeles, as well as a private practice in New York. I am a nationally-recognized expert in the field of transgender medicine.

5. As a director and health care provider with the LA LGBT Center, I oversee work funded by federal grants, including but not limited to grants funded under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, under Section 330 of the Public Health Service Act as a FQHC, and from the Centers for Disease Control and Prevention ("CDC"). The purpose of many of the grants I oversee is frustrated by the Executive Order. These grants account for a significant portion of my work and the health care services that I and those I supervise provide to patients. Losing the funding would mean inadequate care for our patients.

6. Many of the grants received by the LA LGBT Center are explicitly directed at reducing health disparities based on race, LGBT status, and other factors. For example, the LA LGBT Center receives a Section 330 grant as a Federally Qualified Health Center precisely because we are a safety net provider for medically underserved populations facing barriers to traditional care. We receive these government funds to provide services to patient populations that other more traditional health care providers cannot reach, and who face significant health disparities—such as patients who are Black, Brown, and LGBT. Similarly, the funds we receive from the Minority HIV/AIDS Fund are specifically directed to strengthening HIV prevention and care among racial and ethnic minorities. In HIV services, transgender people and young queer men of color are at disproportionate risk of contracting HIV as a result of systemic racism and related barriers to care.

7. This work can succeed only when those of us at the LA LGBT Center who provide these services can receive training concerning how racism and bias affect the communities we serve; the way these communities historically have been treated by medical researchers, health care providers and the medical mistrust that results; health disparities based on race, sex, and LGBT status; and how all of this can affect interactions between members of these communities and our staff, and our continued ability to provide high quality medical care. Workplace training concerning culturally competent care, including instruction with respect to systemic racism and implicit bias, is especially crucial for all of our staff, including for me, given the vulnerability of our patient population. The LA LGBT Center provides such training to all of our staff, including me. Such trainings are provided as part of an onboarding process for new hires, and additional training is provided around specific job roles.

8. Many if not most of the individuals in our very diverse patient population already face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority people, and/or as people of color. For example, transgender people have a 41% lifetime risk of attempting suicide. This shocking observation can be explained by the intense dysphoria inherent in living in a body and a society that does not reflect and validate who you know yourself to be at a core level. In order to avoid this tragic consequence, transgender people require compassionate, sensitive, and competent care that often includes medical and/or surgical procedures. These patients have significantly improved mental health outcomes when able to proceed with the treatments they need. Treatments for gender dysphoria have been deemed medically necessary by the World Professional Association of Transgender Health ("WPATH") and the Endocrine Society, as well as other major medical organizations, in the same way that the American College of Cardiology has deemed treatment for hypertension medically necessary. However, too often other providers deny such care or discriminate in other ways against transgender patients, which not

only affects these patients' physical health but their mental health as well. Cultural competency training is vital in instructing providers not only about relevant standards of care, but also to ensure that patients receive respect and dignified treatment from everyone involved in their care, including receptionists, surgical technicians, security personnel, and even the person entering patients' names and pronouns into the medical record.

9. LGBT patients often experience discrimination at the hands of other medical providers, including in life-threatening emergencies. I and the other providers that I supervise at the LA LGBT Center have treated many patients who have experienced traumatic stigma and discrimination as a result of explicit or implicit bias—based on their sexual orientation, gender identity, sex and related sex stereotypes, and HIV status—when seeking care from other providers. For example:

a. A transgender patient went to a urologist due to uncomfortable urination lasting for several years after her vaginal surgery. She was repeatedly referred to as "sir" and "he" despite repeated requests to use the correct pronouns. When the patient confronted the clerk, the clerk said "this is what your ID says, so this is how we will refer to you." When she saw the doctor, he also called her "sir," completely humiliating her in the most unprofessional manner. He did not close the door to the exam room during their visit, so that the entire waiting room could hear his conversations with her, and he asked her to remove her pants in full view of the waiting room. She was so traumatized by this experience that four years later, she continues to live with daily pain rather than risk being subjected to discrimination by another transphobic urologist.

b. A transgender patient started bleeding profusely from her vagina one week after surgery. Because there are so few trans-competent surgeons in the United States,

this patient's surgeon was thousands of miles away. When she finally spoke to an ER doctor, the physician looked disgusted and said "what do you want me to do about it?" then walked away. She had to pack her own vagina with gauze pads and leave the ER, not knowing if she would live or die, and only coming to see us three days later after having lost a significant amount of blood.

c. A gay male patient with a serious and concerning neurological condition went to a neurologist. At this visit, the doctor had religious brochures throughout the waiting room. On arrival in the exam room, he was given a brochure about a particular Christian faith and asked if he had any questions. The patient felt extremely uncomfortable with this insertion of religion into what he felt should be a neutral space. As a result, he did not return for care and experienced a delay of several more months trying to find a new doctor he could trust.

d. A person living with HIV was referred to a surgeon for a routine procedure. The surgeon sent a note back to the patient's primary care physician asking him to refer the patient to someone "who was more familiar with treating patients like him." Again, this patient waited another two months to have this surgery, which could have caused severe or life-threatening complications.

e. A lesbian woman went to her doctor and was told that lesbians are not at risk for HPV and, therefore, she did not need cervical cancer screening. This patient knew enough to find a new doctor, but many patients would accept this information as fact and never receive a Pap smear, significantly increasing their chances of dying from cervical cancer. This type of medical error based on discriminatory stereotypes demonstrates what will happen when medical personnel are invited to discriminate instead of focusing on the health needs of patients in their care.

f. A gay man went to his primary care physician with urinary burning and discharge. Because his health care provider did not ask, the provider did not know that this patient was sexually active with men. Therefore, the provider did only one test, which was negative, and sent him to a urologist. The urologist did another test, which was negative, then performed a procedure to look inside this man's bladder with a camera. It was not until he came to the LA LGBT Center that we performed a proper medical history and exam and were able to treat him immediately for his sexually transmitted infection. We also determined that he had sex with five other people from the time of his first symptoms to the time he was finally treated, weeks later. Had any of these providers stopped to ask the man about his sexual practices, they would have immediately tested him and treated him for a sexually transmitted disease. Instead, he saw three providers, received hundreds of dollars in unnecessary testing and passed his infection along to five other people who themselves had to go down similar testing and treatment paths.

10. I and the other providers that I supervise at the LA LGBT Center also have treated many patients who have experienced past traumatic stigma and discrimination as a result of systemic racism and/or explicit or implicit bias based on race.

a. Some patients have sought medical care from us after interactions with law enforcement that have resulted in injury. Our Black and Brown patients are more likely to report injuries or other health concerns after negative interactions with police. For example, I treated a patient whose arm was broken during an altercation with police which the patient believed was because of his race. Black and Brown patients are more likely than White patients to report such experiences.

b. Our youth services department works with many youth of color who have unnecessary interactions with law enforcement simply because White neighbors disproportionately report young Black and Brown people to police for loitering.

c. Another patient of color was given inadequate medical treatment while incarcerated and ended up paralyzed as a result. Staff at the LA LGBT Center worked to get him accessible housing, and strived to overcome his understandable mistrust of health care providers when giving him medical care because he had lost all trust in the medical system after having been paralyzed from not getting the care he needed.

d. Another patient reported receiving biased treatment in his dialysis center based on his race. Staff at the center repeatedly ignored him while attending to White patients and his care took much longer than other patients' care. Because of this experience and his humiliation, he declined to go back to get his dialysis, and ended up sick and in an emergency room. Not only did he become dangerously ill, but his emergency care cost the health care system tens of thousands of dollars more than it should.

11. These incidents constitute merely a handful of illustrations of the myriad ways in which our patient populations face barriers to care as a result of systemic racism, sexism, and anti-LGBT bias, including explicit or implicit bias on the part of health care providers on the basis of race, sex, and LGBT status. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, such as when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many of my and the LA LGBT Center's transgender patients and patients of color express strong distrust of the health care system generally, and a demonstrative reluctance to seek care outside the LA LGBT Center unless they are in a crisis or in physical or mental stress. This

is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, more expensive to treat, or even no longer curable in the case of some cancers.

12. It is extremely difficult to provide effective care after patients have been rejected or discriminated against by other providers. The patients' level of trust at that point is so low that they expect to be mistreated, stereotyped, and discriminated against. This requires providers at the LA LGBT Center to spend a significant amount of time trying to undo the damage (often cumulative, particularly with intersectional marginalized identities) of these past experiences. Patients who have been discriminated against have lost trust in the system and in health care providers. Discrimination creates added health stressors that damage the patient-physician relationship, resulting in inferior health outcomes for patients. It takes a long time to re-earn the trust patients hope for, but are afraid to give us.

13. Training health care workers in culturally competent practices, including training to recognize and address implicit biases based on race, sex, and LGBT status, is part of a health care facility's overarching obligation to foster patients' well-being and to do no harm. Good medical care is based on trust as well as frank and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers. A patient who fails to fully disclose their gender identity and sex assigned at birth may not undergo medically-indicated tests or screenings (such as tests for cervical

or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women). Patients need to be encouraged to fully disclose all information relevant to their health care and potential treatment, which can be achieved only when patients are assured that the information they provide will be treated confidentially and with respect. When patients are unwilling to disclose their sexual orientation and/or gender identity to health care providers out of fear of discrimination and denial of treatment, their mental and physical health is critically compromised.

14. In sum, when patients experience discrimination in medical settings—whether intentional or as a result of implicit bias—medical mistrust between a patient and care provider increases, and the quality of patient care is compromised. Patients often stop seeking care or their care is detrimentally delayed out of fear of repeated discrimination and denials of care. As a result, patients' conditions remain untreated for a longer period of time, if they ever get treatment, causing more acute health conditions and disease processes, and increasing the eventual cost of their care. Some conditions can become incurable simply because of a delay in treatment. When medical staff fail to care for every patient in the best way that they can, putting patients' best interests at the center of medical care, medical mistrust is worsened, care is delayed, and health care becomes more expensive.

15. To overcome medical mistrust, health care providers must first acknowledge it exists. For example, to overcome medical mistrust among patients of color, providers must acknowledge and address patients' fears resulting from historical and continuing structural racism in medicine, including a history of unethical experimentation and abuse. As health care providers, we also must overcome medical mistrust among patients who individually have had negative interactions with medical establishment, law enforcement, and other institutions that govern peoples' lives, or who

are aware of such experiences among other members of their communities. We need to train our staff to address the issues that lead to medical mistrust.

16. As health care providers, we also must explicitly acknowledge and confront the role of implicit bias among health care workers as a contributor to medical mistrust and health disparities and inequities. Implicit or unconscious biases are embedded stereotypes about groups of people that are automatic, unintentional, deeply engrained, universal, and able to influence behavior. Such biases can influence peoples' judgment and cause them to behave in biased ways even when they are not intentionally acting based on prejudice. Research demonstrates that people hold implicit biases even when well-intentioned, resulting in actions and outcomes that do not necessarily align with a person's explicit intentions. Implicit bias among health care workers shapes their behavior and produces differences in diagnosis, treatment, and health outcomes along the lines of race, sex, and LGBT status. Many health disparities are inexplicable for any reason other than implicit bias on the part of health care providers.

17. Discrimination and resulting medical mistrust not only harm patients, but harm the public health as well. Bias in medical settings during an epidemic of an infectious disease, such as, HIV/AIDS or a pandemic such as COVID-19, places the entire population at greater risk for increased disease because people who are disproportionately at risk for infection are less likely to seek or have access to testing, less likely to seek or have access to treatment, and less likely to provide information to contact tracers. The LA LGBT Center trains our staff to identify and combat implicit bias, not only to ensure better access to quality health care absent discrimination on the basis of race, sex, and LGBT status, but to protect the public health.

18. During a pandemic, access to health care services is paramount. The Executive Order's prohibition on workplace trainings to address implicit bias and systemic racism, and its prohibition on the use of certain grant funds to "promote" such concepts invites discrimination and damages

the public health during a crisis, particularly when communities of color face severe disparities with respect to morbidity and mortality from COVID-19. This Executive Order chills not only the use of vital training tools, but grant-funded targeted outreach to communities of color, women, and LGBT people, including efforts to address medical mistrust and encourage use of a vaccine among these communities. This will result in sicker patients and increased mortality from a global pandemic. People will not show up to the health care system, and they will then spread Coronavirus to countless more people around them. We already have a problem with transgender people avoiding the emergency room when they need care out of fear of discrimination. After a person has been told enough times by an emergency room: "we don't serve your kind here," they are not likely to go back even if it means they might die. Health care providers must make particular efforts during a public health crisis to provide affirming and culturally competent care free of bias—whether explicit or implicit—in order to encourage people to seek the health care they need—not only for a patient's own sake but for the sake of the public health generally. LGBT people and members of other marginalized communities otherwise may go untested, spread the virus further, and die at home, avoiding an emergency room out of fear of being subjected to such discrimination in their most vulnerable moments.

19. The Executive Order similarly decreases our ability to combat other epidemics. For example, communities of color face disparities with respect to syphilis. Congenital syphilis is on the rise, particularly in pregnant Black women. The LA LGBT Center has staff who perform syphilis contact tracing. These staff members need to address medical mistrust and affirmatively work to build trust with patients in order to perform this work. Patients share sensitive information about their relationships (i.e., information about the people they may have infected, or who may have infected them) only with trusted individuals. Indeed, the LA LGBT Center receives public funding to perform this work precisely because the Center enjoys greater trust among the

communities it serves than does the government or other health care provider alternatives. Whether the epidemic is syphilis or COVID-19, without a relationship of trust between health care providers and patients, we cannot adequately combat an epidemic.

20. A large body of literature shows clear disparities in healthcare for Black people in America. Numerous studies also show that implicit and explicit bias exist among healthcare providers and that bias is related to negative health outcomes. For example, infant mortality in the US is three times higher for Black babies than White babies. A study by Greenwood, et al from 2020 showed this disparity is cut in half when Black babies are cared for by Black physicians. In order to combat the clearly established and pervasive influence of racial bias in health outcomes, a group of White doctors at the LA LGBT Center has created a learning collaborative to prevent themselves from being part of the problem. They are using part of their time funded by federal grants to do this work. We are concerned that even these individual efforts to improve the quality of our care could be deemed noncompliant with the Executive Order and risk the loss of our grants.

21. I personally wish to continue to participate in workplace diversity training at LA LGBT Center in order to better serve my patients. Specifically, I would like to participate in trainings on systemic racism and implicit bias. If LA LGBT Center can no longer provide those trainings, I will suffer directly in the exercise of my profession. It is the responsibility of physicians to be expert in the factors impacting their patients' health, whether it is the diabetes a patient developed because the patient's neighborhood was a fresh-produce desert, the hypertension a patient developed from having to work three jobs rather than having time to exercise, or the suicidality a patient developed from being Black and transgender in a racist and transphobic society. I cannot perform my job effectively without access to training on systemic racism, sexism, LGBT bias, and implicit bias. As a white man, I need to be both learning and championing diversity and race equity in my

workplace. I would not be able to lead my very diverse team effectively if I could not engage in these efforts.

22. By undermining training requirements, and chilling employers, supervisors, and trainers from training staff about systemic racism, critical race theory, and implicit bias, the Executive Order is very likely to result in many more incidents of discrimination and greater harm to LGBT individuals, patients living with HIV, patients who are struggling with mental health or substance use issues, and especially patients of color, including the patients whom I treat and whose treatment I supervise. The Executive Order chills us from addressing the very challenges the government funds us to address.

23. One of the guiding ethics of medicine is to treat all patients equally. We do not treat blue-eyed people better than brown-eyed people. We do not treat women better than men. We do not provide better care to blonde-haired people than red-haired people. However, systemic barriers to care can get in the way. Medical personnel see people in their most vulnerable states; the trust placed in us is sacred. The Executive Order's suppression of concepts and ideas central to preventing discrimination against our patients frustrates the mission and activities of the LA LGBT Center, my mission and activities, and the guiding principle for health care professionals that we should do no harm.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 13, 2020

Respectfully submitted,

DocuSigned by:
Ward Carpenter, MD
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Ward Carpenter, MD

JENNIFER C. PIZER (SBN 152327)
jpizer@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, California 90010
Telephone: (213) 590-5903

CAMILLA B. TAYLOR*
ctaylor@lambdalegal.org
SCOTT A. SCHOETTES*
sschoettes@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, Illinois 60601
Telephone: (312) 663-4413

M. CURREY COOK*
ccook@lambdalegal.org
OMAR GONZALEZ-PAGAN*
ogonzalez-pagan@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: (212) 809-8585

KAREN L. LOEWY*
kloewy@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Telephone: (202) 804-6245

AVATARA SMITH-CARRINGTON*
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: (214) 219-8585

ANNE JOHNSON PALMER (SBN 302235)
Anne.JohnsonPalmer@ropesgray.com
ROPES & GRAY LLP
Three Embarcadero Center
San Francisco, CA 94111-4006
Telephone: (415) 315-6337

DOUGLAS HALLWARD-DRIEMEIER*
Douglas.Hallward-Driemeier@ropesgray.com
ROPES & GRAY LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006-6807
Telephone: (202) 508-4776

KIRSTEN MAYER*
Kirsten.Mayer@ropesgray.com
JESSICA L. SOTO*
Jessica.Soto@ropesgray.com
ROPES & GRAY LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Telephone: (617) 951-7753

ETHAN M. WEINBERG*
Ethan.Weinberg@ropesgray.com
ROPES & GRAY LLP
1211 Avenue of the Americas
New York, NY 10036-8704
Telephone: (212) 596-9688

Counsel for All Plaintiffs
** admitted pro hac vice*.

UNITED STATES DISTRICT COURT
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SAN JOSE DIVISION

SANTA CRUZ LESBIAN AND GAY COMMUNITY CENTER d/b/a THE DIVERSITY CENTER OF SANTA CRUZ; LOS ANGELES LGBT CENTER; AIDS FOUNDATION OF CHICAGO; B. BROWN CONSULTING, LLC; BRADBURY-SULLIVAN LGBT COMMUNITY CENTER; NO/AIDS TASK FORCE d/b/a CRESCENTCARE; SERVICES AND ADVOCACY FOR GLBT ELDERS; DR. WARD CARPENTER, *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States; U.S. DEPARTMENT OF LABOR; EUGENE SCALIA, in his official capacity as Secretary of Labor; CRAIG E. LEEN, in his official capacity as Director of the Office of Federal Contract Compliance Programs; OFFICE OF MANAGEMENT AND BUDGET; RUSSELL VOUGHT, in his official capacity as Director of the Office of Management and Budget; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF JUSTICE; WILLIAM PELHAM BARR, in his official capacity as United States Attorney General; U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT; BENJAMIN SOLOMON CARSON, SR., in his official capacity as Secretary of Housing and Urban Development; U.S. DEPARTMENT OF VETERANS AFFAIRS; ROBERT WILKIE, in his official capacity as Secretary of Veterans Affairs; NATIONAL ENDOWMENT FOR THE HUMANITIES; JON PARRISH PEEDE, in his official capacity as Chairman of the National Endowment for the Humanities; NATIONAL ENDOWMENT FOR THE ARTS; MARY ANNE CARTER, in her official capacity as Chairman of the National Endowment for the Arts, *Defendants*.	Case No. 5:20-cv-07741-BLF **[PROPOSED] ORDER GRANTING MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION**

Upon consideration of Plaintiffs' Motion for Nationwide Preliminary Injunctive Relief and Memorandum of Points and Authorities and, with the benefit of oral argument, this Court finds that Plaintiffs have demonstrated a need for preliminary injunctive relief in this case. *See Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008); *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131–35 (9th Cir. 2011). Thus, the Court GRANTS Plaintiff's motion and issues the following preliminary injunction:

1. Defendants are hereby enjoined from enforcing Executive Order 13950 against any recipient of federal funding, including Plaintiffs. Specifically, Defendants shall not:
    a. Condition the receipt of federal funding or contract eligibility on compliance with Executive Order 13950;
    b. Open or conduct investigations of any individual or organization with regard to compliance with Executive Order 13950, including investigations generated from calls to the Department of Labor's hotline;
    c. Conduct assessments as to whether any workplace trainings teaching the "divisive concepts" generate liability under the Civil Rights Act of 1964;
    d. Conduct reviews of agency spending on diversity and inclusion programs, or assess trainings to determine whether they "teach, advocate, or promote" the "divisive concepts" in Executive Order 13950, including through the use of keyword searches of such materials;
    e. Issue further guidance to federal agencies and employees regarding the implementation or enforcement of Executive Order 13950;
    f. Publish any further Requests for Information ("RFI") that seek comments, information, or materials from federal contractors, subcontractors, and their employees regarding workplace trainings involving the concepts prohibited by

Executive Order 13950, or review any materials provided to any federal agency or employee pursuant to any existing RFI;

g. Terminate existing governmental contracts or grants for purported non-compliance with:

   i. Any provision of Executive Order 13950,

   ii. Any agency action taken to implement Executive Order 13950, or

   iii. Any term of a contract or grant imposed to implement Executive Order 13950; or

h. Take any other action, whether or not listed above, intended to effectuate or enforce:

   i. Any provision of Executive Order 13950,

   ii. Any agency action taken to implement Executive Order 13950, or

   iii. Any term of a contract or grant imposed to implement Executive Order 13950.

2. This injunction shall take effect immediately.

3. This injunction shall apply to all Defendants as well as any of Defendants' officers, agents, servants, employees, and attorneys. This injunction shall further apply to any other persons who are in active concert or participation with Defendants or Defendants' officers, agents, servants, employees, and attorneys. Fed. R. Civ. P. 65(d)(2).

4. The Court's reasons for issuing this injunction are contained in a forthcoming opinion, as well as in the transcripts of proceedings held on _____. Fed. R. Civ. P. 65 (d)(1)(A).

5. This injunction shall be in effect until further order of the Court.

IT IS SO ORDERED.

Dated this ____ day of _____, 202_

_____
BETH LABSON FREEMAN
UNITED STATES DISTRICT JUDGE