Improving Data Collection for LGBTQ+ Communities
Webinar Talking Points

[TITLE SLIDE - SLIDE 0]
Good morning, folks! My name is Heather Jue Northover and I want to thank you for joining us on this webinar, Improving Data Collection for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and two sprit (or LGBTQ+) Communities! As part of our commitment to consult with communities with lived experience and expertise, and to provide greater transparency of our internal practices, this presentation is designed to:

- Provide an overview of LGBTQ+ data collection opportunities, challenges and limitations
- Present proposed recommendations for the collection of sexual orientation and gender identity (or SOGI) demographic data
- Launch a 30-day public comment period to hear feedback from stakeholders

By the end of this webinar, you will be able to:

- Explain the importance of disaggregating data
- Name some challenges in collecting and reporting SOGI data
- Provide some feedback on our proposed recommendations and know how to give additional feedback during our open comment period

[SLIDE 1]
Over the next hour, we will cover these topics:

- An overview of the Center for Health Equity and our data strategic priority;
- The importance of disaggregating data;
- Opportunities for improving LGBTQ+ data collection, as well as limitations and challenges we experience in collecting demographic data; and
- Proposed recommendations for SOGI data collection.

We will also have some time for Q&A at the end of the presentation.
Please note, this webinar is being recorded.

[SLIDE 2]
Today, you will hear from three presenters.

[SLIDE 3]
Now that you know a little about us, we would like to know a little bit about you and who’s in the virtual room. Please participate in this poll. Let us know the affiliation that best describes you.

[SLIDE 4]
To begin, I am going to provide a brief overview of the Center for Health Equity – what it is and why we are doing this work.

[SLIDE 5]
So I think we all want communities filled with the resources and opportunities that allow everyone to thrive. All these things listed here on the screen are needed to – in the words of Dr. Spock - live long and prosper.
We consider a healthy community as one that:

- Meets basic needs for all – clean air to breathe, clean water to drink, heathy, affordable foods, safe, affordable shelter and safety
- Has adequate levels of economic and social development – good schools and safe jobs with living wages
- Includes social equity and relationships that are supportive and respectful
- Has a sustainable, clean environment

And while there are many neighborhoods in LA County that have the community conditions in which everyone can thrive, stark inequities across place, race/ethnicity and income exist in LA County

[SLIDE 6]
In fact, these differences by

- race and ethnicity
- geography (place),
- income level.

can lead to up to 12 year difference in life expectancy. Depending on the color of our skin, where we live and how much money we make, we are more or less likely to have access to the resources and opportunities that allow us to grow healthy and thrive and lead to differences in health outcomes, quality of life, and longevity. There is a:

- 12-year difference between Walnut (87.5) and Lancaster (75.9)
- 12-year difference between Asian (86.7) and Back (73.9)

And these differences are largely the result of past and present policies and practices influenced by bias, prejudice and power imbalances, rather than individual characteristics and behavior. Language, sexual orientation, gender and biological sex, physical and mental abilities, and religion are also factors that affect our health due to similarly unfair policies and practices. And in thinking about intersectionality, some of us may have multiple identifies that may compound or mitigate our risk for poor health outcomes.

[SLIDE 7]
To combat these inequities, the Health Agency dedicated resources to advance health equity with the goal of increasing awareness, changing the narrative, motivating action and making change through the Center for Health Equity.

When we say equity, it is important to note that equality and equity doesn't mean the same thing. While equality means treating everyone the same, equity aims to promote fairness, but it can only work if everyone starts from the same place and has the same needs. Equity means giving everyone what they need to thrive.

We define health equity to mean that everyone has the goods, services, resources, opportunities and power needed for optimal health and well-being.

[SLIDE 8]
The Center organizes its work around one goal and four strategic priorities. The goal is our guiding star – the conditions we want to see – the elimination of gaps in health outcomes. The 4 strategic priorities will determine *how* we will do our work across the Health Agency and County of Los Angeles. They include:

- Provide useful and inclusive health equity data
- Support policy and systems change for the equitable distribution of opportunity and resources
- Build public, private, and community partnerships that share power and respect community autonomy
- Strengthen organizational readiness and capacity to adopt a just culture and advance health equity
- They are designed to improve service quality, provision and coordination, while also addressing the conditions and policies that drive and maintain health inequities.

We hope that institutions adopt these strategies and apply them to their own areas of responsibility, control and influence so our work is amplified across multiple sectors and movements in the county.

[SLIDE 9]
Last year, we hosted a series of community engagement events, including a forum in Los Angeles for Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, and Two-Spirit community partners, County staff, and other stakeholders on October 9, 2018.

I want to acknowledge and thank again our cosponsors for that evening including C2P LA Coalition, In the Meantime Men's Group, LA84, Los Angeles LGBT Center, TSPN LA, and The Wall Las Memorias, as well as all of the participants who provided valuable perspective during the event. Part of your feedback led to today's webinar and the work we're doing.

[SLIDE 10]
During the gallery walk and small group discussions, attendees provided input on what specific activities we should include in each strategic priority. When talking about data, participants felt sharing cross sector data and disaggregating data were important activities to ensure useful and inclusive data for their communities.

They also wanted more centralized access to data and encouraged us to develop partnerships with trusted community liaisons

[SLIDE 11]
So now that you all have a little context and background, I am going to turn it over to my colleague, Jerome Blake, who will provide a brief overview of the Center's data strategic priority and the importance of disaggregating data.

[SLIDE 12]
Thank you, Heather, and thank you all for joining the webinar today. As Heather mentioned earlier, the Center's work is organized around four strategic priority areas to support our main goal of eliminating gaps in health outcomes. Today I'll be providing:

- A very brief overview on the **data strategic priority area**
- A brief background on **DATA DISAGGREGATION**, and
- Information on what it is, why is it important to LGBTQ+ communities, and show examples of where disaggregated data can provide better insight on issues affecting communities.

[SLIDE 13]
In terms of data, The Center envisions residents and community-based organizations having easy access to useful and inclusive health equity data. We will work to ensure that data are **collected, analyzed and shared** in ways that value lived experiences. We want our health reports to lift community voices and tell their unique stories, from their point of view using better data and storytelling techniques.

We want to ensure that the data are **disaggregated** to include historically underrepresented communities and that data are **easily accessible** for community members and community-based organizations, who can use data to drive action through cross-sector policy and systems change.

[SLIDE 14]
So, what is data disaggregation and why should we disaggregate LGBTQ+ data?

[SLIDE 15]
Data Aggregation refers to Information and raw data gathered and expressed in a summary form for the purposes of statistical analysis. We gather representative data combined and summarized into an aggregate group or cluster e.g. "All LA County Residents". The emphasis here is on statistical analysis, since aggregate data has larger observation numbers and tends to produce more stable estimates in health outcome analyses.

On the other hand - data Disaggregation refers to the breaking down of aggregate data collected and compiled from multiple individuals into its component units. Instead of summarized data for "ALL LA County Residents", we break can the data down by demographics such as age, or race/ethnicity or other component groupings. In general, statistical analysis of disaggregated population data tend to be more challenging as we increase the level of disaggregation. This is due to smaller sample size and less data stability; therefore, less reliable estimates are sometimes produced.

[SLIDE 16]
For example: we often hear about the need to disaggregate data for the Asian Community. In this case, members of the Asian race/ethnicity are in the aggregate group. And here we see the different levels of disaggregation (based on the orange line). However, notice that with more disaggregation, we get more sub-groups of Asians, and as you can imagine, the actual members of those smaller sub-groups who participate in our data collection efforts get smaller and smaller and harder to generalize.

So, we as epidemiologists, face challenges with increasing levels of disaggregation, because we often get the less statistical power for the sub-populations, particularly on the local level.

[SLIDE 17]
So why is data disaggregation important?

Two main reasons are that with enough statistical power and data stability:

- Disaggregating data can reveal patterns that can be masked by larger, aggregate data, and
- Assessing disaggregated sub-populations can help ensure that resources are spent in communities where they are most needed and have the biggest impact.

For example: aggregate data shows that Asians are doing great economically and academically, and they are stereotyped as the model minority group. However, not all groups do equally well, e.g. the Cambodian communities in Long Beach, may not be doing so well compared to other Asian groups in other areas in the County. Given the lack of disaggregated data, CBOs for the Cambodian Community would not have the data they need to make their case in grant applications for increased community resources.

[SLIDE 18]
Similarly, if we look at Life expectancy data, Heather mentioned earlier that there was a 12-year difference between Asian and Black residents in the County. On aggregate, a typical County resident is expected to live to about 82 years.

Asians on aggregate are expected to live to 5 years longer than a typical county resident up to 87 years. However, when we disaggregate within Asian sub-groups, we see disparities in life expectancy with Indian and Chinese residents living on average 13 years longer than Native Hawaiians and Other Pacific Islanders, who are sometimes grouped together with Asians in health and other surveys external to DPH.
Note: Data are from Portrait of LA Report https://ssrc-static.s3.amazonaws.com/moa/PoLA%20Full%20Report.pdf

[SLIDE 19]
In terms of LGBTQ+ data, there are a few programs that already collect data on sexual orientation and gender identity, such as our DHSP and OHAE, just to name a few. However, DPH data collection is inconsistent and should be better standardized across the department. We are working to improve our SOGI data collection and dissemination since there are new identities entering the cultural lexicon as people endeavor to codify their sexual orientation and gender.

[SLIDE 20]
SOGI data disaggregating is important due to the significant health and well-being disparities that impact Sexual or Gender Minority individuals who come from a wide range of geographic and demographic backgrounds and may have unique lived experiences, health needs, and issues of concern that are obscured without disaggregated data.

They experience large disparities particularly in mental health, disability and health care access. They also face issues of intersectionality, discrimination, and violence (i.e. they may experience multiple sources of discrimination and violence based on sexual orientation, gender identity, race/ethnicity, and class)

[SLIDE 21]
A recent Williams Institute analysis of data from the California Health Interview Survey (CHIS) show that in California, there is an estimated 92,000 Transgender Adults between ages 18-70 years old. And compared to Cisgender Adults, Transgender adults were:

- 6x as likely to have ever attempted suicide
- 3x as likely to have emotions that interfere with relationships, social life, ability to do chores, and work performance (existing research suggest that higher rates of some mental and physical conditions including suicidal thoughts and behaviors, is partly related to the stress that results from stigma and discrimination, as well as delaying healthcare due to fear of discrimination or not receiving transition-related healthcare)
- Transgender adults were also 3x more likely to delay getting prescribed medicine or not get medications at all (which may be due to experiencing barriers such as lack of health insurance coverage, lack of healthcare providers, and experiencing mistreatment by health care providers).

[SLIDE 22]
As I mentioned before, members of the LGBTQ+ community face issues with discrimination and violence. Here we have data on Hate Crimes in LA County that were motivated by Sexual Orientation or Gender Identity.

The LA County Commission on Human Relations 2017 Hate Crimes Report shows that there were:

- 108 Sexual Orientation-Motivated Hate Crimes in 2017. This accounted for 1 out of every 5 reported hate crimes (second largest category behind Racial Hate Crimes).

As you can see from the distribution of those sexual orientation motivated crimes, the majority were anti-gay and lesbian and were violent crimes. There were also 33 crimes motivated by gender identity, of which 94% were violent crimes nearly 3 in 4 targeted transgender women.

[SLIDE 23]
In terms of our cross-sectional SOGI data collection, we have room for improvement and here is an example of why this is the case. Here we have data from our 2015 Los Angeles County Health Survey (LACHS), showing the percent of adults who are at risk for major depression by sexual orientation.
We see that 1 out of every 4 bisexual adults (25%) are at risk.

We also see a similar prevalence among individuals who reported “I don’t know” to the question about their sexual orientation. Both having about 2.5 times higher prevalence compared to cisgender (straight) adults. However, we cannot assume that these individuals fall in this category because they were not sure of their sexual orientation. This category could include individuals who were:

- Queer/Questioning
- Don’t Understand the Question
- Some other sexual orientation

Also, please note that the data could also be confounded by interview language (particularly Spanish), which may affect both the sexual orientation question and the outcome screener.
Note: *The Patient Health Questionnaire-2 (PHQ-2) is used as the initial screening test for major depressive episode. [REFERENCE: Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284-92.]*

[SLIDE 24]
This problem stems from the way we asked the questions in the 2015 survey, which for comparison purposes, mirrored the way National and State surveys asked them at the time.
So, in the 2015 survey:

- We didn’t ask questions that allowed for non-binary or Transgender identities
- The Sexual Orientation response options need to be more granular
- The options also included terms that may “Currently” be considered offensive to members of the LGBTQ+ community.

We addressed some of these issues in our most recent survey in 2017-18. This included adding the recommended two-tier gender identity questions. We also hope to get your feedback on these issues during the open comment period.

[SLIDE 25]
We acknowledge the need to improve on SOGI data collection in LA County. DPH is working to improve and standardize collection and reporting of SOGI data to better understand health behaviors, disparities and health inequities on the local level. There was also a 2018, Board Motion by Supervisors Sheila Kuehl and Hilda Solis, mandating the Health Agency, the Department of Children and Family Services, and the Probation Department to collect gender identity data on LGBTQ+ Youth.

Improved SOGI data collection will improve our LGBTQ+ outreach and engagement, program planning and service delivery.

And with that, Amy Lightstone will talk about opportunities, challenges and recommendations stemming from her work with the Epidemiology and Data Coordination Unit.
NOTE: On January 9th,2018, following a Board Motion by Supervisors Sheila Kuehl and Hilda Solis, all County departments were required to collect gender identity data.
http://file.lacounty.gov/SDSInter/bos/supdocs/120246.pdf

[SLIDE 26]
Thank you, Jerome. I'd now like to discuss

- Opportunities for improving SOGI data collection,
- Our process
- Challenges and limitations
- And a Draft of the recommendations that DPH has come up with for asking questions to collect SOGI data

[SLIDE 27]
Part of my role in DPH is to assist with trying to standardize data throughout our Department so that we are using best practices while being able (as much as possible) to compare data within our Department as well as locally and nationally. To accomplish this goal a Data Standardization Workgroup was formed comprised of epidemiologists and researchers throughout our Department. The first topic we decided to tackle was working to improve the methods of collecting SOGI data.

[SLIDE 28]
To accomplish this goal, we first:

- Reviewed research and literature from experts in the field (e.g., the Williams Institute, the UCSF Center for Health Excellence, SF DPH, BRFSS, and the NYC CHS)
- Considered how questions are asked per electronic health records reporting requirements
- Discussed ways questions have been asked in the past and/or are currently being asked, and
- Recognized the fluidity and sensitivity of these indicators

We then came up with recommendations taking into consideration balancing the need to have comparability with state and national data and being able to trend the data from year-to-year while also being inclusive of how sexual minority individuals may self-identify.

[SLIDE 29]
However, as with anything there are limitations to acknowledge and challenges to try to overcome.

[SLIDE 30]
The limitations include:

1. Government regulations that include electronic health record reporting requirements which are federally mandated.
2. Second, grant funders, some of which require the grantees to report data in a particular manner.
3. And then Data constraints. As Jerome mentioned there are sometimes insufficient data resulting in the need to combine response categories or even questions. For example, combining lesbian/gay responses with those of bisexual being, being unable to analyze sexual orientation data by gender or, some have combined self-identification and sexual behavior. These results can mask or dilute understanding important variations between these groups such as indicators affecting health and health outcomes.

[SLIDE 31]
Challenges include:

1. We want to make sure we are being inclusive and being consistent with the most current nomenclature and terminology, understanding that terms are often evolving.
2. Next, the method of data collection should be considered, whether it is a
    - Phone survey – where someone, a stranger, is asking the questions and what the level of comfort the respondent has in being forthright in answering the question, or a
    - Paper-pencil survey which carries a level of anonymity, or a
    - Clinical setting where a patient is informing or divulging information to a provider and what the level of familiarity and comfortability that person has with the provider
3. And, finally, language – there is the need to be cognizant of how some terms or concepts translate into other languages. Considerations need to be taken into account when there is a need to translate these questions such that the terms used are consistent with those languages rather than a literal translation of the words themselves.

   For example, this very well could have been an issue with the Spanish translations in the Los Angeles County Health Survey sexual orientation question. There was a high proportion of Latino respondents who responded "do not know" to the sexual orientation question (~15% compared to ~2% of the other race/ethnicities). When parsing that out further, there was a significant number of Latinos who responded to the interview in Spanish who reported "do not know": Over 30% of Latinos who completed the interview in Spanish answered do not know, compared to just over 2% of those who completed the interview in English. So, this points to the possibility that the translation of this question into Spanish may not have made sense to those Spanish speakers.

[SLIDE 32]
Now, let me present how we are proposing to ask the SOGI questions.

There are some specific questions we do have and would appreciate your input.

And, it would be great when you're doing so to include a reason or basis for your feedback, such as referencing a survey that is currently being conducted or one that was conducted and was problematic so we can learn from that experience, or interaction you've had with the community or community organizations, or results from research that you or your organization have conducted.

[SLIDE 33]
The criteria for our recommendations regarding the response options is that there are a minimum number of categories to be collected. However, it is up to the discretion of each Program to include additional response options for further granularity, yet, the goal is to then be able to aggregate those responses into the minimum categories so comparisons can be made.

[SLIDE 34]
Let's start with the recommendations regarding gender identity. There needs to be two questions asked to obtain this indicator:

1. How a person currently defines their gender, and
2. What the person's gender was at birth

Both questions need to be asked

[SLIDE 35]
The first option we are recommending comes from ORCHID, the electronic records reporting system used by LA County's Department of Public Health and Department of Health Services.

What is your gender identity?

- Male
- Female
- Female-to-Male (FTM)/Transgender Male/Trans Man
- Male-to-Female (MTF)/Transgender Female/Trans Woman
- Genderqueer, neither exclusively male nor female
- Additional gender category or other: _______
- Prefer not to state

[SLIDE 36]
The second option is "what is your current sex or gender identity?"

You can see that the "Male-to-Female (MTF)" and "Female-to-Male (FTM)" terms are not included. We will discuss further the other response option differences in a minute.

[SLIDE 37]
Let's first discuss the difference in the wording between the two questions.
The main difference between the two questions is the use of the word "sex." The workgroup was concerned that respondents may not grasp the nuance between the term 'sex' and the term 'gender,' and therefore thought it would be useful to include both.

This is the first question we have that we'd like your feedback: Do you think the word "sex" should or should not be included, and why.

[SLIDE 38]
Now, going back to the differences between the response options for these two questions (***and this leads to the second question we have that we would like your input):***
Regarding the response option for someone who does not identify as either exclusively male nor female, what other term or terms should be included:

- genderqueer as in ORCHID
- gender non-binary as in option B
- gender non-conforming
- or is there some other term?

Also should the phrase "neither exclusively male nor female" be included?

And this brings us to our second polling question….

[SLIDE 39]
What term do you think is most appropriate for an individual who does not identify as a male/man or female/woman?

a. Gender non-binary
b. Gender non-conforming
c. Genderqueer
d. None/something else
e. I don't know

[SLIDE 40]
The second difference ***(and third question we would like your input)*** is in the response categories when asking for folks who don't feel they fit into a specifically listed option, how they identify.
Is 'something else' a reasonable way to ask or would 'different identity' be more satisfactory? Or should we use ORCHID's, 'additional gender category or other'?

[SLIDE 41]
Now, let's discuss the options for the second question for gender identity. Here is ORCHID's question.

What sex were you assigned on your birth certificate?

- Male
- Female
- Other: ______
- Prefer not to answer

[SLIDE 42]
And this is option B: What was your sex at birth?

- Male
- Female
- *Non-Binary or X*
- *Something else: _______*

- Prefer not to answer

Regarding the wording of the question, the workgroup thought that including “on your birth certificate” (as in ORCHID) may be confusing as some may never have seen their birth certificate and others may not have a birth certificate. Additionally, we thought that using the word “assigned” (also in ORCHID) may be too sophisticated or confusing for some populations in responding to this question.

Highlighted in blue font are the differences in the response categories from what ORCHID has.
First, to stay current and consistent with changes occurring on birth certificates, the workgroup felt it important to capture ‘non-binary’ or ‘X’ as these categories are now being added to birth certificates and/or driver’s licenses and ID cards in some cities and states. Second, instead of “Other” the workgroup thought “something else” seemed more natural. The idea of including this category is to capture responses that are not listed and/or future potential changes in terminology. If data are consistently being captured here, that would indicate considering adding other response options.

[SLIDE 43]
Turning now to the questions for sexual orientation. We have two questions here as well. This is the question and response options directly from ORCHID:
What is your sexual orientation?

- Straight or heterosexual
- Lesbian, gay, or homosexual
- Bisexual
- Other: ___________
- Don’t know
- Prefers not to state

[SLIDE 44]
And this is the other option that we are recommending programs consider.

This question comes from the BRFSS, a CDC-sponsored national telephone survey, and the workgroup felt it is a simply worded and an appropriately sensitive question. The text in purple we are leaving up to the Programs’ discretion and needs to decide whether to include or not.

And as you can see, there are more response options than in ORCHID. They are:
- pansexual
- not sure yet
- don't understand the question

[SLIDE 45]
Again. we have some questions that we would like your feedback. ***And in case anyone is keeping track, this is the fourth question for your input.*** While we're recommending that the term 'homosexual' be used at the discretion of the Program, is the term considered offensive in the context it is being used?

[SLIDE 46]
And, the **fifth question for you**: is "pansexual" a term that we should keep? Is this a term people are using? If the ultimate decision is to include pansexual as an option, then the group also recommends considering adding definitions for pansexual and bisexual.

And, ***for the sixth question for you,*** if we do keep the term 'pansexual,' what do we do if the numbers are too small to be able to report reliable data? Do we combine with another category or are the data not reported at all?

[SLIDE 47]
Now, going back to discuss the response options a little further between ORCHID and those of Option B. As we had discussed, we want to make sure (to the best of our abilities) that we can make comparisons between data and be able to aggregate to a minimum set of categories. By going back a moment to review the response options--between these two questions. Here are ORCHID's
What is your sexual orientation?

[SLIDE 48]
And here are the ones we are proposing.

As you can see, these response categories are more inclusive than those from ORCHID. Therefore, we are recommending that if the ORCHID question is used, that these be the response categories also used. It is our belief that these categories can be combined in order to meet those of ORCHID's.

However, we need your help, which brings us to our ***seventh question for you:*** If we are to keep 'pansexual' as an option, to which of ORCHID's categories should 'pansexual' be included? We're proposing that "Not sure yet" and "Don't understand the question" should be put into ORCHID's category of "Don't know."

As a reminder and just to re-iterate, when providing feedback, please include the basis for your decision; Such as referencing a survey that is currently being conducted or one that was conducted and it was problematic so we can learn from that, an experience or interaction you've had with the community or community organizations, or results from research that you or your organization have conducted, etc.

And this brings us to our third and final polling question.

[SLIDE 49]
Should the term “pansexual” be included as a response option for sexual orientation?

a. Yes
b. No
c. I don’t know

[SLIDE 50]
Next Steps

[SLIDE 51]
PUBLIC COMMENT PERIOD
As we mentioned, this webinar is designed as a launch to our open comment period. After this webinar, you will receive a survey with questions about the webinar and additional inquiries about the proposed data collection questions. If you have additional comments or thoughts about what we’ve talking about today or about SOGI data collection/dissemination in general, please email us at….with your feedback. We will also post this webinar (along with our speaking notes for people to follow along who may be hearing impaired) and the survey online at our website: healthequity.lacounty.gov. This will probably be available around mid-June. We will notify you all once it’s up.

After we collect all they feedback, we will synthesize it into a brief and will share this information with other departments in the County attempting to do similar work.

Next, Jerome is going to talk about our Data Advisory Board.

Data Advisory Board:
In our effort to ensure data is collected, analyzed and shared in useful and inclusive ways that value lived-experiences and lift community voices, the Center for Health Equity will convene an ad-hoc cross-sector data advisory board. The board will seat CBO’s and residents from communities in the County with disproportionately poor health outcomes, at the table with DPH staff that produce data reports and other data products, so we can discuss accessibility and other data issues and get guidance/feedback on our major reports.

For those who might be interested in participation on the DAB, make sure you complete the Post Webinar and Public Comment Survey. We will be sending out applications in the near future.

LGBTQ+ Liaison
Another exciting development is our plan to add a new position to the Center for Health Equity. This position will be responsible for strengthening organizational readiness and capacity to address health inequities that impact lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and two spirit (LGBTQ+) communities in LA County. In this position, the Liaison is responsible for:

- Implementing the DPH recommendations to support LGBTQ+ youth;

- Collaborating with Health Agency leadership and community stakeholders to implement strategies that reduce gaps in health outcomes among LGBTQ+ communities; and
- Developing and leading training opportunities for Health Agency workforce and community members.

Among the many desired qualifications, we are looking for a candidate with a strong orientation and understanding of health equity and its intersection with race, ethnicity, gender and sexual orientation identities, as well as personal and professional experience working with LGBTQ+ communities in Los Angeles County.

Further notifications about this position and how to apply if interested will be disseminated through our listserv. If you're interested, please sign up for our listserv through our website or by emailing us.