RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF ROY HARKER, EXECUTIVE DIRECTOR OF AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Roy Harker, declare as follows:

1. AGLP: The Association of LGBTQ+ Psychiatrists is a 501(c)(3) non-profit organization based in Philadelphia, Pennsylvania, and incorporated in Pennsylvania. AGLP is a community of psychiatrists that educates and advocates on Lesbian Gay Bisexual and Transgender mental-health issues. AGLP's goals are to foster a fuller understanding of LGBTQ mental-health issues; research and advocate for the best mental healthcare for the LGBTQ community; develop resources to promote LGBTQ mental health; create a welcoming, safe, nurturing, and accepting environment for members; and provide valuable and accessible services to our members. AGLP strives to be a community for the personal and professional growth of all LGBTQ psychiatrists, and to be the recognized expert on LGBTQ mental health issues.

2. AGLP (formerly known as the Association of Gay and Lesbian Psychiatrists) represents the interests of 450 LGBTQ+ psychiatrists who are members of the Association. AGLP was founded in the 1970s when gay and lesbian members of the American Psychiatric Association (APA) met secretly at the annual meetings. At that time, in most states, homosexuality could be used as cause to rescind someone's license to practice psychiatry. In1973, the APA removed homosexuality from their diagnostic manual (DSM). This allowed a more open association of lesbian and gay psychiatrists, who could be a little less fearful for their jobs if they were found out to be gay. Even today, the mission of providing support and a safe space for LGBTQ psychiatrists to meet continues to be important to many of AGLP's members. AGLP is the oldest organized association of LGBTQ professionals in the country.

3. AGLP is an independent organization from APA, but works closely with APA through many projects, including but not limited to, LGBTQ representation on the APA Assembly (the Minority Caucus of the APA and AGLP's own representative), APA position statements, LGBTQ Committees of the DSM, the creation and staffing of an AIDS Committee, and research and advocacy of particular interest to the LGBTQ+ Community through their quarterly *Journal of Gay and Lesbian Mental Health, and seminars and discussion groups that are conducted concurrently with the APA's annual meeting*. AGLP works within the APA to influence policies relevant to the LGBTQ community, including issuing position statements that bring awareness to and advocate

against the misuse of religion to discriminate against the LGBTQ community as well as educating about how discrimination and stigmatization of LGBTQ people adversely affects their mental health and right to happiness.

4. AGLP continues to work with APA and independently to support our members and advocate for LGBTQ patients. AGLP also assists medical students and residents in their professional development, encourages and facilitates the presentation of programs and publications relevant to gay and lesbian concerns at professional meetings; and serves as liaison with other minority and advocacy groups within the psychiatric community.

5. I have been the sole staff person for AGLP for over twenty-five years, first as National Office Director for five years, then as Executive Director since 1999. I am an alumnus of Drexel and Temple Universities in Philadelphia, and completed the American Society of Association Executives ("ASAE") Association Executive Certification in February of 2018, the highest professional credential in the association industry. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the Denial of Care Rule from taking effect.

6. The Denial-of-Care Rule fosters greater discrimination against LGBTQ patients, who already experience widespread discrimination in obtaining healthcare and hence suffer significant health disparities in comparison to the general population. Research documents the history of this discrimination and the negative health outcomes that result. AGLP's members report that their LGBTQ patients and patients living with HIV report having experienced frequent discrimination by other healthcare providers and suffer from more acute medical conditions resulting from such discrimination and fear of seeking medically-necessary healthcare services. A large percentage of AGLP members' transgender patients anecdotally report having negative experiences related to their gender identity when seeking medical care, including being exposed to verbal harassment or refusals of care. In comparison to other populations, LGBTQ patients face significant health disparities—higher risk factors for poor physical and mental health, higher rates of HIV, decreased access to appropriate health insurance, insufficient access to preventative medicine, and higher risk of poor treatment by healthcare providers.

7. AGLP firmly believes that gender identity is part of the natural spectrum of human experience and expression**,** as is the position of the APA. The transgender and gender non-conforming community has been marginalized and continues to fight for basic civil rights. Discrimination and harassment are especially significant sources of stress for transgender youth who are navigating an especially challenging period of their life and are vulnerable to depression and suicide when not supported by family and schools. This is especially true when even their healthcare providers, the people whom they turn to in their most vulnerable times of need, discriminate against them or deny them care. Religious objections by healthcare providers have been detrimental to the health of LGBTQ patients, and these harms would be exacerbated by the Denial-of-Care Rule. As an organization of psychiatrists who often serve and care for patients from the LGBTQ community, AGLP knows that discrimination against LGBTQ individuals in healthcare access and coverage remains a pervasive problem and that too often this discrimination is based in religious objections.

8. AGLP has long strongly held and publicly asserted that all people, whether LGBTQ or not, deserve the equal protections provided by the Fifth and Fourteenth Amendments to the Constitution; that religious liberty justifications for denying healthcare are thinly disguised efforts to return to marginalization and stigmatization of same-sex and transgender orientations and identities; that the principle cited behind such religious-liberty arguments would threaten the equal protection of vast numbers of other minority citizens; that virtually every major mental-health organization has concluded that there is no credible scientific evidence that LGBTQ citizens are psychologically impaired *per se* or need to change their orientations or identities; that LGBTQ citizens represent no more burden on American society than any other minority group, and, in fact, have made substantive contributions to the arts, sciences, and businesses in America; and that discrimination and stigmatization of LGBTQ citizens adversely affects their mental health and right to happiness. Therefore: AGLP steadfastly condemns all legislative and administrative efforts, including the Denial-of-Care Rule, to stigmatize and discriminate against LGBTQ citizens.

9. The Denial-of-Care Rule will result in greater discrimination against LGBTQ patients and in increased denials of services based not just on the medical services that patients seek, but on

the basis of the patients' LGBTQ identities in violation of the law, medical ethics, and standards of care. The Denial-of-Care Rule presents a direct conflict with nondiscrimination standards adopted by all the major health-professional associations, who have already recognized the need to ensure LGBTQ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other healthcare settings. All the leading health-professional associations—including the AMA, American Osteopathic Association, American Academy of Physician Assistants, American Nurses Association, American Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that healthcare providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity. By allowing discrimination against patients on the grounds of moral and religious freedom, the Denial-of-Care Rule obviates the ethical standards that healthcare professionals are charged to uphold.

10. If not enjoined, the Denial-of-Care Rule will harm AGLP members, LGBTQ patients whose interests AGLP also represents, and the patients who AGLP members treat. The Rule invites healthcare facilities to discriminate against LGBTQ employees and patients without concern about the impact that a complaint for non-compliance with purported conscience protections would have on ensuring the provision of medically-necessary care for patients, adherence with medical standards of care, ethical requirements, accreditation requirements, and nondiscrimination requirements in employment and in the provision of patient care. The Rule, therefore, frustrates AGLP's mission of achieving and enforcing safe workspaces for LGBTQ psychiatrists and nondiscriminatory healthcare services to AGLP members' LGBTQ patients. The Denial-of-Care Rule frustrates AGLP's mission of advocating for nondiscrimination standards of care for patients and nondiscriminatory work environments for its members that protect against discrimination on the basis of sexual orientation and gender identity and advocating for cultural competency standards of care for treatment of LGBTQ patients.

11. Some members of AGLP are employed by religiously-affiliated healthcare organizations. AGLP has members who are Medical Directors and administrators in Hospitals and Clinics all over the Country and, in the course of their employment, these healthcare providers treat LGBTQ patients. Members of AGLP employed by religiously-affiliated hospitals will experience employment discrimination for adhering to their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically-necessary care that is in the patient's best interest. The Rule impinges on and conflicts with AGLP members' legal obligations as healthcare providers and harms the patients that they serve.

12. Additionally, some members of AGLP are employed by the federal government. In the course of their employment, these health professionals have benefited from, and have depended upon, protections against discrimination in federal sector employment based on sexual orientation and gender identity. These nondiscrimination policies have deterred anti-LGBTQ harassment and other forms of discrimination, regardless of the motive for that discrimination. The Denial-of-Care Rule is in direct conflict with those nondiscrimination policies.

13. The Denial-of-Care Rule invites harassment and discriminatory treatment of AGLP members in the workforce by fellow employees who claim a right to accommodation for discriminatory behavior justified by the Rule. AGLP members and their LGBTQ patients are stigmatized and demeaned by the message communicated by the Denial-of-Care Rule that their government privileges beliefs that result in the disapproval and disparagement of LGBTQ people in the healthcare context. The Denial-of-Care Rule invites religious-based discrimination against AGLP members as well as their LGBTQ patients.

14. Based on their years of working with LGBTQ patients who have reported concealing their identities out of fear of discrimination, AGLP members know that the Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. AGLP will need to be a resource for patients who are in need of medical services but do not know where to go for LGBTQ-affirming healthcare. The Rule will predictably result in more denials of care, and, consequently, more requests for referrals. With an increase in referral requests as a result of the Denial-of-Care Rule, AGLP will need to allocate additional resources to assisting AGLP members and their patients with healthcare referrals. AGLP offers an online referral service to patients seeking LGBTQ-affirming counselling, support, and psychiatric treatment. The Denial-of-Care Rule adversely impacts AGLP by necessitating the diversion and reallocation of resources in order to provide referrals to increasing numbers of patients. The Denial-of-Care Rule will make it more difficult and resource-intensive for AGLP to locate and monitor appropriate referrals that will not cause further harm to AGLP patients who have already been discriminated against or who fear discrimination on the basis of religious objections to the patients' gender identities or sexual orientation. AGLP will have to continuously update its online referral search engine, especially because many healthcare providers currently listed on the website are affiliated with religious hospitals and organization. As a result of the Denial-of-Care Rule, AGLP expects to see increased use of its referral resources and assistance, which will require AGLP to allocate additional staff time to support such requests.

16. As a result of the Denial-of-Care Rule, AGLP is required to expend its resources to educate and assist its members and the LGBTQ patients its members serve to defend against the harms that the Rule causes. AGLP has been working with other medical and health associations, including the APA, to express disapproval of the Denial-of-Care. Such work has diverted resources away from other proactive projects and outreach efforts that are core to AGLP's mission. AGLP also spends resources answering AGLP members' inquiries about the Denial-of-Care Rule given the pervasive concern that the Denial-of-Care Rule contradicts medical ethical requirements and standards of care. AGLP must spend resources educating its members and the general healthcare community about AGLP's position on the Denial-of-Care Rule and its negative effects on healthcare practices and providers as well as their patients.

17. The Denial-of-Care Rule empowers and incites religious-based discrimination against AGLP members and will create discriminatory work environments for AGLP members. AGLP, in

turn, sees and will continue seeing an increase in psychiatrists seeking its assistance with addressing such discrimination. AGLP will need to help its members navigate through these hostile work environments and may need to intervene on its members' behalves when necessary. The increased demand for such services will further hamper AGLP's other work because AGLP already has a very limited bandwidth for such services.

18. AGLP members receive various forms of federal funding directly and indirectly via federal programs. AGLP's members may, therefore, be subject to the restrictions of the Denial-of-Care Rule. Without such funding, AGLP members would not have the resources to provide proper treatment to their patients or proceed with their medical research programs. AGLP's members, therefore, have a reasonable fear that they could be sanctioned and lose federal funding for the work that they do as a result of nondiscrimination policies, ethical requirements, and standards of care that they enforce in their psychiatric practices, which are vital to providing proper care to their patients.

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

Dated: June 5, 2019

Respectfully submitted,

/s/ Roy Harker

Roy Harker

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF SARAH HENN, MD, MPH, CHIEF HEALTH OFFICER, WHITMAN-WALKER HEALTH, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Sarah Henn, Declare as follows:

1. I am Chief Health Officer of Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health (Whitman-Walker). I received my medical degree from the University of Virginia; interned at Emory University; was a resident in Internal Medicine at the University of Virginia; and completed an Infectious Disease Fellowship at the University of Maryland. I earned a Masters of Public Health degree at The Johns Hopkins Bloomberg School of Public Health. I maintain active board certifications in Infectious Disease and Internal Medicine. I have been a physician at Whitman-Walker since 2007, and became Chief Health Officer in May 2018. I oversee all healthcare-related services at Whitman-Walker, as well as maintain a panel of patients for whom I provide direct care. In addition, I oversee Whitman-Walker's Research Department, am the primary investigator for multiple HIV and Hepatitis C treatment and prevention trials, and am the Leader of our Clinical Research Site for the AIDS Clinical Trials Group funded by the National Institutes of Health. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

2. Whitman-Walker provides a range of services, including medical and community healthcare, transgender care and services, behavioral-health services, dental-health services, legal services, insurance-navigation services, and youth and family support. Whitman-Walker provides primary medical care, HIV and Hepatitis C specialty care, and gender-affirming care to transgender and gender non-binary persons within the diverse community of the greater Washington, DC metropolitan area. In calendar year 2018, our medical, dental, behavioral-health and community-health professionals provided health services to 20,797 patients—including medical care to 11,471 individuals, dental care to 2,354 patients, and walk-in sexually-transmitted-infection testing and treatment to 1,719 persons. In 2018, 3,573 of our patients were individuals living with HIV; 1,837

identified as transgender; and 9,990 identified as gay, lesbian, bisexual or otherwise non-heterosexual.

3. Whitman-Walker's patient population, including patients to whom I provide direct care and whose care I oversee, includes many persons who have experienced refusals of healthcare or who have been subjected to disapproval, disrespect, or hostility from medical providers and staff in hospitals, medical clinics, doctor's offices, or Emergency Medical Services personnel because of their actual or perceived sexual orientation, gender identity, gender presentation, ethnicity or race, religious affiliation, poverty, substance use history, or for other reasons. My patients and those whose care I oversee tell us that they are apprehensive or fearful of encountering stigma and discrimination in healthcare settings because of their past experiences. Many of our patients have delayed medical visits or postponed recommended screenings or treatment because of such fears. Frequently, persons living with HIV, diagnosed with sexually transmitted infections, struggling with substance use disorders, or whose gender identity is different from the sex that they were assigned at birth, face heightened stigma and discrimination and are particularly apprehensive in medical encounters. Our patients' concerns have been magnified by their belief that the federal government is permitting, if not encouraging, healthcare personnel to discriminate against them because of personal moral or religious beliefs in accordance with the Denial-of-Care Rule.

4. Whitman-Walker's mission and fundamental principles of medical ethics that I adhere to in overseeing and providing care to patients dictate that all patients are deserving of the best and most respectful care available to them. All healthcare professionals are taught that their personal beliefs about a patient's actions, identity or beliefs cannot compromise the care that they provide to that patient in any way. Whitman-Walker and I, in my role as Chief Health Officer for Whitman-Walker, communicate that message to all healthcare staff from the beginning of the recruitment process to the first day of employment, and reinforce the message regularly. The possibility that

individual providers or other healthcare staff at Whitman-Walker could invoke the Denial-of-Care Rule to opt out of any aspect of care would fundamentally disrupt our care model and operations, violate basic tenets of medical ethics, and could not be accommodated without lasting damage to the health center, patient morale, and our reputation in the community. It would be very difficult, if not impossible, for Whitman-Walker to accommodate individual healthcare staff who object to, for example, providing treatment for gender dysphoria, counseling pregnant clients with their pregnancy termination options, assisting with harm-reduction care for substance abusers, or providing healthcare services to lesbian, gay, or bisexual patients. Any such effort to accommodate individual employees at the expense of patients would fundamentally compromise Whitman-Walker's mission and the quality of patient care, and would harm patients, including my own.

5. 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' mental and physical health. 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; and 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 healthcare and potential treatment, which can only be achieved when patients are assured that the information they provide will be treated confidentially and with respect, and will not be used against them to deny treatment. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full

disclosure, and by encouraging providers to avoid topics that may offend their personal moral or religious beliefs in their encounters with patients.

6. Furthermore, there is every reason to believe that the Denial-of-Care Rule's message that healthcare providers and staff have the legal right to refuse care or opt out of serving patients with particular needs, based on personal beliefs, will result in more discrimination against LGBT patients and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other healthcare facilities outside Whitman-Walker. Even before the Rule was issued, I and other Whitman Walker healthcare providers, including referral coordinators, behavioral-health providers, and other staff, have learned of many instances of discrimination, from our patients and from communications with outside providers and staff. Examples include the following:

a. Whitman-Walker was recently contacted by a transgender woman suffering from tonsillitis. She wanted treatment but knew of no hospital or facility other than Whitman-Walker where she could go. The caller reported that in her suburban area, she and other transgender individuals she knows are routinely disrespected and poorly treated when they seek medical care, and asked for advice on where transgender patients can receive good care.

b. A gay man reported that he consulted a cardiologist for a heart issue. The cardiologist reviewed his medications and saw that one was Truvada – an antiretroviral medication that is used for "Pre-Exposure Prophylaxis" or "PrEP" – taken by persons who are not HIV-infected to avoid contracting HIV during sex. The cardiologist was startled and disapproving, and began lecturing the patient about what the cardiologist considered his inappropriate sex life.

c. A transgender man, together with his girlfriend, consulted a fertility clinic about their pregnancy options. Clinic staff told them that they would not help people like them.

d. A transgender patient of Whitman-Walker attempted to fill a prescription at a non-Whitman-Walker pharmacy for a hormone prescribed to assist in their gender transition, and was refused by the pharmacist.

e. Our patients seeking to fill prescriptions for Truvada for PrEP have also been refused by some pharmacies.

f. A gay man who is a long-term HIV survivor went to a local hospital emergency room after an accident that occurred during sex. He was treated with contempt by ER staff and was lectured about his sex life.

g. A transgender individual went to a local hospital emergency room suffering from acute abdominal pain. The individual was subjected to intrusive, hostile questioning by ER personnel, loudly and in public, about their anatomy and gender identity.

h. One of our physicians, while in residency at a hospital in a major Midwestern city, heard other residents refuse to refer to transgender patients by pronouns conforming to their gender identity, citing their religious beliefs. They continued to refuse even when informed that they were violating hospital policy.

i. A transgender woman was scheduled to receive an ultrasound for cancer. The first radiological technician she encountered refused to perform the ultrasound. When she protested, a second technician performed the procedure, but mocked her openly.

j. Transgender patients have reported to us that they have been in medical or mental-health crisis and called for an ambulance, and that the Emergency Medical Service personnel who have arrived on the scene have intentionally used pronouns inconsistent with their gender identity, even when the patients have asked them to stop and told them that their language was increasing their distress.

k. A gay man who was engaged in sex, while under the influence of drugs, experienced a physical episode and was fearful he was having a heart attack. He called an ambulance, but the Emergency Medical Service personnel who arrived belittled him and his situation and refused to take him to an emergency room.

l. Local hospitals and surgeons have refused to perform gender-transition-related surgeries on Whitman-Walker transgender patients, even when they routinely perform the procedures in question on non-transgender patients, including in situations where the patient's insurance would cover the procedure or when the patient was able to pay for the procedure. This has happened with orchiectomies, breast augmentations, and breast reductions - procedures which are all routinely performed for treatment of cancer or for other reasons, not related to gender identity.

m. A number of primary care physicians in our area have refused to prescribe hormone therapy for transgender patients seeking to transition from the sex they were assigned at birth to their actual gender identity. Many of these doctors have stated that they are not "comfortable" with such hormone therapy.

n. Our providers have seen situations in which a teenager who is transgender or gender-nonconforming has presented at a local hospital with symptoms for which hospitalization was indicated, but their hospitalization was delayed and even denied because hospital personnel took them less seriously than they took other young people with similar presentations who were not transgender.

o. Our transgender patients frequently report instances of being treated with disrespect and hostility by staff in doctors' offices, hospitals, and clinics. Frequently, staff at these facilities will refuse to address patients by their chosen names and gender pronouns, if these are not the same as the patients' legal names and sex assigned at birth, or if patients appear to be transgender. The persistent use of names and pronouns other than what the patients have requested appears intentional and intended to communicate strong disapproval of the patients. I and my staff who frequently consult with transgender patients hear of such experiences from as many as four out of every five transgender patients.

7. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, 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 if not most of my and Whitman-Walker's transgender patients express strong distrust of the healthcare system generally, and a demonstrative reluctance to seek care outside Whitman-Walker 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, or even no longer curable in the case of some cancers.

8. These and many other experiences reveal that many medical providers and other staff continue to harbor explicit or implicit biases against LGBT people. Many providers and staff who harbor such feelings or beliefs nonetheless have provided care to LGBT patients, and kept their personal beliefs in check, because of anti-discrimination laws; non-discrimination policies at many hospitals, clinics, and other healthcare facilities; and professional norms. The Denial-of-Care Rule counteracts such non-discrimination policies and norms, and encourages healthcare providers and staff to act on their personal beliefs. The result will likely be a significant increase in discriminatory incidents, denials of care, and the attendant harms to patients' health and well-being.

9. In addition to instances of discrimination against LGBT patients, I and the providers who I supervise have been informed of many examples of discrimination against patients based on other personal biases, especially personal disapproval of persons who use illegal drugs and persons who are not proficient in English—particularly Spanish speakers who are (correctly or incorrectly) thought to be immigrants. For example:

a. Whitman-Walker has a robust and very successful substance-use-disorder treatment program. Many of our patients are on Medically-Assisted Therapy or MAT, for opioid use disorders. A patient of ours was denied an opioid antagonist, Narcan, in a crisis situation because the EMS personnel available expressed disapproval of the patient in question. This was witnessed outside of our own clinic where we had to use our own clinic stock of the medication to reverse the life threatening overdose. The Denial-of-Care Rule encourages healthcare providers to deny patients life-saving medications.

b. Whitman-Walker has a number of patients whose primary language is Spanish and who lack English proficiency. I and the providers I supervise have patients who, in hospital and medical-clinic settings, were refused Spanish-language interpreters, even when such interpreters were available in the facility, because the provider or other staff thought that the patient ought to know English, or because of bias against immigrants. Patients in these situations have had difficulty understanding their diagnosis and/or treatment plan, greatly increasing risk of a negative result and harm.

10. The Denial-of-Care Rule encourages providers and other healthcare staff to think that any personal belief, whether or not based in a religious faith, is sufficient grounds to deny or opt out of care. Such an understanding could have disastrous impacts on the care that is available to patients, resulting in significant harm to patients' health and well-being, including patients in my care and those whose care I supervise.

11. Whitman-Walker is a certified healthcare provider under the Medicare program and also under the District of Columbia's Medicaid program. As a healthcare provider with Whitman-Walker, I am individually credentialed under Medicare and also under the District of Columbia's Medicaid programs. Both programs are overseen by HHS' Center for Medicare and Medicaid Services (CMS). These funds and related benefits account for the insurance of 70 percent of the patients we serve. This represents a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients. A large portion of the population that we serve rely heavily on Medicaid and Medicare for their healthcare needs. A loss of Medicare or Medicaid funding, as a possible sanction, under the Denial-of-Care Rule, resulting from enforcement of Whitman-Walker's nondiscrimination mandate which applies to all of our healthcare providers and staff, would result

in service reductions, if not closure of our programs in their entirety. As a physician individually credentialed under these programs, I have a reasonable fear not only that Whitman-Walker's continued certification under these vital programs might be endangered, but also that I could individually be sanctioned for enforcing Whitman-Walker's mission with respect to the providers and other staff that I supervise.

12. In addition to overseeing medical care of patients, and working with my own patients, I oversee Whitman-Walker's Research Department, and am personally involved in a number of clinical research projects. Much of this research is funded by HHS or by institutions affiliated with or themselves funded by HHS—for example, the National Institutes of Health and the Centers for Disease Control and Prevention. In 2019, our federally-funded research contracts and grants total more than $2 million. My understanding is that such research could be at risk under the Denial-of-Care Rule unless Whitman-Walker were to accommodate employees who might wish to opt out of providing care because of their personal moral or religious beliefs. As I previously noted, such accommodation would be impossible for Whitman-Walker: it would thwart our mission, be inconsistent with fundamental professional standards, and could endanger patients. Research also requires the following of strict protocols for patient safety and these would be jeopardized by the rule. Important research could suffer as a result. Our current federally-funded research projects that are of great public importance include a wide range of HIV-related studies, including research as a Clinical Research Site of the AIDS Clinical Trials Group into novel treatments and HIV cure; a longitudinal study over several decades into the health of HIV-positive and HIV-negative gay and bisexual men; a study of less intrusive ways to diagnose anal cancer; the effects of stigma, stress, and drug use on biomarkers in Black men; health-related behavioral coaching of young gay and bisexual men of color; the first longitudinal cohort study of HIV-negative transgender women, to

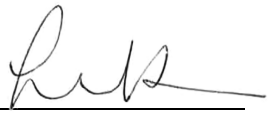
determine causes of HIV acquisition; and the effects of stress on transgender women of color who are HIV-positive and on hormone therapy.

13. I am designated as an Investigator or Principal Investigator on many of the federal research grants and contracts described above. As Whitman-Walker's Chief Medical Officer and as the acting director of our Research Department, my responsibility includes enforcing our nondiscrimination mandate with respect to all of our providers and staff, including those working on federally funded research. I, therefore, have a reasonable fear that the ability to conduct federally funded research would could be severely impeded potentially putting research participants at risk or that I might be subject to sanctions as an Investigator of federal research grants and contracts under the Denial-of-Care Rule.

I hereby declare, under penalties of perjury, that the facts stated in this declaration are personally known to me, and that they are true.

Dated: June 5, 2019

Respectfully submitted,



Sarah Henn

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

No. 19-cv-2916 NC

DECLARATION OF PAUL E. LORENZ IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, PAUL E. LORENZ, declare as follows:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I am the Chief Executive Officer of the hospitals and clinics owned and operated by the County of Santa Clara ("County"), which includes Santa Clara Valley Medical Center ("Valley Medical Center"), O'Connor Hospital, and St. Louise Hospital. I have held this position since March 2019, and I have served as Chief Executive Officer of Valley Medical Center since November 2012. Prior to my current role with the County of Santa Clara, I served as the Chief Deputy Director of the Ventura County Health Care Agency for the County of Ventura. I have served in public healthcare for over 27 years.

3. The County of Santa Clara has owned and operated Valley Medical Center for more than one hundred years. On March 1, 2019, the County assumed ownership and operations of O'Connor Hospital, St. Louise Hospital, and De Paul Health Center. The County acquired these facilities after their prior owner, the nonprofit Verity Health System, filed for bankruptcy. The County's acquisition of these facilities was driven by its commitment to ensuring access to healthcare for all people within the County and, in particular, for vulnerable populations.

4. The County, through the County of Santa Clara Health System, operates Santa Clara Valley Medical Center, O'Connor Hospital, and St. Louise Hospital on a consolidated hospital license with a single consolidated medical staff.

Background the County's Health System, Including Valley Medical Center

5. The County of Santa Clara Health System is the only public safety-net healthcare provider in Santa Clara County, and the second largest such provider in the State of California. Generally, safety-net providers have a primary mission to care for the indigent population as well as individuals who are uninsured, underinsured, or covered by Medicaid, which is the federal healthcare insurance program for low-income individuals. Because of this primary mission, safety-net providers are by their nature extremely dependent on federal funding.

6. The County's Health System is a fully integrated and comprehensive public healthcare delivery system that includes three hospitals and a network of clinics, which provide a full range of health services, including emergency and urgent care, ambulatory care, behavioral health services, comprehensive adult and pediatric specialty services, the highest-level neonatal intensive pediatric care unit, women's and reproductive health services, and other critical healthcare services. Valley Medical Center, for example, which was the County's sole hospital and network of clinics before the Count acquired O'Connor Hospital, St. Louise Hospital, and De Paul Health Center, includes a tertiary-level acute-care hospital with 731 licensed beds, as well as numerous primary and specialty care clinics. Valley Medical Center's hospital is a Level 1 Adult Trauma Center and Level 2 Pediatric Trauma Center. As described by the American Trauma Society, a Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation and a Level 2 Trauma Center is able to initiate definitive care for all injured patients. Valley Medical Center has over 6,000 employees, including an estimated 1,202 physicians and advance practice providers. Valley Medical Center trains approximately 170 medical residents and fellows each year as a graduate medical education provider and teaching institution.

7. The County's Health System also operates a Gender Health Center that provides (1) resources and psychological support for people of all ages, including children, teens, and young adults, who seek to understand and explore their gender identity; (2) medical care, including hormone treatments; and (3) primary care, including HIV and STI testing. Patient services at the Gender Health Center include standard primary care and acute care, as well as specialized care for the psychological and physical elements of gender transition. The County also operates a family-planning clinic, which provides contraception and abortion services, and it operates a clinic dedicated to serving the needs of LGBT patients.

8. The County's Health System provides the vast majority of the health-care services available to poor and underserved patients in the County. In fiscal year 2017, there were more than 800,000 outpatient visits to Valley Medical Center's primary care clinics, express care clinics, specialty clinics, and emergency department, and over 120,000 days of inpatient stays in

the hospital. Patients who are uninsured, or reliant on California's Medicaid program (Medi-Cal) or Medicare, the federal insurance program for elderly and disabled individuals, were responsible for approximately 88% of outpatient visits and approximately 85% of inpatient days. In 2018, Valley Medical Center's hospital had an average daily census of 363 patients admitted to inpatient care and handled 3,087 births and 88,856 emergency department visits.

9. O'Connor Hospital, located in San José, provides emergency medical services, urgent care services, primary care, hospital care, and reproductive-health services. O'Connor Hospital operates a nationally recognized acute care hospital with 334 licensed acute beds; 24 licensed skilled nursing (SNF) beds; an estimated 681 physicians and advance practice providers and 1,446 employees. The hospital handled an estimated 51,948 emergency visits, 4,311 surgical cases, and 1,631 births in 2018. O'Connor Hospital is the home of one of the only family medicine residency programs in the Bay Area. In addition, the hospital has clinical specialties, including but not limited to, cancer, cardiology and cardiac rehabilitation, maternal child health services, orthopedics and joint replacement, rehabilitation and sports therapy, spine care and pain management, stroke prevention and treatment, and wound care.

10. St. Louise Regional Hospital, located in the City of Gilroy, provides a wide range of high-quality inpatient and outpatient medical care. St. Louise Regional Hospital operates the only acute care hospital in the southern, rural part of the County, specializing in maternal child health services, emergency services, women's health, breast cancer care, imaging, surgical and specialty procedures, and wound care. The hospital operates 72 licensed, acute beds, 21 licensed skilled nursing (SNF) beds, and employees an estimated 262 physicians and advance practice providers and 500 employees.

The County Health System's Religious and Moral Exemption Policy

11. Valley Medical Center has a policy allowing its current and prospective medical staff members and employees to request in writing not to participate in certain patient care that conflicts with the staff member's cultural values, ethics, or religious beliefs, which is in the process of being made applicable to the County's newly acquired hospitals and clinics as well. A copy of that policy is attached as **Exhibit A**. The policy as implemented applies to employees

who participate in direct medical care, including doctors and nurses. Once an exemption is requested, the appropriate manager or director determines whether the request can be granted in light of staffing levels and other relevant circumstances. If the request is granted, the staff member's tasks, activities, and duties may be redistributed to ensure appropriate patient care. The policy requires staff to continue participating in patient care until their objection is reviewed and an accommodation is made, a process that can take up to two weeks. The policy makes clear that exemptions will not result in disciplinary or recriminatory action. However, a manager or director may decline to accept an employee or medical staff member for permanent assignment when the employee/medical staff member has requested not to participate in an aspect of care that is commonly performed in that assignment. The policy makes clear that patient care may not be adversely affected by the granting of an exemption and that medical emergencies take precedence over personal beliefs.

12. The collective bargaining agreement between the County and the Registered Nurses Professional Association, which represents nurses employed by the County, incorporates similar provisions regarding religious and ethical objections to participating in care. The County's collective bargaining agreements with County hospital and clinic employees who do not directly provide medical care, such as clerical workers, do not address or contemplate religious or ethical objections.

13. The County Health System views this policy as appropriately addressing the healthcare needs of patients, including patients' rights to be treated in a nondiscriminatory manner; our need to plan in advance to ensure appropriate staffing; and the cultural values and ethical and religious beliefs of our employees. Without prior notice and the ability to plan assignments around religious objections, including during the initial hiring process, the County would be unable to appropriately staff many of its operations.

14. Valley Medical Center also has a policy, which is most relevant to end-of-life care, that allows physicians to decline to participate in medically ineffective care or to decline to participate in an individual healthcare decision or instruction that is against the physician's conscience. This policy is also in the process of being made applicable to the County's newly

acquired hospitals and clinic. The policy, which is attached as **Exhibit B**, requires that the provider communicate their objection to the patient, or the person authorized to make health-care decisions for the patient (the patient's proxy); provide assistance to transfer the patient to another provider whose views are more consistent with the patient's; and continue providing care until the transfer can be accomplished. The policy encourages open communication and joint decision-making where possible and does not permit a physician to object to assisting the patient with a transfer to another provider. The County's Health System views this policy as an appropriate effort to ensure that patients, or their proxies, can exercise their rights to self-determination and informed consent while also ensuring that physicians who have an objection to carrying out the desires of a patient or their proxy are not required to participate in health-care instructions or care to which they object.

15. As a safety-net provider, the County's Health System serves vulnerable patients from a variety of backgrounds, including LGBTQ patients. Were an employee to refuse to assist or treat a patient on the basis of the patient's sexual orientation or gender identity, it could imperil patient health, harm that patient's trust in our hospitals, and undermine the County's mission to provide healthcare to vulnerable populations.

16. Further, it is critical to the operation of the Gender Health Clinic that the County be able to require providers and employees not to discriminate against patients. The Gender Health Clinic is a safe space for people of all ages to understand and explore their gender identity, and an accepting place for youth and their families to receive information and care throughout this process. The Clinic's mission and ability to provide the standard of care necessary for the community would be imperiled if the County were required to allow employees who object to providing care to transgender patients on moral or religious grounds to serve in that setting.

17. Similarly, the County provides contraceptive care and abortion procedures in ambulatory, inpatient, and emergency settings. Our current policy requiring advance notice of religious or moral objections to providing such care, and permitting transfer of tasks and assignments when necessary to accommodate an objection, allows the system to appropriately

staff clinics and hospital units that provide these services so that patients may receive necessary care.

18. The hospitals, particularly in our emergency departments and operating rooms, require a religious objector to assist in patient care in the event of an emergency, until a non-objecting staff member is available to relieve them. If an objector were to refuse to assist in patient care during an emergency, this could lead to delays in care and worse medical outcomes, including potentially fatalities. Our facilities also rely on their ability to require advance notice of all religious, cultural, or ethical objections to providing patient care in order to plan and maintain appropriate staffing.

19. If the County could not require all staff to provide care in an emergency and could only require notice of religious objections once a year, we would face serious obstacles to satisfying our obligations to provide emergency services under the federal Emergency Medical Treatment & Labor Act (EMTALA) and to comply with nondiscrimination laws. To satisfy these legal obligations, our hospitals might have to increase staff dramatically to ensure that each role in our system was at a minimum doubly staffed. The additional staff would be necessary to account for the possibility that any staff member, without notice, could refuse to provide care and refuse to refer or provide information to a patient, even in an emergency situation. Even with doubling staffing, a cost that we could not afford, our hospitals might not be able to anticipate every provider's objection and so would remain at risk of noncompliance despite expending tremendous resources.

20. As CEO of three hospitals and numerous clinics that serve nearly two million people, I am responsible, together with my team, for managing staffing, budgeting, and ensuring that the County's health facilities operate in compliance with federal, state, and local laws and regulations. To carry out these responsibilities, I and my team must have certainty about the County's legal obligations as a recipient of federal funding. For example, it is vital to our operations and to patient care that we know whether we can require—and therefore rely on—employees to assist patients in the event of an emergency, or whether the federal government is eliminating or limiting the obligation of a religious objector to assist a patient in an emergency

situation. Without clarity on this subject and others, we cannot adequately plan or budget, and we will not know what we must do in order to be able to certify our compliance with our federal grant and funding obligations.

21. I have reviewed and am familiar with the model text for the "Notice of Rights under Federal Conscience and Anti-Discrimination Laws" in the rule published by the U.S. Department of Health and Human Services, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the Rule). I am concerned about the effects on patient care that would result from the model text, if displayed in locations accessible to patients, which tells providers they "have the right to decline to participate in, refer for, undergo, or pay for certain healthcare-related treatments, research, or services . . . which violate your conscience, religious beliefs, or moral convictions under Federal law." The model text might encourage or suggest that it is permissible for a provider, for example, to refuse to treat a transgender patient who comes to the emergency room seeking care for a broken arm based on the provider's "moral convictions," even though such refusal of service would violate federal non-discrimination law and EMTALA. And, if the notice is seen by a patient, it would discourage open communication with the provider, for fear that services will be denied.

Impact of Loss of Federal Funding

22. The County's Health System is extremely dependent on federal funding, most of which it receives directly or indirectly through the Department of Health and Human Services (HHS), with such funding accounting for more than two-thirds of the overall budget for the system in a typical fiscal year. For example, in fiscal year 2016, Valley Medical Center received approximately $1 billion dollars in direct federal funding or funding that is contingent upon federal revenue streams from HHS, primarily from Medicare and Medicaid programs. This funding covered approximately 70% of Valley Medical Center's expenses for fiscal year 2016. Specifically, Valley Medical Center received and relies upon several types of federal payments, including: (1) Medicare payments; (2) Medi-Cal payments; (3) Medicaid waiver payments, which fund demonstration projects designed to improve and expand overall coverage and improve health outcomes for low-income individuals; (4) homeless health-care grants, which fund access

to quality primary health-care services for homeless and other vulnerable individuals; and (5) disproportionate-share payments and supplemental reimbursements paid to qualifying hospitals that serve a large number of Medicaid and uninsured patients.

23. The County's health system already operates at a significant deficit because of the volume of uncompensated costs it incurs in serving uninsured and under-insured patients. For example, during Fiscal Year 2017-18, Valley Medical Center received approximately $131.8 million in subsidies from the County's General Fund so it could continue to provide critical healthcare services to uninsured and under-insured patients. The County's recently acquired hospitals and additional clinic were purchased through a bankruptcy proceeding, and while the County hopes to run those hospitals in a cost-neutral manner, those hospitals may also face financial shortfalls that the County will have to cover, furthering stretching the County's fiscal resources. The impact of any loss in federal funding would not be limited to services traditionally funded by federal dollars. A withdrawal of federal funding for the County would require a countywide realignment of funding and priorities, and money that is currently allocated from the County's General Fund to support programs that do not receive federal funding could be diverted to address the loss of federal funding.

24. Without federal funding, the County Health System's ability to provide a broad range of quality services to thousands of patients—including infants and children, those with chronic diseases, and the elderly—would be greatly diminished, or even potentially eliminated. If the County's services had to be significantly curtailed, our patients would face increased health-care costs and reduced access to care, we could be forced to lay off many County employees, and the overall wellbeing of our community would suffer.

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

Dated: June 4, 2019

Respectfully submitted,

PAUL E. LORENZ

EXHIBIT A

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

Administrative Policies and Procedures

VMC #132.01

August 9, 2017

TO:	SCVMC Employees
FROM:	Paul E. Lorenz Chief Executive Officer, SCVMC
SUBJECT:	**Non-Participation in Certain Patient Care**
REFERENCE:	TJC RI.1.10.7 Health and Safety Code §123420 "Refusal to Participate in Abortion" 42 USCS § 300a-7 (b)

PURPOSE:

SCVMC recognizes and understands that situations may arise in which the prescribed course of treatment or care for a patient may conflict with an individual's cultural values, ethics or religious beliefs. Therefore, SCVMC has established a mechanism whereby an individual may request not to participate in such treatment or care. There have been minor changes in the policy. SCVMC Nursing Standard NP-6 is deleted since this policy covers the employee rights.

POLICY:

Santa Clara Valley Medical Center (SCVMC) employees are provided a mechanism to request not to participate in certain patient care, including treatment that conflicts with the staff member's cultural values, ethics or religious beliefs. Patient care may not be adversely affected by the granting of such a request for exemption. Exemptions shall not result in disciplinary or recriminatory action.

Areas in which employees may request not to participate include, but are not limited to, abortion, sterilization, emergency contraception, withdrawal of life sustaining treatment, or procurement of organs for transplants.

An employee's request not to participate in an area such as contagious diseases, unless medically contraindicated, will not be considered.

PROCEDURE:

Responsible Party	**Action**
Department Manager, Cost Center Manager, Medical Director	Informs prospective employees about policies on patient care that may influence their decision regarding their employment in a specific unit.
Human Resources	Considers prospective employee for other position vacancies for which they might be qualified for, if such prospective employee objects to participating in certain patient care under this policy. Ensures that new employees are informed that SCVHHS provides a mechanism whereby an employee may request not to participate in a prescribed course of treatment or patient care. Acts as resource to managers requesting SCVMC information on employees' request not to participate in certain patient care or treatments

PROCEDURE: (continued)

Responsible Party	Action
Employee/Medical Staff Member	Notifies supervisor of request not to participate in direct patient care or treatment that may conflict with his/her cultural values, ethics or religious beliefs by completing the "Request to Not Participate in Direct Patient Care or Treatment. (Attachment 1) NOTE: The request will be considered after a completed form is submitted. Please allow two weeks for processing of the request. Understands that medical emergencies take precedence over personal beliefs. In the absence of an approved request, must accept assignments. If the request is approved, accepts assignment in an emergency until arrangements are made to provide relief.
Department Director/Cost Center Manager/Medical Director	Evaluates request and determines whether such request can legitimately and appropriately be granted, taking into consideration all circumstances, including staffing levels. If granted, will arrange to redistribute tasks, activities and duties to other qualified individuals as needed to ensure appropriate quality care for patient. Notifies employee/medical staff member of disposition of request. Files original request in the manager's file and forwards a copy to Human Resources and to the employee/medical staff member-making request. In a medical emergency, assigns staff to provide patient care. Identifies and assigns relief as soon as possible. May refuse to accept staff for permanent assignment who request not to participate in a particular aspect of care or treatment commonly performed in the manager's area of responsibility.

Attachments:

1 Request to Not Participate in Direct Patient Care or Treatment

Issued: 05/29/97
Revised: 10/03/05, 7/11/12, 12/16/13, 08/09/17 Signature approval on file.

Attachment 1
Policy VMC #132.01

Request to Not Participate in Direct Patient Care or Treatment

I, _____ am an employee, medical staff member or prospective employee or medical staff member of Santa Clara Valley Medical Center (SCVMC). I request that during the course of my employment or membership that I am not assigned to participate in

_____
specific procedure/treatment

because _____

_____
cultural values, ethics or religious beliefs in conflict with such participation

I understand that this request will be considered and that SCVMC will determine whether these are sufficient grounds for granting this request. This determination may take two weeks.

SCVMC is obligated to treat medical emergencies. I understand that medical emergencies take precedence over my personal beliefs. If this request is granted, I will participate in medical emergencies until a qualified substitute is provided.

_____ _____
Signature Date

Approved Denied _____
Date

_____
Authorized Signature

Distribution:

Original: Manager's File
Copy: Employee/Medical Staff Member
Personnel File

SCVMC 4248 REV 10/06/05

EXHIBIT B

May 8, 2015

TO:	SCVMC Employees
FROM:	Paul E. Lorenz Chief Executive Officer, SCVMC
SUBJECT:	**Medically Ineffective Interventions, Requests Concerning**
REFERENCE:	California Probate Code § 4734-4736 VMC #305.3, Life Support Measures/Do Not Resuscitate American Medical Association (AMA) Policy E-2.035, Futile Care AMA Policy E-2.037, Medical Futility in End-of-Life Care SCVMC Bioethics Committee Bylaws CMA Document #0403, Responding to Requests for Non-Beneficial Treatment, January 2011

BACKGROUND:

Under California law, a health care provider or institution "may decline to comply with an individual health care instruction or health care decision that requires medically ineffective interventions or health care contrary to generally accepted health care standards." (Cal. Probate Code § 4735.)

If a health care provider or institution so declines to comply with an individual health care instruction, or health care decision, the health care provider or institution "shall do all of the following: (1) promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient, (2) unless the patient or person then authorized to make health
care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision, and (3) provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care must be continued." (Cal. Probate Code § 4736.)

"Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person." (California Probate Code section 4650)

Under California law, a health care provider may decline to comply with an individual health care instruction or decision "for reasons of conscience." (Cal. Probate Code § 4734.)

There is no legally accepted definition of "medically ineffective" or "futile" intervention. However, the California Medical Association has defined medically ineffective or non-beneficial treatment as "any treatment or study that, in a physician's professional judgment, produces effects that cannot reasonably be expected to be experienced by the patient as beneficial or to accomplish that patient's expressed and recognized medical goals, or has no realistic chance of returning the patient to a level of health that permits survival outside of the acute care setting." (CMA Document #0403, Responding to Requests for Non-Beneficial Treatment, January 2011)

It is generally accepted that a patient or proxy should not be given a treatment simply because they demand it, and that denials of interventions may be justified by reliance on openly stated ethical principles and accepted standards of care. This policy and procedure uses a *process* based approach to assist in fair and satisfactory decision making about what constitutes medical ineffective interventions or care contrary to generally accepted health care standards.

GUIDING PRINCIPLES:

The question of whether an intervention is medically ineffective or contrary to generally accepted health care standards will often depend on the efficacy of treatment ("quantitative factors"). In addition, there may be value judgments involved ("qualitative factors"), such as whether accomplishing a particular physiologic goal would result in a satisfactory quality of life. These judgments must give consideration to patient or proxy beliefs and assessments of worthwhile outcome. Additionally, these judgments must take into account the physician's treatment purpose, which includes doing no harm and ceasing interventions having no benefit to the patient or to others with legitimate interests.

Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy, and physician on what constitutes medically ineffective interventions or care contrary to generally accepted health care standards, and what falls within acceptable limits for physician, patient, proxy and family. Joint decision-making should occur between patient or proxy and physician to the maximum extent possible. Attempts should be made to negotiate disagreements, if they arise, and reach resolution within all parties' acceptable limits. Physicians should, at each step of the process, consider obtaining the assistance of consultants such as the Palliative Care team, clergy or the Bioethics Committee, who may be able to clarify the values and goals of the involved parties and improve the patient's or proxy's understanding of the treatment options.

If the disagreement about an appropriate plan of care rests between members of the healthcare treatment team, refer to "Lack of consensus between members of the health care team," below.

POLICY:

If a physician declines or plans to decline to comply with a patient's or proxy's health care instruction or decision which the physician has concluded requires medically ineffective interventions or health care contrary to generally accepted health care standards, or compliance with such health care instruction or decision is against the physician's conscience, the physician will promptly inform the patient and follow the procedures set forth below. A patient or proxy may request a review of the physician's decision or proposed decision not to comply with the patient's or proxy's individual health care instruction or decision.

PROCEDURE:

Responsible Party	**Action**
Physician	A. Lack of consensus between physician and patient/proxy:

1. If, after discussions with the patient or proxy regarding diagnosis, prognosis and recommendations, and considering the reasons for the patient's or proxy's preferences, there is a lack of consensus, the physician will:
   (a) promptly inform the patient or proxy that the physician plans to decline to comply with the patient's or proxy's health care instructions,
   (b) document why the intervention(s) is considered medically ineffective or contrary to generally accepted health care standards,

PROCEDURE: (continued)

Responsible Party	**Action**
	(c) discuss the treatment plan with the healthcare treatment team, including representatives from each of the healthcare disciplines involved in the patient's care, (d) immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution whose view is more consistent with the patient's, and continue to provide the same level of care to the patient until a transfer can be accomplished. Reasonable efforts may include requesting Case Management to assist with transfers to external facilities in accordance with relevant VMC policies. (e) if the patient cannot be transferred, inform the patient or proxy that, if they request, the physician's decision can be reviewed by the Medical Director or MAOC and may be reviewed by the Bioethics Committee as appropriate. The physician will forward such requests, on behalf of the patient, to the Medical Director or to the MAOC. (f) after approval from the Medical Director or MAOC and documentation in the medical record, the physician may then proceed with withdrawing or withholding the requested intervention(s). (g) at all times, continue appropriate pain relief and other palliative care. 1. At any time, the physician may request assistance from Spiritual Care, Social Services, the VMC Medical Director, or the Bioethics Committee. Requests for Bioethics Committee review will be made as provided in the Bioethics Committee Bylaws (attached). B. Lack of consensus between members of the healthcare team regarding treatment plan: 1. The primary team shall coordinate a meeting of at least one responsible party from each of the contributing healthcare disciplines involved in the patient's care, in order to reach a group consensus. 2. If necessary, consider a Palliative Care consult to assist with the above meeting and consensus building. 3. If still unable to reach consensus, any team member may request a case review with the Bioethics Committee or Medical Director (or MAOC). 4. Document in the medical record all efforts made, whether or not consensus is reached, along with reasons for primary team's decisions regarding ultimate plan of care. 5. In the event that consensus still cannot be reached, the primary treatment team has the final decision regarding the plan of care. However, when there is no consensus regarding life-sustaining treatment decisions, the Medical Director or MAOC must be notified about the final plan of care decisions.
Patient/Proxy	A patient or their proxy may request the physician, the Social Services Department, or the Customer Service Department, for a review of the physician's decision to decline to comply with an individual health care instruction or health care decision.
Social Services Dept./Customer Service Department	Receives patient's/proxy's concern and contacts the Medical Director/MAOC, or refers the case to the Bioethics Committee.

PROCEDURE: (continued)

Responsible Party	**Action**
VMC Medical Director or MAOC	Reviews case when requested.
	Refers the matter to the Medical Ethics Committee for a case review when appropriate.
	Issues a final decision and notifies the primary attending physician of the decision. Also notifies the patient or proxy if previously in communication with them directly.
	Transfers the patient's care to another physician if the primary physician disagrees with the decision and care plan. (No physician will be required to perform or withhold care, when he or she believes it is medically or ethically inappropriate or against his or her conscience.)

Attachments:

1 Bioethics Committee Bylaws and Ethics Consultation Procedure

Issued: 10/04/04
Revised: 08/09/07, 07/13/09, 07/06/12 Signature approval on file.

ETHICS CONSULTATION PROCEDURE
SANTA CLARA VALLEY MEDICAL CENTER

1. An Ethics consultation is requested by a medical or hospital staff member, a patient, member of the patient's family or other interested party.

2. Ethics consultation is called in to either the Co-Chairs or any members of the Medical Ethics committee.

3. The Committee member will forward the consultation request to the assigned consult physician for that week (Refer to Ethics Committee consult physician assignment).

4. Consult physician will review patient's medical record to clarify the clinical ethical question or concern. Further clarification can be done with the person(s) directly involved with the patient's care. These can include (but are not limited) to the Attending Physician(s), Nursing Staff, Therapists, Social Workers, and Chaplain. Discussion with the patient, and/or patient's family, interested party, and/or surrogate decision-makers may also be appropriate.

5. Consult physician will fill out the Medical Ethics Case Consultation Form and schedule a date and time for case conference. The case conference announcement will be distributed to Medical Ethics committee members. Patient's primary care team and any other hospital staff who are intimately involved in the ethical questions raised will be invited along with patient and any family member or interested party.

6. Patient's primary team will present the case and ethical question. Family or any interested party, if present, may also speak. Ethics committee members may ask primary team and family members questions as appropriate.

7. Non-members of Ethics Committee will be excused and Ethics Committee will discuss the case and possible committee's recommendations. Committee discussion will be documented and stored in the Committee's file.

8. The Medical Ethics committee's recommendations will be forwarded to the patient's attending physician and discussed with the initiator of consult by the consult physician. A consult note will also be placed in the patient's chart. The content of the note will be discussed and agreed by the committee members prior to being written in the chart. The committee's recommendations are only advisory.

9. The case conference will be discussed in the next monthly Medical Ethics committee meeting. The committee chair may follow up on the patient's case as indicated.

10. Consultation during evenings, weekends or holidays is not available at this time.

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF ALECIA MANLEY, INTERIM CHIEF OPERATING OFFICER OF THE MAZZONI CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Alecia Manley, declare as follows:

1. Mazzoni Center, located in Philadelphia, Pennsylvania, was founded in 1979 and is a multi-service, community-based healthcare and social-service provider that aims to advance the health and well-being of LGBTQ communities and people living with HIV. The mission of Mazzoni Center is to provide quality comprehensive health and wellness services in an LGBTQ-focused environment, while preserving the dignity and improving the quality of life of the individuals whom it serves.

2. I am the Interim Chief Operating Officer and serve as a member of the Interim Leadership Team at Mazzoni Center. I have over twenty years of experience providing social services to HIV positive and LGBTQ+ communities. I joined Mazzoni Center in 2001 as a Medical Case Manager and became the Care Services Director in 2005. I expanded the scope of Mazzoni Center's social services to include services for LGBTQ+ youth and transgender and gender non-conforming communities. I oversee Mazzoni Center's HIV prevention and care services, gender affirming services, education, and legal services. I am submitting this Declaration in support of Plaintiffs' Motion for Preliminary Injunction to prevent the Denial-of-Care Rule from taking effect.

3. Mazzoni Center has been serving the needs of the LGBTQ communities, and people living with HIV, nearly 40 years. To meet the wellness needs of these populations, Mazzoni Center provides a broad continuum of services, including medical, behavioral-health, HIV-testing, prevention and counseling, housing, and legal services. In 2010, Mazzoni Center began offering legal services upon recognizing that the physical and emotional health of people who are LGBTQ is often negatively impacted by external factors resulting from societal prejudices and pressures, and that such impact can be ameliorated by using available legal tools to address and strengthen social determinants of health. Mazzoni Center patients and clients include some of the most

vulnerable members of the LGBTQ population, including youth, people of color, and people who are low-income.

4. Mazzoni Center programs and services for LGBTQ youth include programming for Gay-Straight Alliances in Philadelphia-area schools and weekly youth and adolescent drop-in hours which offer medical, behavioral-health, and legal services to people under the age of 25. As an agency that provides medical and mental-health services targeted at LGBTQ youth, Mazzoni Center is in a unique position to comment upon the long-term effects of systematic discrimination on people who are LGBTQ.

5. In addition to the services they receive from Mazzoni Center, patients of Mazzoni Center often access healthcare services from other organizations, including religiously affiliated organizations. Across its continuum of services, Mazzoni Center serves patients who report having experienced discriminatory treatment when accessing healthcare services from such organizations. To ensure that LGBTQ people can access services they need, Mazzoni Center's Education programs provide cultural-competency training to service providers, and its Legal Services program advocates on behalf of those individuals employing a range of strategies that include informal advocacy, structured negotiation, and representation in administrative and court proceedings to address discriminatory treatment.

6. Many Mazzoni Center patients and clients report that they have experienced, are experiencing, or fear that they will experience, negative effects from religious discrimination or objections presented as being based on someone else's religious or moral objections. Some patients and clients have experienced rejection that came from religious or moral objections claimed by their family members, with long-lasting traumatic effects. Other individuals sought out Mazzoni Center's services because other healthcare providers had rejected them, or because these patients expected and feared that they would be rejected on the basis of religious objections to their LGBTQ

identities. As a result of this discrimination and well-grounded fear of discrimination, LGBTQ patients' health and well-being are compromised.

7. Mazzoni Center was founded, and continues to exist, because people who are LGBTQ need access to health and wellness services that affirm them and their identities. Despite that need, there was, and continues to be, an insufficient number of providers across the continuum of services who are able and willing to address the needs of LGBTQ people. Many people who contact and receive services from Mazzoni Center inform us that they have had, or are having, difficulty finding LGBTQ-affirming care elsewhere. Some of our patients and clients travel long distances to reach Mazzoni Center because of our LGBTQ-affirming environment, and because they do not have access to services closer to their homes.

8. By inviting discrimination against LGBTQ people based on their LGBTQ identities and related medical histories, the Denial-of-Care Rule encourages LGBTQ people to remain closeted to the extent possible when seeking medical care. But remaining closeted to a healthcare provider can result in significant adverse health consequences. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

9. As a result of the Denial-of-Care Rule, Mazzoni Center will be forced to redirect additional staff and resources to assist patrons in finding LGBTQ-affirming healthcare providers. Mazzoni Center's staff and resources already have been diverted from other program activities to engage in advocacy, policy analysis, and community outreach to address the ill-effects of the Denial-of-Care Rule. Mazzoni Center has a dedicated team of employees who focus on serving its mission by fostering a welcoming, affirming – and nondiscriminatory – atmosphere for patients and clients to access supportive, LGBTQ-affirming healthcare and wellness services. Employees

of Mazzoni Center will be negatively impacted by the Denial-of-Care Rule in the form of increased demand on their time and resources by patients, a diminished number of affirming resources to provide and refer to, the need to develop new resources and training materials from scratch, and the added trauma that many patients likely will experience by the notices that the Rule requires.

10. The Denial-of-Care Rule's requirements are antithetical to Mazzoni Center's mission of providing comprehensive services to people in an LGBTQ-affirming environment. The Rule requires that Mazzoni Center give notice that providers are able to deny services based on moral objections. The Rule fails to require that objecting employees notify Mazzoni Center that they have objections before being hired or even as their religious beliefs change throughout their employment. Those requirements, and the Rule's failure to require staff denying services based on these objections to provide referrals to where patients can get the healthcare services that they need, eviscerate the LGBTQ-affirming environment that is the heart of Mazzoni Center's mission.

11. Including a notice that providers can deny services based on moral objections in job position announcements, together with the Rule's prohibition on asking job applicants if they have religious and/or moral objections to treating LGBTQ people, will make it difficult, if not impossible, to confirm that prospective employees will serve our patients and clients with respect – or whether they will serve members of the LGBTQ communities at all.

12. Additionally, requiring that Mazzoni Center provide notices regarding healthcare providers' conscience rights in waiting rooms and other areas at Mazzoni Center, and implicitly putting the onus on patients to request LGBTQ-affirming healthcare to ensure that they will not be discriminated against by employees of our organization, undermines and frustrates Mazzoni Center's mission. Such notices are the antithesis of the mission that our organization was created to achieve – to provide affirming healthcare for LGBTQ patients and people living with HIV. Such notices, in and of themselves, would cause significant harm to our patients' health and well-being

by confronting them with rude and painful reminders of the rejection, hostility, and discrimination that they experienced elsewhere by people claiming objections to their LGBTQ identities. These notices would virtually slam the door in our patients' faces, telling them that despite our mission, they should brace themselves even while they are here for the disapproval and objections that may be lurking inside even at Mazzoni Center.

13. Members of the LGBTQ community, including the people whom Mazzoni Center serves, are well aware of the existence of those objections, and do not need to be reminded of them when seeking healthcare, certainly not when they seek healthcare from a place like Mazzoni Center that was established to achieve the exact opposite. People come to Mazzoni Center because it is a place of healing, a place that ensures that all patients have a safe, identity-affirming space to access care and treatment that preserves their dignity. The Denial-of-Care Rule compromises Mazzoni Center's reputation and existence.

14. Mazzoni Center receives various forms of Health and Human Services funding, including Public Health Service Act funding. Mazzoni Center receives Title X Family Planning funding, HIV Prevention funding from the Centers for Disease Control and Prevention, Underserved Populations funding from the Office of Violence Against Women, Department of Justice, and both pass-through and direct Ryan White CARE Act funding through Health Resources and Services Administration grants. Mazzoni Center, therefore, has a reasonable fear that it could be sanctioned and lose federal funding if subject to a complaint under the Denial-of-Care Rule in the course of Mazzoni Center's efforts to ensure the best possible medical care for its patrons.

I declare, under penalty of perjury, that the facts stated in this declaration are personally known to me, and that they are true.

Dated: June 5, 2019

Respectfully submitted,

/s/ Alecia Manley
Alecia Manley

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G., IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G., declare as follows:

1. I am an obstetrician/gynecologist certified by the American Board of Obstetrics and Gynecology since 2011. I am licensed to practice in Washington, Missouri, Kansas, and Oklahoma. I have extensive experience in the provision of abortion in the outpatient setting, as I am the Medical Director of Trust Women's clinics in Washington, Oklahoma, and Kansas. I also provide abortion services at Planned Parenthood of the St. Louis Region and Southwest Missouri, and I am the provider of record at Planned Parenthood in Columbia, Missouri and in Kansas City, Missouri.

2. Additionally, I am the Director of the Ryan Residency Collaborative, a collaboration between Oklahoma University and Washington University School of Medicine in St. Louis, Missouri, that offers formal training in abortion and family planning to residents in obstetrics/gynecology; the Assistant-Director of the Fellowship in Family Planning at Washington University School of Medicine; and an Associate Professor at Washington University School of Medicine, in the Department of Obstetrics and Gynecology's Division of Family Planning. Through my various academic roles, I have taught numerous medical students and trained nearly 250 residents in family planning as well as a number of family planning fellows.

3. I also have experience providing healthcare services to LGBTQIA communities.[1] At Washington University School of Medicine, I am a member of a physician team developing specialized care for the transgender community in both pediatric and adult settings. Within this multidisciplinary approach, I have specifically helped develop and implement the integration of gynecologic services for transgender patients. The gynecologic care I provide in this space ranges from talking to families about ovary/sperm preservation prior to transition, pre-operative and

[1] This term refers to lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual people and other sexual and gender minority individuals.

operative surgical care for hysterectomies, post-operative vaginal care for transgender women, management of bleeding resulting from hormonal transition, and care surrounding sexually transmitted infections.

4. Additionally, I have spoken and written extensively on the provision of family-building healthcare services to LGBTQIA communities within forums such as the American Medical Association, the Association of American Medical Colleges, and the American College of Obstetricians and Gynecologists. Family-building healthcare services focus on assisting those who fall outside the traditional two-person, opposite sex unit with achieving pregnancy, such as through assisted reproductive technology, surrogacy, and adoption. I have also lectured in multiple venues on the need for gender and sexual minorities to access contraception and abortion care services. I serve on the advisory board of Washington University School of Medicine's OUTmed, a coalition of faculty who work to improve visibility of LGBTQIA communities on campus, ensure LGBTQIA patients and their families can identify competent and caring providers in the network, and assist with evaluation and implementation of medical education curriculum as it pertains to healthcare to LGBTQIA communities.

5. I am a 2007 graduate of the Kirksville College of Osteopathic Medicine. I also have a Master of Science degree in clinical investigation from Washington University, with which I am able to study public health from a research-focused perspective. I completed my residency in obstetrics and gynecology at Washington University School of Medicine in 2011. I then completed a two-year fellowship in family planning at Washington University. My curriculum vitae, which sets forth my experience and credentials more fully, is attached here as Exhibit A.

6. My practice focuses on providing patients with full-spectrum reproductive healthcare, including second-trimester abortions, medical and surgical abortions in the first trimester, contraceptive care, and specialized gynecologic care for LGBTQIA communities,

including gender-affirming surgeries and other therapies. I take a full-spectrum approach to the care I provide because it centers on the patient and what is best for them. Being able to provide full-spectrum reproductive healthcare allows me to develop a level of trust and strengthens the relationship between myself and patients, as they don't have to worry whether all of their needs will be met in ways that are consistent with their values and unique healthcare needs.

7. In many ways, my choice to center my work on abortion care and LGBTQIA communities is predictable. In both instances, patients face tremendous stigma. Their health—and, more broadly, their lives—are inappropriately influenced by ideology and unscientific rhetoric. The consequences of these realities are that our system allows for systemic discrimination, intentional oppression, and overt acceptance that the health and wellbeing of some is more important than that of others. Although healthcare providers cannot assume all of the responsibility to fix the injustices of such a system, they should seriously consider the responsibility they bear for ensuring the best public health outcomes. Optimizing public health outcomes requires equitable access to healthcare centered on scientific evidence, delivered across all geographies, and absent external judgment and stigma, whether the patient be a transgender man seeking a hysterectomy or a cisgender woman needing an abortion.

8. The importance of this approach and the availability of these necessary services goes beyond the obvious health outcomes. Pay inequity, low or nonexistent paid parental leave, and the general lack of supportive structures for pregnant persons and LGBTQIA individuals make it difficult for these populations to attain the level of economic independence necessary to parent the way they may want to. Equitable and comprehensive access to care is one important step to combat these conditions and empower my patients to parent when and in the manner they choose.

9. The services I provide also enable my patients to maximize their health and participate fully in society. Planning for pregnancy and spacing pregnancy are often incredibly

important factors in optimizing pregnancy outcomes. Contraception and abortion are important healthcare interventions that can prevent a host of physical and mental health conditions, including life-threatening conditions that are diagnosed after or worsen during pregnancy. Optimizing health through the use of contraception and abortion is important for pregnancy, but also in the larger context of my patient's lives. My patients often note that their ability to control their reproductive lives is essential to their ability to achieve career and educational goals, and to maintain the economic stability essential for a healthy family unit.

10. The need for reproductive health services is not limited to cisgender, binary, heteronormative populations alone. These services are just as important to patients across a variety of identities, including LGBTQIA individuals. Members of these communities also seek to prevent pregnancy, or build families, and access a whole host of other reproductive health services.

11. I submit this declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services relating to "Conscience Rights in Health Care" (the "Denial or Care Rule," or the "Rule"). My opinions are based on my personal knowledge, as well as my training, education, clinical experience, ongoing review of the relevant professional literature, discussions with colleagues, participation in associations, and attendance at conferences in the fields of obstetrics, gynecology, and gynecologic surgery.

Trust Women Seattle

12. Trust Women Seattle, located in Seattle, Washington, opened in June 2017 and provides reproductive healthcare, including abortion services, contraceptive care, and general gynecological care, as well as a growing number of services for LGBTQ patients, including the provision of gender-affirming hormone therapies. The clinic receives Medicaid funding through Washington State and is a "subrecipient" under the Rule.

13. Medicaid funding for non-abortion services at Trust Women allows the clinic to continue providing a full range of reproductive healthcare services to patients. Without such funding, it would be difficult, and likely impossible, for the clinic to stay open.

14. To the extent that the Rule would prevent Trust Women Seattle from continuing to implement its compassionate and non-judgmental approach to care for all patients or its policies regarding emergency treatment, it is unworkable and would undermine the very mission of the clinic.

Medical Ethics

15. To the extent that the Rule permits or encourages staff at healthcare facilities to delay and deny patients information and care based on religious and moral refusals, and to the extent that the Rule conditions federal funding for recipients and subrecipients on permitting such discrimination, it is contrary to medical ethics.

16. When a provider's personal beliefs conflict with a patient's need for care, medical ethics as well as state and federal law require the needs of the patient to take precedence. This expectation within the medical community is clear and well-accepted. In these situations, where providers' interests conflict with patients' interests, providers have a duty to state upfront their conflicting personal beliefs and ensure the patient is immediately transferred to the care of another willing provider.[2]

[2] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*, 110 Obstetrics & Gynecology 1203 (2007) ("Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."); American Medical Association, *Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, Ethics, https://www.ama-assn.org/delivering-care/physician-exercise-conscience (last visited June 5, 2019) ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

17. The Denial of Care Rule contravenes medical ethics by prioritizing not only the interests of the provider, but also the interests of those not directly providing care to the patient, such as a receptionist, janitor, and other administrative staff. For example, if a receptionist were to turn a patient away because of a disagreement with the healthcare choices of that patient, or even the patient's mere existence as an authentic being, it would undermine patient health and the clinic itself. This overt and allowable stigmatization could lead to loss of patient autonomy through internalization of disapproval, leaving them feeling paralyzed to make the best decisions for themselves or sometimes any decision at all. When patients are turned away or delayed in accessing care, their health, well-being, and privacy suffer.

18. Moreover, medical ethics require healthcare providers to ensure that patients' interests are protected, even in cases where a provider objects on moral or religious grounds to a particular course of treatment. In my opinion, to the extent that the Rule would permit staff to exercise effective veto power over a patient's opportunity to access a healthcare service by omitting information, treatment, or a referral, the Rule runs counter to any reasonable understanding of a healthcare provider's duty to patients. Providers hold knowledge related to health and diseases, and our job as providers is to take that information, make it understandable, and provide it to patients in a way that enables them to make an informed decision in the context of their values and life circumstances. It is not our job to make decisions for our patients, nor is it appropriate to color our care with our own values and circumstances. Moreover, were even administrative staff to exercise such a veto, it would be unconscionable. Staff without medical training and knowledge of a patient's medical history may give a patient incomplete information or deny them care without understanding the full implications for patient health.

Impact on Patients

19. Approximately 43 million pregnant persons in the United States are at risk of unwanted pregnancy.[3] Yet, state restrictions on abortion have contributed to the diminishing number of abortion clinics across the country, which has in turn contributed to diminished access to abortion care.[4] According to the most recent data from 2014, the number of abortion clinics decreased 17% from 2011.[5] In many areas, the lack of abortion care is particularly acute: 89% of counties in the United States do not have an abortion clinic at all,[6] and several states have only one clinic left.[7]

20. But even without state attacks on abortion, it can be difficult for clinics to survive in today's world. Lack of funding, based on defunding efforts and insurance bans, already hampers providers' ability to provide care. In addition, security concerns and provider unavailability pose serious operational hurdles. As a result, clinics in many counties can only provide abortion services on a limited basis, restricted to certain methods, certain gestational ages, specific indications, or on certain days.[8]

---

[3] *Contraceptive Use in the United States*, Guttmacher Institute (July 2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[4] *See, e.g.*, Grossman D et al., *Change in Abortion Services after Implementation of a Restrictive law in Texas*, 90(5) Contraception 496 (2014); *see also* White K et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105(5) Am. J. of Pub. Health 851, 853-56 (2015).

[5] Jones RK & Jerman J, *Abortion Incidence and Service Availability In the United States, 2014*, 49(1) Persp. on Sexual & Reprod. Health 17 (2017).

[6] *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

[7] *Id.*

[8] *Id.*

21. Lower-income women are already unable to access contraception at the same rate as higher-income women.[9] These disparities, exacerbated by the increasing restrictions on family planning services, including publicly-funded clinics and services, result in deepening poverty for the most vulnerable women in the United States.[10] In short, many low-income women cannot access the contraceptive services and education they need to avoid unintended pregnancy, and when they become pregnant, it is increasingly difficult to access abortion services.

22. There is no typical abortion patient. A recent study found that 24% were Catholic, 17% were mainline Protestant, 13% were evangelical Protestant, and 8% identified with some other religion.[11]

23. There are a variety of reasons people require pregnancy termination, and each is valid. It is not uncommon for people with wanted pregnancies to require termination, because of fetal anomalies, because the pregnancy threatens the patient's health, or because the pregnancy is simply no longer viable. Yet, I am familiar with numerous instances in which many of these patients are not provided with complete information about the option to terminate, even if it is the most medically appropriate option, simply because their clinician has a personal objection. Patients in these situations have been subjected to last-minute, dire transfers and have even been rejected by providers of non-pregnancy related care as a result of their reproductive choices. I hear stories like

[9] *See* Secura GM et al., *The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception*, 203(2) Am. J. of Obstetrics & Gynecology 115.e1 (2010).

[10] *See* Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[11] *Id.*

these every month, and I care for people who have been deceived and lied to, resulting in unnecessary stress and delayed procedures.

24. Contraception, an essential form of healthcare, is also already under threat.[12] For example, pharmacists have refused to provide over-the-counter emergency contraception and sought to vindicate their asserted right to deny it in court.[13] And as of 2015, only 60% of federally qualified health centers even offered contraceptive care to more than 10 female persons per year.[14] In my own practice, I have seen patients transferred to us because they were unable to access contraception from their previous provider.

25. Title X is already under attack from another federal administrative rule, which was recently enjoined nationwide by two district courts.[15] In the healthcare system, including in hospitals, there are already clinician and healthcare providers who impose religious beliefs above scientific fact and refuse to provide the most effective means of contraception, such as IUD's under the auspice that they are abortifacients despite concrete scientific evidence to the contrary. If more individuals are denied access to contraception under the Rule, it will lead to an increase in unintended pregnancy and abortion.

---

[12] *See* American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, *Committee Opinion No. 615: Access to Contraception*, 125 Obstetrics & Gynecology 250 (2015).

[13] *See* Yang YT & Sawicki NN, *Pharmacies' Duty to Dispense Emergency Contraception: A Discussion of Religious Liberty*, 129(3) Obstetrics & Gynecology 551 (2017).

[14] Jennifer J. Frost & Mia R. Zolna, *Response To Inquiry Concerning The Availability Of Publicly Funded Contraceptive Care To U.S. Women*, Guttmacher Institute (May 2017), https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.

[15] *Oregon v. Azar*, No. 6:19-CV-00317-MC, 2019 WL 1897475 (D. Or. Apr. 29, 2019); *Washington v. Azar*, No. 1:19-CV-03040-SAB, 2019 WL 1868362 (E.D. Wash. Apr. 25, 2019).

26. Additionally, access to LGBTQIA-specific care is limited, and members of these communities are already experiencing discrimination and marginalization within the healthcare system. For example, there are clinicians who explicitly refuse to provide care to LGBTQIA patients or their children. In fact, most of my transgender patients report having had negative experiences with other healthcare providers before their appointment with me. And almost all of my transgender patients that require prolonged hospitalization prefer early discharge, out of fear that hospital staff members might say something hurtful or treat them disrespectfully. Indeed, my transgender patients have reported to me that other providers have repeatedly rescheduled their appointments, intentionally used the wrong pronouns, and even refused to use pronouns at all, calling them "it." I hear stories like this regularly.

27. The Denial of Care Rule threatens to exacerbate this preexisting lack of access to abortion, contraception, and LGBTQIA-specific care. To the extent that it discourages entities like Trust Women from offering any services to which our employees, volunteers, or contractors may possibly object and threatens to remove or even claw back funding from entities that do not comply with such broad requirements, it is unworkable and could force Trust Women and other providers across the country to drastically alter the care we offer to patients or close entirely.

28. The Rule also further stigmatizes abortion, contraception, and care to LGBTQIA communities. By specifically highlighting these types of care as religiously or morally objectionable the Rule suggests that the services are not common, necessary, and important to maintain health, and furthermore suggests that only certain Americans are deserving of comprehensive and dignified healthcare. We have seen the tremendous impact that stigma can have

on patients. For example, abortion stigma fosters fear and psychological stress in patients.[16] When patients perceive the community's disapproval of their choice, they feel the need to maintain secrecy around their decision and experience shame, causing substantial stress.[17] Moreover, this stigma will deter patients from seeking these types of care out of fear of judgment and discrimination.

29. Whether because patients encounter a refuser, providers are forced to close their doors, or patients are deterred from seeking care because of stigma and a justified fear of discrimination, individuals seeking abortion, contraception, and LGBTQIA-specific care will either be delayed or totally denied such care as a result of the Rule.[18]

Impact of Delayed Care

30. A report from the National Academies of Science found that overall abortion is safe, but if anything is making it less safe, it is the number of restrictions being passed in states that create delays and prevent women from accessing care.[19] On average, a pregnant person already must wait at least a week between attempting to make an appointment and actually receiving an

[16] *See* Norris A et al., *Abortion stigma: a reconceptualization of constituents, causes, and consequences*, 21(3 Suppl) Women's Health Issues S49 (2011).

[17] *See* Major B et al., *Abortion and mental health: Evaluating the evidence*, 64(9) Am. Psychol. 863 (2009).

[18] *See, e.g.*, Brief for National Abortion Federation and Abortion Providers as Amici Curiae in Support of Petitioners at 20-35, *Whole Woman's Health v. Cole*, 136 S. Ct. 499 (2015) (No. 15-274); *see also* Yao Lu & David J. G. Slusky, *The Impact of Women's Health Clinic Closures on Preventive Care*, 8(3) Am. Econ. J.: Applied Econ. 100 (2016).

[19] *See* National Academies of Science, Engineering, and Medicine, The Safety and Quality of Abortion Care in the United States (The National Academies Press 2018).

abortion.[20] Some states have mandatory delay laws, which require patients to wait up to 72 hours after receiving certain state-mandated information and their procedure. When paired with the limited number of clinics in each state (in some instances only one), these restrictions on access to care can force a pregnant person to wait weeks for an appointment. Further, insurance bans that prevent coverage for abortion makes it harder for women to come up with the funds necessary, which also creates delays.

31. Delays in obtaining an abortion compound the logistical and financial burdens patients face. Some common factors include having to travel long distances or encountering significantly increased wait times due to the ever-shrinking number of abortion clinics.[21] These delays also increase the cost of an abortion and other associated costs like travel and childcare. The cost of abortion rises as gestational age increases, and abortions during the second trimester are substantially more expensive than in the first trimester.[22] Financial burdens also result from missed work. In one study, delays were shown to have caused 47% of patients to miss an extra day of work

[20] Finer LB et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74(4) Contraception 334 (2006).

[21] *See generally, e.g.*, *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf; *Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, Texas Policy Evaluation Project (Oct. 5, 2015), http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf.

[22] *See* Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48(4) Persp. on Sexual & Reprod. Health 179, 184 (2016); Jones RK et al., *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28(3) Women's Health Issues 212 (2018).

and caused more than 60% of patients to shoulder the burden of increased transportation costs and lost wages by a family member or friend.[23]

32. Delays in obtaining an abortion can also push patients into later stages of pregnancy before they are able to access care. And although abortion is a very safe procedure, risks increase with later gestational ages.[24] Patients pushed into later stages of pregnancy may also be denied the option to have particular types of abortions. For example, medication abortion is typically available only up to 10 weeks after a woman's last menstrual period. Patients can choose medication abortion for a variety of personal reasons, including that it is more private, less invasive, and allows the patient to drive herself to the clinic for her procedure—an option that is not available for all surgical procedures. Additionally, a second trimester surgical procedure is more complex, costlier, and carries greater risks than a first trimester surgical procedure. Moreover, patients approaching legal limits in their state based on when medication abortion may be prescribed or abortion performed may be forced to seek care in another state if they are delayed in accessing care.[25]

33. For patients with certain medical conditions or indications, delays in obtaining an abortion present even more serious risks. For example, for pregnant persons with cancer, currently undergoing or awaiting initiation of addiction treatment, or with serious cardiovascular conditions, for example, it is medically preferred and safer to perform an abortion at earlier gestational ages without unnecessary delay. There are also pregnant persons for whom medication abortion may be

[23] Sanders JN et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26(5) Women's Health Issues 483 (2016).

[24] *See* Bartlett LA et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103(4) Obstetrics & Gynecology 729 (2004).

[25] *See* Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49(2) Persp. on Sexual & Reprod. Health 95 (2017).

medically indicated or preferred, including those with uterine anomalies and those who are survivors of sexual assault who may not be comfortable with an invasive physical exam.

34. Delays in obtaining an abortion can also inflict unnecessary emotional distress and psychological harm. I have found this to be particularly true for pregnant persons who have wanted pregnancies but have made the decision to terminate after receiving a diagnosis of a lethal or grave fetal anomaly, or pregnant persons who have made the decision to end a pregnancy that occurred following rape. Delays also increase the likelihood that a patient will be forced to disclose her decision to have an abortion to others from whom she would prefer to keep the decision confidential.[26]

35. Similarly, delays in obtaining LGBTQIA-specific care can lead to poor physical and mental health outcomes. For example, while all care should be timely, for transgender patients seeking to transition, it is important that they be able to do so as soon as they are ready.[27] Once a patient has identified transitioning as integral to their process of feeling whole, the best mental and physical health outcomes stem from completion of that process.

Impact of Denials of Care

36. If patients are denied care entirely, they will encounter a whole host of additional harms. Denying someone an abortion and forcing them to carry to term increases the risk of serious health harms, including eclampsia and death.[28] In addition, denying someone an abortion can lead

[26] *See, e.g.*, Sanders JN et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26(5) Women's Health Issues 483 (2016).

[27] *See* Nguyen HB et al., *Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition*, 20(12) Current Psychiatry Rep. 110 (2018).

[28] *See* Gerdts C et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26(1) Women's Health Issues 55 (2016).

to increased risk of life threatening bleeding, cardiovascular complications, risk of diabetes associated with pregnancy, as well as any other risk that results from pregnancy.

37. In fact, ending a pregnancy is safer than continuing a pregnancy, with one study estimating 28.6% of hospital deliveries involve at least one obstetric complication, compared to only 1% - 4% of first-trimester abortions.[29] A pregnant person is 14 times more likely to die from giving birth than as a result of an abortion, which is particularly poignant in the United States, the only developed nation with a rising maternal mortality rate.[30]

38. Being denied a wanted abortion also results in economic insecurity for pregnant persons and their families, and an almost fourfold increase in the odds that household income will fall below the federal poverty level.[31]

39. In 2014, three-fourths of abortion patients were already low income—49% living at less than the federal poverty level, and 26% living at 100-199% of the poverty level.[32] 59% of abortion patients in 2014 had at least one previous birth.[33]

---

[29] Berg CJ et al., *Overview of Maternal Morbidity During Hospitalization for Labor and Delivery in the United States: 1993-1997 and 2001-2005*, 113(5) Obstetrics & Gynecology 1075 (2009).

[30] *See* Raymond EG & Grimes DA, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 Pt 1) Obstetrics & Gynecology 215 (2012) (analyzing data from 1998 to 2005).

[31] *See* Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive And Women Who Are Denied Wanted Abortions in the United States*, 108(3) Am. J. of Pub. Health 407 (2018).

[32] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[33] *Id.*

40. Some patients who are denied abortion care may resort to extremes and even self-harm or attempted self-managed abortion. At least a few times per year I am asked to care for a pregnant person whose reported reason for attempted suicide is not wanting to be pregnant and not being able to secure an abortion. Additionally, the rate of self-managed abortions has risen across the country as abortion has become increasingly difficult to access.[34]

41. Additionally, patients who are denied contraception are less able to safeguard their own health and welfare. The ability to prevent or space pregnancy, facilitated by easy and affordable access to contraception, has significant health benefits.[35] Ensuring the best pregnancy outcomes requires optimizing patient health between pregnancies. Thus, denials of contraception not only increase the rates of unintended pregnancies, but also adversely affect the health of persons who subsequently become pregnant although they have conditions that could make pregnancy dangerous.

42. Furthermore, many patients rely on contraception for other medical conditions, including treatment for endometriosis, polycystic ovarian syndrome, acne, menstrual irregularity, menstrual migraines, and for decreasing the risk of endometrial, ovarian, and colorectal cancers.[36] Thus, denials of contraception can prevent patients from accessing treatment for these conditions.

---

[34] *See, e.g.*, *Study Finds at Least 100,000 Texas Women Have Attempted to Self-Induce Abortion*, Texas Policy Evaluation Project (Nov. 17, 2015), https://liberalarts.utexas.edu/txpep/releases/self-induction-release.php.

[35] *See Report of a WHO Technical Consultation on Birth Spacing*, World Health Organization, (2007), http://apps.who.int/iris/bitstream/10665/69855/1/WHO_RHR_07.1_eng.pdf (recommending pregnant persons space their births at least two years apart in order to reduce the risk of maternal morbidity and mortality).

[36] *See* Carrie Armstrong, *ACOG Guidelines on Noncontraceptive Uses of Hormonal Contraceptives*, 82(3) Am. Fam. Physician 288 (2010).

43. Contraceptive coverage is also a necessary component of an equitable society, as it allows pregnant persons and LGBTQIA patients to make decisions about their health, reproductive lives, education, careers, and livelihoods. Denying access to this coverage denies them equal opportunity to aspire, achieve, participate in, and contribute to society based on their individual talents and capabilities.

44. The Denial of Care Rule will result in increased numbers of LGBTQIA persons experiencing stigmatizing denials of care. Patients who are denied LGBTQIA-specific care will have worse health outcomes.[37] Already today, even without the Rule, as a result of preexisting stigma, lesbian patients in particular are already less likely to disclose their sexual identity and less likely to access primary care.[38] Many transgender patients already experience overt disrespect from their providers, resulting in a tiered level of care.[39] This stigma and discrimination may be particularly acute in rural areas, where perception of provider bias may be more prevalent.[40]

---

[37] *See, e.g.*, Sara Berg, *Better Training Needed to Address Shortcomings in LGBTQ Care,* American Medical Association (July 17, 2018), https://www.ama-assn.org/delivering-care/population-care/better-training-needed-address-shortcomings-lgbtq-care; Mark L. Hatzenbuehler et al., *The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study*, 100(3) Am. J. of Pub. Health 452 (2010); Amaya Perez-Brumer et al., *"We don't treat your kind": Assessing HIV health needs holistically among transgender people in Jackson, Mississippi*, 13(11) PLoS One 1 (2018).

[38] *See* Zeeman L, *A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities*, Eur. J. of Pub. Health (2018).

[39] *See, e.g.*, Hatzenbuehler ML & Pachankis JE, *Stigma and Minority Stress as Social Determinants of Health Among Lesbian, Gay, Bisexual, and Transgender Youth: Research Evidence and Clinical Implications*, 63(6) Pediatric Clinics of North Am. 985 (2016); Raifman J, *Sanctioned Stigma in Health Care Settings and Harm to LGBT Youth*, 172(8) JAMA Pediatrics 713 (2018).

[40] *See, e.g.*, Willging CE et al., *Brief reports: Unequal treatment: mental health care for sexual and gender minority groups in a rural state*, 57(6) Psychiatric Serv. 867 (2006); Lee MG & Quam JK, *Comparing supports for LGBT aging in rural versus urban areas*, 56(2) J. of Gerontological Soc. Work 112 (2013).

45. Stigmatization and discrimination cause poor health outcomes. When a hospital's cafeteria staff refuse to bring transgender patients their food, for example, this immediately impacts these patients' mental health and may push them out of the healthcare system entirely. For example, patients might sign themselves out of the hospital early and begin to manage their own healthcare decisions in ways that might not optimize their physical health.

46. Denials of care also hinder patients from accessing full-spectrum care, which offers significant benefits. Because so much of the provision of healthcare depends on the relationship between patient and provider, it is to the patient's benefit to access a full spectrum of healthcare from a provider that they know, trust, and have built a robust relationship with. When a provider delivers care consistent with the full scope of their training, the provider has a more comprehensive understanding of the patient's values, communication style, priorities, and motivators, which affords a stronger relationship to deliver the most effective care. But, there are many generalists in OB/GYN and other areas of healthcare that are do not provide full-spectrum care. Denials of care contribute to an increasingly fragmented healthcare system, whereby patients must see even more providers to address various facets of their health. This limits patients' opportunity to seek full-spectrum care.

47. In sum, to the extent that the Rule would permit and even require denials of care and information to patients, consequently increasing stigma and decreasing access to full-spectrum healthcare for reproductive healthcare and LGBTQ patients, the Rule is an assault on the physical and mental health of patients, with compounding harms and drastic consequences that fly in the face of medical ethics.

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

Dated: June 5, 2019

Respectfully submitted,

/s/ Colleen P. McNicholas
COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G.

EXHIBIT A

CURRICULUM VITAE
Colleen Patricia McNicholas, DO, MSCI, FACOG

Date: October 2018

Address:

Department of Obstetrics and Gynecology
Washington University in St. Louis
660 S Euclid Ave
Mailstop 8064-37-1005
St. Louis, Missouri 63110-1094

Present Position:

Associate Professor
Washington University School of Medicine in St. Louis
Department of Obstetrics and Gynecology
Division of Family Planning

Director- Ryan Residency Collaborative
Oklahoma University and Washington University School of Medicine

Assistant-Director- Fellowship in Family Planning
Washington University School of Medicine in St. Louis

Education:

Undergraduate:	1998-2003	Benedictine University Lisle, Illinois B.S. Forensic Chemistry
Graduate:	2003-2007	Kirksville College of Osteopathic Medicine Kirksville, Missouri Doctor of Osteopathy
	2011-2013	Washington University in St. Louis St. Louis, Missouri Masters of Science in Clinical Investigation
Internship:	2007-2008	Atlanta Medical Center Atlanta, Georgia Internship
Residency:	2008-2011	Washington University School of Medicine Residency in Obstetrics and Gynecology
Fellowship:	2011-2013	Washington University School of Medicine Clinical Instructor – Obstetrics and Gynecology Clinical Fellow – Family Planning

Academic Positions/Employment:

2018-	Associate Professor Department of Obstetrics and Gynecology Washington University School of Medicine
2014-2018	Director, Ryan Residency Training Program Washington University School of Medicine

	2013- 2018	Assistant Professor Department of Obstetrics and Gynecology Washington University School of Medicine
	2012-2014	Missouri Baptist Medical Center, St Louis, MO Laborist

University and Hospital Appointments and Committees:

Appointments

2013-	Attending Physician Barnes Jewish Hospital St. Louis, MO
2014-	Director, Ryan Residency Training Program Department of Obstetrics and Gynecology Washington University School of Medicine
2016-	Co-Director, Fellowship in Family Planning Department of Obstetrics and Gynecology Washington University School of Medicine
2016-	Obstetrics and Gynecology Performance Evaluation Committee Washington University/Barnes Jewish OB/GYN Residency
2016-	Washington University School of Medicine Institutional Review Board Member
2018-	Washington University School of Medicine Committee on Admissions

Committees:

2014- 2017 2017-2020	American College of Obstetrics and Gynecology Committee on the Healthcare for Underserved Women Member
2015- 2017 2017-2020	American College of Obstetrics and Gynecology Underserved Liaison to Committee on Adolescent Health Care
2015-	International Federation of Gynecology and Obstetrics (FIGO) Women's Sexual and Reproductive Rights Committee Master Trainer, Integrating Human Rights in Health
2016-	Ibis Reproductive Healthcare Over the counter oral contraceptive working group Policy Subcommittee
2017-	MERCK Global Advisory Board on Contraception
2017-	Washington University School of Medicine OUT Med Advisory Board

Volunteer	2015-	Saturday Neighborhood Health Clinic Washington University School of Medicine Volunteer Attending Physician Faculty, Primary Care

Volunteer Attending Physician Faculty, Americore Homeless

Medical Licensure and Board Certification:

Licensure

Missouri, Kansas, Oklahoma, Washington
Illinois Pending

Board Certification:

2014- current	American Board of Obstetrics and Gynecology General Obstetrics and Gynecology Diplomate

Honors and Awards:

2001	Gregory Snoke Memorial Scholarship
2001	American Chemical Society Analytical Achievement Award
2001	American Chemical Society Division of Analytical Chemistry 2001 Undergraduate Award
2002	PGG Industries Foundation J. Earl Burrell Scholarship
2003	Senior Academic Award: College of Arts and Science
2006	Presidents Award: Women in Medicine
2011	Kody Kunda Resident Teaching Award
2012	ACOG Health Policy Rotation, LARC Program January 2013
2012	Physicians for Reproductive Health and Choice (PRCH) Leadership Training Academy
2012	President's Award: St. Louis Gynecologic Society, best research presentation
2016	Fellowship in Family Planning, Warrior Award
2016	Physicians for Reproductive Health, Voices of Courage: A Benefit Celebrating Extraordinary Abortion Providers
2016	2015 Roy M. Pitkin Award, Obstetrics and Gynecology (The Green Journal)
2018	Massingill Family Scholarship, 2018 Robert C. Cefalo Leadership Institute
2018	ACOG District VII Mentor of the year award

Editorial Responsibilities:

2011-	*Reviewer*, Contraception
2011-	*Reviewer*, Journal of Family Planning and Reproductive Health Care
2012-	*Reviewer*, American Journal of Obstetrics and Gynecology
2012-	*Reviewer*, European Journal of Obstetrics and Gynecology and Reproductive Biology
2013-	*Reviewer*, Obstetrics and Gynecology

Professional Societies and Organizations:

2003-	Medical Students for Choice
2006-2011	Association of Reproductive Health Professionals
2006-	American Congress of Obstetricians and Gynecologists

Leadership Roles

- 2013: The American College of Obstetricians and Gynecologists/Bayer HealthCare Pharmaceuticals Research Fellowship in Contraceptive Counseling (Selection committee)

- 2012-2018: American Congress of Obstetrics and Gynecology Congressional Leadership Conference, participant
  - 2015: Presenter, Reproductive Health Legislation in the States
  - 2016: Presenter, Reproductive Health Legislation in the States

- 2014-2020: Committee on Health Care for Underserved Women
  - Author, CO-Healthcare for Women with Disabilities
  - Author, Policy statement- Marriage and Family Equality
  - ACOG Liaison, AAMC Family Building Webinar series
  - Author, CO- Trauma informed care

- 2015-current: Committee on Adolescent Health Care, Underserved Liaison

- 2015-current: Missouri ACOG Section Advisory Committee, Member
  - 2015- current: Member, Legislative Committee

2006- Gay and Lesbian Medical Association
2006- Women in Medicine
Leadership Roles

- 2010-current Board Member
- 2016: Chair of annual conference, Aug 2016
- 2018-2020: Board Treasurer

2008-2011 St. Louis Obstetrics and Gynecology Society
Leadership Roles: resident board member
2011- Society of Family Planning

Invited Presentations:

2001 Cadmium's effect on Osteoclast Apoptosis
12th Annual Argonne Symposium for Undergraduates in Science, Engineering and Mathematics

2002 Cadmium's effect on Osteoclast Apoptosis
2002 Experimental Biology Conference

2012 Contraception for medically complicated women
Women in Medicine Annual meeting

2013 The troubling trend of legislative interference.
Washington University School of Medicine, OBGYN Grand Rounds.

2013 An update on abortion: Why lesbians and those who treat them should care
The Gay and Lesbian Medical Association

2013 Findings from the Contraceptive CHOICE Project. Are you meeting your patient's contraceptive needs?
Washington University School of Medicine Annual OB/GYN Symposium

2013 Legislative interference and the impact on public health.
Washington University Brown School of Social Work.

2014 Business of Medicine Medical Student Elective Course
Legislating Medicine
Washington University School of Medicine

2014 Practical tips for your first RCT, lessons learned
Lecture in Randomized Control Trial course

2014	Uniting tomorrow's leaders of the RJ movement with providers of today National Abortion Federation Annual Meeting
2014	Systems based practice and advocating for your patients Washington University School of Medicine OB/GYN residency core lecture
2014	Abortion in sexual minority populations *National Abortion Federation*
2014	Complications of uterine evacuation St. Louis University OB/GYN Grand Rounds
2014	Medical contraindications in CHOICE Participants using combined hormonal contraception Over the Counter Oral Contraceptive Working Group
2015	Implementing immediate postpartum LARC Kansas University OB/GYN grand rounds
2015	The evidence for immediate Post-partum IUD insertion Kansas City Gynecologic Society
2105	Business of Medicine Medical Student Elective Course Legislating Medicine Washington University School of Medicine
2015	Getting Politics Out of the Exam Room: Combating Legislative Interference in the Patient-Provider Relationship National Abortion Federation Annual Meeting
2015	Are you meeting your patient's contraceptive needs? Tennessee Department of Health.
2015	Colorado Initiative to reduce unintended pregnancy (webinar): Reducing Unplanned Pregnancies in Colorado through Strategies to Promote Long-Acting Reversible Contraception Huffington Post, Live
2105	Method mix it up: Expanding options to meet the unique contraceptive needs of young people FIGO World Conference
2015	Getting to Yes-Interventions to Increase LARC Acceptance with a Focus on IUC Nurse Practitioners Women's Health Annual Symposium
2015	Put your megaphone where your mouth is: Getting your professional society to speak up Forum on Family Planning
2015	When Politics Trumps Science- Why is Birth control at Center Stage? Carbondale Illinois Grand Rounds
2016	Using research to effectively advocate

Physicians for Reproductive Health Leadership Training Academy

2016 Partial Participation and Abortion Training in Residency: A Structure for Optimizing Learning and Clinical Care
APGO/CREOG

2016 Are we meeting the needs of our teen and adolescent patients? Our role in preventing unintended pregnancy. Barnes Jewish Hospital/Washington University School of Medicine CME Outreach.

2016 The emerging role of physicians as advocates
St Louis OB/GYN Society

2016 Legislation and Advocacy
Washington University School of Medicine- Elective course
Gun violence as a public health issue

2016 Legislative advocacy and the impact on public health
Washington University, Brown School of Social Work

2017 GOV 101
Learning to advocate at the MO legislature

2017 Reevaluating the longevity of LARC
GrandRounds, BayState Medical Center

2018 Ryan Residency Program Annual Meeting
Patient and Community Advocacy in Residency Training

2018 Physician advocacy, the key to public health
Keynote Speaker
Washington University
Center for Community Health Partnership & Research (CCHPR)
Global Health Center Summer Research Program

2018 XXII World Congress of Gynecology and Obstetrics
Whether, when, and how many: a global movement toward reproductive freedom
Rio de Janeiro, Brazil

2018 Domestic and Global epidemiology of abortion
Washington University, Brown School of Social Work

Research Support:

3125-946435
Role: Principal Investigator
MERCK
Ovarian function with prolonged use of the implant
Award: January 2017-June2018
Award Amount: $279,126

U01DK106853 (Colditz, Sutcliffe)
Role: Co-investigator
NIH/NIDDK
LUTS prevention in adolescent girls and women across the lifespan
Award: 07/01/2015-06/31/2020

(Peipert, McNicholas)
Role: Co-Principal Investigator
Anonymous Donor
EPIC: Evaluating prolonged use of the IUD/implant for Contraception
Award: Sep8, 2014 – Aug 31, 2018
Award Amount: $ 1,000,000

National Institutes of Health- Loan Repayment Program
Role: Principal Investigator
EPIC: Evaluating prolonged use of the IUD/implant for Contraception
Aug 17, 2014- July 31, 2017
Award Amount: $70,000
Aug 1, 2016- July 31, 2018
Award Amount: $70,000
Aug 1, 2018- July 31, 2020

81615 (Peipert, McNicholas)
Role: Co-Principal Investigator
William and Flora Hewlett Foundation
LIFE: Levonorgestrel Intrauterine system For Emergency Contraception; a multicenter randomized trial
June1, 2014- May 31, 2015
Award Amount: $351,500

IRG-58-010-57 (McNicholas)
Role: Principal Investigator
American Cancer Society Institutional Research Grant (ACS-IRG)
Evaluating the impact of the IUD on HPV and cervical cancer risk
January 1, 2014-December 31, 2014
Award Amount: $30,000

SFPRF12-1 (McNicholas)
Role: Principal Investigator
Society of Family Planning Research Fund
Effectiveness of Prolonged use of IUD/Implant for Contraception (EPIC)
January 2012 – July 2014
Award Amount: $70,000

UL1 TR000448 (Evanoff)
Role: Postdoctoral MSCI Scholar
NIH-National Center for Research Resources (NCRR)
Washington University Institute of Clinical and Translational Sciences (ICTS)
July 1, 2011 – June 30, 2013

5T32HD055172-03 (Macones, Peipert)
Role: Clinical fellow, trainee
NIH T32 Research Training Grant
July 1, 2011 – June 30, 2013

Bibliography:

Peer-reviewed Publications:

1. Allsworth JE, Hladky KJ, Hotchkiss T, McNicholas C, Rohn A. Discussion: 'Douching and the risk for sexually transmitted disease' by Tsai et al. *Am J of Obstet and Gynecol* 2009;200(1):e11-4.

2. Stoddard A, McNicholas C, Peipert JF. Efficacy and safety of long-acting reversible contraception. *Drugs*. 2011 May 28;**71**(8): p. 969-80. PMID: 21668037

3. McNicholas C, Hotchkiss T, Madden T, Zhao Q, Allsworth J, Peipert JF. Immediate postabortion intrauterine device insertion: continuation and satisfaction. *Women Health Iss.* 2012 Jul-Aug; 22(4):e365-369. PMID: 22749197

4. McNicholas C, Peipert JF. Long-acting reversible contraception for adolescents. *Curr Opin Obstet Gyn.* 2012 Oct; 24(5):293-298. PMID: 22781078

5. McNicholas C, Peipert JF. Initiation of long-acting reversible contraceptive methods (IUDs and implant) at pregnancy termination reduces repeat abortion. *Evid Based Med.* 2013 Jun;18(3):e29. PMID: 23161505

6. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth JE, Peipert JF. Cervical lidocaine for IUD insertional pain: a randomized controlled trial. *Am J Obstet Gynecol. 2012* Nov;207(5):384 e381-386. PMID: 23107081

7. McNicholas C, Zhao Q, Secura G, Allsworth J, Madden T, Peipert J. Contraceptive failures in overweight and obese combined hormonal contraceptive users. *Obstet Gynecol*. 2013 March; 121(3):585-92. PMID: 23635622

8. McNicholas C. Transcending politics to promote women's health. *Obstet Gynecol.* 2013 Jul;122(1):151-3. PMID: 23743460

9. Eisenberg D, McNicholas C, Peipert JF. Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents. *J Adolescent Health*. 2013 Apr;52(4 Suppl):S59-63. PMID: 23535059

10. Grentzer J, McNicholas C, Peipert J. Use of the etonorgestrel-releasing implant. *Expert Rev. of Obstet and Gynecol.* 8 (4), 337-344. 2013

11. Secura G, McNicholas C. Long-acting reversible contraceptive use among teens prevents unintended pregnancy: a look at the evidence. *Expert Rev. of Obstet Gynecol*. 8(4), 297-299. 2013

12. McNicholas C, Peipert JF, Madipati R, Madden T, Allsworth, J Secura G. Sexually transmitted infection prevalence in a population seeking no-cost contraception. *Sex Transm Dis.* 2013 July;40(7):546-51. PMID: 23965768

13. Sehn JK, Kuroki LM, Hopeman MM, Longman RE, McNicholas CP, Huettner PC. Ovarian complete hydatidiform mole: case study with molecular analysis and review of the literature. *Hum Pathol*. 2013 Dec;44(12):2861-4. PMID: 24134929

14. Madden T, McNicholas C, Zhao Q, Secura G, Eisenberg D, Peipert JF. Association of Age and Parity with IUD Expulsion. *Obstet Gynecol.* 2013 Oct; 124 (4): 718-26. PMID: 4172535

15. Secura G, Madden T, McNicholas C, Mullersman J, Buckel C, Zhao Q, Peipert JF. No-Cost Contraception Reduces Teen Pregnancy, Birth, and Abortion. *New Engl J Med.* 2104 Oct; 371(14); 1316-23. PMCID: 4230891

16. McNicholas C, Madden T, Secura G, Peipert JF. The Contraceptive CHOICE Project Round Up: What we did and what we learned. *Clin Obstet Gynecol.* 2014 Dec; 57(4); 635-43. PMCID: 4216614

17. McNicholas C, Maddipati R, Swor E, Zhao Q, Peipert JF. Use of the Etonogestrel Implant and Levonorgestrel Intrauterine Device Beyond the U.S. Food and Drug Administration-Approved Duration. *Obstet Gynecol,* 2015 Mar; 125(3):599-604.

18. Grentzer J, Peipert J, Zhao Q, McNicholas C, Secura G, Madden T. Risk-based screening for Chlamydia trachomatis and Neisseria gonorrhoeae prior to intrauterine device insertion. *Contraception* 2015 Jun; S0010-7824(15)00250-4. PMID:26093189

19. Mejia M, McNicholas C, Madden T, Peipert J. Association of Baseline Bleeding Pattern on Amenorrhea with Levonorgestrel Intrauterine System Use. *Contraception.* 2016 Nov;94(5):556-560. PMID: 27364099

20. Hou M, McNicholas C, Creinin M. Combined Oral Contraceptive Treatment for Bleeding Complaints with the Etonogestrel Contraceptive Implant: A Randomized Controlled Trial. *Eur J Contracept Reprod Health Care.* 2016 Oct;21(5):361-6. PMID: 27419258

21. Zigler RE, Peipert JF, Zhao Q, Maddipati R, McNicholas C. Long-acting reversible contraception use among residents in obstetrics/gynecology training programs. *Open Access J of Contracept*. 2017 Jan; 2017(8) 1—7. PMID: 29386949

22. Zigler RE, McNicholas C. Unscheduled vaginal bleeding with progestin-only contraceptive use. *Am J of Obstet and Gynecol*. 2017 May;216(5):443-450. PMID: 27988268

23. McNicholas C, Swor E, Wan L, Peipert JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. *Am J Obstet Gynecol*. 2017 Jan 29. PMID:28147241

24. McNicholas C, Peripert JF. Is it time to abandon the routine pelvic exam in asymptomatic nonpregnant women? *JAMA* 2017 Mar 7;317(9):910-911. PMID:28267835

25. McNicholas C, Madden T. Meeting the Contraceptive Needs of a Community: Increasing Access to Long-Acting Reversible Contraception. *MO Med*. 2017 May-Jun; 114(3):163-167. PMID:30228573

26. Iseyemi A, Zhao Q, McNicholas C, Peipert JF. Socioeconomic Status As a Risk Factor for Unintended Pregnancy in the Contraceptive CHOICE Project. *Obstet Gynecol*. 2017 Sep;130(3):609-615. PMID: 28796678

27. McNicholas C, Klugman J, Zhao Q, Peipert J. Condom Use and Incident Sexually Transmitted Infection after Initiation of Long-Acting Reversible Contraception. *Am J of Obstet and Gynecol.* 2017 Dec;217(6):672.e1-672.e6. PMID: 28919400

28. Zigler RE, Madden T, Ashby C, Wan L, McNicholas C. Ulipristal Acetate for Unscheduled Bleeding in Etonogestrel Implant Users: A Randomized Controlled Trial. *Obstet Gynecol*. 2018 Oct;132(4):888-894. PMID: 30130151

Non-Peer Reviewed Invited Publications:

1. McNicholas C. Rev. of Recent advances in obstetrics and gynecology, *Royal Society of Medicine Press*, 2008.

2. McNicholas C, Levy B. The original minimally invasive hysterectomy; no hospitalization required. *Expert Rev. of Obstet and Gynecol*. 8(2), 1-3. 2013

Chapters:

1. Gross G, McNicholas C. Rev. of Shoulder dystocia and birth injury: prevention and treatment, by James A. O'Leary 3rd Ed
2. McNicholas C, Peipert JP. Pelvic inflammatory disease. *Practical Pediatric and Adolescent Gynecology*. Oxford. Wiley-Blackwell. ISBN: 978-0-470-67387-4.
3. McNicholas C, Madden T., *2015 Contraceptive counseling for obese women.* In E. Jungheim (Ed) Obesity and Fertility. Springer, New York. ISBN 978-1-4939-2611-4

Abstracts:

1. McNicholas C, Maddipati R, Secura G, Peipert J. Use of the contraceptive implant beyond the FDA-approved duration. Poster Presentation. North American Forum on Family Planning. Miami, FL October 2014.

2. McNicholas C, Swor E, Peipert J, Secura G. Serum etonogestrel levels in women using the contraceptive implant beyond the FDA-approved duration. *Oral Presentation. North American Forum on Family Planning*. Seattle, WA October 2013.

3. McNicholas C, Zhao Q, Peipert J, Secura G. Condom use and incident sexually transmitted infection after initiation of long-acting reversible contraception. *Oral Presentation. 40th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology*. Sante Fe, NM Aug 2013.

4. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth JE, Peipert JP. Cervical lidocaine for IUD insertional pain: a randomized controlled trial. *Poster Presentation*. *North American Forum on Family Planning*. Denver, CO. October 2012.

5. McNicholas C, Maddipati R, Allsworth J, Madden T, Peipert J, Secura G. Baseline sexually transmitted infection prevalence in a low risk urban population. *Oral Presentation*. *39th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology.* Whistler, BC Aug 2012.

6. McNicholas C, Maddipati R, Allsworth J, Madden T, Peipert J, Secura G. An epidemiologic comparison of *Chlamydia Trachomatis* and *Trichomonas Vaginalis*: Information from the Contraceptive CHOICE Project. *Poster Presentation*, *39th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology*. Whistler, BC Aug 2012.

7. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth J, Peipert J. Cervical lidocaine for IUD insertional pain: a randomized control trial. *Oral Presentation. St. Louis Gynecologic Society*. April 2012.

8. Madden T, McNicholas CP, Secura GM, Allsworth JE, Zhao Q, Peipert JF. Rates of Expulsion and Continuation of Intrauterine Contraception at 12 months in Nulliparous and Adolescent Women. *Oral Presentation, Association of Reproductive Health Care Providers.* Sept 2010.

9. McNicholas CP, Madden T, Secura GM, Allsworth JE, Zhao Q, Peipert JF. Rates of Expulsion and Continuation of Intrauterine Contraception at 12 months in Nulliparous and Adolescent Women. *Oral Presentation, Rothman Resident Research Day.* April 2010.

10. McNicholas C. Acute Myelogenous Leukemia (AML) in an HIV Patient. A Diagnosis of exclusion and the implications of Cytogenetics. *Publication and Poster presentation Seaton Hall Research Colloquium.* May 2006.

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF DR. KEN MILLER IN SUPPORT OF PLAINTIFFS' PRELIMINARY INJUNCTION

I, Dr. Ken Miller, declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I am the Medical Director for the County of Santa Clara's Emergency Medical Services (EMS) Agency and the County's EMS System. I have held this position since 2016. Prior to my current role at the County's EMS System, I was the assistant medical director at the Orange County Emergency Medical Services Agency from 1999 to 2016 and medical director at Orange County Fire Authority from 1997 to 2016. I am a board-certified emergency physician with a subspecialty certification in emergency medical services. I have a Ph.D. in pharmacology. I have served in emergency medical services for forty-four years.

3. The County's EMS Agency is responsible for all certification and credential processing for Emergency Medical Technicians (EMTs) who work within the County, including firefighters trained as EMTs. Within the County, every EMT who responds to an EMS call must be accredited and licensed by the County's EMS Agency. And, while the State is responsible for licensing paramedics, the EMS Agency accredits paramedics, wherever they are employed, to work within the County. As a licensing and accrediting agency, EMS plays an oversight role in ensuring that all EMTs and paramedics uphold the ethical and professional standards of their profession. The EMS Agency strives to ensure that all County residents receive safe, quality, and effective prehospital care.

4. The County's EMS Agency oversees emergency medical response operations throughout the County. The EMS System includes fourteen 9-1-1 dispatch centers (six of which provide emergency medical dispatch), eight non-9-1-1 permitted ground ambulance providers, eleven fire departments, two air ambulance providers, and eleven hospitals to coordinate response to medical emergencies. The County of Santa Clara contracts with Rural/Metro of California, Inc. to provide emergency medical response and ambulance transportation throughout most of the County in response to 9-1-1 calls, except in the City of Palo Alto and the campus of Stanford

University, where emergency medical response and ambulance transportation in response to 9-1-1 calls is provided by the City of Palo Alto's fire department.

5. All ambulance service providers and air ambulance service providers in the County must be permitted by the County's EMS Agency and must operate in accordance with State laws, regulations, and guidelines, the County of Santa Clara's Ordinance Code and ambulance permit regulations, the EMS Agency's Prehospital Care Policy Manual, and any agreements entered into with the County of Santa Clara. The EMS System relies on roughly 2,374 EMTs, and 635 paramedics to provide emergency prehospital care to County residents.

6. EMTs are often dispatched as part of a two-person team. If one person were to refuse to provide care or to drive an ambulance because of an objection to the care the patient was currently receiving or was likely to receive, it would not be possible for that pair to simultaneously transport a patient and provide the medical aid that may be necessary to stabilize a patient, putting patient care at risk. Such a scenario could result in an otherwise avoidable fatality or serious injury.

7. The County's contract with Rural/Metro includes a nondiscrimination provision prohibiting it from "discriminat[ing] in the provision of services provided under this contract because of . . . sex/gender, sexual orientation, mental disability, physical disability, medical condition . . . or marital status." We require Rural/Metro and its EMT/Paramedic employees when they are dispatched to an incident scene to provide aid to any patient experiencing a medical emergency. If the EMS Agency became aware that an EMT refused to provide medically indicated care to someone in an emergency, the EMS Agency could undertake a progressive discipline process. And a refusal to provide aid to a person during an emergency could constitute grounds for discipline, under California Health & Safety Code section 1798.200.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this Declaration was executed on June 5, 2019 in San José, California.

Respectfully submitted,

/s/ Ken Miller MD PhD
KEN MILLER

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

No. 19-cv-2916 NC

DECLARATION OF PHUONG H. NGUYEN, M.D., INTERIM CHIEF MEDICAL OFFICER, SANTA CLARA VALLEY MEDICAL CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Phuong H. Nguyen, M.D., declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I currently serve as Interim Chief Medical Officer for the Santa Clara Valley Medical Center ("Valley Medical Center"). I have been employed by Valley Medical Center in various capacities for a total of nineteen (19) years, and I have practiced as an obstetrician/ gynecologist in a clinical capacity throughout my employment with Valley Medical Center. As of March 1, 2019, when the County of Santa Clara assumed operations of O'Connor Hospital and St. Louise Hospital, I became Interim Chief Medical Officer of the single consolidated medical staff for the three hospitals.

3. The County of Santa Clara Health System operates three hospitals—Valley Medical Center, O'Connor Hospital, and St. Louise Hospital under a single consolidated hospital license and with a single consolidated medical staff. The consolidated medical staff includes 1202 physicians and advance practice providers at Valley Medical Center, 681 physicians and advance practice providers at O'Connor Hospital, and 262 physicians and advance practice providers at St. Louise Hospital. As Interim Chief Medical Officer, I supervise the consolidated medical staff, including overseeing the recruitment, hiring, training, scheduling, and supervision of physicians.

4. Valley Medical Center has policies that allow medical staff, including physicians, who have a religious or moral objection to providing certain patient care to request not to participate in that care. Those policies are being made applicable to physicians who provide care at O'Connor and St. Louise hospitals as part of the integration of those hospitals into the County's Health System. The County has procedures in place to determine whether such objections can reasonably be accommodated, in light of circumstances such as staffing levels, and to take into account religious objections in scheduling and staffing decisions. Our policies make clear that patient care must not be compromised. For example, in an emergency an objecting

physician would need to provide care until the physician can be relieved. Similarly, for end-of-life care decisions involving medically ineffective care or other healthcare instructions for which a physician has an objection, the objecting physician must assist in the transfer of the patient to another provider.

5. It would create staffing challenges if the hospitals could no longer reassign objecting staff members or shift their hours to accommodate or account for their religious objections. It is necessary to assign certain personnel to specific shifts to ensure that there are sufficient non-objecting staff to provide patient care. And if a person's religious objection is incompatible with their current role, reassignment to a different role may be necessary. While we strive to achieve mutually agreeable, voluntary reassignments, schedule changes, and other accommodations whenever possible, in some instances we require the flexibility to make assignment or scheduling decisions without the objecting staff member's consent.

6. Further, there are some circumstances in which no accommodation would be possible. For example, if a receptionist objected to informing people that our hospitals provide contraceptive and abortion care and refused to transfer inquiries about such care to another receptionist, I cannot think of any accommodation that would avoid compromising patient access to care. And even if a receptionist were willing to transfer all calls about contraceptive or abortion care to another receptionist, this could require double staffing, at the cost of a second salary. It would be operationally unworkable for the County of Santa Clara Health System if an employee retains a unilateral right to veto a reassignment.

7. Delaying necessary health care can trigger immediate and long-term costs to the County and communities nationwide. Under current County policies, patients seeking care for routine procedures that a provider may have a religious or moral objection to providing are promptly transferred to another provider or are initially scheduled to be served by a provider who does not object. If a regulatory change impedes the County's ability to ensure the timely provision of care for such patients, the resulting delays may exacerbate their medical needs, resulting in increased costs for treatment. Since the County is a safety-net provider, many of those increased costs would be borne by the County—either directly, where the County absorbs

the cost of care for uninsured or underinsured patients, or indirectly because federal health insurance programs like Medicaid and Medicare rarely cover the full cost of treatment.

8. Delays in care may also lead to malpractice claims, which are costly to defend and may lead to expensive settlements or court-ordered damages, at potentially great cost to the County. County physicians and other providers are bound by medical ethics to act in the best interest of our patients. Delaying care because a provider did not register a religious or moral objection in advance is in conflict with those ethical obligations. Patients whose medical conditions are worsened by delays or denials of care may experience preventable adverse outcomes such as long-term injury or even death as a result.

9. For example, a patient could present at Valley Medical Center with vaginal spotting, pain, missed period, and positive home pregnancy test in the context of having an intra-uterine device as a contraceptive method—a condition many Valley Medical Center physicians are qualified and willing to manage and treat. If an employee or physician were to turn that patient away from the hospital, based on moral or religious convictions, without referring her to a willing physician or otherwise providing any information about appropriate treatment, the patient could be denied prompt care, the County could be exposed to liability, and its providers could be in violation of their ethical and legal duties. Health care professionals are legally and ethically obligated to provide their patients with complete and accurate information about their treatment options.

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

Dated: June 4, 2019

Respectfully submitted,

PHUONG H. NGUYEN, M.D.

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF RACHAEL PHELPS, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, Rachael Phelps, M.D., F.A.A.P., declare as follows

1. I am the Medical Director of Plaintiff Medical Students for Choice ("MSFC"). MSFC is a 501(c)(3) non-profit that advocates for full integration of reproductive healthcare, including contraception and abortion, into the curricula at medical schools and residency programs. MSFC is comprised of student-led chapters at medical schools, and these grass-roots, student activists are supported by the national MSFC staff who implement programming, manage resources, and provide expertise. Medical student activists make up the majority of our Board of Directors, and the MSFC student chapters provide data and information about the state of family planning training at the local level to guide the strategic planning of the Board.

2. MSFC's central mission is to expand access to health services that allow patients to lead safe, healthy lives consistent with their own personal and cultural values, including with respect to all aspects of sexual and reproductive health. MSFC furthers this mission by supporting future generations of family planning providers in accessing training in contraception and abortion.

3. MSFC has 163 chapters in 45 U.S. states, and another 55 chapters outside of the U.S. We have thousands of current student members.

4. Despite the considerable number of students seeking family planning training and the fact that outpatient abortion is simple, safe, and an extremely common procedure, one of the most common medical procedures undergone by women,[1] most medical students do not receive training in abortion, and some do not even receive training in contraceptive care. Less than half of our members learned about

[1] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 77 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective."). 1 in 4 women will seek abortion in their lifetime. *See* Jones RK & Jerman J, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) Am. J. of Pub Health 1904 (2017).

first-trimester abortion from their schools. Many members learn inaccurate and limited information about contraception.

5. I received my medical degree in 1997 from Johns Hopkins University School of Medicine. I completed residency in Pediatrics in 2000 and a fellowship in Family Planning in 2001. I was a resident and fellow at the University of Rochester, and only the second family planning fellow at that hospital. I am board-certified in Pediatrics.

6. After finishing my fellowship, I joined Planned Parenthood of the Rochester/Syracuse Region, which has now become Planned Parenthood of Central and Western New York ("PPCWNY"), as an abortion provider. I served in a variety of roles there, Medical Director of Surgical Services, Associate Medical Director and Medical Director, from 2001-2018. I left that position to become the Medical Director of MSFC. I continue to provide family planning and abortion care at Planned Parenthood.

7. At the University of Rochester, I am a Clinical Instructor in the OB/GYN Department and a Clinical Instructor in the Department of Pediatrics. I train medical students and residents in contraception and abortion. I am frequently invited by other institutions and organizations to lecture on contraception and abortion.

8. I authored the chapter on unintended pregnancy and options counseling in the Hillard textbook, *Practical Pediatric and Adolescent Gynecology*.

9. I have received awards in my field, including the National Council of Jewish Women Hannah G. Solomon Humanitarian Award, the Dr. Barnett A. Slepian Memorial Fund Clinical Training Award, Alpha Omega Alpha Honor Medical Society Alumni Induction by the University of Rochester, and the American Medical Student Association: Women Leaders in Medicine Award. My curriculum vitae, which sets forth my qualifications fully, is attached as Exhibit A.

10. At MSFC, I lecture student chapters about contraceptive methods and abortion care. I am also the coordinating director for MSFC's intensive training program. I monitor the state of family planning education in the United States.

11. I submit this Declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services ("HHS") relating to "Conscience Rights in Health Care" (the "Rule").

12. I understand that teaching hospitals and residency programs are considered "direct recipients" under the Rule, and all of the institutions and programs currently training our student members across the country would be subject to the Rule.

13. At MSFC, we run educational seminars. Each year, we run an intensive conference over several days. Our current budget allows us to accept only 400 students a year for our intensive conference. We also provide abortion training institutes, for which admission is competitive, and we can only accept less than 50% of those who apply.

14. There are many ways to deny, delay, or obstruct patient care. Once healthcare is delayed or denied, the harm is immediate and cannot be undone. To the extent the Rule enables individual employees at healthcare facilities subject to the Rule, even those not trained as healthcare providers, such as receptionists or cleaning staff, to refuse to assist in a variety of ways with a patient's access to needed healthcare, it will harm patient health and reduce access to contraception and abortion in family planning training programs throughout the nation.

15. Even without the Rule, reproductive healthcare is already being pushed out of mainstream healthcare at numerous hospitals across the country, and patients face a multitude of unnecessary barriers when trying to obtain basic family planning services. Abortion is a fundamental part of healthcare: it is a common medical procedure—1 in 3 women in the U.S. have undergone an abortion and an

estimated 1 in 4 women will need an abortion in the future—and it is extremely safe[2]—14 times safer than childbirth[3] and even safer than a shot of penicillin.[4]

16. Even in progressive states, some hospitals fail to offer reproductive healthcare due to the moral or religious objections of a few, and on occasion, even due to the moral or religious objections of a lone individual. This is equally true for education about contraception and abortion in medical schools and residencies. The small minority of individuals who object to either education about or provision of reproductive healthcare often prevent the majority of medical students who want this education and training from receiving it and ultimately block the doctors who want to provide this care from serving their patients' healthcare needs.

17. For example, I have been informed of circumstances in which university teaching hospitals do not provide certain types of abortion care, such as second trimester abortion care, because of the opinion of a few or even one staff member in a position of power, despite the presence of physicians trained in and willing to provide these desperately needed services. In one instance, the chair of a department of one hospital refused to allow the hospital's doctors to participate in abortion care, even though multiple doctors were willing to assist with abortions, thus preventing the trained and willing OB/GYN physicians in this teaching hospital from providing abortion care to the patients in their community. As a result, despite having trained and willing OB/GYNs who want to provide this care, the hospital does not provide any abortion care beyond 12 weeks.

---

[2] National Academies of Science, Engineering, and Medicine, *supra* note 1.

[3] Raymond EG & Grimes DA, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 Pt 1) Obstetrics & Gynecology 215 (2012).

[4] *Compare* Raymond EG & Grimes DA, *supra* note 3 *with* Neugut AI et al., *Anaphylaxis in the United States: an Investigation into its Epidemiology*, 161(1) Archives of Internal Med. 15 (2001).

18. First-trimester abortion providers serve patients at outpatient clinics in that region, but, due to the anesthesia department chair's policy, there is now no second-trimester abortion access for patients with Medicaid in the region and only extremely limited access for patients with private insurance. Due to the lack of access to time-sensitive health-care imposed by this one objection, patients must travel hours to obtain second-trimester abortions at a hospital in another city. Because this one hospital must now meet the need for their own community, as well as the unmet need created in another city by this one objection, all patients seeking an abortion beyond 13 weeks must wait up to 2-4 weeks to get an appointment for care. This means a woman seeking an abortion at 14 or 15 weeks will often have to wait until she is 18 or 19 weeks to access an abortion. Such delays harm patients. While the risk of morbidity and mortality remains significantly lower than childbirth throughout the second trimester, it increases approximately 20% for each additional week that the procedure is delayed.[5]

19. As an example of harmful delay, I have seen some physicians suggest admitting a woman experiencing placental abruption or a complication from an abortion procedure to the Intensive Care Unit and transfusing the patient until fetal cardiac activity ceased. This is a dangerous and cruel practice. Continual transfusions are, themselves, dangerous. When a patient loses a lot of blood and they are repeatedly given donated blood, they can lose their ability to clot due to a serious condition called disseminated intervascular coagulopathy ("DIC"). If DIC sets in, the patient requires other types of transfusions like plasma and platelets, and the end result can be organ failure and even death. DIC is, unlike a 5-minute suction procedure, extremely dangerous and poses a significant risk.

20. In another instance, I had a patient in her late teens who already had a child and was scheduled to have an abortion in the first trimester. While awaiting her

[5] *See* Newmann S et al., *Clinical guidelines: Cervical preparation for surgical abortion from 20 to 24 weeks' gestation*, 77(4) Contraception 308 (2008).

appointment, she went to see her OB/GYN who, knowing she was planning to have an abortion, falsely informed her that she was farther along in her pregnancy and that, in fact, she was too far along to have an abortion, which was also untrue.

21. Another recent patient, already a mother, thanked me for treating her with compassion and kindness. She explained that when she sought a referral for an abortion from her long-time provider, he verbally abused her. Rather than respecting her decision, the staff at that office gave her baby formula and prenatal supplies.

22. Under ethical principles and federal law, healthcare providers can refuse to perform a procedure, even in an emergency, as long as there is an alternate provider available.[6] Healthcare providers should not refuse to provide care, information, or referrals if doing so would prevent the patient from obtaining the care they need.

23. As healthcare providers, we take an oath to put the needs of our patients above our own. To the extent that the Rule tips the scale so far in favor of the provider (and non-medical staff) that it enables almost anyone in a hospital to not only refuse to provide care but to obstruct the patient's ultimate access to care, it violates medical ethics and puts patients at risk.

24. There are countless individuals involved in the treatment of patients in any hospital setting. It takes a coordinated effort of multiple individuals with varying levels of training and professionalism to ensure that a patient receives care in a safe and timely manner: schedulers making appointments, receptionists checking

---

[6] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*, 110 Obstetrics & Gynecology 1203 (2007) ("Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."); American Medical Association, *Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, Ethics, https://www.ama-assn.org/delivering-care/physician-exercise-conscience (last visited June 6, 2019) ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

patients in, medical assistants rooming patients, phlebotomists drawing blood for lab testing, technicians placing IVs, laboratory technicians running lab testing and entering results, radiology technicians performing ultrasounds, radiologists reviewing the resulting scans, technicians cleaning instruments, pharmacy technicians stocking medicines, pharmacists filling prescriptions, housekeeping cleaning exam rooms, billing staff getting pre-authorizations and billing for services, technicians transporting patients, and nurses to recover patients and administer medications. To the extent that the Rule would encourage or permit any of these individuals to object to what the Rule deems "assisting" in a procedure, the Rule would harm patient care in the hospital setting. It only takes one objecting individual at a hospital to bring the process to a grinding halt.

25. All of these scenarios discussed above describing harms to patients that result from delayed or denied abortion care impact patients in need of miscarriage management as well. In the context of miscarriage management, it is also often the case that patients are refused appropriate and timely treatments for miscarriages, even when carrying non-viable fetuses with no chance of survival, due to the presence of fetal cardiac activity.

26. When patients who need appropriate and timely treatments for miscarriages are denied such care, they are at risk of infections, sepsis, hemorrhage, DIC due to repeated transfusions as described above, and a greater risk of subsequent pregnancy complications or infertility. These delays in care compound the already deeply painful experience of losing a much wanted pregnancy.

27. As healthcare providers, we are in a position of power with respect to our patients. We have knowledge that they do not. We control their access to diagnostic testing and therapeutic treatments that they need to protect their health and lives. We hold the skills necessary to perform the procedures and surgeries they need. With that power comes a fundamental duty—to use our power only to benefit the patient who has entrusted us with their life and health. We have an ethical responsibility to

give them the information they need to make their own informed decisions and to either provide the treatment they need or refer them to someone who can. Withholding information or treatment, lying, or obstructing patient care is never the appropriate exercise of our duty to our patients.

28. Those hospitals across the U.S. where abortion is offered or can be offered—*i.e.*, not religiously-affiliated hospitals that provide no contraception or abortion services[7]—are already under great pressure to avoid providing contraception and abortion.

29. Hospitals across the U.S. are large businesses that demand significant administrative resources. The Rule, to the extent that it requires employers to permit an unprecedented number and type of refusals, is extremely unworkable for any hospital. Many hospitals already deem contraception and abortion too much trouble to protect because of the effort required to accommodate refusals and the additional expense they entail. To the extent that the Rule conflicts with policies requiring treatment of patients in emergencies and other requirements for patient

---

[7] *See, e.g.*, Adam Sonfield, *In Bad Faith: How Conservatives Are Weaponizing "Religious Liberty" To Allow Institutions To Discriminate*, Guttmacher Policy Review (May 16, 2018) https://www.guttmacher.org/gpr/2018/05/bad-faith-how-conservatives-are-weaponizing-religious-liberty-allow-institutions; United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018) [hereinafter *Ethical and Religious Directives*]. The *Ethical and Religious Directives*, which govern all Catholic health institutions and must be integrated into any hospital wishing to merge with a Catholic facility, forbid doctors working in Catholic hospitals from participating in all abortion and contraception procedures and counseling, except "natural family planning." *Id.* at 19. The *Ethical and Religious Directives* also significantly restrict postpartum and direct sterilization, elimination of ectopic pregnancy, medical miscarriage management or other fetal loss, screening for fetal anomalies, assisted reproductive technologies like IVF, and HIV and STI prevention counseling. *See id.* at 18-19; *see also* Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage Of Medicine Report*, MergerWatch 1 (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=XlfagUpjX2g9GXDKAyqHQHDUbig%3D ("Catholic hospitals operate under ethical directives that prohibit the provision of key reproductive health services (such as contraception, abortion, sterilization and infertility services). We documented instances in which, as a result of these directives, women suffering reproductive health emergencies — including miscarriages — have been denied prompt, appropriate treatment at Catholic hospitals." (citing *Ethical and Religious Directives*)).

care, it is both practically and financially untenable. When hospital administration is disrupted by refusals that threaten the organization and patient experience, reproductive healthcare pays the price. This has been true across the country.

30. In my capacity as Medical Director of MSFC, I am aware of the curricula at medical schools across the country in the 45 states where our chapters are located. Contraception and abortion have been marginalized in medical education in many areas. By pushing training in abortion and contraceptive services out of additional hospitals in the country, the Rule threatens to significantly constrict education of future physicians in contraception and abortion in the areas where it still exists.

31. A survey of our chapters at a cross-section of medical schools demonstrated that, while 85% of U.S. medical schools covered erectile dysfunction drugs, like Viagra, one out of four medical schools provide no education on IUDs, the most effective contraceptive method available.[8] And while almost 90% of medical students learn about counselling patients on prenatal care, less than half learn about counselling their patients on family planning.[9] This meager training in contraception is not commensurate with the need for such training. A sexually active woman who wants only two children will need contraception to prevent pregnancy for more than 30 years,[10] and 99% of American women aged 15-44 who have ever had sexual intercourse have used at least one contraceptive method.[11] There is no other class of medication that is more fundamental to the health and lives of the American population than contraception, yet most doctors

---

[8] *See* Steinauer J et al., *First impressions: what are preclinical medical students in the US and Canada learning about sexual and reproductive health?*, 80(1) Contraception 74 (2008).

[9] *Id.*

[10] *Contraceptive Use in the United States*, Guttmacher Institute (July 2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[11] Daniels K & Mosher WD, *Contraceptive methods women have ever used: United States, 1982-2010*, 62 Nat'l Health Stat. Rep. *1* (2013).

leave medical school with inadequate and often inaccurate education and training in its provision. Despite the fact that almost half of all pregnancies in the U.S. are unintended and that all of these patients need pregnancy options counselling, only 30% of medical schools cover this topic.[12] In addition, only a minority (40%) of medical schools covered first trimester surgical abortion, and of those schools that did cover abortion care, one third spent less than 30 minutes on the topic.[13] More than a third of schools spent more class time on erectile dysfunction drugs than on all methods of abortion.[14]

32. A student who participated in a lecture program I gave to 30-40 students at her medical school recently told me that she only received a short lecture on birth control pills and that much of the information conveyed during the lecture was medically inaccurate. Long Acting Reversible Contraception (LARC) methods, like IUDs and implants, were not mentioned at all, despite the fact that these methods are the most effective contraceptive methods available, 20 times more effective than birth control pills for adult women and 40 times more effective than birth control pills for teens.[15] When the student inquired of the professor about additional instruction in family planning, the professor stated that they did not want to "risk offending" any students opposed to contraception or abortion. Should the Rule go into effect, it will embolden refusals that will result in full exclusion of these topics from medical education.

33. At my initial lecture at MSFC's yearly intensive conference, I take the students through the most up-to-date contraceptive methods. I always poll the audience. Of

---

[12] *See* Steinauer, *supra* note 8.

[13] *See id.*

[14] *See id.*

[15] Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 New England J. of Med. 1998 (2012).

the percentage of students who were taught anything about contraception, approximately half had learned medically inaccurate information.

34. In short, some medical schools already deem contraception and abortion too politically sensitive to include substantively. Others find it to be simply insignificant. This exclusion of contraception and abortion from mainstream medical education disserves patients because they will often see healthcare providers who are misinformed or underinformed about contraception and abortion, even if those providers do not oppose contraception and abortion. When women are not offered the most effective birth control options because their doctors are poorly trained in contraception, they have more unintended pregnancies, more abortions, and more pregnancy complications due to lack of birth spacing. This leads directly to worse maternal and child health outcomes as well decreased educational and professional attainment, and increased poverty. The Rule will make matters worse, and the health of women and children will suffer.

35. As described above, it is already the case that religious-based objections to care by institutions and individuals are pushing abortion and contraception care and training out of healthcare facilities across the country. There are, however, institutions and individuals that remain committed to providing and championing this care. These institutions have implemented thoughtful processes to accommodate religious refusals while protecting patient health and safety. If permitted to go into effect, the Rule will undermine these thoughtful processes, because it cannot be implemented in a manner that ensures patient health, and avoids liability for harms to patients, without providers risking the loss of all HHS federal funding. The Rule therefore creates extremely powerful incentives for even the most committed providers to stop providing abortion and contraception. As a result, these hospitals will be incentivized, if not forced, to forego providing contraception and abortion.

36. The provision of training in contraception has worsened since anti-choice advocates have cast contraception as equivalent to abortion. This messaging and others that emphasize the exceptionality or political sensitivity of contraception and abortion are fueled by the anti-choice movement, which is highly organized and well-funded.[16] The Rule is the regulatory embodiment of a biased approach to family planning that prioritizes the beliefs of the provider over the well-being of the patient, and it will impose this approach on every hospital in the U.S.

37. Contraception and abortion are essential components of healthcare.[17]

38. Patients have autonomy and the right to make personal health decisions that we, their healthcare providers, may disagree with. Our responsibility is to educate them about risks and benefits of the available treatment options and to provide them with the care they choose. We are free to practice medicine how we choose, as long as we stay within ethical boundaries and we do no harm. Withholding information critical to a patient's care or impeding a patient from receiving care when medically appropriate in unethical and causes harm. We have an ethical and professional duty to provide our patients with complete and accurate medical information and referrals to other providers for care that we are not capable or willing to provide.

39. OB/GYNs are specialists who serve pregnant persons. At least approximately half of any OB/GYN's patients are of reproductive age. To fail to provide them with

---

[16] *See, e.g.*, White K et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105(5) Am. J. of Pub. Health 851 (2015); *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

[17] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, *Committee Opinion No. 615: Access to Contraception*, 125 Obstetrics & Gynecology 250 (2015); American College of Obstetricians and Gynecologists College Executive Board, *College Statement of Policy: Abortion Policy*, American College of Obstetricians and Gynecologists (Nov. 2014), https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20190416T1311496019.

any information or assistance with family planning, even by informing them that such options are available, is the equivalent to obstructing or denying care and impedes a patient's fundamental right to bodily autonomy.

40. Even outside the context of obstetrical and gynecological care, all manner of physicians and other providers routinely order pregnancy tests for patients. For example, pregnancy tests are performed routinely by all primary care providers, emergency physicians, surgeons prior to surgery, sub-specialists prior to starting certain medications, radiologists before imaging studies, and anesthesiologists prior to anesthesia. It is the most frequently ordered laboratory test on women in medicine.

41. It is standard medical practice for any provider ordering a laboratory test to be able to interpret the test results, to understand all potential treatment options based on the test results, to counsel the patient on all of their treatment options, and then to either provide appropriate treatment or refer for treatment based on the test results.[18] The Rule's enforcement will press the relatively few hospitals providing contraception and abortion, and education about those services, to discontinue their commitment to reproductive healthcare, resulting in an expanding number of physicians who will not know how to counsel a patient who is pregnant. Many patients will be told they are pregnant by physicians who have little to no knowledge about contraception and abortion. This is particularly worrisome given that almost half of all people with a positive pregnancy test are experiencing an unintended pregnancy.[19] Many patients in that situation will not be told of all of their treatment options by their provider—no information about abortion (although

---

[18] *See* American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 363*: *Patient Testing: Ethical Issues in Selection and Counseling*, 109 Obstetrics & Gynecology 1021 (2007).

[19] *See Contraceptive Use in the United States*, Guttmacher Institute (July 2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

25% of pregnant persons choose abortion in their lifetime)[20] and no information about methods of contraception for future use.

42. When patients do not receive accurate or appropriate contraceptive counseling, women are at greater risk of unintended pregnancy and thus in greater need of abortion services.[21]

43. These outcomes of the Rule will be problematic even if the provider is only misinformed or underinformed. Other healthcare providers are opposed to contraception and abortion and will be emboldened by the Rule to actively prevent their patients from obtaining that care. To the extent that the Rule permits healthcare providers to obscure needed information, for example, to decline to tell a patient that she has a fetal anomaly until it is too late for her to have an abortion, it is unethical and threatens patient health and autonomy.

44. I have also encountered a resident in a rotation at a health center where I provide care. He told me that if he encountered any patients with an unintended pregnancy, he would not provide pregnancy options counselling himself or refer them to another healthcare provider who could, but rather, he would send them to a crisis pregnancy center, which do not provide any health care, so they could be convinced not to have an abortion. The Rule will encourage physicians like this resident to obstruct patient care.

45. Patients denied care will face increased health risks and be funneled into more expensive ports of entry into the healthcare system like emergency rooms or other acute care facilities.

46. In the interest of preventing unintended pregnancies, medical schools should be instructing students in evidence-based contraception.[22] If the Rule goes into effect,

---

[20] *See* Jones & Jerman, *supra* note 1.

[21] *See* Lawrence B. Finer & Mia R. Zolna, *Declines in unintended pregnancy in the United States, 2008–2011*, 374 New England J. of Med. 843 (2016).

[22] *See* Blumenthal PD et al., *Strategies to prevent unintended pregnancy: increasing use of long-acting reversible contraception*, 17(1) Hum. Reprod. Update 121 (2011); Jennifer J. Frost et al.,

many medical schools will restrict their contraceptive education because they fear that they will be accused of violating the rule and because they wish to avoid complaints from students, professors, board members, or others who may object personally to the provision of contraception and abortion.

47. Some time ago, outpatient abortion clinics attempted to meet the educational needs of students and residents in family planning with external rotations. Many clinics have now closed due to increasing restrictions and political pressure.[23] The Rule will create and expand areas of the country where patients simply cannot access abortion care at all, and providers cannot become educated in effective family planning, creating both access and educational deserts.

48. MSFC strives to fill this gap. We already struggle to do so with our existing resources. Almost all people need reproductive healthcare at some point in their lives. Should the Rule go into effect, MSFC will be even less able to instruct the growing number of medical students and residents who want and need education in contraception and abortion so that they can meet the healthcare needs of their patients, and patients across America will pay the price.

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

Dated: June 6, 2019

Respectfully submitted,

R. Phelps MD

Rachael Phelps, M.D., F.A.A.P.
Medical Director
Medical Students for Choice

Contraceptive Needs and Services, 2013 Update, Guttmacher Institute (July 2015), https://www.guttmacher.org/report/contraceptive-needs-and-services-2013-update.

[23] The number of U.S. abortion-providing facilities declined 3% between 2011 and 2014 (from 1,720 to 1,671). Jones RK & Jerman J, *Abortion Incidence and Service Availability In the United States, 2014*, 49(1) Persp. on Sexual & Reprod. Health 17 (2017). The number of clinics providing abortion services declined 6% over this period (from 839 to 788). *Id.*

EXHIBIT A

Curriculum Vitae

Rachael Phelps MD, FAAP

114 University Ave
Rochester, NY 14605

Rachael.phelps@ppcwny.org
(585)734-5379

EDUCATION:

The University of Rochester, Department of Family Medicine:
Fellowship in Family Planning (2000-2001)

The University of Rochester, Department of Pediatrics:
Residency in Pediatrics (1997-2000)
American Board of Pediatrics Certification (10/2000- present)

The Johns Hopkins University School of Medicine:
Doctor of Medicine (1997)

The Pennsylvania State University:
Bachelor of Science in Anatomy and Physiology (1992)
Minor in Fine Arts
University Scholars Program
Graduated Cum Laude
Dean's List (7/8 semesters)
Golden Key National Honors Society
Alpha Epsilon Delta Premedical Honors Society
Phi Lambda Upsilon National Honorary Chemical Society
Phi Sigma Eta Freshman National Honor Society

PROFESSIONAL EXPERIENCE:

- Medical Students for Choice (2019)
  - Medical Director
- Planned Parenthood of Central and Western New York (2014- present):
  - Medical Director (2014- 2018)
  - Program Director for the following clinical services (2014- 2018)
    - Medication Abortion
    - Surgical abortion
    - Basic Breast
    - Colposcopy
    - Early Pregnancy Evaluation and Management of Complications
    - Sedation
    - Ultrasound
  - Family planning staff physician (2014- 2018)
  - Abortion provider (2014- present)
- Planned Parenthood of the Rochester/Syracuse Region (2001- 2013):
  - Medical Director (2011- 2013)
  - Associate Medical Director (2009- 2010)
  - Medical Director of Surgical Services (2005-2009)
  - Program Director for Surgical services (2009-2013)
  - Program Director for Early Pregnancy Loss (2007-2013)
  - Program Director for Ultrasound (2005-2013)
  - Family planning staff physician (2002- 2013)
  - Abortion provider (2001-2013)
- University of Rochester Clinical Instructor in the Department of Obstetrics and Gynecology (2012-present)

- University of Rochester Clinical Instructor in the Department of Pediatrics (2001-present)
- Liletta trainer and Speaker's Bureau (2015- present)
- Implanon/Nexplanon Training Faculty (2006-present)
- Planned Parenthood Federation of America Accreditation Consultant Surveyor (2009-2013)
- University of Rochester- Department of Family Medicine- Reproductive Health Program: Clinical Faculty (2001-2005)
    - Provided clinical training and weekly seminars on contraception, abortion and ultrasound
- Visiting Faculty for National Institute of Health/ National Institute Child Health and Human Development: Preventing Unplanned Pregnancy: Advances in Hormonal Contraception (2003)
- Pediatric Links with the Community: Co-director (2001-2005)
- Anthony Jordan Teen Center: Clinician (1998-2002) Clinical Director (2001-2002)

LEADERSHIP and COMMUNITY SERVICE:

- Healthy Baby Network Board of Directors (2017-present)
- Planned Parenthood Federation of America's Medical Director's Council (2006-present)
    - Board of Trustees (2017-present)
    - CEO/Medical Director Partnership taskforce (2016-present)
- Physicians for Reproductive Health: Adolescent Reproductive and Sexual Health Education Project Faculty ARSHEP (2005-present)
- Planned Parenthood Medical Director Mentor (2012-present)
- Columbia University: New York Promoting and Advancing Teen Health (NYPATH) Initiative: Advisory Council (2011-2016)
- VOXENT Clinical Advisory Group (2013-2016)
- Planned Parenthood Federation of America's National Medical Committee Member (2008- 2014 & 2017)
    - Executive Subcommittee (2010-2014)
    - Nominating Subcommittee Chair (2014)
    - Nominating Subcommittee (2012 &2013)
    - Subcommittee Chair (2013 &2014)
- Actavis Women's Health Advisory Board (2014)
- ANSIRH Early Abortion Training Workbook 4th addition: Advisory Committee (2012)
- Association of Reproductive Health Professionals' Expert Medical Advisory Committee: Non-Hormonal Contraception Quick Reference Guide (2012)
- Association of Reproductive Health Professionals' Expert Medical Advisory Committee: Choosing a Birth Control Method Quick Reference Guide (2009 & 2011)
- Association of Reproductive Health Professionals and the National Campaign to Prevent Teen Pregnancy Expert Advisory Committee: Providers' Perspectives: perceived barriers to contraceptive use in youth and young adults (2007)
- University of Rochester Adolescent Medicine Fellowship Scholarship Oversight Committee (2007-2009 & 2011-2014)
- National Board of Directors for Medical Students for Choice (2006-2009)
    - Chair of Fundraising Committee (2006-2009)
- Centers for Disease Control Expert Focus Group: Hepatitis B Vaccination in Teens (3/02)

Medical School:

AMSA's Women's Rights Month: Chairperson (1992)
Women's Fund Association: President (1993-1995)
Johns Hopkins Medical Students for Choice: Founder and Co-President (1994-1995)
Johns Hopkins American Medical Women's Association Chapter: Founder (1994-1995)
Educator in Dunbar Teen Sexuality Education Program (1993-1995)
Hotline Crisis Counselor at the House of Ruth Shelter for Battered Women (1993)

Undergraduate:

Collegians Helping Aid Rescue Missions: Director (1990-1992)

AWARDS:

- National Council of Jewish Women Hannah G. Solomon Humanitarian Award (2017)
- The Dr. Barnett A. Slepian Memorial Fund Clinical Training Award (2012)
- Alpha Omega Alpha Honor Medical Society Alumni Induction by the University of Rochester (2011)
- The Medical Students For Choice Alumni Award (2010)
- American Medical Student Association: Women Leaders in Medicine (2010)
- Rochester Business Journal: Forty Under 40 (2009)
- University of Rochester Pediatric Residency Program: Blue Wig Award (1998)

PUBLICATIONS/RESEARCH:

Hillard: Practical Pediatric and Adolescent Gynecology 2013. Chapter author: Unintended pregnancy: options and counseling

Coles MS, Makino KK, **Phelps RH**. Knowledge of Medication Abortion Among Adolescent Medicine Providers. J Adol Health. 2012;50:383-388.

Coles MS, Makino KK, **Phelps RH**. Medication abortion knowledge among Adolescent Medicine providers. Poster presentation. Society for Adolescent Health and Medicine Annual Meeting. March 30, 2011. Seattle, WA.

Coles MS, Makino KK, **Phelps RH**. Barriers and supports to medication abortion provision by adolescent medicine providers. Poster presentation. North American Forum on Family Planning. 2011. Washington, DC.

Phelps RH, Dream Team: The European Approach to Teens, Sex and Love, in pictures. Slate Magazine (2010)

Phelps RH., Schaff E.A., and Fielding S.L. Mifepristone abortion in minors. *Contraception* 64 (2001) 339-344.

TRAINING OF RESIDENTS AND MEDICAL STUDENTS:

- University of Rochester Department of OB/GYN residency program- abortion training (2010-present)
- University of Rochester Family Medicine Residency program- pregnancy options counseling and abortion shadowing (2014-present)
- University of Rochester Division of Adolescent Medicine- pregnancy options counseling and abortion shadowing for all pediatric and internal medicine-pediatric residents during required adolescent medicine rotation (2007-present)
- University of Rochester Department of Internal Medicine Residency Program- women's health elective (2007-present)
- University of Rochester Department of Family Medicine Chief Resident– abortion and ultrasound training to competency (2007-2009)
- University of Rochester Division of Adolescent Medicine fellowship- abortion and ultrasound training to competency for 2 fellows, month elective for all others (2007-present)
- Rochester General Hospital Department of OB/GYN Residency Program- abortion and ultrasound training to competency (2005-present)
- University of Rochester Department of Family Medicine Ryan Family Planning fellowship– abortion and ultrasound training to competency (2005-2006)

- University of Rochester School of Medicine- reproductive health summer externship-2 students per summer (2005-present)
- University of Rochester Department of Emergency Medicine Residency Program- first trimester transvaginal ultrasound (2005-2009)
- University of Rochester Pediatric Links with the Community (Pediatrics, Family medicine and Internal Medicine-Pediatrics residents)- pregnancy options counseling (2001-present)

NATIONAL INVITED LECTURES AND GRAND ROUNDS:

- Albany Planned Parenthood Day of Action: Rally Keynote Speaker (2018)
- American Academy of Pediatrics National Conference: Contraception for Teens: Tips, Tricks and Tools (2017)
- Alfred State University: One in 3: This Common Secret (2017)
- Albany Planned Parenthood Day of Action: Rally Keynote Speaker (2017)
- MSFC Annual Conference: (2016)
    - Plenary: Reflections on the Election and the Future of Women's Access to Reproductive Health Care
    - Emergency Contraception: It's Complicated! Providing Our Patients with a Last Chance to Prevent Pregnancy
    - One in 3: This Common Secret… How to have a Conversation about Abortion
    - Practitioners' Perspectives Panel
- University of Rochester Annual Anne E. Dyson Pediatrics Grand Rounds and Child Advocacy Forum (2016)
    - Panel Discussion: "Solutions Summit: Making Progress against Poverty, School Failure and Childhood Disease by Investing in Effective Teen Pregnancy Prevention"
    - Preventing Teen Pregnancy with Long-Acting Reversible Contraception (LARC)
- Duval County, FL: Teens and LARC: Fact, Fiction & First Line Contraception (2016)
- Duval County, FL: Providing Evidence Based Contraception for Adolescent Patients (2016)
- American Academy of Pediatrics National Conference: Evidence Based Contraception for Adolescents (2015)
- Indian Health Service National Webinar: Teens and LARC: Fact, Fiction & First Line Contraception (2015)
- Adolescent Reproductive and Sexual Health Education Project Annual Faculty Conference (2014)
    - EC Update
    - Evidence Based Contraception
    - LARC and Teens
- MSFC Annual Conference: (2013)
    - Beyond Abstinence and Risk: Exploring a New Paradigm for Teen Pregnancy Prevention
    - Evidence Based Contraception: Providing the Best Birth Control To Your Patients
    - Practitioners' Perspectives Panel
- National Abortion Federation Annual Conference: Beyond Abstinence and Risk: Exploring a New Paradigm for Adolescent and Young Adult Sexual Health (2013)
- Adolescent Reproductive and Sexual Health Education Project Annual Faculty Conference: Adolescent Medicine Specialists and Abortion Care: Overcoming Barriers (2013)
- American Medical Student Association Annual Conference (2013)
    - Abortion Provision: What It Means To Make It a Part of Your Career
    - Clinical Session: Manual Vacuum Aspiration Papaya Workshop
- Medical Students for Choice Annual Conference (2012)
    - Barriers to the Best Birth Control: What Stands in Women's
    - Evidence Based Contraception: Providing the Best Birth Control to your Patients
    - Practitioner's Perspectives Panel
- Champlain Valley Physician's Hospital Grand Rounds David McDowell Reproductive Health Lectureship Series: Lessons from Europe: Adolescent Pregnancy Prevention (2012)

NATIONAL INVITED LECTURES (cont.):

- Bassett Medical Center (2012)
  - Pediatric Grand Rounds: Evidence Based Contraceptive Care for Adolescents
  - Interdisciplinary Grand Rounds: Contraceptive Counseling: Dispelling Myths and Assessing Risk

- SUNY Upstate Department of Pediatrics Grand Rounds: Evidence Based Contraception for Teens (2012)
- American Medical Student Association Annual Conference: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2012)
- SUNY Upstate Pediatrics Grand Rounds: We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2011)
- Medical Students for Choice Annual Conference (2011)
  - Intrauterine Contraception: The BMW of Birth Control
  - Evidence Based Contraception: Providing the Best Birth Control to your Patients
  - Practitioner's Perspectives Panel
- Northern Ontario School of Medicine: Evidence Based Contraception (2011)
- Funders Network on Population, Reproductive Health and Rights
  Washington Briefing: Keynote address: Why I am an Abortion Provider (2011)
- Planned Parenthood of Southeastern Pennsylvania Annual Fundraiser: Keynote speaker: Why I am an Abortion Provider (2011)
- George Washington University School of Medicine: Current and Future Barriers to Abortion Access (2011)
- NAF Annual Conference Closing Plenary: "Owning Our Moral Center" (2011)
- PPFA National Leadership Conference: Why I am an Abortion Provider (2010)
- Medical Students for Choice Annual Conference (2010)
  - Keynote Address: An MSFCer's Personal Reflections: Current and Future Barriers to Abortion Access for Women
  - Evidence Based Contraception
  - Practitioner's Perspectives Panel

- American Medical Student Association Annual Conference: Post Abortion Care: Improving Maternal Mortality in the Developing World (2010)
- University of Rochester Department of OB/Gyn Grand Rounds: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2010)
- RGH Department of Pediatrics Grand Rounds : We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2009)
- Indian Health Service Adolescent Health Conference on the Navajo Nation (2009)
  - Contraception for Adolescents
  - Pregnancy Options Counseling for Teens
- University of Utah School of Medicine MSFC: Unplanned Pregnancy and Abortion in the U.S. (2009)
- ARHP Webinar: Choosing a Birth Control Method (2009)
- Medical Students for Choice National Leadership Training Conference (2009)
  - Keynote Address: Why I Provide Abortions
  - Abortion 101
  - Practitioner's Perspectives Panel
- University of Buffalo: American Medical Student Association: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)

- Western Regional Medical Students for Choice Conference: Keynote: Better than a Ban: Proven Practices to Decrease Abortion through the Prevention of Unplanned Pregnancy (2009)

NATIONAL INVITED LECTURES (cont.):

- American Medical Student Association Annual Conference: Fear and Loathing: How the U.S. Approach to Adolescent Sexuality Differs from the Rest of the World and What We Can Do About It (2009)
- University of Rochester Department of Pediatrics Annual Dyson Day Grand Rounds: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)
- University of Rochester Annual Anne E. Dyson Pediatrics Grand Rounds: We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2009)
- Vanderbilt School of Medicine Women's Health Week: We Can Do Better: Proven Practices in the Prevention of Unplanned Pregnancy (2008)
- Medical Students for Choice Annual Conference (2008):
  - The BMW of Birth Control: Implanon Workshop
  - Practitioner's Perspectives
  - How Late is "Too Late"? Considering Our Comfort with Gestational Age and Abortion
- Brown School of Medicine's Annual Reproductive Health Donor Lecture: We Can Do Better: Proven Practices to Decrease Abortion through the Prevention of Unplanned Pregnancy (2008)
- University of South Dakota: Better than a Ban: Proven Practices in the Prevention of Unplanned Pregnancy (2008)
- South Dakota State University: Better than a Ban: Proven Practices in the Prevention of Unplanned Pregnancy (2008)
- Children's National Medical Center: Options Counseling for Pregnant Adolescents (2008)
- Medical Students For Choice Annual Conference (2008):
  - EC Advanced Edition: The Controversy, the Evidence and Remaining Questions
  - Practitioner's Perspectives
  - Closing Plenary: Preventing Unplanned Pregnancy and Abortion in the U.S. and Canada: What Can We Learn from Europe?
- Medical Students For Choice Annual Conference (2007):
  - International Family Planning and Reproductive Health
  - Practitioner's Perspectives
  - How Late is "Too Late"? Considering Our Comfort with Gestational Age and Abortion
- American Medical Students Association 57th Annual Convention: The Right to Reproductive Choice: Bringing it Home to Our Curricula (2007)
- Medical Students for Choice Southeastern Regional Conference (2006):
  - Keynote Address
  - Abortion Provider Panel
  - Manual Vacuum Aspiration Workshop
- Medical Students for Choice National Leadership Training Program: Keynote address: Physicians as Leaders for Choice (2006)
- Southeastern Regional Medical Students for Choice Conference(2005):
  - Unplanned Pregnancy: Why is the U.S. Failing?
  - Preventing Maternal Mortality through Post Abortion Care
- American Academy of Physician Assistants Annual Conference: Advanced Gynecologic Procedures Workshop (2004)
- National Abortion Federation Mifepristone Early Options Series (2001):
  - Continuum of Patient Care
  - Patient Management
- National Abortion Federation Annual Conference: Advanced Medical Abortion Management (2001)

LOCAL INVITED LECTURES:

- Rochester General Hospital Department of OB/GYN Residency Program:
  - Unplanned Pregnancy and Abortion in the U.S. (annually 2005-present)
  - Medication Abortion (annually 2005-present)
  - Surgical Abortion Techniques (annually 2005-present)
- University of Rochester Department of Pediatrics Community Advocacy in Residency Education Program: How to Advocate through Speaking to the Media (annually 2002- present)
- MCTP Youth Leaders: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- Highland Family Medicine Leadership Track: Political Advocacy and Reproductive Health (2017)
- PPCWNY Rochester Donor event: Panel Discussion with Dr. Willie Parker (2017)
- Trillium Outreach Staff: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- NCJW: One in 3: This Common Secret (2017)
- Healthy Baby Network Annual Meeting Keynote: Life, Liberty & the Pursuit of Happiness: Why health care should be a right not a privilege (2017)
- URMC Pediatric Residency: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- MCTP Youth Workers: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- Delaware Pediatrics: Evidence Based Birth Control for Adolescents (2016)
- St. John Fisher College: School of Nursing: Teens and LARC: Fact, Fiction and First Line Contraception (2016)
- The WNY Women's Bar Association & SUNY Buffalo Law School: Whole Women's Health Care V. Cole: Will Administrative Regulations be the Undoing of Roe v. Wade? (2016)
- Pediatric Emergency Medicine Fellows Conference: Teens and LARC: Fact, Fiction and First Line Contraception (2016)
- Rochester City School District: Teens and LARC: Fact, Fiction and First Line Contraception (2016)
- MSFC SUNY Upstate: Evidence Based Contraception (2016)
- URMC Annual Pediatric Nursing Conference: STIs and Adolescents: Screening, Diagnosis and Treatment (2016)
- PPCWNY Annual Cocktail Reception: One in 3: This Common Secret (2016)
- Ithaca Ending Abortion Stigma: Pro-Choice and the Medical Professional: How to Live it. How to Support it (2016)
- PPCWNY Former Board Member Luncheon: Reflections on the Election and the Future of Women's Access to Reproductive Health Care (2016)
- Nurse Family Partnership: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- Roe v Wade Anniversary Panel (2015)
- A Path Appears: Panel discussion at The Little on teen pregnancy and poverty (2015)
- Perinatal Network: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- SOAR youth leaders: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- Pediatric Nursing Conference: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- University of Rochester Pediatrics Residency: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- Teens' Health and Success Partnership: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- NYPATH statewide webinar: Teens and LARC: Fact, Fiction & First Line Contraception (2014)
- AAP Contraceptive Updates for the Pediatrics Practice: Evidence Based Contraception (2014)
- The Susan B. Anthony Institute of Women and Gender Studies: Women's History Month Panel: The Last Clinic (2014)
- Chatterbox Luncheon Lecture: 1 in 3: Dispelling Myths About the "A" Word (2014)
- SUNY Upstate School of Medicine: Evidence Based Contraception (2014)

- Rochester Village Educators Network: LARC and Teens (2014)
- Perinatal Network: LARC and Teens (2014)
- Youth Services Quality Council: LARC and Teens (2014)

LOCAL INVITED LECTURES (cont.):

- March of Dimes Mothers To Be: Choosing the Best Birth Control Postpartum (2013)
- University of Rochester MSFC: Pregnancy Prevention: Lessons from Europe (2013)
- SUNY Upstate School of Medicine: Evidence Based Birth Control (2013)
- Onondaga County Pediatric Society: Barriers to Birth Control Access: What Stands in Teens' Way (2012)
- Finger Lakes Perinatal Network Forum: Evidence Based Contraception: How to Advocate for the Best Contraception for Women (2012)
- SUNY Upstate School of Medicine MSFC: Abortion Provider panel (2012)
- University of Rochester School Of Medicine MSFC: Advocating for Abortion Care (2012)
- SUNY Upstate School of Medicine MSFC: Evidence Based Contraception (2012)
- Finger Lakes Regional Perinatal Network Forum: Evidence Based Contraception (2011)
- Monroe County Case Workers: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2011)
- Rochester City School Summit on Condoms in Schools: Panelist (2011)
- University of Rochester Family Medicine: Evidence Based Contraception (2011)
- RIT Osher Pfaudler Lecture Series: We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2011)
- University of Rochester Department of Pediatrics Leadership Education in Adolescent Health Fellowship Seminar: Unplanned Pregnancy, Abortion, and Adolescents (annually 2002-2011)
- University of Rochester Adolescent Medicine Education Series:
    - Evaluation and Management of Abnormal Pregnancy (2007-2010)
    - Follow-up and Management of Medical and Surgical Abortion Complications (2007-2010)
- Orgasm Inc. "Talk Back at The Little" Panelist (2010)
- University of Rochester Medical Students for Choice Chapter: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2010)
- Rochester Area Tipsters Club: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2010)
- University for Rochester Internal Medicine- Pediatrics Noon Conference : Evidence Based Contraception (2010)
- Albion Correctional Facility : Evidence Based Contraception (2010)
- University of Rochester Medical Students for Choice Chapter: Introduction to surgical abortion techniques and Papaya workshop (2010)
- University of Rochester Med/Peds Noon Conference: Evidence Based Contraception (2010)
- Roe v. Wade Anniversary Celebration: Keynote: Protecting Our Future: A Report form the Front Lines (2010)
- Metro Council for Teen Potential: Contraception Update (2009)
- Nurse Family Partnership: Birth Control Update (2009)
- Batavia Community Lecture: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)
- University of Rochester Medical Students for Choice Chapter: Why I Became an Abortion Provider (2009)
- Building Healthy Children: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)
- Strong Memorial Hospital Inpatient Adolescent Psychiatric Department: Birth Control Workshop (2009)
- Threshold Adolescent Clinic : Options Counseling (2009)

- University of Rochester School of Medicine: 2nd year medical student OB/GYN core lecture: Medical Aspects of Abortion (2008-2012)
- University of Rochester Department of Pediatrics Noon Conference: Pregnancy Options Counseling (2009)

LOCAL INVITED LECTURES (cont.):

- University of Rochester Medical Students for Choice Chapter: Why I Became an Abortion Provider (2009)
- Lifetime Care Visiting Nurses: Evidence Based Postpartum Contraception (2009)
- University of Rochester Department of Family Medicine Residency lecture: Evidence Based Contraception: Providing the Best Birth Control to Your Patients (2008)
- Barnett Slepian's 10th Anniversary Memorial Service: Guest Speaker (2008)
- University of Rochester Department of Pediatrics Community Advocacy in Residency Education Program: Preventing Teen Pregnancy (2007 & 2008)
- University of Rochester Medical Students for Choice Chapter: Provider Panel (2008)
- Rochester General Hospital Department of OB/GYN Grand Rounds: Emergency Contraception and Adolescents (2007)
- Nazareth College Undergraduate Human Sexuality Course Guest Lecturer: Reproductive Health Care Access in the US (2007)
- The Western New York Council Of Child and Adolescent Psychiatry: Adolescent Reproductive Health Care Update (2007)
- University of Rochester Medical Students for Choice: Manual Vacuum Aspiration Papaya Workshop (2006)
- Nazareth College Graduate Global Feminism Seminar (2006):
  - Improving Maternal Mortality through Post Abortion Care
  - Unplanned Pregnancy and Abortion: Why is the U.S. Failing?
- SUNY Upstate Medical Students for Choice: Unplanned Pregnancy and Abortion: Why is the U.S. Failing (2006 & 2007)
- University of Rochester Medical Students for Choice: Physicians as Leaders for Choice (2006)
- University of Rochester Department of Pediatrics Community Advocacy in Residency Education Program: International Work that Makes a Difference: Keys to Success (2006)
- University of Rochester Department of Pediatrics Resident Conference: HPV and Pap Management (2006)
- University of Rochester Women's Caucus: Panel on female sexuality and the double standard (2006)
- University of Rochester Pediatric Resident Conference: Hormonal Contraception in Adolescents (2006)
- University of Rochester Department of Pediatrics Resident Conference: Unplanned Pregnancy and Abortion in Adolescents (2006)
- SUNY Upstate Medical University Department of OB/GYN Grand Rounds: Unplanned Pregnancy and Abortion in the U.S. (2005)
- University of Rochester Department of Family Medicine Reproductive Health Program Seminar Series (weekly 2001-2005):
  - Week 1: Contraception: Evidence Based Use of Oral Contraceptives, Emergency Contraception, and New Contraceptive Technologies
  - Week 2: Vaginal Ultrasound: Normal Anatomy, Normal and Abnormal Pregnancy
  - Week 3: Medical Abortion: Regimens, Counseling, and Patient Management
  - Week 4: Surgical Abortion: Surgical Technique, Complications, Tissue Examination and International Post Abortion Care
- University of Rochester Department of OB/GYN 3rd year medical student lecture: Introduction to Abortion (monthly 2003-2005)
- Planned Parenthood of the Southern Finger Lakes: First Trimester Ultrasound: Lecture and Clinical Practicum (2004)

- Planned Parenthood community lecture: Politicians Prescribing Women's Health Care without a License (2004)
- University of Rochester Medical Students for Choice: Improving Maternal Mortality in the Developing World through Post Abortion Care (2004)

LOCAL INVITED LECTURES (cont.):

- Planned Parenthood Chatterbox Society Luncheon: Understanding Teen Sexuality (2003)
- University of Rochester Medical Students for Choice: Preventing Teen Pregnancy (2003)
- 30th Anniversary of Roe v. Wade (Rochester, NY): Keynote Address (2003)
- University of Rochester Department of Pediatrics Resident Conference: Unplanned Pregnancy and Abortion in Adolescents (2003)
- University of Rochester Department of Family Medicine: Unplanned Pregnancy in Adolescence (2001)

- University of Rochester Amnesty International Panel: The Impact of the "Global Gag Rule" (2001)
- University of Rochester School of Medicine: Interviewing the Adolescent Patient (2001)
- University of Buffalo Medical Students For Choice: Introduction to Mifepristone Medical Abortion (2001)
- University of Rochester Pediatric Resident Conference: Hormonal Contraception in Adolescents (2001)
- University of Rochester Health Services: Introduction to Medical Abortion (2001)
- Roe v Wade Anniversary Panel: Medical Abortion and Emergency Contraception (2001)
- Annual Nurse Practitioner Conference: Adolescent Contraception (2000)

MEDIOGRAPHY:

- NPR WXXI Evan Dawson Connections: Pro-choice advocates discuss a possible post-Roe v. Wade world (2018)
- NPR WXXI Evan Dawson Connections: Dr. Willie Parker and Reproductive Rights (2017)
- NPR WXXI: "When to Get Your Next Mammogram or Cervical Cancer Screening? Most Women Don't Know" (2016)
- NPR WXXI: Radio Guest on Connections w/ Evan Dawson: "The Future of Women's Health if Roe v. Wade is Overturned" (2016)
- Syracuse Post Standard Letter to the Editor "Family planning is key to solving the world's problems" (2016)
- Rochester Democrat and Chronicle: Guest Essay "Info to know about Zika" (2016)
- Vox: "The biggest myth about abortion that you probably believe is true" (2016)
- Syracuse Post Standard Commentary: "Congress must reject move to gut family planning aid" (2015)
- NPR WXXI: Radio Guest on Connections w/ Evan Dawson: Access to Abortion (2014)
- Time Warner Cable: LARC and Teens (2014)
- Slate Magazine: Quoted in "The Cleverest New Anti-Abortion Law" (2013)
- NPR WXXI radio interview: EC over the counter for teens (2013)
- Syracuse Post Standard Letter to the Editor "Stay Healthy by getting STD tests and treatment" (2012)
- ABC News online: Quoted in "Teens Should be Offered IUDs, Top Doctors Group Says" (2012)
- Rochester Democrat and Chronicle Letter to the Editor "Access to Contraception Good for Women's Health" (2011)
- Syracuse Post Standard Letter to the Editor "Stop Playing Politics with Women's Lives" (2011)
- Syracuse Post Standard Letter to the Editor "Medication Abortion Can Save Lives of Women" (2010)
- NPR Pat Morrison Show "The New Abortion Providers" (2010)
- New York Times Magazine: Profiled in "The New Abortion Providers" (2010)

- Syracuse Post Standard: In defense of Roe v. Wade: Dr. Rachael Phelps, associate medical director of Planned Parenthood of the Rochester/Syracuse Region, comments on 37th anniversary of Supreme Court ruling (2010)
- Youth Pages: Shifting the Paradigm of Adolescent Sexual Health (2009)

MEDIOGRAPHY (cont.):

- Rochester Democrat and Chronicle: Guest editorial on the New York State Reproductive Health and Privacy Protection Act (2008)
- WHEC Channel 10: New York State Reproductive Health and Privacy Protection Act (2008)
- The Citizen, Auburn, NY: Editorial on federal abortion ban (2007)
- In Good Health: "IUDs and Implanon: Birth Control's Best Kept Secrets" (2007)
- Rochester Democrat and Chronicle Friday Face-off: Guest editorial and on-line debate on federal abortion ban (2007)
- Syracuse University Newspaper interview: Implanon (2007)
- Syracuse University Newspaper interview: HPV (2006)
- In Good Health interview: Abortion Access in Western New York (2006)
- In Good Health interview: Medication Abortion (2006)
- Syracuse Post Standard: Editorial on pharmacist provision of emergency contraception (2005)
- WHEC Channel 10: Teens and sex (2005)
- R News: HPV and HSV in adolescents (2004)
- Rochester Democrat and Chronicle interview: Herpes (2004)
- R News: Teen pregnancy (2003)
- Syracuse NPR: Partial birth abortion (2003)
- WROC Channel 8: Teen sexuality (2003)
- WHEC Channel 10: Condoms and HIV(2003)
- WARM radio Hillside Family Forum: Planning a healthy pregnancy (2003)
- WROC Channel 8: Jordan Teen Center's future (2002)

MEDIA TRAINING:

- Fellowship in Family Planning Communications Workshop (2012)
- PPFA Media Training Workshop at NMC (2010)
- Medical Students for Choice Media Training Workshop (2006)
- National Abortion Federation Media Training Workshop (2001)

INTERNATIONAL EXPERIENCE:

- **Kenya**: Policy work to legalize abortion with IPAS (2001)
- **Bangladesh**: Post-abortion care clinical trainer with Engender Health /AVSC International (2001)
- **Philippines**: Post-abortion care clinical trainer with Engender Health / AVSC International (2001)
- **Pakistan**: Post-abortion care clinical trainer with Engender Health / AVSC International and International Rescue Committee in Afghan refugee camps in Tribal Belt of Northwest Frontier Province (2000)
- **Kenya**: Introduction to post-abortion care and the management of complications of illegally induced abortion with IPAS (2000)

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF RANDY PUMPHREY, D.MIN., LPC, BCC, SENIOR DIRECTOR OF BEHAVIORAL HEALTH, WHITMAN-WALKER HEALTH, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Randy Pumphrey, declare as follows:

1. I am the Senior Director of Behavioral Health at Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health (Whitman-Walker). After earning a B.S. in American Studies, I received Masters of Divinity and Doctor of Ministry degrees from Wesley Theological Seminary. I initially worked as a Board Certified Chaplain at St. Elizabeth's Hospital (which became the Commission on Mental Health Services for the District of Columbia and the Psychiatric Institute of Washington), and subsequently received my Professional Counselor Licensure in 1997. I have worked in mental-health and substance-use-disorder treatment since 1984, initially as an intern at Washington Hospital Center, then with St. Elizabeth's Hospital. In 1998 I became the Clinical Director of the Lambda Center, a joint partnership between the Psychiatric Institute of Washington and Whitman-Walker Clinic. I joined Whitman-Walker's staff in 2007 as the Manager of Mental Health Services, and became Senior Director of Behavioral Health in 2015. In addition to managing Whitman-Walker's behavioral-health services, I maintain a panel of patients for whom I provide direct care.

2. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

3. As the Senior Director of Behavioral Health, I oversee Whitman-Walker's robust portfolio of mental-health services, and substance-use-disorder-treatment services. Our mental-health services include individual and group psychotherapy, psychiatry, and peer counseling. For individuals struggling with substance misuse, we offer individual and group counseling and support, and Medically-Assisted Treatment (MAT). In 2018, we provided mental-health or substance-use-disorder-treatment services to 2,342 patients. Our psychiatrists, psychologists, licensed psychotherapists, and trained peer counselors have a special mission to the lesbian, gay, bisexual and transgender (LGBT) community, and also to individuals living with HIV and their families and caregivers.

4. Many if not most of the individuals in our very diverse behavioral-health-patient population face considerable stigma and discrimination—as people living with HIV, as sexual or gender minority people, as people of color—and many of them struggle with internalized stigma

and with acute or lower-level but persistent trauma. Many of them have experienced difficulty in finding therapists or other mental-health or substance-use-disorder professionals who are understanding and welcoming of their sexual orientation, gender identity, or struggles with HIV. We frequently receive phone calls and other inquiries from people seeking non-discriminatory, welcoming assistance with their substance use, depression, anxiety, or other challenges. Many of these individuals have suffered from traumatizing encounters with hostile or disapproving healthcare professionals.

5. All Whitman-Walker employees, and all volunteers who serve as peer counselors or otherwise are involved in any way with our behavioral-health services, are asked to commit to our mission, which is to be welcoming to and understanding of every patient, regardless of sexual orientation, gender identity, race or ethnicity, income or educational background, or life experience. We welcome staff and volunteers from a wide range of religious, spiritual, cultural, and philosophical perspectives, but patient needs must always be paramount. The message of the Denial-of-Care Rule, that the personal beliefs or feelings of a provider or other healthcare staff member can justify refusal to participate in any aspect of their job or of the care of any patient, threatens to substantially harm patients who already are vulnerable to stigma and discrimination. The message that healthcare staff members' personal preferences or beliefs take priority over patient needs also violates fundamental professional ethical standards that apply to all licensed therapists, psychologists, psychiatrists, and substance-use-disorder-treatment professionals, including myself.

6. Behavioral-health treatment assumes, and requires, trust between the patient and provider, and full and frank disclosure by the patient of all potentially relevant information about their life, including their sexual orientation, sexual and affectional experiences, and gender identity. I, and the providers that I supervise at Whitman-Walker, frequently work with patients who have concealed some or all aspects of their sexual and affectional orientation or history, or gender identity, from non-Whitman-Walker therapists or other behavioral health providers, often to the patients' harm. The Denial-of-Care Rule will very likely discourage LGBT people and others needing treatment from fully disclosing relevant information to their therapists or counselors, or to

those helping them with substance-use issues, which will likely increase their distress and undercut the effectiveness of their treatment.

7. For persons with a minority, traditionally stigmatized sexual orientation—such as gay, lesbian, or bisexual—or whose gender identity is transgender or gender-nonconforming, competent mental-health services, or services for treatment of substance-use disorders, require an accepting—indeed, an affirming—attitude towards their sexual orientation or gender identity by their provider. Discriminatory behavior, statements, or attitudes expressed by a provider are a tremendous barrier to effective care. It is critical that a patient feel empowered and supported in fully disclosing their sexuality and gender identity to their counselor, therapist, psychologist, or psychiatrist. Without a trusting patient-provider relationship and full disclosure of all possibly relevant feelings and facts by the patient, effective treatment is unlikely to be possible. This is critical for good medical care as well. In my work with patients as a behavioral-healthcare provider, I have counseled patients about the importance of full disclosure of their sexuality and gender identity to their doctor and other medical personnel.

8. Even before the Denial-of-Care Rule was proposed or issued, I and the providers and other behavioral-health staff that I supervise at Whitman-Walker have learned from patients about many incidents of discrimination or mistreatment in other behavioral-health settings that were motivated by the personal beliefs of providers or other staff. For instance:

a. A transgender teenager was hospitalized after a suicide attempt. Hospital staff refused to address the teenager by the young person's preferred pronouns and gender throughout the teenager's hospital stay. This was experienced by the teenager as disapproval and contempt for the young person's gender identity. This discrimination exacerbated the teenager's acutely fragile state when the teenager was so desperately in need of healthcare providers' support and healthcare services that were free of judgment.

b. A facility that specializes in inpatient mental health and substance-use-disorder treatment, and which has explicit non-discrimination policies,

nonetheless has significant trouble from nurses on weekend shifts (when the facility uses pool nurses rather than regular employees), who express strong disapproval of LGBT patients based on their religious beliefs or cultural upbringing. Despite the facility's non-discrimination policies, LGBT patients encounter hostility, expressions of disapproval, and lack of responsiveness to their needs or requests from these nurses. For patients hospitalized for mental or substance-use disorders, these experiences can activate their disorders.

c. A Muslim woman patient who also identifies as Lesbian was hospitalized for suicidal ideation based on depression and anxiety from PTSD at an inpatient facility. While processing her discharge, a nurse at the facility, who identified herself as Christian, stated that she believed that 911 was a blessing since it woke up Christians about how bad Muslims are. The client reported feeling very exposed and vulnerable and told the nurse that not only was she Muslim, but she herself had been the victim of terrorism. The encounter with the nurse exacerbated the patient's depression and anxiety.

d. As I previously noted, behavioral health staff that I supervise often receive calls or other communications from LGBT persons expressing desperation about finding a therapist or substance use professional who will not discriminate against them because of their sexual orientation or gender identity.

e. Our behavioral-health providers who regularly interview our transgender patients to assess their stage of gender transition and readiness for gender-affirming surgical procedures, or who provide psychotherapy for these patients, report that the large majority of the patients they meet with—as many as four out of every five—report incidents of mistreatment or discrimination by healthcare providers and staff at hospitals, other clinics, doctor's offices, and other facilities.

9. These incidents reveal that many healthcare providers and other staff harbor explicit or implicit biases against LGBT people. Because of legal requirements, healthcare facility non-discrimination policies, and professional norms, many of them have kept their personal beliefs and feelings in check. By empowering healthcare staff to think that they have the legal right to act on their personal beliefs, even at the expense of patient needs, the Denial-of-Care Rule is very likely to result in many more incidents of discrimination and greater harm to LGBT individuals struggling with mental health or substance use issues, including the patients whom I treat and whose treatment I supervise.

10. I and Whitman-Walker provide referral services for patients who need specialist care that we do not provide—including inpatient behavioral healthcare as well as specialist medical care. We also receive many outside requests for recommendations for LGBT-welcoming, non-discriminatory therapists and substance-use professionals in the community. The Denial-of-Care Rule will make it significantly more difficult for us locate and monitor appropriate referrals, and patients will suffer as a result. Even more concerning, our behavioral-health patients who may need hospitalization for a mental-health or substance-use crisis, or may need specialist medical care, will be in greater danger of encountering discrimination at inpatient behavioral health facilities or when they seek medical care outside Whitman-Walker—which may make their care at Whitman-Walker more difficult and perhaps less successful.

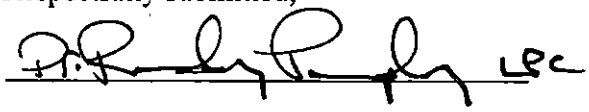
11. Whitman-Walker is a certified healthcare provider under the Medicare program and also under the District of Columbia's Medicaid program. Healthcare providers with Whitman-Walker, are credentialed under the Medicare program and also under the District of Columbia's Medicaid program. Both programs are overseen by HHS's Center for Medicare and Medicaid Services (CMS). These funds and related benefits account for a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients, especially because a large portion of the population that we serve relies heavily on Medicaid and Medicare for its healthcare needs. A loss of Medicare or Medicaid funding as a possible sanction under the Denial-of-Care Rule resulting from enforcement of Whitman-Walker's nondiscrimination mandate, which applies to all of our

healthcare providers and staff, would result in service reductions if not closure of our programs in their entirety. As a clinician who provides care under these programs, I have a reasonable fear not only that Whitman-Walker's continued certification under these vital programs might be endangered, but also that I could individually be sanctioned for enforcing Whitman-Walker's mission with respect to the providers and other staff that I supervise.

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

Dated: June 4, 2019

Respectfully submitted,



Randy Pumphrey

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF NASEEMA SHAFI, CHIEF EXECUTIVE OFFICER, WHITMAN-WALKER HEALTH IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Naseema Shafi, declare as follows:

1. I am Chief Executive Officer of Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health (Whitman-Walker). I received a J.D. degree from the University of Maryland School of Law in 2005. I have served at Whitman-Walker for more than twelve years, first as a Compliance Analyst and Director of Compliance; then Chief Operating Officer, and subsequently Deputy Executive Director. I assumed the CEO position in January 2019. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

2. Whitman-Walker was founded in 1973, and legally incorporated in 1978 to respond to the healthcare needs of the lesbian, gay, bisexual and transgender (LGBT) community. Our team provides a range of services, including medical and community care, transgender care and services, behavioral-health services, dental services, legal services, insurance-navigation services, and youth and family support in Washington, DC. The mission of Whitman-Walker is to offer affirming community-based health and wellness services to all with a special expertise in LGBT and HIV care. We empower all persons to live healthy, love openly, and achieve equality and inclusion. In 2018, Whitman-Walker provided healthcare services to more than 20,700 individuals.

3. Whitman-Walker's patient population is quite diverse and reflects Whitman-Walker's commitment to being a healthcare home for individuals and families that have experienced stigma and discrimination, or have otherwise encountered challenges in obtaining affordable, high-quality healthcare. In calendar year 2018, 58% percent of our healthcare patients and clients who provided their sexual orientation identified as lesbian, gay, bisexual, or otherwise non-heterosexual, and 9% of our patients and clients—more than 1,800 individuals—identified as transgender or gender nonconforming.

4. We at Whitman-Walker also employ dynamic and diverse employees who reflect the diversity of the populations we serve. At the present, we employ 284 medical and behavioral-health providers and support staff, medical-adherence and insurance-navigation professionals, community health-workers, lawyers and paralegals, researchers, administrators, and professionals working in finance, development, human resources, and external affairs. We have employees of

many races, ethnicities, genders, sexual orientations, religious and spiritual traditions, and life experiences. What unites us all is our shared commitment to creating and sustaining a welcoming, inclusive healthcare home for everyone who seeks our care.

5. The Denial-of-Care Rule empowers religiously motivated discriminatory behavior by healthcare providers that would be corrosive of fundamental professional standards, threaten Whitman-Walker's patients' welfare, and place significant strain on our ability to fulfill our critical mission. The Denial-of-Care Rule's message that healthcare providers could be legally entitled to refuse or restrict care, based on their personal religious or moral beliefs, flies in the face of the standards and ethics of every healthcare profession, and would sow confusion and undermine the entire healthcare system. Healthcare is a fundamentally patient-oriented endeavor and the Denial-of-Care Rule's sweeping right to avoid "complicity," with complete disregard for the harm that might result to others, is legally, morally, and medically unsupportable, and is fundamentally corrosive to healthcare providers like Whitman-Walker.

6. As written, provisions in the Rule that empower healthcare personnel to refuse to provide care based on their personal beliefs apply to entities that receive any grant, contract, loan, or loan guarantee under the Public Health Service Act (PHSA); any Health and Human Services-administered grant or contract for biomedical or behavioral research; or funds for any health service program or research activity under any HHS-administered program. Section 88.3(a)(1). "Health service program" is defined so broadly that it seems to cover any health or wellness services or other activities. Section 88.2. As a Federally Qualified Health Center, Whitman-Walker receives grants and other financial support under the PHSA. We receive substantial funding under the Ryan White Care Act, which is administered by HHS. The majority of our third-party revenues for medical and behavioral-health services are reimbursed through Medicaid and Medicare, which are HHS-administered programs. As Dr. Henn, our Chief Health Officer, discusses in her Declaration, Whitman-Walker receives major funding for biomedical and behavioral research from HHS entities.

7. We are particularly concerned that the Denial-of-Care Rule is written so broadly that it would empower healthcare personnel to deny care based on personal objections to LGBT people.

HHS expressly leaves open the possibility that LGBT care might be denied, and that it might interpret the legal right to refuse to assist in "sterilization" procedures to include care for transgender patients.

8. The impact on Whitman-Walker and its patients of a broad, legally unsupported expansion of healthcare providers' refusal rights would be particularly drastic. Providing welcoming, high-quality care to the LGBT community and people living with HIV is at the core of Whitman-Walker's mission. These are communities that are in particular need of affirming, culturally competent care because of the widespread stigma and discrimination they have experienced and continue to experience. By encouraging employees of hospitals, health systems, clinics, nursing homes, and physician offices to express and act on their individual beliefs, rather than focusing on patients' specific healthcare needs, the Rule invites chaos to the overall healthcare system and undercuts Whitman-Walker's operations. Specifically, the Rule would create real harm to the sustainability of Whitman-Walker by consuming precious resources with unnecessary work-arounds and potential litigation; and increasing uncompensated patient care volume. This rule may also raise the specter of misalignment within our work-force if we have staff whose religious beliefs may cause them to wish to deny care themselves. Whitman-Walker's very mission would be at risk of being frustrated in such an environment.

9. Whitman-Walker strives to ensure that all staff understand that one's personal, religious, and moral views are irrelevant to Whitman-Walker's patients' needs and mission. It would be very difficult, if not impossible, for Whitman-Walker to accommodate individual healthcare staff who might object to providing basic aspects of Whitman-Walker's services—for example, providing treatment for gender dysphoria, counseling pregnant clients on their pregnancy termination options, HIV-prevention-related counseling, harm-reduction care for substance users, or healthcare services to lesbian, gay, or bisexual patients—without fundamentally compromising its mission and the quality of patient care.

10. The Denial-of-Care Rule announces a very broad definition of a healthcare worker's alleged right to refuse to "assist in the performance" of care to which they object for personal reasons. HHS' definition is so broad that it seems to encompass providing referrals and information

to patients and any assistance receiving care to which the employee objects, at Whitman-Walker or any place else. This could affect not only our physicians, physician assistants, nurses and nurse practitioners, and therapists, but medical assistants, persons conducting HIV and Sexually Transmitted Infection testing and counseling, front-desk staff, and persons who provide scheduling services and information over the phone. Many of Whitman-Walker's LGBT patients and patients living with HIV have experienced substantial stigma and discrimination and are appropriately concerned with being welcomed or not welcomed in a healthcare setting. If they encounter discrimination at Whitman-Walker from any staff person at any point, Whitman-Walker's reputation as a safe and welcoming place would be undermined. There are multiple "patient touches" in Whitman-Walker's system as in any healthcare system: from the staff person answering the phone or sitting at the front desk to the physician to the pharmacy worker. Because each of these interactions with Whitman-Walker staff can convey respect and affirmation or disrespect and rejection, they have a direct impact on patients' engagement in their own healthcare and can thus, depending on their nature, either promote or undermine patient health.

11. Consistent with its commitment to welcoming and nondiscriminatory healthcare, Whitman-Walker's growing work force is very diverse. Encouraging individual employees to think that their discriminatory beliefs can prevail over their duties to patients—and to their fellow employees—would introduce confusion and discord into Whitman-Walker's staff as well as pose barriers to patient care. We have had situations in which an employee has expressed personal religious or moral discomfort or disagreement with homosexuality or bisexuality; or with healthcare intended to help a transgender person transition from the sex they were assigned at birth to their own gender identity; or with a patient's drug use or sexual behavior. In such situations, we emphasize to the employee that patient needs, and maintaining a respectful and welcoming environment for every patient, are paramount and must prevail over personal beliefs of staff. If individual employees felt legally empowered to refuse to provide care, and Whitman-Walker were limited in how it could respond to such situations, the harm to our mission could be devastating.

12. The harm to Whitman-Walker's operations, finances, and employee morale would be particularly complicated because Whitman-Walker, like many healthcare entities, has a quasi-

unionized workforce. Attempts to accommodate, for instance, one employee's unwillingness to work with LGBT patients or women seeking reproductive healthcare would impose burdens on and increase workloads for other staff, and likely would result in grievances filed by other employees affected by the conscience accommodations. This is especially true where the Denial-of-Care Rule limits Whitman-Walker's options for maintaining policies and procedures for requesting religious or moral-based accommodations in advance to ensure that Whitman-Walker has sufficient staff available to meet patients' needs. Whitman-Walker would incur substantial financial costs and drains on staff time that would substantially challenge its ability to care for a growing patient load. Whitman-Walker, for example, would have to hire additional human resources staff to address the increase in accommodation requests as well as grievances related to hostile work environments resulting from religious-based objections to performing core job responsibilities and increased workloads for other staff.

13. There would also be increased difficulty in determining whether job applicants will be unwilling to perform essential job functions, which seems likely to undermine Whitman-Walker's philosophy of fostering a diverse workforce. Whitman-Walker's current recruiting process is developed to ascertain whether a job applicant would provide healthcare consistent with Whitman-Walker's mission to establish a welcoming, nondiscriminatory environment for all patients and staff, without violating the law. Whitman-Walker emphasizes these principles of inclusion with language that reflects diversity principles in our job descriptions. If an applicant appears to draw lines based on religious or moral principles that are inconsistent with Whitman-Walker's mission, hiring managers will be in a complex position of trying to ascertain whether such applicants could end up causing harm to patients given the Denial-of-Care Rule's prohibition on inquiring about these issues directly. Moreover, adherence to our mission is emphasized in our new employee orientation process, and all employees are currently required to sign a statement committing to our values of inclusiveness, non-judgment, and fully caring for every patient and for fellow staff. Providing care in a non-discriminatory manner, putting aside people's individual religious beliefs, is a core part of Whitman-Walker's job criteria for new applicants. Changing those criteria thwarts Whitman-Walker's mission.

14. The Rule's provisions regarding the accommodation of staff with personal "conscience" objections to any portion of our mission, our services, or our patients, would cause major damage to our operations and patients. My understanding is that the Rule would frustrate the important process that many mission-based organizations like Whitman-Walker have: an assessment of employees' alignment with their mission. The Rule provides that, after hiring, we could ask staff to inform us of their objections, but the objecting staff must consent to our accommodation offers and may unilaterally reject any proffered accommodations. These provisions appear to impose one-sided obligations on the employer that are unworkable for a healthcare center: there does not appear to be any requirement that the objecting employee be reasonable or willing to compromise, and the Rule expressly declares that the employer cannot object to an accommodation that would impose an undue hardship on the employer or that would compromise patient care. Furthermore, the Rule does not provide for any emergency exception to ensure that all patients receive immediate, life-saving care, regardless of staff members' religious beliefs.

15. More specifically, the accommodation provisions are not feasible for Whitman-Walker for a number of reasons. First, requiring us to devote our limited financial resources to hiring additional staff, in order to ensure that patient care does not suffer from accommodating some staff's personal objections, would almost inevitably force us to reduce our existing services. Second, the Rule states that an accommodation cannot "exclude [a] protected [person] from fields of practice on the basis of their protected objections." Section 88.2 (definition of "Discriminate or Discrimination"). Given Whitman-Walker's commitment to providing affirming healthcare to all, a healthcare provider or any other employee with objections to, for instance, LGBT patients, could not be maintained in any patient-facing role, which likely would "exclude" them from a "field of practice." Subjecting any of our patients to the risk of interactions with any Whitman-Walker staff member who expresses opposition or hostility to them or their course of treatment would result in irreversible damage to our reputation and would likely be harmful to the patient's well-being. Third, the rule provides that staff can be asked to specify their objections only once per year "unless supported by a persuasive justification." As a result, Whitman-Walker could be faced with unexpected objections in the intervening twelve months, based on newly emergent patient needs,

otherwise unanticipated situations, or an employee's evolving religious beliefs. The inability to know of objections in advance will interfere with Whitman-Walker's provision of services to its patients, either by forcing Whitman-Walker to divert resources to redundant staffing or by leaving it without an employee willing to deliver appropriate care. Fourth, any healthcare professional or other staff person may be needed to respond to an emergency situation beyond the scope of their regular duties—for instance, responding to a patient who is overdosing, or who is in acute distress or in a crisis situation that may challenge the staff person's personal comfort level. In addition, as I have already noted, efforts to accommodate an individual provider's or other staff person's personal objections to particular patients, procedures or job-related activities will inevitably decrease staff morale, increase conflict between staff members, and likely lead to grievance procedures in our quasi-unionized workplaces.

16. HHS has also defined the "workforce" covered by the Rule to include not only employees, but also contractors, trainers, and even volunteers. This interpretation is even more disruptive of our operations and patient services. For many years, Whitman-Walker has offered walk-in sexually-transmitted-infection testing, treatment and counseling, in a program that is largely staffed by volunteer healthcare professionals. In 2018, that program served more than 1,700 individuals. We also rely extensively on trained volunteers for our HIV testing and counseling services, our peer support counseling services, and our Legal Services Department. Many of the thousands of patients and clients receiving these services every year are in very vulnerable situations, and the possibility that our staff would have limited control over how these volunteers chose to deliver services, and how they might interact with patients and clients, threatens critical components of our mission.

17. Whatever its effect on Whitman-Walker ability to provide affirming, non-discriminatory care to all of our own patients, it is quite likely that the Denial-of-Care Rule will result in a substantial increase in discrimination against LGBT individuals by healthcare providers and institutions outside of Whitman-Walker. Dr. Henn's and Dr. Pumphrey's declarations describe a number of incidents of discrimination that our patients have encountered in other healthcare facilities and offices that our patients have reported to our medical and behavioral health providers.

In addition, the lawyers in our Legal Services Department learn of similar incidents from their clients.

18. Since the mid-1980s, Whitman-Walker has had an in-house Legal Services Department. Our attorneys and legal assistants provide information, counseling, and representation to Whitman-Walker patients, and to others in the community who are LGBT or living with HIV, on a wide range of civil legal matters that relate directly or indirectly to health and wellness – including access to healthcare and discrimination based on HIV, sexual orientation, or gender identity. They also oversee legal clinics, staffed largely by volunteer attorneys, which assist transgender and gender-nonconforming individuals to change their legal names and to correct their birth certificates, driver's licenses, passports, Social Security records, and other identity documents to reflect their new names and actual gender identities. Over the years, Whitman-Walker Legal Services staff and volunteer attorneys have encountered many instances of discrimination by healthcare providers and their staff based on the sexual orientation or gender identity of patients. Recent examples include:

a. As recounted in Dr. Henn's Declaration, Whitman-Walker transgender patients seeking gender transition-related surgery have been rejected at local hospitals, even for procedures that are often performed on non-transgender patients (such as breast surgery), and even though the patients had health insurance or were otherwise able to pay for the procedures.

b. A transgender woman who was about to have surgery at a Washington, DC hospital for an inner ear condition (unrelated in any way to her transgender-related healthcare) was confronted and harassed by hospital staff objecting to her gender identity. She was repeatedly and intentionally referred to as "he" and as "a man" by staff in the radiology department when she went for a pre-surgical scan; by desk staff at the surgery center; and by the nurse preparing her for surgery. Several nurses talked about her with each other and laughed. One staff person refused to talk with the patient when she addressed them. Even the anesthesiologist who she was expected to entrust with her life in one of her most vulnerable moments before surgery, mocked

her and intentionally referred to her as a man. Healthcare providers are supposed to provide comfort to patients when they seek healthcare. Instead, the staff increased her fear just before her surgery because they showed complete disrespect and lack of care for the patient's health and well-being.

c. Another transgender woman went to the office of an ophthalmologist at the same medical center for an eye exam. She arrived on time, filled out the initial paperwork, and then waited for about 45 minutes without being called for her appointment. The patient went to the desk to inquire, and was treated rudely by the staff. The staff then arbitrarily called a security guard to eject her from the office. As the patient spoke to the security guard, one of the clinic staff came to her and said, loudly and offensively, "Sir, your kind needs to go away. We're not serving your kind." She complained to the Office of the Chief Medical Officer and was eventually seen by the ophthalmologist on another day, after considerable effort by her and Whitman-Walker staff.

d. A transgender woman was seen by a medical provider at Whitman-Walker, who examined her and determined she might have broken her ankle. She was sent to the Emergency Room at a Washington, DC hospital. She identified herself to the ER check-in staff as a woman and presented a driver's license that contained a female gender marker. She then waited for a number of hours (she remembers five or six) without being examined. When she inquired about the delay, she was treated rudely and mis-gendered by ER staff. She was finally called from the waiting area, but was taken to the men's dressing room, rather than the area for women patients, to undress and put on a gown for a scan. During the four or more hours before she received the scan, examination and treatment, she suffered very significant physical pain.

e. Another LGBT patient with end-stage renal disease, was confronted by a staff person at the dialysis clinic the patient attends regularly for care. The employee expressed a strong dislike for LGBT people and objected to being involved in the patient's care at the clinic.

19. The Denial-of-Care Rule will invite an increase in discriminatory experiences for LGBT patients seeking healthcare services, resulting in harm to the patients and community that Whitman-Walker serves.

20. Escalating healthcare discrimination and fear of such discrimination, resulting from the Denial-of-Care Rule, is also likely to result in increased demand for Whitman-Walker's healthcare services, which will present considerable operational and financial challenges. Many of Whitman-Walker's healthcare services lose money due to low third-party reimbursement rates and indirect cost reimbursement rates in contracts and grants which are substantially less than Whitman-Walker's cost of service. Increased demand for Whitman-Walker's healthcare services, driven by increased discrimination and fear of discrimination outside of Whitman-Walker, would exacerbate that pressure. We likely will be called upon to see more patients, and that patient care does not financially cover itself. As a result, Whitman-Walker may not be able to meet the increased demand and sustain the additional financial burdens resulting from an increased load of patients who either fear discrimination elsewhere or who were discriminated against or denied services at other institutions.

21. At the same time, given Whitman-Walker's mission to provide healthcare to marginalized communities, including the LGBT community and people living with HIV, Whitman-Walker needs to increase its education programs and community outreach to help those affected by the Denial-of-Care Rule find the healthcare services that they need and assist them with their trauma resulting from the Rule. Whitman-Walker needs to continue informing the community about its commitment to serving all patients in a non-discriminatory and welcoming manner and notify its patients that the Denial-of-Care Rule will not change Whitman-Walker's commitment to providing exceptional healthcare services to all members of the community. Whitman-Walker will continue fighting for its patients' rights, including, for example, advocating on behalf of transgender patients

who seek treatment for gender dysphoria, but who are rejected due to providers' religious or moral objections to treating such patients. As a result of the Denial-of-Care Rule, Whitman-Walker will also need to devote more resources to working with outside providers and organizations to remind them of the importance of providing healthcare to all patients on non-discriminatory terms.

22. The Denial-of-Care Rule also adversely impacts Whitman-Walker by necessitating a diversion and reallocation of resources in order to provide referrals to patients that it does not have the resources to treat either because Whitman-Walker has reached its capacity for new patients (especially in the behavioral-health departments) or because the patient requires treatment in a specialty that Whitman-Walker does not have. These types of referrals are routine at Whitman-Walker where its focus is on primary care and HIV-specialty care. The Denial-of-Care Rule will make it significantly more difficult and resource-intensive for us to locate, monitor, and provide appropriate referrals. With an increase in referral requests as a result of the Denial-of-Care Rule, Whitman-Walker will need to allocate additional staff time to pre-screen service referrals to ensure that staff are sending patients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to Whitman-Walker patients.

23. As I previously noted, Whitman-Walker receives various forms of federal funding for health and wellness-related services and for biomedical and behavioral research from HHS and from institutions affiliated with or themselves funded by HHS, including but not limited to funds under the PHSA, direct grants, Medicaid and Medicare programs administered by the Centers for Medicare and Medicaid Services, the FQHC and Ryan White funding administered by the Health Resources and Services Administration; funds under the 340b drug subsidy program, research grants from the Centers for Disease Control and Prevention and the National Institutes of Health, and Medicaid and Medicare reimbursements. The financial risk associated with these funds and related benefits accounts for tens of millions of dollars in revenue for the health center. Whitman-Walker, therefore, has a reasonable fear that it could be sanctioned and lose many millions of dollars of federal funding as a result of our nondiscrimination policies and other practices designed to ensure the highest quality patient care and compliance with applicable medical guidelines, standards of care, and ethical requirements. If Whitman-Walker were to be sanctioned and lose

federal funding as a result of the Rule's enforcement, the impact would include massive service reduction if not closure.

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

Dated: June 5, 2019

Respectfully submitted,

Naseema Shafi

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

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

I, Adrian Shanker, declare as follows:

1. Bradbury-Sullivan LGBT Community Center ("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, 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.

2. I am the Founder & Executive Director of Bradbury-Sullivan Center. 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 LGBT Healthlink, which was a CDC-funded national disparity network for LGBT tobacco and cancer disparity work. At Bradbury-Sullivan Center, in addition to staff management, board development, fundraising, and strategic planning, I administer data collection for the Pennsylvania LGBT Health Needs Assessment. With Health Programs employees at Bradbury-Sullivan, I also develop health promotion campaigns to make behavioral, clinical, and policy changes to improve LGBT health. Since 2017, I have led the successful community efforts to ban "conversion therapy" in the cities of Allentown, Bethlehem, and Reading, Pennsylvania. In 2012 and 2018, Philadelphia Gay News named me Person of the Year and in 2019 Lehigh Valley Business named me a Healthcare Hero. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the Denial of Care Rule from taking effect.

3. Bradbury-Sullivan Center's programs and services for the LGBT community include arts and culture, health promotion, youth programs, pride programs, and supportive services. Youth services include healthy eating, active living, and HIV prevention in an every-day

after-school program. Supportive services include providing non-judgmental HIV/STI testing, Affordable Care Act open enrollment events, medical-marijuana enrollment assistance, and support groups, as well as hosting a free legal clinic. Bradbury-Sullivan Center also provides referrals to LGBT-welcoming healthcare providers, including providers engaged in services for transgender community members and family-planning services.

4. In addition to obtaining services from Bradbury-Sullivan Center, patrons of Bradbury-Sullivan Center often access healthcare services from other organizations, including religiously affiliated organizations. Bradbury-Sullivan Center works with patrons who have experienced discriminatory treatment when accessing healthcare services from such organizations and it advocates on behalf of those patrons by providing referrals to LGBT-welcoming agencies, training agencies to provide LGBT-welcoming services, and, when necessary, communicating with the agencies to inform them of their legal obligations to serve LGBT people. The Denial-of-Care Rule has major effects on Bradbury-Sullivan Center's advocacy and ability to continue such services given that the Denial-of-Care Rule invites healthcare providers to refuse to provide care to LGBT patients on the basis of religious or moral objections to LGBT patients' sex, relationship status, familial status, gender and sexual identities, healthcare needs, and medical decisions.

5. Bradbury-Sullivan Center services a region of Pennsylvania with limited options for LGBT-inclusive healthcare services. Finding LGBT-affirming healthcare options is already a struggle for the LGBT community in the region. LGBT patients experience both geographic barriers to healthcare and barriers to accessing LGBT-affirming healthcare. For some medical specialties, there often is only one or very few healthcare providers in the region who have the specialty necessary to treat a patient, so a denial of care from a provider could make it practically impossible for a patient to receive any specialty care at all. This is especially concerning given that some of the region's healthcare providers are religiously-affiliated organizations that could claim religious-based objections to providing any and all care to LGBT patients, invoking the Denial-of-Care Rule to claim an exemption from existing nondiscrimination laws, relevant medical ethical rules, and standards of care. As a result, the Denial-of-Care Rule will worsen health disparities

affecting the LGBT community and exacerbate the difficulties that members of the LGBT community have in finding and accessing necessary and respectful healthcare.

6. Bradbury-Sullivan Center patrons are already experiencing negative effects from religious discrimination in the provision of healthcare, compromising their health and well-being. For example:

a. We heard from a community member whose family member was a patient in an inpatient-care setting and was forced to participate in a so-called "conversion therapy" support group. When the patient complained about such requirements, he faced harassment and retaliation.

b. Another community member visited Bradbury-Sullivan Center for HIV testing after experiencing judgmental treatment from his primary healthcare provider. He told our staff that he did not feel comfortable receiving the service from his original healthcare professional as a result of the judgmental treatment.

c. Additionally, a program participant in one of our transgender support groups shared with a staff member that her doctor made negative, religious-based comments to her three years ago and as a result she avoided medical care for those three years. She went back for a physical examination this year and the doctor refused to touch her during her physical.

7. Bradbury-Sullivan Center also assists patrons who contact the Center because they are having difficulty finding LGBT-affirming healthcare services. Bradbury-Sullivan Center recently received an increase in referral requests. As a result of issuance of the Denial-of-Care Rule, and the inevitable increase in denials of care and discrimination that it will elicit, Bradbury-Sullivan Center may need to hire a case-manager to address the community's need for referrals to welcoming providers. Facing the Rule's imminent implementation, Bradbury-Sullivan Center has already needed to invest additional staff time to strengthen its referral process through the creation of a supportive services referral guide. It is increasingly difficult for Bradbury-Sullivan Center to find LGBT-affirming healthcare providers for certain specialties in particular, and the Denial-of-Care

Rule will further diminish the number of specialists available by emboldening additional providers to refuse healthcare treatment to LGBTQ patients, without even requiring the providers to inform prospective patients of the reason they are being turned away, let alone requiring them to give referrals or otherwise take steps to ensure that patients get the medically necessary healthcare that they need. This harms the community members that Bradbury-Sullivan Center serves and results in a major drain on its resources that need to be diverted from other programming.

8. Bradbury-Sullivan Center spends a significant amount of resources documenting health disparities in the LGBT community. 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 healthcare provider with whom they do not have a relationship, putting them at increased risk of finding a provider who is not LGBT-welcoming. With an increase in refusals of care as a result of the Denial-of-Care Rule, LGBT people will be far less likely to receive the healthcare treatment that they need because, after being turned away, they are unlikely to seek other care out of fear of repeated rejections. Data from 2018 also indicated that over 50% of LGB and 75% of the transgender community fear going to a healthcare provider due to negative past experiences directly related to the patients' sexual orientation or gender identities.

9. The Denial-of-Care Rule will worsen those numbers as a result of increased refusals of healthcare providers to provide care to the LGBT community. This directly affects the Bradbury-Sullivan Center because it will have an increase in community members seeking referrals to LGBT-affirming healthcare providers, an increase in community members experiencing the trauma of discriminatory or unwelcoming healthcare experiences, and worsened community health outcomes among the population served by Bradbury-Sullivan Center.

10. 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 healthcare provider when they come out as LGBT. More than half of respondents report fear of a negative reaction by a healthcare 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. In other words, LGBT people, who are disproportionately likely to need a wide range of medical care, already have reason to fear, and often do fear, negative consequences of disclosing to healthcare providers their sexual orientation, history of sexual conduct, gender identity, transgender status, history of gender-confirming medical treatment, and related medical histories.

11. By inviting discrimination against LGBT people based on their LGBT status and related medical histories, the Denial-of-Care Rule encourages LGBT people to remain closeted to the extent possible when seeking medical care. Bradbury-Sullivan Center's research demonstrates that more than a quarter of LGBT respondents are not out to *any* of their healthcare providers. Fewer than half are out to all of them. The Denial-of-Care Rule undoubtedly will exacerbate those numbers.

12. However, remaining closeted to a healthcare provider can result in significant adverse health consequences. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

13. Bradbury-Sullivan Center will have to expend more resources on its health promotion campaigns to ensure that LGBT people have access to preventative screenings for cancer, testing services for HIV and other STIs, and tobacco-cessation services given that the Denial-of-Care Rule will drastically change the healthcare landscape for the LGBT patient population. This is especially true for the transgender community because existing data predict that the transgender community will be especially afraid to seek out such care out of fear of mistreatment or rejection as a result of the Denial-of-Care Rule. There are many other new services, including, but not limited to, education and community outreach programs, that Bradbury-Sullivan Center anticipates having to initiate as a result of the Denial-of-Care Rule. For example, Bradbury-Sullivan Center intends to increase community-education efforts about the importance of having a

primary healthcare provider to ensure that LGBTQ patients have a healthcare provider whom they can trust so that they do not avoid seeking necessary care.

14. Bradbury-Sullivan Center also works with independent clinics to help them implement non-discriminatory policies and practices. Bradbury-Sullivan Center anticipates having to make clinical and structural policy changes at the organizations with which it collaborates, as a result of the Denial-of-Care Rule. In turn, the Bradbury-Sullivan Center will have to work harder to ensure that these clinics maintain and establish clear policies that prevent discrimination against the LGBTQ community, including having the correct signage that will signal to LGBTQ people that they are still welcome and will not be mistreated in such facilities in spite of the Denial-of-Care Rule.

15. Bradbury-Sullivan Center has a dedicated team of employees who focus on fostering a welcoming, nondiscriminatory atmosphere for patrons to access supportive services. Many employees of Bradbury-Sullivan Center could be negatively impacted by the Denial-of-Care Rule in the form of increased demand on their time and resources by patrons, a diminished number of affirming resources to provide, and the need to develop new resources and training materials from scratch.

16. Bradbury-Sullivan Center receives pass-through funding from HHS through a grant agreement with Pennsylvania Department of Health for Bradbury-Sullivan Center's youth program. Bradbury-Sullivan Center's state funding for this program comes from the federal Maternal & Child Health Block Grant. Bradbury-Sullivan Center, therefore, has a reasonable fear that it could be sanctioned and lose federal funding if subject to a complaint under the Denial-of-Care Rule in the course of Bradbury-Sullivan Center's efforts to ensure the best possible services for youth program participants.

As a result of the Denial-of-Care Rule, Bradbury-Sullivan Center will be required to redirect additional staff and resources from providing our own services to assisting patrons in finding healthcare providers in the region who will serve LGBT patients in a nondiscriminatory manner. Bradbury-Sullivan Center's staff and resources already have been diverted from other

program activities to engage in advocacy, policy analysis, and creation of resources to address the ill-effects of the Denial-of-Care Rule.

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

Dated: June 9, 2019

Respectfully submitted,

/s/ Adrian Shanker
Adrian Shanker

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF NARINDER SINGH IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Narinder Singh, declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I am the Director of Pharmacy for the County. I have held this position since October of 2003. Prior to my current role, I served as the Director of Pharmacy at the University of Southern California. In my current role as Directory of Pharmacy for the County, I am responsible for medication management across the County, overseeing creation of our formulary, and overseeing all pharmacy staff. The County's Pharmacy Department ("Pharmacy Department") employs around 350 pharmacy staff, including technicians and assistants.

3. The Pharmacy Department operates twelve pharmacies throughout the County of Santa Clara Health and Hospitals System. Patients can pick up their prescriptions at these pharmacies, and our pharmacy staff also provide medications prescribed to admitted patients.

4. The Pharmacy Department operates two of its twelve pharmacy locations under the umbrella of the County Public Health Department. One of these pharmacies provides free, donated medicine to individuals who cannot afford the retail cost of such drugs. The other pharmacy specializes in serving patients with HIV/AIDS, patients with tuberculosis, patients from the Public Health Department's STD clinic, and patients being discharged from the County jail.

5. The Pharmacy Department staff support communicable disease control by procuring, storing, maintaining, and distributing essential medications and vaccines during outbreaks; and distributing approximately 20,000 state-funded influenza vaccines, annually, to healthcare providers in Santa Clara County to administer to low-income and elderly residents at no charge. The pharmacies associated with the Public Health Department also oversee all enrollment workers in Santa Clara County for the state-sponsored AIDS Drug Assistance Program, which serves low-income HIV/AIDS patients. In addition, the Pharmacy Department staff support the County's emergency preparedness program should there be a need for mass prophylaxis or rapid response to a chemical incident. We also have a central fill location at which

we receive and sort medication for distribution to our other twelve locations.

6. The Pharmacy Department fills prescriptions for a variety of medications, including prescriptions for hormonal replacement therapy for transgender people, medication for chemical castration, emergency and oral contraceptives, and the medication for a medical abortion. At some of our pharmacies, there is only one pharmacist on site at any given time.

7. We recognize that situations may arise in which appropriate patient care conflicts with a pharmacist's cultural values, ethics, or religious beliefs. Accordingly, the County has a policy allowing its current and prospective medical-staff members and employees to request in writing not to participate in certain patient care that conflicts with the staff member's cultural values, ethics, or religious beliefs. Pharmacists are covered by this policy. A copy of the policy is attached to the Declaration of Paul Lorenz as Exhibit A.

8. I understand that pharmacists are required by California regulations to provide a patient consultation for any new prescription or changes in existing prescriptions unless the patient refuses the pharmacist consultation. If a pharmacist employed by the County fails to offer a consultation to a patient, the State Board of Pharmacy could levy fines against the County.

9. In the past, a pharmacist voiced an objection to dispensing emergency contraception to patients. To accommodate the objection, if that pharmacist was working shifts where there were multiple pharmacists, the pharmacist would refrain from dispensing emergency contraceptive medication and request that other pharmacists do so instead. If that pharmacist was the only pharmacist on duty, they would call another Pharmacy Department location and request that another pharmacist perform the required patient consultation over the phone. Eventually, that pharmacist was assigned to different position in the Pharmacy Department where they would not be charged with providing care that they objected to.

10. Had this pharmacist declined to provide or connect a patient with a consultation, the Pharmacy Department could have been subject to State fines for noncompliance with patient consultation requirements. Further, because sometimes only one pharmacist is on site, advance notice of and planning for religious objections is critical to ensuring that patients can obtain their prescribed medications even if the pharmacist on duty objects to providing certain types of

medication, providing medication for certain uses, or serving certain groups of people. If patients encounter obstacles to obtaining prescribed medication due to a pharmacist's personal objections, they may be discouraged from, delayed in, or prevented from obtaining necessary medication. And if the need for a medication is time sensitive, the patient may suffer adverse impacts or lose out on the opportunity to access specific care. For example, a delay in obtaining emergency contraception may result in unplanned pregnancy and the lifelong consequences that flow from it.

11. We also rely on certain pharmacists to review new drugs to be added to the County formulary, or the lists of drugs that can be prescribed by County providers. If those specific pharmacists declined to review medications they objected to on religious or ethical grounds to the County's formulary, it would be impossible to order those drugs throughout the entire system until someone else added the drugs. It takes months to train someone to be able to review new drugs for the formulary, and if we were not promptly informed of a pharmacist's objection to adding a drug to our system, it could greatly delay patient and provider access to necessary medication. Further, if we could not ensure that a pharmacist was comfortable with writing the clinical monographs necessary for formulary review before hiring them to work on formularies, this could create inefficiencies and delay the issuance of proper formularies. Similarly, if a staff member in charge of purchasing medications declined to order a drug based on an ethical or religious objection without informing us, it would delay patient access to medication as we would only discover this had been done once we ran out of medication.

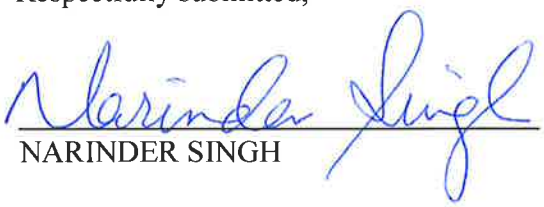
12. The Pharmacy Department also employs technicians and assistants to perform nonclinical activities, such as delivering drugs or directly handing drugs to patients being discharged or currently being treated in the Emergency Department. Were a technician or assistant to elect not to take drugs to a patient due to a religious or moral objection, this would delay patient access to necessary medication. This would be particularly problematic if the technician or assistant did not inform anyone that they had not delivered the drug and could create a highly dangerous situation in which a pharmacist was unaware that a patient had not received their prescribed medication.

13. Additionally, pharmacists work closely with doctors during clinical interventions.

During these interventions, doctors may request information regarding a specific drug from the pharmacist. If a pharmacist had a moral or ethical objection to the type of care being provided or the drug being requested, they could refuse to assist the doctor or not provide the requested information. If the doctor was not made aware of the pharmacists' objection, they may not realize that information necessary to provide adequate patient care may have been withheld.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this Declaration was executed on June 5, 2019 in San José, California.

Respectfully submitted,



NARINDER SINGH

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF JILL SPROUL IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, JILL SPROUL, declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I am the Chief Nursing Officer for all of the hospitals and clinics operated by the County of Santa Clara ("County"), including Santa Clara Valley Medical Center ("Valley Medical Center"), O'Connor Hospital, and St. Louise Hospital.[1] Prior to my current role, I served as Nurse Manager for Valley Medical Center's Burn Center and as Valley Medical Center's Interim Director of Critical Care. I have served in public health care for 29 years.

3. The County employs approximately 3,000 nurses. In my role as Chief Nursing Officer, I am responsible for overseeing staffing of nurses, defining the scope of nurse practice at the County's three hospitals, and establishing policies and standards that govern how nurses carry out their duties and are supervised.

4. The County recognizes that situations may arise in which appropriate patient care conflicts with a nurse's cultural values, ethics, or religious beliefs. Accordingly, the County has a policy allowing its current and prospective medical-staff members and employees to request in writing not to participate in certain patient care that conflicts with the staff member's cultural values, ethics, or religious beliefs. A copy of the policy is attached to the Declaration of Paul Lorenz as Exhibit A.

5. The policy provides that once an exemption is requested, the appropriate manager or director determines whether the request can be granted in light of staffing levels and other relevant circumstances. If the request is granted, the staff member's tasks, activities, and duties may be redistributed to ensure appropriate patient care.

///

[1] The County only recently acquired O'Connor and St. Louise hospitals, so my knowledge of the historical practice of those hospitals is limited. I do know, however, that the religious objection policies in place for Valley Medical Center and will be made applicable to these two hospitals in the near future as part of the integration of these hospitals into the County's Health System.

6. The policy makes clear that a request for an exemption will not result in disciplinary or recriminatory action. However, a manager or director may decline to accept an employee or medical staff member for permanent assignment when the employee/medical staff member has requested not to participate in an aspect of care that is commonly performed in that assignment. The policy also makes clear that patient care may not be adversely affected by the granting of an exemption and that medical emergencies take precedence over personal beliefs.

7. Before we adopted this policy in 2017, we had in place a Nursing Standard, which applied to religious objections to abortions. That Nursing Standard similarly provided that a nurse could submit a request not to participate in medical procedures that resulted in abortions, but also provided that a nurse would still have to participate in such procedures in the event of an emergency until relief personnel could take over the nurse's responsibilities. A copy of that standard is attached as **Exhibit A**.

8. Objections to participation in patient care on moral, ethical, or religious grounds are also addressed in the Memorandum of Agreement ("MOA") between the County and the Registered Nurses Professional Association, the exclusive bargaining representative for nurses at the County's three hospitals. Section 18.2 of that MOA—like Valley Medical Center's policy—recognizes that while nurses must generally be free to refuse to provide care based on their moral, ethical, or religious beliefs without threat of discipline, in an emergency a nurse must provide necessary care until other personnel can take over. Under such circumstances, our nurses have agreed that a patient's right to receive necessary nursing care takes precedence over the exercise of a nurse's individual beliefs. A copy of the Memorandum of Agreement is attached as **Exhibit B**.

9. Nurses sometimes object to providing certain types of care, including assisting in organ donation procedures or in terminating pregnancies. In those situations, prior notice of conscience objections has allowed us to make staffing plans to ensure that a nurse's moral or religious objection can be accommodated without compromising patient care. Currently, twenty-seven nurses in our Operating Room Department have objections to participating in abortions on file. We also regularly honor informal objections that are raised to managers. Because we are

aware of our nurses' objections, we are able to accommodate them by assigning other nurses to perform the patient care to which they object.

10. Our nurses' willingness to provide care in emergency situations is critical to ensuring patient safety. Valley Medical Center includes a Level I trauma center equipped to provide the highest level of comprehensive care to patients suffering from life-threatening traumatic injuries. There, nurses are part of teams that treat people who are in serious medical crisis, such as situations where a patient is bleeding out or has experienced severe burns. Further, other healthcare needs may also not initially present as emergent but may become so. For example, while most abortion procedures can be scheduled in advance, sometimes patients scheduled for routine obstetric care may develop an unexpected medical need for an abortion, which can be provided in an outpatient, ambulatory setting if caught quickly. Were a nurse to abandon or refuse to treat a patient during a time-sensitive emergency, patient care and safety would be seriously compromised.

11. As Chief Nursing Officer, I constantly deal with staffing challenges. Night shifts, holiday periods, and flu season are all especially challenging times from a staffing perspective, and it can be difficult to fill shifts during these periods. Were a nurse to unexpectedly object to providing care, there might be no other nurse to take over their responsibilities in a timely manner, which would undermine patient care and could even be life threating in an emergency situation. Even if there were another nurse available, abruptly changing nurse assignments would disrupt our nurses' work flow and result in additional patient hand-offs when a non-objecting nurse takes over mid-shift. Medical research reflects that inadequate handoffs of patients can pose dangers to patient health. Patient care and safety would also be put at risk if a nurse decided not to assist a patient on moral, ethical, or religious grounds and failed to provide notice to other staff, because the rest of the medical team might not immediately be aware that the nurse had declined to assist the patient and care might be delayed.

12. Additionally, it is critical that the County be able to match our nurses with jobs or schedules that are consistent with their moral, ethical, or religious objections. If a nurse objected to care regularly provided in his or her assignment but declined reassignment, this would cause

repeated staffing challenges and might regularly undermine patient care. If the County lacked the ability to take objections into account when setting nurse schedules, or if nurses could unilaterally reject any schedule or assignment set to accommodate their religious objections, patient care could be disrupted, and we could face short staffing for certain medical procedures.

13. Our hospital regularly serves vulnerable patients from a variety of backgrounds, including LGBTQ patients. Were a nurse to refuse treatment to a patient based solely on the patient's identity, harm that patient's trust in our hospitals, and undermine the County's mission to provide healthcare to vulnerable populations.

14. As a safety-net provider, we are often the last resort or only option for patients with limited healthcare options, such as those who are uninsured or underinsured. If those patients are turned away from our hospitals, they may have no other options to address their healthcare needs.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this Declaration was executed on June 5, 2019 in San José, California.

Respectfully submitted,

Jill L. Sproul, MS, RN

JILL SPROUL

EXHIBIT A

ABORTION PROCEDURE, EMPLOYEE OBJECTION TO PARTICIPATION IN ELECTIVE

I. POLICY

Nursing personnel who object to participating in an elective abortion procedure on moral, ethical, or religious grounds shall not be required to participate in the specific medical procedures which result in an abortion, except in cases of medical emergencies or spontaneous abortions.

II. PURPOSE

To comply with Health and Safety Code Division 106, Part 2, Chapter 2, §123420 and JCAHO Standards which protect a medical employee's right to refrain from participating in medical procedures that conflict with that employee's ethics, religious beliefs, or cultural values.

III. PROCESS

A. A member of the nursing staff who objects to abortions on moral, ethical, or religious grounds shall state so in writing by completing and signing a form entitled "Employee Statement regarding Abortion." (see page 2) These forms are kept in the Nursing Office. The nursing staff member should allow two weeks after submitting this form for processing of his/her request

B. Once a member of the nursing staff who has submitted an Employee Statement regarding Abortion has received approval of his or her request, that employee shall not be required to participate in the specific medical procedures which result in abortions (except in cases of medical emergencies or spontaneous abortions), and the refusal by such an employee to do so shall not result in any disciplinary action, denial of privileges, or any other penalty.

C. Specific nursing service areas where abortions are commonly performed may refuse to accept permanently assigned staff who object to participate in abortion procedures.

D. Because SCVMC is obligated to treat all emergencies, medical emergencies or spontaneous abortions must take precedence over personal beliefs, such as those of nursing staff members who have submitted Employee Statements regarding Abortion.

E. Should a need arise where a nursing staff member who has signed the Employee Statement regarding Abortion is called upon to care for the patient during a medical emergency relating to abortion or during a spontaneous abortion, the nursing staff member must do so promptly until relief personnel arrive to take his or her place. Relief personnel will be provided as soon as possible.

IV. ATTACHMENT

Employee Statement Regarding Abortion form.

References: Administration Policies and Procedure VMC#132.01 "Non-Participation in Certain Patient Care".

History: Original 10/81; **Revised** 9/84, 11/89 5/91, 7/95 (A-6903-108), 3/97, 2/02, 7/07; **Reviewed** 5/88, 5/93, 6/98, 8/01, 1/05, 6/10 **Deleted** 5/2014

SANTA CLARA VALLEY MEDICAL CENTER
DEPARTMENT OF NURSING SERVICE

EMPLOYEE STATEMENT REGARDING ABORTION

I the undersigned, an employee (or prospective employee) of the Santa Clara Valley Medical Center, request that during the course of my employment at the Medical Center I not be assigned to duties involving direct participation in the initiation, induction, or performance of an abortion on a patient in this hospital.

This statement is made because of my moral, ethical or religious beliefs relating to such procedures.

I understand that medical emergency situations or spontaneous abortions take precedence over personal beliefs, and that if I am called upon to assist in such cases, I will do so promptly until such time when other qualified personnel will be provided to relieve me. I understand that qualified personnel will be provided as soon as possible.

Date _____

Time_____

_____ _____

Signature Witness

EXHIBIT B

AGREEMENT

Between

COUNTY OF SANTA CLARA

And

REGISTERED NURSES PROFESSIONAL ASSOCIATION

NOVEMBER 10, 2014 THROUGH OCTOBER 20, 2019

TABLE OF CONTENTS PAGE

PREAMBLE

This Memorandum of Agreement is entered into by the County of Santa Clara (hereinafter referred to as the County) and the Registered Nurses Professional Association (hereinafter referred to as the Association). This Memorandum of Agreement incorporates by this reference all appendices attached.

ARTICLE I – RECOGNITION

The County recognizes Registered Nurses Professional Association as the exclusive bargaining representative for all classified and unclassified nurses in coded and uncoded classifications within the Registered Nurses bargaining unit.

For the purpose of this Agreement, a nurse shall be defined as a person employed in coded and uncoded classifications in a bargaining unit covered by this Agreement.

The following classifications are included in the Registered Nurses bargaining unit:

Assistant Nurse Manager
Certified Registered Nurse Anesthetist
Clinical Nurse I
Clinical Nurse II
Clinical Nurse III
Clinical Nurse Specialist
Infection Control Nurse
Nurse Coordinator
Nurse Practitioner
Psychiatric Nurse I
Psychiatric Nurse II
Staff Developer
Per Diem Clinical Nurse
Per Diem Psychiatric Nurse
Per Diem Nurse Practitioner

ARTICLE 2 - NO DISCRIMINATION

Section 2.1 - Employment

Neither the County nor the Association shall discriminate (except as allowed by law) against nurses because of race, age, sex, color, disability, creed, national origin, religion, Association activity, affiliations, political opinions, or sexual preference.

Section 2.2 - Association Affiliation

Neither the County nor the Association shall interfere with, intimidate, restrain, coerce or discriminate against any nurse in the nurse's free choice to participate or join or refuse to participate or join the Association.

Section 2.3 - Affirmative Action

The County and the Association agree to cooperate to achieve equitable representation of women, minorities and disabled at all occupational levels designated by Federal, State and County Affirmative Action goals and timetables, as adopted by the Board of Supervisors.

ARTICLE 3 - ASSOCIATION SECURITY

Section 3.1 - Relationship Affirmation

The intent and purposes of this Agreement are to encourage harmonious relationships between the County and the Registered Nurses it employs who are subject hereto; to promote and improve that relationship subject to their joint duties to the community and to the high standards of patient care; to clarify certain rights and privileges of the parties; to set forth and define rates of pay, economic benefits and other conditions of employment that shall apply to such nurses; and to establish amicable processes for collective bargaining. The Association agrees that it will cooperate with the County and support its efforts to assure efficient operation, to serve the needs of the community, and to meet the highest of professional standards in such services.

Section 3.2 - Dues Deductions

a) Maintenance

Nurses covered by this Agreement who have authorized Association dues deductions as of date of signature of this Agreement shall continue to have such deductions made by the County during the term of this Agreement, except that such nurses may terminate such dues deductions during the month of February pursuant to paragraph (e) of this Section.

b) Condition of Employment

Each person employed during the term of this Agreement shall at the time of employment and as a condition of employment execute an authorization for the payroll deduction of Association dues or of a service fee equivalent to Association dues on a form provided by the Association and shall continue said authorization in effect, except that such nurses may terminate such dues deductions pursuant to paragraph (e) of this Section.

c) Implementation

Any nurse hired by the County subject to this Agreement shall be provided by the County with a notice advising that the County has entered into an agency shop agreement with the Association and that all employees subject to this Agreement must either join the Association, pay a service fee to the Association, or execute a written declaration claiming a religious exemption from this requirement. Such notice shall include a form for the employee's signature authorizing payroll deduction of Association dues or a service fee. Said nurse shall have five working days from the initial date of employment to fully execute the authorization form of his/her choice and return said form to County payroll. If the form is not completed properly and returned within five working days, the County shall commence

and continue a payroll deduction of service fees from the regular bi-weekly pay warrants of each employee. The effective date of Association dues, service fee deductions or charitable contributions for such nurse shall be the beginning of the first pay period of employment except that initiation fees shall be deducted in two installments in successive pay periods, beginning with the first pay period. The nurse's earnings must be sufficient after other legal and required deductions are made to cover the amount of dues or service fees check-off authorized. When a nurse is in a non-pay status for an entire pay period, no withholding will be made to cover the pay period for future earnings. In the case of a nurse who is in a non-pay status during only part of the pay period, and the salary is not sufficient to cover the full withholding, no deduction shall be made. In this connection, all other legal and required deductions (including health care and pension deductions), have priority over Association dues and service fee.

d) Religious Exemption

A nurse subject to this Agreement who is a member of a bona fide religion, body or sect which has historically held conscientious objections to joining or financially supporting a public employee organization and which is recognized by the National Labor Relations Board as such, shall, upon presentation of verification of active membership in such religion, body, or sect be permitted to make a charitable contribution equal to the service fee in lieu of Association membership or service fee payment.

Declarations of or applications for religious exemption and any supporting documentation shall be forwarded to the Association by the objecting nurse in accordance with paragraph e below. The Association shall have fifteen days after receipt of a request for religious exemption to challenge any exemption. If challenged, the deduction to the charity shall commence but shall be held in escrow pending resolution of the challenge in accordance with Association policy. The Association shall inform the County of the outcome of the challenge. Charitable deductions shall be by regular payroll deduction only. For purposes of this Section, a charitable deduction means a contribution to the Valley Medical Center Foundation or the Santa Clara Family Health Foundation.

e) Revocation

A nurse may terminate authorization for Association dues and commence authorization of service fee, or terminate service fee deduction and commence charitable contribution deduction by giving notice thereof to the Association and the County

Controller by individual letter deposited in the U.S. Mail (1) within the last ten (10) working days in the month of February prior to the expiration of the Agreement, or (2) within the first ten (10) working days following the date of first employment, whichever applies. If the canceled letter is not postmarked, it must be received and date stamped within the time limits specified in (1) or (2) above.

The County shall promptly forward a copy of the letter of revocation to the Association.

A nurse who makes changes to deductions during the month of February shall have the deduction changed on the first pay period in April.

A nurse who makes changes to deduction within ten (10) working days following the date of first employment shall have the deduction changed following the receipt of the notification by the County.

f) No Fault

The Association agrees to indemnify, defend and hold the County harmless from any and all claims, demands, suits, or any other action arising from the provisions of this Section or from complying with any demand for termination or revocation hereunder.

g) Leaves of Absence

Upon return from leaves of absence, the County shall reinstate the payroll deduction of Association dues for those nurses who were on dues check-off immediately prior to taking leave, provided the employee has not authorized cancellation of dues check-off in accordance with the prescribed provisions.

Section 3.3 - Other Deductions

The County shall deduct other deductions for insurance programs from pay checks of nurses under reasonable procedures prescribed by the County for such deductions which may include nurses not within the recognized bargaining unit of the Association in accordance with procedures that may be established between the parties.

Section 3.4 - Association Notices and Activities

a) Bulletin Boards

The Association, where it represents nurses of a County Department, shall be provided by that Department use of adequate and accessible space on designated bulletin boards for communications.

The glass covered, locked bulletin board purchased by the Association and installed by Valley Medical Center will be maintained in the cafeteria hallway at Santa Clara Valley Medical Center.

b) Distribution

The Association may distribute material to nurses in its representation unit through normal channels, including use of County's e-mail.

c) Visits by Association Representatives

Any Representative of the Association shall give notice to the Department Head or designated representative when entering departmental facilities. The Representative shall be allowed reasonable contact with nurses on County facilities provided such contact does not interfere with the nurse's work. Solicitation for membership or other internal nurse organization business shall not be conducted during work time. Prearrangement for routine contact may be made on an annual basis.

For this purpose rest periods are not work time.

d) Facilities

County buildings and other facilities shall be made available for use by the Association or its Representatives in accordance with administrative procedures governing such use.

e) Names and Addresses of Covered Nurses

The County shall supply the Association with a bi-weekly data processing run of names and addresses and classifications of work of all nurses within the representation unit. Such list shall be supplied without cost to the Association except that addresses shall not be supplied of those nurses who request the County in writing to not provide such information. A copy of such request shall be forwarded to the Association.

f) Notification of Association Coverage

When a person is hired in any classification covered by a bargaining unit represented by the Association, the County shall notify that person that the Association is the recognized bargaining representative for the nurses in said unit and present that person with a copy of the present Agreement, and a copy of the purpose and objectives of RNPA as approved.

g) Report of Transactions

The County shall supply the Association a data processing run covering the following nurse transactions as are currently

available on the system: newly hired nurse, provisional appointments, reinstatement, re-employment, return from leave, return from military leave, miscellaneous, promotion, return to former class, voluntary demotion, disciplinary demotion, transfer, title change, suspension, temporary military leave, injury or illness leave, other leave, indefinite military leave, resignation, probationary resignation, probationary release, provisional release, miscellaneous release, dismissal, retirement, death, layoff.

Section 3.5 - New Nurse Orientation

The Association shall be allowed a Representative at County-wide orientations for new nurses or departmental orientations where they are held in place of County-wide orientations. Such Representative shall be allowed twenty (20) minutes to make a presentation and answer questions to nurses in classifications represented by their organization. The Association may present packets to represented nurses at orientation, such packets being subject to review by the County. The County or department, where appropriate, will notify the Association one (1) week in advance of such orientation sessions.

Section 3.6 - Printing of Agreement

The parties agree to share equally the cost of printing bound copies of this Agreement. The Association shall reimburse the County for the actual cost of copies ordered by the Association. The design and format of the printed Agreement shall be jointly determined by the parties. It is agreed that the contract will be printed not more than one hundred and twenty (120) days after final agreement on all language.

ARTICLE 4 - OFFICIAL REPRESENTATIVES AND NEGOTIATING COMMITTEE

Section 4.1 - Official Representatives

a) Notification of Official Representatives

The Association agrees to notify the County of their Official Representatives for its representation unit and changes in such Representatives. It may also designate alternates to such Official Representatives for purposes of specific meetings by advance notice to the appropriate level of Management.

b) Release Time

Up to three (3) Official Representatives at any given time shall be allowed thirty-two (32) hours of release time each pay period. Effective November 10, 2002, up to three (3) Official Representatives at any given time shall be allowed release time. The total combined time may not exceed eighty (80) hours per pay period and the total for one (1) individual shall not exceed thirty-two (32) hours per pay period. This provision shall cover all shifts and must be taken in a minimum of one (1) hour increments. This time shall be scheduled in advance by mutual agreement between the Association and Management.

c) Release Time Log

RNPA Representatives who are on their shift during approved release time will log the time they leave their work assignments and the time they return on a form provided by the County.

Section 4.2 - Negotiating Committee

There shall be six (6) Official Representatives for the Registered Nurses Unit. The County agrees to release six (6) persons upon such request where required.

a) Compensatory Time

Those negotiators who are on their own time during the meetings will not be granted compensatory time.

b) Resource People

Resource people for negotiations shall be allowed on their own time, leave without pay, PTO, or compensatory time off to attend scheduled negotiation meetings for this Association to provide information to the committee on specific items on an as needed basis and as mutually agreed, prearranged and scheduled by the committee. The County shall facilitate arranging time off for resource people attending negotiations.

ARTICLE 5 - LAYOFF

Section 5.1 - Seniority Defined

For purposes of layoff, seniority is defined as the total length of continuous employment in a coded classification from the first date of hire within the bargaining unit. First date of hire shall be adjusted for all time on suspension or leave without pay which extends beyond one full pay period, but shall not be adjusted for all time on Maternity Leave, Worker's Compensation Leave and Military Leave. If an employee resigns and is subsequently reinstated within 12 months of the resignation, the seniority shall be restored for the period of time previously served within the bargaining unit.

The County will provide the Union with a copy of the appropriate current seniority list prior to the issuance of notices described below in Section 5.8.

Section 5.2 - Transfer of Prior Employer Service

If a function of another employer is transferred to the County, with employees performing nursing duties comparable to those performed by this bargaining unit, the County and the RNPA will meet and confer over the definition of seniority for the transferred employees.

Section 5.3 - Changes to Classes

The County and the Association agree that to the extent possible, nurses should not lose their rights under this Article because classes have been revised, established, abolished or retitled.

Section 5.4 - Order of Layoff and Reassignment

When the County determines that bargaining unit positions will be reduced or eliminated which results in a layoff, the order of layoff shall be based on seniority as applied to each classification. The order shall be: a) provisional nurses in inverse seniority; b) nurses on original probation in inverse seniority; c) permanent nurses in inverse seniority.

The provisions of Appendix B "Classifications and Areas of Competency" shall apply for purposes of layoff and reassignment as a result of layoff.

Employees will be retained within their current assigned work unit on the basis of seniority. The employees (other than those in the classifications of Clinical Nurse I, II, III or Psychiatric Nurse I or II) for whom no position exists at the same code status within the current assigned work unit will be reassigned in order of seniority as follows:

a) to a vacant position in the same code status and classification within the related competency area; or if no such position exists,

b) to a position held by the least senior individual in the same code status and classification within the related competency area; or if no such position exists,

c) to a vacant position in the same code status and classification within another competency area; or if no such position exists,

d) to a position held by the least senior individual in the same code status and classification within another area of competency; or if no such position exists,

e) to a position of the next lower code status within the same classification, following the sequence "a" through "d" above until all successive code statuses are exhausted; or if no such positions exist,

f) to a position in the next lower classification applying the sequence "a" through "e" above until all lower classifications are exhausted;

The employees in the classifications of Clinical Nurse I, II, III or Psychiatric Nurse I or II for whom no position exists at the same code status and same or lower classification in the series within the current assigned work unit will be reassigned in order of seniority as follows:

a) to a vacant position in the same code status and same or lower classification within the related competency area; or if no such position exists,

b) to a position held by the least senior individual in the same code status and same or lower classification within the related competency area; or if no such position exists,

c) to a vacant position in the same code status and same or lower classification within another competency area; or if no such position exists,

d) to a position held by the least senior individual in the same code status and same or lower classification within another area of competency; or if no such position exists,

e) to a position of the next lower code status and same or lower classification, following the sequence "a" through "d" above until all successive code statuses are exhausted.

Nurses in full-time status who are assigned to less than a full-time position as a result of layoff will retain full-time benefits pursuant to section 7.4b of this agreement.

Employees who are currently part-time cannot assert seniority to claim a position with more hours than currently held.

Section 5.5 - Reassignment from a Lower Classification

After all nurses within an affected classification have been afforded the opportunity to be reassigned according to Section 5.4 and a vacancy remains in that classification, that vacancy shall be filled by reassignment of the most senior nurse in the next lower classification from the vacancy's related area of competency and then another area of competency as identified in Appendix B.

Section 5.6 - Competency Standards

The classifications, the work units, and the areas of competency for layoff purposes are listed in Appendix B. The County shall establish written competency standards for each area of competency. These standards shall not be greater than the hiring standards.

Section 5.7 - Employee Competency Profile

Prior to the issuance of layoff notice, the employee will be provided the opportunity to complete an Employee Competency Profile or add any information to an existing profile which might qualify the employee for an area of competency. Failure to respond will be construed as acceptance of the information on file.

Section 5.8 - Notice of Layoff

a) Notice to the Association of Intent to Reduce or Eliminate Bargaining Unit Positions

The County will notify the Association of the decision to reduce or eliminate bargaining unit positions which would result in a layoff. At a minimum, the notice shall include the total proposed reduction. Upon request, the Association shall be afforded an opportunity to meet with the County prior to layoff notices being issued to discuss the circumstances requiring the layoff and any proposed alternatives.

b) Notice to Employee

The County shall provide a written layoff notification to any nurse whose employment is being terminated, whose code status is being reduced, or whose classification is being changed as a result of layoff. Additionally, employees shall receive a notice of reassignment due to layoff. The notice shall be provided at least 20

working days before the effective date. The Association will receive concurrent notices.

Section 5.9 - Training Opportunities

Nurses who are reassigned as a result of layoff according to Section 5.4 will be provided orientation training and skills upgrade, up to a maximum of six weeks, if needed. Additional training beyond six weeks may be provided on an individual basis.

Section 5.10 - Layoff

a) Layoff

In the event that a nurse is not reassigned as a result of layoff as in Section 5.4, the nurse shall be laid off, unless the employee has a right to return to a former classification in another bargaining unit. If a nurse refuses the reassignment pursuant to Section 5.4 "a" through "d" or refuses to return to a former class in another bargaining unit, the nurse may be deemed to have been offered and to have declined such work.

b) Inplacement

If a nurse has been issued a layoff notice pursuant to Section 5.8 and has no reassignment in lieu of layoff rights pursuant to Sections 5.4 or 5.5, then that nurse shall be considered for inplacement.

Inplacement is an offer of transfer (within specific wage bands) or demotion to a nurse with a layoff notice into a vacant position which the County intends to fill during the layoff notice period.

The following conditions apply to the inplacement process:

1. A nurse must be qualified to transfer or demote. The Personnel Director shall determine qualifications.

   a. Testing requirements will be the same as if the nurse had been reclassified.

   b. In determining qualifications and possible positions, transfers and demotions to both related and non-related classes may be considered.

2. Transfers resulting from layoffs will be deemed a "lateral transfer" if movement from one class to another does not exceed an upward salary change of 10% (ten percent).

3. The normal transfer (ordinance code) rules apply when an inplacement transfer occurs. If a nurse has underlying

permanent status the probationary period following the transfer shall be considered a subsequent probation. Consistent with this status, the nurse on a subsequent probation with underlying permanent status, has Personnel Board appeal rights.

4. The nurse may express a preference for certain occupational fields, assignments or departments. However, the nurse has no right to claim any position nor is the County required to offer placement.

5. A position shall not be considered "vacant" for inplacement purposes if the position has been identified as claimable under Section 5.4 or 5.5 by another nurse who has been issued a layoff notice under Section 5.8 or by a nurse on a re-employment list established pursuant to Section 5.11.

6. A nurse who is placed under Section 5.4 or laid off under Section 5.10 shall have his/her name placed on all re-employment lists pursuant to Section 5.11 for the appropriate classification.

7. In determining placement offers, the Association and the County, on a case by case basis, may by mutual agreement include as part of the placement offer:

   a. basic skill competency training and/or;

   b. literacy training and/or;

   c. other methods (other than transfer or demotion) of filling vacant positions that do not violate Merit System principles or County Ordinance Code provisions.

8. All inplacement offers must be made and accepted or rejected prior to the effective date of the layoff notice. Time permitting, the Personnel Department may assist nurses on the re-employment list in addition to those workers with layoff notices. Such nurses shall be entitled to all provisions of this Agreement.

9. If a worker is not placed by the effective date of the layoff notice, he/she shall be laid off under the provisions of the layoff notice.

10. Nurses are eligible to transfer to vacant positions within a unit in accordance with 6.9 prior to filling positions by inplacement of employees outside the bargaining unit into RNPA. Vacancies existing within a unit seven (7) calendar

days prior to date of layoff shall not be posted and shall be considered for purposes of inplacement. This provision relates to inplacement of employees outside of RNPA and does not include employees with return to former classification rights.

Section 5.11 - Re-employment List

a) The names of such probationary and permanent nurses reassigned or laid off in accordance with this Article shall be entered upon a re-employment list in inverse order of seniority. The County shall maintain re-employment lists by classification and code status. At the time of a nurse's placement on a re-employment list, the County will inform the nurse in writing of the employee's responsibility to leave the address and/or telephone number where the employee can be contacted.

b) When a vacancy exists which the County intends to fill, the most senior nurse on the appropriate re-employment list shall be offered appointment, provided the required competencies are met. Nurses on re-employment lists shall retain the right to take promotional exams and/or receive promotional preference on exams.

1. If the County is able to contact the nurse to communicate the offer of re-employment, the nurse will be encouraged to respond within forty-eight (48) hours, but, if requested, will be allowed up to four (4) working days to respond.

2. If the County is unable to make contact, the County will send the offer by certified mail, return receipt, to the last known address. The nurse must respond to the offer within ten (10) working days from the date of mailing.

3. If no response is received within the above time limits, the nurse will be deemed to have been offered and to have refused such work.

Section 5.12 - Extra-Help and Per Diem Work for Laid Off Nurses

Interested nurses who are placed upon the re-employment list due to layoff and who elect to be available for extra-help or per diem work shall be given preference for any work in their former Department/Agency for which they are currently qualified. The election to be available for extra-help and per diem work must be made in writing at the time of layoff. Employees may decline to be available for extra-help and per diem work or may decline such work itself without affecting any rights under this Article.

Section 5.13 - Names Dropped from Re-employment List

No name shall be carried on a re-employment list for a period longer than two (2) years, and the names of persons re-employed in a permanent position within the same classification shall, upon such re-employment be dropped from the list. Refusal to accept one of two offers of re-employment within the same classification, shall cause the name of the person to be dropped from the re-employment list.

Section 5.14 - Rights Restored

Upon re-employment of a nurse from a re-employment list, all rights acquired by a nurse prior to the nurse's placement on such list shall be restored; including but not limited to PTO accrual rates, seniority as defined in Section 5.1, salary step and time-in-step placement, and educational leave.

Section 5.15 - Temporary Layoff

In the event of a decrease in census of any unit requiring a temporary reassignment of work areas or layoff of Registered Nurses for less than thirty (30) calendar days, the appointing authority shall:

a) Attempt to float any affected nurse to any unit which the nurse has been oriented.

b) As an educational opportunity, allow a nurse to request an orientation to an unfamiliar unit.

c) Request volunteers to take time-off by using PTO, comp. time or leave without pay.

d) Implement a layoff of nurses by inverse seniority, if there are insufficient volunteers. This subsection, however, shall not apply to any classification of nurses that are designated as FLSA exempt.

It is agreed that this provision shall be applied by unit and shift. It is also understood that the hospital will not assign extra-help, per diem or registry RN to the unit on that shift when this section is implemented.

ARTICLE 6 - PERSONNEL ACTIONS

Section 6.1 - Probation

a) Each new nurse shall serve a probationary period of nine (9) months, which shall be counted as twenty (20) complete pay periods. Upon successful completion of such probationary period, the nurse shall be deemed a permanent employee. A leave of absence without pay shall not be credited toward completion of the nurse's probationary period. The parties agree that probationary nurses shall have all rights in this Agreement, unless otherwise specified, including full and complete access to the grievance procedure. Any nurse released during the probationary period shall, upon request, be provided with a statement of the reasons for the release. Consistent with County Charter Section 704(e), probationary nurses may not grieve suspensions, demotions, or dismissals.

b) Probationary nurses shall have the right to request and receive Department/Agency administrative review of disciplinary action taken during probation. Such review must be requested in writing within ten (10) working days of the disciplinary action or it is waived. The review process shall consist of a meeting with the clinical director or his or her designee. The review process shall proceed promptly after a request is received. The clinical director or his or her designee shall hear and make a decision within fifteen (15) working days.

Section 6.2 - Disciplinary Action - Unclassified Nurses

Unclassified nurses who have completed a period equal to the probationary period for a comparable classified position may grieve disciplinary action on the grounds that such discipline was not for cause. Such grievance shall comply in all respects with Article 16 of this Agreement.

Notice of disciplinary action must be served on the nurse in person or by certified mail prior to the disciplinary action becoming effective. Notice shall be included in the nurse's personnel file and a copy sent to the Association and shall include:

a) Statement of the nature of the disciplinary action.

b) Effective date of the action.

c) Statement of the cause thereof.

d) Statement in ordinary and concise language of the act or omissions upon which the causes are based.

e) Statement advising the nurse of the right to appeal from such action and the right to Association representation.

Section 6.3 - Personnel Files

The County shall maintain a personnel file for each nurse. The Santa Clara Valley Health and Hospital System may also maintain a personnel file for each nurse. Nurses shall have the right to review their personnel file(s) or authorize review by their representative. No material will be inserted into the nurse's personnel file(s) without prior notice to the nurse. Nurses may cause to be placed in their personnel file(s) responses to adverse material inserted therein and a reasonable amount of correspondence originating from other sources directly related to their job performance.

Materials relating to suspensions which become final will be removed after four (4)years if no other suspensions have occurred during the four (4) year period except those involving charges as listed in A25-301(a)(4) Brutality in the performance of duties and (b)(2) Guilty of immoral conduct or a criminal act.

Materials relating to suspensions may be removed from the nurse's personnel file earlier than the regular removal schedule by mutual agreement between the Union, the Office of Labor Relations and the CNO or his/her designee.

Materials relating to disciplinary actions recommended but not taken, or disciplinary actions overturned on appeal, shall not be retained in a nurse's personnel file.

Section 6.4 - Disciplinary Action - Permanent Classified

The County may take disciplinary action for cause against any permanent classified nurse by suspension, demotion or discharge by notifying the nurse in writing. Notice of disciplinary action must be served on the nurse in person or by certified mail prior to the disciplinary action becoming effective. The notice shall be included in the nurse's personnel file(s) and a copy sent to the Association and shall include:

a) Statement of the nature of the disciplinary action.

b) Effective date of the action.

c) Statement of the cause thereof.

d) Statement in ordinary and concise language of the act or omissions upon which the causes are based.

e) Statement advising the nurse of the right to appeal to the Personnel Board from such action and the right to Association representation.

Such nurse shall be given either five (5) days' notice of discharge, or demotion, or five (5) days' pay, except where circumstances require immediate action.

In cases of questionable gross negligence or incompetence as defined in the Nurse Practice Act, the nurse, at the sole election of the appointing authority or their designee, may be placed on administrative leave with pay, not to exceed fifteen (15) working days, pending an investigation. If circumstances permit, a nurse will be advised in writing that they are being placed on administrative leave under this provision.

6.5 - Counseling and Unfavorable Reports

a) Counseling

In the event that a nurse's performance or conduct is unsatisfactory or needs improvement, informal counseling shall be provided by the nurse's first level supervisor. Counseling shall be separate and distinct from on-going worksite dialogue. Documentation of such counseling (including verbal counseling) shall be given to the nurse as it is developed. Such documentation shall not be placed in a nurse's personnel file(s) and when the situation allows counseling, counseling shall be used prior to any unfavorable reports being issued. Counseling shall be removed from supervisory files within two (2) years, and shall not be used in the progressive disciplinary process provided no subsequent related counseling or other personnel action was issued.

b) Unfavorable Reports on Performance or Conduct

If upon such counseling a nurse's performance or conduct does not improve and disciplinary action could result, a written report shall be prepared by the supervisor including specific suggestions for corrective action, if appropriate. A copy shall be given to the nurse and a copy filed in the nurse's personnel file(s). No unfavorable reports shall be placed in a nurse's file(s) unless such report is made within ten (10) working days of the County's knowledge of the occurrence or incident which is the subject of this report. Provided no additional report has been issued during the intervening period, each report shall be removed from the nurse's file(s) at the end of two (2) years. Upon resignation, any such reports shall be removed from the nurse's file(s). Unfavorable reports may be removed from the nurse’s personnel file earlier than the regular removal schedule by mutual agreement between the Union, the Office of Labor

Relations and the CNO or his/her designee. Nurses shall have the right to grieve the factual content of such reports or attach a written response to the report for inclusion in their personnel file(s).

Section 6.6 - Return to Former Class

As an alternative to appointment from any employment list, any current regular nurse, upon recommendation of the appointing authority and approval by the Director of Personnel, may be appointed without further examination to a position in any class in which regular status had formerly been acquired, or to any related class on a comparable level with the former class.

Section 6.7 - Unclassified Appointment

No nurse, while holding a position in the unclassified service, shall be assigned to or occupy any classified position.

Section 6.8 - Rights Upon Promotion to Classified or Unclassified Service or Transfer to Unclassified Service

Any permanent nurse who receives a provisional or probationary promotion, or who is transferred or promoted to a position in the unclassified service shall retain all rights and benefits as a permanent nurse of the nurse's former class while in such provisional, probationary, or unclassified status. These include the right to participate in promotional examinations and the right to return to the nurse's former class if released while in such status. All such service shall count toward seniority credits in the nurse's former class in the event the layoff procedure is involved.

Any permanent nurse who receives a provisional promotion, or who is transferred or promoted to a position in the unclassified service, the duration of which is known to be for less than six (6) months, shall be considered to be on leave from the nurse's permanent position and departments are authorized to make substitute appointments to such vacated positions.

Section 6.9 - Transfers and Job Opportunities

Santa Clara Valley Health and Hospital System shall establish a system to facilitate transfers and career mobility of Registered Nurses.

a) All coded vacancies, transfer opportunities, and all special assignment positions created within existing job specifications, that the County intends to fill shall be posted on the work unit where the vacancy exists for a period of seven (7) calendar days. The County will transmit electronically to the RNPA all vacancies every payroll period.

b) Code and / or shift change requests within a unit shall be based on seniority within the unit subject to the following:

1) Nurses who have been issued an Unfavorable Report, suspension, subsequent probationary release or demotion within the past twelve (12) months may only transfer to a higher code status with management approval. T/A CP 1/13/31

2) The nurse is available to fulfill the position within six (6) weeks of the request.

c) If a vacant position exists after exhausting the above provisions, management shall post a notice of the vacancy for transfers of eligible nurses outside the work unit for seven calendar days. The vacancy may also be posted as promotional or open/competitive. Should the vacancy be posted as promotional or open/competitive, any nurse interested and eligible for transfer will be interviewed and considered prior to interviewing outside candidates. The vacancies will be posted on a bulletin board outside the Nursing Office and the Cafeteria at Valley Medical Center at least bi-weekly. In addition, the list shall be distributed to designated individuals in non-hospital locations for posting in nursing areas All Job postings may be accessed at the following websites: www.sccgovatwork.org and www.sccjobs.org.

Section 6.10 – Exchange of Shifts

Nurses may exchange shifts within the same code status and within the same work unit using the following process:

1. From February 1 through February 10 and August 1 through August 10 of each year, nurses desiring to change shifts within his/her same code status may submit in writing to management a request to change shifts. For example: day shift nurse holding a 3/5ths position requesting to exchange to night shift 3/5ths position.

2. Such requests shall be maintained in the schedule binder of each unit. Nursing management shall notify nurses of a viable shift change by February 15 and August 15 of each year.

3. If two or more requests to exchange to the same different shift are received, the nurse with the most seniority shall be granted shift exchange provided there is a staff member on the opposite shift in the same code status desiring to exchange. Seniority for the purposes

of shift exchange is defined as continuous date in the unit as a coded RN. Date of seniority for this purpose will be adjusted for unpaid leaves of absence.

4. Exchange of shifts will occur as soon as practical but not to exceed six weeks after notification to both parties.

ARTICLE 7 - PAY PRACTICES

Section 7.1 - Salaries

Effective on the dates listed all salaries shall be as listed in Appendix A attached hereto and made a part hereof. The parties agree that the rates of pay established by this Agreement are commensurate with those prevailing throughout the County for comparable work as required by the Charter for the County of Santa Clara.

Section 7.2 - Basic Pay Plan

The Basic Pay Plan consists of the salary ranges and the assignment of classes to such ranges as provided in this Section. Each nurse shall be paid within the range for the nurse's class according to the following provisions.

a) Step One

The first step in each range is the minimum rate and shall normally be the hiring rate for the class. In cases where it is difficult to secure qualified personnel or a person of unusual qualifications is engaged, the Director, with the approval of the County Executive, may approve appointment at the second, third, fourth or fifth step. If a nurse is hired under the difficult-to-secure-qualified- personnel clause, the County will move those nurses within that same class to the same salary step as that being received by the new nurse. The Association will receive a monthly listing of positions by class and department which list positions hired above the first salary step.

Effective April 11, 2005 Step 1 and Step 2 of the Clinical Nurse I wage scale shall be eliminated thereby making the entry wage for Clinical Nurse I to be at the Step 3 level.

b) Step Two

The second step shall be paid after the accumulation of six (6) months of competent service at the first step.

c) Step Three

The third step shall be paid after the accumulation of twelve (12) months of competent service at the second step.

d) Step Four

The fourth step shall be paid after the accumulation of twelve (12) months of competent service at the third step.

e) Step Five

The fifth step shall be paid after the accumulation of twelve (12) months of competent service at the fourth step.

f) Longevity Pay – Step Six

Effective August 7, 2000 a sixth step is established at approximately five percent (5%) above step five for the existing classifications of Clinical Nurse III, Psychiatric Nurse II, Nurse Coordinator, Staff Developer, Clinical Nurse Specialist, Infection Control Nurse, and Nurse Practitioner. The sixth step shall be paid after the accumulation of thirty-six (36) months of competent service at the fifth step. Beginning November 12, 2001 eligibility for sixth step shall be extended to the classifications of Assistant Nurse Manager and Certified Registered Nurse Anesthetist.

g) Longevity Pay – Step Seven

Effective August 7, 2000 a seventh step is established at approximately five percent (5%) above step six for the existing classifications of Clinical Nurse III, Psychiatric Nurse II, Nurse Coordinator, Staff Developer, Clinical Nurse Specialist, Infection Control Nurse and Nurse Practitioner. The seventh step shall be paid after the accumulation of one hundred and thirty two months (132) of competent service subsequent to attainment of step five of the nurse's current classification.

Effective August 7, 2000, former Clinical Nurse IVs and Clinical Nurse Vs, who are currently Clinical Nurse III's and had their salaries frozen, shall be eligible to be paid at step seven.

h) Longevity Pay Steps – Steps A, B and C

Effective November 8, 2004 pay steps A, B and C are established as sub-steps within a salary range at approximately two and one half percent (2.5%), five percent (5%) and seven and one half percent (7.5%) higher than a corresponding step (e.g. step 7, step 7A, step 7B and step 7C). The A step shall be paid during the 15th year through the 19th year of service in this bargaining unit. The B step shall be paid during the 20th year through the 24th year of service in this bargaining unit. The C step shall be paid during the 25th year and beyond of service in this bargaining unit.

i) Time for Salary Adjustments

Salary adjustments shall be made on the first day of the pay period in which the required accumulation of months of competent service occurs.

j) For nurses hired on or after February 4, 2013, the following salary steps shall apply:

1) Effective February 4, 2013, two lower sub-steps below step one shall be established for all classifications at 5% difference between each step. The first sub-step shall be

the hiring rate for all new nurses hired on or after February 4, 2013.

2) Sub step 98 is the minimum rate and shall normally be the hiring rate for the classification. In cases where it is difficult to secure qualified personnel or a person of unusual qualities is engaged, the County Executive may approve the appointment at step 99, one, two, three, four or five.

3) Sub step 99 shall be paid after the accumulation of twelve (12) months competent service at sub step ninety-eight.

4) Step one shall be paid after the accumulation of twelve months competent service at step ninety-nine.

5) Step two shall be paid after the accumulation of six months competent service at step one.

6) Step three shall be paid after the accumulation of twelve months competent service at step two.

7) Step four shall be paid after the accumulation of twelve months competent service at step three.

8) Step five shall be paid after the accumulation of twelve months competent service at step four.

9) Sub-step 98 and 99 Elimination:
Sub-steps 98 and 99 shall be eliminated effective November 10, 2014.

Nurses hired on or after February 4, 2013, into sub-step 98/99 and who remain in sub step 98/99 on November 10, 2014 shall be placed in step 1 effective November 10, 2014.

Nurses who remain in sub-step 98/99 on or after June 23, 2014, shall receive the difference between sub-step 98/99 and step 1 for all hours paid starting from June 23, 2014 through November 9, 2014.

Section 7.3 - Effect of Promotion, Demotion or Transfer on Salaries

a) Promotion

Upon promotion, a nurse's salary shall be adjusted as follows:

1. For a promotion of less than ten percent (10%) the salary shall be adjusted to the step in the new range which provides for a corresponding percentage increase in salary.

2. For a promotion of ten percent (10%) or more the salary shall be adjusted to the step in the new range which provides for ten percent (10%) increase in salary or to the first step in the new range, whichever is greater.

Any other promotion will be in accordance with regular County procedure.

b) Demotion

Notwithstanding the provisions of Section 7.2, upon demotion of a nurse with permanent status in the nurse's current class, the nurse's salary shall be adjusted to the highest step in the new class not exceeding the salary received in the former class.

c) Transfer

Upon transfer, the salary shall remain unchanged.

d) No Loss of Time-In-Step

Notwithstanding the provisions of Section 7.2, no salary adjustment upon promotion, demotion, or transfer shall effect a loss of time acquired in the former salary step, and such time as was acquired in the former salary step shall be included in computing the accumulation of the required months of service for eligibility of the employee for further salary increases.

e) Voluntary Demotion

In the event of a voluntary demotion required by a work-connected illness or injury and a resulting disability, the salary of the nurse shall be placed at the step in the salary range which corresponds most closely to the salary received by the nurse as of the time of injury. In the event that such voluntary demotion would result in a salary loss of more than ten percent (10%), the nurse's new salary shall be set at the rate closest to, but not less than ten percent (10%) below the nurse's salary as of the time of injury.

f) Lateral Transfers

When making a lateral transfer or demotion to another class, an application review by the Personnel Director shall be deemed as an appropriate qualifying examination for nurses in instances where a qualifying examination is required. If otherwise qualified under this provision, and the only prohibition to lateral transfer is the salary of the new class, it shall be deemed to be a lateral transfer if the move from one classification to another does not exceed twelve percent (12%) upward range movement.

Section 7.4 - Part-Time Salaries

a) Salary Ranges

The salary ranges provided in the attached Appendix are for full-time service in full-time positions, and are expressed in dollars per the number of working days in a bi-weekly pay period. If any position is established on any other time basis, the compensation for such position shall be adjusted proportionately.

b) Benefits

Beginning with the 1996 open enrollment period, part-time nurses may elect to be covered by either the County's health care package (medical, dental, vision, and life) or medical coverage only and shall authorize a payroll deduction for the appropriate prorated cost.

Nurses who become part-time nurses as a result of a layoff from full-time will continue to receive full-time benefits until such time as they are offered a full-time position in their current classification or higher.

Nurses may withdraw from the insurance package at any time. Nurses may enroll in the insurance package upon entering part-time, upon changing from any increment of part-time to any other increment of part-time or to full-time, or once per year during the County-wide insurance window.

Any nurse in a part-time status who pays for medical benefit coverage will be reimbursed in the following pay period the additional pro-rated premiums consistent with any hours worked above their code status the previous month. This shall begin with changes coinciding with the 1996 open enrollment period.

c) Split Codes

The County shall provide a minimum of fifty (50) full-time codes to be filled on a half-time basis at any one time. The location and choice of these codes will be determined on a departmental basis. Requests for split codes shall not unreasonably be denied. Reasonable denial shall include, but not be limited to, demonstration that the work is not divisible, demonstration that qualified partners, if needed, are not available, or that the fifty (50) available codes are filled. Nurses shall make a written request for a split code to their immediate supervisor. If the request is denied, it shall be reviewed by their Department Head and they shall receive a written response.

Section 7.5 - Work Out of Classification

a) Pay

Work out of classification assignments shall only be made if such assignment is 15 consecutive calendar days or more. When a nurse is temporarily assigned work out of classification to a vacant position or a position where the incumbent is unavailable for work due to an authorized leave, the nurse will receive pay consistent with the promotional pay procedure as set forth in Article 7.3. When such payment for higher level duties is appropriate under these terms and conditions, it will commence on the first day of the assignment and continue throughout the duration thereof. Any nurse assigned work out of classification must meet the minimum qualifications of the classification to which the nurse is assigned. The Association will be notified in writing of any work out of classification pay which continues beyond three (3) months.

Work out of classification to vacancies within the bargaining unit shall be posted within the unit for a period of five days. In order to be considered, nurses expressing interest in such assignment shall notify his/her Nurse Manager in writing. No nurse shall be assigned work out of classification in a vacancy within the bargaining unit for more than twelve (12) consecutive months per occurrence.

b) Application to Holiday and Sick Leave

Upon eligibility for pay in accordance with Section 7.5(a), a nurse temporarily assigned work out of classification shall receive the pay for:

1. Holidays when the nurse is assigned work out of classification the day prior to and following the holiday.

2. Sick leave absences when the nurse is assigned work out of classification and while absent is not relieved by the incumbent or by another nurse assigned work out of classification in the same position.

c) Vacant Regular Codes

Work out of classification may be assigned to cover vacant regular codes after ordinance code provisions for filling such vacancies have been followed and with approval of the Director of Personnel. The appointing authority shall consider appointment of nurses under work out of classification provision before making a provisional appointment.

Section 7.6 - Paychecks

a) Night Employees

The County agrees to provide paychecks for night nurses by 12:01 a.m. on payday.

b) Shortage Errors

Cash advance by the Controller's Department to cover a shortage error in a nurse's paycheck shall be provided to the nurse within one (1) working day after written notification of discrepancy by the department to Finance. The department will notify Finance within one (1) working day after verification of the shortage. This provision is to cover only those discrepancies above a net one hundred dollars ($100.00).

Shortage errors of less than a net one hundred dollars ($100.00) shall be adjusted within two (2) pay periods of when the department learns of the error.

c) Overpayment Errors

When a net twenty-five dollar ($25.00) or more overpayment error occurs, the nurse will repay the overpayment in the same amount and within the same number of pay periods in which the error occurred. In cases that necessitate pay back of overpayments totaling more than $200.00, the County shall notify the Association prior to implementing repayment action.

Section 7.7 - Automatic Check Deposit

All nurses hired after the effective date of this Agreement shall be paid by automatic check deposit. By March 1, 2008 all nurses hired prior to the effective date of this Agreement shall be paid by automatic check deposit unless the nurse certifies he/she does not have a bank account.

ARTICLE 8 - HOURS OF WORK, OVERTIME, PREMIUM PAY

Section 8.1 - Hours of Work

Eight (8) hours work shall constitute a full day's work and forty (40) hours work shall constitute a full week's work unless otherwise provided by law, code or other agreement. Nurses assigned to an eight (8) hour shift which is shortened to seven (7) hours due to daylight savings time shall be paid for eight (8) hours, and nurses assigned to an eight (8) hour shift which is lengthened to nine (9) hours due to daylight savings time, shall be paid overtime one (1) hour as defined in Section 8.2(b).

Section 8.2 - Overtime Work

a) Overtime Defined

1. Exempt Nurses

Overtime is defined as time worked beyond eighty (80) hours on a bi-weekly pay period, or beyond eight (8) hours in any work day except as mutually agreed upon between the County and the Association. Time for which pay is received but not worked such as vacation, sick leave, and authorized compensatory time off, will be counted towards the base period. The County Executive shall determine by administrative order those classes and positions which shall be eligible for overtime work and for cash payment.

2. Non-exempt Nurses

For non-exempt nurses all provisions regarding overtime shall be as set by the Fair Labor Standards Act. All disputes regarding that Act shall be within the sole jurisdiction of the U.S. Department of Labor and shall not be subject to grievance or arbitration under this contract. At least five (5) working days prior to filing any complaint regarding the Act with the U.S. Department of Labor, the Association shall give the County written notice. Such notice shall contain specific information so that the County can prepare a response.

b) Rate of Pay

When overtime work is assigned and is authorized by the appointing authority to be worked, compensation for such time worked shall be time off with pay computed as noted in 1. and 2. below, except that such overtime work shall be paid in cash for nurses where required by State or Federal law or when specifically authorized by administrative order of the County Executive.

1. Regular Overtime - one and one-half (1 1/2) hours for every hour of overtime worked.

2. Continuous Shift - one and one-half (1 1/2) hours for the first four (4) hours of overtime contiguous to their regular shift of a minimum of eight (8) hours and two (2) hours for any additional hours worked.

All compensatory time off must be taken within twelve (12) months of the date the overtime was worked, and failure to take the compensatory time off shall be deemed a waiver of the compensatory time by the nurse. In the event the appointing authority does not provide compensatory time off during the mandatory time period, the nurse may take compensatory time off as a matter of right immediately before the end of the pay period in which the compensatory time would be lost. Compensatory time balances shall be paid in cash on separation. A nurse may elect in advance to receive compensatory time-off credit in lieu of cash compensation for overtime where compensatory time off is allowed, if the appointing authority agrees.

c) Distribution of Overtime

In situations where the need for overtime work exists, coded nurses in the applicable work unit shall first be offered the overtime work. Overtime work shall be distributed among nurses in the applicable work unit as equally as practicable.

Section 8.3 - Meal Periods

a) Length

Nurses shall be granted a meal period not less than thirty (30) minutes nor more than one (1) hour, scheduled at approximately the mid-point of the work day. Nurses required to be at work stations for eight (8) or more consecutive work hours shall have their meal during work hours.

b) Overtime Meals

If a nurse is assigned two (2) or more hours of overtime work contiguous to the nurse's regular work shift or is called in within three (3) hours of the nurse's scheduled quitting time and then works two (2) or more hours of overtime work, the County will reimburse the cost of the meal actually purchased and consumed by the nurse on the nurse's own time to a maximum amount of nine dollars ($9.00). Nurses shall be provided additional meals as above for every seven (7) hour period of overtime completed thereafter. Nurses must present their claim for the reimbursement within fourteen (14) calendar days following the shift it was earned or the meal reimbursement is waived.

c) County Facilities

Whenever the duties or responsibilities of any County nurse require the nurse to be present and on duty during the serving of meals in a County facility and where such duty or responsibility occupies that nurse's meal period, such individual shall be entitled to that meal without charge.

d) Meal Rates

In each County dining facility where meals are served to nurses at the nurse's expense, the Department Head in charge of the operation of that facility shall prescribe the rates to be charged. The rates so prescribed shall, as a minimum, be sufficient to defray the costs of the food served.

Section 8.4 - Rest Periods

All nurses shall be granted and take a rest period of fifteen (15) minutes during each half shift of four (4) hours of work. Rest periods shall be considered as time worked for pay purposes. Should an individual nurse anticipate not being able to take his/her rest period due to patient care needs, he/she shall promptly notify his/her charge nurse or supervisor, or if unable to directly notify the charge nurse or supervisor, the nurse shall inform the relief nurse, in which case every effort shall be made to ensure the nurse is offered an alternate rest period during his/her shift. Any alternate rest period offered shall be considered a rest period and not a meal period.

If a nurse is not offered a rest period, the missed break shall be reported utilizing the Notice of Staffing Level Concerns form and process as listed in Section 18.10(d),(e), and (f).

Section 8.5 - Clean-Up Time

All nurses whose work causes their person or clothing to become soiled shall be provided with reasonable time and adequate facilities for wash-up purposes.

Section 8.6 - On-Call Pay

a) Definition

On-call is defined as the requirement to remain immediately available to report for duty to perform an essential service when assigned by the appointing authority, subject to approval by the County Executive. On-call duty is in addition to and distinct from the normal work week. This Section is only applicable to those situations where nurses are recalled to work when previously placed on an on-call status.

b) Classifications Eligible
Each Department Head, subject to approval by the County Executive, shall designate which class(es) of nurse(s) shall be subject to on-call duty.

c) Rates of Pay
Nurses assigned to on-call duty shall receive, in addition to their regular salary, one half (1/2) of their regular base rate of pay for each hour of assigned call duty. Nurses who are called into work while on-call will receive one and one-half (1 1/2) times their regular base rate of pay for each hour worked. Shift differentials shall be paid in accordance with Section 8.8.

d) Beepers
Beepers shall be provided to all nurses when placed on on-call status.

Section 8.7 - Call-Back Pay
If overtime work does not immediately follow or precede the regular work shift, a minimum of four (4) hours call-back time shall be credited the nurse. Call-back pay is subject to all provisions of Article 8, Section 2, Overtime Work.

The O.R. Nurse or Recovery Room Nurse may elect to receive compensatory time off credit in lieu of cash compensation for call-back time worked.

An O.R. Nurse or Recovery Room Nurse shall be granted a day charged to Paid Time Off, leave without pay, or compensatory time, on the O. R. or Recovery Room Nurse's normal work day following five (5) or more hours of call-back time.

Nurses will be credited for each call-back during a scheduled shift.

Section 8.8 – Call-In Pay
Availability does not constitute confirmation to work. Definite confirmation must be made by authorized personnel before the nurse reports to work. If staffing needs change and the nurse reports to work for a specific area, no work is available and no alternate assignment can be made, the nurse shall be reimbursed for a minimum of four (4) hours.

No work or pay is required under this provision if the employer has attempted to contact the nurse by phone (contact or attempted contact has been documented) at least one and one half (1.5) hours prior to the start of the shift to inform the nurse not to report. This provision is waived if the nurse declines an alternate assignment.

Section 8.9 - Shift Differentials

a) Definition of shifts:

1. DAY shift -- any scheduled shift of at least eight (8) hours beginning on or after 6:00 a.m. and ending on or before 6:00 p.m.

2. EVENING shift -- any scheduled shift of at least eight (8) hours beginning on or after 2:00 p.m. and ending on or before 2:00 a.m.

3. NIGHT shift -- any scheduled shift of at least eight (8) hours beginning on or after 10:00 p.m. and ending on or before 10:00 a.m.

b) Part Time/Overlapping Shifts:

1. For shifts of fewer than eight (8) hours, a differential will be paid on the hours worked only if at least half the hours fall between 5:00 p.m. and 6:00 a.m.

2. For shifts which fall across the shifts as defined above, a differential will be paid if at least half the hours fall between 5:00 p.m. and 6:00 a.m.

3. For shifts which fall across both the evening and night shifts as defined above, the differential will be paid according to which shift contains the majority of hours worked. If the split is half and half, the night shift differential will be paid.

c) Pay Rates:

1. The hourly rate for evening shift differential is $4.00.

2. The hourly rate for night shift differential is $7.25.

3. The above differentials are paid on productive hours worked only.

Section 8.10 - Split Shift Pay

A nurse who is performing services upon a split shift shall be paid an additional twelve dollars ($12.00) per day. "Split Shift" is defined as eight (8) hours of work which are not completed within any nine (9) consecutive hours in a work day.

Section 8.11 – Charge Nurse Differential

A Clinical Nurse I, II, or III, and Psychiatric Nurse I, or II who is assigned as a charge nurse shall receive an additional two dollars and seventy five cents ($2.75) per hour.

Section 8.12 – Weekend Off Provision

The County will attempt to grant every other weekend off and each nurse will not be required to work more than two (2) consecutive weekends in a row. The County guarantees that nurses will not be required to work more than twenty-six (26) weekends per year. If the County requires a nurse to work more than two (2) consecutive weekend days, or more than twenty-six (26) required above, the nurse will receive time and one-half for work in excess of that required. These penalties shall not be duplicated for the same weekend worked. Work as used in this section shall mean productive time. Weekend work required shall be prorated for newly coded nurses and for any nurse who is off the payroll due to an authorized leave of absence.

The above weekend off provisions may be waived on the written request of the individual nurse.

The weekend day a nurse is required to work must be the same day during consecutive weekends, e.g. a nurse who works the first Saturday, the second Saturday, and the third Saturday and Sunday would receive penalty pay at time and one half for the third Saturday. A nurse who works the first Saturday, the second Saturday, and the third Sunday would not receive penalty pay at time and one half for the third Sunday.

A nurse must pick up at least half of a scheduled shift on each weekend day worked to be eligible for penalty pay, e.g. a nurse working an eight hour shift who works the first Saturday for three hours, the second Saturday for eight hours, and the third Saturday for eight hours would not receive penalty pay at time and one half for the third Saturday. A nurse working an eight hour shift who works the first Saturday for four hours, the second Saturday for eight hours, and the third Saturday for eight hours would receive penalty pay at time and one half for eight hours the third Saturday. A nurse working an eight hour shift who works the first Saturday for eight hours, the second Saturday for three hours, and the third Saturday for eight hours would not receive penalty pay at time and one half for the third Saturday. A nurse working an eight hour shift who works the first Saturday for eight hours, the second Saturday for four hours, and the third Saturday for eight hours would receive penalty pay at time and one half for eight hours the third Saturday.

The examples listed are not exhaustive.

Section 8.13 – Weekend Shift Differential

A weekend differential of two dollars ($2.00) per hour will be paid to Registered Nurses for productive time worked on a Saturday and/or Sunday. For the Night Shift only, the weekend will begin at the start of the RN's regularly scheduled Saturday shift (i.e., 11:00 p.m. on Friday) and terminate at the end of his/her regularly scheduled shift on Sunday (i.e., 7:30 a.m. on Sunday).

This differential shall not be pyramided with other penalty premiums or paid on overtime shifts. The value of the weekend differential does not increase regardless of hours worked or rates of pay, etc.

Section 8.14 – Float Differential

The order of float shall be as follows:

a) Volunteers;
b) Extra help and per diem;
c) Coded nurses:
    1. All coded nurses working overtime will float prior to regularly scheduled coded unit nurses;
    2. All coded nurses working over-code will float prior to regularly scheduled coded unit nurses.

Each nurse will only float within areas as follows:

1. Medical-Surgical Units (3 Surgical, 4 Surgical, 4 Medical)
   Admission, Discharge, Transfer (ADT) Nurse

2. Neonatal ICU
   Pediatrics
   Pediatric Intensive Care Unit

3. Adult Intensive Care Units (MICU, CCU, SICU, TICU)
   Burn Unit
   Cardiac Cath Lab
   Interventional Radiology

4. Rehabilitation Unit 1 RHB
   Rehabilitation Unit 2 RHB
   Rehabilitation Trauma Unit RTC2

5. Labor and Delivery

6. Mother Infant Care Center (MICC)

7. Operating Room

8. Post Anesthesia Care Unit (PACU)
   Ambulatory Surgery Unit (ASU)

9. Transitional Care Neurosurgery Unit
   Medical Short Stay Unit

10. Drug and Alcohol

11. Psychiatric Inpatient
    Emergency Psychiatric Service

12. Custody Health Services

13. Ambulatory Care Clinics

14. Emergency Department
    (not to float except in emergency)

15. Renal Care Center/ Renal Dialysis Unit

16. Resource Nurse

17. Endoscopy

b) If a float assignment outside like areas is necessary, Management shall attempt to send volunteers from the unit to be floated from prior to making an involuntary assignment. If a coded nurse is required to float outside of one of the like areas, the nurse shall receive one dollar ($1.00) per hour for such assignment. A nurse who requests to float in order to broaden the nurse's experience may put the nurse's name on a list, maintained in the Nursing Office, indicating where the nurse requests to float. In this case, a differential shall not be paid.

Except in emergencies (emergency is defined as a situation when reasonable efforts to float from like areas fails), no nurse will be assigned to an area without having adequate orientation to that area. Adequate orientation will be determined by the Director of Nursing with input from the Nurse Manager, and Staff Developer.

Assignments shall include only those duties and responsibilities for which competency has been validated. A registered nurse with demonstrated competencies for the area shall be responsible for the nursing care, and shall be assigned as a resource to the

RN who has been assigned to the unlike area and who has not completed competencies for that area.

This Section will not apply when one of the units is temporarily closed.

c) The County will attempt to expand the float pool at Valley Medical Center. Coded Floats and Resource Nurses will be paid the current differential.

Section 8.15 - Temporary Work Location

When a nurse is assigned to work at a location different from the nurse's regularly assigned work location, the nurse shall be allowed to travel on County time to that work location. Time allotted for travel and mileage paid shall be based on actual miles traveled. Actual miles traveled shall be defined as all miles driven on County business. However, no mileage reimbursement shall be paid for miles traveled to the first field or work location of the day from the nurse's place of residence or from the last field or work location of the day to the nurse's place of residence, unless the miles traveled exceeds the distance normally traveled by the nurse during their normal home-to-work commute. In that case, the nurse may claim reimbursement for only the added mileage which exceeds their normal home-to-work location.

The County will either supply transportation for such travel or shall pay mileage based on the above distances. The County assumes no obligation to the nurse who for self-convenience voluntarily reports to other than the regularly assigned work location.

Section 8.16 - Bilingual Pay

On recommendation of the appointing authority and the Director of Personnel, the County may approve payments of one hundred fifty ($150.00) per month to a bilingual nurse whose abilities have been determined by the Director of Personnel as qualifying to fill positions requiring bilingual speaking and/or writing ability. Bilingual skill payments will be made when:

a) Public contact requires continual eliciting and explaining information in a language other than English; or

b) Where translation of written material in another language is a continuous assignment; or

c) The position is the only one in the work location where there is a demonstrated need for language translation in providing services to the public.

The County shall review positions covered by this Agreement not less than annually to determine the number and location of positions to be designated as requiring bilingual abilities. The County will post the names and language skills by work unit of those employees who are being paid a bilingual differential.

Differential may be removed when the criteria ceases to be met.

Section 8.17 - Hazard Duty

a) The work places covered and included in this Section are the JPD Ranches and the locked/secured sections of the following facilities:

The Main Jail
Elmwood
North County Jail
JPD Hall
Psychiatric Inpatient
Emergency Psychiatric Services

b) A premium for Hazard Duty of ninety-five cents ($.95) per hour shall be paid to coded classifications while in paid status whose entire assignment for the County is in a work place described in paragraph a). This payment shall be made irrespective of classification, pay level, overtime status, holiday work, or other wage variations. This hazard duty premium shall be included in the pay status time of the coded classifications described in this paragraph b).

c) A premium for hazard duty of ninety-five cents ($.95) per hour shall be paid to coded classifications, whose entire assignment is not in a work place described in paragraph a), for only the hours assigned and worked in a work place described in paragraph a). This payment shall be made irrespective of classification, pay level, overtime status, holiday work or other wage variations. This hazard duty premium shall not be included in the pay status time of the coded classification described in this paragraph c). A nurse must work a minimum of thirty (30) consecutive minutes per entry into a work place described in paragraph a) prior to being eligible for the hazard duty premium. Coded classifications shall receive an additional full hourly premium for time worked of more than six (6) minutes in any hour after the first hour of work.

d) The hazard duty premium shall not be allowed in computing payments at the time of termination.

Section 8.18 - Alternate Work Schedules

The only alternate shifts recognized are ten (10) and twelve (12) hour shifts. A nurse may elect to work an alternate work schedule based on eighty (80) hours per two (2) week period. Time worked in excess of eighty (80) hours bi-weekly shall be subject to overtime pay provisions of this Agreement. This schedule shall be a voluntary/optional alternative to a previous eight (8) hour per day schedule with mutual agreement of the nurse and management. A nurse working a regularly scheduled ten (10) or twelve (12) hour shift shall be compensated for each hour worked at the regular hourly base pay. Hours worked in excess of ten (10) or twelve (12) hours of a regularly scheduled ten (10) or twelve (12) hour shift, shall be subject to overtime provisions of Article 8, Section 2 (Overtime Pay).

Shift differential shall be paid for all hours worked as specified in Article 8, Section 8 (Shift Differentials).

Section 8.19 - Changes in Schedules

Except for emergencies, changes in a nurse's scheduled work unit, scheduled regular shift or scheduled regular number of hours in the work day will not be made unless the nurse is given advance notice of the change and is provided the opportunity to discuss the proposed change with the appropriate supervisor.

Section 8.20 - Additional Shift Work

Draft schedules shall be posted two weeks in advance of the posting of the final schedule. Nurses shall indicate availability for additional shift work in writing. Prior to posting of the final work schedule, nurses in part time codes will be given preference over Per Diem and Extra-Help nurses for available, additional shifts in their work unit. Additional shift work within a unit shall be distributed as equally as practicable among coded nurses in the following sequence:

a) Part time coded nurses within the work unit the additional shifts are available;
b) Part time coded nurses outside the work unit, provided such nurse can claim competency in the area the additional shifts are available.

Additional shifts do not result in overtime compensation or weekend off provision penalty pay unless pre-approved by Management.

Section 8.21 - Voluntary Reduced Work Hours Program

a) The County agrees to establish a Voluntary Reduced Work Hours Program for full-time nurses represented by the Association.

The purpose of the Program is to reduce work hours and a commensurate amount of pay on a voluntary basis.

b) Nurses may elect a two and one-half percent (2 1/2%), five percent (5%), ten percent (10%) or twenty percent (20%) reduction in pay for a commensurate amount of time off for a six (6) month period. Admission into the plan will be at six (6) month intervals.

c) All nurses in the Program will revert to their former status at the end of six (6) months. If a nurse transfers, promotes, demotes, terminates, or in any other way vacates or reduces the nurse's present code, the nurse will be removed from the Program for the balance of the six (6) month period.

d) Compensatory time shall accrue as earned and shall not be scheduled on any day considered as a County holiday. Nurses may use the reduced hours time in advance of accrual and will reimburse the County for hours taken in advance of accrual upon early termination from the Program.

e) Participation in this Program shall be by mutual agreement between the nurse and the Department/Agency Head. At no time will approval be given if it results in overtime. Restrictions by Department/ Agencies within work units shall be uniformly applied.

f) It is understood by the County that due to this Program there may be lower levels of service.

g) All nurses will be notified in writing regarding the Program specifics and the sign-up options. Such written notice to be mutually agreed upon by the parties.

h) Full and timely disclosure of actual sign-ups and any analysis developed will be made available to both the County and the Association.

i) This agreement governs as to the Voluntary Reduced Work Hours Program, but will in no way alter the meaning of the Association and County Agreements currently in effect. This will include any departmental, side letter agreements, etc.

Section 8.22 - National Certification Pay

Annual compensation of two hundred fifty dollars ($250.00) may be issued to a coded nurse who is certified or recertified in a clinical specialty. Each coded nurse may apply for National Certification Pay provided:

a) The certification is clinically relevant to the nurse's area of clinical specialty and will enhance the nurse's knowledge base and skill in providing expert patient care.
b) The certification is issued by a nationally recognized accrediting agency and applicable to current area of practice.
c) Certification that is required by the California Board of Registered Nursing (BRN) to meet certification or recertification requirements as a Certified Registered Nurse Anesthetist (CRNA) does not qualify for National Certification pay.
d) Certification that was used to meet the California Board of Registered Nursing credentialing requirements as a Nurse Practitioner or Clinical Nurse Specialist does not qualify for National Certification pay.
e) Verification of successful completion of such certification is submitted during the April submission month.

ARTICLE 9 - PAID TIME OFF

Section 9.1 - Purpose

Paid Time Off was developed to allow more flexibility in the use of nurse's time off. The following were taken into consideration in establishing the amount of time accrued each pay period:

3 Personal leave days
12 Holidays
1 Birthday
Vacation

9.2 - Paid Time Off Accrual

a) Each nurse shall be entitled to annual Paid Time Off. Paid Time off is earned on an hourly basis. For purposes of this section, a day is defined as eight (8) work hours. Prior to February 16, 2003, the provisions of the prior contract will apply to PTO total yearly accrual, accrual factor, hourly accrual factor per pay period and maximum allowable balances.

Effective February 16, 2003, the accrual schedule shall be as follows:

SERVICE YEARS & WORK DAY EQUIVALENT	TOTAL YEARLY ACCRUAL IN WORK DAYS	ACCRUAL FACTOR PER HOUR	HOURLY ACCRUAL FACTOR PER PP	MAXIMUM ALLOWABLE BALANCE
1st year (1st through 261 days)	27	0.103846	8.307	81 work days
2nd through 4th year (262 through 1044 days)	29	0.111538	8.923	87 work days
5th through 9th year (1045 through 2349 days)	33	0.126923	10.153	99 work days
10th through 14th year (2350 through 3654 days)	35	0.134615	10.769	105 work days
15th through 19th year (3655 through 4959 days)	37	0.142307	11.384	111 work days
20th year and thereafter (4960 days and beyond)	39	0.150000	12.000	117 work days

Section 9.3 – Pre-Scheduled Usage

Paid Time Off may be used for any lawful purpose by the nurses; the time requested shall require the approval of management with due consideration of nurse convenience and administrative requirements. Requests for paid time off shall not be unreasonably denied. Approvals / denials shall be made in writing to the requesting nurse in accordance with Nursing Standards within thirty (30) days of the receipt of the request. All Paid Time Off hours must be exhausted before Leave Without Pay may be used with the exception of leaves of absence Where there are no earnings in one (1) full pay period. A nurse may be granted Leave Without Pay for less than one (1) pay Period upon the approval of the appointing authority or their designee.

Each unit shall maintain a vacation calendar effective June thirtieth (30) for the upcoming calendar year. The purpose of the calendar is to aid in vacation planning by the nurse and is not to be considered as an approval of a nurse's request. The scheduler will enter nurse's vacation requests(s) on such calendar as it is received.

Before denying a request, the employer will make all reasonable attempts to accommodate conflicts considering the utilization of over code work, scheduling extra help and per diem, and voluntary shift trades in support of vacation scheduling.

Upon request of a nurse denied vacation, management shall meet with the nurse on an individual basis no later than forty five (45) days before schedules are finalized in order to explore all reasonable options for resolving such conflicts. Requests for vacation shall be prioritized by submission date. Should two or more requests be submitted on the same date seniority, as defined in Section 5.1- Seniority Defined, will be used to resolve the conflict.

Section 9.4 - Paid Time Off Carry Over

In the event the nurse does not take all the paid time off to which he/she is entitled in the succeeding payroll year (twenty-six (26) or twenty-seven (27) pay periods), the nurse shall be allowed to carry over the unused portion, provided that the nurse may not accumulate more than three (3) years' earnings except:

a) When absent on full salary due to work-related compensation injury which prevents the nurse from reducing credits to the maximum allowable amount, or

b) In the case of inability to take paid time off because of extreme emergency, such as fire, flood or other similar

disaster, an additional accumulation may be approved by the County Executive.

Section 9.5 - Paid Time Off Pay-Off

Upon termination of employment a nurse shall be paid the monetary value of the earned Paid Time Off balance as of the actual date of termination of employment.

Section 9.6 - Nurse's Exit from Paid Time Off Program

In the event that a nurse covered by this section ceases to be covered by this section, the nurse shall revert back to Ordinance Section A25-693 "Vacations", A25-688 "Bereavement Leave", A25-694 "Sick Leave" and A25-664 "Holidays", or superseded agreement with a recognized employee organization. Any balance of paid time off shall be reconverted to vacation leave, and any paid time off accumulated over an amount allowed without reference to this section shall be credited as compensatory time off which must be used within one (1) year. Any balance in the Sick Leave Bank shall be converted to Sick Leave.

9.7 – Annual Cash Out of PTO

a) If a nurse has no more than two (2) occurrences of unscheduled absences, the nurse may cash out up to eighty hours of PTO. During the term of this agreement, a nurse may only cash out up to forty (40) hours under this subsection.

b) If the nurse has no more than four occurrences of unscheduled absences, the nurse may cash out up to forty hours of PTO.

Section 9.8 - Sick Leave Conversion to PTO

A nurse’s eligibility for sick leave conversion is determined by the number of occurrences of sick leave usage. Sick leave use attributed to Worker’s Compensation shall not be counted as an occurrence. The period for 2008 sick leave conversion eligibility begins December 17, 2007 and ends December 14, 2008. The period for 2009 sick leave conversion eligibility begins December 15, 2008, and ends December 27, 2009. The period for 2010 sick leave conversion eligibility begins December 28, 2009 and ends December 26, 2010. The conversion of sick leave to PTO will be for those nurses meeting the eligibility requirements below and upon the nurse’s request to the Health and Hospital Systems Human Resources Department. A nurse must identify any sick leave use attributed to Worker’s Compensation with the request in order for such leave to be disregarded as an occurrence. Requests for sick leave conversion for 2008 must be submitted in February 2009 and conversion to PTO shall be credited on March 9, 2009(paycheck of March 27, 2009). Requests for sick leave conversion

for 2009 must be submitted in February 2010 and conversion to PTO shall be credited on March 22, 2010 (paycheck of April 9, 2010). Requests for sick leave conversion for 2010 must be submitted in February 2011 and conversion to PTO shall be credited on March 21, 2011 (paycheck of April 8, 2011).

Sick leave may be converted annually on the following basis (prorated for nurses other than full time on the basis of code status):

a) If a nurse has no sick leave usage, seven (7) days of sick leave will be converted into PTO.

b) If a nurse has one (1) occurrence of sick leave usage, six (6) days of sick leave will be converted into PTO.

c) If a nurse has two (2) occurrences of sick leave usage, five (5) days of sick leave will be converted into PTO.

d) If a nurse has three (3) occurrences of sick leave usage, two (2) days of sick leave will be converted into PTO.

e) If a nurse has four (4) occurrences of sick leave usage, one (1) day of sick leave will be converted into PTO.

f) If a nurse has five (5) or more occurrences of sick leave usage, no sick leave shall be converted to PTO.

Section 9.9 - Usage of Paid Time Off on Holidays

a) The following shall apply to all holidays listed below:

1. Holiday falls on regularly scheduled day to work and nurse does not work -- Charge maximum eight (8) hours PTO.

2. Holiday falls on regularly scheduled day to work and nurse works -- Charge maximum eight (8) hours PTO and pay time and one-half for all hours worked.

3. Holiday falls on scheduled day off and nurse does not work -- Nothing is charged as holidays are in PTO accrual rate.

4. Holiday falls on scheduled day off and nurse works -- No charge to PTO Bank and pay time and one-half for all hours worked.

5. Half-time nurses who do not work the holiday may elect in advance to charge four (4) hours to PTO and the remainder to leave without pay.

b) The following shall be observed as legal holidays:

1. January 1st

2. Third Monday in January

3. Third Monday in February

4. March 31st

5 Last Monday in May

6. July 4th

7. First Monday in September

8. Second Monday in October

9. Veteran's Day to be observed on the date State of California workers observe the holiday

10. Fourth Thursday in November (Thanksgiving Day)

11. The Friday following Thanksgiving Day (Day After Thanksgiving)

12. December 25th

13. Other such holidays as may be designated by the Board of Supervisors.

All previous informal time off practices are eliminated and unauthorized.

c) Nurses shall enjoy the same number of holidays, regardless of variations in work weeks. For nurses who are assigned to positions which are not normally staffed on the weekends (Saturdays and Sundays, such as the clinics and Staff Development), holidays which fall on Sunday are observed on the following Monday and holidays which fall on Saturdays shall be observed on the preceding Friday. For employees who are assigned to positions which normally work on weekends (such as the Medical Units, ICU's, Institutional Units, etc.) the holiday shall be observed on the actual day listed in (b), supra.

d) The employer will use its best efforts to rotate equitably holiday time off among coded nurses for each unit for Thanksgiving, Christmas and New Year holidays.

e) A nurse may elect in advance to receive compensatory time off credit in lieu of cash compensation.

f) A nurse may elect in advance to use compensatory time off for a holiday in lieu of charging PTO.

Section 9.10 - Call Back From PTO

When a nurse is called back from PTO, which has been scheduled at least five (5) calendar days in advance of the first day of PTO, the nurse shall be paid at 1 1/2 times the nurse's base hourly rate.

Section 9.11 – PTO Illness Conversion

If a nurse on PTO becomes ill, the nurse may convert PTO to sick leave with pay. Such conversion must be supported by a statement from an accredited physician.

ARTICLE 10 - SICK LEAVE PROVISIONS

Section 10.1 - Sick Leave Bank Usage and Accrual

Each nurse shall be entitled to sick leave. Such leave may be used for personal illness or for medical consultation to preserve the nurse's health. Except for emergencies, all absences for medical consultation must be approved by the nurse's supervisor. Such leave shall be earned on an hourly basis and computed at the rate of ninety-six (96) hours per year and may be accrued without limitation. The accrual factor per hour is .045977 and the accrual factor per full pay period is 3.678.

Section 10.2 - Sick Leave Usage for Care of Immediate Family

A nurse who has acquired a sufficient right to sick leave with pay may be granted permission to use same not to exceed three (3) working days of such leave in order to care for a sick or injured member of the nurse's immediate family requiring care. "Immediate family" shall mean the mother, father, grandmother, grandfather of the nurse or of the spouse of the nurse and the spouse, son, son-in-law, daughter, daughter-in-law, brother, sister, grandchild, brother-in-law or sister-in-law of the nurse or any person living in the immediate household of the nurse.

Section 10.3 - Doctor's Notes

Request for sick leave with pay in excess of three (3) working days must be supported by a statement from a licensed medical practitioner who is eligible for third party reimbursement. Management may require such a supporting statement for absences of less than three (3) days when there is reasonable cause.

Section 10.4 - Bereavement Leave

Leaves of absence with pay shall be granted nurses in order that they may discharge the customary obligations arising from the death of a member of their immediate family. "Immediate family" shall mean the mother, father, grandmother, grandfather of the nurse or of the spouse of the nurse and the spouse, son, son-in-law, daughter, daughter-in-law, brother, sister, grandchild, brother-in-law, sister-in-law, registered domestic partner or step-parent of the nurse or any person living in the immediate household of the nurse. Up to forty (40) hours pay shall be granted which will consist of sixteen (16) hours not charged to any accumulated balance followed by twenty-four (24) hours chargeable to sick leave, if necessary. An additional twenty-four (24) hours, sixteen (16) chargeable to sick leave and eight (8) not charged to any accumulated balance, is authorized if out-of-state travel is required.

Section 10.5 - Sick Leave Bank Pay Off

For purposes of this paragraph, a day is defined as eight (8) work hours.

Upon death or retirement, up to sixty (60) days of accrued sick leave shall be paid off at a rate of fifty percent (50%) of the equivalent cash value. All accrued balances beyond sixty (60) days shall be paid off at the rate of twelve and one-half percent (12 1/2%) of the accrued cash value (one hour's pay for one day of accrual).

Upon resignation in good standing, nurses with ten (10) or more years' service shall be paid up to sixty (60) days of accrued sick leave at the rate of twenty-five percent (25%) of the equivalent cash value. All accrued balances beyond sixty (60) days will be paid off at the rate of twelve and one-half percent (12 1/2%) of the accrued cash value.

Section 10.6 - Reinstatement Pay Back

Nurses receiving a sick leave bank payoff in accordance with Section 10.5 may, if reinstated within one (1) year, repay the full amount of sick leave bank payoff received and have the former sick leave bank balance restored. Repayment in full must be made prior to reinstatement.

Section 10.7 - Sick Leave Conversion

A portion of unused sick leave may be converted to PTO in accordance with Section 9.8.

ARTICLE 11 - LEAVE PROVISIONS

Section 11.1 - Leave Without Pay

a) Reasons Granted

Leaves of absence without pay may be granted to nurses for up to one (1) year. Extensions to leaves approved for less than one (1) year shall not unreasonably be denied provided adequate advance notice is given. If a nurse wishes to return to work early from a leave of absence, the nurse shall provide reasonable advance notice to the appointing authority. Leaves beyond one (l) year may be granted due to unusual or special circumstances. The following are approved reasons for such leaves:

1. Illness beyond that covered by sick leave.

2. Education or training which will benefit the County, including advancement in nursing.

3. Other personal reasons which do not cause inconvenience on the department.

4. To accept other government agency employment.

5. Paternity leave, not to exceed six (6) months.

b) Leave for Association Business

Upon thirty (30) days' advance notice, a long term leave without pay to accept employment with the Association shall be granted by the appointing authority for a period of up to one (l) year. No more than three (3) nurses shall be granted a leave at any one time. A leave may only be denied if:

1. The notice requirement is not met.

2. The number of nurses on leave has reached the maximum of three (3).

3. The nurse has specialized skills and abilities which are necessary and could not be replaced.

With notice no less than thirty (30) days prior to the conclusion of the leave, such leave may be extended up to one (l) year upon approval of the appointing authority.

c) Revocation

A leave may be revoked by the Director of Personnel upon evidence that the cause for granting it was misrepresented or has ceased to exist.

d) Seniority Rights

Maternity leaves of more than thirteen (13) pay periods; leaves of absence of more than two (2) pay periods; and suspensions shall not be counted as time spent in a salary step in computing eligibility of the nurse for further salary increases. All time spent on industrial injury leave shall be counted.

Section 11.2 - Family Leave

a) Maternity and Adoptive Leave

1. Length

Upon request, maternity leave without pay shall be granted to natural or adoptive parents by the appointing authority for a period of up to six (6) months. With notice no less than one (1) month prior to the conclusion of the leave, such leave may be extended up to one (1) year upon approval of the appointing authority. A request for extension can only be denied for good cause. A nurse who is pregnant may continue to work as long as her physician approves with concurrence from the Department.

2. Sick Leave Use

If, during the pregnancy leave or following the birth of a child, the nurse's physician certifies that she is unable to perform the duties of her job, she may use her PTO or accumulated sick leave during the period certified by the physician. The authorized PTO or sick leave shall be charged either prior to or at the termination of the leave.

b) Paternity Leave

Upon request, paternity leave without pay shall be granted to natural or adoptive parents not to exceed six (6) months. All provisions of Section 11.1 shall apply to this paternity leave provision.

c) Other Family Leave

Upon request, family leave shall be granted for the placement of a foster child, or to attend to the serious illness of a family member in accordance with the Family and Medical Leave Act, and for the serious illness of a same sex domestic partner, for a period of up to six (6) months.

Section 11.3 - Leaves to Perform Jury Duty or to Respond to a Subpoena

a) Response to Summons

A nurse shall be allowed to take leave from the nurse's County duties without loss of wages, PTO, sick leave or nurse benefits for the purpose of responding to summons to jury selection or serving on a jury for which the nurse has been selected, subject to the limitation that a nurse shall receive paid leave to serve on a jury for which the nurse has been selected not more than once during a calendar year and provided that the nurse executes a written waiver of all compensation other than the mileage allowance, for which the nurse would otherwise receive compensation by virtue of the nurse's performance of such jury duty. No nurse shall be paid more than the nurse's regular shift pay or regular work week pay as a result of jury duty service. The nurse is required to notify the nurse's appointing authority when the nurse has received a jury summons and when the nurse's jury service is completed.

b) Jury Duty

Nothing in this Section shall prevent any County nurse from serving on a jury more than once per calendar year, provided, however, that such additional periods of absence from regular County duties as a result thereof shall be charged, at the option of such nurse, to either accrued Paid Time Off (PTO) or leave without pay.

c) Response to a Subpoena

No nurse shall suffer loss of wages or benefits in responding to a subpoena to testify in court if that nurse is not a party to the litigation.

d) Release Time

In the event a nurse is called to court under the above provision, the following shall apply:

1. Swing or PM shift shall have release time the day of court attendance; time spent in court shall be deducted from the regular shift on that day with no loss of wages or benefits.

2. Night or graveyard shift shall have release time on the shift prior to court attendance; and that nurse shall suffer no loss of wages or benefits.

3. When a nurse, whose regularly scheduled hours includes two (2) full shifts (16 hours) of scheduled duty between 11:00 p.m., Friday to 3:00 a.m., Monday, is selected for a jury

and is required to be in Court during his/her regular days off, the department will make every effort to provide the following Saturday or Sunday as a regularly scheduled day off. The weekend cannot count as a weekend worked for weekend off provisions.

e) Return to Work

For the purpose of this Section, a nurse who responds to a summons to jury duty and who is not selected as a juror shall not be deemed to have performed jury duty and shall return to work as soon as possible.

Section 11.4 - Compulsory Leave

a) Fitness for Duty Examination

If any non-probationary nurse is required by the appointing authority to take a fitness for duty examination not connected with preexisting or existing industrial injury to determine if the nurse is incapacitated for work, the following provisions will apply and will be given to the nurse in writing:

1. Before making a decision, the physician designated by the appointing authority will consult with the nurse's personal physician and will advise the nurse of this procedure.

2. If the nurse's personal physician agrees with the decision of the physician designated by the appointing authority, the decision is final.

3. If the physicians disagree, and the nurse so requests, they will select a third physician whose determination will be final. Cost for such examination by the selected physician will be equally shared by the nurse and the appointing authority.

b) Court Related

The appointing authority may require a nurse who has been formally charged in a court of competent jurisdiction with the commission of any felony or of a misdemeanor involving moral turpitude, provided said crime is related to the nurse's employment status, to take a compulsory leave of absence without pay pending determination by way of a plea, finding or verdict at the trial court level as to the guilt or innocence of such nurse.

1. Determination of Innocence

If there is a determination of innocence or the charges are dropped, the nurse shall be reinstated to the nurse's position with return of all benefits, including salary,

that were due for the period of compulsory leave if the nurse was available for work during this period. Despite reinstatement, the nurse remains subject to appropriate disciplinary action if warranted under the circumstances. Any such disciplinary action may be imposed effective as of the commencement date of the compulsory leave imposed under this Section.

2. Determination of Guilt

If there is a determination of guilt, the appointing authority may take appropriate disciplinary action. If the action is a suspension and the suspension is for a shorter duration than the compulsory leave, the nurse shall receive the difference between the compulsory leave and the suspension in salary and all benefits.

Section 11.5 - Military Leave

a) Governing Provision

The provisions of the Military and Veterans Code of the State of California and the County ordinance code shall govern the military leave of nurses of the County of Santa Clara.

b) Physical Examination

Any regular or provisional nurse shall be allowed time off with no loss in pay for the time required to receive a physical examination or re-examination as ordered by provisions of a national conscription act or by any branch of the National or State military services.

Section 11.6 - Educational Leave for Registered Nurses

a) Each July 1 a credit of forty (40) hours per year shall be granted for educational leave for all full-time nurses. Educational leave will be accumulative to a maximum of eighty (80) hours. Educational leave for part-time nurses will be prorated. There shall be a three (3) month waiting period for all nurses hired after the execution of this contract. However, each nurse who uses any time earned between three (3) and six (6) months must sign a note which states that the nurse will authorize a deduction from the nurse's last paycheck for the time used if the nurse leaves County employment within one (1) year of the date of hire.

b) The individual nurse shall decide the educational program in which they shall participate. It is understood that all use of educational leave shall be principally related to nursing practices within the County.

c) Details in the written application for educational leave shall include but not be limited to the course, institute, workshops, classes, or homestudy subjects, hours, faculty and purpose of taking the course, seminar, etc. The application shall be received by the Administration no less than ten (10) working days prior to the requested date of leave of absence. At least five (5) working days prior to the commencement of the leave of absence date, the Administration shall respond in writing to the nurse. When notification of a course is received less than ten (10) working days prior to the course date, Administration may consider approval.

d) In all instances set forth above, the leave request shall be subject to approval by the Department. Such leaves shall not unduly interfere with staffing requirements for patients' care or duplicate comparable training offered by the Department. The Department agrees that it shall not unreasonably withhold approval.

e) Proof of attendance may be requested by the Department. The nurse may be requested by the Department to report such activity in writing.

f) Every effort shall be made to arrange scheduling for the individual nurse's use of educational leave time.

g) If the educational leave falls on the nurse's day off, the nurse shall select one of the following:

1. The day will be charged to educational leave and the nurse will have a day added to the nurse's Paid Time Off balance, or

2. The day will be charged to educational leave and the nurse will be given another day off during the pay period, or

3. The day will not be charged to educational leave.

4. Educational leave granted for homestudy courses shall not be counted toward the base period in calculation of overtime.

h) Participation in the Registered Nurses Unit educational leave program shall not alter the RN's right to benefits included in the Professional Development Fund Section of this Agreement.

i) The County shall provide three (3) courses approved by the Board of Registered Nursing for continuing educational credit,

provided qualified instructors are available and interested. The County is under no obligation to hire additional instructors.

j) Educational leave for homestudy courses will be paid at the rate of one (1) hour for each contact hour completed. A copy of the certificate verifying successful completion is required for educational leave to be paid.

ARTICLE 12 - PROFESSIONAL DEVELOPMENT AND TUITION REIMBURSEMENT

Section 12.1 - Professional Development Fund

a) General

1. The County will fund, on a matching basis, up to eighty thousand dollars ($80,000) per fiscal year for group and individual professional development, California Board of Registered Nursing (BRN) Registered Nurse licensure, certification and recertification in a nursing specialty, and for education, as described in sections "b" and "c". An additional amount of fifteen thousand dollars ($15,000) per fiscal year shall be funded for the use by nurses in the classifications of Nurse Practitioner and Clinical Nurse Specialist for individual claims that are beyond the $300 annual matching limits. Funds not used for any period shall be carried over for use in the next period.

b) Individual

1. Funded on a matching basis: fifty percent (50%) by the nurse and fifty percent (50%) by the County, up to a maximum County contribution of three hundred dollars ($300) for nurses in the classifications of Clinical Nurse I, II, & III, Psychiatric Nurse I & II, Nurse Coordinator, Staff Developer, Infection Control Nurse, Assistant Nurse Manager, and Certified Registered Nurse Anesthetist per fiscal year. For nurses in the classifications of Nurse Practitioner and Clinical Nurse Specialist the matching cap is eight hundred dollars ($800) per fiscal year.

2. The requested expenditure must relate to the nurse's job or one to which the nurse could reasonably aspire within County service.

3. Requests will be processed on a "first come, first served" basis, but priority will be given to first requests by an individual for the current year.

4. At least five (5) working days must be allowed for prior approval in the amount of the estimated County contributions for authorized expenses other than licensure reimbursement.

5. Allowable expenses shall include but not be limited to: certifications and recertifications in a nursing specialty; conference and seminar registration fees; actual cost of California BRN Registered Nurse licensure fees; tuition not reimbursed under the tuition reimbursement program; books

and materials required for a conference, seminar or course; expenses for travel out of the county to attend a conference, seminar or course, including transportation, meals, lodging, car rental, etc., per County reimbursement policy, procedures and schedules.

6. An itemized statement of expenses for programs shall be submitted by the nurse for reimbursement or accounting as the case may be.

7. All nurses whose BRN licenses expire during the term of the agreement must present a receipt or other proof of payment and/or the renewed BRN license within sixty (60) calendar days after expiration of the BRN license in order to receive reimbursement. Requests must be submitted on a form provided by the County.

8. Substitute courses may be approved when approved courses are found to be unavailable.

c) Group

1. Funded on a matching basis: twenty-five percent (25%) by the participating nurses and/or the Association, and seventy-five percent (75%) by the County.

2. The Association will plan and budget group programs for review and approval by the County/Association Committee. Each proposed program will be considered separately on its own merits.

3. The Association will administer the approved programs, making all the necessary arrangements, etc.

d) Quarterly Financial Statement

A quarterly financial statement shall be forwarded to the Association on the status of the fund no later than two (2) weeks after the end of each quarter.

Section 12.2 - Tuition Reimbursement

a) Fund

The County shall maintain a tuition reimbursement program for the term of this Agreement. The total monies in this program will be administered at the County level. The fund will consist of two hundred thousand dollars ($200,000) per fiscal year. Effective July 1, 2008, the fund will increase to three hundred thousand ($300,000) per fiscal year. One quarter (1/4) of each year's fund will be available on the following quarterly dates:

Fiscal Year 14-15
2nd quarter - October 1, 2014
3rd quarter - January 1, 2015
4th quarter - April 1, 2015

Fiscal Year 15-16
1st quarter - July 1, 2015
2nd quarter - October 1, 2015
3rd quarter - January 1, 2016
4th quarter - April 1, 2016

Fiscal Year 16-17
1st quarter - July 1, 2016
2nd quarter - October 1, 2016
3rd quarter - January 1, 2017
4th quarter - April 1, 2017

Fiscal Year 17-18
1st quarter - July 1, 2017
2nd quarter - October 1, 2017
3rd quarter - January 1, 2018
4th quarter - April 1, 2018

Fiscal Year 18-19
1st quarter - July 1, 2018
2nd quarter - October 1, 2018
3rd quarter - January 1, 2019
4th quarter - April 1, 2019

Fiscal Year 19-20
1st quarter - July 1, 2019
2nd quarter - October 1, 2019

Funds not used for any period shall be carried over for use in the next period. Funds shall be encumbered to fifteen percent (15%) above the amount allotted for each funding period for the first one and one half fiscal years including any unused amount carried over from the prior funding period. This additional amount for encumbrance for the last one half fiscal year of this Agreement may be decreased based on the actual usage pattern. No amount may be approved or expended beyond funds available for the term of the Agreement.

b) Eligibility

Nurses are eligible to participate in the program provided:

1. The nurse is not receiving reimbursement from any other government agency or private source. (This applies to reimbursement only.)

2. The training undertaken is related to the nurse's occupational area or has demonstrated value to the County.

3. The application was filed with the appointing authority or their designee prior to the commencement of the course. Applications requiring time off must be filed with the appointing authority at least ten (10) days prior to the commencement of the course.

4. Substitute courses may be approved when approved courses are found to be unavailable.

5. There are sufficient funds available in the program.

c) Disapproval

Management may disapprove an application for tuition reimbursement provided:

1. Notice of disapproval is given to the nurse within ten (10) working days of the application.

2. The County alleges disapproval is necessary because any of the provisions above have not been met. When a nurse disagrees with the disapproval and files a grievance, they shall be allowed to continue the course with time off as provided for in this Section, except for denial based on paragraph b(5) above. If a final determination is made against the nurse, time off shall be made up by working, charging Paid Time Off (PTO) or comp time, or payroll deduction, and tuition reimbursement shall not be paid. If a final determination is made supporting the nurse, they shall be fully reimbursed in accordance with this Section.

d) Reimbursement

Total reimbursement for each nurse participating in the program will not exceed nine hundred dollars ($900.00) per fiscal year. Mileage and subsistence will not be authorized unless the training is required of the nurse. Within the above limit, nurses shall receive full immediate reimbursement for tuition, including approved home study courses and other required costs (including textbooks) upon presentation of a receipt showing such payment has been made.

e) Deduction Authorization

The nurse shall sign a note which states that, upon receipt of reimbursement, they authorize:

1. Deduction from their wages in the event they do not receive a passing grade of C or better.

2. Deduction of fifty percent (50%) of the amount of reimbursement if they leave County employment within one (1) year after satisfactory completion of the course.

3. Deduction of the full amount of reimbursement if they leave County employment before completion of the course.

4. Any monies deducted from nurses under this Section will be redeposited into the Tuition Reimbursement Fund.

f) Make-Up Time

Nurses taking a course only available during working hours must make up fifty percent (50%) of the time away from the job. Make-up time may be deducted from the nurse's accrued educational leave, Paid Time Off (PTO) or compensatory time balance. Make-up time will not be allowed when it results in the payment of overtime. The department will make every effort to allow the nurse time off except where the payment of overtime will result. A nurse and the appropriate level of management may mutually rearrange the duty shift beyond eight (8) hours but within the eighty (80) hour pay period for purposes of participating in non-duty education and/or training deemed by the County to be to the benefit of the nurse and the County and such arrangement will be considered a waiver of Section 8.2.

g) Quarterly Financial Statement

A quarterly financial statement shall be forwarded to the Association on the status of the fund no later than two (2) weeks after the end of each period.

ARTICLE 13 - BENEFIT PROGRAMS

Section 13.1 - Workers' Compensation

a) Eligibility

Every nurse shall be entitled to industrial injury leave when the nurse is unable to perform services because of any injury as defined in the Workers' Compensation Act.

b) Compensation

A nurse who is disabled as a result of an industrial injury shall be placed on leave, using as much of the nurse's accumulated compensable overtime, accrued sick leave, and PTO time as when added to any disability indemnity payable under the Workers' Compensation Act will result in a payment to the nurse of not more than the nurse's full salary unless at the time of the filing of the Supervisor's Report of Injury the nurse indicates on the form provided by the supervisor that he/she does not want such integration of payments to take place. This choice shall be binding for the entire period of each disability unless the employee later requests in writing that the Workers' Compensation Division begin integration. In such case, integration shall be implemented at the beginning of the next pay period.

If integration occurs, the first three (3) days are to be charged to the nurse's accrued but unused sick leave. If the temporary disability period exceeds fourteen (14) calendar days, temporary disability will be paid for the first three (3) days.

c) Industrially Injured Workers - Temporary Modified Work Program

The County has established a program to return workers with temporary disabling occupational injuries or illnesses to modified duty within the County as soon as medically practical. Pursuant to the program, the County will make every reasonable effort to provide meaningful work assignments to all such workers capable of performing modified work. The maximum length of such work program shall not exceed twelve (12) weeks. With the approval of the Worker’s Compensation Division, a temporary modified work assignment may be extended to no more than 16 weeks.

There are three kinds of "Temporary Modified Work" shown in order of preference:

1. Return to the worker's same job with some duties restricted.

2. Return to the same job, but for fewer hours per day or fewer hours per week. To be used if an injured worker cannot return on a full time basis.

3. Return temporarily to a different job. This is the least desirable and will only be attempted if the regular job cannot be reasonably modified to meet the injured worker's medical limitations.

d) Clothing Claims

Loss of, or damage to, a nurse's clothing resulting from an industrial injury which requires medical treatment will be replaced by the County through the following:

The Department will review and make a determination on all such incidents as submitted in writing by the nurse. Reimbursement will be limited to the lesser of:

1. Seventy-five percent (75%) of proven replacement cost, or

2. The repair cost.

However, both of the above are limited by a fifty dollar ($50.00) maximum. (Nothing in this Section is intended to replace or supersede Article 13.2 which provides for replacement of items damaged, lost or destroyed in the line of duty.)

e) Tracking of High Incidents of Industrial Injury

The County shall design and initiate a study/analysis of on-the-job injury/illness incidents to identify whether there are areas of unusually high injury and/or illness. The County may submit the report to the County-wide Safety Committee. The parties agree to review and determine what course of action, if any, may be required based on the findings.

Section 13.2 - Repair/Replace Claims

County shall provide the necessary protective clothing to nurses and classifications pursuant to such requests by the nurses affected as provided by law under Cal-OSHA, Title 8, Article 10. The County shall pay the cost of repairing or replacing the uniforms, clothing and equipment of County nurses which have been damaged, lost or destroyed in the line of duty when the following conditions exist:

a) The clothing, uniform or equipment is specifically required by the department or necessary to the nurses to perform the nurse's duty; and not adaptable for continued wear to the extent that they may be said to replace the nurse's regular clothing; or

b) The clothing, uniform or equipment has been damaged or destroyed in the course of making an arrest, or in the issuance of a citation, or in the legal restraint of persons being placed in custody or already in custody, or in the service of legal documents as part of the nurse's duties or in the saving of a human life; and

c) The nurse has not, through negligence or willful misconduct, contributed to such damage or destruction of said property.

Claims for reimbursement shall be reviewed and approved by the Department in accordance with procedures set forth by the County Executive.

Section 13.3 - Insurance Premiums

a) The HMO plan design will be $10 co-payments for office visits, $35 co-payment for emergency room visits, $5-$10 co-payment for prescriptions (30-day supply) and $10-$20 co-payment for prescriptions (100-day supply) and $100 copayment for hospital admission; the Point of Service plan design will be $15/$20/30% (Tier 1/2/3) for office visits, $50/$75/30% co-payment for emergency room visits, and $5/$15/$30 (generic/brand/formulary) co-payment for prescription (30-day supply) and $10/$30/$60 co-payment for prescription (90-day supply).

Hearing aid coverage, up to $1000 for 1 to 2 devices every 36 months, will be counted in all health plans.

Effective November 10, 2014 the County and employees will share in the cost of medical plan premiums. The County, in order to provide one health plan where there is not premium sharing, will continue to offer Valley Health Plan without premium sharing. For all other plans, the County will pay the cost of any premiums for "employee only" and "employee plus dependent" tiers that is not covered by the employee's share of the premium. The employee share shall be 2% of premium in effect as of November 10, 2014, converted to a flat rate.

Effective November-07-2016, and each November thereafter, for those plans and tiers where the employee pays a portion of the premium, the dollar amount of the then current employee contribution shall constitute the base onto which an additional amount equal to 10% of the increase in medical plan premiums rate for the plan year, if any, will be added to form the new total employee contribution. The County share of the premiums will decrease accordingly.

During the term of the agreement the employee contribution shall be capped at an amount equal to 10% of the increase. Employees shall not pay a higher share of the increase in medical plan premium rate than other bargaining units during the term of the agreement. Should a bargaining unit negotiate a lower term on a year for year basis during the term of this agreement, the share paid by RNPA members shall be adjusted accordingly.

Dual Coverage

Effective November 1, 1999, married couples and same sex domestic partners who are both County employees shall be eligible for coverage under one medical plan only with the County paying the full premium for dependent coverage. Married couples and registered domestic partners who had one dependent coverage and one single coverage will have the single coverage dropped effective November 1, 1999. If both employees have single coverage, one will be converted to dependent coverage. County employee couples are not eligible to participate in the Health Plan Bonus Waiver Program.

High Deductible Health Plan (HDHP)

The parties agree to investigate the feasibility of adding by mutual agreement a High Deductible Health Plan (HDHP) with or without Health Savings Account (HSA) or Health Reimbursement Account (HRA) as an option to current health plans.

Medical Premiums during Medical, Family, Maternity or Industrial Injury Leave of Absence

The County shall pay the nurse's premium subject to applicable co-payments in this Section as follows:

1. While on medical, maternity or industrial injury leave of absence without pay, up to thirteen (13) pay periods of employee only coverage. A portion of the leave may include dependent coverage in accordance with the Family and Medical Leave Act, The California Family Rights Act and the County's Family and Medical Leave Policy.

2. For a nurse on family leave without pay, in accordance with the County's Family and Medical Leave Policy, up to twelve (12) weeks of dependent coverage.

Registered Domestic Partners

a) County employees who have filed a Declaration of Registered Domestic Partnership in accordance with the provisions of

Family Code 297-297.5 shall have the same rights, and shall be subject to the same responsibilities and obligations as are granted to and imposed upon spouses. The term "spouse" in this contract shall apply to Registered Domestic Partners.

b) Tax Liability
Employees are solely responsible for paying any tax liability resulting from benefits provided as a result of their Domestic Partnership.

b) Dental Insurance
The County agrees to contribute the amount of the current monthly insurance premium to cover the nurse and full dependent contribution and to pick up inflationary costs during the term of this Agreement. The existing Delta Dental Plan coverage will be continued in accordance with the following schedule:

Basic and Prosthodontics:	75-25 - no deductible. $2,000 maximum per patient per calendar year.
Orthodontics:	60-40 - no deductible. $2000 lifetime maximum per patient (no age limit).

The County will continue to provide an alternative dental plan. The current alternate dental plan is Pacific Union Dental. The County will contribute up to the same dollar amount to this alternative dental plan premium as is paid to the Delta Dental Plan.

c) Life Insurance
The County agrees to increase the existing base group Life Insurance Plan to twenty-five thousand dollars ($25,000) per nurse for the term of the Agreement.

d) Social Security
Effective October 12, 1981, the County did cease payment of the nurses' portion of Social Security.

e) Vision Care Plan
The County agrees to provide a Vision Care Plan for all nurses and dependents. The Plan will be the Vision Service Plan - Plan A with benefits at 12/12/24 month intervals with twenty dollar ($20.00) deductible for examinations and twenty dollar ($20.00) deductible for materials. The County will fully pay the monthly

premium for nurse and dependents and pick up inflationary costs during the term of the agreement.

f) County-wide Benefits
The parties agree that, during the term of this Agreement, County-wide changes in benefits, such as medical, dental, life insurance or retirement, shall be applied to nurses in this Unit.

Section 13.4 - Training for Nurses With Disabilities

a) Vocational Rehabilitation
When a nurse is determined by the County to be unable to return to the classification in which the nurse held permanent status because of a work-connected illness or injury and does not elect a disability retirement, that nurse will be offered vocational rehabilitation.

b) Lateral Transfer/Demotion Openings
If the nurse meets all the qualifications for a particular position (this would take into account the nurse's medical limitations, prior work experience and skills) and an opening exists that involves a lateral transfer or demotion, the position shall be offered to the nurse.

c) Salary Level
In accordance with Chapter VI, Article 5, Section A25(e) of the Personnel Practices, "...the salary of the nurse shall be placed at the step in the salary range which corresponds most closely to the salary received by the nurse as of the time of injury. In the event that such a demotion would result in a salary loss of more than ten (10) percent, the nurse's new salary shall be set at the rate closest to but not less than ten percent (10%) below his/her salary as of the time of injury."

d) Training Program
In those cases where the nurse may not have the necessary prior experience or all the required skills but there is reasonable assurance that the nurse will be capable of obtaining them through a designated formal on-the-job training program, the County will make reasonable efforts to place the nurse in a training program.

e) Placement Review
If, after a period on the job, it is demonstrated that the nurse is unable to develop the required skills, knowledge and abilities and/or cannot meet the physical requirements to handle the new position, the nurse will be placed on a leave of absence and the placement process begins again.

f) Promotions

Any position which involves a promotion will call for the normal qualifying procedures, written and/or oral examination. However, if it is found that a nurse meets all the qualifications for a higher paying position and an eligibility list is already in existence, the nurse shall be allowed to take a written and/or oral examination, and, if the nurse qualifies, the nurse's name will be placed on the eligibility list commensurate with his/her score.

g) Referral to Accredited Rehabilitation Agency

In those cases where the County is unable, for one reason or another, to place a nurse in any occupation, that nurse's case will be referred to an accredited rehabilitation agency as approved by the Division of Industrial Accidents for testing, counseling and retraining at either the County's or State's expense.

h) State Legislation

The provisions of this Section shall not apply if State legislation removes from the County the control of training for disabled employees.

Section 13.5 - Short-Term Disability Program

The County shall provide a short-term disability plan at no expense to the County under the same terms and conditions as provided County-wide.

Section 13.6 - Retirement

The County will continue the present benefit contract with PERS which is the 2% at 55 Retirement Plan.

Effective April 11, 2005 the County ceased paying the employee's statutorily required contribution and adjusted the base pay of all employees upwards by 7.49% and implemented an employee self-pay PERS member contribution on a pre-tax basis pursuant to Internal Revenue Code 414(h)(2).

The County has amended its contract with PERS effective December 17, 2007 for the 2.5% at 55 Plan for Miscellaneous employees. In consideration for this amendment, the Association agrees for each nurse covered under this benefit to contribute to PERS, through payroll deduction effective December 17, 2007, an additional amount of 3.931% of PERS reportable gross pay added to the current self-pay member contribution of 7% through June 14, 2009.

Each nurse's payroll deduction of 3.931% includes the 1% member contribution and the 2.931% employer contribution. The 1% member contribution, in addition to the 7% member contribution, shall be deducted for the duration of the Agreement.

Effective June 15, 2009, each nurse, in addition to making the 8% member contribution, shall have a payroll deduction equal to the difference between the employer share for 2.5% at 55 and the employer share for 2% at 55 as computed by PERS for all Miscellaneous employees effective July 1, 2009 provided that the deduction for the employer share will not exceed 2.931%. This deduction shall continue for the duration of the Agreement.

Employees who are hired on or after January 1, 2013, and who are considered "new employees" and who are considered "new members" of PERS, as defined in Government Code section 7522.04 shall not be entitled to the benefits enumerated above. All such employees shall be in the Miscellaneous retirement tier of 2% at age 62 with a minimum retirement age of 52 and final compensation calculated on the highest average of pensionable compensation earned during a period of 36 consecutive months.

The employee contribution rate shall be 50% of the normal cost for the 2% @ age 62 PERS plan expressed as a percentage of payroll as defined in the Public Employees' Pension Reform Act of 2012. The County shall not pay any portion of the employee contribution rate (EMPC.) If the normal cost increases or decreases by more than one quarter of 1% of payroll the employee contribution rate will be adjusted accordingly.

Pursuant to the California Public Employees' Pension Reform Act of 2013 – Government Code Section 7522, employees convicted of certain felonies may be deemed to have forfeited accrued rights and benefits in any public retirement system in which he or she is a member.

Medical Benefits for Retirees

a) For Employees Hired before August 12, 1996:
The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of employees who have completed five (5) years service (1,305 days of accrued service) or more with the County and who retire on PERS directly from the County on or after December 5, 1983. Retirees over sixty-five (65) or otherwise eligible for Medicare Part B must be enrolled in such a plan, and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or the same sex domestic partner

of an employee eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

b) For Employees Hired on or after August 12, 1996:
The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of employees who have completed eight (8) years of service (2,088 days of accrued service) or more with the County and who retire on PERS directly from the County on or after December 5, 1983. Retirees over the age of sixty-five (65) or otherwise eligible for Medicare Part B must be enrolled in such a plan and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or the same sex domestic partner of an employee eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

c) For Employees hired on or after June 19, 2006:
The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of employee who have completed ten (10) years of service (2610 days of accrued service) or more with the County and who retire on PERS directly from the County. Retirees over 65 or otherwise eligible for Medicare Part B must be enrolled in such a plan, and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or same sex domestic partner of a employee eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

Continuous Years of Service
The years of service expressed in Section 13.6 a), b), c) and d) must be continuous service with the County and shall have been completed immediately preceding retirement directly on PERS from the County.

Delayed Enrollment in Retiree Medical Plan
A retiree who otherwise meets the requirements for retiree only medical coverage under the Sections above may choose to delay enrollment in retiree medical coverage. Application and coverage may begin each year at the annual medical insurance open enrollment period or within 30 days of a qualifying event after retirement.

Employee Contribution toward Retiree Medical Obligation Unfunded Liability

Effective with the pay period beginning February 4, 2013, all coded employees shall contribute on a biweekly basis an amount equivalent to 15% of the lowest cost early retiree premium rate. Effective with the pay period beginning June 24 2013, all coded employees shall contribute on a biweekly basis an amount equivalent to 7.5% of the lowest cost early retiree premium rate. Such contributions are to be made on a pre-tax basis, and employees shall have no vested right to the contributions made by the employees. Such contributions shall be used by the County exclusively to offset a portion of the County's annual required contribution amount to the California Employers Retirement Benefit Trust established for the express purpose of meeting the County's other post-employment benefits (OPEB) obligations and shall not be used for any other purpose.

Contributions made between June 23, 2014 and November 9, 2014 shall be rebated to each nurse.

d) For Employees Hired on or After December 08, 2014:

The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of workers who have completed fifteen (15) years of service (3915 days of accrued service) or more with the County and who retire on PERS directly from the County. Retirees over 65 or otherwise eligible for Medicare Part B must be enrolled in such a plan, and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or registered domestic partner of a worker eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

Section 13.7 - Deferred Compensation Plan

The County will continue the present deferred income plan. If the County proposes to change the plan, it shall provide appropriate notice to the Association and the parties shall meet and confer pursuant to Article 20 over said changes.

ARTICLE 14 - USE OF PRIVATE VEHICLES AND MILEAGE PAYMENT

Section 14.1 - Use of Private Vehicles

a) No Requirement

No nurse shall be required as a condition of obtaining or continuing County employment, to possess or provide a private vehicle for use in connection with her/his County employment. Use of County vehicles shall be in accordance with County policies and regulations.

b) Authorization of Use

Departments may authorize the use of private vehicles by their Department nurses, with each Department maintaining a continuous listing of those nurses authorized to use their private vehicles. Each nurse so authorized shall have completed applicable County authorization requirements governing County driver permits and insurance. Nurses not having completed such requirements and thereby not on the listing shall be neither required nor authorized to use their private vehicles.

c) Damage

A nurse whose vehicle is damaged in a collision with another vehicle while driving a personal vehicle on County business shall, following the approval of the Accident Review Board ESA Claims Division or if denied by ESA and subsequently approved on appeal to the Accident Review Board, be reimbursed for such damage not to exceed five hundred dollars ($500.00) provided:

1. The driver of the other vehicle is responsible for the accident as verified by a police report, and the damages shall be unrecoverable from the other party by reason of lack of liability insurance, or

2. The damage is caused by a hit-run or unidentified driver as verified by a police report, and/or

3. The amount of damage to be reimbursed by the County is not recoverable under any policy of insurance available to the nurse. The County shall be subrogated to the rights of recovery from the responsible party.

Section 14.2 - Mileage Reimbursement for Use of Private Vehicle

Effective September 1, 2000, the rate of reimbursement shall be equal to the "standard mileage rate" for auto expenses established by the Federal Government as the maximum tax-exempt mileage rate. Subsequent to September 2000, the County rate of reimbursement shall be adjusted on the first day of the month that any change by the Federal Government "standard mileage rate" is effective.

Section 14.3 - County Business Travel

Nurses who are required in the performance of their duties to travel shall receive business travel reimbursement in accordance with Santa Clara County Policy.

Section 14.4 - Parking Stickers for Nurses with Disabilities

All nurses determined by the County to be disabled in accordance with standards of the State of California Department of Motor Vehicles will be issued a disabled parking sticker for their private vehicle.

ARTICLE 15 - NURSES IN UNCLASSIFIED POSITIONS

a) Specially Funded Nurses

All nurses in unclassified coded positions within the Association's bargaining unit shall be subject to and protected by this Agreement and departmental agreements, except as otherwise provided.

b) Seniority

Time worked in such positions shall apply to seniority for the purposes of departmental agreements, salary increments and all other matters in the same manner for all other unclassified coded positions.

c) Examinations

Such nurses shall be allowed to participate in examinations in the classified service equivalent to the positions they occupy as well as all open and/or promotional examinations for which they qualify under Merit System Rules.

d) Career Opportunities

It is the County's intention to encourage and promote career opportunities for regular County nurses. In the interest of equitable treatment and to fulfill its contractual commitment, the County will not fill more than fifty percent (50%) of coded vacancies in a classification with unclassified nurses when regular County nurses are certifiable.

e) New Programs

Upon final approval by the County and the granting authority of new special programs funded from State and/or Federal sources which create full-time positions of one (1) year's duration or more, the parties agree to meet and confer on:

1. Coverage of such positions by all or any portion of the terms of this Agreement.

2. The impact the utilization of such positions may have on employees in positions currently covered by this Agreement.

ARTICLE 16 - GRIEVANCE PROCEDURE

County and the Association recognize early settlement of grievances is essential to sound employee-employer relations. The parties seek to establish a mutually satisfactory method for the settlement of grievances of nurses, the Association, or the County. In presenting a grievance, the aggrieved and/or the aggrieved's representative is assured freedom from restraint, interference, coercion, discrimination or reprisal.

Section 16.1 - Grievance Defined

a) Definition

A grievance is defined as an alleged violation, misinterpretation or misapplication of the provisions of this Memorandum of Agreement, Department Memoranda of Agreement and/or Understanding, Merit System Rules, or other County ordinances, resolutions, Policy and/or Procedure Manuals, or alleged infringement of an employee's personal rights (i.e., discrimination, harassment) affecting the working conditions of the nurses covered by this Agreement, except as excluded under Section 16.1(b).

b) Matters Excluded From Consideration Under the Grievance Procedure

1. Disciplinary actions taken under Section 708 of the County Charter except where nurses voluntarily waive their right to appeal such disciplinary actions to the Personnel Board.

2. Probationary release of nurses.

3. Position classification.

4. Merit System Examinations.

5. Items requiring capital expenditure.

6. Items within the scope of representation and subject to the meet and confer process.

Section 16.2 - Grievance Presentation

Nurses shall have the right to present their own grievance or do so through a representative of their own choice. Grievances may also be presented by a group of nurses, by the Association, or by the County. No grievance settlement may be made in violation of an existing rule, ordinance, memorandum of agreement or memorandum of understanding, nor shall any settlement may be made which affects the rights or conditions of other nurses represented by the Association without notification to and consultation with the Association.

The Association shall be provided copies of individual or group grievances and responses to same. Such grievances may not proceed beyond Step One without written concurrence of the Association at each step.

The Association shall have the right to appear and be heard in all individual or group grievances at any step. Upon request by County, the Association shall appear and be heard in such grievances at any step.

Section 16.3 - Procedural Compliance

Association grievances shall comply with all foregoing provisions and procedures. The County shall not be required to reconsider a grievance previously settled with a nurse if renewed by the Association, unless it is alleged that such grievance settlement is in violation of an existing rule, ordinance, memorandum of understanding, or memorandum of agreement.

A grievance is deemed to be presented or filed when it is either received by the Office of Labor Relations if presented in person or by facsimile or by electronic mail; or on the day it is postmarked, whichever occurs first.

A response by the County is deemed to be made when it is either received by the Association when presented in person or by facsimile or by electronic mail; or on the day it is postmarked, whichever occurs first.

Section 16.4 - Informal Resolution/Time Limits

It is agreed that nurses will be encouraged to act promptly through informal discussion with their immediate supervisor on any act, condition or circumstance which is causing nurse dissatisfaction and to seek action to remove the cause of dissatisfaction before it serves as the basis for a formal grievance. Time limits may be extended or waived only by written agreement of the parties.

If either party fails to comply with the grievance time limits, and the matter proceeds to arbitration, the party who missed the time limits, as determined by the arbitrator, shall pay the full cost of the arbitrator.

Section 16.5 - Formal Grievance

a) Step One

Within fifteen (15) working days of the occurrence or discovery of an alleged grievance, the grievance shall be presented in writing to the Office of Labor Relations. The grievance form shall contain information which identifies:

1. The aggrieved;

2. The specific nature of the grievance;

3. The time or place of its occurrence;

4. The rule, law, regulation, or policy alleged to have been violated, improperly interpreted, applied or misapplied;

5. The consideration given or steps taken to secure informal resolution;

6. The corrective action desired; and,

7. The name of any person or representative chosen by the nurse to enter the grievance.

A decision shall be made by the County in writing within fifteen (15) working days of receipt of the grievance. A copy of the decision shall be directed to the person identified in (7) above. A copy shall be sent to the Association and this copy shall dictate time limits.

b) Step Two

If the aggrieved continues to be dissatisfied, the aggrieved may, within fifteen (15) working days after receipt of the first step decision, present a written presentation to be directed to the County Executive's designated representative indicating the aggrieved wishes the grievance to be referred to an impartial arbitrator. The arbitrator shall be advised of and agree to the following provisions:

1. Within ten (10) working days of receipt of the grievance at step two, one (1) arbitrator shall be selected from the panel and a hearing scheduled within thirty (30) calendar days.

2. If the selected arbitrator cannot be scheduled within ninety (90) calendar days the parties will mutually agree to either another arbitrator or extend the time limit for the hearing.

3. Arbitration proceedings shall be recorded but not transcribed except at the request of either party or the arbitrator. Upon mutual agreement, the County and the Association may submit written briefs to the arbitrator for decision in lieu of a hearing.

The arbitrator's compensation and expenses shall be borne equally by the nurse or the Association and the County. Decisions of the arbitrator shall be final and binding.

Section 16.6 – Arbitrators

For the term of this agreement the County and the Union have agreed to the following panel:

Christopher D. Burdick	John Kagel
Katherine Thomson	Alexander Cohn
Matthew Goldberg	Catherine Harris
Barry Winograd	Luella Nelson
Robert Hirsch	

The parties may also mutually agree to choose another arbitrator not on the above list.

Section 16.7 - Arbitration Release Time

The following statement on nurse participation in grievance arbitration hearings is agreed to:

a) The nurse on whose behalf the grievance has been filed will be granted release time for the entire hearing. Release time to serve as a witness will be granted on a scheduled basis, i.e., when the nurse is scheduled to appear. In the case of a group grievance, release time will be granted for the designated spokesperson for the entire hearing. Release time also will be granted to the appropriate Unit Representative.

b) Other requests for leave for the purpose of participation in a grievance arbitration hearing will also be granted and charged to the nurse's own leave time - provided the absence does not unduly interfere with the performance of service.

ARTICLE 17 - CONFLICT OF INTEREST

Nurses are to abide by all applicable Federal, State and Local Statutes or contract requirements regarding conflict of interest in outside employment. Nurses intending to engage in outside employment shall file an advance statement of such intent for the approval of the appointing authority.

ARTICLE 18 - NURSING PRACTICE ISSUES

Section 18.1 - Supervision

All Interim Permitees will be directly supervised and will not assume team leader duties. A Clinical Nurse I will not work in charge position except as provided for in Section 8.10 of this Agreement.

Section 18.2 - Conscientious Objector Clause

The rights of patients to receive the necessary nursing care are to be respected. As individuals, licensed nurses hold certain moral, ethical, and religious beliefs and in good conscience may be compelled to refuse involvement with abortions. The licensed nurse must be free to exercise this right without being subjected to ridicule, harassment, coercion, censure, termination, or other forms of discipline. Emergency situations will arise where the immediate nature of the patient's needs will not allow for personnel substitutions. In such circumstances the patient's right to receive the necessary nursing care would take precedence over exercise of the nurse's individual beliefs and rights until other personnel can be provided.

Section 18.3 - Malpractice Protection

The County's obligation to defend and indemnify its officers and employees is prescribed by California Government Code 825 et seq. and 995 et seq. The County shall indemnify and defend nurses in this Unit in accordance with the applicable law when and if they are sued for errors or omissions (malpractice) within the course and scope of their duties, save and except where the applicable law excuses County's obligation to defend (e.g., fraud, malice, etc.). This paragraph and the terms and conditions thereof shall be enforceable, at law in accordance with the applicable law, but shall not be subject to the grievance provision of this Agreement.

Section 18.4 - Inservice Education Program For Nurses

a) While all nurses are responsible for their own professional growth, Santa Clara Valley Medical Center will maintain a Staff Development Program for nurses, including the following:

1. Provide an organized plan of orienting all newly hired nurses to the objectives, policies, goals, and procedures of the hospital and of nursing service at regularly scheduled intervals.

2. Provide an organized plan of orienting all nurses to the job descriptions, responsibilities, and work assignments for nursing classifications at regularly scheduled intervals.

3. Keep the nursing staff abreast on a continuing basis of new and expanding nursing care programs and of new techniques, equipment, facilities and concepts of care.

4. Each nurse must complete both (1) and (2) above before being permanently assigned to a unit and shift. Until completion of the formal orientation, the nurse will be considered as still in a structured learning experience and not part of the unit's regular nursing staff.

b) In each area, a clinical nurse(s) is responsible for coordinating inservice programs with the Nursing Staff Development. These programs shall be relevant to updating and upgrading skills particular to the unit in order to promote optimal nursing care to each patient.

It is understood that the department has the authority to approve all voluntary attendance at inservice education programs.

Section 18.5 - Staff Meetings

The date, time and location of regularly scheduled staff meetings will be posted seven calendar days in advance. Nurses assigned attendance at meetings, lectures, or inservice courses while off shift will be subject to all overtime provisions. Nurses on shift will be compensated at the regular rate.

Section 18.6 - Professional Performance Committee

a) The Valley Medical Center Professional Performance Committee shall be composed of nurses currently employed by the hospital. The Committee shall have a representative from each nursing unit, one (1) from each satellite clinic, and one (1) Institution Nurse elected by the nurses from that unit and clinic. All appointed and new positions will be filled by election by October 31 of each year.

b) Nurses employed by the County recognize their obligation to perform the highest level of nursing care for the patients. The Professional Performance Committee shall act as an advisory body to Nursing Service and Administration. The hospital will make a good faith effort to implement recommendations agreed to by the P.P.C. and the Director of Nursing.

c) The Committee shall not involve itself in grievances as defined and set forth in this Agreement. The purpose and function shall be as set forth in its bylaws and shall include the following:

1. Recommend nursing policies and procedures to the Nursing Administrator.

2. Review nursing policies and procedures prior to implementation, when possible, except in emergencies.

3. Maintain representative on Valley Medical Center Nursing Committees as designated by management.

d) The Nursing Administrator or representative will meet with the P.P.C. at their regularly scheduled meeting when requested. The Nursing Administrator will respond in writing to all written recommendations within thirty (30) days unless extended by mutual agreement.

e) Attendance at P.P.C. will be voluntary by the elected representative or an alternate. Committee members will be granted release time to attend the meetings. Those members who attend during other than duty time will be granted up to four (4) hours of compensatory time.

Meetings will be held monthly for three (3) hours or more as agreed to by the Nursing Administrator.

Section 18.7 Advanced Practice Professional Performance Committee

a) The Advanced Practice Professional Performance Committee (APPPC) shall be composed of Nurse Practitioners, Certified Registered Nurse Anesthetists and Clinical Nurse Specialists covered by the contract and employed by the County.

b) Each APRN within the employ of the County may attend APPPC meetings with prior management approval.

c) A minimum of (three)(3) Advanced Practice Professionals, (one)(1) RNPA representative and (one)(1) Nursing Administration representative shall make up the board of the APPPC. The position of Chairperson, Vice Chairperson and Secretary will be held by an APRN. All positions are to be elected by the APRN staff only. Necessity for additional seats on the board will be determined by the Chair and Vice-Chair. Duration of appointment to a particular board position shall be determined by the committee. All policies regarding the function of the APPPC shall be placed in writing and submitted to the Chief Nursing Officer and Deputy Director, ACHS/FQHC. A copy of these policies will be kept at the offices of RNPA. The agenda shall be determined and distributed one (1) week in advance. A copy of all minutes shall be forwarded to the Chief Nursing Officer, Deputy Director of ACHS/FQHC and RNPA.

d) The function of the APPPC shall be as follows:

1. To serve as a forum for discussion of administrative and medical practice issues which arise for APRNs within the SCVHHS.

2. The Chairperson, or designee, of this committee shall serve as a liaison between the committee and the Chief Nursing Officer, the Deputy Director, ACHS/FQHC and the Assistant Medical Director.

3. The development and review of APRN practice protocols prior to the submission of these protocols to the Interdisciplinary Care Committee/Medical Executive Committee.

4. To provide updates on state and federal legal changes to practice.

Section 18.8 - Safety

The County necessarily abides by safety standards established by the State Division of Industrial Safety and pursuant to the Occupational Safety and Health Act.

Section 18.9 - Nursing Practice

If a nurse objects to an assignment on the basis that it exceeds the nurse's professional qualifications and the nurse is unable to resolve the objection with the immediate supervisor, the objection will be noted, in writing utilizing the "Objection to Assignment" form, by the nurse and delivered to the Director of Nursing's office or the appropriate administrator prior to the nurse leaving at the end of the shift. A written response from the Director of Nursing or designee will be forwarded to the nurse.

Section 18.10 - Performance Evaluation

a) Each nurse shall be subject to a written appraisal of work performance. Performance evaluations are done:

   1. Annually;

   2. Prior to a promotion;

   3. During the probationary period.

Performance evaluations will not be used in the disciplinary process.

b) The evaluation shall consist of comparison of the nurse's performance against written standards established by Management for:

1. Work Unit competencies;

2. Job classification;

3. Unit role expectations;

4. Any appropriate legal or regulatory requirements.

18.11 – Staffing

The County shall maintain a staffing system for nurses based on the assessment of patient needs, to include the number and the acuity of the patient(s) assigned to a nurse in compliance with applicable state laws and regulations including AB 394 chaptered October 10, 1999. This assessment shall include meal and rest periods when determining staffing needs.

a) Assessment of Patient Acuity

During each shift, bedside nurses shall assess and determine patient acuity on an ongoing basis. The nurse shall consult with the charge nurse or manager as needed.

b) Staffing Decisions

In the absence of the Nurse Manager or Assistant Nurse Manager, the Charge Nurse shall have the authority to make necessary staffing decisions based upon patient acuity and census. Nurses involved in direct patient care are included in the calculation of nurse-to-patient ratios.

c) Staffing Report

Staffing reports shall be submitted by the Nurse Manager by shift and unit to nursing administration reflecting staffing levels for each shift, including beginning, middle and end of shift.

d) Notice of Staffing Levels Concerns

Nurses may report nurse to patient staffing levels that they believe are out of compliance by notifying the next level of management. Should a nurse believe staffing levels cannot be easily remedied, he/she may submit a Notice of Staffing Levels form. Such form shall be submitted to the nurse's charge nurse or immediate supervisor. The Charge nurse or supervisor who receives the form shall note the action(s) taken, if any, to resolve the staffing concern and shall forward the form to the Nurse Manager and the appropriate Nursing Director with a copy to the Chief Nursing Officer and RNPA. Notice of Staffing Levels forms shall be reviewed at the monthly Patient Acuity Task Force meeting. After review at the Patient Acuity Task Force meeting, the nurse reporting the concern shall be informed of the action taken to resolve the staffing concern, if any.

e) Patient Acuity Task Force

The Patient Acuity Task Force shall be comprised of an equal number of management, including the Nurse Manager of Nursing Systems, and RNPA representatives. The Patient Acuity Task Force shall meet on a monthly basis to assess and develop strategies for alleviating staffing concerns within nursing units. The Task Force shall also develop forms to be used as described in (c) and (d) above.

The Patient Classification Team shall include the Nurse Manager of Nursing Systems and one clinical nurse per shift/per unit to meet twice yearly to review inter-rater reliability of the patient classification system to determine whether the system accurately determines patient needs. Members of the Patient Classification Team shall then review and validate with each nurse in the unit that he/she is proficient. The Nurse Manager of Nursing System shall report the results of the twice yearly review to the Patient Acuity Task Force.

f) Dispute Resolution

In the event of a dispute regarding a staffing concern that is not able to be resolved in accordance with sub-section (d), such concern shall be subject to an internal review by the Management Audit Division for the Board of Supervisors when:

1) The staffing concern was not de minimis, (i.e. staffing concern was not cured within four (4) hours) and;
2) The staffing concern was not able to be resolved in accordance with sub-section (d) at the monthly meeting following the alleged violation and;
3) The staffing concern has not been resolved to the satisfaction of a majority of the Patient Acuity Task Force.

The Management Audit Division for the Board of Supervisors shall review the staffing concern and information provided by the Patient Acuity Task Force, Nursing Administration and RNPA and shall report his/her conclusions to the Patient Acuity Task Force and to Nursing Administration. Nursing Administration shall submit such report for the next scheduled Health and Hospital Committee meeting.

g) Section 18.10 is not subject to the grievance and arbitration procedures of this Agreement.

Section 18.12 – Safe Patient Handling

The County shall maintain a safe patient handling policy for all patient care units in acute care facilities in accordance with applicable state and or federal law, including AB1136, as applicable.

Such policy shall address providing nurses with appropriate equipment and staff assistance for moving patients, thereby eliminating, to the extent possible, manual lifting that may cause injuries.

Each nurse is responsible for the observation and direction of the lifting and mobilization of patients, and participates as needed in patient handling. The County will provide uniform training in the handling of patients on the appropriate use of lifting devices, equipment, and body mechanics on an annual basis.

ARTICLE 19 - STRIKES AND LOCKOUTS

During the term of this Agreement, the County agrees that it will not lock out nurses and the Association agrees that it will not engage in any concerted work stoppage. A violation of this Article will result in cessation of Association dues deduction by the County.

ARTICLE 20 - FULL AGREEMENT

It is understood this Agreement represents a complete and final understanding on all negotiable issues between the County and its Departments and the Association. This Agreement supersedes all previous memoranda of understanding or memoranda of agreement between the County and its Departments and the Association except as specifically referred to in this Agreement. All ordinances or rules covering any practice, subject or matter not specifically referred to in this Agreement shall not be superseded, modified or repealed by implication or otherwise by the provisions hereof. The parties, for the term of this Agreement, voluntarily and unqualifiedly agree to waive the obligation to negotiate with respect to any practice, subject or matter not specifically referred to or covered in this Agreement even though such practice, subject or matter may not have been within the knowledge of the parties at the time this Agreement was negotiated and signed. In the event any new practice, subject or matter arises during the term of this Agreement and an action is proposed by the County, the Association shall be afforded all possible notice and shall have the right to meet and confer upon request. In the absence of agreement on such a proposed action, the County reserves the right to take necessary action by management direction.

ARTICLE 21 - SAVINGS CLAUSE

If any provision of this Agreement should be held invalid by operation of law or by any court of competent jurisdiction, or if compliance with or enforcement of any provision should be restrained by any tribunal, the remainder of this Agreement shall not be affected thereby, and the parties shall enter into negotiations for the sole purpose of arriving at a mutually satisfactory replacement for such provision.

If the State of California notifies the County of Santa Clara that legislation has been implemented which assesses monetary penalties to local governments which settle wages and/or benefits with increases in excess of certain limits, those benefits and/or wages shall not be implemented or continue to be paid. The parties shall immediately enter into negotiations for the sole purpose of arriving at a mutually agreed upon alternative.

The County reserves the right to cease payment or seek repayment of wages and/or benefits upon which the State of California is basing the monetary penalty. The Union reserves the right to contest the legality of the payment cessation or repayment.

It is understood that the purpose of this Section is to ensure that the County does not incur any liability or penalties on either the original agreement provisions, or the negotiated alternate provisions.

ARTICLE 22 - IMPLEMENTATION

It is understood by the County and the Association that to fully implement this Agreement it will be necessary for the County to amend several existing County ordinances, some of which require the approval of the County Personnel Board, so that such ordinances will not conflict with the provisions of this Agreement. The County and the Association agree to cooperate to secure the enactment of such ordinances.

ARTICLE 23 - TERM OF AGREEMENT

This Agreement shall become effective only upon approval by the Board of Supervisors and upon the ratification by the Association, and shall remain in full force and effect to and including November 9, 2014 and from year to year thereafter; provided, however, that either party may serve written notice on the other at least sixty (60) days prior to October 20, 2019, or any subsequent October 19, of its desire to terminate this Agreement or amend any provision thereof.

DATED: 2/23/2015

COUNTY of SANTA CLARA

Lisa Dumanowski

Cynthia Mihulka

Matthew Cottrell

Jackie Lowther

Joyce Van De Pitte

Terry Edmonson

Kim Johnson

Francesco Germinario

REGISTERED NURSES PROFESSIONAL ASSOCIATION

Elizabeth LaRosa, RN
President

Jane Valdez, RN, CORN
Vice President

Daisy Brown, RN
Vice President

Katherine Volpe, RN
Negotiator

Zeniah Andres, RN
Alternate Negotiator

APPENDIX A – RNPA SALARIES

Effective November 10, 2014

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Assistant Nurse Manager - Extra Help	X1J	4682.64	4916.96	5162.72	5420.96	5692.16	---	---	10145.72	12333.01
Assistant Nurse Manager - Step A	S2A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Assistant Nurse Manager - Step B	S2B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Assistant Nurse Manager - Step C	S2C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01
Certified Registered Nurse Anesthetist	S1V	6887.60	7239.20	7608.96	7997.60	8406.00	8835.28	---	14923.13	19143.10
Certified Registered Nurse Anesthetist - Extra Help	X1K	6408.56	6734.80	7078.80	7440.40	7828.40	---	---	13885.21	16961.53
Certified Registered Nurse Anesthetist - Step A	Y1A	7059.76	7420.16	7799.12	8197.44	8616.16	9056.08	---	15296.14	19621.50
Certified Registered Nurse Anesthetist - Step B	Y1B	7232.08	7601.20	7989.52	8397.44	8826.24	9276.96	---	15669.50	20100.08
Certified Registered Nurse Anesthetist - Step C	Y1C	7404.32	7782.00	8179.60	8597.36	9036.40	9497.76	---	16042.69	20578.48
Clinical Nurse I	S89	3719.52	3905.44	4100.72	4306.64	4522.32	---	---	8058.96	9798.36
Clinical Nurse I - Extra Help	X1A	3445.04	3617.28	3815.20	4006.48	4207.20	---	---	7464.25	9115.60
Clinical Nurse I - Step A	C3A	---	---	4203.36	4414.08	4635.28	---	---	9107.28	10043.10
Clinical Nurse I - Step B	C3B	---	---	4305.92	4521.68	4748.40	---	---	9329.49	10288.20
Clinical Nurse I - Step C	C3C	---	---	4408.40	4629.44	4861.44	---	---	9551.53	10533.12
Clinical Nurse I - U	Q89	3719.52	3905.44	4100.72	4306.64	4522.32	---	---	8058.96	9798.36
Clinical Nurse II	S76	3942.24	4140.24	4347.60	4565.12	4793.52	---	---	8541.52	10385.96
Clinical Nurse II - Extra Help	X1H	3667.68	3851.76	4044.72	4247.12	4459.60	---	---	7946.64	9662.46
Clinical Nurse II - Step A	D0A	4040.88	4243.76	4456.32	4679.20	4913.20	---	---	8755.24	10645.26
Clinical Nurse II - Step B	D0B	4139.36	4347.12	4565.04	4793.44	5033.28	---	---	8968.61	10905.44
Clinical Nurse II - Step C	D0C	4237.92	4450.72	4673.76	4907.44	5152.88	---	---	9182.16	11164.57
Clinical Nurse II - U	Q87	3942.24	4140.24	4347.60	4565.12	4793.52	---	---	8541.52	10385.96
Clinical Nurse II - U - Step A	E1A	4040.88	4243.76	4456.32	4679.20	4913.20	---	---	8755.24	10645.26
Clinical Nurse II - U - Step B	E1B	4139.36	4347.12	4565.04	4793.44	5033.28	---	---	8968.61	10905.44
Clinical Nurse II - U - Step C	E1C	4237.92	4450.72	4673.76	4907.44	5152.88	---	---	9182.16	11164.57
Clinical Nurse III	S75	4347.60	4565.12	4793.52	5033.44	5285.28	5549.36	5826.88	9419.80	12624.90
Clinical Nurse III - Extra Help	X1I	4044.72	4247.12	4459.60	4682.64	4916.96	---	---	8763.56	10653.41
Clinical Nurse III - Step A	S7A	4456.32	4679.20	4913.20	5159.12	5417.20	5688.08	5972.48	9655.36	12940.37
Clinical Nurse III - Step B	S7B	4565.04	4793.44	5033.28	5285.20	5549.36	5826.80	6118.32	9890.92	13256.36
Clinical Nurse III - Step C	S7C	4673.76	4907.44	5152.88	5410.96	5691.52	5965.68	6263.76	10126.48	13571.48

Effective November 10, 2014										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Clinical Nurse III - U	Q86	4347.60	4565.12	4793.52	5033.44	5285.28	5549.36	5826.88	9419.80	12624.90
Clinical Nurse III - U - Step A	Q8A	4456.32	4679.20	4913.20	5159.12	5417.20	5688.08	5972.48	9655.36	12940.37
Clinical Nurse III - U - Step B	Q8B	4565.04	4793.44	5033.28	5285.20	5549.36	5826.80	6118.32	9890.92	13256.36
Clinical Nurse III - U - Step C	Q8C	4673.76	4907.44	5152.88	5410.96	5691.52	5965.68	6263.76	10126.48	13571.48
Clinical Nurse Specialist	S35	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Clinical Nurse Specialist - Extra Help	X1L	4682.64	4916.96	5162.72	5420.96	5692.16	---	---	10145.72	12333.01
Clinical Nurse Specialist - Step A	S4A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Clinical Nurse Specialist - Step B	S4B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Clinical Nurse Specialist - Step C	S4C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01
Infection Control Nurse	S04	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Infection Control Nurse - Extra Help	X1F	4682.64	4916.96	5162.72	5420.96	5692.16	---	---	10145.72	12333.01
Infection Control Nurse - Step A	S0A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Infection Control Nurse - Step B	S0B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Infection Control Nurse - Step C	S0C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01
Nurse Coordinator	S39	4793.52	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	10385.96	13919.53
Nurse Coordinator - Extra Help	X1M	4459.04	4682.32	4916.56	5162.24	5420.40	---	---	9661.25	11744.20
Nurse Coordinator - Step A	S3A	4913.20	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	10645.26	14267.58
Nurse Coordinator - Step B	S3B	5033.28	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	10905.44	14615.46
Nurse Coordinator - Step C	S3C	5152.88	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	11164.57	14963.69
Nurse Coordinator - U	Q39	4793.52	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	10385.96	13919.53
Nurse Coordinator - U Step A	Q4A	4913.20	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	10645.26	14267.58
Nurse Coordinator - U Step B	Q4B	5033.28	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	10905.44	14615.46
Nurse Coordinator - U Step C	Q4C	5152.88	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	11164.57	14963.69
Nurse Practitioner	S59	5549.36	5826.88	6118.48	6424.40	6752.00	7096.48	7459.12	12023.61	16161.42
Nurse Practitioner - Extra Help	X1N	5162.72	5420.88	5692.16	5976.80	6281.44	---	---	11185.89	13609.78
Nurse Practitioner - Step A	Y0A	5688.08	5972.48	6271.36	6585.04	6920.64	7273.76	7645.36	12324.17	16564.94
Nurse Practitioner - Step B	Y0B	5826.80	6118.32	6424.24	6745.60	7089.52	7451.28	7832.08	12624.73	16969.50
Nurse Practitioner - Step C	Y0C	5965.68	6263.76	6577.28	6906.32	7258.16	7628.64	8018.40	12925.64	17373.20
Per Diem Clinical Nurse	S99	---	63.18/Hrly	---	79.88/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	79.01/Hrly	---	99.89/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	63.18/Hrly	---	79.88/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	3904.96	4100.72	4306.64	4522.32	4748.48	---	---	8460.74	10288.37

Effective November 10, 2014										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Psychiatric Nurse I - Step A	D5A	4002.64	4203.36	4414.08	4635.28	4867.04	---	---	8672.38	10545.25
Psychiatric Nurse I - Step B	D5B	4100.24	4305.92	4521.68	4748.40	4985.84	---	---	8883.85	10802.65
Psychiatric Nurse I - Step C	D5C	4197.92	4408.40	4629.44	4861.44	5104.48	---	---	9095.49	11059.70
Psychiatric Nurse II	S57	4347.60	4565.12	4793.52	5033.44	5285.28	5549.36	5826.88	9419.80	12624.90
Psychiatric Nurse II - Extra Help	X1C	4044.72	4247.12	4459.60	4682.64	4916.96	---	---	8763.56	10653.41
Psychiatric Nurse II - Step A	E2A	4456.32	4679.20	4913.20	5159.12	5417.20	5688.08	5972.48	9655.36	12940.37
Psychiatric Nurse II - Step B	E2B	4565.04	4793.44	5033.28	5285.20	5549.36	5826.80	6118.32	9890.92	13256.36
Psychiatric Nurse II - Step C	E2C	4673.76	4907.44	5152.88	5410.96	5691.52	5965.68	6263.76	10126.48	13571.48
Staff Developer	S38	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Staff Developer - Extra Help	X1E	5008.72	5259.44	5522.40	5798.56	6088.72	---	---	10852.22	11693.06
Staff Developer - Step A	S5A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Staff Developer - Step B	S5B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Staff Developer - Step C	S5C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01

APPENDIX A – RNPA SALARIES

Effective November 9, 2015

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Assistant Nurse Manager - Extra Help	X1J	4834.80	5076.72	5330.48	5597.12	5877.12	---	---	10475.40	12733.76
Assistant Nurse Manager - Step A	S2A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Assistant Nurse Manager - Step B	S2B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Assistant Nurse Manager - Step C	S2C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00
Certified Registered Nurse Anesthetist	S1V	7111.44	7474.40	7856.24	8257.52	8679.12	9122.40	---	15408.12	19765.20
Certified Registered Nurse Anesthetist - Extra Help	X1K	6616.80	6953.68	7308.80	7682.16	8082.80	---	---	14336.40	17512.73
Certified Registered Nurse Anesthetist - Step A	Y1A	7289.20	7661.28	8052.56	8463.84	8896.16	9350.40	---	15793.26	20259.20
Certified Registered Nurse Anesthetist - Step B	Y1B	7467.12	7848.16	8249.12	8670.32	9113.04	9578.40	---	16178.76	20753.20
Certified Registered Nurse Anesthetist - Step C	Y1C	7644.96	8034.88	8445.36	8876.72	9330.08	9806.40	---	16564.08	21247.20
Clinical Nurse I	S89	3840.40	4032.32	4233.92	4446.56	4669.28	---	---	8320.86	10116.77
Clinical Nurse I - Extra Help	X1A	3556.96	3734.80	3939.12	4136.64	4343.92	---	---	7706.74	9411.82
Clinical Nurse I - Step A	C3A	---	---	4339.92	4557.52	4785.92	---	---	9403.16	10369.49
Clinical Nurse I - Step B	C3B	---	---	4445.84	4668.56	4902.72	---	---	9632.65	10622.56
Clinical Nurse I - Step C	C3C	---	---	4551.60	4779.84	5019.36	---	---	9861.80	10875.28
Clinical Nurse I - U	Q89	3840.40	4032.32	4233.92	4446.56	4669.28	---	---	8320.86	10116.77
Clinical Nurse II	S76	4070.32	4274.72	4488.88	4713.44	4949.28	---	---	8819.02	10723.44
Clinical Nurse II - Extra Help	X1H	3786.80	3976.88	4176.16	4385.12	4604.48	---	---	8204.73	9976.37
Clinical Nurse II - Step A	D0A	4172.16	4381.68	4601.12	4831.20	5072.80	---	---	9039.68	10991.06
Clinical Nurse II - Step B	D0B	4273.84	4488.40	4713.36	4949.20	5196.80	---	---	9259.98	11259.73
Clinical Nurse II - Step C	D0C	4375.60	4595.36	4825.60	5066.88	5320.32	---	---	9480.46	11527.36
Clinical Nurse II - U	Q87	4070.32	4274.72	4488.88	4713.44	4949.28	---	---	8819.02	10723.44
Clinical Nurse II - U - Step A	E1A	4172.16	4381.68	4601.12	4831.20	5072.80	---	---	9039.68	10991.06
Clinical Nurse II - U - Step B	E1B	4273.84	4488.40	4713.36	4949.20	5196.80	---	---	9259.98	11259.73
Clinical Nurse II - U - Step C	E1C	4375.60	4595.36	4825.60	5066.88	5320.32	---	---	9480.46	11527.36
Clinical Nurse III	S75	4488.88	4713.44	4949.28	5196.96	5457.04	5729.68	6016.24	9725.90	13035.18
Clinical Nurse III - Extra Help	X1I	4176.16	4385.12	4604.48	4834.80	5076.72	---	---	9048.34	10999.56
Clinical Nurse III - Step A	S7A	4601.12	4831.20	5072.80	5326.72	5593.20	5872.88	6166.56	9969.09	13360.88
Clinical Nurse III - Step B	S7B	4713.36	4949.20	5196.80	5456.96	5729.68	6016.16	6317.12	10212.28	13687.09
Clinical Nurse III - Step C	S7C	4825.60	5066.88	5320.32	5586.80	5876.48	6159.52	6467.28	10455.46	14012.44
Clinical Nurse III - U	Q86	4488.88	4713.44	4949.28	5196.96	5457.04	5729.68	6016.24	9725.90	13035.18

Effective November 9, 2015										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Clinical Nurse III - U - Step B	Q8B	4713.36	4949.20	5196.80	5456.96	5729.68	6016.16	6317.12	10212.28	13687.09
Clinical Nurse III - U - Step C	Q8C	4825.60	5066.88	5320.32	5586.80	5876.48	6159.52	6467.28	10455.46	14012.44
Clinical Nurse Specialist	S35	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Clinical Nurse Specialist - Extra Help	X1L	4834.80	5076.72	5330.48	5597.12	5877.12	---	---	10475.40	12733.76
Clinical Nurse Specialist - Step A	S4A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Clinical Nurse Specialist - Step B	S4B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Clinical Nurse Specialist - Step C	S4C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00
Infection Control Nurse	S04	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Infection Control Nurse - Extra Help	X1F	4834.80	5076.72	5330.48	5597.12	5877.12	---	---	10475.40	12733.76
Infection Control Nurse - Step A	S0A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Infection Control Nurse - Step B	S0B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Infection Control Nurse - Step C	S0C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00
Nurse Coordinator	S39	4949.28	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	10723.44	14371.76
Nurse Coordinator - Extra Help	X1M	4603.92	4834.48	5076.32	5330.00	5596.56	---	---	9975.16	12125.88
Nurse Coordinator - Step A	S3A	5072.80	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	10991.06	14731.25
Nurse Coordinator - Step B	S3B	5196.80	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	11259.73	15090.40
Nurse Coordinator - Step C	S3C	5320.32	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	11527.36	15449.89
Nurse Coordinator - U	Q39	4949.28	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	10723.44	14371.76
Nurse Coordinator - U Step A	Q4A	5072.80	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	10991.06	14731.25
Nurse Coordinator - U Step B	Q4B	5196.80	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	11259.73	15090.40
Nurse Coordinator - U Step C	Q4C	5320.32	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	11527.36	15449.89
Nurse Practitioner	S59	5729.68	6016.24	6317.28	6633.12	6971.44	7327.04	7701.52	12414.30	16686.62
Nurse Practitioner - Extra Help	X1N	5330.48	5597.04	5877.12	6171.04	6485.52	---	---	11549.37	14051.96
Nurse Practitioner - Step A	Y0A	5872.88	6166.56	6475.12	6799.04	7145.52	7510.08	7893.76	12724.57	17103.14
Nurse Practitioner - Step B	Y0B	6016.16	6317.12	6632.96	6964.80	7319.92	7693.44	8086.56	13035.01	17520.88
Nurse Practitioner - Step C	Y0C	6159.52	6467.28	6791.04	7130.72	7494.00	7876.56	8278.96	13345.62	17937.74
Per Diem Clinical Nurse	S99	---	65.23/Hrly	---	82.48/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	81.58/Hrly	---	103.14/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	65.23/Hrly	---	82.48/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4031.84	4233.92	4446.56	4669.28	4902.80	---	---	8735.65	10622.73
Psychiatric Nurse I - Extra Help	X1B	3750.88	3939.12	4136.64	4343.92	4561.20	---	---	8126.90	9882.60
Psychiatric Nurse I - Step A	D5A	4132.72	4339.92	4557.52	4785.92	5025.20	---	---	8954.22	10887.93
Psychiatric Nurse I - Step B	D5B	4233.44	4445.84	4668.56	4902.72	5147.84	---	---	9172.45	11153.65
Psychiatric Nurse I - Step C	D5C	4334.32	4551.60	4779.84	5019.36	5270.32	---	---	9391.02	11419.02

Effective November 9, 2015										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Psychiatric Nurse II - Extra Help	X1C	4176.16	4385.12	4604.48	4834.80	5076.72	---	---	9048.34	10999.56
Psychiatric Nurse II - Step A	E2A	4601.12	4831.20	5072.80	5326.72	5593.20	5872.88	6166.56	9969.09	13360.88
Psychiatric Nurse II - Step B	E2B	4713.36	4949.20	5196.80	5456.96	5729.68	6016.16	6317.12	10212.28	13687.09
Psychiatric Nurse II - Step C	E2C	4825.60	5066.88	5320.32	5586.80	5876.48	6159.52	6467.28	10455.46	14012.44
Staff Developer	S38	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Staff Developer - Extra Help	X1E	4583.84	4813.28	5053.84	5306.64	5572.16	---	---	9931.65	12073.01
Staff Developer - Step A	S5A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Staff Developer - Step B	S5B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Staff Developer - Step C	S5C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00

APPENDIX A – RNPA SALARIES

Effective October 24, 2016

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Min
Assistant Nurse Manager	S11	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Assistant Nurse Manager - Extra Help	X1J	4979.84	5228.96	5490.32	5764.96	6053.36	---	---	10789.65	13115.61
Assistant Nurse Manager - Step A	S2A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Assistant Nurse Manager - Step B	S2B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Assistant Nurse Manager - Step C	S2C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06
Certified Registered Nurse Anesthetist	S1V	7324.72	7698.56	8091.92	8505.20	8939.44	9396.00	---	15870.22	20358.00
Certified Registered Nurse Anesthetist - Extra Help	X1K	6815.28	7162.24	7528.00	7912.56	8325.28	---	---	14766.44	18038.10
Certified Registered Nurse Anesthetist - Step A	Y1A	7507.84	7891.04	8294.08	8717.68	9163.04	9630.88	---	16266.98	20866.90
Certified Registered Nurse Anesthetist - Step B	Y1B	7691.12	8083.60	8496.56	8930.40	9386.40	9865.68	---	16664.09	21375.64
Certified Registered Nurse Anesthetist - Step C	Y1C	7874.24	8275.92	8698.72	9142.96	9609.92	10100.56	---	17060.85	21884.54
Clinical Nurse I	S89	3955.60	4153.28	4360.88	4579.92	4809.28	---	---	8570.46	10420.10
Clinical Nurse I - Extra Help	X1A	3663.60	3846.80	4057.28	4260.72	4474.16	---	---	7937.80	9694.01
Clinical Nurse I - Step A	C3A	---	---	4470.08	4694.24	4929.44	---	---	9685.17	10680.45
Clinical Nurse I - Step B	C3B	---	---	4579.20	4808.56	5049.76	---	---	9921.60	10941.14
Clinical Nurse I - Step C	C3C	---	---	4688.08	4923.20	5169.92	---	---	10157.50	11201.49
Clinical Nurse I - U	Q89	3955.60	4153.28	4360.88	4579.92	4809.28	---	---	8570.46	10420.10
Clinical Nurse II	S76	4192.40	4402.96	4623.52	4854.80	5097.68	---	---	9083.53	11044.97
Clinical Nurse II - Extra Help	X1H	3900.40	4096.16	4301.44	4516.64	4742.56	---	---	8450.86	10275.54
Clinical Nurse II - Step A	D0A	4297.28	4513.12	4739.12	4976.08	5224.96	---	---	9310.77	11320.74
Clinical Nurse II - Step B	D0B	4402.00	4623.04	4854.72	5097.60	5352.64	---	---	9537.66	11597.38
Clinical Nurse II - Step C	D0C	4506.80	4733.20	4970.32	5218.88	5479.92	---	---	9764.73	11873.16
Clinical Nurse II - U	Q87	4192.40	4402.96	4623.52	4854.80	5097.68	---	---	9083.53	11044.97
Clinical Nurse II - U - Step A	E1A	4297.28	4513.12	4739.12	4976.08	5224.96	---	---	9310.77	11320.74
Clinical Nurse II - U - Step B	E1B	4402.00	4623.04	4854.72	5097.60	5352.64	---	---	9537.66	11597.38
Clinical Nurse II - U - Step C	E1C	4506.80	4733.20	4970.32	5218.88	5479.92	---	---	9764.73	11873.16
Clinical Nurse III	S75	4623.52	4854.80	5097.68	5352.80	5620.72	5901.52	6196.72	10017.62	13426.22
Clinical Nurse III - Extra Help	X1I	4301.44	4516.64	4742.56	4979.84	5228.96	---	---	9319.78	11329.41
Clinical Nurse III - Step A	S7A	4739.12	4976.08	5224.96	5486.48	5760.96	6049.04	6351.52	10268.09	13761.62
Clinical Nurse III - Step B	S7B	4854.72	5097.60	5352.64	5620.64	5901.52	6196.64	6506.56	10518.56	14097.54
Clinical Nurse III - Step C	S7C	4970.32	5218.88	5479.92	5754.40	6052.72	6344.24	6661.28	10769.02	14432.77

Effective October 24, 2016										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Clinical Nurse III - U	Q86	4623.52	4854.80	5097.68	5352.80	5620.72	5901.52	6196.72	10017.62	13426.22
Clinical Nurse III - U - Step A	Q8A	4739.12	4976.08	5224.96	5486.48	5760.96	6049.04	6351.52	10268.09	13761.62
Clinical Nurse III - U - Step B	Q8B	4854.72	5097.60	5352.64	5620.64	5901.52	6196.64	6506.56	10518.56	14097.54
Clinical Nurse III - U - Step C	Q8C	4970.32	5218.88	5479.92	5754.40	6052.72	6344.24	6661.28	10769.02	14432.77
Clinical Nurse Specialist	S35	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Clinical Nurse Specialist - Extra Help	X1L	4979.84	5228.96	5490.32	5764.96	6053.36	---	---	10789.65	13115.61
Clinical Nurse Specialist - Step A	S4A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Clinical Nurse Specialist - Step B	S4B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Clinical Nurse Specialist - Step C	S4C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06
Infection Control Nurse	S04	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Infection Control Nurse - Extra Help	X1F	4979.84	5228.96	5490.32	5764.96	6053.36	---	---	10789.65	13115.61
Infection Control Nurse - Step A	S0A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Infection Control Nurse - Step B	S0B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Infection Control Nurse - Step C	S0C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06
Nurse Coordinator	S39	5097.68	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	11044.97	14802.84
Nurse Coordinator - Extra Help	X1M	4742.00	4979.44	5228.56	5489.84	5764.40	---	---	10274.33	12489.53
Nurse Coordinator - Step A	S3A	5224.96	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	11320.74	15173.08
Nurse Coordinator - Step B	S3B	5352.64	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	11597.38	15542.97
Nurse Coordinator - Step C	S3C	5479.92	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	11873.16	15913.38
Nurse Coordinator - U	Q39	5097.68	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	11044.97	14802.84
Nurse Coordinator - U Step A	Q4A	5224.96	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	11320.74	15173.08
Nurse Coordinator - U Step B	Q4B	5352.64	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	11597.38	15542.97
Nurse Coordinator - U Step C	Q4C	5479.92	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	11873.16	15913.38
Nurse Practitioner	S59	5901.52	6196.72	6506.72	6832.08	7180.56	7546.80	7932.56	12786.62	17187.21
Nurse Practitioner - Extra Help	X1N	5490.32	5764.88	6053.36	6356.16	6680.08	---	---	11895.69	14473.50
Nurse Practitioner - Step A	Y0A	6049.04	6351.52	6669.36	7002.96	7359.84	7735.36	8130.56	13106.25	17616.21
Nurse Practitioner - Step B	Y0B	6196.64	6506.56	6831.92	7173.68	7539.44	7924.24	8329.12	13426.05	18046.42
Nurse Practitioner - Step C	Y0C	6344.24	6661.28	6994.72	7344.64	7718.80	8112.80	8527.28	13745.85	18475.77
Per Diem Clinical Nurse	S99	---	67.19/Hrly	---	84.95/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	84.02/Hrly	---	106.23/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	67.19/Hrly	---	84.95/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4152.72	4360.88	4579.92	4809.28	5049.84	---	---	8997.56	10941.32

Effective October 24, 2016										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Psychiatric Nurse I - Step A	D5A	4256.64	4470.08	4694.24	4929.44	5175.92	---	---	9222.72	11214.49
Psychiatric Nurse I - Step B	D5B	4360.40	4579.20	4808.56	5049.76	5302.24	---	---	9447.53	11488.18
Psychiatric Nurse I - Step C	D5C	4464.32	4688.08	4923.20	5169.92	5428.40	---	---	9672.69	11761.53
Psychiatric Nurse II	S57	4623.52	4854.80	5097.68	5352.80	5620.72	5901.52	6196.72	10017.62	13426.22
Psychiatric Nurse II - Extra Help	X1C	4301.44	4516.64	4742.56	4979.84	5228.96	---	---	9319.78	11329.41
Psychiatric Nurse II - Step A	E2A	4739.12	4976.08	5224.96	5486.48	5760.96	6049.04	6351.52	10268.09	13761.62
Psychiatric Nurse II - Step B	E2B	4854.72	5097.60	5352.64	5620.64	5901.52	6196.64	6506.56	10518.56	14097.54
Psychiatric Nurse II - Step C	E2C	4970.32	5218.88	5479.92	5754.40	6052.72	6344.24	6661.28	10769.02	14432.77
Staff Developer	S38	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Staff Developer - Extra Help	X1E	4721.28	4957.60	5205.44	5465.76	5739.28	---	---	10229.44	12435.10
Staff Developer - Step A	S5A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Staff Developer - Step B	S5B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Staff Developer - Step C	S5C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06

APPENDIX A – RNPA SALARIES

Effective October 23, 2017

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Assistant Nurse Manager - Extra Help	X1J	5129.20	5385.76	5654.96	5937.84	6234.96	---	---	11113.26	14907.53
Assistant Nurse Manager - Step A	S2A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	13509.08
Assistant Nurse Manager - Step B	S2B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Assistant Nurse Manager - Step C	S2C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69
Certified Registered Nurse Anesthetist	S1V	7544.40	7929.44	8334.64	8760.32	9207.60	9677.84	---	16346.20	20968.65
Certified Registered Nurse Anesthetist - Extra Help	X1K	7019.68	7377.04	7753.84	8149.92	8574.96	---	---	15209.30	18579.08
Certified Registered Nurse Anesthetist - Step A	Y1A	7733.04	8127.76	8542.88	8979.20	9437.92	9919.76	---	16754.92	21492.81
Certified Registered Nurse Anesthetist - Step B	Y1B	7921.84	8326.08	8751.44	9198.24	9667.92	10161.60	---	17163.98	22016.80
Certified Registered Nurse Anesthetist - Step C	Y1C	8110.40	8524.16	8959.68	9417.20	9898.16	10403.52	---	17572.53	22540.96
Clinical Nurse I	S89	4074.24	4277.84	4491.68	4717.28	4953.52	---	---	8827.52	10732.62
Clinical Nurse I - Extra Help	X1A	3773.44	3962.16	4178.96	4388.48	4608.32	---	---	8175.78	9984.69
Clinical Nurse I - Step A	C3A	---	---	4604.16	4835.04	5077.28	---	---	9975.68	11000.77
Clinical Nurse I - Step B	C3B	---	---	4716.56	4952.80	5201.20	---	---	10219.21	11269.26
Clinical Nurse I - Step C	C3C	---	---	4828.72	5070.88	5324.96	---	---	10462.22	11537.41
Clinical Nurse I - U	Q89	4074.24	4277.84	4491.68	4717.28	4953.52	---	---	8827.52	10732.62
Clinical Nurse II	S76	4318.16	4535.04	4762.16	5000.40	5250.56	---	---	9356.01	11376.21
Clinical Nurse II - Extra Help	X1H	4017.36	4219.04	4430.48	4652.08	4884.80	---	---	8704.28	10583.73
Clinical Nurse II - Step A	D0A	4426.16	4648.48	4881.28	5125.36	5381.68	---	---	9590.01	11660.30
Clinical Nurse II - Step B	D0B	4534.00	4761.68	5000.32	5250.48	5513.20	---	---	9823.66	11945.26
Clinical Nurse II - Step C	D0C	4642.00	4875.12	5119.36	5375.44	5644.24	---	---	10057.66	12229.18
Clinical Nurse II - U	Q87	4318.16	4535.04	4762.16	5000.40	5250.56	---	---	9356.01	11376.21
Clinical Nurse II - U - Step A	E1A	4426.16	4648.48	4881.28	5125.36	5381.68	---	---	9590.01	11660.30
Clinical Nurse II - U - Step B	E1B	4534.00	4761.68	5000.32	5250.48	5513.20	---	---	9823.66	11945.26
Clinical Nurse II - U - Step C	E1C	4642.00	4875.12	5119.36	5375.44	5644.24	---	---	10057.66	12229.18
Clinical Nurse III	S75	4762.16	5000.40	5250.56	5513.36	5789.28	6078.56	6382.56	10318.01	13828.88
Clinical Nurse III - Extra Help	X1I	4430.48	4652.08	4884.80	5129.20	5385.76	---	---	9599.37	11669.14
Clinical Nurse III - Step A	S7A	4881.28	5125.36	5381.68	5651.04	5933.76	6230.48	6542.00	10576.10	14174.33
Clinical Nurse III - Step B	S7B	5000.32	5250.48	5513.20	5789.20	6078.56	6382.48	6701.68	10834.02	14520.30
Clinical Nurse III - Step C	S7C	5119.36	5375.44	5644.24	5926.96	6234.24	6534.56	6861.04	11091.94	14865.58

Effective October 23, 2017										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Clinical Nurse III - U	Q86	4762.16	5000.40	5250.56	5513.36	5789.28	6078.56	6382.56	10318.01	13828.88
Clinical Nurse III - U - Step A	Q8A	4881.28	5125.36	5381.68	5651.04	5933.76	6230.48	6542.00	10576.10	14174.33
Clinical Nurse III - U - Step B	Q8B	5000.32	5250.48	5513.20	5789.20	6078.56	6382.48	6701.68	10834.02	14520.30
Clinical Nurse III - U - Step C	Q8C	5119.36	5375.44	5644.24	5926.96	6234.24	6534.56	6861.04	11091.94	14865.58
Clinical Nurse Specialist	S35	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Clinical Nurse Specialist - Extra Help	X1L	5129.20	5385.76	5654.96	5937.84	6234.96	---	---	11113.26	13509.08
Clinical Nurse Specialist - Step A	S4A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	16424.54
Clinical Nurse Specialist - Step B	S4B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Clinical Nurse Specialist - Step C	S4C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69
Infection Control Nurse	S04	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Infection Control Nurse - Extra Help	X1F	5129.20	5385.76	5654.96	5937.84	6234.96	---	---	11113.26	13509.08
Infection Control Nurse - Step A	S0A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	16424.54
Infection Control Nurse - Step B	S0B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Infection Control Nurse - Step C	S0C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69
Nurse Coordinator	S39	5250.56	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	11376.21	15246.92
Nurse Coordinator - Extra Help	X1M	4884.24	5128.80	5385.36	5654.48	5937.28	---	---	10582.52	12864.10
Nurse Coordinator - Step A	S3A	5381.68	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	11660.30	15628.25
Nurse Coordinator - Step B	S3B	5513.20	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	11945.26	16009.24
Nurse Coordinator - Step C	S3C	5644.24	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	12229.18	16390.74
Nurse Coordinator - U	Q39	5250.56	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	11376.21	15246.92
Nurse Coordinator - U Step A	Q4A	5381.68	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	11660.30	15628.25
Nurse Coordinator - U Step B	Q4B	5513.20	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	11945.26	16009.24
Nurse Coordinator - U Step C	Q4C	5644.24	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	12229.18	16390.74
Nurse Practitioner	S59	6078.56	6382.56	6701.92	7037.04	7395.92	7773.20	8170.48	13170.21	17702.70
Nurse Practitioner - Extra Help	X1N	5654.96	5937.76	6234.96	6546.80	6880.48	---	---	12252.41	14907.70
Nurse Practitioner - Step A	Y0A	6230.48	6542.00	6869.44	7213.04	7580.56	7967.36	8374.40	13499.37	18144.53
Nurse Practitioner - Step B	Y0B	6382.48	6701.68	7036.80	7388.88	7765.60	8161.92	8578.96	13828.70	18587.74
Nurse Practitioner - Step C	Y0C	6534.56	6861.04	7204.56	7564.96	7950.32	8356.16	8783.04	14158.21	19029.92
Per Diem Clinical Nurse	S99	---	69.21/Hrly	---	87.50/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	86.54/Hrly	---	109.42/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	69.21/Hrly	---	87.50/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4277.28	4491.68	4717.28	4953.52	5201.28	---	---	9267.44	11269.44

Effective October 23, 2017										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Psychiatric Nurse I - Step A	D5A	4384.32	4604.16	4835.04	5077.28	5331.12	---	---	9499.36	11550.76
Psychiatric Nurse I - Step B	D5B	4491.20	4716.56	4952.80	5201.20	5461.28	---	---	9730.93	11832.77
Psychiatric Nurse I - Step C	D5C	4598.24	4828.72	5070.88	5324.96	5591.20	---	---	9962.85	12114.26
Psychiatric Nurse II	S57	4762.16	5000.40	5250.56	5513.36	5789.28	6078.56	6382.56	10318.01	13828.88
Psychiatric Nurse II - Extra Help	X1C	4430.48	4652.08	4884.80	5129.20	5385.76	---	---	9599.37	11669.14
Psychiatric Nurse II - Step A	E2A	4881.28	5125.36	5381.68	5651.04	5933.76	6230.48	6542.00	10576.10	14174.33
Psychiatric Nurse II - Step B	E2B	5000.32	5250.48	5513.20	5789.20	6078.56	6382.48	6701.68	10834.02	14520.30
Psychiatric Nurse II - Step C	E2C	5119.36	5375.44	5644.24	5926.96	6234.24	6534.56	6861.04	11091.94	14865.58
Staff Developer	S38	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Staff Developer - Extra Help	X1E	4862.88	5106.32	5361.60	5629.68	5911.44	---	---	10536.24	12808.12
Staff Developer - Step A	S5A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	16424.54
Staff Developer - Step B	S5B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Staff Developer - Step C	S5C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69

APPENDIX A – RNPA SALARIES

Effective October 22, 2018

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Assistant Nurse Manager - Extra Help	X1J	5283.04	5547.28	5824.56	6115.92	6422.00	---	---	11446.58	13914.33
Assistant Nurse Manager - Step A	S2A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Assistant Nurse Manager - Step B	S2B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Assistant Nurse Manager - Step C	S2C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40
Certified Registered Nurse Anesthetist	S1V	7770.72	8167.28	8584.64	9023.12	9483.76	9968.16	---	16836.56	21597.68
Certified Registered Nurse Anesthetist - Extra Help	X1K	7230.24	7598.32	7986.40	8394.40	8832.16	---	---	15665.52	19136.34
Certified Registered Nurse Anesthetist - Step A	Y1A	7964.96	8371.52	8799.12	9248.56	9721.04	10217.28	---	17257.41	22137.44
Certified Registered Nurse Anesthetist - Step B	Y1B	8159.44	8575.84	9013.92	9474.16	9957.92	10466.40	---	17678.78	22677.20
Certified Registered Nurse Anesthetist - Step C	Y1C	8353.68	8779.84	9228.40	9699.68	10195.04	10715.60	---	18099.64	23217.13
Clinical Nurse I	S89	4196.40	4406.16	4626.40	4858.72	5102.08	---	---	9092.20	11054.50
Clinical Nurse I - Extra Help	X1A	3886.64	4080.96	4304.32	4520.08	4746.56	---	---	8421.05	10284.21
Clinical Nurse I - Step A	C3A	---	---	4742.24	4980.08	5229.52	---	---	10274.85	11330.62
Clinical Nurse I - Step B	C3B	---	---	4858.00	5101.36	5357.20	---	---	10525.66	11607.26
Clinical Nurse I - Step C	C3C	---	---	4973.52	5222.96	5484.64	---	---	10775.96	11883.38
Clinical Nurse I - U	Q89	4196.40	4406.16	4626.40	4858.72	5102.08	---	---	9092.20	11054.50
Clinical Nurse II	S76	4447.68	4671.04	4904.96	5150.40	5408.00	---	---	9636.64	11717.33
Clinical Nurse II - Extra Help	X1H	4137.84	4345.60	4563.36	4791.60	5031.28	---	---	8965.32	10901.10
Clinical Nurse II - Step A	D0A	4558.88	4787.92	5027.68	5279.12	5543.12	---	---	9877.57	12010.09
Clinical Nurse II - Step B	D0B	4670.00	4904.48	5150.32	5407.92	5678.56	---	---	10118.33	12303.54
Clinical Nurse II - Step C	D0C	4781.20	5021.36	5272.88	5536.64	5813.52	---	---	10359.26	12595.96
Clinical Nurse II - U	Q87	4447.68	4671.04	4904.96	5150.40	5408.00	---	---	9636.64	11717.33
Clinical Nurse II - U - Step A	E1A	4558.88	4787.92	5027.68	5279.12	5543.12	---	---	9877.57	12010.09
Clinical Nurse II - U - Step B	E1B	4670.00	4904.48	5150.32	5407.92	5678.56	---	---	10118.33	12303.54
Clinical Nurse II - U - Step C	E1C	4781.20	5021.36	5272.88	5536.64	5813.52	---	---	10359.26	12595.96
Clinical Nurse III	S75	4904.96	5150.40	5408.00	5678.72	5962.88	6260.88	6574.00	10627.41	14243.66
Clinical Nurse III - Extra Help	X1I	4563.36	4791.60	5031.28	5283.04	5547.28	---	---	9887.28	12019.10
Clinical Nurse III - Step A	S7A	5027.68	5279.12	5543.12	5820.56	6111.76	6417.36	6738.24	10893.30	14599.52
Clinical Nurse III - Step B	S7B	5150.32	5407.92	5678.56	5962.80	6260.88	6573.92	6902.72	11159.02	14955.89
Clinical Nurse III - Step C	S7C	5272.88	5536.64	5813.52	6104.72	6421.20	6730.56	7066.80	11424.57	15311.40

Effective October 22, 2018										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Clinical Nurse III - U	Q86	4904.96	5150.40	5408.00	5678.72	5962.88	6260.88	6574.00	10627.41	14243.66
Clinical Nurse III - U - Step A	Q8A	5027.68	5279.12	5543.12	5820.56	6111.76	6417.36	6738.24	10893.30	14599.52
Clinical Nurse III - U - Step B	Q8B	5150.32	5407.92	5678.56	5962.80	6260.88	6573.92	6902.72	11159.02	14955.89
Clinical Nurse III - U - Step C	Q8C	5272.88	5536.64	5813.52	6104.72	6421.20	6730.56	7066.80	11424.57	15311.40
Clinical Nurse Specialist	S35	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Clinical Nurse Specialist - Extra Help	X1L	5283.04	5547.28	5824.56	6115.92	6422.00	---	---	11446.58	13914.33
Clinical Nurse Specialist - Step A	S4A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Clinical Nurse Specialist - Step B	S4B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Clinical Nurse Specialist - Step C	S4C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40
Infection Control Nurse	S04	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Infection Control Nurse - Extra Help	X1F	5283.04	5547.28	5824.56	6115.92	6422.00	---	---	11446.58	13914.33
Infection Control Nurse - Step A	S0A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Infection Control Nurse - Step B	S0B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Infection Control Nurse - Step C	S0C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40
Nurse Coordinator	S39	5408.00	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	11717.33	15704.17
Nurse Coordinator - Extra Help	X1M	5030.72	5282.64	5546.88	5824.08	6115.36	---	---	10899.89	13249.94
Nurse Coordinator - Step A	S3A	5543.12	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	12010.09	16096.94
Nurse Coordinator - Step B	S3B	5678.56	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	12303.54	16489.37
Nurse Coordinator - Step C	S3C	5813.52	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	12595.96	16882.32
Nurse Coordinator - U	Q39	5408.00	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	11717.33	15704.17
Nurse Coordinator - U Step A	Q4A	5543.12	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	12010.09	16096.94
Nurse Coordinator - U Step B	Q4B	5678.56	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	12303.54	16489.37
Nurse Coordinator - U Step C	Q4C	5813.52	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	12595.96	16882.32
Nurse Practitioner	S59	6260.88	6574.00	6902.96	7248.08	7617.76	8006.32	8415.52	13565.24	18233.62
Nurse Practitioner - Extra Help	X1N	5824.56	6115.84	6422.00	6743.20	7086.88	---	---	12619.88	15354.90
Nurse Practitioner - Step A	Y0A	6417.36	6738.24	7075.52	7429.36	7807.92	8206.32	8625.60	13904.28	18688.80
Nurse Practitioner - Step B	Y0B	6573.92	6902.72	7247.84	7610.48	7998.56	8406.72	8836.32	14243.49	19145.36
Nurse Practitioner - Step C	Y0C	6730.56	7066.80	7420.64	7791.84	8188.80	8606.80	9046.48	14582.88	19600.70
Per Diem Clinical Nurse	S99	---	71.28/Hrly	---	90.12/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	89.14/Hrly	---	112.70/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	71.28/Hrly	---	90.12/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4405.52	4626.40	4858.72	5102.08	5357.28	---	---	9545.29	11607.44

Effective October 22, 2018										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Psychiatric Nurse I - Step A	D5A	4515.84	4742.24	4980.08	5229.52	5491.04	---	---	9784.32	11897.25
Psychiatric Nurse I - Step B	D5B	4625.92	4858.00	5101.36	5357.20	5625.04	---	---	10022.82	12187.58
Psychiatric Nurse I - Step C	D5C	4736.16	4973.52	5222.96	5484.64	5758.88	---	---	10261.68	12477.57
Psychiatric Nurse II	S57	4904.96	5150.40	5408.00	5678.72	5962.88	6260.88	6574.00	10627.41	14243.66
Psychiatric Nurse II - Extra Help	X1C	4563.36	4791.60	5031.28	5283.04	5547.28	---	---	9887.28	12019.10
Psychiatric Nurse II - Step A	E2A	5027.68	5279.12	5543.12	5820.56	6111.76	6417.36	6738.24	10893.30	14599.52
Psychiatric Nurse II - Step B	E2B	5150.32	5407.92	5678.56	5962.80	6260.88	6573.92	6902.72	11159.02	14955.89
Psychiatric Nurse II - Step C	E2C	5272.88	5536.64	5813.52	6104.72	6421.20	6730.56	7066.80	11424.57	15311.40
Staff Developer	S38	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Staff Developer - Extra Help	X1E	5008.72	5259.44	5522.40	5798.56	6088.72	---	---	10852.22	13192.22
Staff Developer - Step A	S5A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Staff Developer - Step B	S5B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Staff Developer - Step C	S5C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40

APPENDIX B - CLASSIFICATIONS AND AREAS OF COMPETENCY FOR LAYOFF PURPOSES ONLY

B.1 - Classifications

Assistant Nurse Manager

Areas of Competency

1. Medical/Surgical
2. Rehabilitation
3. Neonatal Intensive Care, Pediatrics, Pediatric Intensive Care
4. Critical Care
5. Post Anesthesia Care Unit(PACU), Ambulatory Surgery Unit (ASU)
6. Transitional Care Neurosurgery Unit, Medical Short Stay Unit
7. Labor and Delivery
8. Mother Infant Care Center (MICC)
9. Operating Room
10. Ambulatory Care
11. Renal Care Center
12. Psychiatry/Behavioral Health

Clinical Nurse Specialist

Areas of Competency

1. Enterostomal
2. Oncology
3. Psychiatry/Behavioral Health
4. Rehabilitation
5. Maternity
6. Neonatal
7. Pediatric

Staff Developer

Areas of Competency

1. Medical/Surgical
2. Rehabilitation
3. Neonatal Intensive Care, Pediatrics, Pediatric Intensive Care
4. Critical Care
5. Labor and Delivery
6. Mother Infant Care Center (MICC)
7. Operating Room
8. Ambulatory Care
9. Custody Health Services

10. Psychiatry/Behavioral Health
11. General

Infection Control Nurse

Area of Competency

1. Infection Control

Nurse Coordinator

Areas of Competency

1. HIV/AIDS Services
2. Diabetes Patient Education
3. Dialysis
4. Nursing Information Systems
5. Psychiatry/Behavioral Health, Drug and Alcohol
6. Comprehensive Perinatal Services Program (CPSP)
7. Endoscopy
8. SART
9. Mother Infant Care Center (MICC)
10. Lactation
11. Cardiovascular
12. Anticoagulant
13. Homeless Program
14. Oncology
15. Stroke Coordinator

Clinical Nurse I/II/III

Areas of Competency

1. Medical-Surgical Units
(3 Surgical, 4 Surgical, 4 Medical,
Admission, Discharge, Transfer (ADT) Nurse

2. Rehabilitation (1RHB,
2 RHB, Rehabilitation Trauma Unit RTC2)

3. Neonatal Intensive Care Unit,
Pediatrics, Pediatric Intensive Care Unit

4. Adult Intensive Care Units (MICU, TICU, CCU, SICU), Burn Unit, Emergency Department, Cardiac Cath Lab, Interventional Radiology, Resource Nurse, PICC Nurse

5. Post Anesthesia Care Unit (PACU),Ambulatory Surgery Unit (ASU)

6. Transitional Care Neurosurgery Unit, Medical Short Stay Unit

7. Labor and Delivery

8. Mother-Infant Care Center (MICC)

9. Operating Room

10. Ambulatory Care

11. Renal Care Center

12. Custody Health Services

13. Coded Float:
Competency areas for coded float nurses are determined based upon the greatest percentage of assignments within Appendix B, Clinical Nurse I, II, III Areas of Competency 1-13 in the preceding twelve (12) months.
In the event of a layoff, those coded floats determined to be competent in the area being laid off will be included in the layoff process.

Psychiatric Nurse I/II

Area of Competency

1. Psychiatry/Behavioral Health, Drug & Alcohol.

Nurse Practitioner

Areas of Competency

1. Family
2. Adult
3. Neonatal Care
4. Pediatric
5. Women's Health
6. Gerontology
7. Psychiatry/Behavioral Health
8. Oncology

B. 2. - Areas of Competency Not Covered

If an area is not covered by this appendix, the parties shall meet and confer on the related areas of competency.

B.3 - Certifications and Specialty Skills

County may retain less senior nurses or nurses in a lower class who have certifications or specialty skills as designated:

1. Chemotherapy Certification on 4 Medical and Infusion Center
2. Open Heart qualified in SICU
3. Intra-aortic Balloon Pump (IABP) Certification in the CCU
4. Cardiac Cath Lab qualified in the Cath Lab
5. Informatics Nurse Certification for Nursing Information Systems Nurse Coordinator positions.

Appendix C
Per Diem and Extra Help Nurses

1. Per Diem (PD) and Extra Help (EH) Nurses are appointments to non-permanent positions established to meet peak load or other unusual work situations.

   PD and EH nurses may access sccjobs.org and complete job interest notification(s) to be notified of coded nursing positions that are being posted on an open/competitive basis.

2. PD nurses are required to be available to work at least eight (8) shifts a month, two of which are weekend shifts(if applicable). Four (4) weekend shifts per month may be approved as an alternate schedule to the eight shifts per month work requirement.

   Each PD and EH nurse must be available to work one of the three major holidays: Thanksgiving, Christmas or New Year's Day on a rotating basis. Christmas Eve and New Year's Eve will be considered as meeting the holiday requirement for the evening shift. When assigned and worked, extra help and per diem nurses shall be paid at time and one half for all hours worked on two of the three major holidays as noted above.

3. EH nurses are required to be available to work a minimum of four (4) shifts per month, one of which will be a weekend shift.

4. Each PD and EH nurse is expected to float to units within their like area(s) as set forth in Section 8.14 b) however PD/EH nurses are not eligible for the premium pay.

5. No nurse may receive pay in an extra help capacity in the same classification in the same department for more than 1,040 hours in any fiscal year, unless otherwise approved by the Board of Supervisors.

   a) Should an extension of hours be requested, the County shall provide RNPA at least twenty (20) days' notice in advance of the scheduled Board of

Supervisors meeting. RNPA shall respond within five (5) days of receipt of notice to request to meet and discuss or such request is deemed to have been waived.

b) If a request to meet is made, the County and RNPA shall meet and discuss for not more than five (5) working days. If concerns are not alleviated or agreement not reached, the County may proceed.

c) The Board of Supervisors may proceed without meeting should they determine circumstances justify urgent action. Reasonable advance notice will be provided to the notice with intention to proceed on such basis.

6. Nurses who work as PD or EH shall be compensated on an hourly basis in accordance with the provisions of the County of Santa Clara Salary Ordinance Section B. (3).

7. Overtime is defined as time worked beyond eighty (80) hours on a bi-weekly pay period, or beyond eight (8) hours in any work day except as mutually agreed upon between the County and the Association. Compensation for regular overtime shall be paid in cash at the rate of one and one-half (1 ½) times the regular hourly rate. Compensation for continuous shift overtime shall be paid in cash at the rate of one and one-half (1 ½) times the regular hourly rate for the first four (4) hours of overtime contiguous to the regular shift of a minimum of eight (8) hours and two (2) times the regular hourly rate for any additional hours worked.

8. PD or EH nurses may elect to work an alternate work day of ten (10) or twelve (12) hour shift with mutual agreement of the nurse and management. This schedule shall be a voluntary/optional alternative to an eight (8) hour work day assignment. A PD or EH nurse working an alternate ten (10) or twelve (12) hour shift shall be compensated for each hour worked at the regular hourly base pay. Hours worked in excess of ten (10) or twelve (12) hours of the alternate ten (10) or twelve (12) hour shift, shall be subject to overtime provisions (Appendix C, #7).

9. PD and EH nurses shall be subject to all provisions of Article 1; Article 2; Section 3.1, 3.2, 3.4; Article 4; Section 6.3; Sections 7.1, 7.6, 7.7; Sections 8.3, 8.4, 8.5, 8.9, 8.14 a) 8.14 b) (except for differential); Section 13.7; Article 14; Article 16; Article 17; Sections 18.2, 18.3, 18.4, 18.5, 18.8, 18.9,

18.10 (except for e), 18.11; Article 19; Article 20; Article 21; Article 22 and Article 23 of the Agreement between the County and RNPA and this Appendix.

10. Each PD and EH nurse will be evaluated annually. The evaluation shall consist of a comparison of the nurse's performance against written standards established by Management for:

1) Work Unit competencies;
2) Job classification;
3) Unit role expectations;
4) Any appropriate legal or regulatory requirements.

The County and RNPA shall meet within 90 days of agreement to discuss options in assisting extra help and per diem nurses achieve employment in coded positions. Discussions shall include training for assisting extra help and per diem nurses be successful in the testing process and job advancement skills.

The County commits to train managers and supervisors on the effective use of eligible lists, filling temporary vacancies and using the recruitment process including the use of selective certification and alternatives to extra help and per diem including Provisional and Substitute Provisional appointments.

A PD nurse is eligible for and may request a performance salary increase, contingent upon achieving a rating of standard or above in all categories of the performance evaluation and provided that he/she has worked a minimum of 1,040 hours since the last performance increase. An evaluation used for salary increase shall not be older than 90 days. Each PD nurse may only receive one performance salary increase within a one year time frame.

11. The parties acknowledge the value of permanent positions in maintaining quality of patient care while recognizing the need to use an appropriate staffing mix. The staffing mix accounts for flexibility and fluctuations based on peak loads and unusual work situations.

On a monthly basis the County shall provide the Association with a list of all RNPA represented PD and EH nurses names, classification, department and hours worked. Each year during the month of July, the County shall provide the

Association with a summary of all RNPA represented PD and EH hours by name, classification, department, cost center, and hours for the entire preceding fiscal year.
On a quarterly basis the County shall provide the Association with a report on the aggregate staffing mix of permanent, extra help and per diem.

12. The County and the Association shall meet on a quarterly basis during the term of the agreement to review and discuss the use of PD and EH nurses.

INDEX

U

V

W

INDEX

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

No. 19-cv-2916 NC

DECLARATION OF TONI TULLYS, M.P.A., DIRECTOR OF COUNTY OF SANTA CLARA BEHAVIORAL HEALTH SERVICES DEPARTMENT, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, TONI TULLYS, MPA, declare as follows

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I am the Director of the County's Behavioral Health Services Department ("BHSD"), which is part of the County's broader Health System. I have held this position from December 2014 to the present. In this role, I provide leadership on behavioral health issues for all of Santa Clara County and oversee approximately 822 BHSD employees, full-time and part-time, who provide a wide array of services to safeguard and promote the health of the community. I also oversee over $500 million in behavioral health services delivered by County staff and contracted providers.

3. Prior to becoming the Director of Behavioral Health Services for the County, I was the Deputy Director of the Alameda County Behavioral Health Care Services Department. I have worked in various administrative and patient care capacities in public and private health care organizations for more than 30 years. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

4. The Behavioral Health Services Department's mission is

> "[t]o assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity."

5. BHSD is dedicated to improving the health and well-being of Santa Clara County residents and provides an array of behavioral health services to approximately 35,000 people annually. BHSD provides preventative mental health and substance use care and also serves individuals with mental health issues, serious mental illness, and substance use disorders. These services have been developed for every age group, from newborns to the elderly. BHSD provides treatment services to a wide range of residents including Medi-Cal beneficiaries, patients with a

sliding-fee option based on their ability to pay, and a small number of commercially insured patients that receive mild to moderate services.

6. BHSD provides prevention and treatment services for all persons struggling with substance use and mental health challenges, including at-risk youth, young adults, and families. For example, it provides individual counseling, group counseling, and case management services, which may include connecting youth to medical care, legal resources, transportation, job training, psychiatric services, and housing resources. Within BHSD, a dedicated Substance Use Treatment Services division provides prevention programs to children and youth and treatment services to persons struggling with substance abuse through services such as withdrawal management, outpatient treatment, recovery services, residential treatment, recovery residences, Medication-Assisted Treatment (MAT), perinatal services, and residential treatment services to assist County residents who struggle with substance abuse.

7. The County provides emergency psychiatric services at Santa Clara Valley Medical Center's Emergency Psychiatric Services (EPS) facility, the only 24-hour locked psychiatric emergency room in Santa Clara County. Nearly all patients at this facility are on involuntary psychiatric holds. In addition, BHSD operates Mental Health Urgent Care a walk-in crisis clinic with a psychiatrist on duty seven days a week for those seeking voluntary services. BHSD also provides post hospital services for patients who were served by the County's 48-bed acute inpatient psychiatric unit, and BHSD contracts with three additional community hospitals for inpatient mental health treatment.

8. Federal funding, either direct or indirect, from the U.S. Department of Health and Human Services is a major component of the budget for BHSD. Funding streams to BHSD, many of which flow through the State of California, include but are not limited to Medi-Cal and Medicare payments and several sources of funding from the Substance Abuse and Mental Health Administration, among many others. In total, in a typical fiscal year such as FY 2017-18, BHSD received approximately $112 million in federal funds, revenue that is a significant portion of the overall budget, which had overall gross expenditures of approximately $498 million. Without

those funds, the County Behavioral Health Services Department would have to dramatically reduce services even while the need for mental health services is growing in Santa Clara County and the County is planning to expand services provided through BHSD. The impact of any loss in federal funding would not be limited to services traditionally funded by federal dollars. A withdrawal of federal funding for the County would require a countywide realignment of funding and priorities, and money that is currently allocated from the County's General Fund to support programs that do not receive federal funding could be diverted to address the loss of federal funding.

9. The County Behavioral Health Services Department has a policy related to religious and moral objections to certain patient care, attached as **Exhibit A**. That policy requires BHSD staff and staff of all contracted service providers to inform BHSD prior to beginning work for BHSD, and annually thereafter, if there are certain services the provider does not offer due to religious or moral objections. BHSD will then inform beneficiaries and provide access to care through different providers.

10. BHSD's providers are expected to be competent to provide care for any patient and must not discriminate on the basis of health status or need for health care services, race, color, national origin, sex, gender, sexual orientation, gender identity, or disability. BHSD's providers also must offer culturally and linguistically competent, high-quality services to socially disadvantaged and ethnically diverse groups.

11. BHSD has a process for either patients or providers to voice concerns about their ability to continue in the treatment relationship, as building trust between the provider and patient is essential to the success of mental health treatment. When a provider is unable or unwilling to continue providing care for a patient, BHSD requires the provider to work with BHSD, which may include working directly with a new provider, to ensure continuity of care for the patient. That transition effort may also include following up with the patient to ensure they have scheduled necessary appointments and otherwise are receiving the treatments and services they need. Without timely notice of a refusal to provide care for religious or moral reasons and a

smooth transition to another provider, patients may not receive necessary and timely treatment, which could harm the patients and their communities and lead to additional healthcare needs and associated costs.

12. In my capacity as Director of Behavioral Health Services, I reviewed and am familiar with the model text for the "Notice of Rights under Federal Conscience and Anti-Discrimination Laws" from the Final Rule published by the U.S. Department of Health and Human Services, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."

13. Many of the clinics operated by and contracting with BHSD are physically small places where notices for employees would be in plain view of patients as well. The model text may give patients the impression that providers are able to object in the moment to providing care based on their conscience, religious beliefs, or moral convictions—potentially deterring patients from sharing sensitive information that is critical to their care. For example, to receive appropriate care, patients who are seeking mental health care may need to disclose to their provider sensitive information such as their medical history or plans to seek treatments such as abortion, sterilization, assisted suicide, or gender-affirming care. But the model notice may give the client an impression that revealing such information is unwelcome or even risky.

14. Given the vital importance in mental health care of trust between patients and providers, a notice such as this model text would unacceptably interfere with the patient-provider relationship, interrupting the continuum of care that the Behavioral Health Services Department is required to provide, interfering with the functioning of BHSD, and undermining BHSD's mission.

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

Dated: June 9, 2019

Respectfully submitted,

TONI TULLYS, M.P.A.

EXHIBIT A

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 2100

- [x] **BHSD County Staff**
- [x] **Contract Providers**
- [x] **Specialty Mental Health**
- [x] **Specialty Substance Use Treatment Services**

Title: LIMITATION ON MORAL OR RELIGIOUS GROUNDS

Approved/Issue Date:	**Behavioral Health Services Director:**	
Last Review/Revision Date:	**Next Review Date:**	**Inactive Date:**

REFERENCE:

- 42 CFR § 438.10 (e), (g). Information Requirements.
- 42 CFR § 438.52. Choice of MCO's, PIHPs, PAHPs, PCCMs and PCCM entities.
- 42 CFR § 438.100 (b). Enrollee Rights.
- 42 CFR § 438.102 (a)-(b). Provider-enrollee Communications.

POLICY:

Providers will not be required to deliver, reimburse for, or offer coverage of a counseling or referral service if the provider objects to the service on moral or religious grounds. Beneficiaries will know which providers have objections based on religious or moral grounds prior to referral or change.

DEFINITIONS:

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Provider. A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 2100

- [x] **BHSD County Staff**
- [x] **Contract Providers**
- [x] **Specialty Mental Health**
- [x] **Specialty Substance Use Treatment Services**

Title: LIMITATION ON MORAL OR RELIGIOUS GROUNDS

PROCEDURE	
Responsible Party	**Action Required**
Enrollees and Potential Enrollees	May contact the state to request information on how and where to obtains such services if BHSD chooses not to furnish the services because of moral or religious objections.
BHSD	1. Reimburses for counseling and referral services based on moral or religious grounds. 2. Notifies beneficiaries about providers that may not provide services based on moral or religious grounds at least 30 days prior to the effective date of the change. 3. Notifies enrollees at least 30 days in advance of BHSD implementing any new policy to discontinue the provision and reimbursement of counseling or referral services based on moral or religious grounds. 4. Furnishes the state with information on services it does not cover based on moral or religious grounds whenever it adopts this type of policy.
Providers	1. Prior to entering into a contract, providers will submit documentation to the BHSD about any services they do not cover because of moral or religious objections. 2. Providers will submit information to beneficiaries about any services they do not cover because of moral or religious objections. 3. Submit updates to BHSD annually or when there is a change in the services not covered due to moral or religious grounds.
Attachments:	

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF MODESTO VALLE, CHIEF EXECUTIVE OFFICE OF CENTER ON HALSTED, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Modesto Valle, declare as follows:

1. Center on Halsted is a 501(c)(3) non-profit organization based in Chicago and incorporated in Illinois. Center on Halsted is a comprehensive community center dedicated to securing the health and well-being of the LGBT people of the Chicago area. More than 1,400 community members walk through our doors each day for a range of social and/or direct service engagements.

2. As a comprehensive community center dedicated to advancing community and securing the health and well-being of LGBT people in Chicago, Center on Halsted provides programs and services for the LGBT community, including case management, lunches, job development, social programing, and housing for seniors; housing, meals, counseling, and leadership development for youth; and anti-violence services. Center on Halsted provides a wide range of behavioral-health services for all ages, including gender-transition-related counseling, individual and group therapy, anti-violence crisis counseling, and HIV-related healthcare, including HIV testing and linkage to Pre-Exposure Prophylaxis or PrEP, which is extremely effective at preventing HIV transmission. Center on Halsted will soon be expanding the breadth of healthcare services that it provides via the opening of its own Health and Wellness Clinic, likely within the next year.

3. Community members not only obtain services from Center on Halsted, they also access healthcare services from a range of other community based organizations and agencies, including religiously-affiliated organizations. For example, seniors who are served by Center on Halsted currently access services through Catholic Charities and religiously-owned hospitals and care facilities, organizations that receive federal financial support for their programs and services. When these seniors encounter problems with service agencies, including denial of healthcare services based on their LGBT status or identity, Center on Halsted intervenes to advocate on the

patrons' behalf. Center staff communicate with agencies informing them of their legal obligation to ensure that LGBT people who Center on Halsted serves have the ability to secure healthcare services on equal, nondiscriminatory terms. When agencies deny services to LGBT individuals, word spreads among community members, causing many of those who the Center on Halsted serves to be fearful of also being discriminated against by these organizations.

4. I have been the Chief Executive Officer of Center on Halsted since 2007 and have been instrumental in establishing many of the programs that are offered through the Center, including bringing several landmark efforts to the Center, such as the first LGBTQ-friendly affordable housing project for Seniors and the HIV/AIDS and STI Program. I attended DePaul University and Notre Dame's Seminary School. In addition, I hold certificates in nonprofit management from Harvard Business School and Northwestern University's Kellogg School of Management. I was recently appointed to the CenterLink Board of Directors and have served on the board of the NAMES Project Foundation, Equality Education Project, City of Chicago LGBT Health Council, Illinois Violence Prevention Authority Board, City of Chicago Employment Task Force, Welcoming Committee NATO, Illinois HIV/AIDS Advisory Council, Board Member of Horizons Community Services and the Chicago Children's Choir. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

5. Unless enjoined, the impact that the Denial-of-Care Rule will have on the patrons and clients whom Center on Halsted serves will be profound. People across nearly every demographic and along the entire spectrum from closeted to fully out come through Center on Halsted's doors to be in a space where they feel safe in the entirety of their authentic selves. What Center on Halsted provides is a space where judgement is not passed, nor services withheld based on personal prejudice. Center on Halsted is also a place where people do not have to sacrifice safety

or delay healthcare out of fear of being told that who they are does not meet someone's moral or religious standards. If there is one thing that the 1,400 people walking through our doors have in common, it is that they know they are welcomed, whether that is to join a community group, hear a lecture, receive mental-health services, participate in a family group, take in an art show, use a computer, get an HIV test, or just relax. From our experiences serving our community, the Denial-of-Care Rule will cause the people Center on Halsted serves to feel a greater need to hide their identities and same-sex relationships when accessing healthcare services from healthcare providers outside of Center on Halsted out of fear that the healthcare providers may have religious objections to serving LGBT people. Causing clients to omit potentially vital parts of their life history may result in a misdiagnosis and an incomplete or inappropriate treatment or recommendation. Staying in the closet may also lead to greater isolation, which is harmful in itself and negatively affects an individual's health and well-being.

6. The Denial-of-Care Rule will evoke trauma and fear among members of our community, resulting in increased demand for Center on Halsted's LGBT-affirming mental-health counseling. This will especially impact transgender and behavioral-health services that Center on Halsted currently provides. The additional demand for services and advocacy caused by discrimination resulting from the Rule will strain Center on Halsted's resources.

7. Center on Halsted will likely see an increased need for behavioral health services, especially for LGBT homeless youth who are particularly vulnerable, as many have been kicked out of their homes before encountering rejection or other discriminatory treatment by a healthcare provider. When at-risk youth experience additional rejections and denials of care by their healthcare providers, the very people whom they reach out to for support in their most vulnerable moments, they are more likely to engage in high-risk behaviors and will thus require Center on Halsted's services more often and in a greater state of trauma. With the Denial-of-Care Rule in

effect, Center on Halsted may have fewer ways to mentor these youth away from high-risk behaviors when the availability of complementary support, such as replacing the familial and community safety nets with ones using social services, is reduced by discriminatory denials of service.

8. The Rule will also cause added stress on LGBT clients for whom accessing social services will be like stepping into a minefield. This will mean that Center on Halsted will need to re-examine all referral linkages, which will become increasingly difficult as the Denial-of-Care Rule will empower individuals within agencies to discriminate. In effect, this reduces the already severely damaged trust that LGBT clients – especially young clients – have, which is troubling as trust is necessary for a client to reach out for help. For example, if a young client fears that a once trusted organization may have a healthcare provider or gatekeeper whose religious beliefs about the child's gender identity reflects those of the adults who abused and abandoned them, it keeps the young person in a state of heightened vulnerability.

9. Center on Halsted is also seeing a rise in the numbers of requests for gender transition letters from our behavioral-health department. Transition letters are written by qualified Behavioral Health staff on behalf of Transgender clients seeking gender confirmation surgery. The rise in requests is likely because some transgender clients are growing more afraid of harassment, denials of care, and elongated procedures intended only to obstruct their access to transition-related care. Center on Halsted's behavioral-health staff also anticipate that already disproportionately high suicide rates within the transgender community will climb if there is a return to more obstacles to transition-related options.

10. Center on Halsted will need to educate the community about the Denial-of-Care Rule in particular in order to inform clients of the additional steps clients may need to take in order to determine whether particular providers are competent and affirming. If the law takes effect, we

are likely to see an increase in reports of LGBT people being denied services. Between the Transgender Military Ban, the denial of gender self-determination for school children, and this Rule, LGBT people are negatively affected on multiple levels, which will require designing multi-level responses to address individual, interpersonal, systemic, and cultural impacts.

11. For instance, in addition to direct services, Center on Halsted provides training to healthcare professionals across fields. Due to increased stigma and discrimination, a lack of LGBT affirming healthcare options, and increased denials of care, the Denial-of-Care Rule will increase healthcare disparities affecting the LGBT community. For over a decade, Center on Halsted has invested heavily in training and providing technical assistance to the healthcare industry in Chicago related to learning to work toward ensuring equitable services to the LGBT community. The Denial-of-Care Rule will require us to re-write these training programs and any related materials as well as require us to reach out to healthcare organizations and businesses in the Chicago region to re-train their personnel. The Denial-of-Care Rule thus undermines our mission of maintaining nondiscriminatory healthcare environments at these institutions and forces us to redirect resources to retraining and ensuring that these healthcare organizations and businesses retain and reinforce their nondiscrimination requirements. Some of the training programs we have offered were funded through government grants such as the Victims of Crimes Act grant.

12. As a result of the Denial-of-Care Rule, LGBT people and people living with HIV in Illinois will be at a higher risk of lacking culturally competent healthcare providers who will not further traumatize them or exacerbate the reasons that they sought healthcare in the first place. Increased discrimination against LGBT clients creates a need for more and longer training engagements. In fiscal year 2017, Center on Halsted trainers provided twenty-five trainings to nearly 600 health and safety professionals. The Denial-of-Care Rule frustrates Center on Halsted's work in this area as it could prevent Center on Halsted from teaching and achieving its pillar

principles that are based on a client-centric, nondiscriminatory approach to healthcare, including teachings that religious-based objections to treating LGBT clients, and the negative treatment of LGBT clients and clients living with HIV, can significantly and adversely alter a client's health and well-being without potentially violating the Rule. When healthcare providers affirm negative messaging about clients' self-worth, particularly during clients' most vulnerable moments of need for health-related care, clients' confidence and trust in the medical care that they receive is eroded, negatively affecting their health and well-being because they are less likely to seek care for their medical needs and by the time they do seek care, their conditions are often more acute.

13. Related to gender transitions, Center on Halsted is concerned about the Denial-of-Care Rule's preamble that characterizes transgender-affirming care as "sterilization." Much of transgender-affirming care has no impact on reproductive function or may have merely an incidental impact on reproductive function. For many transgender individuals, gender confirmation surgery is a treatment for gender dysphoria, but it is not done for the purpose of preventing procreation. Bodily autonomy is of paramount importance to everyone, including transgender individuals. While impacts on reproduction may be an incidental effect of some transgender-affirming care, such treatment is *not* sterilization.

14. Center on Halsted is working on opening its own health and wellness clinic that will include behavioral health treatment, therapy, counseling, anti-violence and youth programming, HIV-related healthcare services, PrEP services and access, additional gender-transition-related care options, and referral services to outside organizations for clients seeking healthcare options that Center on Halsted does not provide. This will be another investment Center on Halsted makes in our community, one that is particularly important as more providers use religious-based objections to providing PrEP and other medications as a way to not serve the LGBT community.

15. The Denial-of-Care Rule will empower broad discrimination. We have heard from clients, for example, that their requests for prescriptions like PrEP were rejected because healthcare providers outside of Center on Halsted stated that providing such treatment was contrary to their moral beliefs and would, allegedly, promote "promiscuous" lifestyles and even 'gay sex' generally. Such denials of care could also lead to a rise in PTSD symptoms in those who survived the AIDS epidemic and watched friends and loved ones suffer and die when they were refused treatment within a milieu of fear which was in part perpetuated by the federal government. For clients who may have been reluctant to ask in the first place, being told that the provider morally opposes PrEP may lead the client to leave without the medication and not seek out another provider. This could impede realization of the state's Getting to Zero goal with respect to HIV transmission, which has been showing great promise, and increase the length of time and likelihood of seeing the end of the spread of HIV. This type of discrimination will increase as a result of the Denial-of-Care Rule.

16. In the weeks leading up to, and in anticipation of, the issuance of the Denial-of-Care Rule, Center on Halsted's staff devoted and since then continues to devote increased resources to strategize ways to combat negative effects from the Rule and to work with staff to develop community education options. Center on Halsted has already conducted additional "Know Your Rights" internal staff development sessions regarding discrimination against LGBT people; sent and prepared staff to attend meetings and events with other LGBT stakeholders in the city; and held internal training for staff to manage the added strains on the mental health of our clients. Center on Halsted needs to educate its community about the Denial-of-Care Rule, which erodes their confidence in the healthcare system and puts their lives and the lives of their loved ones in potential jeopardy. Center on Halsted needs to continue messaging the community about Center on Halsted's commitment to serving all clients in a non-discriminatory and welcoming manner and notify its clients that the Denial-of-Care Rule will not change Center on Halsted's commitment to providing

exceptional healthcare services to all members of the community. Center on Halsted will continue fighting for its clients' rights, including, for example, advocating with other entities on behalf of transgender clients who seek treatment for gender dysphoria, but who are denied such treatment due to providers' religious or moral objections to treating transgender clients. Center on Halsted must now devote more resources to working with outside providers and organizations to remind them of the importance of providing healthcare to all clients on non-discriminatory terms. Center on Halsted also must conduct additional internal, staff training to address and assist in managing the added strains that issuance of the Rule has already caused to Center on Halsted's staff and the people they serve. Further, Center on Halsted will ramp up its work at the intersections of identity and health, particularly focusing on transgender people of color, who already live in areas less likely to offer an array of healthcare options. The Denial-of-Care Rule thus already has required, and will further require, considerable diversion and additional expenditure of Center on Halsted's resources, and frustrates Center on Halsted's mission.

17. The Denial-of-Care Rule further adversely impacts Center on Halsted by necessitating the diversion and reallocation of resources in order to provide referrals to clients that it does not have the resources to treat either because Center on Halsted has reached its capacity for new clients (especially in the behavioral-health departments) or because the client requires treatment in a specialty that Center on Halsted does not have. These types of referrals are routine at Center on Halsted where our healthcare work focuses on behavioral health. The Denial-of-Care Rule will require Center on Halsted to expend more resources vetting healthcare providers within its referral network. Further, if a provider to whom we refer clients refuses to treat our referred clients, such a Denial-of-Care is gravely harmful to our reputation, a reputation that Center on Halsted invests heavily in with our clients, as it is essential to client trust. The Denial-of-Care Rule will make it significantly more difficult and resource-intensive for us to locate and monitor

appropriate referrals. With an increase in referral requests as a result of the Denial-of-Care Rule, Center on Halsted will need to allocate additional staff time to pre-screen service referrals to ensure that staff are sending clients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to Center on Halsted's clients. Moreover, Center on Halsted's staff will experience the indignity of discrimination themselves as they attempt to advocate for those whom Center on Halsted serves when healthcare providers interpret the Denial-of-Care Rule as permitting them to deny healthcare services to LGBT clients and refuse to even refer LGBT clients to other resources. The Rule will increase Center on Halsted's operating costs and will take a toll on the health and well-being of the LGBT community that it serves.

18. Center on Halsted's job-recruitment process will be adversely affected in terms of being able to best serve the LGBT communities of Chicago. Center on Halsted would have to devote both programmatic and human-resources time to re-writing job descriptions and interview protocols to adhere to requirements under the Denial-of-Care Rule. Center on Halsted's inability under the Rule to inquire about a job applicant's willingness to treat all clients with equal dignity and respect regardless of the clients' sexual orientation or gender identity will be extremely harmful to Center on Halsted's reputation and mission. The LGBT community is not monolithic. Similarly, for instance, to how the term "Asian" encompasses many identities and cultures, LGBT is used as an expedient way to describe an otherwise incredibly diverse population. There are, for instance, lesbians who deride transgender women. It is not inconceivable that such a lesbian would seek employment at Center on Halsted and, without appropriate policies to inquire about her alignment with Center on Halsted's mission, could be hired. This would erode the very mission of Center on Halsted. To not be able to ask an applicant if they object to any part of Center on Halsted's mission would leave our communities exposed to mental and physical harms, in direct opposition to Center on Halsted's mission. Currently, for instance, Center on Halsted asks "what about the Center"

attracts you as well as what experience the applicant may have working with LGBT communities. An inability to probe in connection with such questions would send a message that Center on Halsted is not interested in hiring and retaining a group of people committed to the LGBT community. Explaining this to our community would also divert already stretched resources. A similar issue of mission erosion would arise in working with volunteers.

19. One of the most disconcerting aspects of the Denial-of-Care Rule is the requirement to open confidential medical records to OCR upon its request and the fact that certain confidentiality requirements may not operate under the Rule. OCR's access to clients' medical records, especially given the recent creation of the "Conscience and Religious Freedom Division," sends a harmful signal to LGBT individuals that their medical records and well-being are vulnerable to discrimination and misuse. This will have a chilling effect on clients' decisions regarding whether to access Center on Halsted's services. Though it is good that LGBT rights have progressed so far so quickly, this means that many LGBT people remember when information was used by the government to harm individuals in the community. The Denial-of-Care Rule will erode the trust of our communities and could lead to a return to closeted life for some. Hiding out of fear of government intrusion in one's life is a far stretch from democratic ideals.

20. The impact on the behavioral-health department will be significant. Each year, the department receives nearly 150 applications for 8 internship positions because so many students want to learn how to provide the LGBT affirming therapeutic interventions that this anchor program has developed since the founding of Center on Halsted. The department also brings on new staff and contract staff. As part of their therapeutic practice, the behavioral health team asks a therapist if they are comfortable disclosing their sexual orientation and gender identity as this is an important and crucial way to establish trust. If asking this question is no longer an option, the model will be compromised.

21. Similarly, if the HIV/AIDS & STI department hires someone who refuses to offer services by not providing HIV/HCV tests to parts of the populations served by Center on Halsted, then that person's salary is in effect wasted, while other staff members, already overworked, will be burdened with having to make up the tests if that objector decides to remain with Center's testing services. Additionally, any reception staff that works on intake for behavioral health could try to use the Denial-of-Care Rule to opt out of working with a client. Given that people making religious-based objection to assisting clients may not be required to report their actions, Center on Halsted may never know if a new client was turned away or why a long-term engaged client stopped engaging. Furthermore, even if Center on Halsted could afford to hire duplicative staff to try to protect against clients being turned away, which it cannot, there would be no way of ensuring that even the duplicative, "extra" staff would not also discriminate against clients or deny them medically necessary treatment.

22. The absence of an emergency exception is also of deep concern. If, for instance, a behavioral-health client, a homeless youth, a senior from the Center's Town Hall Residence, or any other patron experiences an extreme situation requiring an ambulance, operations, reception, and direct-service staff are currently expected to respond immediately. Current staff understand it is their obligation to respond, but the Denial-of-Care Rule threatens that understanding. The absence of an emergency exception could mean that a client in crisis remains in a prolonged state of crisis, potentially causing greater harm to that person or persons around them. This could be as a result of emergency care services exercising religious objections to assisting clients at our Center or even Center staff refusing to abide by their mandated-reporter status that requires them under the Health Insurance Portability and Accountability Act to assist clients in need of emergency care, including calling an ambulance when necessary.

23. In addition to concerns about not being able to appropriately select and supervise staff who work directly with clients, we are also concerned about other personnel that we hire at Center on Halsted, including, for instance, custodial staff. Center on Halsted's Code of Conduct includes the requirements for anyone in the building, including staff, volunteers, interns, and patrons, to provide "considerate and respectful treatment and care" (devoid of "rude, discourteous or raucous behavior") from "experienced, professional, and responsive staff" who extend "participation in services and programs without regard to race, color, sex, gender identity, gender expression, age, religion, disability, national origin, ancestry, sexual orientation, marital status, parental status, military discharge status or source of income." The Denial-of-Care Rule invites behavior that would be contrary to Center on Halsted's Code of Conduct in that it invites discrimination against and mistreatment of LGBT clients. Center on Halsted has built its reputation on being a place where LGBT individuals can be their full, authentic selves. The Denial-of-Care Rule infringes upon our reputation and mission. The Rule could damage us to the point that the LGBT community may cease seeing Center on Halsted as a safe place for the community to go in clients' most vulnerable times of need.

24. Center on Halsted's funding may also be affected. Center on Halsted receives various forms of pass-through federal funding from HHS, including Ryan White funding and funding from the National Institutes of Health and the Centers for Disease Control and Prevention. Center on Halsted also benefits from programs governed by the Centers for Medicare through Medicare reimbursements. If Center on Halsted chooses to best serve its communities and to follow its mission, federal dollars, which comprise about a tenth of the budget, may be cut if we are found to be out of compliance with the Denial-of-Care Rule. Center on Halsted, therefore, has a reasonable fear that it could be sanctioned and lose vital federal funding as a result of our

nondiscrimination policies. The loss of such funding would result in massive service reduction and gut long standing signature programs that are the cornerstones of our work.

25. The daily administration of Center on Halsted will also be affected. When it started to become clear at the beginning of the current administration that LGBT people would experience a shift toward less support, fear and apprehension-based tensions within the community rose, particularly regarding safety concerns. At Center on Halsted, active shooter trainings have become part of all of our staff training rotations as well as part of the onboarding process for all new staff and interns. Not only are LGBT staff feeling the threat that accompanies the loss of support, they are also now on heightened alert because active shooter training is a reminder that they could very well be in harm's way if a shooter targets Center on Halsted. This, coupled with the growing number of ways that the federal government is creating laws that harm the LGBT community and dismantling the protections we worked so hard for, is creating the need for increased staff-supervision time and strategy sessions to help everyone at Center on Halsted understand, cope with, and handle the negative effects of the Denial-of-Care Rule.

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

Dated: June 9, 2019

Respectfully submitted,

/s/ Modesto Valle
Modesto Valle

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF HECTOR VARGAS, EXECUTIVE DIRECTOR OF GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Hector Vargas, declare as follows:

1. American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, ("GLMA") is a 501(c)(3) non-profit organization based in Washington, D.C., and incorporated in California. GLMA's mission is to ensure health equity for lesbian, gay, bisexual, transgender, queer (LGBTQ) and all sexual- and gender- minority (SGM) individuals, and equality for LGBTQ/SGM health professionals in their work and learning environments. To achieve this mission, GLMA utilizes the scientific expertise of its diverse multidisciplinary membership to inform and drive advocacy, education, and research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 and its initial mission focused on responding with policy advocacy and public-health research to the growing medical crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health concerns and issues affecting LGBTQ people, including ensuring that sound science and research inform health policy and practices for the LGBTQ community.

2. GLMA represents the interests of tens of thousands of LGBTQ health professionals, as well as millions of LGBTQ patients and families. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students and other health professionals. GLMA's members reside and work across the United States and in several other countries. Their practices represent the major healthcare disciplines and a wide range of health specialties, including internal medicine, family practice, psychiatry, pediatrics, obstetrics/gynecology, emergency medicine, neurology and infectious diseases.

3. I am the Executive Director of GLMA: Health Professionals Advancing LGBTQ Equality. I received my Bachelor of Arts degree in political science and Spanish in 1989 and law

degree in 1993 from the University of Georgia. I served on the Health Disparities Subcommittee of the Advisory Committee to the Director of the US Centers for Disease Control and Prevention (CDC) and served for four years on President Obama's Advisory Commission on Asian Americans and Pacific Islanders. I have more than 20 years of LGBTQ and civil rights advocacy experience, including on staff with Lambda Legal, the National LGBTQ Task Force and the American Bar Association's Section of Civil Rights and Social Justice. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

4. The Denial-of-Care Rule fosters greater discrimination against LGBTQ patients, who already experience widespread discrimination in obtaining healthcare and suffer significant health disparities in comparison to the general population. Research documents the history of this discrimination and the negative health outcomes that result. The majority of LGBTQ patients and patients living with HIV report having experienced providers refusing to touch them or using excessive precautions, providers using harsh or abusive language, providers being physically rough or abusive, and/or providers shaming LGBTQ patients and blaming these patients for their health status. A large percentage of transgender patients report having negative experiences related to their gender identity when seeking medical care, including being exposed to verbal harassment or refusals of care.

5. LGBTQ patients face significant health disparities—higher risk factors for poor physical and mental health, higher rates of HIV, decreased access to appropriate health insurance, insufficient access to preventative medicine, and higher risk of poor treatment by healthcare providers. Denials of care by healthcare providers asserting religious objections have been detrimental to the health of LGBTQ patients. LGBTQ patients are vulnerable in other ways as well, including higher rates of poverty and limited access to LGBTQ-specific services, that present

significant logistical and economic challenges to obtaining adequate healthcare. These harms are exacerbated by the Denial-of-Care Rule. The Rule will result in greater discrimination against LGBTQ patients and result in increased denials of services based not only on the medical services that patients seek, but on the patients' LGBTQ identities.

6. Among GLMA's strategic commitments is its ongoing collaboration with professional accreditation bodies, such as The Joint Commission, on the development, implementation, and enforcement of sexual-orientation and gender-identity nondiscrimination policies as well as cultural-competency standards of care for treatment of LGBTQ patients. GLMA worked with the Joint Commission and continues to work with similar professional bodies and health professional associations on standards, guidelines, and policies that address LGBTQ health, protecting individual patient health and public health in general.

7. The Denial-of-Care Rule presents a direct conflict with nondiscrimination standards adopted by The Joint Commission and all major health professional associations, who have recognized the need to ensure LGBTQ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other healthcare settings. Many of these efforts were prompted at least in part by GLMA's efforts through the years. For example, GLMA representatives, in coordination with other LGBTQ health experts, participated in the development and implementation of the hospital-accreditation nondiscrimination standards and guidelines developed by The Joint Commission to protect and ensure quality care for LGBTQ patients.

8. Similarly, GLMA has worked with the American Medical Association, among other health professional associations, over the last 15 years to ensure AMA policies prevent discrimination against LGBTQ patients and recognize the specific health needs of the LGBTQ community. All the leading health professional associations—including the AMA, American Osteopathic Association, American Academy of PAs, American Nurses Association, American

Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that healthcare providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity. By allowing discrimination against patients on the grounds of moral and religious freedom, the proposed rule obviates the ethical and medical standards of care that healthcare professionals are charged to uphold.

9. In order for a healthcare organization to participate in and receive federal payment from Medicare or Medicaid programs, the organization must meet certain requirements, including a certification of compliance with health and safety requirements, which is achieved based on a survey conducted either by a state agency on behalf of the federal government or by a federally-recognized national accrediting organization. Accreditation surveys include standards that healthcare organizations not discriminate based on sex, sexual orientation, or gender identity in the provision of services and in employment. A healthcare organization that discriminates on these bases in the provision of patient care or in employment, or that otherwise deviates from medical, professional and ethical standards of care is vulnerable to loss of accreditation. The Denial-of-Care Rule conflicts with these requirements.

10. If not enjoined, the Denial-of-Care Rule will harm GLMA members, LGBTQ patients whose interests GLMA also represents, and the patients who GLMA members treat. The Denial-of-Care Rule creates a safe haven for discrimination and prevents GLMA from achieving its goals with professional accreditation bodies because the Rule intimidates such bodies from holding healthcare providers accountable for discrimination against LGBTQ people and denials of care when the discriminatory conduct is justified on the basis of religious or moral beliefs. The Denial-

of-Care Rule would prevent agencies, to the extent allowed by law, from recognizing the loss of accreditation of a healthcare organization due to a specified anti-LGBTQ belief. The Rule, in turn, invites such facilities to discriminate against LGBTQ employees and patients without concern about the impact such discrimination will have on the organization's ability to continue receiving federal funding. The Rule, therefore, frustrates GLMA's mission of achieving and enforcing accreditation standards relating to nondiscrimination on the basis of sex, sexual orientation, and gender identity, and cultural-competency standards of care for treatment of LGBTQ patients. GLMA even works with medical organizations, like the American Academy of Dermatology, to create nondiscrimination policies and ensure their members understand and adhere to such standards. The Denial-of-Care Rule turns on its head all of the work that GLMA has accomplished in this arena.

11. Some members of GLMA are employed by religiously-affiliated healthcare organizations (for example, hospitals, hospices, or ambulatory care centers) that receive federal funds. These healthcare providers also treat LGBTQ patients. The Denial-of-Care Rule encourages religiously-affiliated healthcare employers to discriminate against employees who are GLMA members for adhering to and enforcing their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically-necessary care that is in patients' best interests. The Rule impinges on and conflicts with GLMA members' ethical and medical standards of care that healthcare providers are charged to uphold and harms the patients that they serve.

12. The Denial-of-Care Rule invites harassment and discriminatory treatment of GLMA members in the workforce by fellow employees who claim a right to accommodation for discriminatory behavior justified by the Rule. GLMA members and their LGBTQ patients are stigmatized and demeaned by the message, communicated by the Denial-of-Care Rule, that their

government privileges beliefs that result in the disapproval and disparagement of LGBTQ people in the healthcare context.

13. As an organization of health professionals who serve and care for patients from the LGBTQ community, GLMA knows that discrimination against LGBTQ individuals in healthcare access and coverage remains a pervasive problem and that often this discrimination is based in religious objections. GLMA members have reported numerous instances of discrimination in care based on religious grounds. GLMA members shared with GLMA the ways religious objections are used to the detriment of the healthcare of LGBTQ patients, including members who have said:

a. "I see patients nearly every day who have been treated poorly by providers with moral and religious objection. Patients with HIV who have been told that they somehow deserved this for not adhering to God's law. Patients who are transgender who have been told that 'we don't treat your kind here'. The psychological and physical damage is pervasive."

b. "[Some providers in my clinic] do not wish to have contact with transgender patients, mumbling religious incompatibilities when asked why. These people have made our transgender patients feel very uncomfortable and unwelcome at times, making them potentially more hesitant to use the health services they may need."

c. "The impact on my patients who were directly denied care was both psychological and physical. With regard to their mental wellbeing they clearly felt marginalized and disrespected. With regard to their physical wellbeing, they experienced delay in care, and in some cases disruption of their routine medication dosing or diagnostic assessment."

14. Based on what patients have told GLMA members about their history and fear of discriminatory treatment, it is clear that the Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid such discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. As a result of the Denial-of-Care Rule, GLMA is required to divert its resources to educate and assist its members and the LGBTQ patients its members serve to defend against the harms that the Rule causes. GLMA's staff and resources already have been diverted from other program activities to engage in advocacy, policy analysis, and program-development to address the ill-effects of the Denial-of-Care Rule. GLMA has worked tirelessly to get medical and other health associations to express their disapproval of the Denial-of-Care Rule, which has diverted large amounts of resources away from other proactive projects and outreach efforts that are core to GLMA's mission. GLMA also spends resources answering GLMA members' inquiries about the Denial-of-Care Rule given the pervasive concern that the Denial-of-Care Rule contradicts medical ethical requirements and standards of care. GLMA must spend resources educating its members and the general healthcare community about GLMA's position on the Denial-of-Care Rule and its effects on healthcare practices and providers.

16. The Denial-of-Care Rule will also adversely impact GLMA and its members by necessitating the diversion and reallocation of resources to maintain its online list of LGBTQ-affirming healthcare providers. As a result of the Denial-of-Care Rule, GLMA and its members expect to see increases in the use of this online service and must consider whether to allocate additional staff time to support this increase in website traffic. Patients have expressed concern

about traveling outside of their home cities 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 healthcare services. GLMA will need to be a resource for these patients.

17. The Denial-of-Care Rule empowers and incites religious-based discrimination against GLMA members and will contribute to discriminatory and even hostile work environments for GLMA members, LGBTQ healthcare providers, and LGBTQ-affirming healthcare providers. GLMA members who insist on treating patients equally and in accordance with medical and ethical standards of care are likely to be required to shoulder extra burdens as fellow employees decline to provide certain care. GLMA members also are likely to encounter push-back, hostility, and even adverse employment actions from their employers or fellow employees for trying to enforce nondiscrimination policies and provide appropriate care to patients. Because the vast majority of GLMA members are LGBTQ themselves, seeing LGBTQ patients treated in a discriminatory way by their colleagues and supported by their employers will have a profound impact on the environment in which they work, GLMA members will also fear that the discrimination faced by LGBTQ patients because of the Denial-of-Care Rule will also impact their own employment and ability to feel safe as LGBTQ employees. GLMA, in turn, sees and will continue seeing an increase in healthcare providers seeking its assistance with addressing such discrimination. The increased demand for such services will drain GLMA's resources and hamper other work, especially since GLMA already has a very limited bandwidth for such services.

18. As a membership organization comprising over a thousand LGBTQ health professionals, GLMA's members receive various forms of federal funding directly and indirectly via federal programs, including Public Health Service Act funding. GLMA's members may, therefore, be subject to the restrictions of the Denial-of-Care Rule. Without such funding, certain GLMA members could not provide proper treatment to their patients or proceed with their medical

research programs. GLMA's members, therefore, have a reasonable fear that they could be sanctioned and lose federal funding for the work that they do as a result of nondiscrimination policies, ethical requirements, and standards of care that they enforce in their healthcare practices, which are vital to providing proper care to their patients.

I hereby declare, under penalties of perjury, that the facts stated in this declaration are personally known to me, and that they are true.

Dated: June 5, 2019

Respectfully submitted,

Hector Vargas

RICHARD B. KATSKEE*
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

GENEVIEVE SCOTT*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

JAMIE A. GLIKSBERG*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jgliksberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL, COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF LEE H. RUBIN PURSUANT TO LOCAL CIVIL RULE 5-1(i)(3)

I, Lee H. Rubin, submit this declaration pursuant to Civil Local Rule 5-1(i)(3) in support of Plaintiffs' Motion for Preliminary Injunction. I have personal knowledge of the facts stated below, and if called upon to testify, I could and would testify competently thereto.

1. I hereby attest that I have on file all holographic signatures corresponding to any signatures indicated by a conformed signature (/s/) within the Declarations submitted as attachments to Plaintiffs' e-filed Motion for Preliminary Injunction.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 11th day of June, 2019 at Palo Alto, California.

By: */s/ Lee H. Rubin*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

On June 11, 2019, Plaintiffs County of Santa Clara, Trust Women Seattle, Los Angeles LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Bradbury-Sullivan Center, Center On Halsted, Hartford Gyn Center, Mazzoni Center, Medical Students For Choice, AGLP: The Association of LGBTQ+ Psychiatrists, GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"), Colleen McNicholas, Robert Bolan, Ward Carpenter, Sarah Henn, and Randy Pumphrey (collectively, "Plaintiffs") filed a Motion for Nationwide Preliminary Injunction ("Motion") to enjoin Defendants from enforcing the Final Rule of the Department of Health and Human Services ("HHS") entitled Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. Pt. 88). A hearing on the motion was held on Wednesday, July 17, 2019 at 1:00 p.m.

The Court, having considered the Motion and the documents filed therewith, all of the papers on file in this action, and the evidence and arguments presented at the hearing, hereby

GRANTS Plaintiffs' Motion For Nationwide Preliminary Injunction.

IT IS HEREBY ORDERED that: Defendants HHS and Alex M. Azar II, in his official capacity as Secretary of HHS, and their officers, agents, servants, employees, and attorneys, and any other persons who are in active concert or participation with them, are enjoined from enforcing the HHS Final Rule entitled Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019).

IT IS SO ORDERED.

Date: _____

_____

HONORABLE NATHANAEL M. COUSINS
United States Magistrate Judge