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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C19-02405 WHA
No. C19-02769 WHA
No. C19-02916 WHA

DECLARATION OF DR. JEANNE HARRIS-CALDWELL IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Dr. Jeanne Harris-Caldwell, declare:

1. I am an executive board member for the Health Services Association, California Community Colleges (HSACCC) and the Dean of Wellness, Social Services, and Child Development at Saddleback College, as the Dean I oversees all operations of health services. Over the last 26 years I have held several progressive leadership and management roles in healthcare, and education in both California Community College, and private college systems.

2. Additionally, I have presented nationally on several occasions on health related topics and most recently for the American College Health Association. HSACCC is a membership organization of CCC healthcare professionals and community partners. HSACCC's mission is to support and foster student access to quality health service programs within the California Community Colleges.

3. The California Community Colleges (CCC) are the largest system of higher education in the nation, with 2.1 million students attending 115 colleges. With a wide range of educational offerings, the colleges provide workforce training, basic courses in English and math, certificate and degree programs and preparation for transfer to four-year institutions. CCCs offer training for students who are pursuing careers as registered nurses, paramedics, emergency medical technicians, phlebotomists, and other health care professionals. Saddleback College offers more than 300 certificate or degree programs from architecture to oceanography. The colleges play a critical rule in California's public education system and healthcare workforce training.

4. The CCCs are organized in 72 districts. Each district's Board of Trustees determines how to provide health services to students. A minority of districts outsource services to a third party; most districts run an on-campus health center. These health centers vary in size from a single practitioner to a team of dozens of medical professionals.

5. Currently, 90 community colleges have a health center. Health centers have the primary purpose of providing a scope of services to meet the student's physical, social, and mental health needs necessary to facilitate a successful completion of their academic goals and objectives. This is accomplished through provision of first aid, urgent care services, health

assessment and treatment, psychological counseling & crisis intervention, health education, and community partnerships.

6. Many of the 90 health centers across within the CCC system offer robust health centers which include medical doctors, registered nurses, nurse practitioners, physician assistants, clinical psychologists, clinical psychiatrists and mental health therapists. These services provide primary care for many of the 2.1 million students within the CCC system.

7. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

8. The Rule will impose an immediate cost on CCC health centers due to its notice, assurance and certification, recordkeeping, and reporting requirements.

9. The notification provision of the Rule will impose costs on CCC health centers. Although the Rule indicates that the notice provisions are now voluntary (unlike in the proposed rule), the Rule also states that adherence to the notice provisions will be taken into consideration when assessing whether an agency is in compliance. To provide notice, CCC health centers will need to: (1) post the notice in Appendix A (or similar text) at each CCC health center establishment where notices to the public and workforce are customarily posted, and thereafter continuously take steps to ensure that the notice is not altered, defaced, or covered by other materials, (2) include the notice on each of its websites, and (3) include the notice in its personnel manuals, applications, and benefits and training materials, as inclusion in these materials will be a factor in determining whether a CCC health center is in compliance. The estimated costs of compliance with these notification provisions is $1,350,000, due to the necessary changes to websites, physical postings, as well as costs associated with updates to training manuals, new employee documentation, internship materials, and updates to benefits handbooks.

10. The Rule also includes an assurance and certification requirement that should be included with all applications, reapplications, and amendments and modifications. The provision also places an obligation on CCC to take actions to come into compliance. Notably and under the compliance provision, if a sub-recipient (as defined by the Rule) is found in violation, CCC will

be subject to remedial action. This Rule thus places some oversight obligation on CCC which could cost CCC $7,200,000 annually for additional staff time (1 staff member for monitoring and compliance, web page maintenance, form revisions, etc. at 78,000 per year with benefits at 90 health care centers) necessary to engage in this sub-recipient monitoring component as some of the health centers are operated by local hospitals. Outsourcing of health centers through MOU is utilized within the CCC system in areas were resources are limited in order to provide access and care for all students within the CCC system.

11. The compliance provision also includes a recordkeeping and reporting requirement applicable to all recipients and sub-recipients which obligates CCC to include information concerning any compliance reviews or complaints to the Office of Civil Rights within the last three years as part of the application process. The costs of the record keeping and reporting requirements are reported in the above figures for compliance.

12. As with any compliance reporting, the HSACCC is additionally estimating another $ 135,000.00 annually for any periodic compliance reviews and/or investigations.

13. The Rule creates a broad exemption for medical professionals and personnel to opt out of healthcare services based on a moral or religious ground. Specifically, personnel may opt out of healthcare services involving abortion, sterilization, and euthanasia. Further, the rule appears to enable objections to providing a broad range of healthcare services, including certain vaccinations if there is an "aborted fetal tissue" connection (rubella, polio, Hepatitis A, chickenpox, small pox), contraception, gender transition/gender dysphoria (counseling, administering hormone prescriptions, etc.), tubal ligations, hysterectomies, and assisted suicide. There does not appear to be any exception provided for emergency situations under the Rule.

14. Many CCC health centers provide services such as immunization/vaccinations, HIV testing and counseling, contraception, STD/STI screening, gynecological services, and referrals for these and follow-up services where appropriate. The Rule appears to target many of these services for potential refusal which could hinder the provision of these services to students. The Rule could also hinder the provision of services to LGBTQ students, including counseling services that members of this community could seek out.

15. In addition, HSACCC is concerned that the rule will impact access or create barriers to care or services including contraception, including emergency contraception, medication abortion, family planning, etc.

16. Currently, if CCC health center staff refuse to provide a service due to a religious or moral objection, substitute staff is found to perform the objected-to service. But the Rule expands the scope of objections that can be made to include objections on the basis of "conscience, religious beliefs, or moral convictions" to not just services such as abortion, sterilization, and euthanasia, but also "other health services." The Rule will be unworkable if it permits a medical provider to refuse "other health services" without notifying a supervisor of the denial of service, or without providing notice or alternative options and/or referrals to patients. Additionally, it would be difficult if not impossible to find a substitute provider at a health center that employs only a single health professional.

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

Executed on 8-27-19 in Mission Viejo, California.

Dr. Jeanne Harris-Caldwell RN MSN CCRN
Executive Board Member
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
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Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF SARAH HENN, MD, MPH, CHIEF HEALTH OFFICER, WHITMAN-WALKER HEALTH, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Sarah Henn, declare:

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 submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

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.

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

Executed on September ___, 2019, in Washington, D.C.

Sarah Henn, MD, MPH

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
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No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF PAUL E. LORENZ, CHIEF EXECUTIVE OFFICER, SANTA CLARA VALLEY MEDICAL CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, PAUL E. LORENZ, 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 Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

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 County 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

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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 2019, Valley Medical Center received approximately $1.19 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 61% 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 2018-19, Valley Medical Center received approximately $45.4 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.

Executed on September 6, 2019 in San José, California.

PAUL E. LORENZ
Chief Executive Officer

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

SANTA CLARA VALLEY MEDICAL CENTER

Administrative Policies and Procedures Manual

VMC #301.45

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)

Medically Ineffective Interventions, Requests Concerning **VMC #301.45**

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.

Medically Ineffective Interventions, Requests Concerning **VMC #301.45**

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.

Attachment 1
VMC # 301.45

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.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF ALECIA MANLEY, INTERIM CHIEF OPERATING OFFICER OF THE MAZZONI CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

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 submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

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 LGTQ 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 of origin, 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, because those providers objected to them because of their LGBTQ identity. 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 numbers 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.

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

Executed on September 9, 2019, in Philadelphia, Pennsylvania.

Alecia Manley
Interim Chief Operating Officer

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G., IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Colleen P. McNicholas, D.O., M.S.C.I., F.A.C.O.G., declare:

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, Illinois, 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 am also the Chief Medical Officer of Planned Parenthood of the St. Louis Region and Southwest Missouri, and I am a former provider at Planned Parenthood in Columbia, Missouri and in Kansas City, Missouri.

2. Additionally, I formally held the positions of 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 helped develop 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 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-

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

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]

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

[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.").

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]

21. Lower-income women are already unable to access contraception at the same rate

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[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.*

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 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

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[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.*

[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).

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.

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

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[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).

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

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[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*

already must wait at least a week between attempting to make an appointment and actually receiving an 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 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,

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of Abortion Care in the United States (2018).

[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).

[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).

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 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

[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).

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 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

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[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).

[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).

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]

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,

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[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.*

[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).

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.

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]

45. Stigmatization and discrimination cause poor health outcomes. When a hospital's

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

[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).

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 and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on Sept 3 in St. Louis, Missouri.

COLLEEN P. MCNICHOLAS
Medical Director, Trust Women

EXHIBIT A

CURRICULUM VITAE
Colleen Patricia McNicholas, DO, MSCI, FACOG

Date: March 2019

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:

2019 -	Chief Medical Officer Planned Parenthood of the St. Louis Region and Southwest Missouri
2018- 2019	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- 2019	Director, Ryan Residency Training Program Department of Obstetrics and Gynecology Washington University School of Medicine
2016- 2019	Co-Director, Fellowship in Family Planning Department of Obstetrics and Gynecology Washington University School of Medicine
2016-2019	Obstetrics and Gynecology Performance Evaluation Committee Washington University/Barnes Jewish OB/GYN Residency
2016-2019	Washington University School of Medicine Institutional Review Board Member
2018-2019	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)

- 2012-2019: 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
  - 2019-curretn: Secretary/Treasurer

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.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF KEN MILLER, M.D., Ph.D., MEDICAL DIRECTOR OF COUNTY OF SANTA CLARA EMS AGENCY, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, KEN MILLER, M.D., Ph.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 Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

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-five 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.

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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 of America that the foregoing is true and correct.

Executed on Sept, 2019 in San José, California.

KEN MILLER, M.D., Ph.D.
Medical Director
County of Santa Clara EMS Agency

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO, Plaintiff, vs. ALEX M. AZAR II, et al., Defendants.	No. C 19-02405 WHA No. C 19-02769 WHA No. C 19-02916 WHA **DECLARATION OF BRANDON NUNES IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT** Date: October 30, 2019 Time: 8:00 AM courtroom: 12 Judge: Hon. William H. Alsup Action Filed: 5/2/2019
STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA, Plaintiff, vs. ALEX M. AZAR, et al., Defendants.	
COUNTY OF SANTA CLARA et al, Plaintiffs, vs. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	

I, Brandon Nunes, declare:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Chief Deputy Director of Operations for the California Department of Public Health (CDPH). CDPH has nearly 3,800 employees working in over 200 program areas to serve the people of California.

3. I was appointed Chief Deputy Director of Operations in May 2015. In this capacity, and as a member of the CDPH directorate, I have responsibility in overseeing and supporting our department's programs to ensure they have the resources they need to successfully implement their mission and the mission of CDPH.

4. Prior to my appointment as Chief Deputy Director of Operations, I worked for over 16 years at the California Department of Finance (DOF) in various roles. The first eight years of my time with DOF was spent in the Office of State Audits and Evaluations (OSAE). OSAE is responsible for all Executive Branch audit functions, including financial audits, performance audits, and compliance audits. During my time at OSAE, I led and supervised a number of audit teams responsible for evaluating and advising on the programmatic, administrative, and fiscal policies of a wide variety of state and local entities. The second half of my career with DOF was spent in the Health and Human Services Budget Unit. During this time, I was responsible for developing, overseeing, and defending the budgets of a number of departments under the California Health and Human Services Agency, including the Department of Public Health and the Department of Social Services.

5. CDPH works to optimize and protect the health and wellbeing of the people in California. Our fundamental responsibilities include infectious disease control and prevention, food safety, environmental health, laboratory services, patient safety, emergency preparedness, chronic disease prevention and health promotion, family health, health equity, and vital records and statistics. Our key activities include protecting people in California from the threat of preventable infectious diseases like Zika virus, HIV/AIDS, tuberculosis, and viral hepatitis, and

providing reliable and accurate public health laboratory services and information about health threats. CDPH also protects patient safety in hospitals and skilled nursing facilities, maintains birth and death certificates, and prepares for and responds to public health emergencies. CDPH works continuously to reduce health and mental health disparities affecting vulnerable and underserved communities to achieve health equity throughout California. Indeed, CDPH programs and services touch the lives of every Californian and visitor to the state 24 hours a day, seven days a week.

6. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

7. The Rule has already imposed costs on California. CDPH has spent more than 30 hours of program staff and attorney time reading and analyzing the Rule in order to determine its potential impacts on our programs, workforce, and partnerships with local health departments.

8. The Rule will impose immediate costs on CDPH. Although the final rule indicates that notice requirements are now voluntary, the Rule also states that adherence to the notice requirements will be taken into consideration when assessing whether an agency is in compliance. In accordance with section 88.5 of the Rule, CDPH will incur costs developing easy-to-understand, accessible materials for CDPH staff and others, including written policies and procedures, electronic notices, and updates to CDPH's internal and external websites. CDPH will also incur costs creating and operationalizing new training modules.

9. Currently, CDPH has nearly 670 contracts that involve federal funding. These contracts help fund public health efforts throughout the state. For fiscal year 2018-2019, CDPH's budget was approximately $3.2 billion, which included approximately $1.5 billion from the federal government.

10. The Rule jeopardizes all federal funds CDPH receives from the U.S. Department of Health and Human Services, including the Centers for Disease Control and Prevention, as well as from the U.S. Department of Education and the U.S. Department of Labor. Loss of this federal funding will have a devastating impact on California, the nation's most populous state, both by

impacting state public health programs and by having a cascading impact on local health departments dependent on federal funding that flows through the state. CDPH—and, in all likelihood, the local health departments—will be unable to absorb such a tremendous loss of funding without a reduction in staffing, programs, and services.

11. When developing its annual budgets, CDPH does so with the expectation that it will receive the federal funds to which it is entitled to under its existing agreements with the aforementioned federal agencies—these funds are now being placed at risk under the Rule. In California, state agencies begin development of their annual budgets in July of the preceding fiscal year.[1] Federal funding is a critical consideration in our budget deliberation process because these dollars make up nearly 50 percent of CDPH's budget. During the budget development period, both programmatic resource and personnel decisions are made with the expectation that the federal funds on which CDPH depends for critical operations will be available. As a result, CDPH forgoes requesting resources from other funding sources in anticipation of these federal funds being available. Once the state budget is enacted, CDPH has no mechanism available to it to receive budget authority to support its programs if federal funding is revoked. A sudden disruption in anticipated federal funds would create budgetary chaos for both state and local public health programs and undermine their ability to deliver vital public health programs and services.

12. Federal funding supports numerous programs within CDPH, including through dollars that support state operations or are passed through to local health departments. With regard to CDPH's 2019-2020 budget, enacted as part of the state budget, the Rule jeopardizes the following public health programs, and corresponding federal funding dollars (among others):

- Public Health Emergency Preparedness Program, which coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases and plans and supports surge capacity in the medical care and public health systems to meet needs during emergencies ($31.8 million for state operations and $59.1 million for local assistance in 2019-2020);

[1] The state's fiscal year begins on July 1 and ends on June 30 of the following year.

- Programs within the Center for Healthy Communities, which work to prevent and control chronic diseases, injuries, and violence, including reducing the prevalence of obesity, reducing and preventing tobacco use, promoting safe and healthy environments, and treating problem gambling ($24.3 million for state operations and $7.5 million for local assistance in 2019-2020);
- Infectious Diseases Program, which works to prevent and control infectious diseases such as: HIV/AIDS, viral hepatitis, influenza and other vaccine-preventable illnesses, sexually transmitted diseases, tuberculosis, emerging infections, and foodborne illnesses ($66.0 million for state operations and $215.6 million for local assistance in 2019-2020);
- Health Statistics and Informatics Program, which develops data systems and facilitates the collection, validation, analysis, and dissemination of health information ($913,000 for state operations in 2019-2020);
- Programs within the Center for Environmental Health, which work to protect and improve the health of all California residents by providing for the safety of food, drugs, and medical devices; conducting underage tobacco enforcement; conduct environmental management programs; and oversee the use of radiation through investigation, inspection, laboratory testing, and regulatory activities ($1.4 million for state operations in 2019-2020);
- Health Facilities Licensing Program, which regulates the quality of care in over 10,000 public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators; certifies nurse assistants, home health aides, and hemodialysis technicians; and oversees the prevention, surveillance, and reporting of healthcare-associated infections in California's general acute care hospitals ($99.3 million for state operations in 2019-2020); and
- Laboratory Field Services Program, which regulates quality standards in approximately 22,000 clinical laboratories, public health laboratories, blood banks, and tissue banks in California; and licenses approximately 60,000 scientific

classifications that include 30 different categories of laboratory personnel including laboratory scientists, phlebotomists, genetic scientists, clinical chemists, and public health microbiologists ($1.7 million for state operations in 2019-2020).

13. The Rule makes CDPH liable for the actions of third parties in a manner that is unprecedented in CDPH's experience and unworkable in practice. This is because the Rule dictates that if a sub-recipient violates the Rule, the sub-recipient's violation jeopardizes CDPH's funding as a recipient. Specifically, the Rule includes an assurance and certification requirement that should be included with all applications, reapplications, and amendments and modifications. The provision also places an obligation on CDPH to take actions to come into compliance. But if a sub-recipient (as defined by the Rule) is found in violation, CDPH will be subject to remedial action, including the loss of some or all of the federal funding described above.

14. By making CDPH responsible for the compliance of sub-recipients, the Rule appears to impose an oversight obligation that requires CDPH to expend funds for additional staff time to monitor the compliance of sub-recipients. Even if monitoring is not required under the Rule, the Rule is so broadly and vaguely written that it is nearly impossible to ascertain how CDPH should communicate with its sub-recipients, including through the re-drafting of its contracts, in order to obligate its sub-recipients to comply with the Rule in a manner that effectively protects CDPH's own federal funding.

15. Terminating CDPH's funding based on the conduct of third parties that CDPH neither controls nor operates would hobble the state's ability to protect the public health. For example, federal funding for CDPH and for all counties could be placed at risk based on the alleged violation of a single county, a separate legal entity from the state (Cal. Gov. Code § 23000, et seq.).

16. As one example, CDPH's Immunization Branch receives substantial annual funding and support under the federal Health and Human Services appropriation, totaling almost $581 million annually. Approximately $537 million supports routine childhood vaccines, $8.7 million covers routine vaccines for uninsured and underinsured adults, and $36.8 million provides financial assistance for state and local operations each year. Of this $36.8 million in operations

funding, close to half ($16 million) is provided to 61 local health departments throughout California. Under the Rule, even if CDPH contractually obligates all local health departments to comply with the Rule, and a single violation is committed without CDPH's knowledge, this violation would put CDPH's funding and pass-through funding at risk. And, as a result of the loss of federal funding, local health departments would struggle to provide immunizations against deadly diseases such as measles, polio, and tetanus.

17. As another example, CDPH's Sexually Transmitted Diseases (STD) Control Branch provides support, guidance, coordination and safety-net services to local STD control programs. CDPH receives $7.4 million in federal funding, including $1.4 million that is passed through to local STD control programs throughout California. Under the Rule, even if CDPH contractually obligates all local health departments to comply with the Rule, and a single violation is committed without CDPH's knowledge, this violation would put CDPH's funding at risk. STD rates are currently on the rise in California: In 2017 compared to 2016, the rate of chlamydia increased 9%, the rate of gonorrhea increased 16%, and the rate of early syphilis increased 21%. If CDPH lost federal funding due to one local health department's non-compliance with the Rule, many local health departments could struggle to continue their work preventing, diagnosing, and treating STDs.

18. In addition to the potential decimation of public health programs in the state due to the potential loss of federal funding, CDPH is also concerned that the Rule's position on vaccinations, and its potential to encourage doctors opposed to the state's efforts to ensure that all families follow the recommended childhood vaccination schedule, will adversely affect California's public health efforts to control the spread of preventable diseases such as measles.

19. As of August 29, 2019, 67 confirmed measles cases, including 38 outbreak-associated cases, have been reported in California. The outbreak of measles has an impact beyond state lines. The last large outbreak of measles in California was associated with Disneyland and occurred from December 2014 to April 2015, when at least 131 California residents were infected with measles, and also infected residents of six other states, Mexico, and Canada.

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

Executed on August 29, 2019, in Sacramento, California.

Brandon Nunes
Chief Deputy Director of Operations
California Department of Public Health

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

vs.

ALEX M. AZAR II, et al.,

Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

vs.

ALEX M. AZAR, et al.,

Defendants.

COUNTY OF SANTA CLARA, et al.

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF NELI N. PALMA IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, Neli N. Palma, declare:

1. I am a member of the California State Bar, admitted to practice before this Court, employed by the Office of the California Attorney General as a Deputy Attorney General, and counsel to Plaintiff State of California in this action. I have personal knowledge of the facts set forth herein, and if called upon as a witness, I could testify to them competently under oath.

2. Attached hereto as Exhibit A is a true and correct copy of the 2019-20 budget for the California Department of Education, available online via ebudget.ca.gov.

3. Attached hereto as Exhibit B is a true and correct copy of the letter from the U.S. Department of Health & Human Services (HHS) Office for Civil Rights deputy director to California, dated August 30, 2018, regarding a "notice of investigation" based upon the allegation that California "violated Federal law when the Department of Managed Health Care issued letters on August 22, 2014, to health insurance issuers in California directing them to amend their health plans to remove coverage exclusions and limitations regarding abortions."

4. On September 3, 2019, counsel for HHS confirmed that HHS did not consider its own August 30, 2018 letter issued to California regarding its investigation of the State part of the administrative record. Attached hereto as Exhibit C is a true and correct copy of this email exchange.

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

Executed on the 9th of September in Sacramento, California.

Neli N. Palma
Deputy Attorney General

EXHIBIT A

6100 Department of Education

California's public education system is administered at the state level by the Department of Education, under the direction of the State Board of Education and the Superintendent of Public Instruction, for the education of approximately 6.2 million students. Administrative branches of the Department include the Executive Branch; the Systems Support Branch; the Teaching and Learning Support Branch; the Performance, Planning, and Technology Branch; and the Legal and Audits Branch.

The primary duties of the Superintendent and the Department are to provide technical assistance to local school districts and to work with the educational community to improve academic performance. Major goals of the Department include: (a) holding local agencies accountable for student achievement in all programs and for all groups of students, (b) building local capacity to enable all students to achieve to state standards, (c) expanding and improving a system of recruiting, developing, and supporting teachers that instills excellence in every classroom, preschool through adult, (d) providing statewide leadership that promotes effective use of technology to improve teaching and learning, (e) increasing efficiency and effectiveness in the administration of K-12 education, including student record keeping and good financial management practices, (f) providing broader and more effective communication among the home, school, district, county, and state, (g) establishing and fostering systems of school, home, and community resources that provide the physical, emotional, and intellectual support to help students succeed, (h) advocating for additional resources and additional flexibility, (i) providing statewide leadership that promotes good business practices so that California schools can target their resources to serve students, and (j) improving the effectiveness and efficiency of the Department.

Because the Department of Education's programs drive a need for infrastructure investment, the Department has a capital outlay program to support this need. For the specifics on the Department's capital outlay program see "Infrastructure Overview."

3-YEAR EXPENDITURES AND POSITIONS

		Positions			Expenditures		
		2017-18	2018-19	2019-20	2017-18*	2018-19*	2019-20*
5200	Instruction	850.1	874.6	874.6	$68,649,092	$72,499,995	$75,319,342
5205	Instructional Support	690.1	662.6	680.1	1,058,713	1,073,161	1,118,293
5210	Special Programs	389.0	394.7	407.7	6,478,988	7,129,263	7,973,511
5220	State Board of Education	11.6	9.8	9.8	2,350	2,786	2,787
5240	State-Mandated Local Programs	-	-	-	1,399,573	841,972	243,222
9900100	Administration	275.8	275.5	275.5	30,879	55,757	55,687
9900200	Administration - Distributed	-	-	-	-30,879	-55,757	-55,687
9990	Unscheduled Items of Appropriation	-	-	-	340,718	7,700	4,000
TOTALS, POSITIONS AND EXPENDITURES (All Programs)		**2,216.6**	**2,217.2**	**2,247.7**	**$77,929,434**	**$81,554,877**	**$84,661,155**

FUNDING		2017-18*	2018-19*	2019-20*
0001	General Fund	$1,443,496	$1,838,355	$2,424,442
0001	General Fund, Proposition 98	46,750,576	48,151,958	49,144,872
0044	Motor Vehicle Account, State Transportation Fund	-	896	896
0140	California Environmental License Plate Fund	403	406	406
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	15,212	14,584	19,332
0342	State School Fund	21,584	21,219	21,219
0349	Educational Telecommunication Fund	-	716	607
0620	Child Care Facilities Revolving Fund	1,155	-	-
0687	Donated Food Revolving Fund	3,042	6,642	6,643
0814	California State Lottery Education Fund	1,382,361	1,305,351	1,304,257
0890	Federal Trust Fund	7,467,493	8,213,000	8,307,087
0903	State Penalty Fund	780	-	-
0942	Special Deposit Fund	1,686	2,222	2,222
0986	Local Property Tax Revenues	20,438,273	21,494,077	22,819,460
0995	Reimbursements	420,293	461,606	542,754
3085	Mental Health Services Fund	137	163	163
3170	Heritage Enrichment Resource Fund	2	40	40
3286	Safe Neighborhoods and Schools Fund	10,426	16,083	19,515
3309	Tobacco Prevention and Control Programs Account, California Healthcare,	14,660	-	-

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

FUNDING		2017-18*	2018-19*	2019-20*
	Research and Prevention Tobacco Tax Act of 2016 Fund			
3321	Department of Education Subaccount, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	24,347	44,026
6036	2002 State School Facilities Fund	1,512	-	-
6044	2004 State School Facilities Fund	460	2,636	-
6057	2006 State School Facilities Fund	34	464	3,100
6086	2016 State School Facilities Fund	-	112	114
8080	Clean Energy Job Creation Fund	-44,151	-	-
TOTALS, EXPENDITURES, ALL FUNDS		**$77,929,434**	**$81,554,877**	**$84,661,155**

LEGAL CITATIONS AND AUTHORITY

DEPARTMENT AUTHORITY

Education Code, Section 33300

PROGRAM AUTHORITY

California Education Code, and select federal laws including, but not limited to, Every Student Succeeds Act, Perkins V Act, Workforce Innovation and Opportunity Act, Individuals with Disabilities Education Act, Child Care and Development Fund and Healthy Hunger Free Kids Act.

MAJOR PROGRAM CHANGES

- An increase of $1.9 billion Proposition 98 General Fund for the Local Control Funding Formula to reflect a 3.26 percent cost-of-living adjustment.
- An increase of $645.3 million Proposition 98 General Fund for special education, which includes $152.6 million to increase base special education funding rates and $492.7 million for a special education early intervention preschool add-on grant for school districts serving children ages 3 to 5 years with exceptional needs.
- An increase of $295 million for Early Learning and Care quality programs, which includes $188 million non-Proposition 98 General Fund for infrastructure and workforce development programs, $102 million one-time federal funds for infrastructure, and $5 million non-Proposition 98 General Fund for a Master Plan to improve the state's early learning and care system.
- A shift of $309.3 million Proposition 98 General Fund for nonlocal educational agency part-day State Preschool to non-Proposition 98 General Fund.
- An increase of $157.5 million non-Proposition 98 General Fund to reflect increased CalWORKs child care cases.
- An increase of $50 million one-time non-Proposition 98 General Fund for an additional 3,086 General Child Care slots.
- An increase of $50 million Proposition 98 General Fund for rate increases for the After School Education and Safety Program.
- An increase of $37.1 million one-time non-Proposition 98 General Fund for the Educator Workforce Investment Grant Program to provide educator professional development.
- An increase of $36 million one-time Proposition 98 General Fund for the Classified School Employee Summer Assistance Program.
- An increase of $31.4 million non-Proposition 98 General Fund for an additional 10,000 nonlocal educational agency full-day State Preschool slots.
- An increase of $26.8 million Proposition 98 General Fund to reflect full-year costs of 2,959 full-day State Preschool slots implemented during the 2018-19 fiscal year.
- An increase of $21.3 million Proposition 98 General Fund for county offices of education to provide technical assistance to school districts.
- An increase of $13.8 million federal funds to establish the 21st Century California School Leadership Academy for

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

professional learning opportunities for school administrators and other school leaders.

- An increase of $10 million one-time non-Proposition 98 General Fund to develop and disseminate a child care provider database in support of collective bargaining efforts.
- An increase of $7.5 million one-time non-Proposition 98 General Fund for fiber broadband connectivity solutions at poorly connected K-12 schools to improve digital learning opportunities for students.
- An increase of $6.7 million one-time non-Proposition 98 General Fund for the California Subject Matter Projects.
- An increase of $3.6 million one-time Proposition 98 General Fund for Inglewood Unified School District and $514,000 one-time Proposition 98 General Fund for Oakland Unified School District for operational support.
- An increase of $1 million one-time non-Proposition 98 General Fund to establish a Computer Science Coordinator to provide statewide organization in implementing new computer science standards.

DETAILED BUDGET ADJUSTMENTS

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
Workload Budget Adjustments						
Workload Budget Change Proposals						
• Shift 2018-19 District LCFF Transition Funding to Base	$-	$-	-	$3,556,177	$-	-
• Special Education Early Intervention Preschool Grant	-	-	-	492,683	-	-
• Shift Part-Day State Preschool for Non-LEAs to non-Proposition 98 General Fund	-	-	-	309,283	-	-
• Early Learning and Care Infrastructure Grants	-	-	-	161,000	-	-
• Special Education Statewide Base Rate Adjustment	-	-	-	152,563	-	-
• Early Learning and Care Workforce Development Grants	-	-	-	129,000	-	-
• Add General Child Care Slots	-	-	-	50,000	-	-
• Increase ASES Program Funding	-	-	-	50,000	-	-
• Educator Workforce Investment Grant	-	-	-	37,100	-	-
• Add 10,000 Full-Day State Preschool Slots	-	-	-	31,400	-	-
• County Office of Education Adjustment for State System of Support Activities	12,350	-	-	21,341	-	-
• Child Care Rate Adjustment Factor	-	-	-	10,520	-	-
• Childcare Collective Bargaining	-	-	-	10,000	-	-
• K-12 High-Speed Network	-	-	-	8,500	-	-
• Broadband Infrastructure Grant Program	-	-	-	7,500	-	-
• Augment California Subject Matter Projects for K-12 Educators	-	-	-	6,700	-	-
• California School Information Services	-	-	-	6,508	-	-
• Special Olympics Northern and Southern	-	-	-	4,000	-	-
• One-Time Funding for Inglewood Unified School District	-	-	-	3,633	-	-
• Standardized Account Code Structure System Replacement Project	-	-	-	3,009	607	-
• Early Learning and Care Division Support	-	-	-	2,778	-	13.0
• Deferred Maintenance Allocation for State Special Schools	-	-	-	2,500	-	-
• Basic Aid Wildfire Property Tax Loss Backfill Appropriation	-	-	-	2,027	-	-
• SoCal ROC Transition Funding	-	-	-	2,000	-	-

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6100 Department of Education - Continued

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
• Child Development Center	-	-	-	1,500	-	-
• California Computer Science Coordinator	-	-	-	1,000	-	1.0
• Disaster Reimbursement Claims for School Meal Programs	-	-	-	727	-	-
• Reappropriate Funding for Ella T. v California Legal Costs	-537	-	-	537	-	-
• One-Time Funding for Oakland Unified School District	-	-	-	514	-	-
• Breakfast After the Bell Program	-	-	-	500	-	-
• San Diego Unified School District Homeless Youth Education	-	-	-	500	-	-
• Special Education Interagency Workgroup	-	-	-	500	-	-
• Instructional Quality Commission (IQC) Support	-	-	-	492	-	-
• Special Education Division Support	-	-	-	452	-	3.0
• Align K-12 Accountability Platforms	-	-	-	350	-	-
• Add the Cal Grant Reporting Mandate to the K-12 Mandate Block Grant	-	-	-	300	-	-
• Oversight of State Board of Education Authorized Charter Schools	-	-	-	284	-	2.0
• Career Technical Education Support	-	-	-	275	-	2.0
• Ongoing Development and Support of the California School Dashboard	-	-	-	271	-	2.0
• Align Funding for the California Collaborative for Educational Excellence to Estimated Costs	-	-	-	232	-	-
• Reappropriate Funding for Employment Lawsuit Legal Costs	-217	-	-	217	-	-
• Adjustment for Operations Costs Associated with the Dashboard and School Accountability Report Card	-	-	-	178	-	-
• Add Funding for the California Association of Student Councils	-	-	-	150	-	-
• Foster Youth Trauma Support Coordination (AB 2083)	-	-	-	142	-	1.0
• Emergency Average Daily Attendance Waiver Request Workload	-	-	-	105	-	1.0
• School Safety Plan Best Practices (AB 1747)	-	-	-	53	-	-
• Adjust State Assessments Funding to Offset Decrease in Federal Funds	-	-	-	29	-	-
• Add the Cal Grant Reporting Mandate to the Mandate Reimbursement Program	-	-	-	1	-	-
• Federal Student Support and Academic Enrichment Grant	-	-	-	-	143,389	-
• Federal CCDBG Carryover for AP Slots	-	-102,295	-	-	102,295	-
• One-Time Federal CCDF Adjustment	-	-	-	-	102,295	-
• Child Nutrition Program Federal Funds Adjustment	-	-	-	-	90,733	-
• CCDF Funding Adjustment	-	-	-	-	54,217	-
• Align Title I Federal Funds to Federal Grant Award	-	-	-	-	33,624	-
• Add One-Time CCDF Quality Carryover	-	-	-	-	17,983	-
• One-Time Federal Funds Carryover for the Migrant Education Program	-	-	-	-	17,000	-

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6100 Department of Education - Continued

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
• Adjust Federal Funds for the Vocational Education Program	-	-	-	-	16,893	-
• One-Time Federal Funds Carryover for the Immediate Aid to Restart School Operations Program	-	-	-	-	13,792	-
• 21st Century California School Leadership Academy	-	-	-	-	13,779	-
• Add 1,298 Alternative Payment Slots	-	-	-	-	12,842	-
• 21st Century Community Learning Federal Grant Adjustment	-	-	-	-	12,697	-
• One-Time CCDF Federal Funds Carryover	-	-	-	-	11,285	-
• Adjust Federal Individuals with Disabilities Education Act Funds	-	-	-	-	8,131	-
• Preschool Development Grant	-	-	-	-	6,600	-
• 21st Century Community Learning Carryover	-	-	-	-	5,000	-
• Adjust Federal Funds for the Migrant Education Program	-	-	-	-	4,278	-
• One-Time Funding for Special Education Dispute Resolution Costs	-	-	-	-	3,184	-
• One-Time Federal Funds Carryover for Migrant Education Program State Level Activities	-	-	-	-	3,000	-
• Early Head Start Grant Extension	-	-	-	-	2,958	-
• CCDF Quality Funding Adjustment	-	-	-	-	2,174	-
• One-Time Federal Funds for the Project School Emergency Response to Violence Program	-	-	-	-	2,000	-
• One-Time Federal Funds Carryover for Individuals with Disabilities Education Act	-	-	-	-	1,815	-
• Adjust Federal Funding for Project AWARE Grant Program	-	-	-	-	1,800	-
• Federal Funds to Support Equitable Services for Eligible Private Schools	-	-	-	-	1,610	-
• One-Time Federal Carryover Funds for Equitable Services for Eligible Private Schools	-	-	-	-	1,453	-
• One-Time Federal Funds Carryover for the Individuals with Disabilities Education Act Preschool Grant Program	-	-	-	-	1,316	-
• One-Time Federal Funds Carryover for the English Language Acquisition Program	-	-	-	-	1,000	-
• Adjust Federal Funds for the Individuals with Disabilities Education Act Preschool Grant Program	-	-	-	-	905	-
• Adjust Funding for State Special Schools Education Technology Voucher Program	-	-	-	-	798	-
• Adjust Federal Funds for Migrant Education Program State Level Activities	-	-	-	-	788	-
• Adjust Federal Funds for the McKinney-Vento Homeless Children Education Program	-	-	-	-	624	-
• Shift Federal Funds Carryover for Project Cal-STOP Grant Program	-	-1,000	-	-	540	-
• Adjust Federal Funds for the Rural and Low Income Schools Program	-	-	-	-	314	-

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6100 Department of Education - Continued

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
• Align Student Assessment Federal Funds to Estimated Costs	-	-	-	-	278	-
• Adjust Fees for Nonpublic Schools and Agencies (NPS/A) Certification Program	-	-	-	-	244	2.0
• Increase Reimbursements for the California High School Proficiency Examination	-	-	-	-	207	-
• One-Time Federal Funds Carryover for the State Improvement Grant Program	-	-	-	-	150	-
• Support for the 21st Century California School Leadership Academy	-	-	-	-	150	1.0
• Special Education: Reporting the Use of Seclusion and Restraints (AB 2657)	-	-	-	-	138	1.0
• One-Time Federal Funds Carryover for the McKinney-Vento Homeless Children Education Program	-	-	-	-	88	-
• Add One-Time Federal Funds Carryover for Assessments	-	-	-	-	76	-
• One-Time Federal Funds for the Newborn Hearing Screening Program	-	-	-	-	50	-
• Homeless Student Coordinators	-	-	-	-	30	1.5
• Adjust Federal Preschool Development Grant	-	10,620	-	-	-	-
• CalWORKs Stage 3 Adjustment	80,000	-	-	-	-	-
• Adjust Federal Funds for State Assessments	-	-	-	-	-29	-
• Shift Funding from Local Assistance to Support Homeless Student Coordinators	-	-	-	-	-30	-
• Adjust Federal Funds for the State Improvement Grant Program	-	-	-	-	-100	-
• Shift Federal Funds for Equitable Services for Eligible Private Schools to State Operations	-	-	-	-	-479	-
• Redirect Federal Individuals with Disabilities Education Act Preschool Grant Funding for State Operations	-	-	-	-	-594	-
• Adjust Federal Funds for the English Language Acquisition Program	-	-	-	-	-724	-
• Adjust Federal Funds for the Neglected and Delinquent Children Program	-	-	-	-	-742	-
• Adjust Federal Funds for the Supporting Effective Instruction Local Grants	-	-	-	-	-825	-
• Align Title IV Federal Funds to Federal Grant Award	-	-	-	-	-2,320	-
• Redirect Federal Individuals with Disabilities Education Act Funding for Special Education Dispute Resolution	-	-	-	-	-3,184	-
• Adjust Title IV Federal Funds to Reflect Shift to Title II State Level Activities	-	-	-	-	-5,735	-
• Title II Set Aside for 21st Century California School Leadership Academy	-	-	-	-	-6,542	-
• Reflect the Elimination of the Federal Advanced Placement Fee Reimbursement Program	-	-	-	-	-11,064	-
• Remove 2018-19 One-Time CCDF Quality Federal Funds Carryover	-	-	-	-	-17,162	-
• Align Student Assessment Funding to One-Time Federal Carryover	-	-	-	-76	-	-

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6100 Department of Education - Continued

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
• Shift K-12 High-Speed Network Operational Funding to E-rate Subsidies	-	-	-	-8,500	-	-
• Offset One-Time CCDF Federal Funds Carryover	-	-	-	-11,285	-	-
• Align Student Assessment Funding to Estimated Costs	-	-	-	-13,575	-	-
• Offset CCDF Funding Adjustment	-	-	-	-54,217	-	-
• Shift District LCFF Funding to One-time	-368,355	-	-	-98,454	-	-
• Offset the Early Learning and Care Infrastructure Grant with Federal CCDF	-	-	-	-102,295	-	-
• Remove Part-Day State Preschool for Non-LEAs from Proposition 98 General Fund	-	-	-	-309,283	-	-
• Shift District LCFF Transition Funding from 2018-19 Appropriation to Base	-	-	-	-3,556,177	-	-
Totals, Workload Budget Change Proposals	**$-276,759**	**$-92,675**	**-**	**$915,669**	**$645,600**	**30.5**
Other Workload Budget Adjustments						
• LCFF Growth Adjustment	-114,548	-	-	1,779,494	-	-
• Education Protection Account Revenue Adjustment	419,097	419,097	-	757,890	757,890	-
• CalWORKs Child Care Caseload Adjustments	-	-	-	157,533	-	-
• Special Education Program for Individuals with Exceptional Needs Cost-of-Living Adjustment	-	-	-	123,478	-	-
• 2018-19 LCFF Transition Funding Adjustment	113,267	-	-	102,844	-	-
• State Preschool Cost-of-Living Adjustment	-	-	-	38,603	-	-
• Child Care Programs Cost-of-Living Adjustments	-	-	-	36,350	-	-
• County Office of Education Minimum State Aid Adjustment	29,053	-	-	35,292	-	-
• District LCFF Minimum State Aid Adjustment	22,863	-	-	22,863	-	-
• Non-LCFF Apportionment Adjustment	2,359	-	-	17,652	-	-
• Mandate Block Grant Cost-of-Living Adjustment	-	-	-	7,668	-	-
• County Office of Education Protection Account Offset Adjustment	8,987	-	-	6,356	-	-
• Child Nutrition Program Cost-of-Living Adjustment	-	-	-	5,462	-	-
• Child Nutrition Program Growth Adjustment	-	-	-	3,311	-	-
• Early Education Program for Individuals with Exceptional Needs Cost-of-Living Adjustment	-	-	-	2,997	-	-
• Other Post-Employment Benefit Adjustments	1,120	958	-	1,120	958	-
• Foster Youth Program Cost-of-Living Adjustment	-	-	-	863	-	-
• Add Full Year Costs of Remaining 2,959 Full Day State Preschool Slots	-	-	-	703	-	-
• Adjust Target County Office of Education Additional Funding Amount	190	-	-	424	-	-
• Adults in Correctional Facilities Cost-of-Living Adjustment	-	-	-	415	-	-

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6100 Department of Education - Continued

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
• County Office of Education LCFF Growth Adjustment	-8,251	-	-	239	-	-
• American Indian Education Centers Cost-of-Living Adjustment	-	-	-	139	-	-
• American Indian Early Childhood Education Program Cost-of-Living Adjustment	-	-	-	19	-	-
• K-12 District Local Property Tax Revenue Offset Adjustment	-	241,803	-	-	1,496,205	-
• K-12 Lottery Adjustment	-	104,484	-	-	103,390	-
• Adult Use of Marijuana Act: Early Learning and Care Services	-	-	-	-	80,463	-
• Adjust Proposition 56 Tobacco Tax Initiative Funding (Local Assistance)	-	1,486	-	-	42,901	-
• County Office of Education Local Property Tax Revenue Offset Adjustment	-	-1,640	-	-	34,987	-
• Adjust School District Funding for Health and Physical Education Drug-Free Schools Program	-	-	-	-	4,036	-
• Adjust Federal Funds for the Adult Education Program	-	-	-	-	3,415	-
• Adjust County Office of Education Funding for Health and Physical Education Drug-Free Schools Program	-	-	-	-	1,257	-
• Adult Education Program Reimbursements	-	-	-	-	1,242	-
• Adjust Proposition 56 Tobacco Tax Initiative Funding (State Operations)	-	-	-	-	1,111	-
• Proposition 47 Truancy and Dropout Prevention Program Adjustment (Local Assistance)	-	-	-	-	920	-
• Proposition 47 Truancy and Dropout Prevention Program Adjustment (State Operations)	-	-	-	-	32	-
• Lottery Adjustment for State Special Schools	-	9	-	-	9	-
• Adjust Federal Funds for the 21st Century Community Learning Centers Program (SB 862)	-	3,347	-	-	-	-
• Adjust Federal Funds for the McKinney-Vento Homeless Children Education Program (SB 862)	-	1,124	-	-	-	-
• Adjust Federal Funds for the Neglected and Delinquent Children Program (SB 862)	-	139	-	-	-	-
• Adjust Federal Funds for the Rural and Low-Income Schools Program (SB 862)	-	335	-	-	-	-
• Adjust Federal Funds for Title I Program (SB 862)	-	41,722	-	-	-	-
• Section 6.10 Deferred Maintenance Project Funding	4,000	-	-	-	-	-
• State School Fund Adjustment	-	-	-	-	-	-
• Support for Homeless Youth Impacted by Wildfires	-	88	-	-	-	-
• Remove One-Time Federal Funds for Alternative Payment Slots	-	-	-	-	-204,590	-
• Education Protection Account Offset Adjustment	-	-419,097	-	-	-757,890	-
• ASES Local Assistance Workload Adjustment	-139	-	-	-140	-	-

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6100 Department of Education - Continued

	2018-19*			2019-20*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
• Early Education Program for Individuals with Exceptional Needs Growth Adjustment	-	-	-	-164	-	-
• Reflect Base Adjustments for Special Education Programs	-	-	-	-605	-	-
• Adjust Mandate Block Grant to Reflect Revised Average Daily Attendance	-	-	-	-1,057	-	-
• Special Education Program for Individuals with Exceptional Needs Growth Adjustment	-	-	-	-6,596	-	-
• Child Care Programs Growth Adjustment	-	-	-	-7,476	-	-
• State Preschool Growth Adjustment	-	-	-	-8,107	-	-
• County Office of Education Local Revenue Adjustment	1,640	-	-	-34,988	-	-
• Special Education Local Property Tax Revenue Offset Adjustment	-	35,069	-	-69,423	69,423	-
• District LCFF Education Protection Account Offset Adjustment	-423,938	-	-	-760,099	-	-
• District LCFF Property Tax Adjustment	-185,335	-	-	-1,395,875	-	-
• Salary Adjustments	3,667	3,083	-	3,667	3,083	-
• Benefit Adjustments	1,182	1,028	-	1,254	1,088	-
• Retirement Rate Adjustments	827	769	-	827	769	-
• Carryover/Reappropriation	-	1,798	-	-	-	-
• SWCAP	-	-	-	-	-1,788	-
• Lease Revenue Debt Service Adjustment	-8	-	-	-27	-	-
• Miscellaneous Baseline Adjustments	-	6,607	-	-8,508	1,994	-
Totals, Other Workload Budget Adjustments	**$-123,967**	**$442,209**	**-**	**$814,398**	**$1,640,905**	**-**
Totals, Workload Budget Adjustments	**$-400,726**	**$349,534**	**-**	**$1,730,067**	**$2,286,505**	**30.5**
Totals, Budget Adjustments	**$-400,726**	**$349,534**	**-**	**$1,730,067**	**$2,286,505**	**30.5**

PROGRAM DESCRIPTIONS

5200 - INSTRUCTION

This program provides direct educational services to children and adults in the state's public elementary and secondary school system. The following elements are included in this program:

School Apportionments:
Supplements local resources to fund general education programs.

Other Compensatory Programs:
Includes Migrant Education, California Indian Education Centers, Education for Homeless Children, and Federal Title I.

Adult Education Programs:
Provides citizenship training and education to improve literacy skills, employability, and parenting abilities to adults served by public high school and unified districts. Adult education programs also meet the special needs of the disabled, older persons, and non or limited-English speaking adults.

Special Education Programs for Exceptional Children:
Provides special education services. Under state law and the federal Individuals with Disabilities Education Act (20 USC 1400 et seq.), individuals with exceptional needs are entitled to a free, appropriate public education. Students requiring special education are served either by local educational agencies using state, federal, and local property tax funds or by the State Special Schools operated by the Department. The Special Schools (three centers for diagnostic services, two residential schools for the deaf and one residential school for the blind) provide highly specialized services including educational assessments and individual educational recommendations and a comprehensive residential and nonresidential educational program composed of academic, nonacademic and extracurricular activities.

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6100 Department of Education - Continued

Vocational Education:
Offers a sequence of courses that provide the academic knowledge and skills needed to prepare for further education and careers in current or emerging employment sectors. Programs include Partnership Academies, Agricultural Education, and Regional Occupational Centers and Programs, and the federal Career and Technical Education Program.

5205 - INSTRUCTIONAL SUPPORT

Instructional Support provides resources to complement the Instruction Program. The following elements are included in this program:

Curriculum Services:

Provides materials and resources for curriculum planning and development in language arts, mathematics, science, history-social science, foreign language, visual and performing arts, health, nutrition, safety, physical education, and environmental/energy education. Provides funding for the K-12 High Speed Network and Rural and Low Income Schools Grants.

"Now is the Time" Advancing Wellness and Resilience in Education:

Provides federal funding to develop a comprehensive, coordinated, and integrated partnership with multiple service systems to help address critical mental health needs of California's kindergarten through grade twelve students.

Administrative Services to Local Educational Agencies:

Provides leadership, guidance, and technical expertise to schools to manage and improve operations, more efficiently use scarce resources, and publish specified documents.

Supplementary Program Services:

Identifies, develops, and disseminates innovative and exemplary programs and practices to schools and aids in the development of alternative educational options. Examples include Foster Youth Services, Career Technical Education Incentive Programs, English Language Acquisition, and Specialized Secondary Programs.

Public Charter Schools:

Public charter schools are created or organized by a group of teachers, parents, community leaders or a community-based organization, and provide instruction in any combination of grades, kindergarten through grade twelve.

Assessments:

Includes the California Assessment of Student Performance and Progress Program, which provides funding to districts for assessments, the English Language Proficiency Assessments for California, and California High School Proficiency Exams.

5210 - SPECIAL PROGRAMS

Child Development:

Provides a full range of child care and development services, including part- and full-time child care and development and supportive services to children from low-income families and families with special needs. Several different programs exist to target resources to specific populations or to address specific needs. The California State Preschool Program provides a wide range of educational services in part-day settings for pre-kindergarten (three and four year old) children from low-income families and parent education for the parents of eligible children. The After School Education and Safety program provides students in grades K-9 with academic support, homework assistance, and enrichment programs, in a safe after-school environment. Child care services for families participating in the California Work Opportunity and Responsibility to Kids (CalWORKs) program help public assistance recipients achieve and maintain self-sufficiency. The Department administers child care for CalWORKs Stages 2 and 3.

Early Head Start-Child Care Partnership:

Provides federal funding for high quality infant and toddler child care to low income families enrolled in subsidized programs administered by county offices, family child care home education networks, center-based homes, and tribal governments receiving federal Child Care and Development funds in selected northern California counties.

Child Nutrition:

Assists participating public and private schools, county offices of education, public and private residential child care institutions, camps, family day care homes, and non-residential adult day care centers in serving nutritious meals by providing educational and technical assistance, and federal and state subsidies. Subsidies are received from the United States Department of Agriculture (USDA) to fund the National School Lunch Program (NSLP), School Breakfast Program, Special Milk Program, Child and Adult Care Food Program, Summer Food Service Program, After School Meals Supplements Program under the

6100 Department of Education - Continued

NSLP, and Seamless Summer Feeding Option, Fresh Fruits and Vegetable Program, and nutrition education and training. Subsidies also are provided by the state through the state-mandated Child Nutrition Programs and the School Breakfast and Summer Food Start-Up and Expansion Grants Program.

Food Distribution:

Makes USDA Foods available to certain California public, private, and nonprofit agencies. The Department is designated as the California state agency for USDA Foods surplus distribution.

5220 - STATE BOARD OF EDUCATION

The State Board of Education sets K-12 education policy in the areas of standards, instructional materials, assessment, and accountability.

5240 - STATE-MANDATED LOCAL PROGRAMS

This program provides funding, pursuant to Section 6 of Article XIIIB of the California Constitution, to reimburse local entities for costs they incur in complying with certain state-mandated education programs.

DETAILED EXPENDITURES BY PROGRAM

		2017-18*	2018-19*	2019-20*
	PROGRAM REQUIREMENTS			
5200	**INSTRUCTION**			
	State Operations:			
0001	General Fund	$108,905	$117,720	$116,251
0814	California State Lottery Education Fund	54	171	171
0942	Special Deposit Fund	711	1,078	1,078
0995	Reimbursements	12,743	12,403	10,506
	Totals, State Operations	**$122,413**	**$131,372**	**$128,006**
	Local Assistance:			
0001	General Fund	$42,867,203	$45,222,953	$46,869,122
0342	State School Fund	21,584	21,219	21,219
0814	California State Lottery Education Fund	1,382,307	1,305,180	1,304,086
0890	Federal Trust Fund	3,417,799	3,890,942	3,741,955
0986	Local Property Tax Revenues	20,438,273	21,494,077	22,819,460
0995	Reimbursements	399,513	434,252	435,494
	Totals, Local Assistance	**$68,526,679**	**$72,368,623**	**$75,191,336**
	PROGRAM REQUIREMENTS			
5205	**INSTRUCTIONAL SUPPORT**			
	State Operations:			
0001	General Fund	$44,860	$50,454	$95,715
0044	Motor Vehicle Account, State Transportation Fund	-	896	896
0140	California Environmental License Plate Fund	43	46	46
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	907	1,077	1,078
0890	Federal Trust Fund	106,486	115,042	117,655
0903	State Penalty Fund	780	-	-
0942	Special Deposit Fund	975	1,144	1,144
0995	Reimbursements	6,663	10,148	10,690
3170	Heritage Enrichment Resource Fund	2	40	40
3286	Safe Neighborhoods and Schools Fund	416	820	976
3309	Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	76	-	-
3321	Department of Education Subaccount, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	1,125	1,125

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6100 Department of Education - Continued

		2017-18*	2018-19*	2019-20*
6036	2002 State School Facilities Fund	1,512	-	-
6044	2004 State School Facilities Fund	460	2,636	-
6057	2006 State School Facilities Fund	34	464	3,100
6086	2016 State School Facilities Fund	-	112	114
	Totals, State Operations	**$163,214**	**$184,004**	**$232,579**
	Local Assistance:			
0001	General Fund	$433,898	$356,565	$348,265
0140	California Environmental License Plate Fund	360	360	360
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	14,305	13,507	18,254
0349	Educational Telecommunication Fund	-	716	607
0890	Federal Trust Fund	421,082	477,592	454,856
0995	Reimbursements	1,260	1,932	1,932
3286	Safe Neighborhoods and Schools Fund	10,010	15,263	18,539
3309	Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	14,584	-	-
3321	Department of Education Subaccount, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	23,222	42,901
	Totals, Local Assistance	**$895,499**	**$889,157**	**$885,714**
	PROGRAM REQUIREMENTS			
5210	**SPECIAL PROGRAMS**			
	State Operations:			
0001	General Fund	$8,096	$8,249	$11,015
0687	Donated Food Revolving Fund	3,042	6,642	6,643
0890	Federal Trust Fund	60,206	76,178	63,630
0995	Reimbursements	114	2,815	3,613
3085	Mental Health Services Fund	137	163	163
	Totals, State Operations	**$71,595**	**$94,047**	**$85,064**
	Local Assistance:			
0001	General Fund	$2,944,318	$3,381,970	$3,878,993
0620	Child Care Facilities Revolving Fund	1,155	-	-
0890	Federal Trust Fund	3,461,920	3,653,246	3,928,991
0995	Reimbursements	-	-	80,463
	Totals, Local Assistance	**$6,407,393**	**$7,035,216**	**$7,888,447**
	PROGRAM REQUIREMENTS			
5220	**STATE BOARD OF EDUCATION**			
	State Operations:			
0001	General Fund	$2,350	$2,730	$2,731
0995	Reimbursements	-	56	56
	Totals, State Operations	**$2,350**	**$2,786**	**$2,787**
	PROGRAM REQUIREMENTS			
5240	**STATE-MANDATED LOCAL PROGRAMS**			
	Local Assistance:			
0001	General Fund	$1,399,573	$841,972	$243,222
	Totals, Local Assistance	**$1,399,573**	**$841,972**	**$243,222**
	PROGRAM REQUIREMENTS			
9990	**UNSCHEDULED ITEMS OF APPROPRIATION**			
	Local Assistance:			
0001	General Fund	$384,869	$7,700	$4,000
8080	Clean Energy Job Creation Fund	-44,151	-	-

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6100 Department of Education - Continued

		2017-18*	2018-19*	2019-20*
	Totals, Local Assistance	**$340,718**	**$7,700**	**$4,000**
	SUBPROGRAM REQUIREMENTS			
9900100	**Administration**			
	State Operations:			
0001	General Fund	$30,879	$55,757	$55,687
	Totals, State Operations	**$30,879**	**$55,757**	**$55,687**
	SUBPROGRAM REQUIREMENTS			
9900200	**Administration - Distributed**			
	State Operations:			
0001	General Fund	-$30,879	-$55,757	-$55,687
	Totals, State Operations	**-$30,879**	**-$55,757**	**-$55,687**
	TOTALS, EXPENDITURES			
	State Operations	359,572	412,209	448,436
	Local Assistance	77,569,862	81,142,668	84,212,719
	Totals, Expenditures	**$77,929,434**	**$81,554,877**	**$84,661,155**

EXPENDITURES BY CATEGORY

1 State Operations	Positions			Expenditures		
	2017-18	2018-19	2019-20	2017-18*	2018-19*	2019-20*
PERSONAL SERVICES						
Baseline Positions	2,217.2	2,217.2	2,217.2	$157,164	$165,701	$164,314
Other Adjustments	-0.6	-	30.5	4,865	6,750	9,810
Net Totals, Salaries and Wages	**2,216.6**	**2,217.2**	**2,247.7**	**$162,029**	**$172,451**	**$174,124**
Staff Benefits	-	-	-	82,066	96,613	97,863
Totals, Personal Services	**2,216.6**	**2,217.2**	**2,247.7**	**$244,095**	**$269,064**	**$271,987**
OPERATING EXPENSES AND EQUIPMENT				$58,978	$110,432	$117,775
SPECIAL ITEMS OF EXPENSES				56,499	32,713	58,674
TOTALS, POSITIONS AND EXPENDITURES, ALL FUNDS (State Operations)				**$359,572**	**$412,209**	**$448,436**

2 Local Assistance	Expenditures		
	2017-18*	2018-19*	2019-20*
Grants and Subventions - Governmental	77,569,862	81,142,668	84,212,719
TOTALS, EXPENDITURES, ALL FUNDS (Local Assistance)	**$77,569,862**	**$81,142,668**	**$84,212,719**

DETAIL OF APPROPRIATIONS AND ADJUSTMENTS

1 STATE OPERATIONS	2017-18*	2018-19*	2019-20*
0001 General Fund, Proposition 98			
APPROPRIATIONS			
006 Budget Act appropriation (State Special Schools)	$57,410	$57,906	$60,611
Allocation for Employee Compensation	-	1,430	-
Allocation for Other Post-Employment Benefits	-	445	-
Allocation for Staff Benefits	-	465	-
Section 3.60 Pension Contribution Adjustment	-	330	-
Totals Available	**$57,410**	**$60,576**	**$60,611**
TOTALS, EXPENDITURES	**$57,410**	**$60,576**	**$60,611**

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6100 Department of Education - Continued

1 STATE OPERATIONS	2017-18*	2018-19*	2019-20*
0001 General Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Department State Operations)	$49,063	$49,125	$54,940
Allocation for Employee Compensation	-	1,184	-
Allocation for Other Post-Employment Benefits	-	354	-
Allocation for Staff Benefits	-	371	-
Reappropriate Funding for Ella T. v California Legal Costs	-	-537	-
Section 3.60 Pension Contribution Adjustment	-	245	-
002 Budget Act appropriation (State Special Schools Lease Revenue Debt Service)	12,105	11,604	11,577
Lease Revenue Debt Service Adjustment	-	-3	-
Lease Revenue Debt Service CY Adjustment	-	-5	-
003 Budget Act appropriation (Standardized Account Code Structure)	1,073	1,293	1,351
Allocation for Employee Compensation	-	30	-
Allocation for Other Post-Employment Benefits	-	10	-
Allocation for Staff Benefits	-	11	-
Section 3.60 Pension Contribution Adjustment	-	7	-
004 Budget Act appropriation	-	938	492
005 Budget Act appropriation (State Special Schools)	39,578	39,878	44,063
Allocation for Employee Compensation	-	889	-
Allocation for Other Post-Employment Benefits	-	274	-
Allocation for Staff Benefits	-	293	-
Section 3.60 Pension Contribution Adjustment	-	214	-
Section 6.10 Deferred Maintenance Project Funding	-	4,000	-
009 Budget Act appropriation (State Board of Education)	2,350	2,625	2,731
Allocation for Employee Compensation	-	61	-
Allocation for Other Post-Employment Benefits	-	14	-
Allocation for Staff Benefits	-	16	-
Section 3.60 Pension Contribution Adjustment	-	14	-
Chapter 32, Statutes of 2018 (Special Olympics)	-	2,000	-
Pending Legislation (California Computer Science Coordinator)	-	-	1,000
Pending Legislation (Educator Workforce Investment Grant)	-	-	37,100
Pending Legislation (Broadband Infrastructure Grant Program)	-	-	7,500
Education Code sections 8483.5 and 8483.51 (After School Education and Safety Program)	2,820	3,453	3,593
Allocation for Employee Compensation	-	73	-
Allocation for Other Post-Employment Benefits	-	23	-
Allocation for Staff Benefits	-	26	-
Section 3.60 Pension Contribution Adjustment	-	17	-
Prior Year Balances Available:			
Item 6100-001-0001, Budget Act of 2015 as reappropriated by Item 6100-491, Budget Act of 2016, 2018 and 2019	-	297	-
Item 6100-001-0001, Budget Act of 2018 (Department State Operations) as reappropriated by Item 6100-491, Budget Act of 2019	-	-	537
Item 6100-001-0001, Budget act of 2015 as reappropriated by Item 6100-491, Budget Act of 2016, 2018 and 2019	-	-	217
Item 6100-005-0001, Budget Act of 2016	-188	-	-
Totals Available	**$106,801**	**$118,794**	**$165,101**
Balance available in subsequent years	-	-217	-
TOTALS, EXPENDITURES	**$106,801**	**$118,577**	**$165,101**
0044 Motor Vehicle Account, State Transportation Fund			
APPROPRIATIONS			
001 Budget Act appropriation	-	$896	$896
TOTALS, EXPENDITURES	**-**	**$896**	**$896**

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6100 Department of Education - Continued

1 STATE OPERATIONS	2017-18*	2018-19*	2019-20*
0140 California Environmental License Plate Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$43	$45	$46
Allocation for Employee Compensation	-	1	-
Totals Available	**$43**	**$46**	**$46**
TOTALS, EXPENDITURES	**$43**	**$46**	**$46**
0231 Health Education Account, Cigarette and Tobacco Products Surtax Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Drug Free Schools)	$907	$1,037	$1,078
Allocation for Employee Compensation	-	22	-
Allocation for Other Post-Employment Benefits	-	7	-
Allocation for Staff Benefits	-	6	-
Section 3.60 Pension Contribution Adjustment	-	5	-
Totals Available	**$907**	**$1,077**	**$1,078**
TOTALS, EXPENDITURES	**$907**	**$1,077**	**$1,078**
0687 Donated Food Revolving Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Donated Food Revolving Fund)	$3,042	$6,591	$6,643
Allocation for Employee Compensation	-	27	-
Allocation for Other Post-Employment Benefits	-	8	-
Allocation for Staff Benefits	-	10	-
Section 3.60 Pension Contribution Adjustment	-	6	-
Totals Available	**$3,042**	**$6,642**	**$6,643**
TOTALS, EXPENDITURES	**$3,042**	**$6,642**	**$6,643**
0814 California State Lottery Education Fund			
APPROPRIATIONS			
Government Code section 8880.5 (State Special Schools)	$54	$162	$171
Lottery Adjustment for State Special Schools	-	9	-
TOTALS, EXPENDITURES	**$54**	**$171**	**$171**
0890 Federal Trust Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Department State Operations)	-	$175,118	$181,285
001 Budget Act appropriation (Department State Operations) as amended by Chapter 181, Statutes of 2017	166,692	-	-
Adjust Federal Preschool Development Grant	-	10,620	-
Allocation for Employee Compensation	-	2,910	-
Allocation for Other Post-Employment Benefits	-	908	-
Allocation for Staff Benefits	-	974	-
Section 3.60 Pension Contribution Adjustment	-	690	-
Totals Available	**$166,692**	**$191,220**	**$181,285**
TOTALS, EXPENDITURES	**$166,692**	**$191,220**	**$181,285**
0903 State Penalty Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$780	-	-
Totals Available	**$780**	**-**	**-**
TOTALS, EXPENDITURES	**$780**	**-**	**-**
0942 Special Deposit Fund			
APPROPRIATIONS			
Government Code section 16370 (California Career Resource Network)	$2	$19	$19
Government Code section 16370 (Endowment Fund)	-	224	224
Government Code section 16370 (Miscellaneous Education Donations and Registration)	973	901	901

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6100 Department of Education - Continued

1 STATE OPERATIONS	2017-18*	2018-19*	2019-20*
Government Code section 16370 (General Education Diplomas)	711	1,038	1,067
Allocation for Employee Compensation	-	15	-
Allocation for Other Post-Employment Benefits	-	5	-
Allocation for Staff Benefits	-	5	-
Section 3.60 Pension Contribution Adjustment	-	4	-
Education Code section 1330 (UI Administration)	-	11	11
TOTALS, EXPENDITURES	**$1,686**	**$2,222**	**$2,222**
0995 Reimbursements			
APPROPRIATIONS			
Reimbursements	$19,520	$25,422	$24,865
TOTALS, EXPENDITURES	**$19,520**	**$25,422**	**$24,865**
3085 Mental Health Services Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$137	$156	$163
Allocation for Employee Compensation	-	4	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	1	-
Section 3.60 Pension Contribution Adjustment	-	1	-
Totals Available	**$137**	**$163**	**$163**
TOTALS, EXPENDITURES	**$137**	**$163**	**$163**
3170 Heritage Enrichment Resource Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$2	$40	$40
Totals Available	**$2**	**$40**	**$40**
TOTALS, EXPENDITURES	**$2**	**$40**	**$40**
3286 Safe Neighborhoods and Schools Fund			
APPROPRIATIONS			
Government Code section 7599.2(b)	$416	$803	$976
Allocation for Employee Compensation	-	9	-
Allocation for Other Post-Employment Benefits	-	2	-
Allocation for Staff Benefits	-	4	-
Section 3.60 Pension Contribution Adjustment	-	2	-
Totals Available	**$416**	**$820**	**$976**
TOTALS, EXPENDITURES	**$416**	**$820**	**$976**
3309 Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$76	-	-
Totals Available	**$76**	**-**	**-**
TOTALS, EXPENDITURES	**$76**	**-**	**-**
3321 Department of Education Subaccount, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund			
APPROPRIATIONS			
Revenue and Taxation Code section 30130.57(b)(1) and (f)	-	$1,111	$1,125
Allocation for Employee Compensation	-	9	-
Allocation for Other Post-Employment Benefits	-	2	-
Allocation for Staff Benefits	-	1	-
Section 3.60 Pension Contribution Adjustment	-	2	-
TOTALS, EXPENDITURES	**-**	**$1,125**	**$1,125**
6036 2002 State School Facilities Fund			
APPROPRIATIONS			

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6100 Department of Education - Continued

1 STATE OPERATIONS	2017-18*	2018-19*	2019-20*
001 Budget Act appropriation	$1,512	-	-
Totals Available	**$1,512**	**-**	**-**
TOTALS, EXPENDITURES	**$1,512**	**-**	**-**
6044 2004 State School Facilities Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$460	$2,636	-
Totals Available	**$460**	**$2,636**	**-**
TOTALS, EXPENDITURES	**$460**	**$2,636**	**-**
6057 2006 State School Facilities Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$34	$464	$3,100
Totals Available	**$34**	**$464**	**$3,100**
TOTALS, EXPENDITURES	**$34**	**$464**	**$3,100**
6086 2016 State School Facilities Fund			
APPROPRIATIONS			
001 Budget Act appropriation	-	-	$114
Allocation for Employee Compensation	-	62	-
Allocation for Other Post-Employment Benefits	-	18	-
Allocation for Staff Benefits	-	18	-
Section 3.60 Pension Contribution Adjustment	-	14	-
TOTALS, EXPENDITURES	**-**	**$112**	**$114**
Total Expenditures, All Funds, (State Operations)	**$359,572**	**$412,209**	**$448,436**

2 LOCAL ASSISTANCE	2017-18*	2018-19*	2019-20*
0001 General Fund, Proposition 98			
APPROPRIATIONS			
106 Budget Act appropriation	-	$11,534	$11,766
107 Budget Act appropriation (County Offices of Education Fiscal Oversight)	5,299	6,271	6,271
113 Budget Act appropriation (Student Assessment Program)	-	128,517	116,043
113 Budget Act appropriation (Student Assessment Program) as amended by Chapter 181, Statutes of 2017	108,416	-	-
119 Budget Act appropriation (Foster Youth Programs)	25,775	26,474	27,337
122 Budget Act appropriation (Specialized Secondary Program Grants)	4,892	4,892	4,892
140 Budget Act appropriation	-	-	6,508
149 Budget Act appropriation (Proposition 98 - After School Education and Safety Program Supplement)	-	50,000	100,000
149 Budget Act appropriation (Proposition 98 - After School Education and Safety Program Supplement) as amended by Chapter 181, Statutes of 2017	50,000	-	-
150 Budget Act appropriation (American Indian Early Childhood Education Program)	559	574	593
151 Budget Act appropriation (American Indian Education Centers)	4,142	4,254	4,393
158 Budget Act appropriation (Adults in Correctional Facilities)	15,096	15,331	15,746
161 Budget Act appropriation (Special Education)	3,124,258	3,299,416	3,994,349
166 Budget Act appropriation (Partnership Academies)	21,428	21,428	21,428
167 Budget Act appropriation (Agricultural Vocational Education)	4,134	4,134	4,134
168 Budget Act appropriation (Proposition 98) Career Technical Education Incentive Grant	-	150,000	150,000
170 Budget Act appropriation (Proposition 98 - Career Technical Education Initiative Program)	15,324	15,360	15,360
172 Budget Act appropriation (College and Career Planning Website and Online Educational Resources)	5,500	6,500	6,500
196 Budget Act appropriation (State Preschool)	-	1,215,467	963,466
196 Budget Act appropriation (State Preschool) as amended by Chapter 249, Statutes of 2017	1,010,166	-	-

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6100 Department of Education - Continued

2 LOCAL ASSISTANCE	2017-18*	2018-19*	2019-20*
201 Budget Act appropriation (Child Nutrition Start-up Grants)	1,017	1,017	1,017
203 Budget Act appropriation (Child Nutrition)	162,502	164,228	173,001
209 Budget Act appropriation (Teacher Dismissal Apportionments)	40	100	100
295 Budget Act appropriation (State Mandates Reimbursements)	49	48	49
296 Budget Act appropriation (State Mandates Block Grant)	228,187	236,262	243,173
Education Code sections 42238.02 and 42238.03 (School District Apportionments)	30,669,243	31,079,421	34,152,947
2018-19 LCFF Transition Funding Adjustment	-	113,267	-
District LCFF Education Protection Account Offset Adjustment	-	-423,938	-
District LCFF Minimum State Aid Adjustment	-	22,863	-
District LCFF Property Tax Adjustment	-	-185,335	-
LCFF Growth Adjustment	-	-114,548	-
Non-LCFF Apportionment Adjustment	-	2,359	-
Shift District LCFF Funding to One-time	-	-368,355	-
Chapter 32, Statutes of 2018 (State System of Support Regional Lead)	-	4,000	-
Education Code sections 2574 and 2575 (County Office of Education Apportionments)	440,175	441,938	470,602
Adjust Target County Office of Education Additional Funding Amount	-	190	-
County Office of Education Adjustment for State System of Support Activities	-	12,350	-
County Office of Education LCFF Growth Adjustment	-	-8,251	-
County Office of Education Local Revenue Adjustment	-	1,640	-
County Office of Education Minimum State Aid Adjustment	-	29,053	-
County Office of Education Protection Account Offset Adjustment	-	8,987	-
Pending Legislation (Standardized Account Code Structure System Replacement Project)	-	-	3,009
Article XIII, Section 36 of the California Constitution (Proposition 30) (transfer to Education Protection Account)	6,809,114	7,278,288	8,036,178
Education Protection Account Revenue Adjustment	-	419,097	-
Chapter 32, Statutes of 2018 (San Francisco USD Facility Improvements)	-	6,000	-
One-Time Funds for San Francisco Unified School District	-	4,000	-
Shift One-Time Funds for San Francisco Unified School District and Sweetwater Union High School District	-	-6,000	-
Chapter 15, Statutes of 2017 (Proposition 98–Equity Performance and Improvement Team)	2,500	-	-
One-Time Funds for Sweetwater Union High School District	-	2,000	-
Chapter 15, Statutes of 2017 (Proposition 98–California-Grown Fresh School Meals Grant Program)	1,500	-	-
Chapter 15, Statutes of 2017 (Bilingual Teacher Professional Development Program)	5,000	-	-
Chapter 32, Statutes of 2018 (Suicide Prevention Training)	-	1,700	-
Education Code section 41329.57(a)(1) (Oakland Unified School District)	1,781	1,707	1,705
Education Code section 41329.57(a)(1) (Vallejo City Unified School District)	513	492	491
Education Code section 41329.575 (South Monterey County Joint Union High School District)	301	265	268
Public Resources Code section 26233 (Transfer to Clean Energy Job Creation Fund)	376,200	-	-
Chapter 32, Statutes of 2018 (Classified School Employees Professional Development Block Grant)	50,000	-	-
Chapter 32, Statutes of 2018 (Lowest Performing Student Block Grant)	300,000	-	-
Chapter 32, Statutes of 2018 (Inclusive Early Education Expansion Program)	167,242	-	-
Education Code sections 8483.5 and 8483.51 (After School Education and Safety Program)	544,193	546,547	546,407
ASES Local Assistance Workload Adjustment	-	-139	-
Chapter 15, Statutes of 2017 (LCAP E-template and Dashboard)	400	-	-
Pending Legislation (LCAP E-template, Dashboard, and SARC)	-	-	528
Chapter 15, Statutes of 2017 (SoCal ROC Transition Funding)	4,000	-	-
Chapter 15, Statutes of 2017 (District LCFF Transition Funding)	1,362,383	-	-

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6100 Department of Education - Continued

2 LOCAL ASSISTANCE	2017-18*	2018-19*	2019-20*
Chapter 32, Statutes of 2018 (District LCFF Transition Funding)	-	3,556,177	-
Chapter 15, Statutes of 2017 (Discretionary Grants - Mandate Funding)	876,581	-	-
Chapter 32, Statutes of 2018 (Discretionary Grants and Mandate Reimbursements)	294,756	-	-
Chapter 32, Statutes of 2018 (Discretionary Grants and Mandate Reimbursements)	-	300,000	-
Prior Year Balances Available:			
Chapter 15, Statutes of 2017 (LCAP E-template and Dashboard)	-	300	-
Chapter 15, Statutes of 2017 (SoCal ROC Transition Funding)	-	3,000	2,000
Chapter 29, Statutes of 2016 (Proposition 98-Evaluation Rubrics Support and Development)	500	500	-
Chapter 32, Statutes of 2018 (State System of Support Regional Lead)	-	-	4,000
Totals Available	**$46,693,166**	**$48,091,382**	**$49,084,261**
TOTALS, EXPENDITURES	**$46,693,166**	**$48,091,382**	**$49,084,261**
0001 General Fund			
APPROPRIATIONS			
194 Budget Act appropriation (Child Development)	-	$1,324,850	$1,896,170
194 Budget Act appropriation (Child Development) as amended by Chapter 249, Statutes of 2017	1,007,698	-	-
CalWORKs Stage 3 Adjustment	-	80,000	-
202 Budget Act appropriation (Preparing, Recruiting, and Training Effective Educators)	-	-	6,700
242 Budget Act appropriation	-	-	150
Pending Legislation (Childcare Collective Bargaining)	-	-	10,000
Pending Legislation (Early Learning and Care Infrastructure Grant)	-	-	58,705
Pending Legislation (Early Learning and Care Workforce Development Grant)	-	-	129,000
Pending Legislation (Special Olympic Northern and Southern)	-	-	4,000
Public Resources Code section 26233 (Transfer to Clean Energy Job Creation Fund)	8,669	-	-
Prior Year Balances Available:			
Reappropriation, Proposition 98 per Item 6100-488	219,809	238,958	152,357
Reappropriation, Proposition 98 reversion account per Item 6100-485	104,880	80,331	6,620
TOTALS, EXPENDITURES	**$1,341,056**	**$1,724,139**	**$2,263,702**
Loan repayment per Chapter 14, Statutes of 2003 (Oakland Unified School District)	-2,095	-2,095	-2,095
Loan repayment per Chapter 53, Statutes of 2004 (Vallejo Unified School District)	-2,266	-2,266	-2,266
NET TOTALS, EXPENDITURES	**$1,336,695**	**$1,719,778**	**$2,259,341**
0140 California Environmental License Plate Fund			
APPROPRIATIONS			
181 Budget Act appropriation (Environmental Education)	$360	$360	$360
TOTALS, EXPENDITURES	**$360**	**$360**	**$360**
0231 Health Education Account, Cigarette and Tobacco Products Surtax Fund			
APPROPRIATIONS			
101 Budget Act appropriation (Drug Free Schools-County Offices)	$3,687	$3,086	$4,343
102 Budget Act appropriation (Drug Free Schools-District Grants)	10,458	9,875	13,911
Prior Year Balances Available:			
Item 6100-102-0231, Budget Act of 2017 (Drug Free Schools-District Grants)	-	480	-
Item 6100-102-0321, Budget Act of 2016	160	66	-
Totals Available	**$14,305**	**$13,507**	**$18,254**
TOTALS, EXPENDITURES	**$14,305**	**$13,507**	**$18,254**
0342 State School Fund			
APPROPRIATIONS			
Education Code section 14002	$38,711,061	$40,790,019	$40,271,345
State School Fund Adjustment	-	-6,256,381	-
TOTALS, EXPENDITURES	**$38,711,061**	**$34,533,638**	**$40,271,345**

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6100 Department of Education - Continued

2 LOCAL ASSISTANCE	2017-18*	2018-19*	2019-20*
Less funding provided by General Fund	-38,689,477	-34,512,419	-40,250,126
NET TOTALS, EXPENDITURES	**$21,584**	**$21,219**	**$21,219**
0349 Educational Telecommunication Fund			
APPROPRIATIONS			
Chapter 32, Statutes of 2018 (Standardized Account Code Structure System Replacement Project)	-	$716	-
Pending Legislation (Standardized Account Code Structure System Replacement Project)	-	-	607
TOTALS, EXPENDITURES	**-**	**$716**	**$607**
0620 Child Care Facilities Revolving Fund			
APPROPRIATIONS			
Education Code section 8278.3(a)(1)	$1,155	-	-
TOTALS, EXPENDITURES	**$1,155**	**-**	**-**
0814 California State Lottery Education Fund			
APPROPRIATIONS			
Government Code section 8880.5	$1,382,307	$1,200,696	$1,304,086
K-12 Lottery Adjustment	-	104,484	-
TOTALS, EXPENDITURES	**$1,382,307**	**$1,305,180**	**$1,304,086**
0890 Federal Trust Fund			
APPROPRIATIONS			
101 Budget Act appropriation (Project School Emergency Response to Violence)	-	$2,000	$2,000
102 Budget Act appropriation (Immediate Aid To Restart School Operations)	-	13,864	13,792
Adjust Federal Emergency Impact Aid Funds	-	3,556	-
104 Budget Act appropriation (Project Advancing Wellness and Resilience in Education Grant)	1,383	1,469	2,526
Adjust Federal Funds for Project Cal-STOP Grant Program	-	1,000	-
112 Budget Act appropriation (Public Charter Schools)	19,000	26,873	25,950
113 Budget Act appropriation (Student Assessment Program)	-	21,129	20,306
113 Budget Act appropriation (Student Assessment Program) as amended by Chapter 181, Statutes of 2017	22,995	-	-
119 Budget Act appropriation (Title I, Neglected and Delinquent)	-	3,112	1,405
119 Budget Act appropriation (Title I, Neglected and Delinquent) as amended by Chapter 181, Statutes of 2017	1,662	-	-
Adjust Federal Funds for the Neglected and Delinquent Children Program (SB 862)	-	139	-
125 Budget Act appropriation (Migrant Education and English Language Acquisition Program)	273,705	273,597	282,939
134 Budget Act appropriation (Title I School Improvement)	-	2,218,510	2,098,707
134 Budget Act appropriation (Title I School Improvement) as amended by Chapter 181, Statutes of 2017	1,843,422	-	-
Adjust Federal Funds for Title I Program (SB 862)	-	41,722	-
136 Budget Act appropriation (McKinney-Vento Homeless Children Education)	9,013	9,262	9,646
Adjust Federal Funds for the McKinney-Vento Homeless Children Education Program (SB 862)	-	1,124	-
Support for Homeless Youth Impacted by Wildfires	-	88	-
137 Budget Act appropriation (Rural and Low Income Schools Grant)	3,512	3,680	3,763
Adjust Federal Funds for the Rural and Low-Income Schools Program (SB 862)	-	335	-
156 Budget Act appropriation (Adult Education)	-	102,515	98,430
156 Budget Act appropriation (Adult Education) as amended by Chapter 181, Statutes of 2017	92,212	-	-
161 Budget Act appropriation (Special Education)	1,243,086	1,279,921	1,287,761
166 Budget Act appropriation (Vocational Education)	112,842	117,683	120,862
193 Budget Act appropriation (Title II, Mathematics and Science Partnership Grants)	-	323	-
One-Time Carryover for the Mathematics and Science Partnerships Program-Budget Revision	-	1,252	-

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

2 LOCAL ASSISTANCE	2017-18*	2018-19*	2019-20*
194 Budget Act appropriation (Child Development)	-	938,039	1,012,008
194 Budget Act appropriation (Child Development) as amended by Chapter 181, Statutes of 2017	764,500	-	-
195 Budget Act appropriation (Title II, Part A-Improving Teacher Quality Grant)	216,049	235,316	228,724
197 Budget Act appropriation (21st Century Community Learning Centers)	-	138,153	150,850
197 Budget Act appropriation (21st Century Community Learning Centers) as amended by Chapter 181, Statutes of 2017	134,758	-	-
Adjust Federal Funds for the 21st Century Community Learning Centers Program (SB 862)	-	3,347	-
201 Budget Act appropriation (Child Nutrition)	2,559,855	2,672,340	2,763,073
240 Budget Act appropriation (Advanced Placement Exam Fees)	-	11,064	-
294 Budget Act appropriation (Early Head Start - Child Care Partnership Grant)	2,807	3,662	3,060
Totals Available	**$7,300,801**	**$8,125,075**	**$8,125,802**
Unexpended balance, estimated savings	-	-103,295	-
TOTALS, EXPENDITURES	**$7,300,801**	**$8,021,780**	**$8,125,802**
0986 Local Property Tax Revenues			
Prior Year Balances Available:			
County Offices Local Revenue	566,128	590,284	626,911
District Local Revenue	19,230,022	20,234,585	21,488,987
Special Education Local Revenue	642,123	669,208	703,562
TOTALS, EXPENDITURES	**$20,438,273**	**$21,494,077**	**$22,819,460**
0995 Reimbursements			
APPROPRIATIONS			
Reimbursements	$400,773	$436,184	$517,889
TOTALS, EXPENDITURES	**$400,773**	**$436,184**	**$517,889**
3207 Education Protection Account			
APPROPRIATIONS			
Article XIII, Section 36 of the California Constitution (Proposition 30)	$6,809,114	$7,278,288	$8,036,178
Education Protection Account Revenue Adjustment	-	419,097	-
TOTALS, EXPENDITURES	**$6,809,114**	**$7,697,385**	**$8,036,178**
Less funding provided by General Fund	-6,809,114	-7,697,385	-8,036,178
NET TOTALS, EXPENDITURES	**-**	**-**	**-**
3286 Safe Neighborhoods and Schools Fund			
APPROPRIATIONS			
Government Code section 7599.1 (c)	$10,010	$15,263	$18,539
Totals Available	**$10,010**	**$15,263**	**$18,539**
TOTALS, EXPENDITURES	**$10,010**	**$15,263**	**$18,539**
3309 Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund			
APPROPRIATIONS			
101 Budget Act appropriation as amended by Chapter 249, Statutes of 2017	$14,584	-	-
Totals Available	**$14,584**	**-**	**-**
TOTALS, EXPENDITURES	**$14,584**	**-**	**-**
3321 Department of Education Subaccount, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund			
APPROPRIATIONS			
Revenue and Taxation Code section 30130.57(b)(1)	-	$21,736	$42,901
Adjust Proposition 56 Tobacco Tax Initiative Funding (Local Assistance)	-	1,486	-
TOTALS, EXPENDITURES	**-**	**$23,222**	**$42,901**
8080 Clean Energy Job Creation Fund			
APPROPRIATIONS			
139 Budget Act appropriation	$340,718	-	-

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

2 LOCAL ASSISTANCE	2017-18*	2018-19*	2019-20*
Totals Available	$340,718	-	-
TOTALS, EXPENDITURES	$340,718	-	-
Less funding provided by General Fund	-384,869	-	-
NET TOTALS, EXPENDITURES	-$44,151	-	-
Total Expenditures, All Funds, (Local Assistance)	$77,569,862	$81,142,668	$84,212,719
TOTALS, EXPENDITURES, ALL FUNDS (State Operations and Local Assistance)	$77,929,434	$81,554,877	$84,661,155

FUND CONDITION STATEMENTS

	2017-18*	2018-19*	2019-20*
0178 Driver Training Penalty Assessment Fund [S]			
BEGINNING BALANCE	$741	$1,399	$1,399
Prior Year Adjustments	658	-	-
Adjusted Beginning Balance	$1,399	$1,399	$1,399
Total Resources	$1,399	$1,399	$1,399
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	-	-	158
Total Expenditures and Expenditure Adjustments	-	-	$158
FUND BALANCE	$1,399	$1,399	$1,241
Reserve for economic uncertainties	1,399	1,399	1,241
0342 State School Fund [S]			
BEGINNING BALANCE	$2,029	$2,547	$2,547
Adjusted Beginning Balance	$2,029	$2,547	$2,547
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4154000 Royalties - Federal Land	25,472	25,472	25,472
4171300 Donations	12	12	12
Total Revenues, Transfers, and Other Adjustments	$25,484	$25,484	$25,484
Total Resources	$27,513	$28,031	$28,031
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	38,711,061	34,533,638	40,271,345
6870 Board of Governors of the California Community Colleges (Local Assistance)	4,457,234	5,014,873	5,179,186
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-38,689,477	-34,512,419	-40,250,126
Less funding provided by General Fund (Local Assistance)	-4,453,852	-5,010,608	-5,174,921
Total Expenditures and Expenditure Adjustments	$24,966	$25,484	$25,484
FUND BALANCE	$2,547	$2,547	$2,547
Reserve for economic uncertainties	2,547	2,547	2,547
0349 Educational Telecommunication Fund [S]			
BEGINNING BALANCE	$1,323	$1,323	$607
Adjusted Beginning Balance	$1,323	$1,323	$607
Total Resources	$1,323	$1,323	$607
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	-	716	607

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6100 Department of Education - Continued

	2017-18*	2018-19*	2019-20*
Total Expenditures and Expenditure Adjustments	-	$716	$607
FUND BALANCE	$1,323	$607	-
Reserve for economic uncertainties	1,323	607	-
3170 Heritage Enrichment Resource Fund S			
BEGINNING BALANCE	$351	$456	$525
Adjusted Beginning Balance	$351	$456	$525
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4172500 Miscellaneous Revenue	112	112	112
Total Revenues, Transfers, and Other Adjustments	$112	$112	$112
Total Resources	$463	$568	$637
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	2	40	40
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	5	3	2
Total Expenditures and Expenditure Adjustments	$7	$43	$42
FUND BALANCE	$456	$525	$595
Reserve for economic uncertainties	456	525	595
3207 Education Protection Account S			
BEGINNING BALANCE	-	-	-
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	$6,809,114	$7,697,385	$8,036,178
6870 Board of Governors of the California Community Colleges (Local Assistance)	841,576	951,362	993,235
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-6,809,114	-7,697,385	-8,036,178
Less funding provided by General Fund (Local Assistance)	-841,576	-951,362	-993,235
FUND BALANCE	-	-	-
3321 Department of Education Subaccount, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund S			
BEGINNING BALANCE	-	-	-199
Adjusted Beginning Balance	-	-	-$199
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Transfers and Other Adjustments			
Revenue Transfer From Tobacco Prevention and Control Programs Account Fund (3309) to the Tobacco Prevention and Control Programs Account (3321) per Revenue and Taxation Code 30130.55(b)(2)	-	-	20,611
Revenue Transfer From the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund (3304) to the Tobacco Prevention and Control Programs Account Fund (3321) per Revenue and Tax Code Section 30130.55(b)(2)	-	24,148	23,893
Total Revenues, Transfers, and Other Adjustments	-	$24,148	$44,504
Total Resources	-	$24,148	$44,305
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	-	1,125	1,125
6100 Department of Education (Local Assistance)	-	23,222	42,901
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	-	-	278
Total Expenditures and Expenditure Adjustments	-	$24,347	$44,304

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6100 Department of Education - Continued

	2017-18*	2018-19*	2019-20*
FUND BALANCE	-	-$199	$1
Reserve for economic uncertainties	-	-199	1
8080 Clean Energy Job Creation Fund [S]			
BEGINNING BALANCE	$409,894	$119,599	$6,075
Prior Year Adjustments	-325,466	-	-
Adjusted Beginning Balance	$84,428	$119,599	$6,075
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Transfers and Other Adjustments			
Revenue Transfer from the Clean Energy Job Creation Fund (8080) to the Alternative and Renewable Fuel and Vehicle Technology Fund (3117) per Public Resources Code 26205.5	-	-75,000	-
Revenue Transfer from the Clean Energy Job Creation Fund (8080) to the State Energy Conservation Assistance Account (0033) per Public Resources Code 26205.5	-	-38,524	-
Total Revenues, Transfers, and Other Adjustments	-	-$113,524	-
Total Resources	$84,428	$6,075	$6,075
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
3340 California Conservation Corps (State Operations)	5,816	-	-
6100 Department of Education (Local Assistance)	340,718	-	-
6870 Board of Governors of the California Community Colleges (Local Assistance)	46,664	-	-
7120 California Workforce Development Board (State Operations)	3,000	-	-
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-384,869	-	-
Less funding provided by General Fund (Local Assistance)	-46,500	-	-
Total Expenditures and Expenditure Adjustments	-$35,171	-	-
FUND BALANCE	$119,599	$6,075	$6,075
Reserve for economic uncertainties	119,599	6,075	6,075

CHANGES IN AUTHORIZED POSITIONS

	Positions			Expenditures		
	2017-18	2018-19	2019-20	2017-18*	2018-19*	2019-20*
Baseline Positions	2,217.2	2,217.2	2,217.2	$157,164	$165,701	$164,314
Salary and Other Adjustments	-0.6	-	-	4,865	6,750	6,750
Workload and Administrative Adjustments						
Adjust Federal Funding for Project AWARE Grant Program						
Various	-	-	-	-	-	117
Adjust Fees for Nonpublic Schools and Agencies (NPS/A) Certification Program						
Assoc Govtl Program Analyst	-	-	2.0	-	-	134
California Computer Science Coordinator						
Educ Programs Consultant	-	-	1.0	-	-	348
Career Technical Education Support						
Educ Programs Consultant	-	-	2.0	-	-	175
Early Learning and Care Division Support						
Assoc Govtl Program Analyst	-	-	4.0	-	-	277
Child Develmt Consultant	-	-	2.0	-	-	175
Educ Administrator I	-	-	1.0	-	-	100
Educ Programs Consultant	-	-	5.0	-	-	437

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6100 Department of Education - Continued

	Positions			Expenditures		
	2017-18	2018-19	2019-20	2017-18*	2018-19*	2019-20*
Staff Svcs Mgr I	-	-	1.0	-	-	80
Emergency Average Daily Attendance Waiver Request Workload						
Assoc Govtl Program Analyst	-	-	1.0	-	-	67
Foster Youth Trauma Support Coordination (AB 2083)						
Educ Programs Consultant	-	-	1.0	-	-	90
Homeless Student Coordinators						
Educ Programs Consultant	-	-	1.5	-	-	-
Increase Reimbursements for the California High School Proficiency Examination						
Educ Programs Consultant	-	-	-	-	-	70
Ongoing Development and Support of the California School Dashboard						
Educ Research & Eval Consultant	-	-	2.0	-	-	175
Oversight of State Board of Education Authorized Charter Schools						
Educ Programs Consultant	-	-	2.0	-	-	180
Preschool Development Grant						
Various	-	-	-	-	-	122
School Safety Plan Best Practices (AB 1747)						
Temporary Help (Limited Term 06-30-2020)	-	-	-	-	-	33
Shift Federal Funds Carryover for Project Cal-STOP Grant Program						
Various	-	-	-	-	-	44
Special Education Division Support						
Educ Programs Consultant	-	-	3.0	-	-	262
Special Education: Reporting the Use of Seclusion and Restraints (AB 2657)						
Educ Programs Consultant	-	-	1.0	-	-	87
Support for the 21st Century California School Leadership Academy						
Educ Programs Consultant	-	-	1.0	-	-	87
TOTALS, WORKLOAD AND ADMINISTRATIVE ADJUSTMENTS	**-**	**-**	**30.5**	**$-**	**$-**	**$3,060**
Totals, Adjustments	**-0.6**	**-**	**30.5**	**$4,865**	**$6,750**	**$9,810**
TOTALS, SALARIES AND WAGES	**2,216.6**	**2,217.2**	**2,247.7**	**$162,029**	**$172,451**	**$174,124**

INFRASTRUCTURE OVERVIEW

The State Special Schools Division has six facilities under its jurisdiction: three residential schools and three diagnostic centers. These facilities comprise a total of approximately 1,042,000 gross square feet on 167.29 acres.

The residential schools serve students ranging in age from 3 to 22. They include Schools for the Deaf in Riverside and Fremont and a School for the Blind in Fremont. The California Schools for the Deaf provide comprehensive educational programs composed of academic, extracurricular, and residential activities for students. The California School for the Blind is a statewide residential campus that provides intensive, disability-specific educational services for pupils who are blind, visually impaired, or deaf-blind. The diagnostic centers are regionally located in Fresno, Fremont, and Los Angeles; the centers address the unique educational needs of California's most difficult to serve special education students.

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6100 Department of Education - Continued

SUMMARY OF PROJECTS

	State Building Program Expenditures	2017-18*	2018-19*	2019-20*
5230	CAPITAL OUTLAY Projects			
0000409	New Gym and Pool Center	2,156	-	-
	Construction	2,156	-	-
0000720	Fremont School for the Deaf: Middle School Activity Center	-	-	2,177
	Construction	-	-	2,177
TOTALS, EXPENDITURES, ALL PROJECTS		**$2,156**	**$-**	**$2,177**

FUNDING		2017-18*	2018-19*	2019-20*
0001	General Fund	$-	$-	$2,177
0660	Public Buildings Construction Fund	2,156	-	-
TOTALS, EXPENDITURES, ALL FUNDS		**$2,156**	**$-**	**$2,177**

DETAIL OF APPROPRIATIONS AND ADJUSTMENTS

3 CAPITAL OUTLAY	2017-18*	2018-19*	2019-20*
0001 General Fund			
APPROPRIATIONS			
301 Budget Act appropriation	-	-	$2,177
Prior Year Balances Available:			
Item 6100-301-0001, Budget Act of 2016 as reappropriated by Item 6100-492, Budget Act 2017	-	1,483	-
Totals Available	**-**	**$1,483**	**$2,177**
Unexpended balance, estimated savings	-	-1,483	-
TOTALS, EXPENDITURES	**-**	**-**	**$2,177**
0660 Public Buildings Construction Fund			
APPROPRIATIONS			
301 Budget Act appropriation as added by Chapter 249, Statutes of 2017	$2,156	-	-
TOTALS, EXPENDITURES	**$2,156**	**-**	**-**
Total Expenditures, All Funds, (Capital Outlay)	**$2,156**	**$0**	**$2,177**

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EXHIBIT B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Voice - (800) 368-1019 TDD - (800) 537-7697 Fax - (202) 619-3818
http://www.hhs.gov/ocr/

OFFICE OF THE SECRETARY
Office for Civil Rights
200 Independence Ave., SW
Washington, DC 20201

VIA U.S. MAIL

August 30, 2018

Edmund G. Brown, Jr., Esq.
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State of California
c/o State Capitol, Suite 1173
Sacramento, CA 95814

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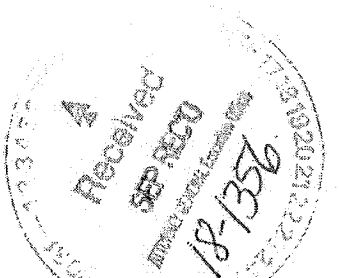

Re: OCR Transaction Number: 17-283890

Dear Governor Brown, Attorney General Becerra, Secretary Dooley, and Director Rouillard:

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) received the attached complaint on September 22, 2017, from Alliance Defending Freedom, filed on behalf of Skyline Church ("Complainant"). The Complainant alleges that the State of California violated Federal law when the Department of Managed Health Care issued letters on August 22, 2014, to health insurance issuers in California directing them to amend their health plans to remove coverage exclusions and limitations regarding abortions.

Under Federal regulations, OCR is designated to receive complaints based on the Federal laws that protect conscience and prevent coercion,[1] including the Weldon Amendment,[2] the Coats-Snowe Amendment,[3] and the Church Amendments.[4] OCR has reviewed the complaint and has determined that it has sufficient authority and cause to investigate the allegations under one or more of these laws.

This letter is a notice of investigation and does not constitute a finding of violation. OCR requests that you take all necessary steps to ensure that individuals who file complaints or participate in the investigation of complaints are free from harassment, intimidation, and retaliation.

If you have any questions, please contact Sarah Bayko Albrecht, Supervisory Civil Rights Analyst, at Sarah.Albrecht@hhs.gov or (202) 774-2432.

Sincerely,

Luis E. Perez
Deputy Director
Conscience and Religious Freedom Division

ENC

[1] Part 88 of 45 C.F.R. sets forth the applicable complaint handling procedures.
[2] Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018).
[3] 42 U.S.C. § 238n.
[4] *Id.* § 300a-7.

ALLIANCE DEFENDING FREEDOM
FOR FAITH. FOR JUSTICE

September 22, 2017

Via E-Mail and U.S. Mail: OCRComplaint@hhs.gov

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, DC 20201

Re: Complaint of Discrimination in Violation of Federal Statutes

Dear Sir or Madam:

Alliance Defending Freedom represents Skyline Church which has been subjected to unlawful discrimination by the state of California. California is subject to the Weldon Amendment (Continuing Appropriations Resolution, Pub. L. No. 113-164, Sec. 101(a) (Sept. 19, 2015)), the Church Amendments (42 U.S.C. § 300a-7), and/or the Public Health Service (PHS) Act (§ 245 (42 U.S.C. § 238n)), by virtue of its status as a recipient of federal funding.

Skyline Church believes that abortion is a grave moral evil. These convictions prohibit Skyline Church from providing insurance coverage for abortion procedures and abortion-inducing drugs in any manner. The rights of Skyline Church to operate as a religious institution without compromising their religious convictions relating to abortion or abortion-causing drugs are protected by the First Amendment to the United States Constitution and the Constitution of the State of California, in addition to the federal conscience laws named above.

On August 22, 2014, the California Department of Managed Health Care (DMHC) notified all private health care insurers in the state that all health care plans issued in California must immediately cover elective abortions. See attached letter to insurers. The insurers were instructed to amend their policies to remove any limitations on health coverage for abortions, such as excluding coverage for "voluntary" or "elective" abortions. DMHC justified this change in policy by interpreting the applicable California law mandating coverage of "basic health care services" to require coverage for all abortions. Because DMHC simply read this abortion coverage requirement into the pre-existing 1975 law, Health & Safety Code section 1340 *et seq.*, there is no exemption

15100 N. 90th Street Scottsdale, AZ 85260 Phone: 800.835.5233 Fax: 480.444.0028 AllianceDefendingFreedom.org

for any religious employer, including churches. Therefore, DMHC has ordered elective abortion coverage into the Skyline Church's insurance plan, despite their sincerely held religious beliefs against abortion.

This directive of the DMHC constitutes unlawful discrimination against a health care entity under section 507 of the Consolidated Appropriations Act, Pub L. No 113-76, 128 Stat. 5 (Jan. 17, 2014) (the Hyde-Weldon Conscience Protection Amendment). DMHC is "subject[ing]" Complainants' "health insurance plan" "to discrimination," by denying its approval of the plan that omitted elective abortions, solely "on the basis that the [plan] does not ... provide coverage of ... abortions." DMHC is an arm of the State of California and purports to be interpreting and applying the law of California, a state that receives billions of taxpayer dollars through "funds made available in this Act" in this and recent appropriations. California accepted those funds with full knowledge of the requirements of the Hyde-Weldon Amendment, but it has chosen to ignore this law. The need to remedy this discrimination is urgent because it is immediately forcing Complainants to offer their employees a health plan that includes elective abortions

Please promptly inform us of the actions your office plans to take regarding this violation. Thank you for your attention to this matter.

Sincerely yours,

/s/ Elissa Graves
Elissa Graves, Esq.

cc: Kevin Theriot, Esq., Senior Counsel, Alliance Defending Freedom Clients

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Washington, DC 20201

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PRIVATE USE $300

$6.25 43

EXHIBIT C

Neli Palma

From: Takemoto, Benjamin (CIV) <Benjamin.Takemoto@usdoj.gov>
Sent: Tuesday, September 3, 2019 4:15 PM
To: Karli Eisenberg
Cc: Kathleen Boergers; Neli Palma; Stephanie Yu; Kopplin, Rebecca M. (CIV)
Subject: RE: California v. Azar et al, No. 3:19-cv-02769-WHA - Missing Document

Hi Karli,

This is confirmation that HHS intended not to include the attached August 30, 2018 letter in the administrative record. However, the underlying complaint is located at page 545,936 of the administrative record.

Best,
Ben

--

Benjamin T. Takemoto
Trial Attorney
U.S. Department of Justice, Civil Division, Federal Programs Branch
P.O. Box 883, Ben Franklin Station, Washington, DC 20044
Tel: (202) 532-4252 / Fax: (202) 616-8460

From: Karli Eisenberg <Karli.Eisenberg@doj.ca.gov>
Sent: Friday, August 30, 2019 7:43 PM
To: Takemoto, Benjamin (CIV) <btakemot@CIV.USDOJ.GOV>
Cc: Kathleen Boergers <Kathleen.Boergers@doj.ca.gov>; Neli Palma <Neli.Palma@doj.ca.gov>; Stephanie Yu <Stephanie.Yu@doj.ca.gov>; Kopplin, Rebecca M. (CIV) <rkopplin@CIV.USDOJ.GOV>
Subject: California v. Azar et al, No. 3:19-cv-02769-WHA - Missing Document

Dear Ben,

We plan on relying on the attached August 30, 2018 letter from HHS to Governor Brown, Attorney General Becerra, Secretary Dooley, and Director Rouillard. We cannot locate it in the administrative record. Will you please confirm that it was not intended to be included? Or supplement?

Thank you.

Karli

Karli Eisenberg
Deputy Attorney General
California Department of Justice

Office of the Attorney General
1300 I Street, Sacramento, CA 95814
Office: (916) 210-7913
Fax: (916) 324-5567
Please note the new phone number.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Voice - (800) 368-1019 TDD - (800) 537-7697 Fax - (202) 619-3818
http://www.hhs.gov/ocr/

OFFICE OF THE SECRETARY
Office for Civil Rights
200 Independence Ave., SW
Washington, DC 20201

VIA U.S. MAIL

August 30, 2018

Edmund G. Brown, Jr., Esq.
Governor
State of California
c/o State Capitol, Suite 1173
Sacramento, CA 95814

Xavier Becerra, Esq.
Attorney General
State of California
Department of Justice
P.O. Box 944255
Sacramento, CA 94244

Diana S. Dooley, Esq.
Secretary
California Health & Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Michelle (Shelley) Rouillard
Director
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: OCR Transaction Number: 17-283890

Dear Governor Brown, Attorney General Becerra, Secretary Dooley, and Director Rouillard:

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) received the attached complaint on September 22, 2017, from Alliance Defending Freedom, filed on behalf of Skyline Church ("Complainant"). The Complainant alleges that the State of California violated Federal law when the Department of Managed Health Care issued letters on August 22, 2014, to health insurance issuers in California directing them to amend their health plans to remove coverage exclusions and limitations regarding abortions.

Under Federal regulations, OCR is designated to receive complaints based on the Federal laws that protect conscience and prevent coercion,[1] including the Weldon Amendment,[2] the Coats-Snowe Amendment,[3] and the Church Amendments.[4] OCR has reviewed the complaint and has determined that it has sufficient authority and cause to investigate the allegations under one or more of these laws.

This letter is a notice of investigation and does not constitute a finding of violation. OCR requests that you take all necessary steps to ensure that individuals who file complaints or participate in the investigation of complaints are free from harassment, intimidation, and retaliation.

If you have any questions, please contact Sarah Bayko Albrecht, Supervisory Civil Rights Analyst, at Sarah.Albrecht@hhs.gov or (202) 774-2432.

Sincerely,

Luis E. Perez
Deputy Director
Conscience and Religious Freedom Division

ENC

[1] Part 88 of 45 C.F.R. sets forth the applicable complaint handling procedures.
[2] Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018).
[3] 42 U.S.C. § 238n.
[4] *Id.* § 300a-7.

ALLIANCE DEFENDING FREEDOM
FOR FAITH. FOR JUSTICE.

September 22, 2017

Via E-Mail and U.S. Mail: OCRComplaint@hhs.gov

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, DC 20201

Re: Complaint of Discrimination in Violation of Federal Statutes

Dear Sir or Madam:

Alliance Defending Freedom represents Skyline Church which has been subjected to unlawful discrimination by the state of California. California is subject to the Weldon Amendment (Continuing Appropriations Resolution, Pub. L. No. 113-164, Sec. 101(a) (Sept. 19, 2015)), the Church Amendments (42 U.S.C. § 300a-7), and/or the Public Health Service (PHS) Act (§ 245 (42 U.S.C. § 238n)), by virtue of its status as a recipient of federal funding.

Skyline Church believes that abortion is a grave moral evil. These convictions prohibit Skyline Church from providing insurance coverage for abortion procedures and abortion-inducing drugs in any manner. The rights of Skyline Church to operate as a religious institution without compromising their religious convictions relating to abortion or abortion-causing drugs are protected by the First Amendment to the United States Constitution and the Constitution of the State of California, in addition to the federal conscience laws named above.

On August 22, 2014, the California Department of Managed Health Care (DMHC) notified all private health care insurers in the state that all health care plans issued in California must immediately cover elective abortions. See attached letter to insurers. The insurers were instructed to amend their policies to remove any limitations on health coverage for abortions, such as excluding coverage for "voluntary" or "elective" abortions. DMHC justified this change in policy by interpreting the applicable California law mandating coverage of "basic health care services" to require coverage for all abortions. Because DMHC simply read this abortion coverage requirement into the pre-existing 1975 law, Health & Safety Code section 1340 *et seq.*, there is no exemption

15100 N. 90th Street Scottsdale, AZ 85260 Phone: 480.444.0020 Fax: 480.444.0028 AllianceDefendingFreedom.org

for any religious employer, including churches. Therefore, DMHC has ordered elective abortion coverage into the Skyline Church's insurance plan, despite their sincerely held religious beliefs against abortion.

This directive of the DMHC constitutes unlawful discrimination against a health care entity under section 507 of the Consolidated Appropriations Act, Pub L. No 113-76, 128 Stat. 5 (Jan. 17, 2014) (the Hyde-Weldon Conscience Protection Amendment). DMHC is "subject[ing]" Complainants' "health insurance plan" "to discrimination," by denying its approval of the plan that omitted elective abortions, solely "on the basis that the [plan] does not ... provide coverage of ... abortions." DMHC is an arm of the State of California and purports to be interpreting and applying the law of California, a state that receives billions of taxpayer dollars through "funds made available in this Act" in this and recent appropriations. California accepted those funds with full knowledge of the requirements of the Hyde-Weldon Amendment, but it has chosen to ignore this law. The need to remedy this discrimination is urgent because it is immediately forcing Complainants to offer their employees a health plan that includes elective abortions

Please promptly inform us of the actions your office plans to take regarding this violation. Thank you for your attention to this matter.

Sincerely yours,

/s/ Elissa Graves
Elissa Graves, Esq.

cc: Kevin Theriot, Esq., Senior Counsel, Alliance Defending Freedom Clients

DENNIS J. HERRERA, State Bar #139669
City Attorney
JESSE C. SMITH, State Bar #122517
Chief Assistant City Attorney
RONALD P. FLYNN, State Bar #184186
Chief Deputy City Attorney
YVONNE R. MERÉ, State Bar #173594
Chief of Complex and Affirmative Litigation
SARA J. EISENBERG, State Bar #269303
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Attorneys for Plaintiff
CITY AND COUNTY OF SAN FRANCISCO

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

vs.

ALEX M. AZAR II, et al.,

Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

vs.

ALEX M. AZAR, et al.,

Defendants.

COUNTY OF SANTA CLARA et al,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF SETH PARDO, Ph.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Seth Pardo, declare as follows:

1. I make this declaration both in my capacity as an expert in LGBTQ behavioral and psychological health, and in my capacity as a fact witness familiar with how transgender people seek health care from the San Francisco Department of Public Health ("SFDPH").

2. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

3. I am an Epidemiologist for the Behavioral Health Branch of the San Francisco Health Network of SFDPH and have held that position since 2017. In that capacity, I design, conduct, and evaluate epidemiological research to determine patterns of health outcomes and their determinants in the community. I also oversee research administration and draft technical reports of evaluation and research findings. I am also the lead program evaluator for Gender Health SF and have been since 2015 and served as the lead program evaluator for the Minority AIDS Initiative – Targeted Capacity Expansion with SFDPH's Behavioral Health Services between 2012 and 2015.

4. In addition to my responsibilities at SFDPH, I have also been an adjunct professor at the California School of Professional Psychology at Alliant International University in San Francisco, California since 2011 and an adjunct professor at the California Institute of Integral Psychology in San Francisco, California since 2016. In the past I have held numerous other academic positions.

5. I am a member of the World Professional Association for Transgender Health, a founding board member for the Association for Gender Research, Education, Academia, and Action, a member of the national advisory board for the University of California San Francisco's Center for Excellence for Transgender Health, a member of the American Psychological Association's Division 44, the Society for the Psychological Study of Sexual Orientation and Gender Diversity, and former chair of the American Psychological Association's Public Interest Directorate Committee for Sexual Orientation and Gender Diversity.

6. I hold a Ph.D. in Developmental Psychology from the Department of Human Development at Cornell University with concentrations in Cognitive and Developmental

Psychology and Feminist, Gender, and Sexuality Studies, and a B.A. in Psychology from Duke University, with distinction, and a certificate in Human Development.

7. My most recent publications examine predictors of emotional wellbeing and clinical health in transgender men. I have many peer-reviewed publications, manuscripts in preparation, presentations, invited lectures, awards, and honors, as detailed in my curriculum vitae, a true and correct copy of which is attached to this declaration as Exhibit A.

8. I have not been separately or additionally compensated to give this declaration, apart from my regular employment by SFDPH.

9. In my experience, members of San Francisco's transgender community are very aware of laws that affect their rights and in particular their access to health care. There is a long history of the transgender community fighting for equal access to healthcare and insurance coverage, and now the regulations entitled "Protecting Statutory Conscience Rights in Heath Care; Delegations of Authority," published in the Federal Register on Tuesday, May 21st, 2019 (the "Final Rule") and other recent actions by the Department of Health and Human Services are threatening to take away relatively recently-won protections for transgender healthcare.

10. Transgender people served by the San Francisco Health Network ("SFHN")—the branch of SFDPH that provides direct patient care— are aware of the Final Rule and their knowledge of it is already increasing anticipated stigma within the community. For example, patients are asking if the Final Rule means that their healthcare will be taken away, and are expressing fear that providers will opt out of providing care for them once the Final Rule goes into effect such that they will be unable to access care. This increase in anticipated stigma caused by the Final Rule is causing patients to request that as of yet unscheduled procedures be scheduled before the Final Rule will go into effect, to ask that recently requested procedures be approved before the Final Rule will go into effect, to attempt to move up scheduled procedures so that they occur before the Final Rule will go into effect, and is causing them increased stress when previously-scheduled appointments are rescheduled for later dates.

11. The San Francisco Bay Area has the highest concentration of surgeons who perform gender-affirming surgeries in the country. Transgender people throughout California,

and the country, come to San Francisco to access its concentration of world-class transgender health experts, many of whom provide care through SFHN. For many transgender people, accessing these gender-affirming surgeries and other transition-related care is life-saving, and without such access, they are at great risk of suicide. If the Final Rule were to go into effect, and religious refusals to transition-related care in San Francisco increased as a result, it would negatively impact health outcomes for the transgender community well beyond just San Francisco residents.

12. It is my expert opinion that when a doctor or other healthcare worker refuses to provide healthcare to a transgender person, on the basis of the worker's religious beliefs, that religious refusal is experienced as discrimination and stigma by the transgender person. When transgender people either actually experience such refusals, or merely anticipate that they might experience such refusals, this enacted or anticipated stigma leads to them delay accessing needed healthcare, and even to avoid accessing needed healthcare entirely. In this way, religious refusals limit access to routine preventative care, as well as care when sick or injured, in the transgender community on a structural level.

13. It is my expert opinion that when transgender people experience religious refusals in healthcare, it leads to adverse health outcomes in the transgender population. This is because religious refusals induce stress, which is a key driver of morbidity and mortality. Furthermore, experiencing religious refusals leads to higher rates of substance abuse, depressive stress, and suicide in transgender populations.

14. It is my expert opinion that men who have sex with men as well as transgender women are disproportionately impacted by and vulnerable to HIV/AIDS. Religious refusals to test for HIV or to write or fill prescriptions for PreP would have a disproportionate negative impact on the transgender community and men who have sex with men.

15. It is my expert opinion that some transgender people undergo hormone therapy as part of transitioning. Many endocrinologists who are not otherwise specialists in providing transition-related care are competent to provide transition-related or maintenance hormone

therapy to transgender people. Religious refusals to write or fill prescriptions for hormones for this purpose would have a disproportionate impact on the transgender community.

16. These expert opinions are based on my academic and professional background, training, and experience, which includes my deep familiarity with the academic literature on LGBTQ populations' access to healthcare. The following specific academic sources also inform my expert opinions:

a. Michal J. McDowell, Jaclyn W. Hughto and Sari L. Reisner, *Risk and Protective Factors for Mental Health Morbidity In a Community Sample of Female-to-Male Trans-Masculine Adults*, 19 BMC Psychiatry 16 (2019);

b. R.P. O'Brien, P.M. Walker, S.L. Poteet, A. McAllister-Wallner, and M. Taylor, *Mapping the Road to Equality: The Annual State of LGBT Communities, 2018*, Sacramento, CA #Out4MentalHealth Project (2018);

c. Jaclyn M. White Hughto, Gabirel R. Murchison, Kristy Clark, John E. Pachankis, and Sari L. Reisner, *Geographic and Individual Differences in Healthcare Access for U.S. Transgender Adults: A Multilevel Analysis*, 3 LGBT Health 424 (Nov. 2016);

d. Jaclyn M. White Hughto, Sari L. Reisner, and John E. Pachankis, *Transgender Stigma and Health*: *A Critical Review of Stigma Determinants, Mechanism, and Interventions* 147 Soc. Sci. Med. 222 (Dec. 2015);

e. Jaclyn M. White Hughto and Sari L. Reisner, *Social Context of Depressive Distress in Aging Transgender Adults* 37 J. of Applied Gerentology 1517 (Dec. 2018);

f. Jaclyn White Hughto, Adam J. Rose, John E. Pachankis, and Sari L. Reisner, *Barriers to Gender Transition-Related Healthcare: Identifying Underserved Transgender Adults in Massachusetts* 2.1 Transgender Health 107 (2017);

g. Sari L. Reisner, Seth T. Pardo, Kristi E. Gamarel, Jaclyn M. White Hughto, Dana J. Pardee, and Colton L. Keo-Meier, *Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults* 2 LGBT Health 324 (2015) (a true and correct copy of this article is attached as Exhibit B); and

h. Meghan Romanelli, Wenhua Lu, and Michael A. Lindsey, *Examining Mechanisms and Moderators of the Relationship Between Discriminatory Health Care Encounters and Attempted Suicide Among U.S. Transgender Help-Seekers* Administration and Policy in Mental Health and Mental Health Services Research (Mar. 2018).

17. My expert opinion is also informed by the interviews that were conducted for the Sexual Orientation and Gender Identity ("SOGI") training created by SFDPH which reflect the impact of anticipated stigma on delaying and avoiding accessing healthcare within the transgender community.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 9, at San Francisco, California.

Seth Pardo, Ph.D.

EXHIBIT A

April 24, 2019

CURRICULUM VITA
SETH T. PARDO

1380 Howard St. 2nd Floor
San Francisco, CA 94103
(415) 255-3678 * seth.pardo@sfdph.org

CURRENT APPOINTMENTS

Behavioral Health Epidemiologist, San Francisco Department of Public Health, 2017 – present.
Program Evaluator, Behavioral Health Services, San Francisco Department of Public Health, 2012 – present.
Research Fellow, The Rockway Institute, Alliant International University, San Francisco, CA, 2011 – present.
Adjunct Professor, California School of Professional Psychology, Alliant International University, San Francisco, CA, 2011 - present.
Adjunct Professor, California Institute of Integral Psychology, San Francisco, CA, 2016 - present.

EDUCATION

International Institute for Humanistic Studies

Extended Advanced Training, In-Depth Communication	2016-present
Advanced Training Certificate, In-Depth Communication	2014
Basic Training Certificate, Existential-Humanistic Mindful Psychotherapy	2012

Cornell University

Ph.D. (Developmental Psychology)	2011
Certificate (Feminist, Gender & Sexuality Studies)	2011
M.A. (Developmental Psychology)	2008

Duke University

Certificate (Human Development)	2003
B.A. (Psychology) with Distinction	2003

RESEARCH INTERESTS

- **Transgender Health:** Psychosocial impacts of surgical access; medical decision-making; identity; predictors of risk and resilience.
- **Health Psychology & Public Health**: Health care disparities; Medical decision-making; psychosocial aspects of alternative reproductive services; health care integration and service linkage.
- **Family and Child Development**: Family relationships of gender nonconforming youth and their parents; psychosocial adjustment and family dynamics of children born via surrogacy.
- **Gender & Sexuality Studies**: Identity & expression; the role of identity in decision-making over the life course; Influence of life transitions on mental health, well-being, and resilience.

PEER REVIEWED PUBLICATIONS

1. **Pardo, S. T.** (in press). Unearthing (Trans)gender: Themes of gendered self-concept and self-expression. *International Journal of Transpersonal Psychology.*
2. Kolesar, A. E. & **Pardo, S. T.** (in press). The religious and philosophical characteristics of a polyamorous sample. *International Journal of Transpersonal Psychology.*
3. Levant, R. F., Alto, K., McKelvey, D., **Pardo, S.T.,** Jadaszewski, S., Richmond, K., Keo-Meier, C., & Gerdes, Z. (2019). Development, variance composition, measurement invariance across five gender groups, and validity of the Health Behavior Inventory-Short Form. *Psychology of Men & Masculinities,* http://dx.doi.org/10.1037/men0000215
4. Levant, R. F., Jadaszewski, S., Alto, K. M., Richmond, K., **Pardo, S. T.,** Keo-Meier, C., Gerdes, Z. (2019). Moderation and mediation of the relationships between masculinity ideology and health status. *Health Psychology, 38*(2), 162-171. http://dx.doi.org/10.1037/hea0000709
5. Daniels, D., Saracino, T., Fraley, M., Christian, J., & **Pardo, S.** (2018). Advancing Ego Development in Adulthood through Study of the Enneagram System of Personality. *Journal of Adult Development,* https://doi.org/10.1007/s10804-018-9289-x
6. Katz-Wise, S. L., Williams, D. N., Keo-Meier, C. L., Budge, S. L., **Pardo, S. T.,** & Sharp, C. (2017). Longitudinal associations of sexual fluidity and health in transgender men and cisgender women and men. *Psychology of Sexual Orientation and Gender Diversity, 4*(4), 460-471.
7. **Pardo, S. T.** & Devor, A. H. (2017). Transgender identity development. In K. Nadal (Ed.), *The SAGE Encyclopedia of Psychology and Gender*. SAGE.
8. **Pardo, S. T.** (2017). Transgender bias in research. In K. Nadal (Ed.), *The SAGE Encyclopedia of Psychology and Gender*. SAGE.
9. **Pardo, S. T.** & Kolesar, A. E. (2017). Romantic relationships with transgender partners. In K. Nadal (Ed.), *The SAGE Encyclopedia of Psychology and Gender*. SAGE.
10. Chick, C., **Pardo, S.,** Reyna, V. F., & Goldman, D. (2017). Decision making (individuals). *Reference Module in Neuroscience and Biobehavioral Psychology*. doi: 10.1016/b978-0-12-809324-5.06393-8
11. Romer, A. L., Reyna, V. F., & **Pardo, S. T.** (2016). Are rash impulsive and reward sensitive traits distinguishable? A test in young adults. *Personality and Individual Differences, (99),* 308-312. doi: 10.1016/j.paid.2016.05.027
12. Reisner, S.L., **Pardo, S.T.,** Gamarel, K.E., White, J.M., Pardee, D., & Keo-Meier, C. L. (2015). Substance use to cope with stigma in healthcare among U.S. female-to-male trans masculine adults. *LGBT Health, 2*(4), 324-332. doi: 10.1089/lgbt.2015.0001
13. Keo-Meier, S. C., Herman, L. I., Reisner, S. L., **Pardo, S. T.,** Sharp, C., & Babcock, J. C. (2014). Testosterone Treatment and MMPI-2 Improvement in Transgender Men: A Prospective Controlled Study. *Journal of Consulting and Clinical Psychology*. E-publication online August 11, 2014 ahead of print.
14. Meier, S. C., **Pardo, S. T.,** Labuski, C., & Babcock, J. C. (2013). Measures of clinical health among female-to-male transgender persons as a function of sexual orientation. *Archives of Sexual Behavior, 42*(3), 463-474.
15. Chu, J. P., Floyd, R., Diep, H., **Pardo, S. T.,** Goldblum, P., & Bongar, B. (2013). A Tool for the Culturally Competent Assessment of Suicide: The Cultural Assessment of Risk for Suicide (CARS) Measure. *Psychological Assessment, 25*(2), 424-34. doi: 10.1037/a0031264

16. Mikalson, P., **Pardo, S.,** & Green, J. (2012). *First, do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer and questioning populations in California. The California LGBTQ Reducing Mental Health Disparities Population Report.* http://www.eqcai.org/atf/cf/%7B8cca0e2f-faec-46c1-8727-cb02a7d1b3cc%7D/FIRST_DO_NO_HARM-LGBTQ_REPORT.PDF.

17. Chick, C., **Pardo, S.,** Reyna, V. F., & Goldman, D. (2012). Decision making (individuals). In V. S. Ramachandran & A. Gebicka (Eds.), *Encyclopedia of Human Behaviour, 2nd Edition.* United Kingdom: Elsevier.

18. Liberali, J. F., Reyna, V. F., Furlan, S., Stein, L. M., & **Pardo, S. T.** (2011). Individual differences in numeracy and cognitive reflection, with implications for biases and fallacies in probability judgment. *Journal of Behavioral Decision Making Special Issue: Individual differences in decision-making competence.* doi: 10.1002/bdm.752

19. Meier, S., Fitzgerald, K., **Pardo, S.,** & Babcock, J. (2011). The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals. *Journal of Gay and Lesbian Mental Health, 15*(3), 281-299.

20. Diamond, L., **Pardo, S. T.** & Butterworth, M. (2011). Border crossings: Transgender experience and identity. S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research.* New York: Springer.

21. **Pardo, S. T.** (2011). Queering transgender: Towards a sociology of transgender. Book Review of *TransForming gender: Transgender practices of identity, intimacy and care. Journal of Sex Research, 48*(4), 409 doi: 10.1080/00224499.2010.487769

22. Rachlin, K., Hansbury, G., & **Pardo, S. T.** (2010). Hysterectomy and oophorectomy in female-to-male transgendered individuals. *International Journal of Transgenderism, 12* (3), 155-166.

23. Pillemer, K., Suitor, J., **Pardo, S.,** & Henderson, C. (2010). Mother's differentiation and depressive symptoms among adult children. *Journal of Marriage and the Family, 72,* 333-345.

24. Savin-Williams, R. C., **Pardo, S. T.,** Vrangalova, S., & Mitchell, R. S. (2010). Gender and sexual prejudice. In D. McCreary & J. Chrisler (Eds.), *Handbook of gender research in psychology*. New York: Springer.

25. Suitor, J.J., Sechrist, J., Plikuhn, M., **Pardo, S. T.,** Gilligan, M., & Pillemer, K. (2009). The Role of Perceived Maternal Favoritism in Sibling Relations in Midlife. *Journal of Marriage and the Family, 71,* 1026-1038.

26. Suitor, J.J., Sechrist, J., Plikuhn, M., **Pardo, S. T.,** & Pillemer, K. (2008). Within-family differences in parent-child relations across the life course. *Current Directions in Psychological Science, 17,* 334-338.

27. **Pardo, S.** (2008, Fall). ISNA Reorganizes. *Gender Matters,* 1, p. 5-6.

28. **Pardo, S. T.** & Schantz, K. (2008, September). Growing up transgender: Safety and resilience. *ACT for (Trans) Youth (Part 2).* Cornell University, Ithaca, NY.

29. **Pardo S. T.** (2008, March). Growing up transgender: Research and theory. *ACT for (Trans) Youth (Part 1).* Cornell University, Ithaca, NY.

30. **Pardo T.** (2008). Sexual Orientation. In F. C. Power, R. J. Nuzzi, D. Narvaez, D. K. Lapsley, & T. C. Hunt (Eds.), *Encyclopedia of Moral Education.* Westport, CT: Praeger.

31. El-Mallakh, R.S., Ghaemi, S.N., Sagduyu, K., Thase, M.E., Wisniewski, S.R., Nierenberg, A.A., Zhang, H.W., **Pardo, T.,** Sachs, G. (2008). Antidepressant-associated chronic irritable dysphoria (ACID) in STEP-BD patients. *Journal of Affective Disorders, 111*(2-3), p. 372-7.

32. Ghaemi, S. N., Shirzadi, A. A., Klugman, J., Berv, D. A., **Pardo, T.**, Filkowski, M. M. (2008). Is adjunctive open-label zonisamide effective for bipolar disorder? *Journal of Affective Disorders, 105*(1-3), 311-314.

33. Pillemer, K., Suitor, J.J., Mock, S., Sabir, M., **Pardo, T.**, & Sechrist, J. (2007). Capturing the complexity of intergenerational relations: Exploring ambivalence within later-life families. *Journal of Social Issues, 63*(4), 775-791.

34. **Pardo, T.** (2007, April). Towards a New Model of Transgender Identity Development. Abstract published in the proceedings of Transgender 2007: The 21st Annual International Foundation for Gender Education Conference, Philadelphia, PA.

35. **Pardo, T.** (2007, July). Gender Nonconformity: Towards a New Model of Gender and Sexual Identity Development. Abstract published in *UCSRT Dialogues Cutting Edge: Research Spotlights.* Publication of the National Sexuality Resource Center.

36. Albanese, M. J., Clodfelter Jr., R. C., **Pardo, T.**, & Ghaemi, S. N. (2006). Underdiagnosis of bipolar disorder in men with substance use disorder. *Journal of Psychiatric Practice, 12*(2), 124-127.

37. Ghaemi, S. N., Hsu DJ, Rosenquist KJ, **Pardo T**, & Goodwin FK. (2006). Extrapyramidal side effects with atypical neuroleptics in bipolar disorder. *Progress Neuro-Psychopharmacology & Biological Psychiatry, 30*, 209-213.

38. Ghaemi, S. N., Schrauwen, E., Klugman, J., Berv, D. A., Shirzadi, A. A., **Pardo, T.**, Goodwin, F. K. (2006). Long-term lamotrigine plus lithium for bipolar disorder: One year outcome. *Journal of Psychiatric Practice, 12*(5), 300-305.

39. Ghaemi, S. N., Zablotsky, B., Filkowski, M. M., Dunn, R. T., **Pardo, T.**, Isenstein, E., & Baldassano, C. F. (2006). An open prospective study of zonisamide in acute bipolar depression. *Journal of Clinical Psychopharmacology, 26*(4), 385-388.

40. Kinrys, G., Wygant, L.E., **Pardo, T**, & Melo, M. (2006). Levetiracetam for treatment-refractory posttraumatic stress disorder. *Journal of Clinical Psychiatry, 67*(2), 211-214.

41. Manwani, S. G., **Pardo, T.**, Albanese, M. J., Zablotsky, B., Goodwin, F.K., & Ghaemi SN. (2006). Substance use disorder and other predictors of antidepressant-induced mania: a retrospective chart review. *Journal of Clinical Psychiatry, 67*(9), 1341-1345.

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43. Ghaemi, S.N., **Pardo T.**, & Hsu, D. J. (2004). Strategies for preventing the recurrence in bipolar disorder. *Journal of Clinical Psychiatry, 65*(Supplement 10), 16-23.

44. Joseph, R. C., Danforth, N., Goren, G. S., Kardos, M., Szekely, A. R., Steingard, R.J., Rosenquist, K.J., Wyshak, G., Hsu, D.J., **Pardo, T.**, & Ghaemi, S.N. (2004). Diabetes and Lipid Profile Risks With Neuroleptics: Reanalysis of 2–5-Year Outcome. *Psychosomatics, 46*, 153-186.

45. Kinrys, G., Worthington, J., Melo, M. J., **Pardo, T.**, Simon, N., Reese, H., Doyle, A., Pollack, M. (2004). Adjunctive levetiracetam for treatment refractory anxiety disorders. *International Journal of Neuropsychopharmacology,* 7(Suppl. 1), S195-S196.

46. Kinrys, G., Melo, M. J., **Pardo, T.**, Hsu, D. (2004). Adjunctive levetiracetam for treatment refractory post-traumatic stress disorder (PTSD). *International Journal of Neuropsychopharmacology,* 7(Suppl. 1), S364.

47. Ghaemi, S. N., **Pardo, S. T.,** & Chriki, L. S. (under revision). Mindfulness-based existential therapy (MBET): A new approach for bipolar disorder. *Journal of Affective Disorders.*

48. Levant, R. F., Richmond, K., Jadaszewski, S., Alto, K., **Pardo, S.T.,** Keo-Meier, C., & Gerdes, Z. (under review). The relationships between masculinity ideology, outcome expectations, health behaviors, and health status, moderated by gender identity. *Gender and Health.*

MANUSCRIPTS IN PREPARATION

1. Rosendale, N., Fishman, A., Goldman, S., **Pardo, S.,** Scarborough, A., Bennett, A., (in preparation). Systemic collection of sexual orientation and gender identity in a public health system: The San Francisco Health Network SO/GI Initiative.
2. Srinivasa, D., **Pardo, S.**, Zevin, B., graham, j., Rapues, J., & Terry, M. (in preparation). Establishing the first government funded transgender program for an uninsured population: A 5-year review of the San Francisco General Hospital Experience.
3. Hartelius, G., Harrahy, M., Couch, C., Adler, H., Thouin, M., Stamp, G., & **Pardo, S. T.,** (under review). Second-Wave Transpersonal Psychology: Embodied, Embedded, Diverse, Transforming.
4. **Pardo, S. T.,** Levant, R. F., Jadaszewski, S., Alto, K. M., McKelvey, D. (in preparation). Gender identity, sexual orientation, partner preferences, sexual behavior, and stigma in a general population sample of trans and gender nonbinary identified persons.
5. Rivera, D. & **Pardo, S. T.** (under review). Gender identity change efforts: The evidence base. In D. Haldeman & M. Hendricks (Eds), *Change Efforts in Sexual Orientation and Gender Identity: From Clinical Implications to Contemporary Public Policy.* Harrington Park Press.
6. Rider, G. N., Keo-Meier, C., Berg, D., **Pardo, S.,** Olson, J., Sharp, C., Tran, K., & Calvetti, S., (Revise & resubmit). Using the Child Behavior Checklist (CBCL) with Transgender/Gender Nonconforming Children and Adolescents. *Clinical Practice in Pediatric Psychology.*
7. **Pardo, S. T.** & Reyna, V. F. (in preparation). Are trans people rational? Identity as a predictor in making tough medical decisions. *Medical Decision Making.*
8. **Pardo, S. T.,** Reyna, V. F., Mills, B. A., Romer, A., Haroon, M., Shreck, E., & Estrada, S. M. (in preparation). Within subject differences in opposite relations between risk perception and risk taking: A follow up study using a fuzzy-trace theory approach.
9. **Pardo, S. T.** (in preparation). Identity developmental milestones in gender diverse individuals who were assigned female at birth. *Psychology of Women Quarterly.*
10. **Pardo, S. T.** (in preparation). Partner preferences, sexual behavior, and developmental milestones in a sample of gender diverse individuals. *Journal of Sexual Orientation and Gender Diversity.*
11. Reyna, V. F., **Pardo, S. T.,** Rahman, S. H., Portenoy, A., Nollet, Z., Su, A., Suh, A., & Alam, A. (in preparation). Risk and rationality in the emergency department: Prediction of cardiac outcomes by physicians vs practice guidelines. *Medical Decision Making.*
12. **Pardo, S. T.** & dickey, l. m. (in preparation). New applications of the Hoffman Gender Scale in transgender and gender nonconforming populations. *Psychology of Men and Masculinities.*
13. Green, R-J., & **Pardo, S. T.** (in preparation). Predictors of depression and relationship satisfaction among individuals in same-sex domestic partnerships. *Journal of Family Psychology*
14. Green, R.-J., & Bergman, K., **Pardo, S. T.,** & Caldwell, Z. (in preparation). Surrogates who help gay men become parents via gestational surrogacy: Personality characteristics, motivations, life histories, and satisfaction with the experience.
15. Green, R-J., & **Pardo, S. T.** (in preparation). Predicting which same-sex couples will marry and assessing the impact of marriage on their relationships and well-being.

16. Green, R.-J., **Pardo, S. T.,** & Bergman, K. (in preparation). Prospective study of motivations and experiences of women who help gay men become parents via surrogacy.
17. Green, R.-J., Rubio, R.J., & **Pardo, S. T.** (in preparation). Comparing families formed via surrogacy by gay male couples versus families formed via surrogacy by heterosexual couples: Children's behavioral outcomes, family processes, and social support.

PRESENTATIONS

1. **Pardo, S.,** Wilkinson, W., & Baker, K. (2019, April). Advancing sexual orientation and gender identity cultural humility in public health care: Policy, research, and practice strategies. Oral Presentation at the 2019 UCSF National Transgender Health Summit, Oakland, CA.
2. Srinivasa, D., **Pardo, S.**, Zevin, B., graham, j., Rapues, J., Pomerantz, J., Kim, E., & Terry, M. (2019, April). Establishing the first government funded transgender program for an uninsured population: A 5-year review of the San Francisco General Hospital Experience. Oral Presentation at the 2019 UCSF National Transgender Health Summit, Oakland, CA.
3. Zevin, B., Rapues, J., Dao, T., Aguilar, K., Hower, M., Warner, L., **Pardo, S.,** & Bien, M. (2019, April). Gender health in public health: Gender Health SF and the system of care. Mini-Symposia presentation at the 2019 UCSF National Transgender Health Summit, Oakland, CA.
4. **Pardo, S.** (2018, August). Any door is the right door: Addressing the service gaps of sexual orientation and gender identity data collection in a complex public health system in San Francisco, CA. L. Alie (Chair). Four models of integrated transgender health care: Making the model fit the needs of a community. Symposium accepted for oral presentation at the American Psychological Association Annual Meeting, San Francisco, CA
5. graham, j. & **Pardo, S.** (2018, February). Gender Health SF: Evaluation Update. Oral Presentation to the Health Commission of the San Francisco Department of Public Health, San Francisco, CA.
6. **Pardo, S.,** Taylor, J.T., & Illing, S. (2017, November). Advancing publicly-funded transition-related care: Holistic support for surgery access, preparation, and recovery. Oral Presentation at the UCSF Transgender Center of Excellence Transgender Health Summit, Oakland, CA.
7. **Pardo, S.** & Baker, K. (2017, November). Sexual orientation and gender identity data collection at the San Francisco Department of Public Health. Oral Presentation at the UCSF Transgender Center of Excellence Transgender Health Summit, Oakland, CA.
8. Aguilar, K., Patterson, K, Roh, R., Dao, L., Hower, M., graham, j., Zevin, B., & **Pardo, S.** (2017, November). Bridging the gap: Utilizing professional patient navigators to support patients seeking gender affirming surgeries. Oral Presentation at the UCSF Transgender Center of Excellence Transgender Health Summit, Oakland, CA.
9. **Pardo, S.** (2017, April). How to conduct focus groups. Presentation to the Mental Health Services Act IMPACT Group, San Francisco Department of Public Health, San Francisco, CA
10. **Pardo, S.** (2017, February). Quality of life, mental health, and baseline demographics of patients served by Transgender Health Services Surgery Access Program. Oral Presentation. USPATH. Los Angeles, CA.
11. **Pardo, S.,** Keo-Meier, S. C., Olson, J. (2017, February). Social transition and systemic clinical care of pre-pubertal transgender and gender non-conforming children. Mini-Symposium. USPATH. Los Angeles, CA
12. Keo-Meier, C., **Pardo, S.,** & Olson-Kennedy, J. (2016, August). TYFA Research Study: Parents reporting on experiences of trans youth. Oral Presentation. Gender Odyssey Family. Seattle, WA.
13. **Pardo, S.** (2016, May). Advancing Trans* Health: Public Health innovations, existing challenges, and best practices. Oral Presentation. Forum on Human Sexuality. California Institute for Integral Studies, San Francisco, CA.

14. **Pardo, S.** (2016, April). Focus groups: A "How To." Presentation to the Mental Health Services Act IMPACT Group, San Francisco Department of Public Health, San Francisco, CA
15. **Pardo, S.** (2016, April). Transgender Health Services: Program Review & Evaluation Update. Presentation to the Mental Health Services Act Advisory Group, San Francisco Department of Public Health, San Francisco, CA.
16. **Pardo, S.** (2016, March). Transgender Health Services: Evaluation Update. Presentation to the Mental Health Services Act Providers Group, San Francisco Department of Public Health, San Francisco, CA.
17. graham, j. & **Pardo, S.** (2016, March). Transgender Health Services: Evaluation Update. Oral Presentation to the Health Commission of the San Francisco Department of Public Health, San Francisco, CA.
18. Hjord, H., **Pardo, S.** & Morrow-Hall, G. (2016, January). Minority AIDS Initiative-Targeted Capacity Expansion Program (MAI-TCE) Final Report. Oral presentation at the San Francisco Department of Public Health, Population Health Division, Community Health Equity & Promotion Branch, San Francisco, CA.
19. Morrow-Hall, G., Hjord, H. K., Matheson, T., **Pardo, S.,** Geckeler, D., Rose, M., & Packer, T. (2015, December). Introducing a Single Session Intervention Program (SIP) for Binge Drinking Gay and Bisexual Men of Color in San Francisco. Oral presentation at the 2015 National HIV Prevention Conference, Atlanta, GA.
20. Rapues, J., Calma, N., & **Pardo, S.** (2015, September). Broadening the horizon on transgender HIV prevention efforts: How San Francisco utilizes the spectrum of prevention to advance trans health within a HIP framework. Workshop accepted for presentation at the 2015 United States Conference on AIDS, Washington, D.C. [withdrew presentation due to scheduling conflicts]
21. Hjord, H., **Pardo, S.,** Beahan, J., Geary-Stock, A., Geckeler, D., & Morrow-Hall, G. (2015, September). Retention in HIV care leading to viral suppression. Poster accepted for presentation at the 2015 United States Conference on AIDS, Washington, D.C.
22. Jadaszewski, S., **Pardo, S. T.,** Keo-Meier, C., Alto, K., & Levant, R. (2015, August). The relationship between gender ideologies and health behaviors of transgender and cisgender persons. Poster presented at the Annual Meeting of the American Psychological Association, Toronto, Canada.
23. Pateropoulos, T., **Pardo, S. T.,** & Porter, N. (2015, August). Mind-Body integration in psychotherapy: A call for empirical study and clinical competence. Poster presented at the Annual Meeting of the American Psychological Association, Toronto, Canada.
24. **Pardo, S. T.** (2015, July). Public health equity: Factors that promote healthy transgender communities. Invited Keynote at the InterAmerican Congress on Psychology, Lima, Peru.
25. **Pardo, S. T.** & Rapues, J. (2015, June). Building capacity for trans health services: Challenges, opportunities, and innovations in system integrations. Webinar presented for the Center for Learning and Innovation, Population Health Division, San Francisco Department of Public Health, San Francisco, CA. http://getsfcba.org/event/building-capacity-for-trans-health-services/
26. Keo-Meier, C., **Pardo, S. T.,** Olson, J., & Sharp, C. (2015, June). Results from the TransYouth Family Allies (TYFA) research study of parents of trans youth. Workshop presented at the Philadelphia Trans Health Conference, Philadelphia, PA.
27. Beahan, J., **Pardo, S. T.,** Morrow-Hall, G., Hjord, H., Adams, L., Geary-Stock, A., & Zimmerman, A. (2015, May). Integrated behavioral health services in HIV care and prevention. Poster accepted for presentation at the 2015 National Health Care for the Homeless Conference & Policy Symposium.
28. Hjord, H., **Pardo, S. T.,** Morrow-Hall, G., Adams, L., Beahan, J., Geary-Stock, A., & Zimmerman, A. (2015, April). The HIV-Informed Model: San Francisco Department of Public Health's Best Practices for Integrated Primary Care Behavioral Health. Poster accepted for presentation at the 2015 National Council for Behavioral Health Conference and Summit.

29. Alvarez, M. E., Baig, M., Castro, D. Keatley, J. G., Margolis, M., McLeod, M., Najarian, G., **Pardo, S.**, Rapues, J., Rendon, J. G., Shockey, J., & Vincent, T. (2015, April). Building capacity of health systems to sustain trans-inclusive HIV prevention and care services. Oral Presentation at the UCSF Transgender Center of Excellence Transgender Health Summit, Oakland, CA.
30. Jadaszewski, S., Levant, F., **Pardo, S. T.,** Keo-Meier, C., Alto, K., & Richmond, K. (2015, March). How does our understanding of gender identity development affect research with trans and cisgender populations? Paper accepted for presentation at the Undergraduate and Graduate Conference of the Committee for Research on Women & Gender, Akron, OH.
31. Gunther, S. & **Pardo, S.** (2015, February). Exploring the Pencil Tapping Task: Analyzing Receptive Vocabulary and Obedience as Correlates of Inhibitory Control. Poster accepted for presentation at the 43rd Annual Meeting of the International Neuropsychological Society, Denver, CO. Abstract 2082518
32. Reisner, S.L., **Pardo, S.T.,** Gamarel, K.E., White, J.M., Pardee, D., Meier, S.C. (2014, November). Experiences of stigma in healthcare among U.S. trans masculine adults: A gender minority stress model of substance use to cope with mistreatment. Oral Presentation, 142nd Annual American Public Health Association Annual Meeting and Exposition, New Orleans, LA. Abstract 301110
33. Keo-Meier, C., **Pardo, S.,** & Reisner, S. (2014, October). Sexual fluidity in trans men. Paper presented at the Australia and New Zealand Professional Association for Transgender Health's Biennial Symposium in K. Glanney (Chair) *Hot Topics* in Adelaide, South Australia, Australia.
34. Keo-Meier, C., Herman, L., Reisner, S., **Pardo, S.,** Sharp, C., & Babcock, J. (2014, October). The positive impact of testosterone on mental health in trans men. Paper presented at the Australia and New Zealand Professional Association for Transgender Health's Biennial Symposium in K. Glanney (Chair) *Hot Topics* in Adelaide, South Australia, Australia.
35. Anderson, A. W., Bergman, K., Green, R-J., & **Pardo, S. T.** (2014, August). Motivations, decision making, and MMPI-2 scores of surrogates willing to help gay men become parents. Poster presented at the American Psychological Association Annual Meeting, Washington, DC.
36. Green, R-J., **Pardo, S. T.,** Rubio, R.J., & Katuzny, K. (2014, August). Same-sex couples: Five year predictors of getting married, staying unmarried, or breaking up. In Same-Sex Couples - Marriage Matters. Symposium presented at the American Psychological Association Annual Meeting, Washington, DC.
37. Martinez, M. X., **Pardo, S.,** Reiter, R., & Kruza, P. (2014, August). Principles for Collecting, Coding, and Reporting Identity Data: Sexual Orientation Guidelines. Presentation to the San Francisco Department of Public Health Health Commission August 5, 2014, San Francisco, CA.
38. Martinez, M. X., Reiter, R., **Pardo, S.,** Rapues, J., & Kruza, P. (2014, July). Principles for Collecting, Coding, and Reporting Identity Data: Ethnicity, Sex and Gender, Sexual Orientation. Presentation to the San Francisco Department of Public Health San Francisco Health Network Executive Leadership Team, July 28, 2014, San Francisco, CA.
39. **Pardo, S.,** Green, R-J., & Schulman, J. (2014, May). Predictors of depression and relationship satisfaction among individuals in same-sex domestic partnerships. In Mental Health in Heterosexual and Same-Sex Couples with Varying Legal Statuses (S.T. Pardo & R-J. Green, co-chair). Paper presented at the Association for Psychological Science, San Francisco, CA.
40. **Pardo, S.,** Handleman, M., Balsam, K., Rothblum, E. (2014, May). Mental health in heterosexual and same-sex couples with varying legal statuses (**S. T. Pardo** & R-J Green co-chairs). Symposia presented at the Association for Psychological Science, San Francisco, CA.
41. Valencia, J. & **Pardo, S. T.** (2014, May). Positive relationships between gluten-free/casein-free diet and autism spectrum symptoms. Poster presented at the Association for Psychological Science, San Francisco, CA.
42. Meier, S.C., **Pardo, S.,** Reisner, S., & Herman, L. (2013, May). Shifts in sexual attractions in transitioning FTM trans men: Evidence from recalled cross-sectional and prospective longitudinal studies. Paper presented at the National Transgender Health Summit in Oakland, CA.

43. Meier, S.C., Reisner, S., **Pardo, S.,** & Herman (2013, May). Testosterone treatment in trans men leads to MMPI-2 improvements. Paper presented at the National Transgender Health Summit in Oakland, CA.
44. Rapues, J. J., Martinez, M. X., **Pardo, S. T.,** Reiter, R. & Zevin, B. (2013, March). Principles for collecting, coding, and reporting social identity data: Sex and gender guidelines, Presentation to the Health Commission, San Francisco Department of Public Health, San Francisco, CA.
45. **Pardo, S. T.** (2013, January). Special topics on transgender identities: Supporting students across the gender spectrum. Invited lecture for monthly colloquium, Weiland Health Initiative, Vaden Health Center, Stanford University, Palo Alto, CA.
46. Romer, A., Reyna, V., & **Pardo, S.** (*2012, March*). Fuzzy-trace theory explains effects of impulsivity on adolescent risk-taking behaviors: A gist for risk. Poster presentation for the 2012 Society for Research on Adolescents Biennial Meeting, Vancouver, British Columbia, Canada.
47. Reyna, V. F., Wilhelms, E. A., Brust, P. G., Sui, W., **Pardo, S. T.,** & Corbin, J. C. *(*2011, November*).* Delay discounting and reward sensitivity: A fuzzy trace theory approach. Poster presentation for the Annual Meeting of the Society for Judgment and Decision Making, Seattle, WA.
48. Reyna, V. F., Hsia, A., Chick, C., & **Pardo, S. T.** *(*2011, November*).* Are Professional Risk Takers Less Susceptible to Framing Effects? A Comparison of Law Enforcement Professionals and Laypeople. Poster presentation for the Annual Meeting of the Society for Judgment and Decision Making, Seattle, WA.
49. Reyna, V. F., Kharmats, A., & **Pardo, S. T.** (2011, November). Improving health outcomes for adolescents using social cognitive theory and goal setting: A randomized control trial of the EatFit curriculum. Paper selected for oral presentation at the Annual Meeting of the Society for Judgment and Decision Making, Seattle, WA.
50. Romer, A., Reyna, V. R., & **Pardo, S. T.** (2011, November). Gist for Risk: Link Between Impulsivity and Fuzzy-Trace Theory Explanations of Adolescent Risk Behavior. Poster presentation at the 45th Annual Convention of the Association for Behavioral and Cognitive Therapies, November 10-13, 2011, Toronto, Canada.
51. Wilhelms, E. A., Brust, P. G., Reyna, V. R., **Pardo, S. T.,** & Sui, W. (2011, October). Reward sensitivity, temporal discounting, gender and risky health behaviors: A fuzzy-trace theory approach. Paper selected for oral presentation at the 33rd Annual Meeting of the Society for Medical Decision Making, Chicago, IL.
52. **Pardo, S. T.** (2011, September). Sexual orientation, behaviors, and identity among gender nonconforming natal females and transmen. In K. Rachlin, (Chair) *TransMasculine Sexuality & Relationships: Current Research and New Theory*. Symposium presented at The World Professional Association for Transgender Health Biennial Symposium, September 2011, Atlanta, GA.
53. Meier, S., **Pardo, S. T.,** Labuski, C., & Babcock, J. (2011, September). Sexual orientation and clinical health outcomes among female to male transsexuals. In K. Rachlin, (Chair) *TransMasculine Sexuality & Relationships: Current Research and New Theory*. Symposium presented at The World Professional Association for Transgender Health Biennial Symposium, September 2011 Atlanta, GA.
54. **Pardo, S. T.** & Reyna, V. F. (2011, August). Identity, threat, and medical decision making. Poster presented at the 119th Annual Convention of the American Psychological Association, August, 2011, Washington, DC.
55. **Pardo, S. T.** & Reyna, V. F. (2011, May). Gender identity, fuzzy trace theory, and medical decision making. Poster presentation at the 23rd Annual Convention of the Association for Psychological Science, May 26-29, 2011, Washington, DC.

56. Reyna, V. F., **Pardo, S. T.,** Rahman, S. H., Portenoy, A., Nollet, Z., Su, A., Alam, A., Suh, A. Chaudhry, S. (2011, May). Risk and rationality in the emergency department. Poster presentation at the 23rd Annual Convention of the Association for Psychological Science, May 26-29, 2011, Washington, DC.

57. Liberali, J. M., Reyna, V. F., Furlan, S., & **Pardo, S. T.** (2011, May). Individual differences in numeracy and cognitive reflection: Fallacies in probability judgment. Poster presentation at the 23rd Annual Convention of the Association for Psychological Science, May 26-29, 2011, Washington, DC.

58. Reyna, V. F., Wilhelms, E. A., Brust, P. G., Sui, W., & **Pardo, S. T.** (2011, May). The role of individual differences in risky decision making. Poster presentation at the 23rd Annual Convention of the Association for Psychological Science, May 26-29, 2011, Washington, DC.

59. Reyna, V., **Pardo, S.,** Booker, K., Davis-Manigaulte, J., Luc, M., Gonzales, E., et al., (2011, April). Interventions to reduce risky decision-making in adolescents. Poster presented at the Conference of the Applied Research and Extension Program Council. Cornell University, Ithaca, NY.. Cornell University, Ithaca, NY.

60. **Pardo, S. T.** (2011, February). Special topics on transgender student experiences: Promoting authenticity, resilience, and how to thrive as a student at Cornell. Continuing Education Workshop, Gannett Health Services, Cornell University, Ithaca, NY.

61. Furlan, S., Liberali, J. M., **Pardo, S. T.,** Stein, L. M., Reyna, V. F., & Chick, C. (2010, November). Inhibition ability: A modulator in the normative-intuitive mismatch. Poster presented at the 51st Annual Meeting of The Psychonomic Society, St. Louis, MO.

62. Liberali, J. M., Furlan, S., Reyna, V. F., Stein, L. M., & **Pardo, S. T.** (2010, November). People with lower numeracy and cognitive reflection scores show higher occurrence of judgment fallacies. Poster presented at the Annual Meeting of the Society for Judgment and Decision Making, St. Louis, MO.

63. Liberali, J. M., Reyna, V. F., Stein, L. M., & **Pardo, S. T.** (2010, November). Remembering is judging as more probable. Poster presented at the Annual Meeting of the Society for Judgment and Decision Making, St. Louis, MO.

64. Liberali, J. M., Reyna, V. F., **Pardo, S. T.,** Furlan, S., & Stein, L. M. (2010, November). Is the cognitive reflection test just another numeracy test? Poster presented at the Annual Meeting of the Society for Judgment and Decision Making, St. Louis, MO.

65. **Pardo, S. T.**, Reyna, V. R., Rahman, S., Portenoy, A. (2010, October). Prediction of cardiac outcomes by physicians vs practice guidelines. Paper presented at the 32nd Annual Meeting of the Society for Medical Decision Making, Toronto, Ontario, Canada.

66. **Pardo, S. T.** (2010, August). Sexual orientation, gender identity, and medical decision making. In V. Munoz (Chair), Intersectionalities and the Future of Lesbian, Gay, Bisexual, and Transgender Health and Well Being: 30th Anniversary of the Committee for Lesbian, Gay, Bisexual, and Transgender Concerns. Symposium presented at the 118th Annual Convention of the American Psychological Association, San Diego, CA.

67. Allie, L., Meier, S. C., & **Pardo, S. T.** (2010, August). Transgender Youth and Families. Conversation Hour at the 118th Annual Convention of the American Psychological Association, San Diego, CA.

68. Reyna, V. F., Mills, B. A., Goldman, D. A., **Pardo, S. T.**, Smith, M., & Reith, G. (2010, April). Gist-based conceptions of risk in adolescent alcohol consumption: A fuzzy-trace theory approach. Poster presented at the 31st Annual Meeting & Scientific Sessions of the Society of Behavioral Medicine (SBM), Seattle, Washington.

69. Reyna, V. F., Mills, B. A., **Pardo, S. T.,** Shreck, E., Romer, A., Smith, M., Lyons, C., Polla, D., Cook, N. (2010, March). Explaining contradictory relations between risk perception and risk taking: A fuzzy-trace theory approach. Poster presented at the Society for Research on Adolescence, Philadelphia, PA.

70. Meier, S. C. & **Pardo, S. T.** (2010, February). The effects of hormonal gender affirmation treatment on mental health in female to male transsexuals. Symposium presented at the Gay and Lesbian Affirmative Psychotherapy (GLAP) 2nd Annual Trans-Clinical Symposium, New York, NY.

71. **Pardo, S. T.,** Reyna, V. F., Mills, B. A., Shreck, E., & Estrada, S. M. (2009, November). Verbatim and gist cues produce opposite relations between risk perception and risk taking: A fuzzy-trace theory approach. Paper presented at the Annual Meeting of the Society for Judgment and Decision Making, Boston, MA.

72. **Pardo, S. T.** & Reyna, V. F. (2009, November). Effects of identity on surgical risk-taking: Attitudes, risk perceptions and intentions. Poster presented at the Annual Meeting of the Society for Judgment and Decision Making, Boston, MA.

73. Estrada, S. M., Reyna, V. F., Mills, B. A., & **Pardo, S. T.** (2009, November). Mood and Reward Sensitivity in Children, Adolescents, and Adults: A Fuzzy-Trace Theory Approach. Poster presented at the Annual Meeting of the Society for Judgment and Decision Making, Boston, MA.

74. **Pardo, S. T.** & Reyna, V. F. (2009, October). Predictors of risk perception and choice in surgical decision making. Poster presented at the 31st Annual Meeting of the Society for Medical Decision Making, Los Angeles, California.

75. **Pardo, S. T.** (2009, August). Making tough decisions: Risk perception and rationality in surgical decision-making. Poster presented at the 117th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada.

76. Haroon, M. & **Pardo, S. T.** (2009, August). HIV risk factors in trans-feminine populations. Poster presented at the 117th Annual Convention of the American Psychological Association, Toronto, Canada.

77. **Pardo, S. T.** (2009, August). Identity as a predictor in risk perception in surgical decision-making. In Hamilton, S. (chair), The intersections of transgender and racial identities. Symposium at the 117th Annual Convention of the American Psychological Association, August 6-9, 2009, Toronto, Ontario, Canada.

78. Hall, A., Famula, M., Gorton, R. N., **Pardo, S. T.** (2009, May). Providing trans-specific health care to transgender students in the college health setting. Symposium presented at the American College Health Association Annual meeting, San Francisco, CA.

79. **Pardo, S. T.** & Reyna, V. F. (2009, May). Identity is an Independent Predictor of Risk Perception but not Choice. Poster presented at the Association for Psychological Science Annual Convention, San Francisco, CA.

80. **Pardo, S. T.** (2008, August). Sexual orientation, behaviors, and identity among gender nonconforming natal females. In R. Fox (Chair), Current research on bisexuality: Identity, behavior, prejudice, and well-being. Symposium presented at the 116th Annual Convention of the American Psychological Association, Boston, MA.

81. **Pardo, S. T.** (2008, August). Partners of Trans. Division 44 Roundtable presented at the 116th Annual Convention of the American Psychological Association, Boston, MA.

82. Suitor, J. J., Plikuhn, M., **Pardo, T.**, & Pillemer, K. (2007, November). The role of parental favoritism in childhood and adulthood on siblings' closeness and conflict in midlife. Symposium

presented at the 60th Annual Scientific Meeting of The Gerontological Society of America, San Francisco, CA

83. **Pardo, T.** (2007, August). The Development of Gender Identity: A Mixed-Method Approach. In L. Moissianac (Chair), Reflecting reflexivities in time: Process findings in LGBT identity development. Symposium presented at The 115th Annual Convention of the American Psychological Association, San Francisco, CA.

84. **Pardo, T.** (2007, August). Identity conceptualization and development in a sample of gender nonconforming biological females. Symposium presented at the 115th Annual Convention of the American Psychological Association, San Francisco, CA.

85. **Pardo, T.** (2007, April). Towards a New Model of Transgender Identity Development. Symposium presented at the 21st International Foundation for Gender Education Annual Meeting: Transgender 2007, Philadelphia, PA.

86. **Pardo, T.** (2007, March). Gender variance: Towards a new model of gender identity development. In Transgender Issues: Identity, resilience, and safe spaces in the University. Symposium presented at the 32nd Annual Conference of the Association for Women in Psychology Annual Meeting, San Francisco, CA.

87. **Pardo, T.** (2007, January). Multiple Identities: Conceptualizations of Gender in Gender Variant Natal Females. Poster presented at the National Multicultural Conference and Summit, Seattle, WA.

88. Hamilton, S., Moradi, B., **Pardo, T.** (2006, August). Transgender Mentorship and Research: Practical Issues in LGBT Research. Round table presented at the 114th Annual Convention of the American Psychological Association, New Orleans, LA.

89. **Pardo, T.**, Baldassano, C.F., Zablotsky, B., Ghaemi, S.N. (2005, May). Safety and efficacy of zonisamide in the treatment of bipolar depression. Poster presented at the 158th Annual Meeting of the American Psychiatric Association, Atlanta, GA.

90. Zablotsky, B., Baldassano, C.F., **Pardo, T.**, Ghaemi, S.N. (2005, May). Effects of zonisamide on weight and sexual function in bipolar depression. Poster presented at the 158th Annual Meeting of the American Psychiatric Association, Atlanta, GA.

91. **Pardo, T.**, Baldassano, C.F., Zablotsky, B., & Ghaemi, S.N. (2005, March). Safety and efficacy of zonisamide in the treatment of bipolar depression. Poster presented at the Mysell Harvard Research in Psychiatry Annual Meeting, Boston, MA.

92. **Pardo, T.**, Baldassano, C.F., Zablotsky, B., & Ghaemi, S.N. (2004, June). Safety and efficacy of zonisamide in the treatment of bipolar depression. Poster presented at the 6th International Conference on Bipolar Disorders, Pittsburgh, PA.

93. **Pardo, T.**, Ghaemi, S.N., El-Mallakh, R.S., Baldassano, C.F., Ostacher, M.M., Hsu, D.J. Soldani, F., Hennen, J., Sachs, G.S., Baldessarini, R.J., & Goodwin, F.K. (2004, March). Does antidepressant discontinuation have an impact on time in remission? Poster presented at the Mysell Harvard Research in Psychiatry Annual Meeting, Boston, MA.

94. Manwani, S., **Pardo, T.**, & Ghaemi, S.N. (2004, May). Bipolar Disorder, Substance-Abuse, and Antidepressant Induced Mania. Poster presented at the 157th Annual Meeting of the American Psychiatric Association, New York City, NY.

95. Ghaemi, S.N., El-Mallakh, R.S., Baldassano, C.F., Ostacher, M.J., Hsu, D.J., **Pardo, T.**, Soldani, F., Rosenquist, K.J., Ko, J.Y., Borrelli, D., Hennen, J., Sachs, G., Goodwin, F.K., & Baldessarini, R.J. (2004, May). Effects of Antidepressants on Long-Term Mood Morbidity in Bipolar Disorder. Poster presented at the 157th Annual Meeting of the American Psychiatric Association, New York City, NY.

96. **Pardo, T.**, Ghaemi, S.N., El-Mallakh, R.S., Baldassano, C.F., Ostacher, M.J., Hsu, D.J., Soldani, F., Rosenquist KJ, Ko JY, Borrelli D, Hennen J, Sachs G, Goodwin FK, & Baldessarini RJ. (2004, May). Effects of Antidepressants on Remission and Mood Episode Cycling in Bipolar Disorder. Poster presented at the 157th Annual Meeting of the American Psychiatric Association, New York City, NY.

97. Hsu DJ, Ghaemi SN, El-Mallakh RS, Baldassano CF, Ostacher MJ, **Pardo T**, Soldani F, Rosenquist KJ, Ko JY, Borrelli D, Hennen J, Sachs G, Goodwin FK, & Baldessarini RJ. (2004, May). Antidepressant Discontinuation and Mood Episode Relapse in Bipolar Disroder. Poster presented at the 157th Annual Meeting of the American Psychiatric Association, New York City, NY.

98. Joseph, R.C., Danforth, N., Goren, G.S., Kardos, M., Wyshak, G., Steingard, R.J., Rosenquist, K.J., Hsu, D.J., **Pardo, T.**, & Ghaemi, S.N. (2004, November). Diabetes and lipid profile risks with neuroleptics: 2-5 year outcome reanalysis. Poster presented at the 51st Annual Meeting of the Academy of Psychosomatic Medicine, San Marco Island, FL.

99. Ghaemi, S.N., El-Mallakh, R.S., Baldassano, C.F., Ostacher, M., Hsu, D.J., **Pardo, T.**, Hennen, J., Sachs, G.S., Baldessarini RJ, & Goodwin FK. (2003, December) Antidepressant treatment in bipolar depression: long-term outcome. Paper presented at the 42nd Annual Meeting of the American College of Neuropsychopharmacology, San Juan, Puerto Rico.

INVITED LECTURES

1. **Pardo, S.** (2017, March). Theory of change. Population Health Division Brown Bag, San Francisco Department of Public Health, San Francisco, CA.
2. **Pardo, S.** (2017, March). Transgender Health. Invited lecture at Mission Mental Health Clinic, San Francisco Department of Public Health, San Francisco, CA.
3. **Pardo, S. T.** & Kolesar, A. K. (2016, March). Gender and sexuality in cross-cultural contexts. Invited graduate lecture for Dr. Raksha Chandrashakar, Bangalore, India.
4. **Pardo, S. T.** (2015, November). Transgender health equity: Promoting wellness with equal access and cultural humility. Invited lecture at Mission Mental Health Clinic, San Francisco Department of Public Health, San Francisco, CA.
5. **Pardo, S.** (2015, November). Transgender Health in public health populations. Invited lecture at Mission Mental Health Clinic, San Francisco Department of Public Health, San Francisco, CA.
6. **Pardo, S. T.** (2015, March). Gender and Sexual identities: A mixed-method investigation of transgender identity narratives. Invited lecture for the California Institute of Integral Studies, San Francisco, CA.
7. Pardo, S. T. & Kolesar, A. K. (2015, March). Cross-cultural diversity in gender and sexuality. Invited graduate lecture for Dr. Raksha Chandrashakar, Bangalore, India.
8. **Pardo, S. T.** (2014, November). Transgender identities and lifespan development. Invited lecture at Mission Mental Health Clinic, San Francisco Department of Public Health, San Francisco, CA.
9. **Pardo, S. T.** (2012, February). Careers in Research Psychology. Invited Lecture for Career Colloquium, Foothill College, Los Altos Hills, CA.
10. **Pardo, S. T.** (2011, February). Gender identity development: Normative and gender non-conforming pathways in adolescence. Guest lecture presented for HD1170: Adolescence and Emerging Adulthood, Cornell University, Ithaca, NY.
11. **Pardo, S. T.** (2011, February). Gender identity, dual processes, and medical decision making. Guest lecture presented for HD6020: Research in Risk and Rational Decision Making, Cornell University, Ithaca, NY.
12. **Pardo, S. T.** (2010, October). Sex differences, gender-role development and sexuality. Guest lecture presented for HD2610: The Development of Social Behavior, Cornell University, Ithaca, NY.
13. **Pardo, S. T.** (2010, March). Transgender identity development. Guest lecture presented for HD1170: Adolescence and Emerging Adulthood, Cornell University, Ithaca, NY.
14. **Pardo, S. T.** (2010, February). SPSS: A "how to" for conducting empirical research analyses in human development. Guest lecture presented for HD3820: Research Methods in Human Development, Cornell University, Ithaca, NY.
15. **Pardo, S. T.** (2009, April). Transgender identity development: Current research from outside the clinician's office. Lecture presented at Sexpose, Cornell University, Ithaca, NY.
16. **Pardo, S. T.** (2009, February). Gender identity development in transgender populations. Guest lecture presented for HD2160: Adolescence and Youth, Cornell University, Ithaca, NY.
17. **Pardo, S. T.** (2009, February). Interventions for risk reduction and avoidance in youth. Guest lecture presented for HD4200: Laboratory in Risk and Rational Decision Making, Cornell University, Ithaca, NY.
18. **Pardo, S. T.** (2008, November). Transgender & Transsexuality. Guest lecture presented for HD3840: Gender & Sexual Minorities, Cornell University, Ithaca, NY.

19. **Pardo, S. T.** (2008, October). Social and emotional development. Guest lecture presented for HD115: Introduction to Human Development, Cornell University, Ithaca, NY.
20. **Pardo, S. T.** (2008, April). Towards a greater understanding of gender and sexual fluidity. Guest lecture presented for PSY170: Clinical Issues for LGBT, Duke University, Durham, NC.
21. **Pardo, S. T.** (2008, April). 'I know what I am, don't label me!': Towards a new understanding of gender and sexual fluidity. OUT for Lunch Lecture Series, Brown University, Providence, RI.
22. **Pardo, S. T.** (2008, March). Understanding fluidity: Gender and sexual identity milestones in transgender and gender nonconforming populations. Human Development Brown Bag Colloquium Series.
23. **Pardo, S. T.** (2008, January). I know what I am: Gender conceptualization, expression, and development in gender nonconforming natal females. Guest lecture presented for the YES Institute Education Week, January 18-21, Miami, FL.
24. **Pardo, S. T.** (2007, November). Transsexuality: Terminology, etiology, identity, and outcomes. Guest lecture presented for HD384 Gender and Sexual Minorities, Cornell University, Ithaca, NY.
25. **Pardo, S. T.** (2007, November). Identity development: Intersections of race and gender. Guest lecture presented for HD171 Black Families and Socialization of the Black Child, Cornell University, Ithaca, NY.
26. **Pardo, S. T.,** Corrall, E. & Dean, G. A. (2007, October). How to prepare and care for transgender patients. Gannett Health Center, Cornell University, Ithaca, NY.
27. **Pardo, S. T.** (2007, October). Social & Emotional development: Gender typing, gender role, and gender identity. Guest lecture presented for HD115 Introduction to Human Development, Cornell University, Ithaca, NY.
28. **Pardo, S. T.** (2007, July). Complications during fetal growth: Intersex conditions and ambiguous genitalia. Lecture presented for HD115 Introduction to Human Development, Cornell University, Ithaca, NY.
29. **Pardo, S. T.** (2007, April). Complications during fetal growth: Intersex conditions and ambiguous genitalia. Lecture presented for HD347 Human Growth and Development: Biological and Environmental Interactions, Cornell University, Ithaca, NY.
30. **Pardo, S. T.** (2007, February). Towards a New Model of Transgender Identity Development. Invited lecture presented at TransNYC, February 13, 2007, New York, NY.
31. **Pardo, T.** (2004, February). Examining Transgender, Transsexual, and Intersex Issues: A biopsychosocial approach. Invited Lecture for Psychology: Gender & Sexuality in Film, Department of Psychology, Northeastern University.

MEDIA

Pardo, S. (2018, November 27). 50 Shades of (Trans)Gender. Podcast for *The Science of Sex*, November 27, 2018.

Saracino, T. & Pardo, S. (2018, June 15). The Enneagram and Ego Development: New Research published in the Journal of Adult Development. Podcast for *The Enneagram Global Summit*, June 11-15, 2018.

Barba, M. (2016, March 16). More transgender residents in SF connected with in-demand surgeons. *San Francisco Examiner*. Retrieved online March 17, 2016 from http://www.sfexaminer.com/transgender-residents-sf-connected-demand-surgeons/

Buchholtz, L. (2015, November 3). Transgender care moves into the mainstream. *Journal of the American Medical Association (JAMA), 314*(7), 1785-1787. doi:10.1001/jama.2015.11043. Retrieved online November 5, 2015 from http://jama.jamanetwork.com/article.aspx?articleID=2463347

Author. (2015, May 27). Studies show positive mental health changes following gender reassignment surgery. *HookedSober Study Hall.* Retrieved online August 28, 2015 from http://www.hookedsober.com/study-hall/studies-show-positive-mental-health-changes-following-gender-reassignment-surgery-2/

Wolf, L. (2014, June 4). Wait! What? I had no idea! Well, how would you? An interview with Dr. Seth T. Pardo. *Teen Talking Circles*. Retrieved June 4, 2014 from http://teentalkingcircles.com/tag/seth-t-pardo/

Adler, E. (2014, February 8). 'I'm a girl': Transgender children face a society slow to accept them. *The Kansas City Star*. Retrieved October 28, 2014 from http://insurancenewsnet.com/oarticle/2014/02/08/i-am-a-girl-transgender-children-face-a-society-slow-to-accept-them-a-458245.html#.VFADcqKrDY8

Moskowitz, C. (2010, November 19). High suicide risk, prejudice plague transgender people. *livescience.* Retrieved November 19, 2010 from http://www.livescience.com/11208-high-suicide-risk-prejudice-plague-transgender-people.html Also available from: http://www.nbcnews.com/id/40279043/ns/health-health_care/#.Vd-slaLN4ng

Consortium of Higher Education LGBT Resource Professionals. (2009, March 23). Queer News On Campus. Retrieved online August 28, 2015 from http://queernewsoncampus.blogspot.com/2009/03/qnoc-digest-20090315.html

Aloi, D. (2009, March 11). Conference airs new approaches in transgender studies. Cornell Chronicle. Retrieved online March 12, 2009 from http://www.news.cornell.edu/stories/2009/03/transrhetorics-airs-new-approaches-growing-field

Berg, A. (2009, March 9). Conference explores new field of trans studies. The Cornell Daily Sun. Retrieved online March 12, 2009 from http://cornellsun.com/blog/2009/03/09/conference-explores-new-field-of-trans-studies/

Teproff, C. (2001, June 4). New Broward policy offers protection to transgender students. *The Miami Herald*. Retrieved June 4, 2011 from

http://www.miamiherald.com/2011/06/04/2251740/new-broward-policy-offers-protection.html

TEACHING

Course	Role	Enrollment
Lifespan Development	Course Instructor	varies, (max = 25)
LGBTQ Lifespan Development (online)	Course Instructor	varies, (max = 25)
Introduction to Developmental Psychology	Course Instructor	varies, (max = 30)
Organizational Psychology Research	Course Instructor	varies, (max = 15)
Research Methods in Clinical Psychology	Course Instructor	varies, (max = 15)
Human Sexuality	Course Instructor	varies, (max = 25)
Research Methods in Counseling Psychology	Course Instructor	varies, (max = 25)
Dissertation Research Cluster	Course Instructor	5 to 8
Adolescence and Youth	Section Instructor	varies, (max = 25)
The Development of Social Behavior	Section Instructor	varies, (max = 30)
Research in Risk & Rational Decision Making	Teaching Assistant	30
Memory and the Law	Teaching Assistant	35
Research Methods in Psychology	Teaching Assistant	35
Gender and Sexual Minorities	Teaching Assistant	250
Development of Social Behavior	Teaching Assistant	250
Human Growth and Development	Teaching Assistant	280
Introduction to Developmental Psychology	Teaching Assistant	300
Adolescence and Youth	Teaching Assistant	300

SERVICE & APPOINTMENTS

Local 21 Chapter Delegate, *San Francisco Department of Public Health, San Francisco, CA* 2018 - present

Community Research Advisor, *California Reducing Disparities Project Phase II* 2017 - present

Behavioral Health Services Lead Coordinator
Committee on Sexual Orientation and Gender Identity (SOGI) Data Collection
San Francisco Department of Public Health, San Francisco, CA 2016 - present

Co-Investigator, *PrEP-T: Advancing PrEP Delivery in the Transgender Community (with Albert Liu, MD, Erin Wilson, PhD, Susan Buchbinder, MD, Joseph Pace, MD, Tri Do, MD, Zettie Page, MD, PhD, and Eric Vittinghoff, PhD, Co-Principal Investigators)* San Francisco Department of Public Health, San Francisco, CA. 2016 - present

Program Coordinator, *SFDPH Quality Management Research and Evaluation Internship Program in affiliation with CSPP Alliant International University Clinical Psychology PhD Program* 2016 - present

Chair, *Committee on Sexual Orientation and Gender Diversity*
American Psychological Association, Washington, D.C. 2017

Board Member, *Committee on Sexual Orientation and Gender Diversity*
American Psychological Association, Washington, D.C. 2015 - 2017

National Advisory Board, *UCSF National Transgender Center of Excellence*
University of California San Francisco, San Francisco, CA. 2015 - present

Co-Chair, *Transgender Advisory Group*

San Francisco Department of Public Health, San Francisco, CA.	2015 - 2017
Lead Evaluator, *Minority AIDS Initiative – Targeted Capacity Expansion* San Francisco Department of Public Health, CA.	2012 - 2015
Advisory Board, *Project AFFIRM (Allen LeBlanc, PhD, Principal Investigator)* San Francisco State University, San Francisco, CA.	2014 - present
Reviewer	
LGBT Health	2016 - present
Transgender Health	2015 - present
International Journal of Transgenderism	2015 - present
Journal of Gay & Lesbian Mental Health	2015 - present
Abstracts for presentation at the American Psychological Assn. Annual Meeting	2015 - present
Journal of GLBT Family Studies	2013 - present
Journal of Homosexuality	2012 - present
Abstracts for presentation at the Society for Medical Decision Making Annual Meeting	2011 - 2013
Journal of Sex Research	2010
Journal of Consulting and Clinical Psychology	2007 – 2008
Adjunct Instructor, *Sofia University* (Formerly the Institute for Transpersonal Psychology), Palo Alto, CA.	2013 - 2014
Adjunct Professor. *Department of Business Psychology, Palo Alto University* Los Altos Hills, CA Palo Alto, CA.	2012
Postdoctoral Research Fellow, *Rockway Institute for LGBT Psychology & Public Policy* Alliant International University, San Francisco, CA.	2011 - 2012
Research Consultant & Data Analyst, *Equality California* LGBTQ Reducing Disparities Project	2011 - 2012
Laboratory Leader & Research Associate, *Laboratory for Rational Decision Making* Department of Human Development, Cornell University Ithaca, NY	2009 - 2011
Consultant on LGBT Student Health Concerns, *Board University Health Services* Cornell University, Ithaca, NY	2009 - 2011
Graduate Student Assistant, *Lesbian, Gay, Bisexual, & Transgender Studies Program* Cornell University, Ithaca, NY	2009 - 2011
Lecturer Department of Human Development, Cornell University, Ithaca, NY	2008
Vice Chair, *Board of Directors* Association for Gender Research, Education, Academia, and Action (AGREAA)	2007 - 2009
Graduate Student Chair, *University Assembly* Cornell University, Ithaca, NY	2008 - 2009
Graduate Student Representative, *Subcommittee on Academic Integrity* University Assembly, Cornell University, Ithaca, NY	2007 - 2009
Department Representative (Human Development)	2006 - 2009
Assembly Member *Graduate & Professional Student Assembly*, Cornell University, Ithaca, NY	2007 - 2009
Research Assistant, *Bronfenbrenner Life Course Center*	

Department of Human Development, Cornell University, Ithaca, NY	2006 - 2008
Graduate Student Committee Representative (Alternate) Department of Human Development, Cornell University, Ithaca, NY	2006 – 2007
Associate in Psychiatry, *Adult Psychopharmacology & Mood Disorders* Harvard Medical School, Cambridge, MA	2003 - 2005
Research Coordinator, *Bipolar Disorder Research Program* Cambridge Health Alliance, Cambridge, MA	2003 - 2005
Research Assistant Department of Psychology, Duke University, Durham, NC	2003
Research Assistant, *Duke University Pain Research Center* Department of Psychiatry, Duke University Medical Center, Durham, NC	2001 - 2003

AWARDS AND HONORS

Health Equity Dissemination Award. $6,000 awarded for dissemination of the Transgender Practice Guidelines Best Practices, Public Interest Directorate, American Psychological Association. 2016.

Mental Health Services Act Community Development Wellness Grant. $5,000 awarded for Transgender Health Sensitivity Training Initiative, San Francisco Department of Public Health. July 2016.

Small Community Development Grant Award. $10,250 awarded for website development and transgender cultural humility training initiative, Transgender 101 Training Initiative, San Francisco Department of Public Health. July, 2014.

Lee Lusted Award Finalist. Society for Medical Decision Making for scientific merit of submitted conference abstract, Notified 8/11.

Conference Travel Grant. $180 awarded to Seth Pardo 8/11 to present at the World Professional Association for Transgender Health Biennial Conference.

Conference Travel Grant. $420 awarded 4/11 to Seth Pardo from the Center of Excellence for Transgender Health.

Graduate Research Fellowship, funded by a grant from United States Department of Agriculture, *Reducing Risk Taking in Adolescence Using Gist-Based Curricula*, to Valerie Reyna, PI. Approximately $7,300 awarded to Seth Pardo, Summer 2011.

Graduate Research Fellowship, funded by a grant from National Institute for Health, *Low-Burden Tools for Improving Prediction and Diagnosis of Cognitive Impairment*, to Valerie Reyna, PI. Approximately $12,000 awarded to Seth Pardo, Spring 2011.

Graduate Research Fellowship, funded by a grant from United States Department of Agriculture, *Reducing Risk Taking in Adolescence Using Gist-Based Curricula*, to Valerie Reyna, PI. Approximately $7,300 awarded to Seth Pardo, Summer 2010.

Graduate Teaching Fellowship, funded by the Department of Human Development, College of Human Ecology, Cornell University, Ithaca, NY. Approximately $24,000 awarded annually to Seth Pardo, 2005-2010.

Human Ecology Alumni Association Research Scholarship, funded by the Human Ecology Alumni Association, College of Human Ecology, Cornell University, Ithaca, NY. $300 awarded to Seth Pardo towards the completion of my dissertation, April 2010.

Knight Institute Fellowship for Writing in the Disciplines, funded by a grant from the College of Arts

and Sciences, Cornell University, Ithaca, NY. Approximately $12,000 (for tuition and stipend) awarded to Seth Pardo, Spring 2010.

Conference Travel Grant. $420 awarded 8/10 to Seth Pardo from the Graduate School, Cornell University, Ithaca, NY.

Graduate Research Fellowship, funded by a grant from United States Department of Agriculture, *Reducing Risk Taking in Adolescence Using Gist-Based Curricula*, to Valerie Reyna, PI. Approximately $7,000 awarded to Seth Pardo, Summer 2009.

Distinguished Volunteer Award, from the Graduate & Professional Student Assembly, Cornell University, Ithaca, NY, 2009

Invited Keynote Speaker. Lavender Graduation, Duke University, Durham, NC, 2008

Student Organizations Awards and Recognition (SOAR Award), from the Graduate & Professional Student Assembly, Cornell University, Ithaca, NY. 2008

Conference Travel Grant. $300 awarded 8/08 to Seth Pardo from the Department of Human Development, Cornell University, Ithaca, NY.

Conference Travel Grant. $300 awarded 8/07 to Seth Pardo from the Department of Human Development, Cornell University, Ithaca, NY.

Conference Travel Grant. $300 awarded 3/07 to Seth Pardo from the Graduate School, Cornell University, Ithaca, NY.

Master's Thesis Research Grant, funded by the Department of Human Development, Cornell University, Ithaca, NY, *An exploratory study of identity conceptualization and development in a sample of gender nonconforming biological females*, to Seth Pardo, PI. $1,300 awarded, 2006.

Conference Travel Grant. $300 awarded 8/06 to Seth Pardo from the Department of Human Development, Cornell University, Ithaca, NY.

Conference Travel Grant. $300 awarded 9/05 to Seth Pardo from the Department of Human Development, Cornell University, Ithaca, NY.

PROFESSIONAL MEMBERSHIPS

- American Psychological Association (APA); Division 44: Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
- Association for Psychological Science, Student Affiliate (APS)
- World Professional Association for Transgender Health (WPATH)
- Association for Gender Research, Education, Academia, and Action, Founding Member (AGREAA)

OTHER SKILLS

- Multilingual (Fluent in English; Proficient in Spanish, Portuguese)
- Fluent in SPSS, Proficient in STATA, Basic SAS; EndNote Software; MS Office; MS Access; Blackboard; Moodle; Canvas; Sharepoint; proficient HTML programming, A3 thinking, Lean 101.

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Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF FRANCES PARMELEE IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Frances Parmelee, declare:

1. I have served as the Assistant Vice Chancellor of College Finance and Facilities Planning Division with the California Community Colleges (CCC) since September 2016. In this role, I oversee and support the Budget Unit, Fiscal Services Unit, Fiscal Standards and Accountability Unit, and Facilities Planning Unit. Prior to joining the Chancellor's Office, I worked as an auditor, audit supervisor and audit manager with the Department of Finance for more than two decades. During this time, I led teams on a variety of financial and performance audits, as well as organization-wide professional development activities. I earned a Bachelor of Science degree in Business Administration, Accounting and Finance from California State University, Sacramento and am an active CPA.

2. The California Community Colleges (CCC) is the largest system of higher education in the nation, with 2.1 million students attending 115 colleges. With a wide range of educational offerings, the colleges provide workforce training, basic courses in English and math, certificate and degree programs and preparation for transfer to four-year institutions. The colleges thus play a critical rule in the state's public education system.

3. I am familiar with the final rule entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the Rule), published in the Federal Register on May 21, 2019.

4. The Rule places at risk federal funds CCC receives from the U.S. Department of Health and Human Services, the U.S. Department of Education, and the U.S. Department of Labor, if California is determined to be in violation of the Rule.

5. Federal funding comes to CCC from appropriations acts approved by Congress and signed by the president. The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Public Law 115-245, which was enacted September 28, 2019, makes appropriations that provide funding to CCC. In fiscal year 2018-2019, CCC received $83.4 million which may be at risk.

6. The following funding sources are at risk:

a. CalWORKs Services. These funds are 0.14% of the overall budget and used for the purpose of assisting welfare recipient students and those in transition off of welfare to achieve long-term self-sufficiency through coordinated student services offered at community colleges including: work study, job placement, child care, coordination, curriculum development and redesign, and under certain conditions post-employment skills training, and instructional services.

b. Foster Care Education Program. These funds are 0.11% of the overall budget and used for provide quality education and support opportunities to caregivers of children and youth in out-of-home care so that these providers may meet the educational, emotional, behavioral and developmental needs of children and youth in the foster care system.

c. Vocational Education. These funds are 1.15% of the overall budget and is aimed at increasing the quality of career technical education statewide.

7. In developing its budget, CCC does so in the expectation that it will receive the federal funds placed at risk under the rule, to which it is entitled under agreements with federal agencies. Based on this process, districts develop their budgets, provide fiscal guidance to its various departments, forecast revenues, and develop multi-year projections for its local boards. A sudden disruption in anticipated federal funds would cause immediate and long-term budgetary and operational chaos since CCC forecasts and plans out the budget for multiple years.

8. Loss of federal funding will have a deleterious impact on CCC. CCC will be unable to absorb such a large loss of funding without reducing staffing, programs, and services.

9. If CCC were to lose federal funding, students who rely on CalWORKS services, the Foster Care Education Program, and our Vocational Education programs would be impacted and would be less able to receive a quality education.

10. The Rule may also necessitate programmatic changes. For example, some colleges have a pre-nursing program requirement that states that all incoming nursing students need to have completed a series of immunizations/vaccinations (including some vaccinations that

the Rule appears to call into question, including MMR (Measles, Mumps & Rubella), Polio, and Varicella (chicken pox). If the community college has a course for pre-med or pre-nursing students wherein the students would be required to do training on vaccines or some other "procedure" that he/she finds objectionable, then the college could not require that the student "assist in the performance" of that procedure. The colleges would need to make changes to their programs to account for such refusals.

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

Executed on Sep 6, 2019 in Sacramento, CA.

Frances Parmelee (Sep 6, 2019)

Frances Parmelee
Assistant Vice Chancellor
California Community Colleges