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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION AND MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: July 17, 2019
Hearing Time: 1:00 p.m.

Trial Date: None Set

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NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION

PLEASE TAKE NOTICE that on July 17, 2019 or as soon thereafter as they may be heard before Magistrate Judge Nathanael M. Cousins, Plaintiffs will hereby and do move pursuant to Rule 65 of the Federal Rules of Civil Procedure and Civil Local Rules 7-2 and 65-2 for a preliminary injunction prohibiting Defendants from enforcing the Final Rule of the Department of Health and Human Services entitled Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. Pt. 88). Without an order from this Court, the Rule will take effect on July 22, 2019, and will cause Plaintiffs to suffer irreparable harm. This motion is based on this notice; the Memorandum of Points and Authorities; the Declarations of Lois Backus (Medical Students for Choice), Elizabeth Barnes (The Women's Centers), Robert Bolan (Los Angeles LGBT Center), Julie Burkhart (Trust Women Seattle), Bruce Butler (County of Santa Clara - Valley Health Plan), Ward Carpenter (Los Angeles LGBT Center), Sara Cody (County of Santa Clara), Darrel Cummings (Los Angeles LGBT Center), Randi Ettner (Plaintiffs' Expert), Roy Harker (AGLP: The Association of LGBTQ+ Psychiatrists), Sarah Henn (Whitman-Walker Health), Paul Lorenz (County of Santa Clara), Alecia Manley (Mazzoni Center), Colleen McNicholas (Trust Women Seattle), Ken Miller (County of Santa Clara's Emergency Medical Services Agency and EMS System), Phuong Nguyen (Santa Clara Valley Medical Center), Rachael Phelps (Medical Students for Choice), Randy Pumphrey (Whitman-Walker Health), Naseema Shafi (Whitman-Walker Health), Adrian Shanker (Bradbury-Sullivan LGBT Community Center), Narinder Singh (County of Santa Clara), Jill Sproul (County of Santa Clara), Toni Tullys (County of Santa Clara Behavioral Health Services Department), Modesto Valle (Center on Halsted), Hector Vargas (GLMA: Health Professionals Advancing LGBTQ Equality); this Court's file; and any matters properly before the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Plaintiffs challenge a regulation, promulgated by the Department of Health and Human Services ("HHS"), that sets out comprehensive new rules for accommodating religious objections in the healthcare context ("the Denial-of-Care Rule" or "Rule"). The Denial-of-Care Rule is

unlawful, and it will hurt people across the United States. This Court should enter a preliminary nationwide injunction to freeze the status quo rather than allowing the Rule to take effect.

Over a period of decades, Congress has adopted context-specific statutes to address individuals and entities that do not wish to participate in certain medical procedures or research based on religious or moral objections. These provisions exist against the backdrop of federal laws that protect access to medical treatment, ensure that patients can obtain the information necessary to give informed consent, and prohibit discrimination in the provision of healthcare services. Hospitals and other healthcare organizations have complied with those laws by carefully crafting policies that accommodate religious objections while ensuring that patients receive care.

The Rule completely upends the existing regime by elevating religious objections over the obligation to provide care, even in emergency situations. Through a number of prohibitions and extremely broad definitions, the Rule greatly expands both the universe of healthcare workers who may decline to serve patients based on religious objections, and the activities to which they may object. The Rule specifically invites individuals to refuse to provide care to women seeking reproductive healthcare and to lesbian, gay, bisexual, and transgender ("LGBT") individuals, especially transgender and gender-nonconforming patients seeking gender-affirming and transition-related care.

The Rule severely limits providers' ability to plan for denials of care based on employees' religious objections. Providers must make immediate policy and staffing changes to try to comply. And the Rule authorizes HHS to impose draconian penalties for noncompliance. If HHS believes that a provider (or any contractor or subrecipient of federal funding) has violated the Rule, it can cut off and claw back all of the provider's federal funding. Worst of all, the Rule has no exception for emergencies. Indeed, HHS expressly acknowledged that the Rule may result in patients being denied lifesaving care, but decided that accommodating religious objections was more important.

Health care organizations, doctors, and patients throughout the country will be severely and adversely affected by the Rule. Plaintiffs here are among them. Plaintiffs include the County of Santa Clara ("County"), which operates several hospitals, clinics, a Public Health Department, an emergency medical response system, a behavioral health department, and a health insurance plan;

five private healthcare facilities across the country that provide reproductive-health services and healthcare services for LGBT individuals; four individual physicians and a licensed counselor who work for these entities; three national associations of medical professionals; and two organizations that provide a wide range of services to the LGBT community. They share a common objective of maintaining an effective, functioning healthcare system, one that protects patients' right of access to health services and dignity while respecting healthcare workers' religion-based objections.

The Denial-of-Care Rule is a paradigmatic example of arbitrary and capricious agency action, because HHS failed to appropriately account for harm to patients or to address how providers can ensure continuity of care while complying with the Rule. It directly conflicts with existing federal laws prohibiting discrimination in healthcare and protecting access to care and information. And it goes well beyond the federal statutes on which it is purportedly based. The Rule also is unconstitutional because it favors religion over nonreligion and certain religious beliefs over others; jeopardizes access to reproductive and transition-related healthcare; fosters unlawful discrimination; chills protected expression; and exceeds Congress's Spending Clause authority. Plaintiffs, their members, and their patients will suffer irreparable, nationwide harm if the Rule goes into effect. This Court should enjoin the Rule.

STATEMENT OF FACTS

A. Congress's Consideration Of Religious Objections And The Needs Of Patients

A number of federal laws ensure that patients receive prompt and nondiscriminatory access to medical care. They include the Patient Protection and Affordable Care Act ("ACA"), which prohibits the Secretary of HHS from promulgating any regulation that impedes timely access to healthcare, creates unreasonable barriers to receiving care, or restricts the ability of providers to provide healthcare information to patients, 42 U.S.C. § 18114, and prohibits discrimination in the provision of healthcare services, 42 U.S.C. § 18116. They also include the Emergency Medical Treatment and Labor Act ("EMTALA"), which requires hospitals to either treat or transfer patients in unstable medical conditions. 42 U.S.C. § 1395dd(b)(1); *see* 42 U.S.C. § 18023(d) (reiterating that healthcare providers must "provid[e] emergency services as required by State or Federal law").

Against this backdrop, Congress has enacted statutes that prohibit discrimination against individuals and entities that refuse, based on religious beliefs or moral convictions, to participate in certain medical procedures, training, or research. HHS relies on those statutes as the basis for the Denial-of-Care Rule. Each statute was enacted to address a particular, limited context. None of them overrides the statutes that protect access to information and care; prohibit discrimination against patients; and require healthcare providers to treat patients in emergency situations.

For example, the Weldon Amendment addresses persons and entities who do not wish to participate in abortion care. It states that no funds appropriated under a particular appropriations statute "may be made available to a Federal agency or program, or to a State or local government," if the recipient "subjects any institutional or individual healthcare entity to discrimination on the basis that the healthcare entity does not provide, pay for, provide coverage of, or refer for abortions." Pub. L. 115-245, § 507(d)(1), 132 Stat. 2981, 3118 (2018). The Coats-Snowe Amendment addresses the more specific context of training to provide abortion. It states, among other things, that "[t]he Federal Government, and any State or local government that receives Federal financial assistance," may not discriminate against a healthcare entity because "the entity refuses to undergo training in the performance of induced abortions," "to require or provide such training," "to perform such abortions," "to provide referrals for such training or such abortions," or "to make arrangements" for them. 42 U.S.C. § 238n(a)(1), (a)(2).

The Church Amendments arose in the context of biomedical research. Among other requirements, they prohibit recipients of "biomedical or behavioral research" funds from discriminating against personnel because they performed or assisted in the performance of a research or healthcare activity, or refused to do so because of "religious beliefs or moral convictions." 42 U.S.C. § 300a-7(c)(2). They also prohibit recipients of certain federal funds from discriminating in employment against physicians or health care personnel because they "performed or assisted in the performance of a lawful sterilization procedure or abortion" or refused to do so, *id.* § 300a-7(c)(1), and prohibit recipients of certain federal funds from discriminating against applicants for training or study based on their "reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in abortions or sterilizations," *id.* § 300a-7(e). Finally,

they provide that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded . . . under a program administered by [HHS]" if the activity "would be contrary to his religious beliefs or moral convictions." *Id.* § 300a-7(d).[1]

Each of these statutes is carefully worded and narrowly drawn. None purports to extend an all-purpose religious-objection right to every person employed by a healthcare provider. And Congress has never suggested that religious objections take priority over the needs of patients or the healthcare system.

B. The Administration's Decision To Disrupt The Existing Scheme By Promulgating The Denial-of-Care Rule

The Trump Administration promulgated the Rule as the centerpiece of an aggressive plan to favor religious objectors over patients. On January 18, 2018, the Acting Secretary of HHS established a new Conscience and Religious Freedom Division in the agency's Office for Civil Rights ("OCR"). The next week, the Acting Secretary proposed the Rule. 83 Fed. Reg. 3880 (Jan. 26, 2018).

More than 242,000 comments were filed by medical associations, medical providers, civil-rights organizations, state and local governments, and others. *See* 84 Fed. Reg. 23,170, 23,180 & n.41 (May 21, 2019). Many of those comments were critical of the Rule. The comments explained that the Rule's expansive new provisions would upset well-developed practices by healthcare providers, medical schools, and other healthcare organizations that respect religious objections without compromising patient care. *E.g.*, American Medical Association ("AMA") Cmt. Ltr. 3, 5 (HHS-OCR-2018-0002-70564).[2] They also explained that the Rule conflicts with federal and state nondiscrimination and emergency-care laws, and that the Rule will cause providers to deny healthcare, including lifesaving care, to patients, particularly patients seeking reproductive healthcare and LGBT patients. *See, e.g.*, AMA Cmt. Ltr. 5-6; Cnty. of Santa Clara Cmt. Ltr. 4-8

[1] HHS cited a laundry list of statutes as potentially authorizing the Rule, 84 Fed. Reg. at 23,171-23,172; this motion addresses the regulatory provisions and statutes most relevant to Plaintiffs.

[2] All comments are available on the official "regulations.gov" website, under Docket ID HHS-OCR-2018-0002, at https://www.regulations.gov/docket?D=HHS-OCR-2018-0002.

(HHS-OCR-2018-0002-54930); Ctr. for Reproductive Rights ("CRR") Cmt. Ltr. 2-5 (HHS-OCR-2018-0002-71830).

On May 21, 2019, HHS published the final Rule, with only modest changes from the proposed Rule. *See* Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. Pt. 88). Although HHS's mission is to "enhance the health and well-being of all Americans," HHS, *Introduction: About HHS*, http://www.hhs.gov/about/strategic-plan/introduction/index.html, in promulgating the Rule HHS decided that its "singular and critical responsibility" was "to vigorously enforce" federal religious-objection laws. 84 Fed. Reg. at 23,178. Despite many concerns raised in the comments, HHS did not sufficiently address what providers must do to comply with the Rule and what options providers have to ensure continuity of care, especially in emergency circumstances. *Id.* at 23,183, 23,191-23,192.

C. What The Denial-Of-Care Rule Does

The Rule goes well beyond the narrowly drawn statutes that Congress enacted to address religion-based objections. It creates a new regime that vastly expands the power of religious objectors at the expense of providers, physicians, and patients. The Rule does this by repeating statutory prohibitions and then defining key statutory terms broadly (more broadly than Congress intended) and applying them across-the-board, rather than in the limited contexts Congress specified. The resulting Rule is completely unmoored from the statutes purportedly authorizing it.

The Rule prohibits all recipients of federal funding from requiring any "**individual** to perform or **assist in the performance of** any part of a health service program or research activity" if that performance or assistance would be contrary to the person's religious or moral beliefs. 84 Fed. Reg. at 23,265, § 88.3(a)(2)(vi) (emphasis added). The Rule's definitions expand this prohibition to reach virtually any person or activity in some way tied to a healthcare procedure. "Individual" may include any member of an entity's "workforce," *id.* at 23,199, and "workforce" includes any "employee[], volunteer[], trainee[], [or] contractor" subject to the control of, or holding privileges with, a healthcare entity. *Id.* at 23,264, § 88.3. "Assist in the performance" is not limited to direct participation in a patient's medical treatment. Instead, it means taking any action

"that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program or research activity undertaken by or with another person or entity," and may include "counseling, **referral**, training, or otherwise making arrangements for the procedure." 84 Fed. Reg. at 23,263, § 88.2 (emphasis added). "Referral," in turn, includes giving any information in virtually any form if the "purpose or reasonably foreseeable outcome" is to "assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure." *Id*. at 23,264, § 88.2.

Together, these provisions invite individuals who are only tangentially involved in patient care to raise religion-based objections and deny patients needed care and information. Objections may be raised by a receptionist who schedules appointments, a janitor who prepares an operating room, an orderly who assists patients in the recovery room, or an ambulance driver who transports a patient to the hospital. *See* 84 Fed. Reg. at 23,186-23,187. And these objections may be to virtually any healthcare-related task, including providing information about treatment options; escorting patients to treatment areas; cleaning or restocking treatment rooms, ambulances, or other facilities; providing, collecting, or filing forms related to patients' health history or insurance information; billing or administering insurance reimbursements; and even scheduling appointments.

The Rule also prohibits "**discrimination**" against individuals and entities that assert certain religious objections. *See, e.g.*, 84 Fed. Reg. at 23,265-23,266, §§ 88.3(a)(2)(iv)-(vi), (b)(2) and (c)(2) (emphasis added). The Rule defines "discriminate" to include virtually any negative action—including any action to "withhold, reduce, exclude from, terminate, restrict, or make unavailable or deny" any "position," "status," "benefit," or "privilege" in employment, or to use any "policies[] or procedures" that subject an individual or entity to "any adverse treatment." 84 Fed. Reg. at 23,263, § 88.2.

The definition includes carve-outs for accommodating objections, but those provisions severely constrain the ability of healthcare entities to ensure that patients receive needed care. For example, the Rule says that an employee may "voluntarily accept[]" an accommodation offered by the employer, *id.*, but it does not authorize employers to impose reasonable accommodations over an employee's objections, even when necessary to protect patients' health. The Rule also limits

employers' ability to identify potential objections in advance. A covered entity may require a worker to inform it of his or her objections, but only if objections are reasonably likely, and the entity can inquire about objections only "after . . . hiring" the worker and "once per calendar year thereafter, unless supported by a persuasive justification." *Id.* And on its face, the Rule precludes providers from requiring objectors to cooperate in ensuring that patients receive appropriate care and information. *See id.* (a covered entity may "use alternate staff or methods to provide or further any objected-to conduct" only if the entity "does not require any additional action by" the objector).

The Rule targets reproductive healthcare and healthcare to LGBT patients. It contemplates that employees may object to tasks even tangentially related to abortion and to emergency treatment of life-threatening ectopic pregnancies. *See* 84 Fed. Reg. at 23,186-23,188. And it repeatedly characterizes medically necessary healthcare procedures sought by transgender patients to treat gender dysphoria as "sterilization," inviting religious and moral objections to providing that care. *See id.* at 23,178 (citing *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017), involving a Catholic hospital's attempt to block a transgender patient's hysterectomy, which was part of a course of treatment for gender dysphoria); *see also id.* at 23,205. Equating treatment for gender dysphoria with "sterilization" is medically inaccurate and contrary to the plain meaning of the term, and it endorses a particular religious view of gender identity. Ettner Decl. ¶ 46. Procedures undertaken for the purpose of sterilization are distinct from procedures undertaken for other purposes that incidentally affect reproductive function. *Id.*; Valle Decl. ¶ 13. For some transgender people who desire children, reproduction may be possible even after completing treatment for gender dysphoria. Ettner Decl. ¶ 47; Valle Decl. ¶ 13.

Significantly, the Rule contains no emergency exceptions. No emergency exceptions appear on the face of the Rule, and the Rule's disapproval of cases and a medical-ethics opinion requiring medical personnel to provide emergency care makes clear that HHS intends for religious objections to take precedence over saving patients' lives. *See* 84 Fed. Reg. at 23,176; 83 Fed. Reg. at 3888. Although serious concerns were raised during the notice-and-comment period about the need to provide emergency care, HHS's only response is that it will evaluate those situations on a case-by-case basis. 84 Fed. Reg. at 23,176. Of course, by then it will be too late for some patients.

The Rule threatens entities with severe penalties. It authorizes withdrawal and clawback of all federal funding, even for programs unrelated to healthcare. *See* 84 Fed. Reg. at 23,180; *id.* at 23,271, § 88.7(i). And it holds healthcare providers responsible not only for their own violations of the Rule, but also any violations by contractors or subrecipients. *See id.* at 23,270, § 88.6(a); *id.* at 23,207. The Rule mandates investigations whenever "any information" demonstrates a "threatened" or "potential" violation, *id.* at 23,271, § 88.7(d), which may include review of confidential information. *Id.* at 23,271, § 88.6(c). The Rule provides no mechanisms for notice, a hearing, or an appeal before HHS terminates or withholds funds. *Id.* at 23,271-23,272, § 88.7(h)(2). OCR "will consider an entity's voluntary posting of a notice of nondiscrimination" including its recommended text as "non-dispositive evidence of compliance." *Id.* at 23,270, § 88.5. But posting of the notice is only *nondispositive evidence* of compliance. There is no safe harbor—not for providers, not for doctors, and not for patients.

D. How The Denial-Of-Care Rule Will Harm Doctors, Patients, and Healthcare Providers

The Denial-of-Care Rule will severely harm Plaintiffs, their members, and their patients. And these effects will be felt by healthcare providers and patients nationwide.

Put simply, the Rule will hurt people, and likely kill some of them. HHS envisioned that any worker who objects to a certain patient or the patient's requested healthcare procedure may refuse to participate in the patient's treatment. As a result, some patients will not receive necessary information and care, including time-sensitive and emergency care—putting their health at substantial risk.

The Rule increases the likelihood that patients will be turned away, without a referral or even basic information about their condition or treatment options. When a patient is turned away, that person (at the very least) will have to incur additional costs and burdens to try to find a willing provider of the needed healthcare. Lorenz Decl. ¶ 24; McNicholas Decl. ¶ 31; Cummings Decl. ¶ 9. Those burdens will fall most heavily on low-income individuals. Bolan Decl. ¶ 2; Cummings Decl. ¶¶ 3-4. Some patients will not receive the necessary treatment—either because they cannot obtain it in time, because they do not have the resources to obtain it somewhere else, or because there is

no other provider in the area. Shanker Decl. ¶ 5; Valle Decl. ¶ 5; Cummings Decl. ¶ 11. And being turned away is a potentially traumatizing and stigmatizing experience. Shafi Decl. ¶ 18; Valle Decl. ¶ 15; Bolan Decl. ¶¶ 6-9; Henn Decl. ¶ 3; McNicholas Decl. ¶ 44; Ettner Decl. ¶¶ 48, 56. These harms will be especially acute for patients seeking reproductive healthcare and for LGBT patients. HHS knows this: It cited examples of individuals objecting to reproductive care and care sought by LGBT individuals as evidence of the need for the Rule. 84 Fed. Reg. at 23,176 & n.27.

The Rule threatens to impede or eliminate access to abortion and contraception. Burkhart Decl. ¶¶ 24-28; Backus Decl. ¶¶ 27-28. Abortion is a common and safe medical procedure. McNicholas Decl. ¶¶ 28, 30. Yet there is a national shortage of abortion providers in the United States, and their numbers are shrinking. McNicholas Decl. ¶¶ 19-21; Backus Decl. ¶ 8. As a result, many patients already must travel long distances (and incur associated costs and delays) to obtain care. Phelps Decl. ¶ 18. Delays in obtaining an abortion compound the logistical and financial burdens that patients face and substantially increase the health risks to patients. Phelps Decl. ¶ 18; McNicholas Decl. ¶ 30. If the Rule goes into effect, the United States will see an even more dramatic reduction in the number of large medical institutions that provide abortions and that teach students and residents about them. Phelps Decl. ¶ 30; Backus Decl. ¶¶ 38-39.

The Rule imposes particular burdens on LGBT individuals, and especially transgender and gender-nonconforming individuals. LGBT people already face acute health disparities and barriers to care, problems which will be compounded by the Rule. Shanker Decl. ¶¶ 5-10; Ettner Decl. ¶¶ 55-56; Cummings Decl. ¶¶ 8-11. A majority of LGBT patients fear going to healthcare providers because of past experiences of anti-LGBT bias in healthcare. Shanker Decl. ¶ 8; Ettner Decl. ¶ 55; Henn Decl. ¶ 3; Vargas Decl. ¶ 5; Bolan Decl. ¶ 9; Cummings Decl. ¶ 9. Many LGBT patients report hostility, discrimination, and denials of care when they disclosed to healthcare providers their sexual orientation, history of sexual conduct, gender identity, transgender status, or past gender-affirming medical treatment. Shanker Decl. ¶¶ 6-10; Henn Decl. ¶¶ 3, 6-8; Bolan Decl. ¶¶ 6-9; Carpenter Decl. ¶ 5; Cummings Decl. ¶ 12; Vargas Decl. ¶¶ 4, 13; McNicholas Decl. ¶ 26; Ettner Decl. ¶ 55. LGBT patients are disproportionately likely to delay preventive screenings and necessary medical treatment, which results in more acute health problems and more adverse

outcomes. Shanker Decl. ¶¶ 8-12; Henn Decl. ¶ 3; Bolan Decl. ¶¶ 6-9; Carpenter Decl. ¶ 6; Manley Decl. ¶ 8; Cummings Decl. ¶¶ 9, 12. The Rule makes it more likely that these patients will be denied care or will avoid seeking care altogether, which will hurt not only the patients but also public health. Bolan Decl. ¶ 11; Cummings Decl. ¶ 9; Henn Decl. ¶¶ 3, 6. The Rule also encourages these patients to remain closeted when seeking medical care, which similarly harms patients and public health. Shanker Decl. ¶¶ 11-12; Vargas Decl. ¶ 14; Henn Decl. ¶ 5; Bolan Decl. ¶¶ 8-10; Carpenter Decl. ¶ 11; Manley Decl. ¶ 8; Harker Decl. ¶ 14; Cummings Decl. ¶¶ 13-14.

Under the Rule, healthcare providers, including the County of Santa Clara, will face serious impediments to providing high-quality and timely healthcare. First, they will immediately have to reevaluate and rewrite their existing religious-objection, staffing, and emergency policies. *See* Lorenz Decl. ¶¶ 19-20; Miller Decl. ¶ 7; Butler Decl. ¶ 5; Singh Decl. ¶ 7; Sproul Decl. ¶¶ 4-6; Tullys Decl. ¶ 9. They also will need to inquire as to the conscience objections of the many employees, contractors, and volunteers who are newly covered under the Rule. For example, Santa Clara Valley Medical Center, a hospital operated by the County, has a policy allowing current and prospective medical staff and employees to request in writing not to participate in certain patient care that conflicts with staff members' cultural values, ethics, or religious beliefs, with the understanding that medical emergencies take precedence over personal beliefs. Lorenz Decl. ¶¶ 11, 18; Nguyen Decl. ¶ 4. If the County can no longer rely on all staff to provide care in an emergency, it will have to consider whether backup or double staffing is necessary to protect patient welfare, which will strain the hospital's budget. Nguyen Decl. ¶ 6; Lorenz Decl. ¶ 19. Other aspects of the Rule also conflict with the County's policies and operational needs and could undermine patient care. Lorenz Decl. ¶¶ 15-17, 20-21; Nguyen Decl. ¶ 7. And if despite a provider's best efforts, an OCR official believes that the provider failed to comply, the provider could lose all Medicare and Medicaid reimbursements and other federal funding—which obviously would affect its ability to continue providing care to patients. Lorenz Decl. ¶¶ 22-24; Tullys Decl. ¶ 8; Cody Decl. ¶¶ 12-22.

The Rule imposes special challenges for providers specializing in reproductive healthcare and healthcare for LGBT individuals. Like the County, they must reevaluate their existing policies, and may be forced to consume precious resources with unnecessary workarounds and duplicative

staffing; to unfairly burden nonobjecting employees; to reduce services; and even to close programs. Shafi Decl. ¶¶ 12-15; Shanker Decl. ¶¶ 13-15; Valle Decl. ¶¶ 16-23; Cummings Decl. ¶¶ 15-19; Manley Decl. ¶¶ 10-13; Burkhart Decl. ¶¶ 19-21, 27; Barnes Decl. ¶ 22. Also like the County, providers that specialize in reproductive healthcare and healthcare for LGBT patients could face situations in which a staff member unexpectedly objects to care, leading to staffing issues and inadequate emergency care. But the reproductive and LGBT care providers will be especially affected by the Rule, because more patients who fear refusal of care at traditional healthcare facilities will come to them for care, straining their already limited resources. Shafi Decl. ¶ 20; Cummings Decl. ¶ 15; Shanker Decl. ¶ 13; Barnes Decl. ¶¶ 30-31. And for those providers of last resort, the ability to provide seamless emergency treatment to a patient can mean the difference between life and death. Henn Decl. ¶ 9 (Whitman-Walker staff administered medication to reverse a life-threatening overdose after emergency medical services personnel expressed disapproval of the patient and refused treatment); Carpenter Decl. ¶ 5 (LA LGBT Center provided care to transgender patient after medical conditions became life-threatening because other providers denied care). Those providers also will need to invest resources in educating the community about the Rule and in battling the erosion of community members' confidence in the healthcare system that will result from the Rule's application. Shanker Decl. ¶ 14; Valle Decl. ¶ 16.

Finally, the Rule will harm Plaintiff medical associations by frustrating their missions of promoting training in abortion care (Backus Decl. ¶ 11) and nondiscriminatory care for LGBT patients (Vargas Decl. ¶¶ 1-2, 6-8; Harker Decl. ¶¶ 1, 6, 9) throughout the country. The Rule also will harm their members and their members' patients by encouraging denials of care. *See* Harker Decl. ¶¶ 6, 9; Backus Decl. ¶ 11; Vargas Decl. ¶¶ 6-10.

ARGUMENT

"The purpose of a preliminary injunction is merely to preserve the relative positions of the parties until a trial on the merits can be held." *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). A plaintiff seeking a preliminary injunction must show "that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Regents of the*

Univ. of Calif. v. U.S. Dep't of Homeland Security, 908 F.3d 476, 505 n.20 (9th Cir. 2018) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)). In applying this standard, "the elements of the preliminary injunction test are balanced, so that a stronger showing of one element may offset a weaker showing of another." *Pimentel v. Dreyfus*, 670 F.3d 1096, 1105 (9th Cir. 2012) (internal quotation marks omitted).

Those requirements are met here. Plaintiffs are likely to succeed in proving that the Denial-of-Care Rule is unlawful on several grounds, including that it violates the Administrative Procedure Act ("APA") because it is arbitrary and capricious, conflicts with existing statutes, and goes far beyond HHS's statutory authority, and that it is unconstitutional. The irreparable injury is clear: Plaintiffs' patients will be harmed if the Rule goes into effect, and Plaintiffs themselves will face immediate and substantial burdens to delivering healthcare and fulfilling their missions. At the same time, the government will not be harmed if the Court delays the Rule's effective date to address the Rule's many problems. And the public interest plainly favors preventing the Rule from taking immediate effect. Because Plaintiffs are located throughout the country and include nationwide organizations, and the threatened harms will occur nationwide, the Court should issue a nationwide injunction.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS

A. Plaintiffs Are Likely To Succeed In Demonstrating that The Rule Violates the APA

1. The Rule is Arbitrary and Capricious

The APA requires courts to "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). An agency rule is arbitrary and capricious if the agency has "relied on factors which Congress has not intended it to consider," "entirely failed to consider an important aspect of the problem," or "offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency must "examine the relevant data and articulate a satisfactory explanation for its action" that includes a "rational connection between the facts found and the choice made." *Id.* (internal

quotation marks omitted). When an agency has failed to "give adequate reasons for its decisions," failed to "examine[] the relevant data," or failed to offer a "rational connection between the facts found and the choice made," the regulation must be set aside. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016). Because the failure to satisfy that threshold requirement makes the regulation procedurally defective, the reviewing court need not reach any argument for deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). *Encino Motorcars, LLC*, 136 S. Ct. at 2125.

HHS acted arbitrarily and capriciously in promulgating the Denial-of-Care Rule. It adopted a one-sided regulation that is not supported by (and is in fact contrary to) the evidence in the administrative record, and it failed to address important issues raised during the notice-and-comment process. These problems are particularly apparent with respect to two issues: harms to patients, and providers' need to reconcile religious objections with their obligation to provide healthcare.

a. Harm to Patients

The Rule will harm patients by causing some providers to deny them necessary healthcare and information. HHS knew that. *E.g.*, 84 Fed. Reg. at 23,251. Yet HHS made no effort to quantify the effects of the Rule on patients or to take steps to reduce or avoid those harms.

HHS received voluminous comments demonstrating that religious-objection laws have been exploited and misused to delay or deny care, particularly for patients seeking reproductive healthcare and LGBT patients. Many patients already face discrimination and other barriers to care. *See, e.g.*, Cnty. of Santa Clara Cmt. Ltr. 5-6; CRR Cmt. Ltr. 4-5. Healthcare providers have refused to treat LGBT patients and their children, even in emergencies. Cnty. of Santa Clara Cmt. Ltr. 5-6. Many LGBT people and people living with HIV have reported providers refusing to touch them or using excessive precautions, using harsh or abusive language, being physically rough or abusive, or shaming them or blaming them for medical conditions. GLMA Cmt. Ltr. 1-2 (HHS-OCR-2018-0002-71703). In a recent study, over one-third of transgender patients reported at least one negative experience related to their gender identity when seeking medical care. *Id.* at 2.

Providers also have denied access to safe pregnancy termination, miscarriage management,

and contraception, all of which are necessary to ensure women's health and well-being. Rape survivors have been denied emergency contraception; pharmacists have refused to provide emergency contraception in time to prevent pregnancy; and hospitals have denied women care to complete miscarriages even when their lives were in danger. CRR Cmt. Ltr. 2-3. If the Rule takes effect, individuals and entities likely will assert religious objections to a much wider variety of care, including reproductive care, transgender care, counseling for same-sex partners, and HIV/AIDS treatment. Lambda Legal Cmt. Ltr. 4-6 (HHS-OCR-2018-0002-72186). Those denials of care will disproportionately affect economically disadvantaged patients. *See*, *e.g.*, CRR Cmt. Ltr. 3-5, 10, 25-26. Worse yet, the Rule includes no exceptions for emergencies, so patients will suffer these harms even when they are seeking lifesaving care. Shafi Decl. ¶¶ 14-15; Henn Decl. ¶¶ 6, 9; Valle Decl. ¶ 22.

The Rule does not adequately address those concerns. HHS acknowledged that "[d]ifferent types of harm can result from denial of a particular procedure," including that a "patient's health might be harmed if an alternative is not readily found, depending on the condition." 84 Fed. Reg. at 23,251. HHS also recognized that a patient denied care likely will incur additional costs in searching for an alternative, and "the patient may experience distress associated with not receiving a procedure he or she seeks." *Id.* And HHS recognized that the Rule would adversely affect "rural communities, underprivileged communities, or other communities that are primarily served by religious healthcare providers or facilities." *Id.* at 23,180.

HHS had essentially two responses to those acknowledged problems: to hypothesize that more doctors would be available overall (but only to provide certain treatments), and to blame the adverse impacts on the underlying statutes rather than the Rule. First, HHS suggested that the Rule would "increase, not decrease, access to care" by attracting providers who otherwise would not practice medicine because of their religious objections. 84 Fed. Reg. at 23,180. HHS's only support for this assertion was a small, outdated, and unreliable political poll, *id.* at 23,181, which acknowledged that it was "not intended to be representative of the entire medical profession" or

even of the membership of the faith-based medical-organizations surveyed.[3] HHS cited no data showing that the Rule was needed to keep providers from quitting or that it would attract any new providers to underserved communities. And HHS failed to acknowledge that attracting these new providers would not solve the problem; increasing the number of providers that refuse to provide certain medical treatments does nothing to help patients who need those treatments.

Second, HHS wrongly attributed the harmful effects of the Rule to the purportedly authorizing statutes. For example, HHS's response to the concern that refusals will cause patients significant distress is that, in the agency's view, Congress did not want to "establish balancing tests that weigh such emotional distress against the right to abide by one's conscience." 84 Fed. Reg. at 23,251. But Congress made no such policy judgment: It established protections for religious objectors but also enacted statutes ensuring that patients would not be harmed. *See* pp. 3-5, *supra*. The *Rule* is what elevates religious objections over the health of patients, and that was a judgment *HHS* made.

HHS ultimately both failed to quantify the harms to patients and failed to give them appropriate weight. HHS decided that it was "appropriate" to finalize the Rule "even though the Department and commenters do not have data capable of quantifying all of its effects on the availability of care." 84 Fed. Reg. at 23,182. HHS also decided that religious refusals were "worth protecting even if they impact overall or individual access to a particular service, such as abortion." *Id.* That is true even for emergencies: All HHS would say about ensuring emergency care is that it would consider specific scenarios on a case-by-case basis. *Id.* at 23,176. And HHS did not address whether existing policies that accommodate objections but ensure patient care would be equally effective and less harmful. By failing to account for and give appropriate weight to the many likely harms to patients, and by failing to consider alternatives to lessen or ameliorate those harms, HHS acted arbitrarily and capriciously.

b. Providers' Need to Reconcile Religious Objections With Providing Healthcare

[3] *See* "Key Findings on Conscience Rights Polling," Memorandum from Kellyanne Conway to Interested Parties at 4 (April 8, 2009), available at https://docs.wixstatic.com/ugd/809e70_2f66d15b88a0476e96d3b8e3b3374808.pdf. The Rule cites the Memorandum at this URL. *See* 84 Fed. Reg. at 23,247 n. 316-318.

HHS likewise failed adequately to address how providers can fulfill their missions and provide healthcare while complying with the Rule. The Rule greatly expands the universe of workers who may assert religious objections and the activities to which they may object. And it severely constrains providers' ability to ensure that these objections do not compromise patient care, especially in emergencies. The agency's action will place systematic and significant burdens on covered entities and expose them to incredibly punitive sanctions. HHS was required to justify those burdens and sanctions. *See Encino Motorcars*, 136 S. Ct. at 2126. It failed to do so.

Commenters explained that hospitals and other healthcare organizations already have policies that allow individuals to opt out of certain procedures on religious or moral grounds while ensuring that patients still will receive care. *See, e.g.*, AMA Cmt. Ltr. 5; Cnty. of Santa Clara Cmt. Ltr. 2; S.F. Dep't of Public Health Cmt. Ltr. 2-3 (HHS-OCR-2018-0002-69109); Boston Med. Ctr. Cmt. Ltr. 2-3 (HHS-OCR-2018-0002-70407); Mass. Med. Soc'y Cmt. Ltr. 1 (HHS-OCR-2018-0002-62998). Those policies often require workers to assist in providing emergency care. Sproul Decl. ¶¶ 8, 10; Lorenz Decl. ¶¶ 18-19; Burkhart Decl. ¶ 21. Commenters expressed concern that the Rule would call those existing policies into question and would restrict providers' ability to require advance notice of objections and to reassign staff to positions where their objections would not result in harm to patients. *E.g.*, S.F. Cmt. Ltr. 3; N.Y. City Cmt. Ltr. 3 (HHS-OCR-2018-0002-71028); Am. Nurses Ass'n Cmt. Ltr. 8 (HHS-OCR-2018-0002-55870). Commenters also urged HHS not to allow religious objections to take precedence over emergency care. *E.g.*, Boston Med. Ctr. Cmt. Ltr. 6; Nat'l Inst. for Reproductive Health Cmt. Ltr. 13 (HHS-OCR-2018-0002-56426).

Rather than craft a rule that addressed and resolved these well-founded concerns, HHS effectively ignored them. HHS acknowledged that providers will have to change their existing policies to provide much greater accommodations for religious objectors. *See, e.g.*, 84 Fed. Reg. at 23,191. But HHS provided little guidance on which policies would be allowed. For example, the agency did not explain (1) whether providers may require objectors to assist in emergencies, *id.* at 23,183, 23,188; (2) how to proceed when an employee rejects a proposed accommodation, *id.* at 23,263; or (3) what providers may do when workers disclose after hiring that they are unwilling to perform the essential functions of a position, *id.* The result is that covered entities have inadequate

notice of what they can and cannot do to protect patients while accommodating religious objections under the Rule. HHS acted arbitrarily and capriciously by failing to account for providers' legitimate concerns and instead leaving those issues to the discretion of individual OCR officials—especially when all of the providers' federal funding is on the line.

2. The Rule Conflicts With Existing Healthcare Laws

The Rule is "not in accordance with law," 5 U.S.C. § 706(2)(A), because it conflicts with a number of federal statutes that protect patients' access to care—especially emergency care—and that prohibit discrimination in the provision of healthcare.

a. ACA—Access to Care and Information

The ACA expressly prohibits the Secretary of HHS from "promulgating any regulation that" "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care," "impedes timely access to health care services," "interferes with communications regarding a full range of treatment options between the patient and the provider," "restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions," or "violates the principles of informed consent and the ethical standards of health care professionals." 42 U.S.C. § 18114.

The Rule violates each of those provisions. It will prevent individuals from obtaining needed healthcare, especially LGBT patients and patients seeking reproductive care. Phelps Decl. ¶ 43; McNicholas Decl. ¶ 28; Ettner Decl. ¶¶ 48, 56. It also will prevent patients from obtaining information about certain healthcare procedures and will chill patients, especially LGBT patients, from discussing their healthcare needs. Valle Decl. ¶ 19; Cummings Decl. ¶¶ 9, 14. As a result, those patients will not have the information necessary to provide informed consent. *See* McNicholas Decl. ¶ 18; 76 Fed. Reg. 9968, 9973 (Feb. 23, 2011) (explaining informed consent). In short, the Rule expressly and wholeheartedly does exactly what Congress prohibited in the ACA.

b. EMTALA

EMTALA requires hospitals with emergency rooms to provide appropriate care to patients in emergencies. Under EMTALA, hospitals with emergency departments must provide "an appropriate medical screening examination within the capability of the hospital's emergency

department" to determine if a medical emergency exists. 42 U.S.C. § 1395dd(a). In a medical emergency, the hospital must either treat the patient "to stabilize the medical condition" or transfer the patient "to another medical facility" for treatment (which for a non-stable patient may be done only with a doctor's consent). *Id.* § 1395dd(b), (c)(1).

The Denial-of-Care Rule contravenes the clear directive of EMTALA to provide care to patients in distress. The Rule gives expansive protections to religious objectors and does not make exceptions for emergencies. The Rule invites any emergency room employee with a religious objection to decline to provide, or assist in providing, emergency services. *See* 84 Fed. Reg. at 23,176; 83 Fed. Reg. at 3888. Under the Rule, the provider apparently cannot require that individual even to assist with a transfer to another facility where the patient can obtain care. *See* 84 Fed. Reg. 23,186-23,187. And the Rule does not allow hospitals to make the scheduling and staffing decisions necessary to ensure that patients facing emergencies receive treatment, because it severely limits their ability to ask about religious objections and to reassign workers with religious objections to other positions. *See* pp. 7-8, *supra*. As a result, under the Rule, providers likely will not be able to fulfill their statutory obligations to examine patients in distress and provide emergency care, or at the very least transfer the patients to hospitals where they can receive the necessary care.

c. ACA—Nondiscrimination

The ACA prohibits discrimination in the provision of healthcare. Specifically, 42 U.S.C. § 18116 prohibits discrimination against individuals in any health program or activity on grounds prohibited by Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 *et seq.*), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), or Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794 *et seq.*). These statutes prohibit discrimination on the basis of race, color, national origin, age, sex, or disability.

The Denial-of-Care Rule directly conflicts with that nondiscrimination mandate. A provider's refusal to treat patients based on religious or moral objections may exclude certain patients from health care programs on grounds prohibited by the ACA. For instance, the Denial-of-Care Rule invites individuals to deny transgender individuals healthcare on the basis of sex. *See*,

e.g., 84 Fed. Reg. at 23,178. Such conduct is prohibited under Title IX, as expressly incorporated by the ACA. *See Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018); *Prestcott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017). The Rule gives objectors new license to discriminate, rather than enforcing Congress's prohibitions on discrimination.

3. The Rule Goes Beyond HHS's Statutory Authority

An agency may act only within the authority Congress gives it. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). Courts reviewing agency action must "hold unlawful and set aside" actions that exceed the agency's statutory jurisdiction. 5 U.S.C. § 706(2)(C).

The Rule goes well beyond the statutes purportedly authorizing it. Each of those statutes provided a particular protection for religious objectors in a specific context. Those statutes are self-executing, and none expressly grants HHS enforcement authority. Nonetheless, HHS decided to assert the authority to enforce those statutes, then attempted to vastly expand their reach. It did so by defining key statutory terms much more broadly than Congress could possibly have intended, and then combining those terms even though Congress kept them separate. Because those definitions and that combination are inconsistent with the statutes that HHS purports to construe, the Rule is unlawful. *See Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 652, 660 (9th Cir. 2011).

a. Assist in the Performance

HHS's definition of "assist in the performance" stretches the term to include activities only tangentially related to any healthcare procedure. Only the Church Amendments refer to "assist[ing] in the performance" of an activity, 42 U.S.C. § 300a-7(c)(1), (d), and nothing in that statutory scheme envisions the broad definition in the Rule.

Specifically, Congress provided that a healthcare professional is not required to "perform" or "assist in the performance" of "any sterilization procedure or abortion." 42 U.S.C. § 300a-7(c)(1); *see* 42 U.S.C. § 300a-7(d) (same for individuals who "assist in the performance of" an HHS-funded "health service program or research activity"). "Performance" means "the execution of an action," and to "assist" means "to give support or aid," such as when "another surgeon

[assisted] on the operation." *Merriam-Webster's Collegiate Dictionary* 70, 863 (10th ed. 1996). By using the terms "perform" and "assist in the performance," Congress required that the person objecting must have a close and direct nexus to the objected-to activity. The sponsor of the Church Amendments warned against reading the statute more expansively: "There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation." 119 Cong. Rec. S9377, S9597 (Mar. 27, 1973).

But that is what HHS did. It defined the terms expansively, and it expressly admitted that it was doing so. *See* 84 Fed. Reg. at 23,186-23,187. Under HHS's definition, "assist in the performance" reaches any action with "a specific, reasonable, and articulable connection to furthering" the objected-to procedure, including "counseling, referral, training, or otherwise making arrangements for" a procedure. *Id* at 23,263, § 88.2. And then HHS expands the Rule's reach even further by separately defining "referral" to include the provision of virtually any information that may lead to a patient obtaining an objected-to procedure. *Id* at 23,264, § 88.2 The result is to invite objections by workers whose activities are remote from the actual performance of procedures or medical procedures—such as a receptionist who greets patients or makes appointments, a clerical worker who explains insurance coverage or submits claims, or a security guard who directs patients to particular areas of the hospital. Indeed, HHS was willing to exclude only "irrational assertions" where "there is no actual connection by which the action specifically furthers the procedure." *Id.* at 84,187.

HHS's definition of "assist in the performance" goes beyond Congress's intended meaning of the phrase. And HHS's inclusion of "counseling" and "referral" in the definition of "assist in the performance" makes that clear. In the underlying statutes, Congress did not include "counseling" and "referral" in "assist[ing] in the performance" of an activity. Instead, Congress separately referred to "counseling" and "referral" as different activities that were independently protected under the statutes. 42 U.S.C. § 300a-7(e) ("counsel"); Pub. L. 115-245, § 507(d)(2), 132 Stat. 2981, 3118 (2018) ("refer"); 42 U.S.C. § 238n(a)(1), (a)(2) ("referrals"). That separate treatment is a strong indication that "counseling" and "referral" mean something different from "assist in the

performance."

b. Discriminate or Discrimination

HHS broadened the Rule's reach even further through its expansive definition of "discrimination." The Weldon Amendment, Coats-Snowe Amendment, and Church Amendments prohibit "discrimination" against certain objectors in certain contexts. *See* Pub. L. 115-245, § 507(d)(2), 132 Stat. 2981, 3118 (2018); 42 U.S.C. § 238n(a)(1), (a)(2); *id.* § 300a-7(c)(1)-(2), (e). As commonly understood, "discrimination" is "a failure to treat all persons equally when no reasonable distinction can be found between those favored and those not favored." *Black's Law Dictionary* (11th ed. 2019). This understanding is well established: The ACA, for example, prohibits "discrimination" in healthcare on the basis of race, color, national origin, age, sex, or disability. 42 U.S.C. § 18116.

The Rule goes far beyond what Congress intended by placing unprecedented limits on accommodation policies and preventing healthcare providers from ensuring patient health and safety. Under the Rule, "[d]iscrimination" means any change to the objecting employee's "position," "status," "benefit[s]," or "privilege[s]" in employment, as well as use of any "policies[] or procedures" that subject the objector to "any adverse treatment." 84 Fed. Reg. at 23,263, § 88.2. The Rule encompasses almost any negative action towards religious objectors without considering whether that action is legally justifiable. That is true even though federal law recognizes a number of rationales and defenses to justify those actions, including that an employer need not provide an accommodation for an employee's religious beliefs when the accommodation would cause undue hardship to the employer. *See* 42 U.S.C. § 2000e(j); *EEOC v. Abercrombie & Fitch Stores, Inc.*, 135 S. Ct. 2028, 2032 (2015); *Peterson v. Hewlett-Packard Co.*, 358 F.3d 599, 607 (9th Cir. 2004).

Under the Rule, a healthcare entity could be deemed to have engaged in unlawful discrimination simply by taking measures that are reasonably necessary to find out about religious objections and ensure that those objections do not compromise patient care. Only actions falling within the definition's narrow and restrictive exceptions are excluded. *See* pp. 7-8, *supra.* Thus, under the Rule's broad definition of "assist in the performance," a worker might object to providing certain information to patients, and might even object to directing patients to someone else who

could help them, and under the Rule's broad definition of "discrimination," the entity employing that worker would be unable to reassign the worker, thereby putting patients at risk.

Congress plainly did not intend its prohibition on "discrimination" to require healthcare entities to put the needs of religious objectors above the needs of all others. And Congress recognized, in the ACA and EMTALA, that providers have obligations to provide healthcare and information, especially in emergency circumstances. To meet those obligations, providers must be able to adopt policies that ensure that patients will receive care even when an employee raises a religious objection. Yet, in its definition of "discrimination," HHS declined to consider the legitimate needs of healthcare providers. And by elevating religious objections over the needs of patients, HHS enables new and unjustified forms of discrimination—turning Congress's mandate not to "discriminate" on its head.

B. Plaintiffs Are Likely to Succeed On Their Establishment Clause Claim

The Establishment Clause provides essential protections for religious freedom. It bars official conduct that favors one faith over others, has the primary purpose or primary effect of advancing or endorsing religion, or coerces religious belief or practice. *See, e.g.*, *McCreary Cnty. v. ACLU of Ky.*, 545 U.S. 844, 860 (2005); *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 302 (2000); *Cmty. House, Inc. v. City of Boise*, 490 F.3d 1041, 1054 (9th Cir. 2007).

The Denial-of-Care Rule violates those constitutional guarantees. It officially prefers the religious beliefs of objectors over the rights and beliefs of providers and patients, and it coerces religious exercise by requiring providers and patients to act in accordance with objecting employees' religious beliefs. The Rule's favoritism toward religious beliefs invoked by objecting employees is subject to strict scrutiny. *See Larson v. Valente*, 456 U.S. 228, 246 (1982). The Rule cannot survive strict scrutiny because, among other reasons, there are obvious less-restrictive alternatives for accommodating objecting employees, including providers' existing policies.

1. The Rule Impermissibly Imposes the Costs and Burdens of Objecting Employees' Religious Beliefs on Patients and Other Third Parties

The Establishment Clause flatly prohibits religious exemptions or accommodations by government that would have a "detrimental effect on any third party." *Burwell v. Hobby Lobby*

Stores, Inc., 134 S. Ct. 2751, 2781 n.37 (2014); *see Cutter v. Wilkerson*, 544 U.S. 709, 720 (2005). That is because religious exemptions that burden third parties impermissibly prefer the religion of those who are benefited over the beliefs and interests of those who are not. *See, e.g.*, *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 15 (1989) (plurality opinion). The Denial-of-Care Rule violates the Establishment Clause because it imposes costs, burdens, and harms on healthcare providers and patients for the purpose of facilitating the religious beliefs and practices of objecting employees.

The prohibition against harming third parties is longstanding and well settled. In *Sherbert v. Verner*, 374 U.S. 398 (1963), for example, the Supreme Court permitted a religious accommodation under a state unemployment-benefits law for an employee who was fired for refusing to work on her Sabbath because the requested accommodation would not "abridge any other person's religious liberties." *Id.* at 409. In *Estate of Thornton v. Caldor*, 472 U.S. 703 (1985), by contrast, the Court invalidated a state law requiring employers to accommodate people observing the Sabbath in all instances because "the statute t[ook] no account of the convenience or interests of the employer or those of other employees who do not observe a Sabbath." *Id.* at 709; *see Texas Monthly*, 489 U.S. at 15, 18 n.8 (plurality opinion) (invalidating tax exemption for religious periodicals because it increased taxes on nonbeneficiaries). Accordingly, in evaluating Establishment Clause challenges, courts must "account [for] the burdens a requested accommodation may impose on nonbeneficiaries" and ensure that the accommodation does not "override other significant interests." *Cutter*, 544 U.S. at 720, 722.

Plaintiffs and other healthcare providers have developed policies and procedures to ensure that they can deliver care to their patients efficiently and fairly while respecting employees' religious beliefs. The Rule undermines essential patient protections by inviting employees, contractors, and volunteers of a healthcare institution to deny care to patients based on religious objections either to the treatment or to the characteristics or circumstances of the patient, without regard to the burdens and harms they will impose on patients and providers. *See* Burkhart Decl. ¶¶ 13-16; Lorenz Decl. ¶¶ 20-23; Vargas Decl. ¶ 13; Sproul Decl. ¶¶ 11-12.

For example, the County of Santa Clara's hospitals allow their employees to opt out of participating in certain procedures when they have religious objections, so long as they provide

notice adequate to allow the hospital to arrange appropriate alternative staffing. *See* Lorenz Decl. ¶¶ 11-13; Tullys Decl. ¶ 11; Sproul Decl. ¶¶ 8-9. But the Rule limits the hospitals' ability to require advance notice of objections, because hospitals can ask about objections only "after . . . hiring" and "once per calendar year" thereafter. 84 Fed. Reg. at 23,263. The Rule also limits the hospitals' ability to make staffing adjustments by permitting only *voluntary* accommodations for objecting employees. *Id.* at 23,263. Thus, the County could not reassign an employee who objects to performing core functions of his or her job but refuses to accept a transfer. The County's policies also require all staff members to assist in emergencies, Sproul Decl. ¶¶ 8, 10; Lorenz Decl. ¶¶ 18-19, but the Rule contains no exceptions for emergencies, 84 Fed. Reg. at 23,176.

If the County retains its existing policies to ensure continuity of patient care, it could be deprived of all Medicare and Medicaid reimbursements and other federal funding, thus compromising its ability to serve the neediest patients. If the County attempts to comply with the Rule while still ensuring patient care, it could be forced to use double-staffing and other prohibitively expensive measures. Lorenz Decl. ¶¶ 18-19. Either way, the Rule will severely burden the County and its patients. *Id.* ¶¶ 11-13, 22-24.

Further, the Rule threatens the very existence of many healthcare facilities whose institutional mission, core functions, or small size do not allow them to operate if an employee denies assistance to patients, refuses to assist in a referral, or refuses reassignment to another job. Lorenz Decl. ¶¶ 15-16; Burkhart Decl. ¶¶ 22-24; Vargas Decl. ¶ 10; Shafi Decl. ¶ 8. That is particularly true for entities that provide abortion and other reproductive-health services or transition-related care or other services to LGBT patients. Lorenz Decl. ¶¶ 15-16; Burkhart Decl. ¶¶ 22-24; Vargas Decl. ¶ 10; Shafi Decl. ¶ 8. In short, although the Establishment Clause flatly prohibits the government from mandating that "religious concerns automatically control over all secular interests," *Caldor*, 472 U.S. at 709, that is what the Denial-of-Care Rule does.

2. The Rule Impermissibly Coerces Patients and Healthcare Providers to Adhere to the Government's Favored Religious Practices

"[T]he Constitution guarantees that government may not coerce anyone to support or participate in religion or its exercise." *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *see Santa Fe*,

530 U.S. at 312. "For the government to coerce someone to participate in religious activities strikes at the core of the Establishment Clause." *Inouye v. Kemna*, 504 F.3d 705, 712 (9th Cir. 2007). But the Denial-of-Care Rule does just that: It uses the government's authority to coerce Plaintiffs and their patients to act in accordance with the religious beliefs and practices of objecting employees.

The Rule emboldens individual employees to dictate whether and how patients receive healthcare based on their own personal religious views. That is true even when those beliefs are expressly contrary to the religious or other mission of a healthcare institution or the patient's own beliefs. Women who seek reproductive healthcare at a clinic that provides family-planning services may have that care denied based on the religious views of a single employee. Barnes Decl. ¶¶ 29-30. LGBT patients may be pressured to conform to religious views on gender expression and sexual orientation that an objecting employee holds, lest they be denied care. *See* Tullys Decl. ¶ 13; Pumphrey Decl. ¶¶ 6-7; Cummings Decl. ¶ 14. And the Rule invites individual employees to refuse to provide patients with complete medical information and instead to give skewed advice based on their own religious beliefs rather than medical protocols. Henn Decl. ¶ 6.

C. Plaintiffs Are Likely to Succeed on Their Equal Protection Claim

By targeting transgender patients' transition-related healthcare needs for religious and moral objection, the Rule discriminates based on sex, gender identity, and transgender status. It therefore is subject to strict scrutiny (for discrimination based on transgender status), or at least heightened scrutiny (for discrimination based on sex). The Rule fails any level of review, because it is not even rationally related to any legitimate governmental interest, let alone adequately tailored to further an exceedingly persuasive or compelling one.

Discrimination against transgender people is discrimination based on sex for several reasons. *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015) (denial of treatment for gender dysphoria constitutes sex discrimination). First, a person's gender identity is a sex-related characteristic. *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016). Second, discriminating based on a person's gender transition is discrimination based on sex, just as firing an employee because she converts from Christianity to Judaism "would be a clear case of discrimination 'because of religion.'" *Schroer v. Billington*, 577 F. Supp. 2d 293, 306 (D.D.C.

2008). Third, discrimination against transgender people is rooted in sex stereotypes, because a transgender person's "inward identity [does] not meet social definitions of masculinity [or femininity]" associated with one's assigned sex at birth. *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *see Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034, 1051 (7th Cir. 2017); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 285-86 (W.D. Pa. 2017).

Separately, discrimination based on transgender status is a suspect classification. *See Norsworthy*, 87 F. Supp. 3d at 1119. Indeed, strict scrutiny is warranted when the government targets a class that (1) has been "historically subjected to discrimination," (2) has a defining characteristic bearing no "relation to ability to perform or contribute to society," (3) has "obvious, immutable, or distinguishing characteristics," and (4) is "a minority or politically powerless." *Windsor v. United States*, 699 F.3d 169, 181 (2d Cir. 2012), *aff'd on other grounds*, 570 U.S. 744 (2013) (internal quotation marks omitted). Although the first two considerations alone can be dispositive, *see Golinski v. U.S. Office of Pers. Mgmt.*, 824 F. Supp. 2d 968, 983 (N.D. Cal. 2012), all of them are present in the government's discrimination based on transgender status and so strict scrutiny applies, *see, e.g.*, *Karnoski v. Trump*, 2018 WL 1784464 *9-*10 (W.D. Wash. Apr. 13, 2018); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1144 (D. Idaho. 2018).

Under heightened scrutiny, a challenged classification is presumptively unconstitutional, and the government bears the burden of demonstrating that the classification bears a substantial relationship to important government interests. *U.S. v. Virginia*, 518 U.S. 515, 533 (1996) ("VMI"). Under strict scrutiny, the government action must be narrowly tailored to serve compelling interests. *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985). Under either standard, the government must account for the harms it causes, including the dignitary harm that results from imposition of a second-class status. *SmithKline Beecham v. Abbott Labs.*, 740 F.3d 471, 482 (9th Cir. 2014).

The Rule is not even rationally related to HHS's asserted interests in "removing unlawful barriers to careers in the health field" and "ensuring the implementation and enforcement of existing laws." 83 Fed. Reg. at 3916. On the contrary, the Rule arbitrarily elevates religious objections over the health and well-being of patients, contrary to federal law and the operational needs of healthcare

providers. Giving a preference for certain religious beliefs (particularly about reproductive care and gender dysphoria) over the needs of patients is not a legitimate government purpose. *McCreary Cnty.*, 545 U.S. at 859-60.

Although the Rule speculates about the possibility that an increased number of healthcare providers will enter the field if they are permitted to deny certain types of care, 84 Fed. Reg. at 23,247, 23,250, HHS admits that it lacks data to support (and the record does not support) that assertion. *See VMI*, 518 U.S. at 533 (hypothesized justifications inadequate under heightened scrutiny). And even if those additional providers entered the field, it would not solve the problem of discriminatory denials of care, because the new providers would be those who want to deny reproductive or transition-related care. HHS acknowledges that some patients (such as LGBT patients and those seeking reproductive care) will be disadvantaged, but concludes that the hypothetical benefits of the Rule to other people justify the Rule. 84 Fed. Reg. at 23,251-23,252. That is a government decision to benefit certain patients at the expense of others, and it is impermissible. *Romer v. Evans*, 517 U.S. 620, 633 (1996) (a preference for one group of people over another is a "denial of equal protection in the most literal sense"). The government may not give effect to "private bias." *Palmore v. Sidoti*, 466 U.S. 429, 433 (1984). When "sincere, personal opposition becomes enacted law and public policy, the necessary consequence is to put the imprimatur of the [government] itself on an exclusion that soon demeans or stigmatizes those whose own liberty is then denied." *Obergefell v. Hodges*, 135 S. Ct. 2584, 2602 (2015).

The Rule's wide-ranging, harmful effects easily could be avoided with a rule that respects religious objections while ensuring patient health, consistent with the existing policies of Plaintiffs and other healthcare organizations. The Rule's illegitimate purpose and poor tailoring, and the existence of obvious less restrictive alternatives, doom the Rule under the Equal Protection Clause.

D. Plaintiffs Are Likely to Succeed On Their Due Process Claim

The Fifth Amendment's Due Process Clause protects the right to make intimate decisions concerning procreation, family life, marriage, bodily integrity, and self-definition because such decisions are core to each person's identity, central to an individual's dignity and autonomy, and "shape an individual's destiny." *Obergefell*, 135 S. Ct. at 2593, 2597, 2599; *see Planned*

Parenthood v. Casey, 505 U.S. 833 (1992); *Lawrence v. Texas*, 539 U.S. 558, 574 (2003). The Rule violates this guarantee by unduly burdening patients' access to abortion; impermissibly interfering with their access to contraception; and impermissibly interfering with transgender and gender non-conforming patients' medical autonomy, bodily integrity, and ability to live in accordance with their gender identity.

1. Abortion

The Supreme Court has repeatedly affirmed a woman's right to "retain the ultimate control over her destiny and her body." *Casey*, 505 U.S. at 869. The government "may not prohibit any woman from making the ultimate decision to terminate her pregnancy" before viability. *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (quoting *Casey*, 505 U.S. at 879). It also may not impose an undue burden on the right to abortion. *Id*. Thus, a law is unconstitutional if its "purpose or effect" is to "'*place a substantial obstacle* in the path of a woman seeking an abortion before the fetus attains viability.'" *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016) (quoting *Casey*, 505 U.S. at 878). When analyzing restrictions on access to abortion, the Court has made clear that where a law's burdens exceed its benefits, those burdens are by definition undue, and the obstacles they embody are by definition substantial. *Id*. at 2300, 2309-10, 2312, 2318. The undue burden standard does not permit restrictions that hinder access to abortion. *Casey*, 505 U.S. at 877.

The Rule violates these principles. First, it empowers a broad class of healthcare employees to impede a pregnant person's exercise of the right to abortion prior to viability. *Casey*, 505 U.S. at 894-96. The Constitution prohibits unjustified state interference with abortion, even when the government invokes the rights of others to attempt to justify that interference. *Id.* at 894-96 (invalidating spousal-notification provision that would enable a husband to prevent his wife from obtaining an abortion; husband's interest did not permit the State to empower him with such "troubling degree of authority over his wife"). Rather than informing a woman's choice, the Rule coerces that choice by empowering third parties, including those with only a tangential connection to the procedure, to delay and even ultimately control a woman's decision. Permitting their views to override those of a pregnant person "hinder[s]" access to abortion in precisely the manner foreclosed by the Supreme Court. *Id*. at 877, 894-96.

Further, the Rule will deter pregnant persons from seeking abortion care, based on stigma, fear of judgment, fear of discrimination, and fear of receiving compromised care. *See* McNicholas Decl. ¶¶ 27-28. Stigma around abortion fosters fear and psychological stress in women seeking care. *See id.* ¶ 28; Barnes Decl. ¶ 30. And empowering a third party to effectively veto a pregnant person's abortion violates their right to make "choices central to personal dignity and autonomy." *Lawrence*, 539 U.S. at 574; *see also Obergefell*, 135 S. Ct. at 2602; *Casey*, 505 U.S. at 851. These deterrents will prevent pregnant people from seeking abortion "as surely as if the [government] had outlawed abortion in all cases." *Casey*, 505 U.S at 894.

Finally, the Denial-of-Care Rule will artificially limit the number of abortion providers across the United States. There already is a national shortage of abortion providers due to hospital mergers and laws restricting access to abortion in states throughout the country. McNicholas Decl. ¶ 19. The significant reduction in providers that likely will result from the Rule will delay and prevent women's access to care, compounding the logistical and financial burdens patients face and increasing their risk of injury and death. *Id.* ¶¶ 26-30.

Whether the Rule forces providers to self-regulate by altering their policies to permit the denial of care to patients, to cease providing abortion services altogether, or to face the loss of all federal funding, it coerces the decision to have an abortion and places an undue burden on the right to abortion in violation of the Due Process Clause.

2. Contraception

The Constitution also protects an individual's right to reproductive autonomy, including the use of contraception. The Supreme Court first recognized a constitutional right to make certain personal, intimate choices about whether and when to have children over fifty years ago. *Griswold v. Connecticut*, 381 U.S. 479 (1965). Since then, the Court has repeatedly reaffirmed that "the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State." *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687 (1977); *see Casey*, 505 U.S. at 852-53; *Eisenstadt*, 405 U.S. at 453.

Strict scrutiny applies to government actions that limit access to contraception. Access to contraception is a core aspect of bodily integrity, personal decision-making, and marital, familial,

and sexual privacy. *Casey*, 505 U.S. at 856. And the Supreme Court has not hesitated to strike down unjustified restrictions on access to contraception. For example, the Court invalidated a state statute that did not ban contraception directly but limited distribution of contraceptives to licensed pharmacists, explaining that it "clearly impose[d] a significant burden on the right of the individuals to use contraceptives" by decreasing access, price competition, and privacy in selection and purchase. *Carey*, 431 U.S. at 689. The Court recognized that the right to make decisions about contraception is fundamental, applied strict scrutiny, and concluded that the statute served no compelling state interest and bore no relation to the State's interest in protecting health. *Id.* at 685, 690-91.

The Denial-of-Care Rule fails strict scrutiny. The Rule lacks even a rational relationship to a legitimate government interest, let alone the required narrow tailoring to serve a compelling government interest. As explained (pp. 9-12, 14-16, *supra*), the Rule does not serve HHS's asserted purposes of encouraging health care providers to enter the field or implementing and enforcing existing laws, and it will cause numerous countervailing harms. The Rule will reduce access to contraception and remove from women and LGBT patients the most effective means by which to prevent unintended pregnancy, coercing them into unwanted pregnancies, imposing numerous health risks, and severely diminishing the fundamental right to reproductive decision-making. McNicholas Decl. ¶ 24; Phelps Decl. ¶ 34. This interferes with their ability to participate fully in the "marketplace and the world of ideas," *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 726 n.11 (1982), and drastically compromises their ability to make "choices central to personal dignity and autonomy," *Lawrence*, 539 U.S. at 574; *see Casey*, 431 U.S. at 690-91.

3. Gender-Affirming Care

The Denial-of-Care Rule invites healthcare providers to deprive transgender and gender non-conforming patients of medically necessary and often life-saving care, including treatment for gender dysphoria, thereby impermissibly burdening their medical autonomy, bodily integrity, dignity, and ability to live in accord with their gender identity. Gender is fundamental to a person's identity; it is the internalized, inherent sense of who a person is (*e.g.*, male, female, or non-binary). Ettner Decl. ¶ 14; Valle Decl. ¶ 13. This is as true for a transgender person as for a non-transgender

person. Ettner Decl. ¶ 14. A person's gender identity is so fundamental that they cannot be required to abandon it. *Id.* ¶ 15; *Hernandez-Montiel v. INS*, 225 F.3d 1084, 1093 (9th Cir. 2000), *overruled on other grounds by Thomas v. Gonzales*, 409 F.3d 1177, 1187 (9th Cir. 2005).

Each person has a fundamental right to live and express oneself in a manner consistent with their gender identity, because doing so is a core aspect of individual self-definition, dignity, and autonomy. *See Lawrence*, 539 U.S. at 562 ("Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct."). The substantive protections of the Due Process Clause protect the right of all people to possess and control their own person, and to "define and express their identity." *Obergefell*, 135 S. Ct. at 2593. This includes the right to live in accord with one's gender identity. *Karnoski*, 2017 WL 6311305, at *8 (plaintiffs likely to succeed in demonstrating that ban on transgender military service violates fundamental right of service members to live and express themselves in accordance with their gender identities) (injunction stayed by Supreme Court pending appeal); *Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 334 (D.P.R. 2018) (policy depriving transgender people of accurate identity documents infringed due process right to self-determination). And it includes the right to make medical decisions for oneself and to medical autonomy. *Coons v. Lew*, 762 F.3d 891, 899 (9th Cir. 2014).

The Rule infringes this protected autonomy and self-determination by inviting healthcare workers and entities to deny transgender patients access to medically necessary healthcare. For transgender and gender-nonconforming patients, the "only real path," *Obergefell*, 135 S. Ct. at 2594, to the full recognition and expression of their true selves, and to be able to participate in public life with dignity, consists of the ability to access gender-affirming medical care, including surgical procedures, hormone therapy, and other medically necessary care. The ability to live in accord with and express one's gender identity is "so fundamentally important . . . that the government may not, absent satisfying a heightened level of scrutiny, infringe or burden an individual's autonomy or freedom to make [such a] decision." Scott Skinner-Thompson, *Outing Privacy*, 110 Nw. U. L. Rev. 159, 171-72 (2015). The Rule severely burdens transgender and gender-nonconforming patients, while not rationally serving even any legitimate governmental

interest, let alone the compelling one required. It therefore violates due process.

E. Plaintiffs Are Likely to Succeed On Their Free Speech Claim

The Denial-of-Care Rule impermissibly chills LGBT patients who seek medical care from being open about their gender identity or transgender status and from expressing themselves in a manner consistent with their gender identities. Courts long have held that disclosing one's gender identity or sexual orientation—sometimes referred to as "coming out"—is protected First Amendment expression. *See Karnoski*, 2017 WL 6311305, at *9 (disclosure of gender identity and transgender status protected); *Log Cabin Republicans v. United States*, 716 F. Supp. 2d 884, 926 (C.D. Cal. 2010) (military's "Don't Ask, Don't Tell" policy was a content-based speech restriction because "[h]eterosexual members are free to state their sexual orientation . . . while gay and lesbian members of the military are not"), *vacated as moot*, 658 F.3d 1162 (9th Cir. 2011); *see Gay Students Org. of Univ. of N.H. v. Bonner*, 509 F.2d 652, 659-61 (1st Cir. 1974); *Henkle v. Gregory*, 150 F. Supp. 2d 1067, 1075-77 (D. Nev. 2001); *Weaver v. Nebo Sch. Dist.*, 29 F. Supp. 2d 1279, 1284-85 (D. Utah 1998); *Fricke v. Lynch*, 491 F. Supp. 381, 385 (D.R.I. 1980). An individual's definition and expression of their gender identity through their appearance also is protected expression. *See Doe ex rel. Doe v. Yunits*, 2000 WL 33162199, at *3 (Mass. Super. Oct. 11, 2000), *aff'd sub nom*, *Doe v. Brockton Sch. Comm.*, 2000 WL 33342399 (Mass. App. Ct. Nov. 30, 2000).

The Rule impermissibly burdens this protected speech and expression. A regulation "may burden speech" even if it "stops short of prohibiting it." *Doe v. Harris*, 772 F.3d 563, 572 (9th Cir. 2014). Here, the Rule will have the "inevitable effect of burdening," *id.* at 574, LGBT patients' disclosure of their transgender status or their gender-nonconforming expression because they will fear denial of healthcare if they do make such disclosure, *see Mendocino Envtl. Ctr. v. Mendocino Cnty.*, 192 F.3d 1283, 1300 (9th Cir. 1999) (government action violates First Amendment if it would cause a person of "ordinary firmness" to self-censor). It does not matter that this chilling depends both on governmental and non-governmental actors (the objecting employees), because the government "may not induce, encourage or promote private persons to accomplish what it is constitutionally forbidden to accomplish." *Norwood v. Harrison*, 413 U.S. 455, 463, 465 (1973). The Rule also denies the benefit of federal healthcare funds to transgender and gender

nonconforming people based on their protected expression. Doing so also penalizes and inhibits the exercise of that fundamental freedom. *Riley v. Nat'l Fed'n of the Blind of N.C., Inc.*, 487 U.S. 781, 794 (1988); *Perry v. Sindermann*, 408 U.S. 593, 597 (1972). And the Rule is overbroad because it impermissibly chills and burdens the exercise of a substantial amount of patients' constitutionally protected speech and expression, beyond any legitimate sweep of the underlying statutes. *See United States v. Sineneng-Smith*, 910 F.3d 461, 470 (9th Cir. 2018).

The Rule burdens speech based on its content and viewpoint, because it attaches different consequences to the same speech depending on the identity of the speaker. *See Police Dep't of Chicago v. Mosley*, 408 U.S. 92, 96 (1972). For example, the Rule facilitates denial of treatment to a transgender woman who discloses her gender identity or checks the box marked "female" at her endocrinologist's office, but not to a non-transgender woman who discloses that she identifies as cisgender and female. The government may not burden speech "because of disapproval of the ideas expressed." *R.A.V. v. City of St. Paul, Minn.*, 505 U.S. 377, 382 (1992) (citations omitted). Content-based regulation is subject to "the most exacting scrutiny," *Texas v. Johnson*, 491 U.S. 397, 412 (1989) (citation omitted), and "[v]iewpoint discrimination is . . . an egregious form of content discrimination," *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 829 (1995).

The Rule cannot satisfy that rigorous First Amendment scrutiny because it lacks sufficient justification for the many harms it will cause. The Rule will harm patients by coercing them to stay in the closet, to self-censor about their medical histories and needs, and to refrain from engaging in gendered expression. Shanker Decl. ¶¶ 11-12; Vargas Decl. ¶ 14; Henn Decl. ¶ 5; Bolan Decl. ¶¶ 8-10; Carpenter Decl. ¶ 11; Manley Decl. ¶ 8; Harker Decl. ¶ 14. Remaining closeted from a healthcare provider can result in significant adverse health consequences, not just to an individual patient, but to public health. *See* Bolan Decl. ¶¶ 10-11 (patient who conceals same-sex sexual history may not be screened for HIV or other infections or cancers, or prescribed medications effective at preventing HIV transmission; transgender patients who do not disclose their transgender status may not be given necessary tests and screenings, such as for testicular or prostate cancer for transgender women); Carpenter Decl. ¶ 5 (patient who did not disclose same-sex sexual

history to provider was not given appropriate testing and passed his infection to five other people before appropriate diagnosis).

Many LGBT patients already fear healthcare providers because of past experiences of anti-LGBT bias after disclosing their sexual orientation or gender identity, and a significant number are not "out" to one or more of their healthcare providers. Shanker Decl. ¶¶ 10-11; Henn Decl. ¶ 3; *see* Ettner Decl. ¶ 55. The Rule will erode trust further between patients and providers, resulting in worse patient outcomes. Carpenter Decl. ¶¶ 8-9; Henn Decl. ¶ 5; *see Conant v. Walters*, 309 F.3d 629, 636-37 (9th Cir. 2002) (recognizing, in a First Amendment challenge, that "barriers to full disclosure would impair diagnosis and treatment"). There is no justification for those harms, and there is a readily available, workable alternative—the policies put in place under the narrow statutes that Congress enacted to protect religious objectors. Because the Rule goes well beyond those statutes, burdening constitutionally protected speech for no good reason, it violates the First Amendment.

F. The County Is Likely to Succeed on Its Separation-of-Powers and Spending Clause Claims

In promulgating the Rule, HHS has usurped congressional authority to impose conditions on federal spending and imposed conditions that transgress the bounds of even Congress' spending power.[4]

Since the Nation's founding, the power of the purse has been allocated to Congress, the branch of the federal government more directly answerable to the people. *See* U.S. Const. art. I, § 8, cl. 1; *see City & Cnty. of S.F. v. Trump*, 897 F.3d 1225, 1231 (9th Cir. 2018). Congress may give Executive Branch agencies some discretion in deciding how to use appropriated funds, but that discretion necessarily is cabined by the scope of the delegation. *City of Arlington, Tex. v. F.C.C.*, 569 U.S. 290, 297-98 (2013). Further, agencies may not use appropriated funds in a way that effectively alters the terms of the anchoring statutes, which Congress has "finely wrought and exhaustively considered" via the legislative process. *Clinton v. City of New York*, 524 U.S. 417,

[4] The County joins in the Spending Clause and separation-of-powers arguments advanced in the motions for preliminary injunctive relief submitted by the State of California and City and County of San Francisco. *See State of California v. Azar*, No. 4:19-cv-02769-HSG (N.D. Cal.), Doc. No. 11; *City and County of San Francisco v. Azar*, No. 4:19-cv-2405-JCS (N.D. Cal.), Doc. No. 14.

439-40 (1998). As explained (pp. 20-23, *supra*), the Rule radically departs from federal religious-objector statutes, falling well outside the authority Congress has delegated.

Indeed, the Rule is so coercive and unfair that even Congress would lack authority to impose the same conditions by statute. The Rule places States and localities like the County at risk of potentially ruinous sanctions, based on unanticipated, after-the-fact, and confusing requirements. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581-84 (2012) (conditioning continued receipt of Medicaid funding on after-the-fact conditions exceeded Congress's Spending Clause powers); *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) (if Congress wishes to condition the States' receipt of federal funds it "must do so unambiguously"). And it threatens funding of critical local functions—including those supporting many of the County's most vulnerable populations, protecting the health and safety of children and individuals with disabilities, and ensuring disaster preparedness—to advance concerns unrelated to the federal interest in the particular programs being funded. *See Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 580; *see also South Dakota v. Dole*, 483 U.S. 203, 207-08 (1987).

HHS lacks authority to so forcibly unravel local public policy choices. The County is responsible under California law for providing medical care for indigent patients, preventing the transmission of communicable disease, and protecting the health and safety of its residents. Cal. Const. art. XI, § 7; Cal. Welf. & Inst. Code § 17000 *et seq.*; Cal. Health & Saf. Code §§ 10100 and 120100 *et seq.* Its hospitals, pharmacies, clinics, and public health department rely on roughly a billion dollars in federal funding for their continued existence and operation. Lorenz Decl. ¶ 22. In mandating that the County allow its staff to turn patients away based on religious objections to the care sought, to refuse to help during an emergency based on such objections, or otherwise to stigmatize and harm patients, the Rule is fundamentally inconsistent with the County's own policy choices and flatly interferes with its exercise of local, public-health functions. It was precisely to protect such policy choices about matters of local concern that the Framers reserved to the States and their political subdivisions all powers not expressly enumerated in the Constitution. *See United States v. Morrison*, 529 U.S. 598, 617-19 (2000); *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996); *Hillsborough Cnty., Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985).

II. IF PERMITTED TO TAKE EFFECT, THE RULE WILL IRREPARABLY HARM PLAINTIFFS, THEIR MEMBERS, AND THEIR PATIENTS

Because of the Rule, Plaintiffs' patients will almost certainly experience delays in obtaining medical care or be denied care altogether, leading them to incur increased costs and suffer worse health outcomes. The Rule will compromise Plaintiffs' ability to fulfill their core functions and ensure adequate patient care, and will require them to incur unrecoverable administrative costs to attempt to comply with the Rule. The Rule also will violate the constitutional rights of Plaintiffs and their patients. This Court should issue a preliminary injunction to prevent these irreparable harms while it considers Plaintiffs' challenge to the Rule.

A. The Rule Will Severely Harm Plaintiffs' Patients

As a result of the Rule, Plaintiffs' patients will encounter new obstacles to obtaining medical care. They will face increased risks that they will be denied care or information because a healthcare worker whom they encounter objects to certain procedures. They will find it more difficult to obtain certain services because the Rule will deter healthcare facilities from offering those services. And some of them will not be able to obtain medically necessary healthcare.

The delay or denial of healthcare, particularly in emergency situations, is likely to cause patients pain, complications, injury, or even death—all irreparable harms. *See Harris v. Bd. of Supervisors, Los Angeles Cnty.*, 366 F.3d 754, 762 (9th Cir. 2004). Patients seeking contraceptive care may suffer substantial consequences such as an unintended pregnancy if their care is delayed. McNicholas Decl. ¶ 41; *see Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 828 (E.D. Pa. 2019). And patients who are not informed of all information and options regarding their care will have their rights to informed consent stripped away. Nguyen Decl. ¶ 9; McNicholas Decl. ¶ 18.

Patients denied care will also face irreparable dignitary and emotional harms. That is particularly true for transgender patients denied transition-related care because an employee objects to their very identity, and for reproductive healthcare patients denied the ability to make choices central to defining their life's course. Lorenz Decl. ¶ 16; Sproul Decl. ¶ 13; Burkhart Decl. ¶ 22; McNicholas Decl. ¶ 43; Pumphrey Decl. ¶ 8; Ettner Decl. ¶¶ 48, 56; *see Whitaker*, 858 F.3d at 1045 (describing harm to transgender boy as a result of being denied access to school's restroom for boys). Patients who anticipate that they may be refused care under the Rule will be deterred from

seeking care or providing information important to their care, fearing hostility and stigma. Lorenz Decl. ¶ 15; McNicholas Decl. ¶¶ 8, 23, 28-29, 44-47; Bolan Decl. ¶ 8; Ettner Decl. ¶ 55. That stigma—"imposition of a second-class status"—is "itself a harm of great constitutional significance." *SmithKline Beecham*, 740 F.3d at 482. "Ultimately, the consequence of the reduced availability and quality of health services is worse health outcomes for patients and the public as a whole." *California v. Azar*, 2019 WL 1877392, at *10 (N.D. Cal. Apr. 26, 2019).

The regime that HHS seeks to create, which elevates religious objections over all other concerns, also violates the constitutional rights of Plaintiffs and their patients. "It is well established that the deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)). When a plaintiff raises even a "colorable claim" of a First Amendment violation, that itself is sufficient to establish irreparable injury. *Warsoldier v. Woodford*, 418 F.3d 989, 1002 (9th Cir. 2005). The Rule's many immediate harms provide good reason to enjoin its enforcement.

B. The Rule Will Require Plaintiff Healthcare Providers to Incur Substantial, Unrecoverable Costs

Certain Plaintiffs, including the County, have adopted policies and practices that accommodate and respect religious objections while ensuring patient care and operational stability. *See* Lorenz Decl. ¶ 11. If the Rule goes into effect, those Plaintiffs will immediately incur significant costs to review their policies and practices and create new ones in an effort to comply with the Rule. *See* Lorenz Decl. ¶ 20; Burkhart Decl. ¶¶ 13, 18, 27. These costs are not recoverable, and they constitute irreparable harm. *See California v. Azar*, 911 F.3d 558, 581 (9th Cir. 2018) (noting that the APA makes no allowance for monetary damages, and thus economic harms are irreparable in APA challenges).

Because the Rule expands the categories of employees who may invoke objections, the costs and administrative burdens associated with managing employees' religious and moral objections will increase substantially. Under the County's current policies, religious objectors must make their managers aware of their objections in advance to permit staffing arrangements that avoid compromising patient care. Lorenz Decl. ¶ 11, Ex. A; *see* Tullys Decl. ¶ 9 (describing provider

requiring prior notice of covered services); Butler Decl. ¶ 5 (same). Workers may raise objections only to the direct provision of care. Lorenz Decl. ¶ 11, Ex. A. Under the Rule, the burden will shift to providers to ask essentially every employee (rather than just medical staff) about any objections that the employee might have to any job duties, even those duties only remotely connected to patient care. *See* 84 Fed. Reg. at 23,186-23,187 (stating that "[s]cheduling an abortion" or "preparing a room and the instruments for an abortion" constitute "assistance"). If the Rule goes into effect, the County will be forced to bear the costs of asking thousands of employees those questions and processing the responses. *See* Lorenz Decl. ¶ 12. Those administrative costs also are an irreparable harm. *See California*, 911 F.3d at 581.

The requirement that the County change its policies to comply with the Rule also conflicts with the County's power as a local government to craft policies and procedures that are tailored to community needs. In threatening to cut off hundreds of millions of dollars in federal funding, HHS will be unlawfully coercing the County to force it to adopt federal policy, contravening the Spending Clause and overstepping the Executive Branch's constitutional role. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581 (2012). That coercion will cause irreparable harm to the County. *See Cnty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 538 (N.D. Cal. 2017) ("By forcing the Counties to make this unreasonable choice [between complying with an unconstitutional Executive Order and losing millions of dollars in federal grants], the Order results in a constitutional injury sufficient to establish . . . irreparable harm.").

C. The Rule Will Compromise Plaintiffs' Operations, Missions, And Core Functions

The Rule will jeopardize Plaintiffs' ability to ensure high quality, compassionate, and culturally competent care and to comply with their legal obligations and medical ethics requirements. Even if Plaintiff providers are able to survey all their employees promptly about religion-based objections, they likely still will not be able to ensure proper patient care. The Rule bars reassignment of employees without their consent, potentially even when an employee cannot fulfill his job duties because of his religious objections. *See* 84 Fed. Reg. 23,191-23,192 (stating that religious objections must not disqualify a person from a job position and leaving unanswered

what happens if the objected-to activities are core job duties). Thus, Plaintiffs may be unable to address religious objections through accommodations and reassignments. *See* Nguyen Decl. ¶ 5. This will interfere with providers' ability to ensure proper care and will harm patients across the country.

For example, a pharmacist in the County's health system who is the only pharmacist on site may refuse to dispense contraception, *see* Singh Decl. ¶¶ 9-10; a receptionist may refuse to schedule a transgender patient for an appointment to discuss gender-affirming care, *see* Nguyen Decl. ¶ 6; or a healthcare professional may refuse to inform a pregnant person that their pregnancy is non-viable, McNicholas Decl. ¶ 23; Phelps Decl. ¶ 25. An employee could object even to passing along the patient's information and requests to a coworker. As a result, the patient may not receive the care they seek. *See* Nguyen Decl. ¶¶ 6, 9; Butler Decl. ¶ 8. The Rule will compromise providers' ability to deliver care, and so it will cause irreparable harm. *California*, 2019 WL 1877392, at *8.

The Rule will frustrate all Plaintiffs' core missions of providing high-quality, nondiscriminatory healthcare. Barnes Decl. ¶¶ 11, 22-25; Burkhart Decl. ¶ 30. That alone is irreparable harm. *See California*, 2019 WL 1877392, at *8 (HHS regulation restricting Title X grants imposed likely harm on organizational plaintiffs' "mission to promote access to high-quality healthcare"). Patients subject to these religious objections will, justifiably, lose trust in healthcare providers, compromising the patient-provider relationship and undermining the providers' missions. Lorenz Decl. ¶ 15; Cody Decl. ¶ 8. For example, communities rely on Trust Women Seattle and Hartford Gyn as safe places for them to receive nonjudgmental care and information. Were these clinics to lose their ability to protect patients from delayed and denied care, stigma, and judgment, they would sacrifice their central missions. Barnes Decl. ¶¶ 20-23; Burkhart Decl. ¶¶ 26, 30.

Providers and patients will suffer significant harm because, although providers previously have been able to expect all staff to assist patients in the event of an emergency, the Rule includes no emergency exception and in fact contemplates that religious objectors can deny care in an emergency. *See* 84 Fed. Reg. at 23,176. The Rule consciously declines to address what providers can require of their employees in an emergency. *See id.* at 23,176. This will threaten patient safety

and cause irreparable harm from the moment the Rule goes into effect. *See City & Cnty. of S.F.*, 897 F.3d at 1244 (need for certainty about how to maintain federal funding justified a permanent injunction). This lack of clarity is especially problematic given providers' obligation to comply with EMTALA. In the face of this uncertainty, the only way that providers could both ensure patient safety and protect their federal funding would be to double staff in preparation for objections during emergencies—a prohibitively expensive practice. Nguyen Decl. ¶ 6; Lorenz Decl. ¶ 19; Burkhart Decl. ¶ 30.

Moreover, without certainty on how to comply and keep their federal funding, the healthcare provider Plaintiffs' ability to budget, plan for the future, and properly serve their patients would be irreparably harmed. *See Cnty. of Santa Clara*, 250 F. Supp. 3d at 537. And providers like the County would face immediate exposure to punitive penalties for any asserted violation of the Rule. If despite the County's best efforts, an OCR official believes that the County has failed to comply, the County could lose all federal funding—which would devastate its ability to continue providing care to patients. *See* Lorenz Decl. ¶ 24; Cody Decl. ¶ 19 ("Many, if not most, of the individuals served through the Public Health Department's various programs simply would not get the care and resources that they need without federally funded services.").

It is already the case that religion-based objections to care by institutions and individuals are pushing abortion and contraception care and training out of healthcare facilities across the country. Phelps Decl. ¶ 35. Under the Rule, there will likely be even more hospitals and facilities that will be forced to forgo providing abortion, contraception, or LGBT services entirely. McNicholas Decl. ¶ 27; Phelps Decl. ¶ 29; Shafi Decl. ¶ 15. That discontinuation of services by some providers would impose additional financial burdens on providers that continue to provide full reproductive and LGBT healthcare services, as patients would look to them to serve the needs previously met elsewhere. *See* Vargas Decl. ¶ 17; Shanker Decl. ¶ 9; Shafi Decl. ¶¶ 20-22; Cummings Decl. ¶¶ 15-16. For example, Medical Students for Choice ("MSFC") already struggles to meet the need for family planning training, and it anticipates that under the Rule, it will not have capacity to instruct the growing number of medical students and residents who want and need education in contraception and abortion. Phelps Decl. ¶ 49. If healthcare entities decide to stop

providing abortion and contraceptive care and associated training to avoid conflict with the Rule, it will devastate access to that care throughout the country. Backus Decl. ¶ 18; Phelps Decl. ¶¶ 30, 35.

Some Plaintiffs will need to redirect their resources to helping patients deal with the Rule's effects, frustrating their missions and causing them irreparable harm. *Cf. Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379 (1982). For example, Center on Halsted has already redirected resources to providing information to its clients about the Rule and to holding internal trainings on it. Valle Decl. ¶ 16. And GLMA has also had to divert resources to educate and assist its members and their patients in understanding the Rule and coming up with ways to ameliorate its adverse effects. Vargas Decl. ¶ 15.

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

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

It is in the public interest to permit Plaintiffs' hospitals and other healthcare facilities to continue operating and serving patients. Many of them are facilities of last resort for patients. Manley Decl. ¶ 7; Shafi Decl. ¶¶ 18-20; Cummings Decl. ¶¶ 9-13; Valle Decl. ¶¶ 5-7, 14. The prevention of widespread public-health harms vastly outweighs any interest that HHS can claim in immediate enforcement of the Rule. *See California v. Azar*, 911 F.3d 558, 582 (9th Cir. 2018) (in an APA challenge to HHS rules about contraceptive coverage, the balance of equities favored a preliminary injunction because the rules risked "potentially dire public health and fiscal consequences" in contravention of the "public interest in access to contraceptive care"). An injunction also would prevent an upheaval in medical practice, which the medical community has vigorously opposed. *See* AMA Cmt. Ltr. 7.

Plaintiffs also have demonstrated that the likely result of the Rule's enforcement against them is a violation of their patients' constitutional rights, which must outweigh any interest that HHS has in immediate changes to Plaintiffs' practices. *See Melendres*, 695 F.3d at 1002 (final factors of preliminary-injunction standard always weigh in favor of "prevent[ing] the violation of a party's constitutional rights"); *Planned Parenthood Ass'n of Cincinnati, Inc. v. Cincinnati*, 822 F.2d 1390, 1400 (6th Cir. 1987) (similar). This harm outweighs any government interest in immediate enforcement of the Rule.

Because there will be many immediate harms to providers, patients, and the public health if the Rule is enforced, and no harms to the government if the Rule is delayed, the public interest clearly favors freezing the status quo pending final resolution of Plaintiffs' claims.

IV. THE COURT SHOULD ENTER A NATIONWIDE INJUNCTION

The Court's authority to issue a nationwide injunction is well-established. *See, e.g.*, *Texas v. United States*, 809 F.3d 134, 188 (5th Cir. 2015) ("It is not beyond the power of a court, in appropriate circumstances, to issue a nationwide injunction."). "[T]he scope of injunctive relief is dictated by the extent of the violation established, not by the geographical extent of the plaintiff." *E. Bay Sanctuary Covenant v. Trump*, 909 F.3d 1219, 1255 (9th Cir. 2018) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979)). There is "no general requirement that an injunction affect only the parties in the suit." *Regents of the Univ. of Cal.*, 908 F.3d at 511 (quoting *Bresgal v. Brock*, 843 F.2d 1163, 1169 (9th Cir. 1987)). Instead, "[a]n injunction may extend 'benefit or protection' to nonparties if such breadth is necessary to give prevailing parties the relief to which they are entitled." *E. Bay*, 909 F.3d at 1255 (internal quotation marks omitted); *accord Azar*, 911 F.3d at 582.

Nationwide relief is necessary to forestall the significant harms threatened here. Plaintiffs are located throughout the United States and include three nationwide associations of medical professionals (MSFC, AGLP, and GLMA) whose members work in hundreds, if not thousands, of healthcare facilities across the country. *See* Vargas Decl. ¶ 2; Phelps Decl. ¶ 3; Harker Decl. ¶ 2. A nationwide injunction therefore is required simply to give complete relief to the Plaintiffs in this case. The Rule will frustrate MSFC's mission by incentivizing "the limited number of remaining

programs training students and residents in abortion and contraception to discontinue family planning training." Backus Decl. ¶ 11. The Rule will undermine GLMA's mission of ensuring nondiscriminatory care for LGBT patients across the country, Vargas Decl. ¶¶ 1-2, not only by encouraging providers to raise more religious objections but by intimidating professional accreditation bodies "from holding healthcare providers accountable for discrimination against LGBTQ people." *Id.* ¶ 10. The Rule will frustrate AGLP's mission of promoting LGBTQ mental health and supporting personal growth for LGBTQ psychiatrists by undermining "safe work spaces for LGBTQ psychiatrists and nondiscriminatory healthcare services to [their] LGBTQ patients." Harker Decl. ¶¶ 1, 6, 9, 10. These harms can be avoided only if the Rule is enjoined as to everyone.

Plaintiff healthcare providers also will be deprived of complete relief if the injunction is limited to the parties in this case. An injunction limited to the parties here will not "prevent the . . . harm . . . detailed in the record." *Azar*, 911 F.3d at 584. If Plaintiffs do not have to comply with the Rule, but all other healthcare providers do, Plaintiffs will become the only option for avoiding the risk of discrimination. That will impose immense burdens on Plaintiffs' operations. The Rule would hamper not only Plaintiffs' "ability to provide services to their *current* clients," but also "their ability to pursue their programs writ large." *E. Bay Sanctuary Covenant v. Trump*, 354 F. Supp. 3d 1094, 1121 (N.D. Cal. 2018).

Finally, Plaintiffs have established that the Rule violates the APA—a paradigmatic circumstance for enjoining a regulation nationwide. *Regents*, 908 F.3d at 511-12 (nationwide injunctive "relief is commonplace in APA cases"). "In this context, '[w]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed." *Id.* at 511 (quoting *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998)). The Rule's harms will be immediate and severe, and they will occur nationwide. But this Court can avoid them simply by putting the Rule on pause.

CONCLUSION

The Court should preliminarily enjoin implementation of the Rule.

DATED: June 11, 2019

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 11th day of June, 2019, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF system for filing.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF LOIS BACKUS, M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, Lois Backus, M.P.H., declare as follows

1. I am the Executive Director of Plaintiff Medical Students for Choice ("MSFC"). MSFC is 501(c)(3) non-profit that advocates for full integration of reproductive healthcare, including abortion and contraception, into the curricula at medical schools and residency programs. A copy of my curriculum vitae setting forth my experience, education, and credentials in greater detail is attached as Exhibit A.

2. MSFC is comprised of student-led chapters at medical schools, and these grass-roots, student activists are supported by the national MSFC staff, who implement programming, manage resources, and provide expertise. Medical student activists make up the majority of our Board of Directors, and the MSFC student chapters provide data and information about the state of family planning training at the local-level to guide the strategic planning of the Board.

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

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

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

6. Despite this considerable number of students desiring family planning training and the commonality, simplicity, and safety of outpatient abortion,[1] most medical students do not receive training in abortion, and some do not even receive training in contraceptive care. Less than half of our members learned about first-trimester abortion from their schools.

[1] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 77 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

7. When future doctors are not educated about abortion and family planning, they are unable to offer their patients the full range of reproductive healthcare.

8. Reproductive choice is only a reality for patients when there are enough family planning providers available to meet patients' needs and such providers are geographically accessible and available in an equitable distribution. Presently, the supply of such providers is not meeting the needs of American patients, in large part because facilities providing abortion are increasingly concentrated in cities, and very few primary care providers are skilled in family planning despite the continuity of care they could offer to patients, especially outside of urban areas.[2] Only a very small number of privately practicing OB/GYNs provide abortion in their practice, and one survey found that 35% of physicians who do not provide abortion do not refer for it either.[3] As threats to abortion training programs increase, this gap widens, further constraining abortion access for patients.[4]

9. Medical schools and residency programs receive substantial funding from HHS. Teaching hospitals receive a significant majority of their training budgets from HHS. In total, HHS provides over $10 billion per year directly and indirectly to teaching hospitals through Medicare, Medicaid, and other funding streams.[5] In 2018, 45 of the 50 top National Institutes of Health grant amounts were to teaching hospitals and medical education programs.[6] Residency

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[2] *See* Susan Yanow, *It Is Time to Integrate Abortion into Primary Care*, 103(1) Am. J. of Pub. Health 14 (2013).

[3] Desai S et al., *Estimating Abortion Provision and Abortion Referrals Among United States Obstetrician-Gynecologists in Private Practice*, 97(4) Contraception 297 (2018).

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

[5] Elayne J. Heisler et al., *Federal Support for Graduate Medical Education: An Overview*, Congressional Research Service (Dec. 27, 2018), https://fas.org/sgp/crs/misc/R44376.pdf.

[6] Alex Philippidis, *Top 50 NIH-Funded Institutions of 2018*, Genetic Engineering & Biotechnology News (June 4, 2018), https://www.genengnews.com/a-lists/top-50-nih-funded-institutions-of-2018.

programs are directly subsidized by federal programs—residents receive salaries from Medicare funding, and residency programs bill to Medicare for the services of their residents.

10. I understand that teaching hospitals and residency programs are considered "direct recipients" under the Rule. All of the institutions and programs currently training our student members must immediately comply with the Rule if it goes into effect. Moreover, to the extent that medical students and residents are considered subrecipients under the Rule, a teaching facility may also bear responsibility for the compliance of their students or residents.

11. MSFC fears that the Rule will significantly incentivize the limited number of remaining programs training students and residents in abortion and contraception to discontinue family planning training. MSFC justifiably fears further and extensive reduction in training programs because it has already become aware of extensive threats to such training even prior to the promulgation of the Rule, and the Rule will provide extremely strong incentives for the remaining providers to turn away abortion patients.

12. The national MSFC staff works to guide its student chapters on how to acquire training in family planning and avoid pitfalls imposed by certain institutions or legal requirements constraining access to such training. We monitor the state of abortion and contraception access across the country closely so we can effectively advise our chapters, and we receive data and information about access to abortion training across the 45 states in which our chapters operate.

13. Even when individual students and residents are willing to be trained in abortion care and contraception, and providers are willing to provide such education and services, their institutions may restrict the services they can learn and provide on the basis of religious or moral objection. These objections have already resulted in a severe reduction in the provision of family planning services.

14. For example, four of the ten largest healthcare systems in the United States by hospital count are now religiously-sponsored, a circumstance attributable in part to massive hospital consolidations between Catholic systems and secular institutions. Catholic hospitals now

care for approximately 1 in every 6 hospital patients in the U.S.[7] These hundreds of hospital consolidations have led many facilities to sacrifice family planning services.[8]

15. That is because religiously-affiliated institutions often have guidelines that prevent them from providing comprehensive reproductive healthcare. For example, the U.S. Conference of Catholic Bishops has issued *The Ethical and Religious Directives for Catholic Health Care* Services, which governs all Catholic health institutions and must be adopted by any hospital wishing to merge with a Catholic facility.[9] The *Directives* forbid doctors working in Catholic hospitals from all abortion and contraception procedures and counseling, except "natural family planning."[10] Aside from the direct prohibition on abortion and contraception, the *Directives* significantly restrict postpartum and direct sterilization, including tubal ligation and hysterectomy, elimination of ectopic pregnancy, medical miscarriage management or other fetal loss, screening for fetal anomalies, assisted reproductive technologies like IVF, and HIV and STI prevention counseling.[11] For example, following the merger of Swedish Medical Center ("Swedish") with Providence Health in 2012, the family medicine residency program at Swedish lost access to abortion training, and those residents have had to travel to other states to obtain it. The purchase of the Los Angeles County/University of Southern California family medicine

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[7] Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage Of Medicine Report*, MergerWatch 1 (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=XlfagUpjX2g9GXDKAyqHQHDUbig%3D.

[8] *See id.*

[9] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018).

[10] *Id.* at 19.

[11] *See id.* at 18-19; *see also* Uttley & Khaikin, *supra* note 7, at 1 ("Catholic hospitals operate under ethical directives that prohibit the provision of key reproductive health services (such as contraception, abortion, sterilization and infertility services). We documented instances in which, as a result of these directives, women suffering reproductive health emergencies — including miscarriages — have been denied prompt, appropriate treatment at Catholic hospitals." (citing United States Conference of Catholic Bishops, *supra* note 9)).

program by Dignity Health in 2012 (formerly known as Catholic Healthcare West) resulted in a ban on abortion training and counseling as well as a prohibition on prescribing birth control for all residents.

16. As a result of these mergers and other factors, it is already the case that huge regions of the country in the South and Midwest of the U.S. have deserts of abortion training where no hospitals or training programs offer abortion or contraception training.[12] This compounds the existing gaps in abortion and contraception access by preventing locally-training physicians from becoming skilled in providing family planning services.

17. In such areas, most of the limited opportunities to acquire training in family planning are offered by independent abortion clinics and Planned Parenthood affiliates. But, these facilities are themselves under tremendous strain from state restrictions in the South and Midwest.[13] And some states, including Oklahoma, require medical students to receive training at public hospitals, none of which provide family planning training.

18. There is no place in the country, however, that is not already experiencing threats to abortion training accessibility based on objections to care.[14] We expect that many hospitals that have not already bowed to the pressure from other institutions, members of their own leadership or staff, and/or political controversy to restrict or cease the provision of abortion and contraception, will quickly self-police and cease offering these services in order avoid the possibility of failing to comply with the Rule's vague and unworkable requirements. Further, we expect this self-regulation to take place not only in the South and Midwest, but in regions of the United States where access to reproductive healthcare is often assumed to be untouchable.

19. Several institutions have already bowed to this pressure, demonstrating the likelihood that the Rule will lead many other institutions to self-regulate. For example, the MSFC

[12] *See* Cartwright AF et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20(5) J. of Med. Internet Res. e186 (2018).

[13] *See id.*

[14] *See id.*

staff has spent two years working with a medical student at a major New York medical school. In 2008, this medical school simply eliminated all abortion information from the medical education curriculum because of the religious concern of a major donor who sat on the Board of the over-arching health system. Since 2017, we have been assisting with producing a proposal to reimplement reproductive healthcare education for medical students at that institution. When asked by an MSFC resident, the medical students indicated that they thought the exclusion of abortion care was normal for American medical schools.

20. Also in New York state, an MSFC alumni treated a patient who was refused service at an emergency room while she was having a pre-viability miscarriage because a fetal heartbeat could still be detected. Although prior to viability, a completion of miscarriage procedure is the standard of care in such circumstances, individuals and institutions with religious and moral objections to abortion often treat these cases as abortion cases. She travelled to another provider, and the hospital and providers who ultimately received the patient further put her in jeopardy when the only anesthesiologist available refused to participate in the completion of miscarriage procedure, even as the patient had begun to hemorrhage.

21. At another major university in the Midwest, the family medicine residency program shut down the abortion training portion of their residency program because they were unwilling to risk the loss of any funding pursuant to a funding restriction that prohibited state funding for training on abortion that was passed in that state. The OB/GYN residency program, which was under separate leadership, elected to use other streams of funding to support their abortion training. Because of that, at that institution, depending on your residency program, even in the overall area of family or reproductive health, you may or may not have access to institutional abortion training due to distinctions in leadership within an overarching structure.

22. At another major east coast university medical school, students can rotate through a clinic for the homeless. Physicians who supervise the rotation are outspoken and anti-choice. As a result, MSFC members who performed the rotation were unable to even counsel patients about

contraception because the supervising physicians informed the students that such care was "upsetting" to them (the physicians).

23. Teaching hospitals—defined as any hospital that provides any training to residents or medical students—are the vast majority of hospitals in the United States. Many training programs also place students at other hospitals in their area. For example, another large medical school sends residents to 5 hospitals. One of these is a Catholic hospital. Based arbitrarily on where they are placed, therefore, residents may not be exposed at all to reproductive healthcare.

24. Catholic hospitals are also not the only religiously-affiliated hospitals that fail to provide reproductive healthcare. Other religiously-affiliated healthcare providers, including Adventist hospitals, do not provide such services.[15]

25. A medical school in Seattle ceased its abortion training due to the adoption of the *Ethical and Religious Directives* and began sending residents to Colorado to receive that training. This imposed significant cost on the program. When Colorado ceased providing training, the program began to send residents to Hawai'i for training at an even greater cost. Few programs will be this committed to training in abortion care.

26. We are familiar with numerous other instances of providers referring to our alumni because they were not allowed to provide the abortion care or contraceptive care needed by a patient at their institution. Even patients seeking to terminate wanted pregnancies due to fetal anomalies or experiencing miscarriage struggle to obtain care if they come across a provider who either refuses to assist or refuses even to provide them with a referral or any other kind of information.

27. Recently, an MSFC alumnus was called in to perform a therapeutic abortion in the second trimester for a patient whose life was endangered by her pregnancy. The hospital treating the patient did not have any trained physicians, and had to bring in an outside physician at considerable expense. These types of costs are also typically passed onto the patient.

[15] Amy Littlefield, *Meet Another Religious Health System Restricting Reproductive Care*, Rewire (Jan. 30, 2019), https://rewire.news/article/2019/01/30/meet-another-religious-health-system-restricting-reproductive-health-care.

28. To the extent that the Rule forces an institution of medical education to comply with onerous and unworkable rules at the risk losing the majority of its funding, we believe that many facilities will simply remove abortion and contraception from their curricula. There are numerous individuals involved in patient care at a major hospital—those responsible for scheduling, cleaning, testing—all before you get to the medical staff. If, under the Rule, all of these people are empowered to delay or deny care or information related to abortion or contraception based on their own beliefs, and the hospital is powerless to intervene without risking loss of all federal funding, the Rule will impose innumerable harms on both patients and healthcare facilities. Rather than risk the loss of funding or an ethical and malpractice crisis related to patients denied and delayed access to care, even in an emergency, many facilities will self-regulate and eliminate contraceptive and abortion services.

29. Aside from the loss of training opportunities for our student and resident members, such a reduction in access to abortion and contraception training will impose significant harm on MSFC as whole by placing even greater strains on our already thinly stretched resources, which even today are insufficient to train all those who need such training outside of their institutions.

30. MSFC alumni are among the shrinking pool of abortion providers across 42 states. These alumni are the primary faculty at our educational programs. We have two sets of programs that we operate for our members who cannot acquire abortion training at their home institutions.

31. First, we run educational seminars that offer intensive education on family planning over several days. We can accept fewer than 500 students a year based on our current budget. This intensive education gives students a full picture of family planning as well as the social and political barriers they may face when seeking to become abortion providers. We also provide abortion training institutes for smaller groups of students. Acceptance to these institutes is competitive. We can accept fewer than 50% of those who apply.

32. Second, we run externship programs through independent clinics and Planned Parenthood affiliates. With the help of these strong allies, we are able to give some of our members a view into the day-to-day provision of care. Our members report that their externship is

mind-opening—not because abortion is controversial—but precisely because of how simple and safe the procedure actually is. Members also have an opportunity to hear the stories of patients seeking abortion first-hand. This externship program is more difficult for residents, as compared with medical students, because they are insured through their training institution's malpractice program, and they must have approval to participate in the program. Residents also have less flexibility in their schedule, and those that are able to take advantage of the program typically do so on vacation or during off-hours.

33. Further complicating the program, the number of clinics providing abortion care is dwindling. According to the most recent data from 2014, the number of facilities in the United States that held themselves out as providers of abortion care on a regular basis has markedly decreased.[16] Almost 90% of counties in the United States do not have an abortion clinic at all,[17] and several states have only one clinic left in the entire state.[18]

34. We financially assist students and residents participating in our training. We typically expend $1,000 to $2,000 per student or resident. These monies are spent on travel, accommodations, administrative fees, and any temporary licensing fees for receiving medical training outside a participant's home state. In total, we are currently spending in excess of $100,000 annually on these expenses, a substantial amount of money for our organization. We anticipate that the Rule could at least double the amount of money we need to spend, and therefore raise, in order to meet the anticipated increase in demand for training opportunities.

35. Although MSFC offers a number of training programs, the existing programs already are unable to meet the need.

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[16] The number of U.S. abortion-providing facilities declined 3% between 2011 and 2014 (from 1,720 to 1,671). Jones & Jerman, *supra* note 4. The number of clinics providing abortion services declined 6% over this period (from 839 to 788). *Id.*

[17] *Id.*

[18] *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.

36. Starting about ten years ago, MSFC began monitoring the impact of efforts to protect individual conscience at the expense of abortion training and patients' access to abortion. MSFC is part of a coalition of groups, including Catholics for Choice and various LGBTQ organizations, that focuses on religious refusals and "conscience rights" around the country. We stay in close contact with this coalition, so we can stay abreast of removals of abortion training and other threats to abortion access at teaching facilities across the country. MSFC has started to train students and residents on the impact of religious and moral refusals in the provision of family planning as well.

37. I have been in reproductive and community healthcare in some form my whole career. I completed a Master of Public Health at Yale, and I spent many years as the Executive Director of Planned Parenthood affiliates.

38. To the extent that the Rule enables almost any hospital staff-person, including some non-medical staff, to refuse to take any action related to an abortion, contraception, or other objected-to care, even in an emergency and without informing the patient, it is the broadest expansion of "conscience rights" that I and MSFC generally have seen or could have anticipated. Were it to take effect, the Rule would be impossible for a hospital to practically implement. Hospitals that provide abortion or have provided abortion already struggle to maintain patient care with medical staff refusing to assist with patients in need of care, as described above.

39. If the Rule goes into effect, the U.S. will see an even more dramatic reduction in the already dwindling number of medical-education institutions where abortion is regularly provided and taught to students and residents. Family planning training in the U.S. is already suffering; and the Rule will immeasurably exacerbate the problem.

40. MSFC would have to try to bridge the gap for highly motivated students. This would mean educating thousands of students a year. There will be many students who we cannot accommodate, and likely many more who will simply give up.

41. We already exist in a national medical system in which most licensed family medicine doctors and OB/GYNs are completely ignorant of both abortion, one of the most

common and extremely safe reproductive procedures for women, and many forms of contraceptive counseling.

42. At MSFC, we believe that licensed physicians have an obligation to serve the needs of their patients. This means that physicians who object to providing care must ensure that their objection does not inhibit the patient from ultimately getting the care that they need in a timely manner. 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. Within the medical community, this bedrock principle is clear and well-accepted *outside of the provision of abortion care*, but compromised with respect to family planning, despite the opinions of major medical organizations that this ethical principle is particularly essential in reproductive healthcare.[19]

43. If this Rule goes into effect, abortion may simply fall out of mainstream medical education, and once a medical practice is removed, it may take years to reintroduce it into a complex hospital system.

44. Anti-abortion laws and campaigns have heavily stigmatized abortion and contraception,[20] and the professionals who providers these services.[21] Already, our students face incredible stigma when they relate their interest in becoming abortion providers. In many cases,

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

[20] *See* Norris A et al., *Abortion stigma: a reconceptualization of constituents, causes, and consequences*, 21(3 Suppl) Women's Health Issues S49 (2011); Smith W et al., *Social Norms and Stigma Regarding Unintended Pregnancy and Pregnancy Decisions: A Qualitative Study of Young Women in Alabama*, 48(2) Persp. on Sexual & Reprod. Health 73 (2016).

[21] *See* Norris, *supra* note 20; Freedman L et al., *Obstacles to the integration of abortion into obstetrics and gynecology practice*, 41(3) Persp. on Sexual & Reprod. Health 146 (2010).

once a physician has "outed" themselves as an abortion provider, they become isolated from the mainstream.

45. This Rule institutionalizes this isolation and will make it impossible even for many highly motivated MSFC members to acquire training. The result, should the Rule go into effect, will be compromised access to reproductive healthcare and staggering health consequences for patients across the nation.

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

Dated: June 6, 2019

Respectfully submitted,

/s/ Lois Backus
Lois Backus, M.P.H., Executive Director
Medical Students for Choice

EXHIBIT A

Lois V. Backus, M.P.H.

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Lois V. Backus, MPH has been a non-profit chief executive in the reproductive health field for 30 years, with more than 17 years as the leader of Medical Students for Choice, an organization supporting the education and training of medical students in abortion.

Executive Experience -- 1989 through Today

2001 to present **Medical Students for Choice** Philadelphia, PA

Executive Director, responsible for leading an international, grassroots organization of more than 10,000 medical student activists worldwide who are working to make family planning a standard part of medical education and training. Primary programs include supporting 163 medical school chapters in the US and 60 chapters in 24 other countries with educational materials, funding, and training conferences in the US.

- Developed training conferences focusing on filling gaps in medical curricula pertaining to abortion, including the annual Conference on Family Planning and the Abortion Training Institutes. These training programs serve more than 500 US medical students each year.
- Expanded the Reproductive Health Externship Funding Program which places medical students in abortion-providing facilities for an intensive 2 to 4 week educational experience. This program serves between 180 and 200 medical students per year.
- Sustained and expanded MSFC's chapters from 96 to over 200 chapters.

1996-2001 **Planned Parenthood of the Columbia/Willamette** Portland, OR

Executive Director, responsible for all aspects of a 115 employee non-profit women's health and advocacy organization, with headquarters and six satellite facilities across Oregon and southwest Washington.

- Expanded the services provided in the flagship clinic to include reproductive surgeries for both men and women.
- Worked closely in collaboration with other social justice organizations to successfully fight ballot measures that would have hindered vital access to health services.
- Developed local community groups to support the expansion of government subsidized family planning services for the underserved in rural communities across Oregon.
- Opened three new facilities providing abortions, including establishing the first independent, comprehensive women's health clinic in central Oregon**.**

1989-1996 **Planned Parenthood of Central Pennsylvania** York, PA

Executive Director, responsible for leading a non-profit women's health organization serving York County, Pennsylvania. During these seven years, nine new services were added, including abortion services.

Education

M.P.H., Yale University School of Medicine, Department of Public Health, New Haven, CT.
A.B., Political Science and Religion, Mount Holyoke College, South Hadley, MA.

Other Relevant Experience

1988-1989 **Toltzis Communications** Glenside, PA
Project Manager Developed healthcare communications solutions for a marketing firm serving the pharmaceutical industry.

1987-1988 **Abington Memorial Hospital** Abington, PA
Coordinator, Community Health Education Provided medical screening and health education to a community of 100,000 people, including planning and implementing large community events.

1985-1987 **People's Medical Society** Emmaus, PA
Director of Policy Affairs Managed a nationwide grassroots organizing project focused on health care access for seniors.

1983-1984 **Community Treatment Complex** Worcester, MA
Program Coordinator Managed a residential treatment program for emotionally disturbed adolescents.

1980-1982 **Centers for Disease Control** Nashville, TN
Public Health Advisor Coordinated a federal sexually transmitted disease tracking program.

1978-1979 **Peace Corps** Kabul, Afghanistan
Volunteer Teacher Taught English and Business Mathematics to vocational college students.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF ELIZABETH BARNES IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, Elizabeth Barnes, declare as follows:

1. I am the President of The Women's Centers, a group of reproductive healthcare clinics in the Northeast of the United States that provides abortion care and contraception, among other services.

2. The Hartford Gyn Center in Hartford, Connecticut is one such clinic. It opened in 1978, and is the only independent, state-licensed family-planning clinic in the State of Connecticut. The clinic also operates a medical residency rotation program.

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

4. Hartford Gyn's mission is to provide women with compassionate abortion care. We provide abortion through 21 weeks of pregnancy as well as other reproductive health services. In carrying out this mission, the autonomy of each patient is paramount. The clinic's practices are designed to support patients in making their own healthcare decisions free from external judgment. The clinic also advocates for the reproductive rights of all patients and seeks to effect corresponding social change.

5. Hartford Gyn is a subrecipient of federal Medicaid funding through the state of Connecticut. I understand that, as a result, Hartford Gyn will be considered a "subrecipient" under the Rule.

6. Connecticut is one of the states that permits the use of state Medicaid funding for elective abortions, with this funding separated from federal dollars also flowing through the state program, which can be used to reimburse non-abortion services.

7. In 2017, Medicaid funding accounted for 70 % of Hartford Gyn's income. Private insurance covered only 17 %, and cash payment and donations from abortion funds made up the remaining 13 %. While the clinic has not yet finalized these figures for 2018, they will remain at approximately these levels.

8. Abortion services accounted for 66 % of Hartford Gyn's services in 2017. The remaining 34 % included contraception and a small amount of gynecological care. Although federal Medicaid dollars do not cover our abortion services, approximately half of the reimbursement we receive for our contraception and gynecological services originates with HHS.

9. Hartford Gyn's survival depends on the receipt of Medicaid funding, in part, because it receives so few patients who pay for their services privately or are covered by private insurance. Given the number of hospital facilities and individual physicians who provide gynecologic services in Connecticut for privately-paying patients, and the fact that the state Medicaid program reimburses providers for abortions and other services, it is impossible that Hartford Gyn would ever be able to rely on privately-paying patients to make up for the loss of federal Medicaid dollars. Reimbursement for gynecological services, a small percentage of our services, would also be insufficient to make up for the loss of federal Medicaid funding. At present, the clinic is barely sustained by the income generated by its current patient population. We exist, not for economic gain, but to pursue our mission of serving women in need of reproductive healthcare, including abortion and contraception.

10. Hartford Gyn would close quickly if it could not receive even a small percentage of its current income and would certainly close if we lost the sizable reimbursement we receive for contraception services. The clinic has no reserve funding, and clawback of any amount would bankrupt the business.

11. To the extent that the Rule prevents the clinic from expecting that staff members interact with all patients without judgment, would permit staff to unilaterally deny patients care and information, or force us to forego our emergency services and staffing practices, it is contrary to our mission and unworkable.

12. If it takes effect, the Rule will impose immediate administrative costs. Under the Rule, the clinic must maintain records of its compliance, although the Rule does not specify the exact form of these records.

13. The clinic will also be subject to investigation or inspection, measures which can be initiated unilaterally by HHS based on a complaint or even in the absence of a complaint. The

Rule is silent as to whether HHS must inform the clinic of an investigation or follow any particular procedure with respect to these investigations or inspections. The Clinic must cooperate with these measures; although the Rule is also silent as to the specific requirements of such cooperation. Further, the Rule states that HHS "shall" inspect any clinic based on any complaint or other information indicating an actual, possible, or threatened violation of the Rule. The Rule specifies that patient privacy is not grounds for denying access to records, even, apparently, patients' unredacted medical records.

14. If OCR finds a violation of the Rule, with or without a complaint, OCR is empowered to withdraw or even clawback our Medicaid funding. I understand that under the Rule, Connecticut's Medicaid program as the direct recipient also bears primary responsibility for our compliance with the Rule, incentivizing the state to fund less reproductive healthcare out of fear that the state might lose its federal funding. I further understand that under the Rule, the conduct or activity of contractors is "attributable" to the state for the purposes of enforcement or liability under the Weldon Amendment, further disincentivizing continued funding to the clinic. Loss of funding would shutter the clinic.

15. Hartford Gyn is unique even among clinics in progressive states for a number of reasons that would make its closure extremely burdensome for patients and providers.

16. First, Hartford Gyn has a broad depth of physician experience and provides advanced care, including abortion through 21 weeks of pregnancy, not provided by other facilities in the area. The clinic also employs a certified nurse-anesthetist, a specialized nurse that is rare and expensive. Hartford Gyn is the only independent abortion provider in Connecticut and the only non-hospital provider offering abortion care services past 19 weeks of pregnancy. Although hospital services may be available at some facilities, high cost and limited appointment availability can push this care out of reach for many people.

17. Second, Hartford Gyn sees patients from all walks of life, including low-income patients who cannot easily access care elsewhere, if at all. Hartford Gyn serves a large number of low-income patients, many of whom rely on Medicaid insurance, funding support, and/or discounted services at the clinic to access care. Further, many of Hartford Gyn's patients often

face difficulties taking time from work, coordinating affordable transportation, and accessing childcare—additional barriers to healthcare access. If Hartford Gyn were forced to close, patients who rely on the clinic for care will be forced to travel further the access care, compounding the logistical and financial challenges they face in accessing care, and preventing some from accessing care altogether, with disproportionate impacts on low-income patients.

18. Third, Hartford Gyn is one of the only facilities in the region that trains physicians in abortion care, especially in the second trimester. Although it does not receive significant outside funding for this training, it provides this service based on its deep commitment to supporting the next generation of providers. Currently, residents at Saint Francis Hospital and Medical Center can receive training from our medical director on Saturdays.

19. Fourth, Hartford Gyn has taken a public stance defending reproductive rights, including in media coverage of the clinic after a "crisis pregnancy center" opened just 30 feet from our office, in the same complex, and our clinic painted a "yellow brick road" for patients to follow when entering the clinic. The clinic is a symbol of the determined provision of constitutionally-protected care in the face of adversity for the reproductive rights movement, and, correspondingly, a known target of anti-abortion activists.

20. Anti-choice protestors target our clinic regularly. They have intimidated and threatened providers and patients at Hartford Gyn, and have misinformed and shamed our patients right outside of our clinic. Staff routinely enter the facility briskly out of fear the anti-choice protestors on the sidewalk or in our courtyard will photograph them, track their vehicle, or cause violence, and some staff have even been targeted at their homes. Further, according to data collected by the Feminist Majority Foundation, clinics located near a crisis pregnancy center were more likely to experience high levels of violence, threats, and harassment. Anti-choice extremists have bombed clinics, killed providers and staff, threatened and exposed the personal information of providers and staff, and shamed and humiliated patients. Those who provide this care live under constant threat.

21. For these reasons, the careful screening of potential staff members before hiring is an essential security precaution at Hartford Gyn. Like that of most private companies, the goal of

an effective background check is to provide an accurate assessment of the applicant's qualifications. As an abortion provider, however, we also assess additional material related to an applicant's reputation, reliability, truthfulness, and objectivity based on the very real concern that an anti-abortion extremist could harm the clinic. We also work to ensure that the patient will be provided care by someone who supports their right to make decisions about their own healthcare and will treat patients in a nonjudgmental and supportive manner. This robust process contributes to the substantial administrative and staff resources expended by facilities providing abortion care services. The Rule creates an opening for anti-abortion extremists to infiltrate and incapacitate our clinic by undermining this process and creating threats to security as well as to the basic right of the patient to non-judgmental supportive care in a safe environment that protects their quality of care, confidential medical information, and dignity.

22. Because our clinic's mission is to provide access to reproductive healthcare services, for all staff and virtually all others working at the clinic, such as contracted cleaning staff, working at Hartford Gyn necessarily involves some kind of connection to abortion care or contraception, and the clinic procedures and practices are designed to ensure our patients receive the highest quality, non-judgmental care. The clinic must operate efficiently due to its already limited income, but in order to do so, all staff must perform functions that touch on the provision of abortion and/or contraception. For example, receptionists' job duties include scheduling patients for abortion and contraception appointments. Similarly, our bookkeeper's job duties include preparing billing for all of the services we provide. There is no alternative human resources structure that could sustain the clinic. To the extent that the Rule would force us to change our structure, we would be forced to close.

23. Similarly, if individual staff could delay or deny care or give incomplete information about medical options based on their own beliefs, our clinic could not function properly, particularly in emergency situations. Such actions would disrupt our mission by failing to honor the beliefs and choices of our patients and by breaking down the trust central to our model of care and to the sustainability of our business.

24. In addition to the staffing and policy issues discussed above, the Rule will create tremendous uncertainty. Because the Rule is written so broadly, we are unable to determine what our rights and our obligations are under the Rule on the day it goes into effect. Given the Rule's breadth and lack of clarity, we cannot accurately predict what we must do to comply, particularly in an emergency, while maintaining our mission and the quality of our patient care. The Rule puts the clinic in an untenable and unacceptable position.

25. If we cannot seek to ensure that our patients receive compassionate, non-judgmental care from every person they encounter in the clinic, we will no longer serve our central purpose.

26. That purpose is to provide essential reproductive healthcare services, including abortion and contraception, in a time when such care is stigmatized and threatened in the United States. The many barriers to care now inherent in healthcare systems—legal restrictions, funding limitations, stigma, among others—can be insurmountable. For many of our patients, Hartford Gyn is the provider of last resort.

27. We strive to empower patients to make their own, autonomous choices. We believe that respecting women's autonomy builds stronger communities and positive social change. This belief inspires our patient-centric approach to care. In order to empower patients to make decisions that support their health and are best-suited for them, we must provide comprehensive, medically-accurate information about our patients' medical options. To that end, we train and expect our staff to support patients with the resources, tools, and medical services they need to realize their choices.

28. When patients arrive at Hartford Gyn, they often comment on the kindness and compassion of the staff and the holistic care we provide. This response is often in some part the result of previous ill-treatment at crisis pregnancy centers or other healthcare facilities.

29. For example, last year, a 21-year-old patient scheduled an appointment with Hartford Gyn. On her way to her appointment, the patient and her mother were instructed to enter Hartford Women's Center, the crisis pregnancy center that opened next to our clinic. An employee of the crisis pregnancy center told the patient and her mother to "come in here" and

then proceeded to tell her that if she had an abortion, she would be "sinning" and that she "might not make it out alive." After wasting significant time, being misinformed about numerous aspects of abortion care, and treated with hostility and condemnation, they were ultimately told that "[t]here is no abortion center here." Unlike countless other patients faced with the same misinformation, the patient was able to find her way to her appointment. Once at Hartford Gyn, the patient reported feeling shame and fear. Our staff spent time with the patient to explain that she had spoken with someone who was not a medical professional and who had given her false information. This patient expected and was entitled to unbiased, non-coercive pregnancy counseling and abortion care from medical professionals.

30. Many patients face similar barriers to reproductive healthcare even at legitimate healthcare institutions, including Catholic hospitals. For an increasing number of communities, the closest or only hospital is a Catholic hospital operating under the guidance of the *Ethical and Religious Directives for Catholic Health Care Services* which govern certain practices at Catholic hospitals. Our patients frequently report that after presenting to their closest emergency room for evaluation, a positive pregnancy test was met with "congratulations!" and a refusal to provide requested resources or referrals to a center that would offer abortion care services. This refusal to provide comprehensive options and referrals causes delays in accessing time-sensitive abortion care, instills shame and fear in patients, and threatens severe health consequences.

31. Even at secular hospitals, there are often limits on the scope of care that is provided, either because of the refusal of an official in power or due to a lack of commitment to providing comprehensive reproductive healthcare, which is often accompanied by an assumption that care will remain available at independent providers like Harford Gyn.

32. Women seeking abortion and contraception, and the providers of such care, have been vilified in many places in the U.S. Anti-abortion activists have caused immeasurable harm, including killing abortion providers, threatening patients, infiltrating clinics, and spreading false information about patients, providers, and reproductive healthcare options, among other security concerns.

33. Hartford Gyn serves a special role in the provision of abortion care locally and nationally, and it is particularly vulnerable to closure if it loses its Medicaid funding. The community and the broader public consider Hartford Gyn to be a responsible and trustworthy medical provider because we have provided nonjudgmental, objective, and compassionate care to women for four decades.

34. We will not continue to operate if we cannot follow our best practices to avoid further harm to and further stigmatization of patients seeking reproductive healthcare. To the extent that the Rule is inconsistent with the practices that protect our patients' health, ensure nondiscrimination, and make it financially and logistically feasible to operate, we will be forced to risk the loss of all funding and closure.

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

Dated: June 5, 2019

Respectfully submitted,

/s/ Elizabeth Barnes
Elizabeth Barnes, President
The Women's Centers

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Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF ROBERT BOLAN, MD, CHIEF MEDICAL OFFICER, LA LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Robert Bolan, declare as follows:

1. I am the Chief Medical Officer and Director of Clinical Research for the LA LGBT Center. I oversee all medical care related services at the LA LGBT Center, as well as maintain a panel of patients for whom I provide direct care. In addition, I oversee the LA LGBT Center's Research Department, am the principal investigator for multiple HIV treatment and prevention trials, and have written and presented extensively on various matters related to the care and treatment of people living with or at risk of acquiring HIV and other sexually transmitted infections (STIs). I am also Clinical Associate Professor of Family Medicine at the University of Southern California (USC) – Keck School of Medicine, and an Adjunct Clinical Professor of Pharmacy Practice at the Western University of Health Sciences. I received my medical degree from the University of Michigan Medical School, interned at St. Mary's Hospital Medical Center, and completed my residency at St. Michael Family Practice Residency. I was the Director of HIV Services in the Department of Family Medicine at the USC Keck School of Medicine, and I have been honored with the Leadership Award from the San Francisco AIDS Foundation. I maintain active board certification with the American Board of Family Physicians and specialty certification with the American Academy of HIV Medicine. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction to prevent the Denial-of-Care Rule from going into effect.

2. As the Chief Medical Officer, I oversee the delivery of healthcare for approximately 9000 patients who come to the LA LGBT Center and have a panel of approximately 300 patients for whom I personally provide medical care. Over 90% of my patients identify within the LGBTQ communities. My patient population is also disproportionately low-income and experiences high rates of chronic conditions, homelessness, unstable housing, trauma history, and discrimination and stigmatization in healthcare services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

3. Our healthcare services span the full spectrum of primary healthcare services, including, but not limited to, HIV treatment and testing, treatment and prevention of sexually

transmitted infections, as well as treatment for gender dysphoria, mental-health disorders, and substance-use disorders.

4. Many if not most of the individuals in our very diverse patient population face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority people, as people of color. In addition, there is a very high incidence of other social determinants of poor health outcomes among our population. These include homelessness, food insecurity, lack of access to transportation, and lack of employment opportunities.

5. Furthermore, there is every reason to believe that the Denial-of-Care Rule will encourage healthcare providers and staff to claim the absolute right to refuse care or opt out of serving patients with particular needs, based on personal beliefs, which 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 the LA LGBT Center. I, and the other providers that I supervise at the Los Angeles LGBT Center, have many patients who have experienced traumatic stigma and discrimination – based on their sexual orientation, gender identity, HIV status, and/or other factors – even before the Denial-of-Care Rule was proposed or issued. Based on the stories that my patients have shared with me, this discrimination, mistreatment, and denial of healthcare services has been motivated by the personal moral or religious beliefs of other healthcare providers and staff outside of the LA LGBT Center.

6. Over the twenty years I have been at the Center I have listened to the stories of countless individuals who have suffered overtly homophobic remarks from healthcare providers and who were either refused care or given clearly inadequate and inappropriate care because of their sexual orientation or gender identities. One of the most egregious examples was a transgender woman who needed extensive surgery to repair diffuse damage done by silicone injections into her breasts several years earlier. In 2009, she was turned away from an academic plastic surgery center in Los Angeles after the surgeon said her problem was caused by her own poor decision-making and she would therefore not be considered for treatment.

7. Incidents like this reveal that many healthcare providers and other staff harbor explicit or implicit biases against LGBT people. Because of legal requirements, healthcare

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

8. 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 the LA LGBT Center's transgender patients express strong distrust of the healthcare system generally and are reluctant to seek care outside the LA LGBT Center unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers.

9. In the case of the transgender woman I described above, her general medical condition gradually deteriorated over the several years it took for me to finally identify a surgeon who would take her case. She was suffering from systemic metabolic complications from the chronic inflammation and skin breakdown caused by the hardened subcutaneous silicone injections. I feared for her survival. Fortunately, the surgeon who cared for her did so with kindness, respect, and compassion, and the patient has had an excellent result. The surgeon saved her life. Nevertheless, the ultimate tragedy in my patient's case was that after the humiliating and callous abuse to which she was subjected by the academic center's specialists, she was completely unwilling to even consider seeing another surgeon for the next six-and-a-half years. Her suffering during that time was completely avoidable had she been treated with basic human respect.

10. With existing health and healthcare disparities affecting the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – the Denial-of-Care

Rule's vague and confusing language will further exacerbate existing barriers to healthcare and result in negative community health outcomes. Good medical care is based on trust as well as frank and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers; 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. 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.

11. The Denial-of-Care Rule will cause LGBT patients and patients living with HIV to lose trust in their healthcare providers (either out of fear of discrimination or on account of being denied care on religious grounds). The Rule will cause LGBT patients to attempt to hide their LGBT identities to an even greater degree when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure about their gender identity, sexual orientation, or related medical histories. Patients will avoid raising any topics, questions, facts that they fear could possibly offend their healthcare providers' personal beliefs, resulting in harm to patients.

12. The Denial-of-Care Rule is also likely to cause an increase in demand for my healthcare services because I have seen a spike in behavioral and mental-health issues resulting from religious or moral-based discrimination and denials of healthcare services.

13. The Denial-of-Care Rule is in direct conflict with the oath I swore as a doctor and many of the federal, state, and insurance rules, regulations, and statutes that I am required to follow. This has personally caused me great confusion and stress as it is unclear how I can work collaboratively with my colleagues who discriminate against or deny care to my patients without violating either current ethical and legal standards or the Denial-of-Care Rule.

14. As a healthcare provider with the LA LGBT Center, I receive various forms of federal funding directly and indirectly via federal programs, including but not limited to those governed by the Centers for Medicare and Medicaid Services through Medicaid and Medicare reimbursements and the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. I may be, therefore, subject to the restrictions of HHS's Denial-of-Care Rule. These funds and related benefits account for a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients, especially because a large portion of the population that we serve relies heavily on Medicaid and Medicare for its healthcare needs. I, therefore, have a reasonable fear that I could be sanctioned and lose federal funding for the work that I do as a result of nondiscrimination policies that I enforce in my department and amongst the staff that I supervise – polices that are vital to providing proper care to my patients and other patients whose care I supervise. If such a loss of funding were to occur, it would result in service reductions if not closure of our programs in their entirety.

15. The "Denial-of-Care Rule" is inherently demeaning and codifies our government's belief that providers' freedoms are the most important and that patients are supplicants when they seek healthcare. This proposed rule is shameful.

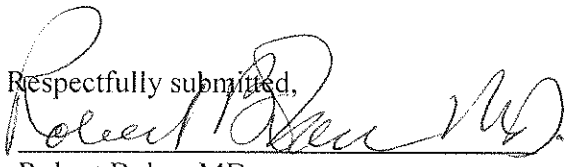
16. As LA LGBT Center's Chief Medical Officer and Director of Clinical Research, my responsibility includes enforcing our nondiscrimination mandate with respect to all of our providers and staff, including those working on federally funded research. I, therefore, have a

reasonable fear that the ability to provide federally funded healthcare services and conduct federally funded research could be severely impeded potentially putting patients and research participants at risk. I could also be subject to sanctions as the principal investigator for many federally funded research programs at the LA LGBT Center.

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

Dated: June 4, 2019

Respectfully submitted,



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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF JULIE BURKHART IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, Julie Burkhart, declare as follows:

1. I am the Founder and Chief Executive Officer of Trust Women, which operates clinics that provide full-spectrum reproductive healthcare and certain health services to the LGBTQ community.[1] Trust Women operates clinics in Kansas, Oklahoma, and Washington State with the goal of ensuring affordable access to abortion, contraception, LGBTQ healthcare, and other reproductive healthcare services.

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

3. 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-confirmation hormone therapies. The clinic receives Medicaid funding.

4. Trust Women's mission is to operate clinics that empower our patients to make autonomous decisions about their healthcare in a compassionate and non-judgmental environment. It is essential to Trust Women's mission that patients be treated with dignity, empathy, and respect, given complete and accurate medical information, and be empowered to make decisions about their health and lives free from judgment or disruptions in their care. Given our structure and the interactions that most staff have with patients and the provision of care, we seek to ensure that all staff treat each patient with dignity and compassion and respect patient autonomy.

5. Trust Women Seattle endeavors to protect our patients from judgment also because we offer services that are stigmatized and under threat in the U.S. We have seen the harm prejudice and judgment impose on our patients, including in their ability to access needed

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

healthcare. For example, many of our patients come to us after being turned away from another provider.

6. To that end, Trust Women Seattle has a "no turn away" policy. For each patient, the clinic staff work to utilize healthcare benefits fully and raise any additional money from donors and other funds, if necessary. This practice ensures that we see patients regardless of their ability to pay.

7. This policy is largely contingent on the continued availability of state Medicaid reimbursement. If the clinic did not receive this income, it would have to attempt to raise significantly more money from contributors and other sources, which is not presently available, and extremely unlikely to be secured solely through these sources.

8. In 2018, approximately 64% of our abortion patients relied on Medicaid; approximately half of our patients receiving contraception relied on Medicaid; and approximately 60% of our income from providing transgender healthcare came from Medicaid.

9. Only 2 patients in the history of the clinic have been denied Medicaid coverage—one due to residency ineligibility and the other due to income above the threshold. The clinic relies on Medicaid approvals to provide services.

10. I understand that Trust Women Seattle is considered a "subrecipient" under the Rule because it receives Medicaid funding through Washington State, which receives that funding as a direct recipient of HHS Medicaid funding.

11. I understand that the Rule states that "any entity that carries out any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of [HHS]," is prohibited from "requir[ing]" any "individual to perform or assist in the performance of any part of a health service program or research activity if such performance or assistance would be contrary to the individual's religious beliefs or moral convictions."

12. I understand that an "entity that carries out any part of a health service program or research activity" funded through HHS includes subrecipients, like Trust Women Seattle, who receive Medicaid reimbursement through state programs under the Rule.

13. Were it to take effect, the Rule would impose immediate compliance and administrative costs. First, in order to ensure compliance, the clinic would need to hire an attorney to review the Rule and our policies. The clinic must also maintain records of its compliance, although the Rule does not specify the form of these records. The Rule states that patient privacy is not grounds to refuse access to OCR when it seeks to inspect records. To the extent that the Rule allows OCR access to unredacted patient information and internal clinic records, it is extremely problematic. Our mission is to protect and empower our patients—opening patient records to inspectors who may be hostile to our mission is antithetical to our central purpose.

14. The clinic will also be subject to investigation or inspection by HHS, which I understand can be initiated by HHS based on a complaint or even in the absence of a complaint. I understand that under the Rule, OCR must conduct an investigation "whenever a compliance review, report, complaint, or any other information found by OCR indicates a threatened, potential, or actual failure to comply with Federal healthcare conscience and associated anti-discrimination laws or [the Rule]." The Rule is silent as to whether HHS must inform the clinic of an investigation or follow any particular procedure with respect to these investigations or inspections. The Clinic must cooperate with these measures, although the Rule is also silent as to the specific requirements of such cooperation.

15. Unannounced inspections and investigations can be very problematic for a small provider. At Trust Women's Kansas clinic, for example, we are already subject to significant scrutiny. The Board of Healing Arts in Kansas subpoenas information from our clinic and inspects the clinic without notice. These actions are based on "complaints" that have invariably been baseless and inappropriate allegations. The Department of Sanitation has also preformed unannounced inspections. All of these inspections and the production of information and records require costly advice from local counsel and the commitment of extensive staff resources, which together divert funds and personnel from our primary mission. We are targeted for these burdensome actions simply because we provide abortion.

16. Across the country, independent family-planning and other specialized reproductive-healthcare clinics are singled out for excessively burdensome treatment at the local, state, and federal level. As another example, in Oklahoma, Trust Women applied for two types of licenses. The Department of Health sat on the applications for 12 months, and we ultimately needed legal counsel to help get the process moving. To the extent that the Rule will impose such burdens on all independent clinics at the federal level, it is unworkable.

17. I understand that if OCR finds a violation of the Rule, OCR may withdraw or even clawback our funding. I understand that under the Rule, Washington State's Medicaid program, as the direct recipient that provides our Medicaid dollars, also bears "primary responsibility" for Trust Women Seattle's compliance with the Rule and stands to lose its HHS funding should Trust Women fail to comply with the Rule, incentivizing the program to discontinue its commitment to funding reproductive healthcare and services to LGBTQ patients. I further understand that under the Rule, the conduct or activity of contractors is "attributable" to the state for the purposes of enforcement or liability under the Weldon Amendment, further disincentivizing continued funding to the clinic. These enforcement mechanisms could shutter our clinics.

18. The Rule is unworkable for Trust Women Seattle. To the extent that it would prevent us from continuing to operate our business, force us to change core policies, or incite staff to exercise a unilateral veto over patient access to information and care, it would be extremely harmful for both our patients and our reputation, would cause devastating harm to our business, and would undermine our mission.

19. Small medical practices like Trust Women Seattle are specialized. We hire staff with special skills to work in our clinic, including staff sensitive to the experiences of women seeking abortion, contraceptive, and services for LGBTQ patients and medical staff with experience in assisting with gynecological care. Many staff members who work at the clinic have a connection to abortion care, contraception, or LGBTQ services, even if it only involves scheduling or doing bookkeeping or other administrative tasks related to such services. Trust Women Seattle is a small business, and part of our business model is to cross-train clinical and some non-clinical staff to serve multiple roles, many of which touch on providing information

about, scheduling, or directly providing abortion, contraception, or transgender care. For example, some employees focus on recording compliance with medical standards, which includes monitoring the provision of abortion care and contraceptive care at the clinic. Others perform medication management, sanitize instruments, and clean operating rooms and laboratories that may be used for general gynecological exams one day, and the provision of contraception or hormone therapy the next.

20. Although these activities do not involve the direct provision of care, if an employee were to refuse to participate in precisely these types of services, it would force a change in staffing structure that would be extremely costly and unworkable for the clinic. Likewise, if any employee were to unilaterally turn away a patient away seeking information or services, it would compromise our ability to provide healthcare services to our patients—the crux of both our mission and business. To the extent that we would have to ensure that all employees were not opposed to a new service anytime we add any services to our practice, it would significantly compromise our ability to expand our services and our resources.

21. Trust Women Seattle also has an emergency policy requiring all office personnel to be familiar with transfer agreements in the case of an emergency. This policy requires that any staff member assist in an emergency transfer, even if only by calling ahead to the hospital. To the extent that the Rule would prevent us from continuing to enforce this policy, it would be unworkable.

22. Were the Rule to prevent the clinic from requiring that staff members interact with all patients without judgment, it would likewise be unworkable. To the extent that we would be prevented from requiring that front-facing employees like receptionists, who do not assist in procedures according to our present understanding, be compassionate and supportive of the independent decision-making of our patients, it would undermine both our business and inhibit our patients' access to healthcare.

23. Patients at Trust Women Seattle have conveyed that they have been disrespected and demeaned by other healthcare providers for making independent decisions about their healthcare, including past and present reproductive healthcare choices. Likewise, transgender

patients have thanked us for addressing them with their chosen identity because they have been to healthcare providers who have refused to use their chosen pronouns or name based on prejudice. Our core mission is to treat all patients with dignity and compassion and, above all, to respect the autonomous choices of our patients. This mission is our central focus because we understand that many of our patients, and many patients around the country, have been marginalized in seeking needed medical services.

24. If, contrary to our practice of empowering patients to make their own decisions, employees were to substitute their opinions about a patient's care for the patient's judgment—essentially exercising a unilateral veto over the patient's receipt of care or information—and the clinic was rendered powerless to protect our patients without risking total loss of funding, we would either be forced to abandon our core mission or close.

25. We are concerned that, for example, an employee who supports access to contraception might be opposed to abortion or to abortion after a certain stage in pregnancy. Alternatively, staff who support abortion access may be willing to serve patients seeking reproductive healthcare but be opposed to treating members of the transgender community. Personal opinions can fall on a spectrum, and we are particularly vulnerable because of the breadth of services we provide and the varied communities we serve. We would be in a particularly untenable position if someone comes to assert a refusal after they were hired and staffed.

26. Extreme anti-abortion or anti-LGBTQ activists also pose a significant threat to the clinic and our staff, a threat that may become more significant if the clinic is unable to exercise the necessary controls within the clinic to protect patients and patient care. Because of the intense opposition to abortion and the ongoing presence of protestors outside our clinic, we are keenly aware of security threats posed by those who radically oppose abortion. It would be extremely dangerous to our staff and patients to have anyone on staff who would pose such a threat, and, to the extent that the Rule renders us powerless to prevent it, we would be forced to either assume that risk or risk total loss of and even clawback of federal funding. Further, patients and their communities trust us to be a safe place for them to receive nonjudgmental care and information.

We would lose that trust and potentially sacrifice the safety of everyone in the clinic were we to compromise our mission in response to the Rule.

27. To the extent the Rule would require Trust Women to change our cross-training and staffing policies or abandon our emergency policies, it would be impossible for Trust Women to continue providing abortion, contraception, and LGBTQ care.

28. It is unlikely, if not impossible, for the clinic to qualify for enough alternative funding from non-Medicaid sources to survive. At present levels, we could not survive.

29. Whether we continue to operate while constraining our provision of abortion, contraception, or LGBTQ services, or instead close altogether, our patients will suffer. Many of our patients rely on us for abortion, contraception, and transgender care that they cannot access anywhere else.

30. Even if we could continue operating by, for example, incorporating another type of practice to supplement the clinic's income, we would have to lay off staff and sacrifice our core mission to provide reproductive healthcare and services to LGBTQ patients. Further, that could not be achieved without fundamentally altering our business model and finding a new location, hiring additional specialized staff and physicians, purchasing new equipment, and retaining specialized administrative support. In short, incorporating another practice to stay open would completely undermine the mission and purpose of our clinic.

31. If we do close, it will be very difficult to reopen. Opening any kind of medical practice is complicated. It requires licensing, finding appropriate space, new equipment, supplies, insurance, and credentialing. Reopening our Seattle clinic after a closure would likely cost in excess of $2,000,000 and, in Seattle, only 7% of downtown real estate is available for rent at all.

32. The Rule thus creates an impossible choice—either fundamentally change the way we operate, potentially compromising our core mission to provide compassionate reproductive healthcare and care to the LGBTQ community, or risk the loss of all funding and closure.

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

Dated: June 5, 2019

Respectfully submitted,

Julie Burkhart, Founder and CEO
Trust Women

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF BRUCE BUTLER IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Bruce Butler, declare:

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

2. I am the Chief Executive officer of Valley Health Plan. In this role I oversee all health plan operations. I have held this position since March of 2015. Prior to my current role at Valley Health Plan, I served as the Chief Strategy Officer for the University of California Office of the President, Division of Health Sciences and Services. I have served in health care for 35 years.

3. Valley Health Plan is a health maintenance organization ("HMO") owned and operated by the County of Santa Clara since 1985. Our mission is to provide affordable healthcare to a wide spectrum of Santa Clara County residents and community members, and to improve the overall health and wellbeing of Santa Clara County and our members. As an HMO, Valley Health Plan offers a set of different healthcare coverage plans that give enrolled members access to a range of medical services from physicians and other healthcare providers with whom Valley Health Plan contracts. The health plan member, or the entity paying for the member's coverage, selects a plan and pays a predetermined fee in exchange for securing the member's access to a set of covered healthcare services, including access to a network of primary and specialty care providers, nationwide pharmacy locations, and in-state laboratory locations, as well as other health care providers for behavioral health, substance abuse, chiropractic, acupuncture, and related services. Many of our provider partners are primarily focused on safety-net populations and our partnership with them provides them with an alternate and steady stream of payments that can help enable their work with safety net populations.

4. We serve a variety of populations, and many of our members have their healthcare plans with us paid for in whole or in part by the federal government:

a. **Commercial members**: For these members, an employer secures healthcare coverage through Valley Health Plan for its employees. Approximately 10,450 people

obtain healthcare through our commercial memberships, and many Santa Clara County employees receive healthcare coverage through this option.

b. **Medi-Cal**: The Santa Clara Family Health Plan (Family Health Plan) is an independent Health Authority created by the County in 1996 that works with the State to provide coverage to Medi-Cal enrollees. The Family Health Plan delegates to Valley Health Plan the responsibility for connecting a large portion of its Medi-Cal enrollees to covered healthcare services. Thus, Valley Health Plan provides administrative services, including access to its extensive provider network, to the Family Health Plan's Medi-Cal enrollees. The Family Health Plan is compensated by the State for providing coverage, and the Family Health Plan in turn compensates Valley Health Plan for its services. Valley Health Plan's current enrollment of Medi-Cal Managed Care members is approximately 120,000. Were we to be disqualified from receiving federal funds passed through the Department of Health and Human Services we would no longer be able to offer services to the Medi-Cal Managed Care members.

c. **Covered California Health Exchange Program**: Valley Health Plan is a Qualified Health Plan Issuer for Covered California, the California Health Benefit Exchange. Covered California is the state marketplace for health insurance, established following the enactment of the Patient Protection and Affordable Care Act (ACA). Under the ACA, each state is tasked with creating a marketplace for health insurance plans. The federal government subsidizes these plans for individuals who meet income-based eligibility requirement. Thus, through the Covered California marketplace, Valley Health Plan offers subsidized health insurance plans to eligible persons. There are approximately 15,000 members enrolled in Valley Health Plan through Covered California.

d. **Family and Individual Plans:** Valley Health Plan offers an off-exchange product for individuals and families that allows those who don't qualify for subsidies to obtain insurance under the same terms as those offered through the Covered California exchange. There are a few hundred members enrolled in Valley Health Plan's direct family and individual plans.

5. When Valley Health Plan enters into a contract with a provider, Valley Health Plan requires that the provider inform us of the entire range of specific services they provide. A

sample of our standard provider agreement is attached as **Exhibit A**. We also require that a provider inform us if the scope of the services it offers is about to change or has changed. Exhibit A at 2.1(l). Without this information, we cannot match our members to providers who can appropriately care for them. For example, an obstetrician/gynecologist is required to list whether they provide abortion and sterilization care as part of the provider contract, and once that provider is part of the VHP network, the provider must provide those services or timely inform us that they no longer offer such services. *See* Exhibit A at 2.1(l). If providers were to not provide us with accurate information about the care they provide, it could delay or bar members from receiving the healthcare to which they are entitled.

6. We require each provider to sign a nondiscrimination provision stating that it "will not differentiate or discriminate in its provision of Covered Services to Members hereunder, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or use of medical services, and . . . will render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other Clinic patients." Exhibit A at 2.1(k). Were our providers allowed to refuse to provide care to specific members on the basis of a member's identity or a connection between a member's identity and the care they were seeking, it would obstruct members' access to healthcare to which they are entitled, undercut our relationship with our members, and endanger member health. We strive to run an inclusive organization, and without the ability to enforce this policy, we would not be able to ensure access to healthcare services.

7. When a member is seeking healthcare services they call Member Services to be connected with a provider who can meet their needs. If one of our representatives responsible for answering calls through Member Services objected to connecting a member with care on the basis of the representative's cultural values, ethics, or religious beliefs, this could delay or bar a member's access to the healthcare to which they are entitled. For example, if a Member Services representative told a member that they could not connect them with services—without noting that this was because of the representative's own provider's cultural values, ethics, or religious beliefs—then that member might be left with the impression that Valley Health Plan would not

cover the service the member was seeking. And, while a limited subset of calls are recorded, Valley Health Plan would largely be left entirely unaware that a member sought certain care and was turned away be a Member Services representative.

8. Further, a Valley Health Plan nurse or doctor must review and approve a request for services before a member can obtain certain services. Valley Health Plan's medical management follows national clinical guidelines for determining medical necessity and whether to approve a specific clinical service. It would undermine our review system if a reviewing nurse or doctor—based on their own cultural values, ethics, or religious beliefs—rejected or ignored a request for service that should have been approved under Valley Health Plan's guidelines, particularly if they did so without informing anyone that the denial or non-action was due to their cultural values, ethics, or religious beliefs. Indeed, if the member did not appeal the ruling, Valley Health Plan might never learn that a nurse or doctor had rejected the request based on their cultural values, ethics, or religious beliefs. And as a result, that member might never get the medically indicated care to which they were entitled.

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

Respectfully submitted,

BRUCE BUTLER

EXHIBIT A

PROVIDER AGREEMENT
BY AND BETWEEN
THE COUNTY OF SANTA CLARA, dba VALLEY HEALTH PLAN
AND
PROVIDER_CONTRACT_NAME

This agreement, effective as of **Effective_Date** ("Effective Date"), is made and entered into by and between **Provider_Contract_Name** ("Provider"), and the County of Santa Clara, a subdivision of the state of California, ("County") doing business as Valley Health Plan ("VHP") for **Type_of_Services** ("Agreement"). Provider and Plan may be referred to individually as "Party" and collectively as "Parties".

RECITALS

WHEREAS, County operates VHP ("Plan"), a Health Care Service Plan licensed pursuant to the Knox-Keene Health Care Service Act of 1975, as amended ("Knox-Keene Act");

WHEREAS; VHP arranges for the provision of Covered Services to Members (as hereinafter defined) of Plan;

WHEREAS, such Members may from time to time require the services of a health care Provider**,** or services at a location, which County is unable to provide, and Plan wishes to insure the provision of such services to Members;

WHEREAS, **Provider_Contract_Name** is a health care Provider duly licensed by the State of California to provide the services under this Agreement and Provider has the authority, applicable knowledge, and expertise to provide **Type_of_Services** at Provider's medical offices located at **«Address», «City», «State» «Zip».**

AGREEMENT

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, and for the good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

ARTICLE I

DEFINITIONS

In addition to the definitions elsewhere in this Agreement, the following capitalized terms shall have the meanings set forth below:

1.1 "Accrediting Agency" means a nationally recognized agency invested in the assurance of quality care to patients, which helps organizations meet regulatory requirements, as well as, distinguish themselves from non-accredited competition. An Accrediting Agency (i) completes initial and periodic assessments of an organization, (ii) evaluates against a defined set of standards, and (iii) determines and issues an official

recognition of accreditation to organizations meeting those set standards. VHP's Accrediting Agency(s) are identified on the Valley Health Plan's website at www.valleyhealthplan.org.

1.2 "Applicable Requirements" means, to the extent applicable to the terms and conditions of this Agreement and the duties, rights and privileges hereunder, the requirements set forth in: (i) the Provider Manual, the VHP Language Assistance Program, and any other policies and procedures of VHP including the Quality Management Programs; (ii) federal and state laws and regulations and any amendments or updates thereto, including the Knox-Keene Act; (iii) the applicable Evidence of Coverage; (iv) Medicare and Medi-Cal laws and regulations or Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) instructions and reporting requirements, including certification requirements; (v) the California Department of Managed Health Care (DMHC); (vi) the California Health Benefit Exchange; and (vii) VHP's Accrediting Agency standards.

1.3 "Authorization" means the written approval by Plan, to be obtained by a Provider, making a Referral or providing certain Covered Services (other than Emergency Services) to any Member, in accordance with Applicable Requirements. Covered Services approved by Plan, as applicable, in accordance with the foregoing are "Authorized".

1.4 "Clean Claim" means a billing form (e.g. UB-04, CMS 1500, or any subsequent form issued by CMS, or applicable electronic claim) submitted by Provider to VHP that (i) identifies the Member; (ii) identifies the items and services with codes listed in this Agreement, including Exhibits, or, if not specifically listed, identifies the items and services provided utilizing codes published in the Current Procedural Terminology ("CPT"), Healthcare Common Procedure Coding System ("HCPCS"), or other industry-standard codes utilized by Provider; (iii) if applicable, contains or attaches a required authorization or form as specified in this Agreement, and (iv) follows all industry standard clean claim practices.

1.5 "Contracted Services" Covered Services that are within Provider's scope of practice provided to a Member pursuant to the Evidence of Coverage in effect at the time services are rendered and compensated in accordance with this Agreement.

1.6 "Coordination of Benefits" ("COB") means the determination of order of financial responsibility that will apply when two (2) or more payors provide coverage of services for an individual Member. When the primary and secondary benefits are coordinated, determination of financial responsibility shall be in accordance with Applicable Requirements.

1.7 "Co-payment" means the amount due from Member for Covered Services that is in accordance with Applicable Requirements and is disclosed and provided for in the Member's Evidence of Coverage. The reference to "Co-payments" may include copayments, deductibles, and co-insurance charges or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.8 "Covered California" shall mean Covered California, California Health Benefit Exchange, the independent entity established within the government of the State of California and authorized under the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), and the California Patient Protection and Affordable Care Act, (Chapter 655, Statutes of 2010) and Chapter 659, Statutes of 2010) ("California Affordable Care Act") to selectively contract with health insurance issuers in order to make available to enrollees of the exchange health care coverage choices available to qualified individuals, employers and employees.

1.9 "Covered Services" means all of the health care services and supplies: (i) that are Medically Necessary; (ii) that are generally available from provider; (iii) that provider is licensed to provide to Members; and (iv) that are covered under the terms of the Member's Evidence of Coverage at the time service is rendered. Plan shall retain the right and sole responsibility to determine whether a service is a Covered Service.

1.10 "Emergency Medical Condition" as set forth in Title 22, California Code of Regulations ("CCR"), section 51056, and California Health and Safety Code section 1317.1, means those services required for alleviation of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Placing the patient's health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.11 "Emergency Services" means those medical and psychiatric services required that are (i) furnished by a physician qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

1.12 "Evidence of Coverage" ("EOC") means the Plan handbook issued to a Member that describes coverage and benefits known as the Combined Evidence of Coverage and Disclosure Form as may be amended, modified, replaced, or supplemented from time to time and issued to Members by Plan pursuant to Title 28 of the California Code of Regulations § 1300.63.2.

1.13 "Language Assistance Program" means the language assistance program established by VHP in compliance with the requirements of the Health Care Language Assistance Act, pursuant to Health and Safety Code Section 1367.04 et seq. and California Code of Regulations ("CCR") 28 CCR 1300.67.04 et seq.

1.14 "Medically Necessary" means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury as determined by a Physician, or, as appropriate, by another Provider under supervision of a Physician, in accordance with accepted medical and surgical practices and standards prevailing at the

time of treatment and in conformity with the professional and technical standards adopted by VHP, as applicable.

1.15 "Member" means each VHP Employer Group, Covered California, Individual and Family Plan, Medi-Cal, Healthy Kids enrollee or other individual included in the products reflected in the exhibits attached to and incorporated by reference to this Agreement.

1.16 "Physician(s)" means each duly licensed and qualified physician who has satisfied Plan's credentialing criteria and is under contract, directly or indirectly, with Plan to provide specified Covered Services to Members.

1.17 "Practitioner(s)" mean the other health care Providers that have entered or will enter into a written agreement, directly or indirectly, with Plan to provide certain Covered Services in return for a negotiated rate of compensation.

1.18 "Provider(s)" means the hospitals, community clinics, primary care and specialty care physicians, skilled nursing facilities, home health agencies, and other health care providers (including institutional, ancillary, behavioral health, and participating Physicians) that have entered or will enter into a written agreement, directly or indirectly, with Plan to provide certain Covered Services in return for a negotiated rate of compensation.

1.19 "Primary Care Physician(s)" ("PCP") means the Physician responsible for supervising, coordinating, and providing initial and primary care to each Member who selects or is assigned to such physician. The PCP is responsible for: managing the delivery of all health and medical care services; for initial referrals for specialist care; and for maintaining the continuity of patient care to such Members. PCP includes physicians practicing in the area of internal medicine, general and family practice, or pediatrics; and may also include physicians in other areas of practice, as applicable, to the extent permitted by VHP and Applicable Requirements.

1.20 "Provider Manual" means, collectively, VHP's standards, protocols, policies and procedures, guidelines, manuals, and related written materials. The Provider Manual(s) are incorporated into this Agreement and may be revised or replaced from time to time, in accordance with the terms of this Agreement. The Provider Manual can be located on Valley Health Plan's website at www.valleyhealthplan.org. If any provisions in the Provider Manual or any amendments thereto are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.

1.21 "QHP Contract" shall mean the Qualified Health Plan contract between Plan and Covered California through which Plan is authorized to enroll individuals as Covered California Members.

1.22 "Quality Management Programs" shall include both Quality Improvement and Utilization Management Programs and means VHP policies, procedures, protocols and functions designed to monitor and ensure the quality and appropriate utilization of Covered Services provided to Members. The Quality Management Programs are described in the Provider Manual.

1.23 "Santa Clara Family Health Plan" ("SCFHP") means the health care service plan licensed pursuant to the Knox-Keene Act and governed by the Santa Clara County Health Authority.

1.24 "Surcharge" means an additional fee that is charged to a Member for Covered Services, which is not permitted under applicable legal requirements, and is neither disclosed nor provided for in the Member's Evidence of Coverage.

ARTICLE II

PROVIDER OBLIGATIONS

2.1 Services.

(a) Provider will provide the **Type_of_Services** services ("Contracted Services") to Members included in the product(s) identified in the exhibits attached to and incorporated by reference to this Agreement.

(b) The Provider(s) must submit an application and be approved pursuant to all applicable credentialing procedures, before he or she may provide medical services pursuant to this Agreement.

(c) Provider will maintain a current list of its Providers who are eligible in accordance with Section 2.9 of this Agreement, to provide medical services hereunder. Provider shall provide an updated list of any changes monthly.

(d) Provider agrees to follow treatment guidelines equivalent to those required by the state in which Provider renders services or as outlined by Provider's specialty.

(e) Providers will accept, diagnose, and treat those Members referred to Provider by Plan in accordance with the terms of this Agreement and consistent with accepted principles of medical practice and ethics.

(f) Except for Emergency Services as defined herein and unless otherwise authorized, Provider will make best efforts to use Physicians and a contracted Providers for those Members requiring additional professional and Covered Services.

(g) Subject to other provisions in this Agreement, the Provider will determine the method, details, and means of performing Contracted Services pursuant to this Agreement. Provider acknowledges that all VHP's decisions, policies and procedures regarding the provision of Covered Services to Members apply solely to Provider's rights to compensation, and will not be construed as interference with, or direction or substitution of, Provider's due diligence and judgment in the provision of Covered Services.

(h) Provider will maintain adequate personnel and facilities to meet its responsibilities under this Agreement. Provider will supervise all personnel employed by it. Provider's personnel, equipment and facilities will be licensed or certified to the extent required by law. Plan or its designee(s), the DHCS, the DMHC or other regulatory agencies may conduct periodic site visits to assess the adequacy of personnel and facilities maintained by Provider. If any of the personnel and/or facilities maintained at any site is found to be inadequate, Plan must be notified, and Provider must develop and implement a plan of correction in accordance with Plan's Quality Management Programs and applicable state and federal laws.

(i) Provider will be responsible, at its sole cost and expense, for providing licensed persons or technicians to assist in the performance of Contracted Services hereunder.

(j) Provider will comply with Plan's drug formularies and treatment protocols, subject to generally accepted medical practice standards. Provider will comply with Title 22, CCR, section 53214, and with DHCS standards for the appropriate use, storage and handling of pharmaceutical items.

(k) Provider will not differentiate or discriminate in its provision of Contracted Services to Members hereunder, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or use of medical services, and Provider will render services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to Provider's other patients.

(l) Provider will notify the Plan of a pending or actual change in scope of service available, or any other factors which might materially affect the Provider's ability to provide services and carry out all other provisions under this Agreement.

(m) Provider agrees to comply with Plan's Language Assistance Program Requirements as outlined in **Exhibit F** that is attached to and incorporated herein by this reference and any other Applicable Requirements.

(n) Provider agrees to comply with Plan's Timely Access Standards as outlined in **Exhibit G** that is attached to and incorporated herein by this reference.

(o) Provider agrees to comply with the Covered California Requirements as specified in **Exhibit H** that is attached to and incorporated herein by this reference.

2.2 Continuity of Care. The completion of Covered Services shall be provided by a terminated Provider to a Member who at the time of the contract's termination was receiving services from that Provider as required by law.

2.3 Standard of Care. Provider shall ensure that Covered Services furnished by Provider to Member are (i) Medically Necessary; (ii) provided in accordance with the standard of care prevailing within the medical community at the time of treatment; (iii)

provided in coordination with appropriate health prevention and education measures; and (iv) in consultation with Plan.

2.4 Improvement Programs. Provider shall establish and maintain quality improvement and utilization management programs to monitor the quality and utilization of Covered Services rendered to members within and across the healthcare organization, settings, and all levels of care. Provider shall fully cooperate with and participate in Plan's Quality Improvement (QI) and Utilization Management (UM) Programs, as applicable. Provider will operate a QI program that is compliant and responsive to public health initiatives, federal, state, and local regulators and accreditation bodies. Provider's QI program shall include a system for monitoring and evaluating accessibility of care. Provider shall support the Plan's ongoing efforts to improve clinical care and services through activities including, but not limited to safe clinical practices, assessment and improvement of clinical care as necessary, measuring quality of services and member experience, and efficient utilization of resources. Provider agrees to implement any reasonable change required by Plan regarding any Provider or problem identified by Plan's Quality Improvement and/or Utilization Management Programs. Provider shall permit Plan personnel to review medical records of Members and Provider shall furnish copies of such pertinent sections of Members' medical records, as may be required, consistent with applicable confidentiality requirements as set forth in this Agreement. Provider agrees to provide to Plan, monthly, all Member data necessary for Plan to maintain and operate its QI and UM Programs and comply with all encounter data submission requirements imposed by Plan and/or any government regulatory agency.

(a) Provider shall designate experienced Utilization Management staff, capable of effectively coordinating the provision of Covered Services to Members. The UM staff shall, among other duties, assist Provider and Plan with respect to implementing Covered Service authorizations, approval of Member referrals, and such other duties as Provider shall designate from time to time. Prior authorization is required for all Covered Services except as determined by DMHC policy. Contacts for prior authorization of Covered Services are referenced in **Exhibit D** which is attached to and incorporated herein by this reference.

(b) Provider shall fully comply with Plan's Quality Management Programs and with any changes thereto. Upon request, Provider agrees to furnish Plan with Provider's performance data for quality improvement activities including compiling and comparing the performance data for display to our Members in order for Plan to meet their regulatory or accreditation requirements. Information requested must be readily available and requested within a reasonable time frame.

(c) Provider shall cooperate with Plan and/or any external peer review organization in the conduct of QI functions and in solving problems which includes potential quality issues. Provider shall provide Plan with information and reports as are reasonably necessary for Plan to conduct, or, if applicable, monitor Provider's delegated conduct of quality improvement functions. Provider shall also provide Plan with information and reports as are necessary for Plan to maintain compliance with DMHC, CMS, Covered California and Accrediting Agency requirements and/or state and federal law.

2.5 Member Transfer or Termination. Provider shall not ask Plan to terminate a Member or transfer a Member to another Provider because of a Member's medical condition or need for, or utilization of Covered Services. However, Plan and Provider may determine that the transfer of certain Members to another Provider may be Medically Necessary. Such determination shall be based on the following: (i) the Member's medical condition; (ii) the standard of care prevailing within the applicable medical community at the time of treatment; (iii) Provider's clinical capabilities, expertise and resources regarding the medical condition and standard of care under review; and (iv) the clinical capabilities, expertise and resources of another Provider under consideration to assume the care of such Member.

2.6 Eligibility Verification. Provider shall obtain from Plan verification of the eligibility of all Members who receive Covered Services pursuant to this Agreement. If eligibility verification is not possible prior to the provision of Covered Services, Provider shall request such verification at the earliest possible opportunity thereafter, prior to billing Plan; provided, however, that Provider shall not be required to obtain Plan's approval prior to rendering Emergency Services to Members. Plan agrees to provide access to eligibility verification twenty-four (24) hours per day, seven (7) days per week. If Provider fails to verify eligibility which results in Provider rendering services to ineligible patients, Plan shall have no financial responsibility to reimburse Provider for any such services rendered to such ineligible patients.

2.7 Authorization Requirements. Provider agrees to comply with VHP's authorization procedures and shall obtain prior authorization from Plan for all Covered Services, as required herein and in the Provider Manual. Additionally, Provider agrees to obtain prior authorization from Plan before providing any item or service not included in the original referral. If prior approval for additional items or services is not obtained, payment for services will be denied. Plan's contacts for prior authorization are set forth in **Exhibit D** to this Agreement.

(a) Upon request, Provider must promptly provide Plan with all information and documentation to enable Plan to determine whether to authorize services. Provider agrees to comply with the prior authorization process as set forth in the Provider Manual, and as required by Plan's Utilization Management Department.

(b) Provider will provide a report to referring physician within three (3) working days, unless a significant finding warrants immediate reporting.

(c) Provider acknowledges that nothing in this contract should be constructed to prevent Provider from freely communicating with patients about treatment options, including medication treatment options, regardless of benefit coverage limitations.

2.8 Member Grievances. Provider shall cooperate with Plan in resolving Member grievances related to the provision of Covered Services in accordance with Plan's Grievance and Appeals Procedures. Provider agrees to make available to Members copies of Plan's Grievance and Appeals Procedures and shall notify Plan within forty-eight (48) hours of the time it becomes aware of any Member grievances. Provider shall investigate all

Member grievances within the time frames specified by Plan and use its best efforts to assist Plan in resolving grievances in a fair and equitable manner.

2.9 Credentialing; Quality Assessment/Improvement; Grievance

(a) Provider must submit an application to Plan in accordance with Plan's credentialing procedures and must provide Plan with any requested information, records, summaries of records and statistical reports specific to Provider including, but not limited to, utilization profiles pertinent to Provider's provision of medical services, professional qualifications, licensing and credentialing information. Provider will not be permitted to provide services to Plan members until they have been notified by Plan that their Credentialing Process is complete and has been approved. Provider will execute any releases requested by Plan to permit credentialing, re-credentialing, discipline, utilization management, and quality assessment and improvement determinations to be made with respect to Provider. Provider must provide such information for all location(s) and/or individual Provider(s) containing the information set forth in **Exhibit C** of this document, which is attached hereto and incorporated herein by reference. Provider will cooperate and assist with site visits required for regulatory, quality assessment or credentialing purposes.

(b) Provider agrees to be bound by and shall fully comply with all Applicable Requirements. Provider shall review the Provider Manual including Plan's Quality Management Programs prior to or promptly following the execution of this Agreement. Provider shall fully comply and cooperate with Plan's Provider Manual requirements including the Quality Management Programs and with any subsequent changes thereto.

(c) Prior to execution of this Agreement and thirty (30) days prior to implementing any change, Provider must provide Plan with the information described in **Exhibit C**, including a list of Providers licensed and/or credentialed employees, Provider sites, addresses and operating hours. Provider will maintain a current list of its Providers who are eligible to provide medical services hereunder. Provider shall provide an updated list specifying any changes of Providers to Plan monthly.

(d) The Parties acknowledge and agree that Plan or another contracting health plan committee that reviews the quality of medical services rendered to Members will act in the capacity of a "peer review committee" for purposes of applicable law. For purposes of this section, "quality of medical services" includes, without limitation, matters involving utilization management and compliance with requirements, rules or regulations relating to the delivery, cost, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities and protections provided to peer review committees under applicable provisions of the California Civil, Evidence and Health and Safety Codes will apply to any such committee when performing the function described herein.

(e) Provider acknowledges that Plan is accredited. Provider's performance under this Agreement must comply with applicable Plan and Accrediting Agency standards. Provider certifies that personnel who are to provide

services to Plan Members maintain appropriate skills, competency, and continuing education commensurate with their current job descriptions. Upon request, Provider will provide Plan with documentation evidencing that the aforementioned standards have been met. Further, Provider agrees to cooperate with and/or participate in any Accrediting Agency review or survey as requested by the Plan and/or Accrediting Agency.

(f) Under Plan's direction, Provider agrees to cooperate in the resolution of all Member medical disputes in accordance with the procedures of, and within the timeframes designated by Plan in its Provider Manual.

(g) Provider acknowledges that Plan has independent obligations with respect to quality management under the Knox-Keene Act. Plan shall be responsible for developing and operating a quality assurance and improvement program in connection with Covered Services.

(h) Provider shall fully comply with Plan's Quality Management Programs and with any changes thereto. Upon request, Provider agrees to furnish Plan with Provider's performance data for quality improvement activities including compiling and comparing the performance data for display to our Members in order for Plan to meet regulatory or accreditation requirements. Information requested must be readily available and requested within a reasonable time frame.

2.10 Reporting Requirements. Provider agrees to provide and timely submit to Plan all reports as may be required under this Agreement and/or by federal, state, and local standard regulations and accreditation bodies. Provider agrees to support and promote Plan's Quality Improvement Programs to sustain and/or improve quality of care, safety, efficiency, and continuity and coordination of services, including behavioral health services when applicable. Provider agrees to maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety, and efficiency of clinical care, and quality of service. Provider reports must reveal trends or patterns and identified opportunities for improvement that are based on current scientific knowledge, and evidence-based clinical practice guidelines recognized in the industry. Provider reports must be structured to produce statistically valid performance measures for care and services rendered. Provider shall exercise ongoing efforts supported by concrete data or evidence(s) to improve structural and organizational performance measures. Provider agrees to re-evaluate and determine the effectiveness of measures implemented based on significant statistical findings against organizational goals or benchmarks set. Provider agrees to establish collaborative partnerships with the Plan to implement interventions or service needs of the Plan's Members throughout the entire continuum of care to improve and achieve desired health outcomes. The Plan has the duty to conduct UM, QI, and fraud prevention detection activities in accordance with Plan policies, federal, state, and local regulations, unless Plan delegated those duties. Provider shall cooperate with Plan in the conduct and oversight of those functions and provide Plan with information as is reasonably necessary for Plan to perform its functions.

ARTICLE III

PLAN OBLIGATIONS

3.1 Plan Operations. Plan agrees to conduct the day-to-day administrative operations of a health care service plan for which it is responsible under state and federal law.

3.2 Compensation. Plan shall pay Provider for Contracted Services provided to Members as set forth in Article IV of this Agreement at the rates agreed to in **Exhibits A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, attached to and incorporated herein by this reference, less Co-payments, as applicable.

3.3 Quality and Utilization of Covered Services. Plan shall monitor the quality and utilization of Covered Services provided to Members in accordance with the policies and procedures of Plan's Quality Improvement Programs and Utilization Review Programs established by Plan. Plan shall monitor and evaluate accessibility of care and address problems that develop. Plan shall review, at least annually, Provider's compliance with standards established by Plan.

(a) Quality Reviews. The Parties acknowledge and agree that Plan reviews the quality of medical services rendered to Members and shall act in the capacity of a "peer review committee" for purposes of Applicable Requirements. For purposes of this section, "quality of medical services" includes, without limitation, matters involving utilization management and compliance with requirements, rules or regulations relating to the delivery, cost, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities and protections provided to peer review committees under applicable provisions of the California Civil, Evidence, and Health and Safety Codes will apply to any such committee when performing the function described herein.

(b) Quality Improvement Services.

i. Plan shall perform quality improvement services.

ii. Plan shall establish a Quality Improvement (QI) Plan and apply criteria and methodologies to review and measure the quality of professional, ancillary and inpatient professional services.

iii. Plan shall conduct, or require a designee to conduct, meetings at least quarterly, pursuant to a set agenda, to review and measure the quality of health care services provided or arranged by Provider or its subcontractors.

iv. Plan shall on a periodic basis, conduct clinical quality improvement evaluations of the care rendered to members, to comply with DMHC requirements, Applicable Requirements and/or Plan policies.

3.4 Provider Manual(s). VHP Provider Manual can be located at www.valleyhealthplan.org. Plan shall make available to Provider a Provider Manual(s) which shall include all administrative policies and procedures of Plan. Plan shall provide forty-five (45) business days' prior written notice to Provider of any amendments to the Provider Manual(s). Such amendments shall become effective upon expiration of the forty-five (45)

business day notice period unless Provider determines that such amendment adversely affects a material duty or responsibility of Provider and/or has detrimental economic effect upon Provider and Provider provides Plan with written notice of such determination within forty-five (45) business days of receiving notice of the applicable amendment from Plan. Plan and Provider shall attempt to agree to a written amendment to the Agreement which addresses the adverse effects of the amendment on Provider. If such an agreement cannot be reached by Provider and Plan, the amendment shall not be effective and shall have no force or effect on Provider and Provider shall have a right to terminate the Agreement in accordance with California Health and Safety Code Section 1375.7(b) prior to the implementation of the amendment.

ARTICLE IV

COMPENSATION

4.1 Billing. Provider shall submit Clean Claims to Plan for all Contracted Services rendered to a Member, within the timeframes established in **Exhibits A-1, A-2, A-3, A-4, A-5 and A-6,** attached to and incorporated herein by this reference.

4.2 Payment.

(a) Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6** of this Agreement minus the Member's Co-payment. Plan will pay Provider for Covered Services rendered to Member within forty-five (45) business days of receipt of Provider's undisputed, Clean Claim. A Clean Claim must include the information required by of this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

(b) Provider will be responsible for the collection of Coordination of Benefit payments for Members, and Plan will pay in accordance with Article 5 of this Agreement.

(c) Balance Billing. Except for applicable Co-payment, Provider shall not invoice or balance bill Plan's Member for the difference between Provider's billed charges and the reimbursement paid by Plan for any Covered Service rendered.

4.3 Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Clean Claims.

(a) Denying, Adjusting or Contesting a Clean Claim. For each claim that is either denied, adjusted or contested, Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes as specified in §1300.71(g) and (h) of the Department of Managed Health Care ("DMHC") Regulations.

(b) Time for Contesting, Adjusting or Denying Claims. Plan may contest or deny a claim, or portion thereof, by notifying Provider in writing, that the claim is

contested or denied, within forty-five (45) working days after the date of receipt of the claim by Plan.

(c) Reimbursement for Overpayment of Clean Claim. If Plan determines it has overpaid a Clean Claim, it shall notify Provider in writing through a separate Notice clearly identifying the claim, the name of the patient, date of service and including a clear explanation of the basis upon which Plan believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

i. If Provider contests Plan's notice of reimbursement of the overpayment of a Clean Claim, Provider, within thirty (30) working days of the receipt of the notice of overpayment of a Clean Claim, shall send written Notice to Plan to state the basis upon which Provider believes that the Clean Claim was not overpaid. Plan shall receive and process the contested notice of overpayment of a Clean Claim as a dispute pursuant to this Agreement and applicable DMHC Regulations.

ii. If Provider does not contest Plan's notice of reimbursement of the overpayment of a Clean Claim, Provider shall reimburse Plan within thirty (30) working days of the receipt by Provider of the notice of overpayment of a Clean Claim.

iii. Plan may only offset an uncontested notice of reimbursement of the overpayment of a Clean Claim against Provider's current Clean Claim submission when: (i) Provider fails to reimburse Plan within the timeframe specified above; and (ii) this Agreement specifically authorizes Plan to offset an uncontested notice of overpayment of a Clean Claim from Provider's current Clean Claim submissions. If an overpayment of a Clean Claim(s) is offset against Provider's current Clean Claim(s) pursuant to this section, Plan shall provide a detailed written explanation to Provider, identifying the specific overpayment or overpayments that have been offset against the specific current Clean Claim(s).

4.4 Non-Covered Services. If Provider renders services to Members that are not Covered Services per the Member's EOC in effect at the time service is rendered, Provider may seek payment for such service(s) from the Member as allowed by law. Provider shall refrain from billing and/or collecting from a Member any charges in connection with services provided to the Member that are Non-Covered Services, unless Provider has first obtained a written acknowledgment of financial responsibility from the Member or the Member's legal representative. Such acknowledgement must be obtained in advance of rendering the Non-Covered Services.

ARTICLE V

COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

5.1 Coordination of Benefits. Certain claims for Contracted Services rendered to Members are claims for which another payor may be primarily or secondarily responsible

under Coordination of Benefit rules. For purposes of this Agreement, "Coordination of Benefits" or "COB" shall mean a method of sequentially assigning responsibility for the payment of Covered Services rendered to a Member among two (2) or more insurers or payors (e.g. Medicare). Plan and Provider shall cooperate to exchange information relating to Coordination of Benefits with regard to any Member for whom Provider has provided Contracted Services. In addition, Provider shall comply with the following requirements in such situations:

(a) Plan as Primary Payor. When Plan is the primary payor, Provider shall accept the amount set forth in this Agreement as payment in full for Contracted Services from Plan. However, Provider shall have the right to collect Co-payments and payments for Non-Covered Services from Members and shall have the right to pursue and retain COB revenue from any secondary payor.

(b) Plan as Secondary Payor. When Plan is the secondary payor, Provider shall promptly bill and take reasonable steps to collect payment from the primary payor. Plan shall pay Provider the difference between the amount collected from the primary payor and one hundred percent (100%) of the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, of this Agreement.

5.2 Compliance with Law. Notwithstanding any other provisions of this Agreement to the contrary, Provider shall, in all instances, collect from a Member, or from those who are financially responsible for such Member, the entire amount of such Member's Co-payment obligation(s) that are required to be collected in accordance with applicable state and federal laws.

5.3 Collection of Charges from Third-Parties. If a Member is entitled to payment from a third-party, Plan shall have no objection to Provider engaging in collection of any claims or demands against such third parties for amounts due for Contracted Services, so long as Provider gives Plan prior written notice of its intent to pursue such collection.

5.4 COB Obligations of Plan. Plan shall provide COB information to Provider by supplying available data from the Member at the point of enrollment and supplying such data to Provider when available.

5.5 Assignment of Third-Party Liability Payments. If Provider collects any third-party liability payments for Contracted Services provided to a Member and has also previously received payments for such Contracted Services from Plan, Provider shall reimburse Plan the amount paid by Plan for said Member.

ARTICLE VI

COMPLIANCE WITH DMHC REGULATORY REQUIREMENTS

6.1 Records Maintenance. Provider shall, with respect to services provided under this Agreement, cooperate fully with Plan by, among other things, maintaining and making available to Plan and the Director of the DMHC, all records necessary: (i) to ensure

continuity and quality of care for Members; (ii) to fulfill Plan's obligations under the Knox-Keene Act and implementing regulations; and (iii) for Plan to verify Provider's compliance with any of the terms and conditions of this Agreement. Provider shall maintain medical records, including without limitation their confidentiality as required under federal HIPAA law, and the Confidentiality of Medical Information Act, California Civil Code Section 56 *et seq*., in a manner consistent with the requirements of Applicable Requirements. Provider shall not allow unauthorized persons to view confidential records and shall have safeguards to prevent unauthorized viewing of confidential files. Provider agrees to maintain all books and records in a form in accordance with the general standards applicable to such books and records at Provider's place of business or at such other mutually agreeable location in California. Provider agrees to maintain all books and records provided for in this Section 6.1 for ten (10) years, or as may be otherwise required under Applicable Requirements, or CMS requirements, and such obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

6.2 Access to Records; Inspection. Plan shall have access, at all reasonable times upon reasonable demand, to the books, records and papers of Provider, (including but not limited to patient medical records,) relating to Covered Services provided to Members under this Agreement, to the cost thereof and to payments received by Provider from Members. Provider agrees to permit the DHCS, DMHC, the California Department of Public Health, or their authorized representatives, to conduct a site evaluation of Provider facilities and/or to inspect, examine or copy, at all reasonable times, upon reasonable demand, all such books and records described in this Section 6.2. Provider agrees to cooperate with all regulatory and governmental agencies in all aspects of the inspection process.

6.3 Knox-Keene Act. Provider understands and acknowledges that Plan is subject to the provisions of the Knox-Keene Act (Chapter 2.2 of Division 2 of the Health and Safety Code) and implementing regulations (Chapter 1 of Division 1 of Title 28 of the California Code of Regulations) ("Regulations"). Any provision required to be in this Agreement by either of the above shall bind Plan whether or not provided in this Agreement. Provider shall comply with any and all Applicable Requirements imposed upon Plan and Provider under the Knox-Keene Act and Regulations.

6.4 No Surcharges. In no event, including but not limited to nonpayment by Provider or Plan, Provider's or Plan's insolvency or breach of this Agreement, shall any Member be liable for any sums owed to Provider by Plan, and Provider shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any Surcharge upon, a Member or other person acting on a Member's behalf. This provision shall not prohibit collection of Co-payments or COB revenues from secondary carriers by which the Member is covered. In the event Plan receives notice that a Member has been surcharged by Provider, Plan shall notify Provider in writing within ten (10) working days of the receipt of said notice and Plan shall take appropriate action. In the event Plan and Provider mutually determine, in writing, that Member has been Surcharged by Provider, Plan may refund the Surcharge to the Member and deduct the amount of such Surcharge from compensation due Provider pursuant to this Agreement. In the event there is a dispute regarding whether Provider has Surcharged a Member, Provider and Plan agree to meet to discuss said dispute no later than ten (10) calendar days following the receipt of a written request by the

other party. Should the Parties fail to mutually resolve said dispute, said dispute shall be submitted by the Parties to dispute resolution as provided in Section 10 of this Agreement within ten (10) calendar days following the aforedescribed meeting of the Parties. The obligations set forth in this Section 6.4 shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of a Member, and the provisions of this Section 6.4 shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Member or persons acting on behalf of either of them.

6.5 Language Assistance Program. Plan shall maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Members have appropriate access to language assistance while accessing any health care service, pursuant to California Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and California Insurance Code §§ 10133.8 and 10133.9. Provider shall make best efforts to cooperate and comply, with Plan's Language Assistance Program, which is outlined in **Exhibit F.**

6.6 Further Amendments. Plan and Provider acknowledge that the DMHC may require that the parties further amend this Agreement to conform to the Knox-Keene Act. If the DMHC requires such further amendments, Plan shall notify Provider in writing of such amendments. Provider shall then have sixty (60) days from the date of Plan's notice to reject the proposed amendments by written notice to Plan. If Plan does not receive such written notice Plan has the option to terminate this Agreement upon sixty (60) days written notice.

6.7 Subcontractors. Without limiting any provision in the Agreement regarding assignment and delegation, Provider agrees to maintain and make available for inspection by Plan and the DMHC, written copies of all contracts between Provider and any of its subcontractors.

6.8 Filing a Complaint. Members of the Plan are entitled to the following information regarding the Department of Managed Health Care:

(a) "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **408-885-4760 or 1-888-421-8444** (toll-free) and use your health plan's Grievance process before contacting the Department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website

www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

6.9 Compliance.

(a) Provider certifies that none of its employees or agents providing service under this Agreement (hereafter "Practitioners") have been convicted of a criminal offense related to health care, nor are any listed by any federal or state agency as debarred, excluded or otherwise ineligible for participation in Medicare, Medi-Cal, or any other federal or state funded health care program. Provider certifies that it has performed an appropriate screening of Providers prior to making this certification, that it will screen all new Providers, and that it will monitor the status of existing Providers. Provider certifies that they and their Practitioners possess all licenses required and those said licenses are in good standing. Provider certifies that in providing these Contracted Services, they and their Practitioners are operating within any and all limitations or restrictions of these licenses. Provider further certifies that none of its directors, managing employees, and owners of five percent interest, or more, in Provider's business have been convicted of any health care related offenses nor excluded from Medicare, Medi-Cal, or any other federal or state funded health care program.

(b) Provider agrees to notify the Plan immediately should Provider or Practitioner be investigated, charged, or convicted of a health care related offense. During the pendency of any such proceedings, Provider or a Practitioner may, at the request of the Plan, be removed from any responsibility for, or involvement in, the provision of services under this Agreement. It is the Provider's obligation to keep the Plan fully informed about the status of such proceedings and to consult with the County prior to taking any action which will directly impact the County. This Agreement may be terminated immediately by Plan upon the actual exclusion, debarment, loss of licensure, or conviction of Provider or of a Provider of a health care offense.

(c) Provider will indemnify, defend, and hold harmless Plan for any loss or damage resulting from the conviction, debarment, or exclusion of Provider, or Practitioners, or subcontractors.

6.10 Directory Requirements. Provider agrees to comply with Health and Safety Code Section 1367.27 et seq. Provider agrees to coordinate with VHP to verify and maintain all directory requirements in compliance with HSC § 1367.27. Said requirements shall include; (1) participation in a bi-annual audit to verify the Provider contact information and participating Provider profile(s) information is accurately represented in the VHP Provider Directory, (2) provide an affirmative response to the Provider Directory audit confirming the information represented is current and accurate, and (3) if information is inaccurate, provide VHP with current and accurate information. The Provider Directory audit process shall include a Provider notification informing Providers they have thirty (30) business days to provide VHP with their affirmative response. If a response is not received within 30 business days, VHP shall issue a final notice providing an additional ten (10) business days to receive Providers affirmative response. Provider acknowledges that non-responsive Providers are removed from the VHP Provider Directory until the directory

information is confirmed. Additionally, Provider agrees to timely notify VHP when either of the following occurs:

(a) Provider agrees to inform the Plan within five (5) business days when the Provider is not accepting new patients.

(b) Provider agrees to inform the Plan within five (5) business days when the Provider changes from not accepting new patients to accepting new patients.

ARTICLE VII

MEDICAL RECORDS, HIPAA AND THE HITECH ACT

7.1 Medical Records. Provider shall maintain for Members a single standard medical record, containing such accurate, descriptive and timely information and preserved for such time period(s) as required by the rules and regulations of the California Department of Public Health, and The Joint Commission or any other comparable accreditation organization. Unless otherwise specifically agreed by Provider, it is the understanding and agreement of the parties that the records described herein are deemed to meet all record keeping requirements required of Plan pursuant to Applicable Requirements.

7.2 Member Access to Medical Records. Provider shall ensure that Members have access to their medical records in accordance with the Applicable Requirements of state and federal laws and regulations.

7.3 Right to Inspect Medical Records. The medical records described in Section 7.1 above shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with Applicable Requirements and general Provider policies. Plan, regulatory agencies with jurisdiction over Plan's business, and their designated representatives shall have the right to inspect, review, and make copies of such records upon request to facilitate Plan's obligation to conduct quality improvement, utilization monitoring, and peer review activities as required by the Provider Manual and Applicable Requirements.

7.4 Confidentiality. Provider and Plan agree to maintain the confidentiality of information contained in the medical records of Members in accordance with Applicable Requirements. Medical records may be disseminated to authorized Plan Physicians or Plan representatives or Review Committees, to Plan itself, or to an appropriate Plan peer review, Quality Improvement or Utilization Management Committee or subcommittee identified by Plan, or as otherwise required by law. Provider shall require that all Providers to comply with Applicable Requirements regarding confidentiality and disclosure of mental health records, medical records and other health and Member information.

(a) Provider acknowledges and agrees that all information received from Plan in connection with patients referred to Provider by Plan under this Agreement, including, without limitation, the compensation provisions, Member lists, marketing materials, Quality Management Programs, Provider Manual, telephone numbers, manuals, records, policies and agreements, are proprietary information and trade secrets of Plan. Provider and the officers, employees and agents of Provider will

keep such information confidential, except to the extent that confidentiality may not be maintained as to any such information under Applicable Requirements. Provider will obtain written consent of Plan prior to dissemination of any marketing materials or materials promoting health and wellness activities or other information that refers to Plan.

7.5 Plan and Governmental Agency Access to Records. Provider shall cooperate and assist with Plan, agencies of the state and federal government and their designees in maintaining and providing medical, financial, administrative and other records of Members as shall be requested by Plan, or such agencies. Plan and such agencies shall have access at reasonable times upon demand to the books, records and papers of Provider and their Practitioners relating to services provided to Members, the quality, appropriateness, timeliness, cost thereof, and any payments received by Provider or their Practitioners for Covered Services provided to Members.

7.6 Compliance with HIPAA and the HITECH Act. The parties hereto agree to comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1966 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), including, but not limited to, the HIPAA Privacy and Security Rules. The parties further agree, if required by HIPAA, or any other Applicable Requirements, to enter into a Business Associate Agreement which complies with the requirements set forth in 45 C.F.R. Sections 164.301, 164.312,164.316, 164.504(e)(2)(i)-(iii) and 42 U.S.C. Sections 17931 and 17935(a).

7.7 Electronic Protected Health Information.

(a) Safeguards. Provider shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information (as defined at 45 C.F.R. 160.103) that it creates, receives, maintains, or transmits on behalf of Plan as required by Subpart 'C' of Part 164 of Title 45 of the Code of Federal Regulations.

(b) Agent and Subcontractors. Provider shall require any agent, including a subcontractor to whom Provider provides Electronic Protected Health Information, to implement reasonable and appropriate safeguards to protect such Electronic Protected Health Information.

(c) Reporting of Unauthorized Use or Disclosure. Provider shall report to Plan any Security Incident (as defined at 45 C.F.R. 160.103) of which Provider becomes aware.

(d) Availability of Records upon Termination. The obligations contained in this Article XIII shall survive termination of this Agreement.

ARTICLE VIII

INSURANCE AND INDEMNITY

8.1 Insurance and Indemnity Requirements. Provider will comply with the insurance and indemnity requirements set forth in **Exhibit E**, which is attached to and incorporated herein by this reference. It is understood and agreed that County is self-insured pursuant to the authority granted in California Government Code section 990.4, and that such self-insurance satisfies Plan's and the County's obligations hereunder.

8.2 Insurance Terms.

(a) Each of the policies required by this Agreement shall provide that, prior to the cancellation, change or amendment thereof; the contracting party shall receive a minimum of thirty (30) days' prior written notice.

(b) If the malpractice insurance coverage provided is "claims made," and either party changes carriers or terminates coverage on or after termination of this Agreement, that party shall purchase a policy of "prior acts" or "tail" coverage for a minimum term of five (5) years from the termination of the policy in effect immediately prior to such tail policy. Such "tail" coverage shall have the same policy limits as the primary malpractice insurance coverage required under this Agreement.

(c) Either party shall provide the other with certificates evidencing such insurance coverages upon the execution of this Agreement or from time to time thereafter as may be requested.

ARTICLE IX

TERM AND TERMINATION

9.1 Term of Agreement. The term of this Agreement shall commence on the Effective Date and continue for a period of one (1) year ("Initial Term") and shall automatically renew thereafter for up to four (4) additional consecutive one-year terms, unless earlier terminated as provided herein. This Agreement shall supersede any Letters of Agreement and/or Payment Agreements that were executed by the Parties prior to the Effective Date of this Agreement. For services rendered on or after the Effective Date of this Agreement, this Agreement's terms shall control.

9.2 Termination without Cause. This agreement may be terminated by the Plan without cause by giving sixty (60) days prior written notice to Provider.

9.3 Termination of Agreement with Cause. Either Plan or Provider may terminate this Agreement for cause as set forth in this Section 9.3, subject to the notice requirement and cure period set forth herein.

(a) Cause for Termination of Agreement by Provider. The following shall constitute cause for termination of this Agreement by Provider:

i. **Failure to Maintain Insurance.** Plan fails to maintain adequate professional and general liability coverage required under this Agreement or to replace coverage that is cancelled or otherwise terminated;

ii. **Insolvency of Plan.** A petition is filed to declare Plan bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Plan's assets, and the insolvency is not cured within thirty (30) days after said event;

iii. **Failure to Maintain Government Approvals.** Plan is unable to secure and maintain in effect any of the necessary governmental licenses required for the performance of its duties under this Agreement, including, but not limited to, its contract with CMS; and

iv. **Breach of Material Term and Failure to Cure.** Plan's breach of any material term, covenant or condition of this Agreement, and subsequent failure to cure such breach as prescribed in Section 9.3 (c).

(b) Cause for Termination of Agreement by Plan. The following shall constitute cause for termination of this Agreement by Plan:

i. **Failure to Maintain Insurance.** Provider fails to maintain adequate professional and general liability coverage required under this Agreement or to replace coverage that is cancelled or otherwise terminated;

ii. **Insolvency of Provider.** A petition is filed to declare Provider bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Provider's assets;

iii. **Failure to Provide Quality Services.** Provider's failure to provide Contracted Services in accordance with the standards set forth in this Agreement, the standards of The Joint Commission or any other comparable accreditation organization and Plan's Quality Improvement and Utilization Management Programs;

iv. **Breach of Material Term and Failure to Cure.** Provider's breach of any material term, covenant or condition of this Agreement, and subsequent failure to cure such breach as prescribed in Section 9.3 (c).

(c) Notice of Termination and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "Terminating Party") shall provide written notice of termination to the other party. The notice of termination shall specify the breach or deficiency underlying the cause for termination. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the Terminating Party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the Terminating Party within the Cure Period, or if the breach or deficiency is not curable, this Agreement shall terminate upon the expiration of the Cure Period. Satisfaction of a cure shall not be unreasonably withheld.

9.4 Termination of Provider. Notwithstanding anything to the contrary in this Agreement, Plan shall have the right to sanction Provider or terminate this Agreement upon

ten (10) days' prior written notice in the event that Plan, or any federal or State agency reasonably believes that Provider is providing inadequate quality of care and/or Provider fails to comply with Plan's statutory obligations under the Knox-Keene Act or regulations whether the Plan directly manages and/or delegates responsibilities consistent with the Knox-Keene Act or Medicare and Medi-Cal laws and regulations. During said ten (10) day period, Provider shall cease providing Covered Services to Members.

9.5 Continuing Care Obligations of Provider.

(a) General Obligations. In the event of termination of this Agreement for any cause or reason, Provider shall continue to provide Contracted Services to Members as required by law, including any Members who become eligible during the termination notice period, for a "Continuing Care Period", Plan shall pay Provider for Contracted Services provided by Provider during the Continuing Care Period at the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, attached hereto.

(b) Obligations if Plan Ceases Operating or Agreement is terminated for Nonpayment.

i. Notwithstanding any provisions of this Agreement to the contrary, Provider agrees that in the event Plan ceases operations for any reason, including insolvency, Provider shall continue to provide services as set forth in Section 9.5 (a) above and shall not bill, charge, collect or receive any form of payment from any Member for Covered Services provided by Provider after Plan ceases operations.

ii. In the event Plan ceases operations or Provider terminates this Agreement on the basis of Plan's failure to make timely payments in accordance with the terms of this Agreement, Provider shall continue to provide Services to those Enrollees who are under the care at the time Plan ceases operations or Provider terminates this Agreement until such Members are reassigned by Provider, as set forth in Section 9.5 (a) above and shall not bill, charge, collect or receive any form of payment from any Member for Covered Services.

(c) Survival of Provisions Following Termination. Provider agrees that the provisions of this Section 9.5 (c) and the obligations of Provider shall survive termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Members.

ARTICLE X

DISPUTE RESOLUTION

10.1 Member Grievances and Appeals. Provider shall review and process all complaints and grievances of Members through Grievance and Appeals Procedures established by Plan. Provider agrees to cooperate fully with Plan in the investigation and resolution of any such Member complaint.

10.2 Dispute Resolution. Controversies between Plan and Provider shall be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties. Provider shall submit disputes to Plan in writing at the address set forth in the Provider Manual(s) and as set forth in this Agreement for resolution pursuant to Plan's dispute resolution procedures described in the Provider Manual(s) to the extent they are not in conflict with the terms and conditions contained herein this Agreement. In the event of any inconsistency between this Agreement and the Provider Manual(s), the terms and conditions of this Agreement shall prevail.

ARTICLE XI

GENERAL PROVISIONS

11.1 Compliance with Applicable Law. Provider and Plan shall comply with all Applicable Requirements, including any amendments or updates thereto. Any provision required to be in this Agreement according to the Applicable Requirements shall bind Plan and Provider whether or not specifically set forth in this Agreement.

11.2 Incorporation of Exhibits. Exhibits A-1, A-2, A-3, A-4, A-5, A-6, B (Reserved), C, D, E, F, G, and H are attached hereto and are hereby expressly incorporated herein by this reference.

11.3 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

11.4 Assignment. This Agreement shall not be assigned, delegated, or transferred by either Party without the prior written consent of the other Party, except that Plan may assign the Agreement to a parent or affiliate of the Plan that assumes the Plan's obligations as a licensed health care service plan. If required by law, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state or federal agencies.

11.5 Invalidity or Unenforceability. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.

11.6 Amendment. Except as set forth below, this Agreement may be modified only upon the mutual written consent of both Parties. Notwithstanding the foregoing, if Plan is required to amend this Agreement to comply with any state or federal law, regulation or instruction from any regulatory agency having jurisdiction over Plan's activities, Plan shall provide at least forty-five (45) days' prior written notice to Provider of such amendment. If Provider fails to accept such amendment within thirty (30) Plan has the option to terminate the Agreement immediately.

11.7 Governing Law. This Agreement shall be governed in all respects by the laws of the State of California, and any applicable federal laws.

11.8 Interruption by Disasters. In the event the operations of Provider's facilities or any substantial portion thereof, are interrupted by war, fire, and other elements, insurrection, terrorism, riots, earthquakes, acts of God, or, without limiting the foregoing, any other cause beyond the control of Provider, the provisions of this Agreement (or such portions hereof as Provider is hereby rendered incapable of performing) may be suspended for the duration of such interruption. Such suspension shall be determined by the mutual written agreement of the Parties and shall include an identification of the necessary adjustments to any provision of this Agreement; provided, however, to the extent that services are provided by Provider, Plan shall compensate Provider for said services in accordance with Article IV herein. Should a substantial part of the services which Provider has agreed to provide hereunder be interrupted pursuant to such event(s) for a period in excess of thirty (30) days, Plan or Provider shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the other party.

11.9 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

11.10 Solicitation of Plan Members, Subscribers or Subscriber Groups. Provider shall not engage in the practice of solicitation of Members, subscribers or subscriber groups without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee of Provider or their respective assignees or successors during the term of this Agreement or during the one (1) year immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members, subscribers or subscriber groups to disenroll from Plan or discontinue their relationship with Plan. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

11.11 Confidential and Proprietary Information. Both Parties agree to maintain confidential, (the "Confidential Information") as specified in the Section 11.11 and Section 11.12: (i) eligibility lists and any other information containing the names, addresses and telephone numbers of Members; (ii) the financial arrangements between either Party and any Provider; (iii) any other information compiled or created by either Party that is proprietary to either Party, and that either Party identifies as proprietary in writing. Neither Party shall disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Either Party may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of the other Party upon the effective date of termination of this Agreement, each Party shall promptly return to the other Party the Confidential Information in its possession, upon the other Party's notice. Both Parties shall maintain the confidentiality of the rates and special terms of this Agreement that are unique to the other Party. The obligations contained in this Section 11.11 shall survive the termination of this Agreement.

11.12 California Public Records Act. The County is a public agency subject to the disclosure requirements of the California Public Records Act ("CPRA"). If Provider's proprietary information is contained in documents submitted to Plan, and Provider claims

that such information falls within one or more CPRA exemptions, Provider must clearly mark such information "CONFIDENTIAL AND PROPRIETARY," and identify the specific lines containing the information. In the event of a request for such information, the Plan will make best efforts to provide notice to Provider prior to such disclosure. If Provider contends that any documents are exempt from the CPRA and wishes to prevent disclosure, it is required to obtain a protective order, injunctive relief or other appropriate remedy from a court of law in Santa Clara County before the Plan's deadline for responding to the CPRA request. If Provider fails to obtain such remedy within Plan's deadline for responding to the CPRA request, Plan may disclose the requested information.

11.13 Notices. All notices, requests, demands and other communications hereunder shall be in writing (hereafter a "Notice"). A Notice shall be deemed given when delivered (i) delivered in person, or (ii) four (4) days after being mailed by certified or registered mail, postage prepaid, return receipt requested, or (iii) one (1) day after being sent by overnight courier such as Federal Express, to the Parties, their successors in interest or their assignees at the following addresses, or at such other addresses as the Parties may designate by written Notice in the manner aforesaid. In addition to the approved delivery methods, a copy of the Notice shall also be sent via secure email or electronic facsimile as follows:

Provider:	**Plan:**
Provider Contact Name, Title Provider_Contract_Name «Address» «City», «State» «Zip» Phone_# Email	Bruce Butler, Chief Executive Officer Valley Health Plan 2480 North First Street, Suite 160 San Jose, CA 95131 (408) 885-5780 And CC: Valley Health Plan Provider Contracts Administration 2480 North First Street, Suite 160 San Jose, CA 95131 ProviderContracts@vhp.sccgov.org Fax: (408) 954-1027

11.14 Free Exchange of Information. No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between a Provider and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by Provider or Plan regarding coverage of treatment that has been recommended or rendered. Moreover, Provider and Plan agree not to penalize nor sanction any Provider in any way for engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

11.15 Severability. If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law and their implementing regulations to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect.

11.16 Attorneys' Fees. Should either party institute any action or procedure to enforce this Agreement or any provision hereof, or for damages by reason of any alleged breach of this Agreement or of any provision hereof, or for a declaration of rights hereunder (including, without limitation, arbitration), each party shall pay its own costs and expenses, including, without limitation, its own attorneys' fees, incurred in connection with such action or proceeding.

11.17 No Third-Party Beneficiaries. This Agreement shall not create any rights in any third-parties who have not entered into this Agreement, nor shall this Agreement entitle any such third-party to enforce any rights or obligations that may be possessed by such third-party.

11.18 Integration of Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

11.19 County No Smoking Policy. Provider and its employees, agents and subcontractors, shall comply with the County's No Smoking Policy, as set forth in the Board of Supervisors Policy Manual section 3.47 (as amended from time to time), which prohibits smoking: (i) at the Santa Clara Valley Medical Center campus and all County-owned and operated health facilities, (ii) within 30 feet surrounding County-owned buildings and leased buildings where the County is the sole occupant, and (iii) in all County vehicles.

11.20 Food and Beverage Standards. Except in the event of an emergency or medical necessity, the following nutritional standards shall apply to any foods and/or beverages purchased by Provider with County funds for County-sponsored meetings or events:

(a) If food is to be provided, healthier food options shall be offered. "Healthier food options" include (i) fruits, vegetables, whole grains, and low fat and low-calorie foods; (ii) minimally processed foods without added sugar and with low sodium; (iii) foods prepared using healthy cooking techniques; and (iv) foods with less than 0.5 grams of trans fat per serving. Whenever possible, Provider shall (i) offer seasonal and local produce; (ii) serve fruit instead of sugary, high calorie desserts; (iii) attempt to accommodate special, dietary and cultural needs; and (iv) post nutritional information and/or a list of ingredients for items served. If meals are to be provided, a vegetarian option shall be provided, and the Contractor should consider providing a vegan option. If pre-packaged snack foods are provided, the items shall contain: (i) no more than 35% of calories from fat, unless the snack food items consist solely of nuts or seeds; (ii) no more than 10% of calories from saturated fat; (iii) zero trans-fat; (iv) no more than 35% of total weight from sugar and

caloric sweeteners, except for fruits and vegetables with no added sweeteners or fats; and (v) no more than 360 mg of sodium per serving.

(b) If beverages are to be provided, beverages that meet the County's nutritional criteria are (i) water with no caloric sweeteners; (ii) unsweetened coffee or tea, provided that sugar and sugar substitutes may be provided as condiments; (iii) unsweetened, unflavored, reduced fat (either nonfat or 1% low fat) dairy milk; (iv) plant-derived milk (e.g., soy milk, rice milk, and almond milk) with no more than 130 calories per 8 ounce serving; (v) 100% fruit or vegetable juice (limited to a maximum of 8 ounces per container); and (vi) other low-calorie beverages (including tea and/or diet soda) that do not exceed 40 calories per 8 ounce serving. Sugar-sweetened beverages shall not be provided.

11.21 Assignment of Clayton Act, Cartwright Act Claims. Provider hereby assigns to the Plan all rights, title, and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. Sec. 15) or under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, materials, or services by the Provider for sale to the Plan pursuant to this Agreement.

11.22 Compliance with All Laws, Including Nondiscrimination, Equal Opportunity, and Wage Theft Prevention.

(a) Compliance with All Laws. Provider shall comply with all applicable Federal, State, and local laws, regulations, rules, and policies (collectively, "Laws"), including but not limited to the non-discrimination, equal opportunity, and wage and hour Laws referenced in the paragraphs below.

(b) Compliance with Non-Discrimination and Equal Opportunity Laws: Provider shall comply with all applicable Laws concerning nondiscrimination and equal opportunity in employment and contracting, including but not limited to the following: Santa Clara County's policies for Providers on nondiscrimination and equal opportunity; Title VII of the Civil Rights Act of 1964 as amended; Americans with Disabilities Act of 1990; the Age Discrimination in Employment Act of 1967; the Rehabilitation Act of 1973 (Sections 503 and 504); the Equal Pay Act of 1963; California Fair Employment and Housing Act (Gov. Code § 12900 et seq.); California Labor Code sections 1101, 1102, and 1197.5; and the Genetic Information Nondiscrimination Act of 2008. In addition to the foregoing, Provider shall not discriminate against any subcontractor, employee, or applicant for employment because of age, race, color, national origin, ancestry, religion, sex, gender identity, gender expression, sexual orientation, mental disability, physical disability, medical condition, political belief, organizational affiliation, or marital status in the recruitment, selection for training (including but not limited to apprenticeship), hiring, employment, assignment, promotion, layoff, rates of pay or other forms of compensation. Nor shall Provider discriminate in the provision of services provided under this contract because of age, race, color, national origin, ancestry, religion, sex, gender identity, gender expression, sexual orientation, mental disability, physical disability, medical condition, political beliefs, organizational affiliations, or marital status.

(c) Compliance with Wage and Hour Laws: Provider shall comply with all applicable wage and hour Laws, which may include but are not limited to, the Federal Fair Labor Standards Act, the California Labor Code, and, if applicable, any local minimum wage, prevailing wage, or living wage Laws.

(d) Definitions: For purposes of this Subsection 11.22, the following definitions shall apply. A "Final Judgment" shall mean a judgment, decision, determination, or order (i) which is issued by a court of law, an investigatory government agency authorized by law to enforce an applicable Law, an arbiter, or arbitration panel and (ii) for which all appeals have been exhausted or the time period to appeal has expired. For pay equity Laws, relevant investigatory government agencies include the federal Equal Employment Opportunity Commission, the California Division of Labor Standards Enforcement, and the California Department of Fair Employment and Housing. Violation of a pay equity Law shall mean unlawful discrimination in compensation on the basis of an individual's sex, gender, gender identity, gender expression, sexual orientation, race, color, ethnicity, or national origin under Title VII of the Civil Rights Act of 1964 as amended, the Equal Pay Act of 1963, California Fair Employment and Housing Act, or California Labor Code section 1197.5, as applicable. For wage and hour Laws, relevant investigatory government agencies include the federal Department of Labor, the California Division of Labor Standards Enforcement, and the City of San Jose's Office of Equality Assurance.

(e) Prior Judgments, Decisions or Orders against Provider: By signing this Agreement, Provider affirms that it has disclosed any final judgments that (i) were issued in the five (5) years prior to executing this Agreement by a court, an investigatory government agency, arbiter, or arbitration panel and (ii) found that Provider violated an applicable wage and hour law or pay equity law. Provider further affirms that it has satisfied and complied with – or has reached Agreement with the County regarding the manner in which it will satisfy – any such final judgments.

(f) Violations of Wage and Hour Laws or Pay Equity Laws during Term of Contract: If at any time during the term of this Agreement, Provider receives a Final Judgment rendered against it for violation of an applicable wage and hour Law or pay equity Law, then Provider shall promptly satisfy and comply with any such Final Judgment. Provider shall inform the Office of the County Executive-Office of Countywide Contracting Management (OCCM) of any relevant Final Judgment against it within 30 days of the Final Judgment becoming final or of learning of the Final Judgment, whichever is later. Provider shall also provide any documentary evidence of compliance with the Final Judgment within 5 days of satisfying the Final Judgment. Any notice required by this paragraph shall be addressed to the Office of the County Executive-OCCM at 70 W. Hedding Street, East Wing, 11th Floor, San José, CA 95110. Notice provisions in this paragraph are separate from any other notice provisions in this Agreement and, accordingly, only notice provided to the Office of the County Executive-OCCM satisfies the notice requirements in this paragraph.

(g) Access to Records Concerning Compliance with Pay Equity Laws: In addition to and notwithstanding any other provision of this Agreement concerning access to Provider's records, Provider shall permit the County and/or its authorized representatives to audit and review records related to compliance with applicable pay equity Laws. Upon the County's request, Provider shall provide the County with access to any and all facilities and records, including but not limited to financial and employee records that are related to the purpose of this Subsection 11.22, except where prohibited by federal or state laws, regulations or rules. County's access to such records and facilities shall be permitted at any time during Provider's normal business hours upon no less than 10 business days' advance notice.

(h) Pay Equity Notification: Provider shall (i) at least once in the first year of this Agreement and annually thereafter, provide each of its employees working in California and each person applying to Provider for a job in California (collectively, "Employees and Job Applicants") with an electronic or paper copy of all applicable pay equity Laws or (ii) throughout the term of this Agreement, continuously post an electronic copy of all applicable pay equity Laws in conspicuous places accessible to all of Provider's Employees and Job Applicants.

(i) Material Breach: Failure to comply with any part of this Subsection 11.22 shall constitute a material breach of this Agreement. In the event of such a breach, the County may, in its discretion, exercise any or all remedies available under this Agreement and at law. County may, among other things, take any or all of the following actions:

i. Suspend or terminate any or all parts of this Agreement.

ii. Withhold payment to Provider until full satisfaction of a Final Judgment concerning violation of an applicable wage and hour Law or pay equity Law.

iii. Offer Provider an opportunity to cure the breach.

(j) Subcontractors: Provider shall impose all of the requirements set forth in this Subsection 11.22 on any subcontractors permitted to perform work under this Agreement. This includes ensuring that any subcontractor receiving a Final Judgment for violation of an applicable Law promptly satisfies and complies with such Final Judgment.

11.23 Contracting Principles. All entities that contract with the County to provide services where the contract value is $100,000 or more per budget unit per fiscal year and/or as otherwise directed by the Board of Supervisors, shall be fiscally responsible entities and shall treat their employees fairly. To ensure compliance with these contracting principles, all Providers shall: (i) comply with all applicable federal, state and local rules, regulations and laws; (ii) maintain timekeeping and expense records, and make those records available upon request; (iii) provide to the County unaudited balance sheet and financial information; (iv) upon County's request, provide County reasonable access, through representatives of Provider, to facilities, timekeeping and expense records that are related to the purpose of the Agreement, except where prohibited by federal or state laws, regulations or rules.

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11.24 Electronic Signature. Unless otherwise prohibited by law or County policy, the parties agree that an electronic copy of a signed contract, or an electronically signed contract, has the same force and legal effect as a contract executed with an original ink signature. The term "electronic copy of a signed contract" refers to a transmission by facsimile, electronic mail, or other electronic means of a copy of an original signed contract in a portable document format. The term "electronically signed contract" means a contract that is executed by applying an electronic signature using technology approved by the County.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by their duly authorized representatives effective as the Effective Date.

Provider_Contract_Name	County of Santa Clara dba **Valley Health Plan**
Signing_Authority's_Name Date Title «TaxId»	Bruce Butler Date Chief Executive Officer, Valley Health Plan Approved By:
TAX ID # Billing NPI # **NPI #**	Jeffrey V. Smith, MD, JD Date County Executive Approved as to form and legality:
	Jennifer S. Sprinkles Date Deputy County Counsel

Exhibits incorporated into Agreements:

Exhibit A-1	Compensation Schedule – Employer Group-Classic
Exhibit A-2	Compensation Schedule – Employer Group-Preferred
Exhibit A-3	Compensation Schedule – Covered California and Individual & Family Plan
Exhibit A-4	Compensation Schedule – Medi-Cal Managed Care
Exhibit A-5	Compensation Schedule – Healthy Kids
Exhibit A-6	Compensation Schedule – County Responsibility Patients
Exhibit B	*RESERVED*
Exhibit C	List of Individual Providers & Sites
Exhibit D	Contacts for Prior Authorization
Exhibit E	Insurance & Indemnity Requirements
Exhibit F	Language Assistance Program Requirements
Exhibit G	Timely Access Standards
Exhibit H	Covered CA Requirements

EXHIBIT A-1
COMPENSATION SCHEDULE
Line of Business: Commercial
Product: Employer Group-Classic

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

VHP Commercial
P.O. Box 26160
San Jose, CA 95159

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-2
COMPENSATION SCHEDULE
Line of Business: Commercial
Product: Employer Group-Preferred

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

VHP Commercial
P.O. Box 26160
San Jose, CA 95159

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-3
COMPENSATION SCHEDULE
Line of Business: Commercial
Product: Covered California and Individual & Family Plan

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

VHP Covered California / IFP
P.O. Box 26160
San Jose, CA 95159

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-4
COMPENSATION SCHEDULE
Line of Business: Government
Product: Medi-Cal Managed Care

PROVIDER_CONTRACT_NAME

BILLING

(a) Provider shall submit Clean Claims for all Contracted Services rendered to a Member, within six (6) months in which services were rendered, pursuant to this Agreement within the requirements set forth below:

(b) VHP Medi-Cal Managed Care: Original (or initial) Medi-Cal claims must be received within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Claims that are not received within the six-month billing limit and do not meet any of the other delay reasons are subject to be reimbursed at a reduced rate or will be denied as follows, in compliance with *California Welfare and Institutions Code, Section 14115.*

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

(c) Claims Submission. Provider shall submit Clean Claims in an electronic format approved by Plan. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s).

- Electronic Clean Claims shall be submitted to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

  VHP's Trading Partner Number: HT007700-001
  Customer Service Number: 877-693-3071

Further information can be located within the VHP Provider Manual or by contacting the Plan's Provider Relations Department at 408-885-2221.

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately as follows:

VHP Medi-Cal Managed Care
P.O. Box 28407
San Jose, CA 95159

PAYMENT

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the following rates, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the California Department of Health Care Services (DHCS) Medi-Cal billing and

reimbursement guidelines, including any applicable reductions, which may be amended by DHCS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable Medi-Cal Fee Schedule, less applicable reductions in effect on the date services are rendered.

Covered Services for which there are no DHCS defined billing and reimbursement guidelines or for which Medi-Cal has not established a rate and which are eligible for payment utilizing industry standard coding and billing conventions, shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-5
COMPENSATION SCHEDULE
Line of Business: Government
Product: Healthy Kids

PROVIDER_CONTRACT_NAME

BILLING

(a) Provider shall submit Clean Claims for all Contracted Services rendered to a Member, within six (6) months in which services were rendered, pursuant to this Agreement within the requirements set forth below:

(b) VHP Healthy Kids: Original (or initial) Healthy Kids claims must be received within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Claims that are not received within the six-month billing limit and do not meet any of the other delay reasons are subject to be reimbursed at a reduced rate or will be denied as follows, in compliance with *California Welfare and Institutions Code, Section 14115.*

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

(c) Claims Submission. Provider shall submit Clean Claims in an electronic format approved by Plan. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s).

- Electronic Clean Claims shall be submitted to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

  VHP's Trading Partner Number: HT007700-001
  Customer Service Number: 877-693-3071

Further information can be located within the VHP Provider Manual or by contacting the Plan's Provider Relations Department at 408-885-2221.

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately as follows:

VHP Healthy Kids
P.O. Box 28410
San Jose, CA 95159

PAYMENT

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the following rates, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the California Department of Health Care Services (DHCS) Medi-Cal billing and

reimbursement guidelines, including any applicable reductions, which may be amended by DHCS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable Medi-Cal Fee Schedule, less applicable reductions in effect on the date services are rendered.

Covered Services for which there are no DHCS defined billing and reimbursement guidelines or for which Medi-Cal has not established a rate and which are eligible for payment utilizing industry standard coding and billing conventions, shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

EXHIBIT A-6
COMPENSATION SCHEDULE
Line of Business: Coverage Program
Product: County Responsibility Patients

PROVIDER_CONTRACT_NAME

BILLING:

Provider shall submit Clean Claims in an electronic or written format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Approved written format claims shall be submitted appropriately to the address below:

Valley Health Plan
VMC / APD Claims
2480 N. First St., Suite 160
San Jose, CA 95131

PAYMENT:

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

County agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Authorized Covered Services shall be reimbursed at one hundred percent (100%) of the applicable and prevailing Medi-Cal Fee Schedule as of the date services were rendered.

Authorized Covered Services billed with a valid code for which Medi-Cal does not report a prevailing rate, will be reimbursed at twenty-five percent (25%) of billed charges.

EXHIBIT C
LIST OF INDIVIDUAL PROVIDERS & SITES

PROVIDER_CONTRACT_NAME

The following list includes the most current roster submitted by Provider as of the Agreement's Effective Date. Updates thereto shall be provided in accordance with Section 2.9 of this Agreement.

Name	Address	Phone No.	NPI # / Type	License Type	License No. & Expiration date

EXHIBIT D
CONTACTS FOR PRIOR AUTHORIZATION OF COVERED SERVICE

PROVIDER_CONTRACT_NAME

Valley Health Plan Customer Service Department

1-888-421-8444, select **option 4** for *VHP Customer Service Department*
Select **option 2** to check *Benefits*, Coverage*, Eligibility, & Authorization Status'*.

- Specify to representative the MEMBER's Plan ID#

**Questions for Medi-Cal and Healthy Kids Members, relating to benefits, coverage limitation/exclusions, and/or description of covered services will be redirected to SCFHP.*

Emergency Department to notify Plan immediately post stabilization by calling 855-254-8264

For further information regarding VHP's Authorization and Referrals Process, please reference the Provider Manual which can be located on the VHP Website at https://www.valleyhealthplan.org/sites/p/manual/Pages/home.aspx.

EXHIBIT E
INSURANCE & INDEMNITY REQUIREMENTS FOR
VHP MEDICAL PROVIDER

PROVIDER_CONTRACT_NAME

Indemnity

The Provider shall indemnify, defend, and hold harmless the County of Santa Clara (hereinafter "County"), its officers, agents and employees from any claim, liability, loss, injury or damage arising out of or in connection with, performance of this Agreement by Provider and/or its agents, employees or sub-Providers, excepting only loss, injury or damage caused by the sole negligence or willful misconduct of personnel employed by the County. It is the intent of the Parties to this Agreement to provide the broadest possible coverage For the County. The Provider shall reimburse the County for all costs, attorneys' fees, expenses and liabilities incurred with respect to any litigation in which the Provider is obligated to indemnify, defend and hold harmless the County under this Agreement.

Insurance

Without limiting the Provider's indemnification of the County, the Provider shall provide and maintain at its own expense, during the term of this Agreement, or as may be further required herein, the following insurance coverages and provisions:

A. Evidence of Coverage

Prior to commencement of this Agreement, the Provider shall provide a Certificate of Insurance certifying that coverage as required herein has been obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate. In addition, a certified copy of the policy or policies shall be provided by the Provider upon request. The Certificate of Insurance shall list the certificate holder as follows:

County of Santa Clara
c/o EBIX RCS, Inc.
P.O. Box 257
Portland, MI USA 48875

This verification of coverage shall be sent to the requesting County department, unless otherwise directed. The Provider shall not receive a Notice to Proceed with the work under the Agreement until it has obtained all insurance required and such insurance has been approved by the County. This approval of insurance shall neither relieve nor decrease the liability of the Provider.

B. Qualifying Insurers

All coverages, except surety, shall be issued by companies which hold a current policy holder's alphabetic and financial size category rating of not less than A-V, according to the current Best's Key Rating Guide or a company of equal financial stability that is approved by the County's Insurance Manager.

C. Notice of Cancellation

All coverage as required herein shall not be canceled or changed so as to no longer meet the specified County insurance requirements without 30 days' prior written notice of such cancellation or change being delivered to the County of Santa Clara or their designated agent.

D. Insurance Required

1. ***Commercial General Liability Insurance*** - for bodily injury (including death) and property damage which provides limits as follows:

   a. Each occurrence - $1,000,000
   b. General aggregate - $2,000,000
   c. Personal Injury - $1,000,000

2. ***General liability coverage shall include:***

   a. Premises and Operations
   b. Personal Injury liability
   c. Severability of interest

3. **Workers' Compensation and Employer's Liability Insurance**

   a. Statutory California Workers' Compensation coverage including broad form all-states coverage.
   b. Employer's Liability coverage for not less than one million dollars ($1,000,000) per occurrence.

4. **Professional Errors and Omissions Liability Insurance**

   a. Coverage shall be in an amount of not less than one million dollars ($1,000,000) per occurrence/aggregate.
   b. If coverage contains a deductible or sell-retention, it shall not be greater than fifty thousand dollars ($50,000) per occurrence/event.
   c. Coverage as required herein shall be maintained for a minimum of two years following termination or completion of this Agreement.

5. **Claims Made Coverage**

   If coverage is written on a claim made basis, the Certificate of Insurance shall dearly state so. In addition to coverage requirements above, such policy shall provide that:

a. Policy retroactive date coincides with or precedes the Provider's start of work (including subsequent policies purchased as renewals or replacements).

b. Policy allows fix reporting of circumstances or incidents that might give rise to future claims.

E. **Special Provisions**

The following provisions shall apply to this Agreement:

1. The foregoing requirements as to the types and limits of insurance coverage to be maintained by the Provider and any approval of said insurance by the County or its insurance consultant(s) are not intended to and shall not in any manner limit or qualify the liabilities and obligations otherwise assumed by the Provider pursuant to this Agreement, including but not limited to, the provisions concerning indemnification.

2. The County acknowledges that some insurance requirements contained in this Agreement may be fulfilled by self-insurance on the part of the Provider. However, this shall not in any way limit liabilities assumed by the Provider under this Agreement. Any self-insurance shall be approved in writing by the County upon satisfactory evidence of financial capacity. Provider's obligation hereunder may be satisfied in whole or in part by adequately funded self-insurance programs or self-insurance retentions.

3. Should any of the work under this Agreement be sublet, the Provider shall require each of its subcontractors of any tier to carry the aforementioned coverages, or Provider may insure subcontractors under its own policies.

4. The County reserves the right to withhold payments to the Provider in the event of material noncompliance with the insurance requirements outlined above.

Acknowledgement of Insurance Requirements

I, ***Signing_Authority's_Name***, on behalf of ***Provider_Contract_Name*** have read and understand the terms and conditions of the Insurance Requirements under this Agreement. I understand that all Insurance certificates MUST be in effect, prior to the services rendered. I understand that if ***Provider_Contract_Name*** is not compliant with these insurance requirements, ***Provider_Contract_Name*** will not be compensated for services rendered until insurance certification is obtained that meets the requirements set forth in this agreement. In addition, if ***Provider_Contract_Name*** fails to obtain the required insurance certification in a timely manner, this agreement may be terminated.

_____

Signature Date

EXHIBIT F
LANGUAGE ASSISTANCE PROGRAM REQUIREMENTS

PROVIDER_CONTRACT_NAME

Without limiting any of other obligations of the Parties under this Agreement, the Parties shall comply with such regulatory requirements of the Health Care Language Assistance Act, pursuant to Health and Safety Code Section 1367.04 et seq. and California Code of Regulations ("CCR") 28 CCR 1300.67.04 et seq., key provisions of which are summarized in this exhibit. To the extent that the provisions in this exhibit are inconsistent with provisions in the Agreement, the terms in this exhibit shall prevail as to the obligations of the Parties under the Health Care Language Assistance Act ("Act").

Plan Responsibilities:

- Plan shall provide a copy of the Plan's Language Assistance Program requirements and all written policies and procedures regarding the Language Assistance Program and the Act.
- Plan shall ensure that the threshold language needs of Plan Members are identified and made available to Provider. Provide list of covered languages and update list as necessary.
- Plan shall generate and periodically update a list of vital documents that Provider shall translate in threshold languages. Vital documents are those documents that contain information that is critical for accessing medical services and/or benefits and are identified in the Plan's operating guidelines and provided to Provider.
- Plan will monitor and audit Provider regarding compliance with language assistance requirements.

Provider Responsibilities:

- Provider agrees to provide or arrange for the provision of qualified interpretation services to Limited English Proficiency (LEP) Members, in threshold languages, at no cost to the Member. Provider shall comply with Plan's Language Assistance Program requirements, policies and procedures so long as they conform to Provider's own Language Assistance Policies and applicable law.
- Provider agrees to provide or arrange for the translation of vital documents in threshold languages.
- Provider will document in the medical record if patient authorizes use of family member as an interpreter.

EXHIBIT G
TIMELY ACCESS STANDARDS

PROVIDER_CONTRACT_NAME

I. Appointments

a. To ensure members have timely access to care, Provider shall follow the following standards set by DMHC and Accrediting Agency.

SERVICE	ACCESS TIME FRAME
Urgent Care Appointment PCP and Specialists • Services not requiring a prior Authorization • Services requiring a prior Authorization	• Within 48 hours of request for appointment • Within 96 hours of request for appointment
Non-urgent Appointment For the diagnosis or treatment of injury, illness, or other health condition. PCP and All Mental Health Providers Specialist and Ancillary Services	Within 10 business days of request for appointment Within 15 business days of request for appointment
Preventative Care Appointment All Practitioners • Periodic follow-up • Standing referrals for chronic conditions • Pregnancy • Cardiac condition • Mental health conditions • Laboratory and radiology monitoring	May be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed healthcare Provider acting within the scope of his/her practice.
Telephone Triage or Screening All Practitioners	• Triage or screening waiting time does not exceed 30 minutes. • Triage or screening must be available to Enrollees 24 hours per day, 7 days a week.

b. When it is necessary for a Practitioner or Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with professionally recognized standards of practice.

c. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care Provider, or the health care professional

providing triage or screening-services, as applicable, acting within the scope of his or her practice and, consistent with professionally recognized standards of practice; has determined and noted in the relevant records that a longer waiting time will not have a detrimental impact on the health of Member. (1300.67.2.2 (c)(5)(G))

II. During and After Business Hours Services

Provider shall employ an answering service or a telephone answering machine during and after business hours, which provide instructions regarding how Members may obtain urgent or emergent care including, when applicable, how to contact another Practitioner who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care, and length of wait time for a return call from the Practitioner. (1300.67.2.2 (c)(8)(B)(1))

III. Timely Access Reporting

Provider shall work with Plan's Quality Management to develop a process for tracking and reporting timely access compliance. Provider shall provide a report of their findings to Plan on a quarterly basis if required.

EXHIBIT H
COVERED CALIFORNIA REQUIREMENTS

PROVIDER_CONTRACT_NAME

Provider shall comply with the following terms required by the QHP Contract. These provisions apply only to services provided to Covered California and Individual & Family Plan Members, collectively "Covered California Members".

1. **Compliance.**

   a. **Compliance Coordination**. Provider shall coordinate and cooperate with Plan to the extent necessary to promote compliance by Plan and Provider with the applicable terms of the QHP Contract.

   b. **Compliance with All Laws.** Provider shall comply with all applicable federal, state, and local laws, regulations, executive orders, ordinances and guidance, including without limitation, the Affordable Care Act and the California Affordable Care Act; the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, and the Knox-Keene Health Care Service Plan Act of 1975, as applicable.

2. **Independent Contractors**. The Parties acknowledge and agree that, as required by 45 C.F.R. § 155.200(e), in carrying out its responsibilities, Covered California is not operating on behalf of Plan or Provider. In the performance of this Agreement, Plan and Provider shall always be acting and performing as an independent contractor, and nothing in the Provider Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venture or principal and agent between or among Plan and Provider. Neither Plan, Provider, or any agents, officers or employees of any of them are agents, officers, employees, partners or associates of Covered California.

3. **Disclosure of Financial Information**. Provider agrees that Plan may disclose information relating to contracted rates between the Plan and Provider that is treated as confidential information by the DMHC pursuant to Health and Safety Code § 1385.07(b). Provider shall cooperate with Plan in providing Covered California with financial information relating to Provider that is (i) provided by Provider or Plan to the DMHC or other regulatory bodies, and (ii) reasonable and customary financial information that is prepared by Provider, including, supporting information relating to Covered California Members as required by Covered California. Possible requests may include (but not be limited to), annual audited financial statements, and annual profit and loss statements.

4. **Network Disruption.**

   a. Plan and Provider shall implement policies and practices designed (i) to reduce the potential for disruptions in Plan's Provider network, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Covered California Members in the execution of the transition of care as required under state laws, rules and regulations in connection with any such disruption. Plan and Provider will maintain adequate

records, reasonably satisfactory to Covered California, documenting its policies and its compliance with these requirements by Plan and Provider.

b. In the event termination of the Agreement requires a block transfer of Covered California Members from Provider to a new Provider, Provider shall cooperate with Plan and Covered California in planning for the orderly transfer of Covered California Members as necessary and as required under applicable laws, rules, and regulations including but not limited to those relating to continuation of care set forth at Health and Safety Code § 1373.95.

c. Provider shall notify Plan with respect to any material changes in its Provider network as of and throughout the term of this Agreement. For purposes of this Agreement, a material change in the disclosures shall relate to an event or other information that may reasonably impact Provider's ability to perform under this Agreement.

5. Member Out-of-Network and Other Costs; Hold Harmless.

a. Plan shall and shall require Providers to, comply with applicable laws, rules and regulations governing liability of Members for Covered Services provided to Members, including, those relating to holding a Member harmless from liability in the event Plan fails to pay an amount owing by Plan to a Provider as required by federal and state laws, rules and regulations.

b. To the extent that Plan (i) provide coverage for out-of-network services and/or (ii) impose additional fees for such services, Plan shall disclose to the Member the amount it will pay for covered proposed non-emergent out-of-network services when requested by the Member.

c. Plan shall require its Providers to inform every Member in a manner that allows the Member the opportunity to act upon that Provider's proposal or recommendation regarding (i) the use of a non-network Provider or facility or (ii) the referral of a Member to a non-network Provider or facility for proposed non-emergent Covered Services. Plan shall require Providers to disclose to the Member who is proposing or considering using out-of-network non-emergent services if a non-network Provider or facility will be used as part of the network Provider's plan of care. Plan's obligation for this provision can be met through an update to their Provider's contract manual that is effective as of January 1, 2014. Providers may rely on Plan's Provider directory as updated from time to time in fulfilling their obligation under this provision.

6. Nondiscrimination.

a. In accordance with the Affordable Care Act § 1557 (42 U.S.C. 18116), Provider shall require as well as its agents and employees to refrain from causing an individual to be excluded from participation in, or to be denied the benefits of, or to be subjected to discrimination under, any health program or activity offered through Covered California on grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), § 504 of

the Rehabilitation Act of 1973 (29 U.S.C. 794), or any other applicable state and federal laws.

b. Provider shall, as well as its agents, employees and sub-contractors to refrain from unlawful discrimination or harassment or from allowing harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity or use of family and medical care leave. Participating Provider Group (PPG) shall and shall require its Sub-Subcontractors as well as their agents and employees to evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. PPG shall and shall require its Sub-Subcontractors as well as their agents and employees to comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2, CCR Section 8103, et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

7. Conflict of Interest; Integrity.

a. Provider shall be free from any conflicts of interest with respect to Covered Services provided under this Agreement. Provider represents that Provider and its personnel do not currently have and will not have throughout the term of the Agreement, any direct or interest which may present a conflict in any manner with the performance of Covered Services required under this Agreement. Provider also represents that it is not aware of any conflicts of interest of any Sub-Subcontractors or any basis for potential violations of Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered Services to Covered California Members, including, federal and state anti-kickback and anti-self-referral laws, rules and regulations. Provider shall immediately (i) identify any conflict of interest that is identified during the term of the Agreement and (ii) take any necessary action to assure that any activities are not properly influenced by a conflict of interest.

b. Provider shall comply with all applicable policies adopted by Covered California regarding conflicts of interest and ethical standards.

8. Customer Service. Provider shall meet all state requirements for language assistance services that are applicable to Plan's Commercial HMO line of business.

9. Credentialing. Plan shall perform, or may delegate activities related to, credentialing and re-credentialing in accordance with this Agreement. Plan agrees to maintain quality accreditation as outlined in this Agreement.

10. **Other Laws.** Provider shall comply with applicable laws, rules and regulations, including the following:

    a. Americans with Disabilities Act. Provider shall comply with the Americans With Disabilities Act (ADA) of 1990, (42 U.S.C. 12101, et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.

    b. Drug-Free Workplace. Provider shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350, et seq.).

    c. Child Support Compliance Act. Provider shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code.

    d. Domestic Partners. Provider shall fully comply with Public Contract Code Section 10295.3 with regard to benefits for domestic partners.

    e. Environmental. Provider shall comply with environmental laws, rules and Regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.

    f. Other Laws. Provider shall comply with all other state and federal laws, rules and regulations applicable to this Agreement and Provider's provision of Covered Services under this Agreement.

11. **Continuity of Care, coordination and cooperation upon termination of Agreement and transition of Members.**

    a. Upon the termination of the Agreement, Provider shall fully cooperate with Plan or Covered California (the "Exchange") in order to affect an orderly transition of Members to another Provider or Certified QHP as directed by the Exchange. This cooperation shall include, without limitation, (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Providers to assure the appropriate continuity of care, and/or (iii) communicating with affected Members in cooperation with the Exchange and/or the succeeding Provider, each as shall be reasonably requested by Covered California.

    b. In the event of the termination or expiration of the Agreement that requires the transfer of some or all Members into any other health plan, the terms of coverage under Plan's QHP Contract shall not be carried over to the replacement Qualified Health Plan (QHP) but rather the transferred Members shall be entitled only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

c. Notwithstanding the foregoing, the coverage of Member under Plan's QHP Contract may be extended to the extent that a Member qualifies for an extension of benefits including, those to affect the continuity of care required due to hospitalization or disability pursuant to Health and Safety Code section 1373.96 et. seq. as amended.

d. For purposes of this Agreement, "disability" means that the Member has been certified as being totally disabled by the Member's treating physician, and the certification is approved by Plan. Such certification must be submitted for approval within thirty (30) calendar days from the date coverage is terminated. Recertification of Member's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:

    (i) Until total disability ceases;
    (ii) For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;
    (iii) Until the Member's enrollment in a replacement plan; or
    (iv) Recertification.

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Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF WARD CARPENTER, MD, CO-DIRECTOR OF HEALTH SERVICES, LA LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Ward Carpenter, declare as follows:

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

2. As the Co-Director of Health Services, I oversee the healthcare of over 17,000 patients who come to the LA LGBT Center for their care; I personally provide care to a panel of 150 patients. All of my patients identify within the LGBTQ communities, and approximately 30% of my patients are people living with HIV. My patient population is also disproportionately low-income and experiences high rates of chronic medical conditions, homelessness, unstable housing, extensive trauma history, and discrimination and stigmatization in healthcare services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

3. I provide a wide spectrum of healthcare services, including, but not limited to, HIV treatment, testing and prevention; STD testing, treatment and prevention; general primary care with an LGBT focus; and comprehensive transgender care. I have worked in this field of medicine continuously since 2004 and have personally cared for over 4000 people in that time. I have worked in two Federally Qualified Health Centers, in New York and Los Angeles, as well as a private practice in New York. I am a nationally-recognized expert in the field of transgender medicine.

4. Many if not most of the individuals in our very diverse patient population face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority

people, as people of color. Transgender people have a 41% lifetime risk of attempting suicide. This shocking observation can be explained by the intense dysphoria inherent in living in a body and a society that does not reflect and validate who you know yourself to be at a core level. In order to avoid this tragic consequence, transgender people require compassionate, sensitive, and competent care that often includes medical and/or surgical procedures that incidentally affect reproduction. These patients have significantly improved mental health outcomes when able to proceed with the treatments they need. Treatments for gender dysphoria have been deemed medically necessary by the World Professional Association of Transgender Health and the Endocrine Society, in the same way that the American College of Cardiology has deemed treatment for hypertension medically necessary. In fact, in the course of treating gender dysphoria, endocrinologists and other healthcare providers use the same medications to treat transgender people as they use to treat non-transgender people with hormone deficiencies. Under the Denial-of-Care rule, medical personnel who are duty-bound to treat someone for one condition – hypertension – could legally refuse to treat that same person for another condition – gender dysphoria – that could become life-threatening if left untreated despite having the necessary tools and expertise to do so. Healthcare discrimination like this will have immediate negative consequences for a distinct and oppressed minority group and cannot be empowered, as it is in the Denial-of-Care Rule.

5. There is every reason to believe that the Denial-of-Care Rule encourages healthcare providers and staff to claim an absolute right to refuse care or opt out of serving patients with particular needs, based on personal beliefs, and will result in more discrimination, mistreatment, and denials of healthcare services against LGBT patients and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other healthcare facilities outside the LA LGBT Center. Even before the Denial-of-Care Rule was proposed or issued, I and the other providers that I supervise at the LA LGBT Center have had many patients who have experienced traumatic stigma and discrimination – based on their sexual orientation, gender identity, HIV status, and/or other factors. For example:

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

b. A transgender patient started bleeding profusely from her vagina one week after surgery. Because there are so few trans-competent surgeons in the United States, this patient's surgeon was thousands of miles away. When she finally spoke to an ER doctor, the physician looked disgusted and said "what do you want me to do about it?" then walked away. She had to pack her own vagina with gauze pads and leave the ER, not knowing if she would live or die, and only coming to see us three days later after having lost a significant amount of blood. These horrific incidents will increase as a result of the Denial-of-Care Rule. The likely result: patients will die.

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

and experienced a delay of several more months trying to find a new doctor he could trust.

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

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

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

transmitted disease. Instead, he saw three providers, received hundreds of dollars in unnecessary testing and passed his infection along to five other people who themselves had to go down similar testing and treatment paths.

6. In sum, the message of these examples is clear: when patients are discriminated against, stereotyped, and mistreated in medical establishments as a result of healthcare providers' personal moral or religious beliefs, patients stop seeking care or their care is detrimentally delayed out of fear of repeated discrimination and denials of care. As a result, their conditions remain untreated for a much longer period of time, if they ever get treatment, resulting in much more acute conditions, ultimately costing the healthcare system millions of dollars in unnecessary expense while harming patients and public health. When medical staff fail to care for every patient in the best way that they can, putting patients' best interests at the center of medical care, medical mistrust is worsened, care is delayed, and healthcare becomes more expensive.

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

8. 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 the LA LGBT Center's transgender patients express strong distrust of the healthcare system generally, and a demonstrative reluctance to seek care outside the LA LGBT Center unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in

disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers. Already, my patients are arriving at the LA LGBT Center with more acute medical conditions than they would otherwise have because the increase in religious-based discrimination has caused patients to fear receiving necessary medical care.

9. With existing health and healthcare disparities that harm the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – the Denial-of-Care Rule's vague and confusing language will further exacerbate existing barriers to healthcare and result in negative community health outcomes. Good medical care is based on trust as well as frank and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers; 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. 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.

10. The Denial-of-Care Rule causes LGBT patients and patients living with HIV to lose trust in their healthcare providers (either out of fear of discrimination or on account of being denied care on religious grounds). As a result, there will be an increase in demand for my and my department's services that will limit my ability to provide adequate care and time to my patients.

This will increase wait times for my patients, and the delays in care may worsen conditions for which my patients are seeking treatment and outcomes of care.

11. The Rule will cause LGBT patients to attempt to hide their LGBT identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure about their gender identity, sexual orientation, or medical histories. Patients will avoid raising any topics, questions, facts that they fear could possibly offend their healthcare providers' personal beliefs, resulting in harm to patients. 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.

12. The Denial-of-Care Rule is also likely to cause an increase in demand for my healthcare services because I have seen a spike in behavioral and mental-health issues resulting from religious or moral-based discrimination and denials of healthcare services.

13. The Denial-of-Care Rule is in direct conflict with the oath I swore as a doctor and many of the federal, state, and insurance rules, regulations, and statutes that I am required to follow. This has personally caused me great confusion and stress as it is unclear how I can work collaboratively with colleagues who may discriminate against my patients without violating either current medical ethical and legal standards of care or the Denial-of-Care Rule.

14. As a healthcare provider with the LA LGBT Center, I receive various forms of federal funding directly and indirectly via federal programs, including but not limited to those governed by the Centers for Medicare and Medicaid Services through Medicaid and Medicare reimbursements as well as funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 and funding from the Centers for Disease Control and Prevention. These funds and related benefits account for a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients, especially because a large portion of the population that we serve relies heavily on Medicaid and Medicare for its healthcare needs. I may be, therefore, subject to

the restrictions of HHS's Denial-of-Care Rule and have a reasonable fear that I could be sanctioned and lose federal funding for the work that I do as a result of nondiscrimination policies that I enforce in my department and amongst the staff that I supervise, which is vital to providing proper care to my patients and other patients whose care I supervise. If such a loss of funding were to occur, it would result in service reductions if not closure of our programs in their entirety.

15. One of the guiding ethics of medicine is to treat all patients equally. We do not treat blue-eyed people better than brown-eyed people. We do not treat women better than men. We do not provide better care to blonde-haired people than red-haired people. Medical personnel see people at their most vulnerable; the trust placed in us is sacred. To tie an employer's hands, to not permit an employer to make respectful and equal treatment of all patients part of a job description, hurts patients by preventing them from accessing needed care even at trusted facilities and practices. If we at the LA LGBT Center need to provide care to the LGBT community, we cannot be forced to hire and continue working with someone who refuses to provide care to this community without violating the LA LGBT Center's mission, medical ethics, and established standards of care.

16. As LA LGBT Center's Co-Director of Health services, 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 provide federally funded healthcare services and conduct federally funded research could be severely impeded, potentially putting patients and research participants at risk, if the Denial-of-Care Rule is allowed to take effect. I could also be subject to sanctions as someone who oversees the LA LGBT Center's clinical research.

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

Dated: June 6, 2019

Respectfully submitted,

Ward Carpenter

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

No. 19-cv-2916 NC

DECLARATION OF SARA H. CODY, M.D., HEALTH OFFICER AND DIRECTOR OF COUNTY OF SANTA CLARA PUBLIC HEALTH DEPARTMENT, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, SARA H. CODY, M.D., declare as follows:

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

2. I am the Director of the County's Public Health Department, as well as the Health Officer for the County and each of the 15 cities located within Santa Clara County. I have held the Health Officer position from 2013 to the present and have held the Public Health Department Director position from 2015 to the present. In these roles, I provide leadership on public health issues for all of Santa Clara County and oversee approximately 450 Public Health Department employees, who provide a wide array of services to safeguard and promote the health of the community.

3. Prior to becoming the Health Officer for the County and each of its cities, I was employed for 15 years as a Deputy Health Officer/Communicable Disease Controller at the County's Public Health Department, where I oversaw surveillance and investigation of individual cases of communicable diseases, investigated disease outbreaks, participated in planning for public health emergencies, and responded to Severe Acute Respiratory Syndrome (SARS), influenza A virus subtype H1N1 (also known as "swine flu" or H1N1), and other public health emergencies.

4. The mission of the Public Health Department is to promote and protect the health of Santa Clara County's entire population. None of Santa Clara County's 15 cities have a health department. All 15 cities, and all Santa Clara County residents, rely on the Public Health Department to perform essential public health functions. The Public Health Department's work is guided by core public health principles of equity, the value of every life, and harm prevention. The Public Health Department's direct services primarily benefit low-income persons, children, people of color, and people living with chronic diseases, such as HIV/AIDS.

5. The work of the Public Health Department is focused on three main areas: (1) infectious disease and emergency response, (2) maternal, child, and family health, and (3) healthy communities.

6. The Public Health Department provides care focused on some of the County's most vulnerable populations including, but not limited to, the LGBTQ community, low-income residents, people who abuse controlled substances, and young women who are pregnant. Approximately 25% of the County's nearly two million residents are considered to be among these vulnerable populations. It is critical that Public Health Department staff be willing and able to serve these populations. For that reason, in recruitment for employment in the Public Health Department, the County inquires into job applicants' experiences with the LGBTQ community and with other vulnerable populations. This recruitment practice ensures that our Department is staffed with employees who are prepared to serve, and are experienced with serving, the needs of all County residents who may interact with the Public Health Department.

7. Several specific programs would be undermined if the Public Health Department were prevented from ensuring that employees staffing those programs were willing to provide the health care services required. For example, the Public Health Department operates a needle exchange program that is critical to preventing the spread blood-borne pathogens such as HIV, hepatitis B and hepatitis C, and also helps to address substance abuse in Santa Clara County. County employees participating in this program necessarily interact with people who abuse controlled substances and typically engage in services such as providing clean needles, safer-sex kits, and referrals for substance abuse treatment. If the Department could not ensure that employees staffed on the needle exchange program are willing to provide these services, the program would not be able to operate efficiently or effectively. Similarly, if the Department could not reassign an employee who objected to providing such services, we would not be able to staff appropriately, undermining this critical program.

8. The Public Health Department provides a range of STI-related services, including sexual-health counseling, STI-prevention services, STI screening, STI treatment, and HIV pre-

exposure and post-exposure prophylaxis. Through both the Crane Center, which focuses on STI screening for HIV and Hepatitis C, and the STI clinic, which provides examinations and treatment for a wide range of STIs, such as syphilis, gonorrhea and chlamydia , the Public Health Department regularly serves the LGBTQ community, women who are pregnant including those who may be considering abortion, and people who are seeking contraceptive care. If a broad swath of Public Health employees—even those not directly providing patient care—could refuse to facilitate or refer patients for certain care based on religious or moral objections, these programs would be dramatically impacted. Such refusals would interfere with the relationship of trust between our providers and our patients and result in situations where patients seeking care are turned away or provided with incomplete information regarding the health care services available.

9. A policy that broadly permits employees to refuse to facilitate patient care could have a serious negative impact on public health. Indeed, STIs are already a serious public health concern in Santa Clara County, which has recently experienced a rise in chlamydia, gonorrhea, and syphilis. Between 2010 and 2017, cases of chlamydia steadily increased from 271.3 cases per 100,000 people in 2010 to 392.7 cases in 2017, and gonorrhea rates increased nearly fourfold from 33.1 cases per 100,000 people in 2010 to 126.4 cases in 2017, with a 26% rapid increase from 2016 to 2017. Rates of early syphilis (i.e., primary, secondary, and early latent syphilis) diagnoses nearly tripled from 6.2 cases per 100,000 people in 2010 to 21.1 cases in 2017, with a sharp 57% increase between 2015 and 2016. HIV/AIDS is another serious public health concern in the County. In 2015, there were 2,734 people living with HIV/AIDS in the County, and in 2017, that number had risen to 3,361 people living with HIV/AIDS in the County. Any requirements that obstruct patient access to treatment are likely to exacerbate these serious public health problems and thus increase the burden on the County to address and prevent the spread of these infections.

10. Public Health's STD/HIV Prevention and Control program distributes free condoms at its clinical sites and through outreach events to the community. If Public Health were

unable to require advance notice of religious objections or reassign objecting employees, an employee who has a religious objection to contraceptives or premarital sex could refuse to participate in and seriously undermine this program. Decreased access to, and education about, contraception is likely to increase unintended pregnancies, triggering immediate and long-term costs to the County and communities nationwide. As the safety-net healthcare provider, the County funds many of the medical services associated with preventing and treating both STIs and unintended pregnancies, which disproportionately affect young, low-income, minority women, without access to higher education, who are likely to rely on County-funded services. The County is also burdened by the long-term costs of unplanned pregnancies, which can limit individuals' ability to succeed in education and the workplace and to contribute as taxpayers and citizens.

11. The Public Health Department depends heavily upon federal funding from the U.S. Department of Health and Human Services. The elimination of this federal funding would be devastating for the residents of Santa Clara County. It would result in a drastic reduction of services and staff positions in Public Health Department programs providing direct services to clients, as well as other programs integral to protecting and promoting public health. Vulnerable communities would be most severely impacted by a loss of federal funding to the Public Health Department.

12. In the County's 2017-18 fiscal year, from July 1, 2017 through June 30, 2018, the Public Health Department's total gross expenditures amounted to approximately $102 million. Total revenues from federal funds in the 2017-18 fiscal year amounted to approximately $36 million, or more than a third of the Department's gross expenditures. Most of these federal funds pass through the State of California to the County.

13. Federal funding is critical to many of the Public Health Department's programs that address infectious diseases. The Public Health Department is responsible for safeguarding the public health by preventing and controlling the spread of infectious diseases and planning for and responding to public health emergencies. Programs in this branch of the Public Health

Department receive reports on 85 different diseases and conditions; track overall trends in infectious diseases; investigate individual cases of concern; provide long-term case management for certain categories of patients (e.g., active tuberculosis cases); provide immunizations and preventive therapy; identify, investigate and control outbreaks; and plan for and respond to public health emergencies. They also ensure that all children attending school or childcare facilities in Santa Clara County comply with State immunization requirements; conduct HIV and other STI testing and education for vulnerable communities; and distribute opioid overdose prevention kits for at-risk individuals. To support its communicable disease control function, the Public Health Department has a public health laboratory, which serves as a local and regional resource which local health providers, clinics, hospitals, and even law enforcement rely on to test and identify infectious diseases, toxins, biohazards, and other substances that could pose a serious risk to public health. This branch of the Public Health Department also includes two pharmacies.

14. For example, in Fiscal Year 2015-2016, Public Health Department programs supported by federal funding included the following:

a. Under the federal government's Ryan White HIV/AIDS Program, the County received $4.0 million in funds to provide core medical services and support services to low-income individuals living with HIV/AIDS in the County. In calendar year 2016, there were 1,267 Ryan White-funded clients in Santa Clara County—nearly half of all the persons living with HIV/AIDS in Santa Clara County.

b. The County received approximately $2 million for drugs provided to uninsured and underinsured HIV/AIDS patients enrolled in the AIDS Drug Assistance Program. These are patients who are at or below 500% of the Federal Poverty Level and do not qualify for no-cost Medi-Cal. The majority of this $2 million consists of federal funds, with state funds comprising the remainder.

c. Through the National Hospital Preparedness Program and Public Health Emergency Preparedness Cooperative Agreement Programs, the Public Health Department has

received $2.6 million in federal funding to prepare for emergencies, such as natural disasters, mass casualties, biological and chemical threats, radiation emergencies and terrorist attacks.

15. Further, in the area of maternal, child, and family health, the Public Health Department provides services for Santa Clara County's most vulnerable children and families. The following are some of the Public Health Department's federally funded programs in this area:

a. The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and medically necessary physical and occupational therapy services to children under 21 years of age with CCS-eligible medical conditions, such as cystic fibrosis, hemophilia, cerebral palsy, muscular dystrophy, spina bifida, heart disease, cancer, and traumatic injuries. The CCS program serves well over 5,000 children each year, and in Fiscal Year 2015-2016, it received $4.9 million in federal funds, not including payments from Medi-Cal.

b. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program safeguards the health of low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, breastfeeding promotion and support, and referrals to health care. The program has a caseload of nearly 16,000 individuals each month, and it received $4.1 million in federal funds in Fiscal Year 2015-2016.

c. The Child Health and Disability Prevention (CHDP) Program, which received $1.6 million in federal funds in Fiscal Year 2015-2016, ensures that low-income children and youth receive routine health assessments and treatment services. Within the CHDP Program, public health nurses also provide case management for foster care youth to ensure that their medical, dental, mental health, and developmental needs are met.

d. The Public Health Nursing Home Visitation program, which received $1.3 million in federal funds (Targeted case management) in Fiscal Year 2015-2016, provides case management services to Medi-Cal beneficiaries in specific target populations to gain access to needed medical, social educational, and other services.

e. The Childhood Lead Poisoning Prevention Program, which received approximately $88,000 in federal funds in Fiscal Year 2015-2016, provides nursing and environmental case management and follow-up for lead-poisoned children, promotes screening for lead poisoning, and provides community education regarding lead poisoning prevention.

16. To create and maintain healthy communities, the Department conducts localized health assessments and planning throughout Santa Clara County, and works with community partners and County leadership to promote system-wide and environmental changes to reduce the incidence of chronic diseases and injuries in Santa Clara County. In Fiscal Year 2015-2016, the chronic disease and injury prevention unit received $1.6 million in federal funds to provide nutrition education and obesity prevention activities and interventions for low-income Californians for primary prevention of nutrition-related chronic disease.

17. In addition to the programs described above, the Public Health Department received $6.1 million in Medi-Cal payments and $2.4 million in Medicare payments in Fiscal Year 2015-2016 for health care provided to patients with Medi-Cal or Medicare coverage. The payments from Medicare, which is the federal health insurance program for elderly and disabled individuals, consist entirely of federal funds. Medi-Cal is financed by the State and federal governments, and the Medi- Cal payments therefore contain a mixture of State and federal funds. Although the apportionment of the funding is not readily known to the County, the Medi-Cal payments are dependent on receipt of federal funding from Medicaid, the federal health insurance program for low-income individuals.

18. The Public Health Department continues to receive comparable federal funding from the U.S. Department of Health and Human Services annually. Given increases in the population of the County, the Public Health Department likely relies on a slightly higher total amount of federal funding now than in Fiscal Year 2015-16.

19. Many, if not most, of the individuals served through the Public Health Department's various programs simply would not get the care and resources that they need without federally funded services. For example, without federal funding for WIC, thousands

more women would not have the appropriate nutrition to ensure healthy pregnancies, healthy birth outcomes, and healthy children, and thousands more children would suffer from poor nutrition. This would impact not only their immediate health but also their developmental readiness for kindergarten and chances for future health and success in life. As another example, loss of funding for CCS would result in reduced therapy and other necessary services for thousands of medically fragile and disabled children with expensive and complicated medical conditions. And as yet another example, loss of funding for clients with HIV/AIDS would mean that hundreds of low-income, chronically ill individuals in our community would not receive the health care, drugs, and other essential services they need to survive and enjoy a reasonable quality of life. Patients with HIV infection who are not adequately treated are also at greater risk of spreading HIV to others. The fees the STI clinic collects do not cover the costs of providing STI-related services, and if the Department's budget loses federal funding, we would not be able to continue with the same level of services going forward.

20. 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 to the Public Health Department from the County's General Fund could be reduced to make up for a loss of federal funds in other departments. A loss of federal funding, combined with a reduction in the General Fund allocation for the Public Health Department, would require the Public Health Department to make difficult decisions about how to reallocate its remaining funds, which communities to prioritize, and which diseases and health conditions to focus on at the expense of others. Rather than being in a position to create and implement proactive strategies to promote health and prevent disease, the Public Health Department would almost certainly be forced into focusing on reactive services designed to address public health crises (e.g., communicable disease control), services that the Public Health Department and Health Officer are mandated by law to provide (e.g., birth and death registration), and a modicum of services for the neediest populations.

21. A withdrawal of federal funding would compromise the Public Health Department's ability to prevent public health emergencies and outbreaks, to prevent chronic diseases, to provide equal opportunity to vulnerable children for a healthy start and optimal health, and to foster healthy families and healthy communities.

22. A sustained loss of federal funding to the County would ultimately result in a far sicker and less healthy community overall and for generations to come. The collateral costs would be many: greater health care costs for individuals, their families, their employers, and for the County itself, which is mandated by law to provide health care to the medically indigent. In addition, I am familiar with a wide body of studies and literature showing that an increase in incidents of sickness and illness can result in financial instability for families, a less productive workforce, and poorer educational and economic outcomes for children.

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

Dated: June 5, 2019

Respectfully submitted,

SARA H. CODY, M.D.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF DARREL CUMMINGS, CHIEF OF STAFF OF THE LOS ANGELES LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Darrel Cummings, hereby state as follows:

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

2. The Center was founded in 1969 and offers programs, services, and global advocacy that span four broad categories: health, social services and housing, culture and education, and leadership and advocacy. The mission of the Center is to fight bigotry and build a world where LGBT people thrive as healthy, equal, and complete members of society. Today the Center's more than 650 employees provide services for more LGBT people than any other organization in the world, with about 500,000 client visits per year.

3. As the largest provider of services to LGBT people in the world, many of the Center's patients tell us that they come to the Center seeking culturally competent healthcare due to being denied care or discriminated against based on their real or perceived sexual orientation, gender identity and HIV status. The Center's client population is disproportionately low-income and experiences high rates of chronic physical and mental conditions, homelessness, unstable housing, trauma and discrimination, and stigmatization in healthcare services. Many of these clients come to the Center from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

4. The Center is one of the nation's largest and most experienced providers of LGBT health and mental healthcare. We accept a variety of health insurance plans, including Medi-Cal

(California's Medicaid program), Medicare, and most private insurance plans. We also provide services to uninsured individuals. We work with these individuals to help them access insurance through Covered California (California's Affordable Care Act "exchange"), and/or navigate other medical- and drug-assistance programs. Where insurance is not available, our services are offered on a sliding-scale basis, based on ability to pay. We pride ourselves on providing leading-edge healthcare, regardless of individuals' ability to pay.

5. The Center receives various forms of Health and Human Services funding, including Public Health Service Act funding. Approximately 80 percent of the Center's funding originates from the federal government, including, but not limited to, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, direct funding from the Centers for Disease Control and Prevention, discounts under the 340B Drug Discount Program, and Medicaid and Medicare reimbursements. The Center also receives federal funding for research programs, and is currently a participant in multiple federally-funded studies, including through National Heart, Lung, and Blood Institute; National Institute of Allergy and Infectious Diseases; National Institute of Child Health and Human Development; the National Institutes of Health, National Institute of Drug Abuse, and the Patient-Centered Outcomes Research Institute. The Center is, therefore, subject to the substantive requirements of the Denial-of-Care Rule and has a reasonable fear that it could be at risk of sanction and loss of federal funding as a result of the Denial-of-Care Rule.

6. As a federally qualified health center, the Center is required to serve anyone on a nondiscriminatory basis who walks into its doors. The Denial-of-Care Rule's vague language makes it difficult for the Center to decipher how to proceed in light of contradictions between the Denial-of-Care Rule on the one hand and, on the other hand, nondiscrimination requirements, medical statutes, rules, standards of care, ethics requirements, and accreditation standards. The Denial-of-Care Rule invites chaos within the Center, will consume the Center's resources, and will

make it more difficult for the Center to provide the same level of premier care to its patients. The Center cannot function in such an environment.

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

8. The Denial-of-Care Rule will worsen health disparities between the LGBT community and other communities. With existing health and healthcare disparities in the LGBT community – particularly the shortage of LGBT/HIV culturally competent providers – the Denial-of-Care Rule's broad and vague language and invitation to providers to engage in discrimination will further exacerbate existing barriers to healthcare and result in negative community health outcomes.

9. For example, the Center's providers have observed patients arriving at the Center with acute medical conditions that could have been avoided but-for the patients' reluctance to seek routine and necessary medical care for fear of discrimination and being turned away. A shocking number of LGBT patients fear going to a healthcare provider due to negative past experiences directly related to their sexual orientation or gender identity. The Denial-of-Care Rule will exacerbate those numbers as a result of increased discrimination and denials of healthcare treatment. For similar reasons, LGBT people are less likely to have a primary care provider whom they consider their personal doctor. That means that in times of need, LGBT people are more likely to randomly select a healthcare provider with whom they do not have a relationship, and they are at increased risk of finding a provider who is not LGBT-affirming. With an increase in refusals of

healthcare services as a result of the Denial-of-Care Rule, LGBT people will be far less likely to receive the healthcare treatment that they need because, after being turned away, they are unlikely to seek other care out of fear of repeated rejections.

10. This directly affects the Center because there will be an increase in community members seeking referrals to LGBT-affirming services that the Center does not have sufficient resources to provide, an increase in community members experiencing the trauma of discriminatory or unwelcoming healthcare experiences, and worsened community health outcomes among the population that the Center serves. Additionally, the Center will have to expend more resources on its health promotion campaigns to ensure that LGBT patients access necessary preventative screenings and testing (including for cancer, HIV and other STIs) given that the Denial-of-Care Rule will change the healthcare landscape for the LGBT patient population.

11. For some patients that the Center serves, especially those who live in regions with limited options for LGBT-affirming healthcare services, finding LGBT-inclusive healthcare options is already a struggle. Additionally, for some medical specialties, there are only a handful of healthcare providers in a patient's region who have the specialty necessary to treat the patient, so a denial of care by even one provider could make it practically impossible for an LGBT patient to receive the specific healthcare service sought. This is even more concerning in regions where patients' only options are religiously-affiliated organizations that could claim religious or moral-based objections to providing any and all care to LGBT patients as a result of the Denial-of-Care Rule, in contradiction to medical ethics and standards of care.

12. The Denial-of-Care Rule's overly broad language invites increased discrimination against LGBT people and people living with HIV at other healthcare centers, outside of the Center. The Center's healthcare providers – particularly its counselors, psychiatrists and other behavioral-health staff – have treated many patients who have experienced traumatic stigma and discrimination

based on sexual orientation, gender identity, HIV status, and/or other factors. The stories that patients tell the Center's staff about their discriminatory experiences outside of the Center include:

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

b. Another transgender patient, who developed profuse bleeding after surgery, was denied treatment at an emergency room where they were told by an emergency room doctor: "what do you want me to do about it?" They arrived at the Center in distress three days later, having lost a significant amount of blood.

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

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

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

f. One patient recalled that when her late partner was in the hospital, she was there most of the time to care for her. There was a nurse who treated them kindly and appropriately until the nurse heard them refer to each other by

"Honey." The look on the nurse's face changed and she treated the couple "like trash" after that. The patient remarked that allowing healthcare employees (everyone from those working in food service and housekeeping to physicians and nurses) to express their religious or moral views when providing care to patients results in placing LGBT patients in a "lesser-than" category of patients.

g. Patients residing at assisted-living facilities have described discrimination and denials of care when their sexual orientation, gender identities, and HIV statuses were revealed. Patients who are transgender have described having to hide their gender identities and transgender status once they are no longer able to care for themselves and are required to find assisted-living arrangements.

h. Patients have described being intentionally referred to by names and pronouns other than their preferred names while seeking healthcare services elsewhere.

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

j. Patients have reported that their primary care physicians do not feel comfortable prescribing HIV preventatives, such as Truvada for PrEP, even when such medications are appropriate and should be provided according to current medical guidelines and standards of care. Patients also have reported that their physicians shame them for requesting PrEP medications and then

deny them the medication, which is how they find their way to the Center. For example, when one patient asked his provider about Truvada, his physician questioned him as to why he needed it and proceeded to tell the patient that he would not need the medication if he were more careful. Another patient was denied PrEP altogether and lectured that he did not need PrEP unless he was having sex with sex workers.

k. Patients also have expressed reluctance to use their insurance for PrEP because they are afraid of having the drug documented on their insurance record. These patients fear that a history of using a medically necessary HIV preventative could be used against them in the future by making them targets for discrimination based on sexual orientation, gender identity and/or transgender status, and HIV status, given the current political climate and discrimination in the healthcare context.

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

m. Multiple patients have stated that they come to the Center to be tested for sexually transmitted infections because the Center does rectal and throat swabs instead of only urine tests. Not all healthcare providers do all three forms of testing even though three-site testing provides the most accurate results for testing and treating sexually transmitted infections. This is especially true for gay men. Someone could test negative for a sexually

transmitted infection with a urine test, for example, but test positive with a rectal swab. Patients report that when they specifically asked their outside provider to do rectal swabs, they were judged. When patients are judged by their physicians and/or cannot be out to their physicians about their sexual orientation and/or gender identity out of fear of discrimination, LGBT patients cannot receive the healthcare services that they need, including prophylactic treatments, and may experience delays in medically necessary treatments, resulting in more acute, life-threatening conditions.

13. Many of the Center's patients and LGBT people in general have reported that they are not out to their other medical providers about their sexual orientation and/or gender identities out of fear of discrimination and denial of healthcare. The discriminatory mischaracterization of transgender-affirming care as "sterilization" in the preamble to the Denial-of-Care Rule will result in an increase in the examples of discrimination cited above. For many transgender individuals, gender confirmation surgery is a treatment for gender dysphoria and is not a surgery meant to affect reproduction, just as a hysterectomy on a cancer patient is not intended to affect procreation. While impacts on reproduction may be an incidental effect of some transgender-affirming care, such treatment is *not* "sterilization."

14. The Denial-of-Care Rule invites further discrimination justified by religious or moral beliefs against the Center's patients and puts the health of LGBT patients at risk. The Rule encourages LGBT patients to attempt to hide their LGBT identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. The Denial-of-Care Rule also adversely impacts the Center by necessitating the diversion and reallocation of resources in order to provide referrals to patients, including for patients that the Center does not have the resources to treat because of increased demand for the Center's services as a result of the Rule. The Denial-of-Care Rule will cause an increased number of LGBT patients and patients living with HIV to seek the Center's assistance in finding LGBT-affirming healthcare providers. The Center will also have more difficulty finding LGBT-affirming healthcare providers, especially those with niche specialties, given that the Rule emboldens healthcare providers to refuse to treat LGBT patients.

16. The increase in referral requests requires the Center to allocate additional staff time to pre-screen service referrals to ensure that staff are sending patients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to the Center's patients. As a result of the Denial-of-Care Rule, the Center may need to hire a case-manager to address the community's need for referrals to welcoming providers. The Center's staff and resources have already been spent engaging in advocacy, policy analysis, and services to address the ill-effects of the Denial-of-Care Rule. The Center will also have to divert resources away from other programming to conduct informational sessions about the Denial-of-Care Rule to answer patients' and staff members' questions about how the Rule will affect them and the services that the Center provides.

17. It will be increasingly difficult to determine whether job applicants will be unwilling to perform essential job functions, which is likely to undermine the Center's philosophy of fostering a diverse workforce. The Center's current recruiting process is developed to ascertain whether a job applicant will provide healthcare consistent with the Center's mission to establish a welcoming, nondiscriminatory environment for all patients and staff, without violating the law. Providing care in a non-discriminatory and inclusive manner, putting aside people's individual religious or moral

beliefs, is a core part of the Center' job criteria for new applicants. If the Center can no longer inquire about whether an applicant will decide which patients to treat on the basis of religious principles that are inconsistent with the Center's mission, hiring managers will be in a complex position of trying to ascertain whether those job candidates might cause harm to patients while at the same time considering risks and requirements under the Denial-of-Care Rule. The Center cannot alter those job criteria without thwarting its mission.

18. Furthermore, if the Center is required to get the consent of religious or moral objectors to a proposed accommodation for their religious beliefs, the Center's operations will be negatively affected, resulting in potential delays in treatment, prevention, and other supportive health services to patients. Under the broad and vague language of the Denial-of-Care Rule, the Center will constantly fear the realistic possibility that any of its staff – from janitorial to cafeteria or security personnel – could discriminate against the Center's patients on the basis of religious beliefs, causing extreme harm to the Center's patients and mission. The Center will have no recourse to reassure its patients that the Center is a safe and affirming place for them to seek healthcare, which could cause irreparable damage to the Center's reputation. Likewise, implementation of the notice provision in the Denial-of-Care Rule that implicitly puts the onus on patients to request an LGBT-affirming healthcare provider who will not have a religious-based objection to treating such patients would result in immediate negative responses from clients and erode patient trust, further thwarting the Center's mission.

19. In short, the Denial-of-Care Rule makes it difficult, if not impossible, for the Center to continue providing the same level of social, mental, and physical healthcare to its patients. The Center's mission includes addressing the need for equity in healthcare for all of the Center's patients and the LGBT community generally. This mission will be frustrated by the Denial-of-Care Rule as there will be a decline in overall LGBT-patient health and public health at large.

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

Dated: June 9, 2019

Respectfully submitted,

/s/ Darrel Cummings
Darrel Cummings

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF DR. RANDI C. ETTNER, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Randi C. Ettner, declare as follows:

1. I have been retained by counsel for Plaintiffs Trust Women Seattle, Los Angeles LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Bradbury-Sullivan LGBT Community Center, Center On Halsted, Hartford Gyn Center, Mazzoni Center, Medical Students For Choice, AGLP: The Association Of LGBTQ+ Psychiatrists, American Association of Physicians for Human Rights d/b/a Glma: Health Professionals Advancing LGBTQ Equality, Colleen Mcnicholas, Robert Bolan, Ward Carpenter, Sarah Henn, and Randy Pumphrey as an expert in connection with the above-captioned matter.

2. I submit this expert declaration based on my personal knowledge.

3. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

Qualifications and Basis for Opinion

4. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

5. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. A true and accurate copy of my curriculum vitae is attached as Exhibit A to this declaration.

6. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1980 to present. I have

published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (1st edition, co-editors Monstrey & Eyler; Rutledge 2007; and 2nd edition, coeditors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

7. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *The International Journal of Transgenderism and Transgender Health*. I am the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People* (7th version), published in 2011. The WPATH promulgated *Standards of Care* ("*Standards of Care*") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

8. I chair the WPATH Committee for Institutionalized Persons, and provide training to medical professionals on healthcare for transgender inmates. I have lectured throughout North America, Europe, and Asia on topics related to gender dysphoria and present grand rounds on gender dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria. I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and GD in Illinois.

9. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases in both state and federal courts as well as administrative proceedings. I have also been a consultant to policy makers regarding appropriate care for transgender inmates and for Centers for Medicare and Medicaid in the state of Illinois.

10. Attached as Exhibit B is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration. I have also relied on my years of experience in this field, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

Compensation

11. I am being compensated for my work on this matter at a rate of $375.00 per hour for preparation of declarations and expert reports. I will be compensated $500.00 per hour for any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will receive a flat fee of $2,500.00 for any travel time to attend deposition or trial, and will be reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing expert testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

Previous Testimony

12. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898 (D. Idaho 2018); *Carillo v U.S. Dep't of Justice Exec.* (Office of Immig. Rev. 2017); *Broussard v. First Tower Loan, LLC*, 135 F. Supp.

3d 540 (E.D. La. 2016); *Faiella v. American Medical Response of Connecticut, Inc.*, No. HHD-CV15-6061263-S (Conn. Super. Ct.); *Kothmann v. Rosario*, 558 F. App'x 907 (11th Cir. 2014).

II. EXPERT OPINIONS

Gender Identity and Gender Dysphoria

13. A person's sex is comprised of a number of components including, *inter alia*: chromosomal composition (detectible through karyotyping); gonads and internal reproductive organs (detectible by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); sexual differentiations in brain development and structure (detectible by functional magnetic resonance imaging studies and autopsy); and gender identity.

14. Gender identity is a well-established concept in medicine. Gender identity refers to a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity. All human beings develop this elemental internal view: the conviction if belonging to a particular gender, such as male or female. Gender identity is innate, has biological underpinnings, and is firmly established early in life.

15. When there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation. Developmentally, it is the overarching determinant of the self-system, influencing personality, a sense of mastery, relatedness, and emotional reactivity, across the life span. It is also the foremost predictor of satisfaction and quality of life. Efforts to change an individual's gender identity are harmful, futile, and unethical.

16. At birth, individuals are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate, and their birth-assigned sex matches that person's actual sex. However, for transgender individuals, this is not the case.

17. For transgender individuals, the sense of one's self—one's gender identity—differs from the sex they were assigned at birth, giving rise to a sense of being "wrongly embodied."

18. The medical diagnosis for that feeling of incongruence and accompanying distress is gender dysphoria, a serious medical condition, formerly known as gender identity disorder ("GID"). Gender Dysphoria is a diagnosis codified in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5"). The critical element of the Gender Dysphoria diagnosis is the presence of symptoms that meet the threshold for clinical impairment. This represents a change from GID, which focused on an individual's *identity* being disordered. This new diagnostic term, Gender Dysphoria, is also an acknowledgment that gender incongruence, in and of itself, does not constitute a mental disorder. As recently as June 16, 2018, the World Health Organization ("WHO") likewise announced it was reclassifying the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because it removes "gender identity disorder" from the chapter on mental and behavioral disorders, recognizing that gender incongruence is not a mental illness, and instead incorporates it within a new chapter dedicated to sexual health.

19. The condition is characterized by incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress or impairment of functioning that results. Gender dysphoria is manifested by symptoms such as preoccupation with ridding oneself of the primary and/or secondary sex characteristics associated with one's birth- assigned sex. Untreated gender dysphoria can result in significant clinical distress, debilitating depression, and suicidality.

20. The diagnostic criteria for gender dysphoria in adults are as follows:

a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 month's duration, as manifested by at least two of the following:

i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
ii. A strong desire to be rid of one's primary and/or secondary sex characteristics.
iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.
iv. A strong desire to be of the other gender.
v. A strong desire to be treated as the other gender.
vi. A strong conviction that one has the typical feelings and reactions of the other gender.

b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

21. Gender dysphoria is a highly treatable condition. Without treatment, however, individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant mental health issues. They are also frequently isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many such individuals are unable to function effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population, far above the baseline for North America (Haas et al., 2014).

22. Gender dysphoric patients who are assigned a male sex at birth but identify as female and lack access to appropriate care are often so desperate for relief that they may resort to life-threatening attempts at auto-castration—removal of the testicles—in the hopes of eliminating the major source of testosterone that kindles the distress (Brown, 2010; Brown & McDuffie, 2009).

23. Gender dysphoria generally intensifies with age. As gender dysphoric individuals approach middle age, they experience an exacerbation of symptoms (Ettner, 2013; Ettner & Wiley, 2013).

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Treatment of Gender Dysphoria

24. The standards of care for treating gender dysphoria are set forth in the WPATH *Standards of Care*, first published in 1979. The *Standards of Care* are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world, and in this country. The American Medical Association, the Endocrine Society, the American Psychological Association the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the WPATH standards. *See*, *e.g.*, American Medical Association (2008) Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); American Psychological Association Policy Statement on Transgender, Gender Identity & Gender Expression Non-discrimination (2008).

25. The Standards of Care identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition)
- Psychotherapy for purposes such as addressing the negative impact of stigma, alleviating internalized transphobia, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to feminize or masculinize the body
- Surgery to alter primary and/or secondary sex characteristics (e.g., breasts, external genitalia, facial features, body contouring)

26. The ability to live in a manner consistent with one's gender identity is critical to a person's health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each

transgender person takes to transition are not identical. Whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

27. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. WPATH specifies that treatment plans and provision of care must be undertaken by qualified professionals, with established competencies in the treatment of gender dysphoria (Section VIII).

28. **Psychotherapy:** Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for medical intervention when medical interventions are required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling does not obviate the need for insulin.

29. **Social Role Transition:** The *Standards of Care* establish the therapeutic importance of changes in gender expression and presentation—the ability to feminize or masculinize one's appearance— as a critical component of treatment. Known as the "real life experience," it requires dressing, grooming, and otherwise conveying, via social signifiers, a public face and role consistent with one's gender identity. This is an appropriate and essential part of identity consolidation. Through this experience, the transgender individual can begin to address the shame some experience of growing up living as a "false self" and the grief of being born in the "wrong body." (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)

30. **Hormone Therapy:** For individuals with persistent, well-documented gender dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress of the condition. Cross sex hormone administration is a well-established and effective treatment modality for gender dysphoria. The American Medical Association, the Endocrine Society, the

American Psychiatric Association and the American Psychological Association all concur that hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically necessary, evidence-based, best practice care for most patients with gender dysphoria.

31. The goals of hormone therapy are (1) to significantly reduce hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with either feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e. those born with insufficient sex steroid hormones). *See Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (2009).

32. The therapeutic effects of hormone therapy are twofold: (1) with endocrine treatment, the patient acquires congruent secondary sex characteristics, i.e., breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2) hormones act directly on the brain, via receptor sites, attenuating the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.

33. For many patients, hormones alone will not provide sufficient breast development to approximate the female torso. For these patients, breast augmentation has a dramatic, irreplaceable, and permanent effect on reducing gender dysphoria, and thus unquestionable therapeutic results.

34. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention. For transgender women, genital confirmation surgery has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains

body congruence resulting from the normal appearing and functioning female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria. Additionally, breast augmentation procedures play the critical role in treatment mentioned in the paragraph immediately above.

35. Decades of methodologically sound and rigorous scientific research have demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many, it is the only effective treatment. The American Medical Association, the Endocrine Society, the American Psychological Association, and the American Psychiatric Association all endorse surgical therapy, in accordance with the WPATH *Standards of Care*, as medically necessary treatment for individuals with severe gender dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017) ("For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role."); American Psychological Association *Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination* (2009) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

36. Surgeries are considered "effective" from a medical perspective, if they "have a therapeutic effect" (Monstrey et al. 2007). More than three decades of research confirms that gender confirmation surgery is therapeutic and therefore an effective treatment for gender dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is the only effective treatment.

37. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from 12 countries, spanning 30 years. They concluded that "reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes" (Pfafflin & Junge 1998).

38. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" (Smith et al. 2005). Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, gender dysphoria, had decreased to such a degree that it had disappeared."

39. As a general matter, patient satisfaction is a relevant measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender confirmation surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al., 1999; Johansson et al., 2010; Hepp et al.; 2002; Ainsworth & Spiegel, 2010; Smith et al., 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith et al., 2005; Weyers et al., 2009); and greater acceptance and integration into the family (Lobato et al., 2006).

40. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al., 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo et al., 2009; Klein & Gorzalka, 2009; Jarolim et al., 2009; Smith et al., 2005; Rehman et al., 1999; DeCuypere et al., 2005).

41. Given the decades of extensive experience and research supporting the effectiveness of gender confirmation surgery, it is clear that reconstructive surgery is a medically necessary, not experimental, treatment for gender dysphoria. Therefore, decades of peer-reviewed research and a medical consensus support the inclusion of gender confirmation surgery as a medically necessary treatment in the WPATH *Standards of Care*.

42. In 2016 WPATH issued a "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A." ("Position Statement"), affirming a statement originally issued in 2008. As the Position Statement explains, "These medical procedures and treatment protocols are not experimental: Decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient."

43. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

44. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that Medicare's policy barring coverage for transition-related surgeries was not valid under the "reasonableness standard." The Board found that the ban "was based principally on" a report from 1981 that has been rendered obsolete by numerous "medical studies published in the more than 32 years since issuance of the 1981 report." The Board specifically concluded that transition-related surgeries are "safe and effective and not experimental." As a result, Medicare's exclusion was struck down and Medicare was directed to consider surgeries on a case-by-case basis.

45. The overwhelming scientific evidence indicates that transition-related care, including gender confirmation surgery, is medically necessary for the treatment of gender dysphoria in some patients.

46. Equating treatment gender confirmation surgery that has been prescribed to treat gender dysphoria with sterilization is medically inaccurate. Procedures undertaken for the purpose of sterilization are distinct from medical procedures undertaken for other purposes that incidentally affect reproductive function.

47. For some transgender people who desire children, reproduction may be possible even when such individuals have obtained transition-related medical care. For example, prior to the initiation of cross sex hormones, the preservation of gametes allows for future possible conception. If hormonal treatment for gender dysphoria has been initiated, it can be discontinued, and harvesting to retrieve gametes or stimulation of testicles or ovaries can be utilized for conception. In addition, for transgender men who retain a uterus, the discontinuation of masculinizing hormones may allow for pregnancy and childbirth.

The Harmful Effects of Denial-of-Care to Transgender People

48. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self, thereby consolidating identity. Developing and integrating a positive sense of self-identity formation is a fundamental undertaking for all human beings. Denial of medically indicated care to transgender people based on moral or religious objections signals that such people are "inferior" or "unworthy," and triggers shame. The "Denial of Care Rule" provides a license to discriminate and challenges the legitimacy of identity. In so doing, the Rule erodes resilience and poses lifelong health risks to transgender and gender nonconforming individuals, including depression, posttraumatic stress disorder, cardiovascular and other disease, premature death and suicide.

49. A wealth of research establishes that transgender people suffer from discrimination, stigma and shame. The "minority stress model" explains that the negative impact of the stress attached to being stigmatized is socially based. The stress process can be both external, *i.e.*, actual experiences of rejection and discrimination (enacted stigma), and as a result of such experiences, internal, *i.e.*, perceived rejection and the expectation of being rejected or discriminated against (felt stigma). A 2015 study of 28,000 transgender and gender nonconforming individuals found that 30% reported being fired, discriminated or otherwise experiencing mistreatment in the workplace. Similarly, 31% of respondents had been mistreated in a public place, including 14% who were denied service, 24% who were verbally harassed and 2% who were physically attacked.

50. This discrimination, often in the form of violence, abuse or harassment, is related to negative health outcomes. A 2012 study of transgender adults found fear of discrimination increased the risk of developing hypertension by 100%, owing to the intersectionality of shame and cardiovascular reactivity. Indeed, a 2012 study of discrimination and implications for health concluded: "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses." Another study found transgender adults' access to college bathrooms and housing was related to suicidality.

51. Until recently, it was not fully understood that these experiences of shame and discrimination could have serious and enduring consequences. But it is now known that marginalization, stigmatization and victimization are some of the most powerful predictors of current and future mental health problems, including the development of psychiatric disorders. The social problems that young transgender people face actually create the blueprint for future mental health, life satisfaction, and even physical health. A recent study of 245 gender-nonconforming adults found that stress and victimization during childhood and adolescence was associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and

suicidality in adulthood. A 2011 Institute of Medicine (IOM) report concurs: "the marginalization of transgender people from society is having a devastating effect on their physical and mental health." And the American Journal of Public Health recently reported that more than half of transgender women "struggle with depression from the stigma, shame and isolation caused by how others treat them."

52. Conversely, Bauer et al. found a 62% reduction in risk of suicide ideation with the completion of medical transition. That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year.

53. While there is a growing body of documentation that structural forms of stigma (policies) harm the health of transgender people, a 2010 study was the first to show that structural stigma is associated with *all-cause mortality* (i.e. deaths from any cause). In other words, stigma—a chronic source of psychological stress--disrupts physiological pathways, increasing disease vulnerability, and leading to premature death.

54. Adding to the corpus of research in this area is a relatively new approach to the investigation of the relationship between discrimination and health. Neuroscientists have discovered that, in addition to causing serious emotional difficulties and physical harms, discrimination, harassment and verbal abuse permanently alter the architecture of the brain. Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause cognitive difficulties in individuals who have been routinely subjected to humiliation and ostracism.

55. Transgender individuals currently face significant discrimination in health care settings and barriers to care. Forty percent (40%) fear accessing care, and forego routine screening and preventative care. A 2017 report by the Center for American Progress of 7,500 transgender adults found 29 % were refused treatment based on their gender identity and 21 % were verbally

abused when seeking healthcare. The report also found that transgender individuals often had to travel to other states to find medical providers. A 2018 survey of 6,450 participants found 24% were denied treatment in doctor's offices or hospitals, 13% in emergency rooms, 11% in mental health clinics and 5% for ambulance or emergency medical services. As a result, transgender individuals have poorer health, greater stress, and higher rates of obesity, even when compared to lesbian and gay populations. Indeed, 23% of respondents to a 2015 study did not see a doctor when they needed to because of fear of being mistreated as a transgender person. These findings led to the Association of American Medical Colleges to convene an advisory committee to develop curricula based on competencies for medical education.

56. "The Denial of Care Rule" further endangers the health and well being of vulnerable individuals by permitting providers to refuse healthcare on the basis of religious or moral objections to transgender individuals' identities. The Rule seeks to create a license to discriminate, posing a serious risk to transgender people. The harms that will befall transgender people are predictable and dire: the exacerbation of symptoms of gender dysphoria, grave damage to mental and physical health, and the undermining of clearly established, evidence based treatment protocols.

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

Dated this 5th day of June, 2019.

Respectfully submitted,

/s/ Dr. Randi C. Ettner
Dr. Randi C. Ettner

EXHIBIT A

RANDI ETTNER, PHD
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POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff Weiss Memorial Hospital, Chicago IL

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-present	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery Consultant: Walgreens; Tawani Enterprises Private practitioner
2011	Instructor, Prescott College: Gender-A multidimensional approach
2000	Instructor, Illinois Professional School of Psychology
1995-present	Supervision of clinicians in counseling gender non conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018
The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating Transference and Countertransference Issues, WPATH global education initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017,

Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015*Gender reassignment surgery*- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; *Care of the aging transgender patient*-University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World

Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonueroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and transmen. *Journal of Child and Adolescent Psychiatry*.

Narayan, S., Danker, S Esmonde, N., Guerriero, J., Carter, A., Dugi III, D., Ettner, R., Radix A., Bluebond-Langner, R., Schechter, L., Berli, J. (2018) A survey study of surgeons' experience with regret and reversal of gender-confirmation surgeries as a basis for a multidisciplinary approach to a rare but significant clinical occurrence, submitted.

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Ettner, R. Pre-operative evaluation in Schechter (Ed.) Surgical Management of the Transgender Patient. Elsevier, 2017.

Berli, J., Kudnson, G., Fraser, L., Tangpricha, V., Ettner, R., et al. Gender Confirmation Surgery: what surgeons need to know when providing care for transgender individuals. *JAMA Surgery*; 2017.

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Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium,* 31-32.

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"Social and Psychological Issues of Aging in Transsexuals," proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin,* 1997.

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin,* 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

"The Work of Worrying: Emotional Preparation for Labor," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018
The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women's Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

EXHIBIT B

BIBLIOGRAPHY

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Colton 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 & Lesbian Mental Health* 15(3): 281-299.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Roy Harker, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 5, 2019

Respectfully submitted,

/s/ Roy Harker

Roy Harker

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Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Sarah Henn, Declare as follows:

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

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

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

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

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

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

5. Good medical care is based on trust as well as frank, and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' mental and physical health. Incomplete communication, or miscommunication, can have dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers; and a patient who fails to fully disclose their gender identity and sex assigned at birth may not undergo medically-indicated tests or screenings (such as tests for cervical or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women). Patients need to be encouraged to fully disclose all information relevant to their healthcare and potential treatment, which can only be achieved when patients are assured that the information they provide will be treated confidentially and with respect, and will not be used against them to deny treatment. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many if not most of my and Whitman-Walker's transgender patients express strong distrust of the healthcare system generally, and a demonstrative reluctance to seek care outside Whitman-Walker unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in

disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers.

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

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

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

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

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

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

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

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

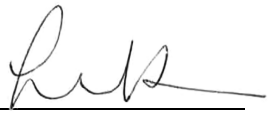
determine causes of HIV acquisition; and the effects of stress on transgender women of color who are HIV-positive and on hormone therapy.

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

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

Dated: June 5, 2019

Respectfully submitted,



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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

No. 19-cv-2916 NC

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

I, PAUL E. LORENZ, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

The County Health System's Religious and Moral Exemption Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Impact of Loss of Federal Funding

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

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

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

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

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

Dated: June 4, 2019

Respectfully submitted,

PAUL E. LORENZ

EXHIBIT A

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

Administrative Policies and Procedures

VMC #132.01

August 9, 2017

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

PURPOSE:

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

POLICY:

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

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

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

PROCEDURE:

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

PROCEDURE: (continued)

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

Attachments:

1 Request to Not Participate in Direct Patient Care or Treatment

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

Attachment 1
Policy VMC #132.01

Request to Not Participate in Direct Patient Care or Treatment

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

_____
specific procedure/treatment

because _____

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

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

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

_____ _____
Signature Date

Approved Denied _____
Date

_____
Authorized Signature

Distribution:

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

SCVMC 4248 REV 10/06/05

EXHIBIT B

SANTA CLARA VALLEY MEDICAL CENTER

May 8, 2015

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

BACKGROUND:

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

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

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

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

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

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

GUIDING PRINCIPLES:

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

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

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

POLICY:

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

PROCEDURE:

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

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

PROCEDURE: (continued)

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

PROCEDURE: (continued)

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

Attachments:

1 Bioethics Committee Bylaws and Ethics Consultation Procedure

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

ETHICS CONSULTATION PROCEDURE
SANTA CLARA VALLEY MEDICAL CENTER

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

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

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

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

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

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

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

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

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

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

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Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Alecia Manley, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 5, 2019

Respectfully submitted,

/s/ Alecia Manley
Alecia Manley

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NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Trust Women Seattle

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

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

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

Medical Ethics

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

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

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

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

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

Impact on Patients

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

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

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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.*

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

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

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

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

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

[11] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

Impact of Delayed Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Impact of Denials of Care

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

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

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

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

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

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

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

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

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

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

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

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

[33] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 5, 2019

Respectfully submitted,

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

EXHIBIT A

CURRICULUM VITAE
Colleen Patricia McNicholas, DO, MSCI, FACOG

Date: October 2018

Address:

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

Present Position:

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

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

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

Education:

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

Academic Positions/Employment:

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

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

University and Hospital Appointments and Committees:

Appointments

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

Committees:

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

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

Medical Licensure and Board Certification:

Licensure

Missouri, Kansas, Oklahoma, Washington
Illinois Pending

Board Certification:

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

Honors and Awards:

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

Editorial Responsibilities:

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

Professional Societies and Organizations:

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

Leadership Roles

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

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

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

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

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

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

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

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

Invited Presentations:

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

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

2012 Contraception for medically complicated women
Women in Medicine Annual meeting

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

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

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

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

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

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

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

Physicians for Reproductive Health Leadership Training Academy

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

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

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

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

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

2017 GOV 101
Learning to advocate at the MO legislature

2017 Reevaluating the longevity of LARC
GrandRounds, BayState Medical Center

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

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

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

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

Research Support:

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

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

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

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

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

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

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

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

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

Bibliography:

Peer-reviewed Publications:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Peer Reviewed Invited Publications:

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

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

Chapters:

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

Abstracts:

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

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

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

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

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

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

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

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

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

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

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Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Dr. Ken Miller, declare:

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

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

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

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

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

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

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

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

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

Respectfully submitted,

/s/ Ken Miller MD PhD
KEN MILLER

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

No. 19-cv-2916 NC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 4, 2019

Respectfully submitted,

PHUONG H. NGUYEN, M.D.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[9] *Id.*

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

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

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

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

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

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

[13] *See id.*

[14] *See id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 6, 2019

Respectfully submitted,

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

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

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

EXHIBIT A

Curriculum Vitae

Rachael Phelps MD, FAAP

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Rochester, NY 14605

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(585)734-5379

EDUCATION:

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

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

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

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

PROFESSIONAL EXPERIENCE:

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

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

LEADERSHIP and COMMUNITY SERVICE:

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

Medical School:

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

Undergraduate:

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

AWARDS:

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

PUBLICATIONS/RESEARCH:

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

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

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

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

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

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

TRAINING OF RESIDENTS AND MEDICAL STUDENTS:

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

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

NATIONAL INVITED LECTURES AND GRAND ROUNDS:

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

NATIONAL INVITED LECTURES (cont.):

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

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

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

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

NATIONAL INVITED LECTURES (cont.):

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

LOCAL INVITED LECTURES:

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

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

LOCAL INVITED LECTURES (cont.):

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

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

LOCAL INVITED LECTURES (cont.):

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

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

LOCAL INVITED LECTURES (cont.):

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

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

MEDIOGRAPHY:

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

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

MEDIOGRAPHY (cont.):

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

MEDIA TRAINING:

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

INTERNATIONAL EXPERIENCE:

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

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Randy Pumphrey, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

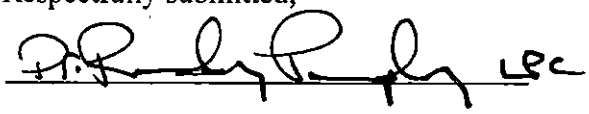
11. Whitman-Walker is a certified healthcare provider under the Medicare program and also under the District of Columbia's Medicaid program. Healthcare providers with Whitman-Walker, are credentialed under the Medicare program and also under the District of Columbia's Medicaid program. Both programs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

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

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

Dated: June 4, 2019

Respectfully submitted,



Randy Pumphrey

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Naseema Shafi, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 5, 2019

Respectfully submitted,

Naseema Shafi

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Adrian Shanker, declare as follows:

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

2. I am the Founder & Executive Director of Bradbury-Sullivan Center. I assumed that role in 2014 when Pennsylvania Diversity Network restructured into Bradbury-Sullivan Center. I received a Bachelor's degree from Muhlenberg College in Religion Studies and Political Science in 2009 and earned a Graduate Certificate in LGBT Health Policy & Practice from The George Washington University in 2017. I previously volunteered as Board President of Equality Pennsylvania, served on the Office of Health Equity Advisory Board for the Pennsylvania Department of Health, and co-chaired LGBT Healthlink, which was a CDC-funded national disparity network for LGBT tobacco and cancer disparity work. At Bradbury-Sullivan Center, in addition to staff management, board development, fundraising, and strategic planning, I administer data collection for the Pennsylvania LGBT Health Needs Assessment. With Health Programs employees at Bradbury-Sullivan, I also develop health promotion campaigns to make behavioral, clinical, and policy changes to improve LGBT health. Since 2017, I have led the successful community efforts to ban "conversion therapy" in the cities of Allentown, Bethlehem, and Reading, Pennsylvania. In 2012 and 2018, Philadelphia Gay News named me Person of the Year and in 2019 Lehigh Valley Business named me a Healthcare Hero. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the Denial of Care Rule from taking effect.

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

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

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

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

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

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

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

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

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

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

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

8. Bradbury-Sullivan Center spends a significant amount of resources documenting health disparities in the LGBT community. Data gathered from that work confirmed that only about 17% of LGBT Pennsylvanians in 2018 had a provider whom they considered to be their personal physician. That means that in times of need, LGBT people are more likely to randomly select a healthcare provider with whom they do not have a relationship, putting them at increased risk of finding a provider who is not LGBT-welcoming. With an increase in refusals of care as a result of the Denial-of-Care Rule, LGBT people will be far less likely to receive the healthcare treatment that they need because, after being turned away, they are unlikely to seek other care out of fear of repeated rejections. Data from 2018 also indicated that over 50% of LGB and 75% of the transgender community fear going to a healthcare provider due to negative past experiences directly related to the patients' sexual orientation or gender identities.

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

10. Bradbury-Sullivan Center's research into health disparities facing the LGBT community reveals that approximately one in four members of the community in our region experience a negative reaction from a healthcare provider when they come out as LGBT. More than half of respondents report fear of a negative reaction by a healthcare provider if they come out. Indeed, approximately three quarters of all transgender respondents fear such a negative reaction.

Our research also identifies pervasive health disparities between LGBT people and the majority population with respect to tobacco use, cancer, HIV, obesity, mental health, access to care, and more, with LGBT people consistently experiencing worsened health outcomes. In other words, LGBT people, who are disproportionately likely to need a wide range of medical care, already have reason to fear, and often do fear, negative consequences of disclosing to healthcare providers their sexual orientation, history of sexual conduct, gender identity, transgender status, history of gender-confirming medical treatment, and related medical histories.

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

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

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

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

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

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

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

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

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

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

Dated: June 9, 2019

Respectfully submitted,

/s/ Adrian Shanker
Adrian Shanker

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

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

I, Narinder Singh, declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

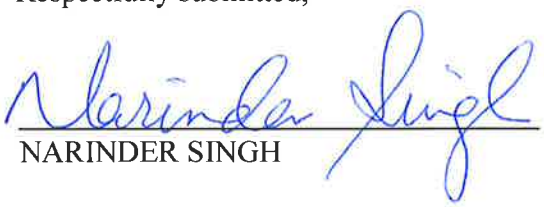
12. The Pharmacy Department also employs technicians and assistants to perform nonclinical activities, such as delivering drugs or directly handing drugs to patients being discharged or currently being treated in the Emergency Department. Were a technician or assistant to elect not to take drugs to a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

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

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

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

Respectfully submitted,



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

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

Defendants.

Case No. 5:19-cv-2916

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

I, JILL SPROUL, declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully submitted,

Jill L. Sproul, MS, RN

JILL SPROUL

EXHIBIT A

ABORTION PROCEDURE, EMPLOYEE OBJECTION TO PARTICIPATION IN ELECTIVE

I. POLICY

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

II. PURPOSE

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

III. PROCESS

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

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

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

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

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

IV. ATTACHMENT

Employee Statement Regarding Abortion form.

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

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

SANTA CLARA VALLEY MEDICAL CENTER
DEPARTMENT OF NURSING SERVICE

EMPLOYEE STATEMENT REGARDING ABORTION

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

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

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

Date _____

Time_____

_____ _____

Signature Witness

EXHIBIT B

AGREEMENT

Between

COUNTY OF SANTA CLARA

And

REGISTERED NURSES PROFESSIONAL ASSOCIATION

NOVEMBER 10, 2014 THROUGH OCTOBER 20, 2019

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PREAMBLE

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

ARTICLE I – RECOGNITION

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

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

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

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

ARTICLE 2 - NO DISCRIMINATION

Section 2.1 - Employment

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

Section 2.2 - Association Affiliation

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

Section 2.3 - Affirmative Action

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

ARTICLE 3 - ASSOCIATION SECURITY

Section 3.1 - Relationship Affirmation

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

Section 3.2 - Dues Deductions

a) Maintenance

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

b) Condition of Employment

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

c) Implementation

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

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

d) Religious Exemption

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

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

e) Revocation

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

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

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

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

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

f) No Fault

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

g) Leaves of Absence

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

Section 3.3 - Other Deductions

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

Section 3.4 - Association Notices and Activities

a) Bulletin Boards

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

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

b) Distribution

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

c) Visits by Association Representatives

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

For this purpose rest periods are not work time.

d) Facilities

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

e) Names and Addresses of Covered Nurses

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

f) Notification of Association Coverage

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

g) Report of Transactions

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

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

Section 3.5 - New Nurse Orientation

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

Section 3.6 - Printing of Agreement

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

ARTICLE 4 - OFFICIAL REPRESENTATIVES AND NEGOTIATING COMMITTEE

Section 4.1 - Official Representatives

a) Notification of Official Representatives

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

b) Release Time

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

c) Release Time Log

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

Section 4.2 - Negotiating Committee

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

a) Compensatory Time

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

b) Resource People

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

ARTICLE 5 - LAYOFF

Section 5.1 - Seniority Defined

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

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

Section 5.2 - Transfer of Prior Employer Service

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

Section 5.3 - Changes to Classes

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

Section 5.4 - Order of Layoff and Reassignment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 5.5 - Reassignment from a Lower Classification

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

Section 5.6 - Competency Standards

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

Section 5.7 - Employee Competency Profile

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

Section 5.8 - Notice of Layoff

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

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

b) Notice to Employee

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

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

Section 5.9 - Training Opportunities

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

Section 5.10 - Layoff

a) Layoff

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

b) Inplacement

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

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

The following conditions apply to the inplacement process:

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

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

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

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

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

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

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

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

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

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

   a. basic skill competency training and/or;

   b. literacy training and/or;

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

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

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

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

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

Section 5.11 - Re-employment List

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

b) When a vacancy exists which the County intends to fill, the most senior nurse on the appropriate re-employment list shall be offered appointment, provided the required competencies are met. Nurses on re-employment lists shall retain the right to take promotional exams and/or receive promotional preference on exams.

1. If the County is able to contact the nurse to communicate the offer of re-employment, the nurse will be encouraged to respond within forty-eight (48) hours, but, if requested, will be allowed up to four (4) working days to respond.

2. If the County is unable to make contact, the County will send the offer by certified mail, return receipt, to the last known address. The nurse must respond to the offer within ten (10) working days from the date of mailing.

3. If no response is received within the above time limits, the nurse will be deemed to have been offered and to have refused such work.

Section 5.12 - Extra-Help and Per Diem Work for Laid Off Nurses

Interested nurses who are placed upon the re-employment list due to layoff and who elect to be available for extra-help or per diem work shall be given preference for any work in their former Department/Agency for which they are currently qualified. The election to be available for extra-help and per diem work must be made in writing at the time of layoff. Employees may decline to be available for extra-help and per diem work or may decline such work itself without affecting any rights under this Article.

Section 5.13 - Names Dropped from Re-employment List

No name shall be carried on a re-employment list for a period longer than two (2) years, and the names of persons re-employed in a permanent position within the same classification shall, upon such re-employment be dropped from the list. Refusal to accept one of two offers of re-employment within the same classification, shall cause the name of the person to be dropped from the re-employment list.

Section 5.14 - Rights Restored

Upon re-employment of a nurse from a re-employment list, all rights acquired by a nurse prior to the nurse's placement on such list shall be restored; including but not limited to PTO accrual rates, seniority as defined in Section 5.1, salary step and time-in-step placement, and educational leave.

Section 5.15 - Temporary Layoff

In the event of a decrease in census of any unit requiring a temporary reassignment of work areas or layoff of Registered Nurses for less than thirty (30) calendar days, the appointing authority shall:

a) Attempt to float any affected nurse to any unit which the nurse has been oriented.

b) As an educational opportunity, allow a nurse to request an orientation to an unfamiliar unit.

c) Request volunteers to take time-off by using PTO, comp. time or leave without pay.

d) Implement a layoff of nurses by inverse seniority, if there are insufficient volunteers. This subsection, however, shall not apply to any classification of nurses that are designated as FLSA exempt.

It is agreed that this provision shall be applied by unit and shift. It is also understood that the hospital will not assign extra-help, per diem or registry RN to the unit on that shift when this section is implemented.

ARTICLE 6 - PERSONNEL ACTIONS

Section 6.1 - Probation

a) Each new nurse shall serve a probationary period of nine (9) months, which shall be counted as twenty (20) complete pay periods. Upon successful completion of such probationary period, the nurse shall be deemed a permanent employee. A leave of absence without pay shall not be credited toward completion of the nurse's probationary period. The parties agree that probationary nurses shall have all rights in this Agreement, unless otherwise specified, including full and complete access to the grievance procedure. Any nurse released during the probationary period shall, upon request, be provided with a statement of the reasons for the release. Consistent with County Charter Section 704(e), probationary nurses may not grieve suspensions, demotions, or dismissals.

b) Probationary nurses shall have the right to request and receive Department/Agency administrative review of disciplinary action taken during probation. Such review must be requested in writing within ten (10) working days of the disciplinary action or it is waived. The review process shall consist of a meeting with the clinical director or his or her designee. The review process shall proceed promptly after a request is received. The clinical director or his or her designee shall hear and make a decision within fifteen (15) working days.

Section 6.2 - Disciplinary Action - Unclassified Nurses

Unclassified nurses who have completed a period equal to the probationary period for a comparable classified position may grieve disciplinary action on the grounds that such discipline was not for cause. Such grievance shall comply in all respects with Article 16 of this Agreement.

Notice of disciplinary action must be served on the nurse in person or by certified mail prior to the disciplinary action becoming effective. Notice shall be included in the nurse's personnel file and a copy sent to the Association and shall include:

a) Statement of the nature of the disciplinary action.

b) Effective date of the action.

c) Statement of the cause thereof.

d) Statement in ordinary and concise language of the act or omissions upon which the causes are based.

e) Statement advising the nurse of the right to appeal from such action and the right to Association representation.

Section 6.3 - Personnel Files

The County shall maintain a personnel file for each nurse. The Santa Clara Valley Health and Hospital System may also maintain a personnel file for each nurse. Nurses shall have the right to review their personnel file(s) or authorize review by their representative. No material will be inserted into the nurse's personnel file(s) without prior notice to the nurse. Nurses may cause to be placed in their personnel file(s) responses to adverse material inserted therein and a reasonable amount of correspondence originating from other sources directly related to their job performance.

Materials relating to suspensions which become final will be removed after four (4)years if no other suspensions have occurred during the four (4) year period except those involving charges as listed in A25-301(a)(4) Brutality in the performance of duties and (b)(2) Guilty of immoral conduct or a criminal act.

Materials relating to suspensions may be removed from the nurse's personnel file earlier than the regular removal schedule by mutual agreement between the Union, the Office of Labor Relations and the CNO or his/her designee.

Materials relating to disciplinary actions recommended but not taken, or disciplinary actions overturned on appeal, shall not be retained in a nurse's personnel file.

Section 6.4 - Disciplinary Action - Permanent Classified

The County may take disciplinary action for cause against any permanent classified nurse by suspension, demotion or discharge by notifying the nurse in writing. Notice of disciplinary action must be served on the nurse in person or by certified mail prior to the disciplinary action becoming effective. The notice shall be included in the nurse's personnel file(s) and a copy sent to the Association and shall include:

a) Statement of the nature of the disciplinary action.

b) Effective date of the action.

c) Statement of the cause thereof.

d) Statement in ordinary and concise language of the act or omissions upon which the causes are based.

e) Statement advising the nurse of the right to appeal to the Personnel Board from such action and the right to Association representation.

Such nurse shall be given either five (5) days' notice of discharge, or demotion, or five (5) days' pay, except where circumstances require immediate action.

In cases of questionable gross negligence or incompetence as defined in the Nurse Practice Act, the nurse, at the sole election of the appointing authority or their designee, may be placed on administrative leave with pay, not to exceed fifteen (15) working days, pending an investigation. If circumstances permit, a nurse will be advised in writing that they are being placed on administrative leave under this provision.

6.5 - Counseling and Unfavorable Reports

a) Counseling

In the event that a nurse's performance or conduct is unsatisfactory or needs improvement, informal counseling shall be provided by the nurse's first level supervisor. Counseling shall be separate and distinct from on-going worksite dialogue. Documentation of such counseling (including verbal counseling) shall be given to the nurse as it is developed. Such documentation shall not be placed in a nurse's personnel file(s) and when the situation allows counseling, counseling shall be used prior to any unfavorable reports being issued. Counseling shall be removed from supervisory files within two (2) years, and shall not be used in the progressive disciplinary process provided no subsequent related counseling or other personnel action was issued.

b) Unfavorable Reports on Performance or Conduct

If upon such counseling a nurse's performance or conduct does not improve and disciplinary action could result, a written report shall be prepared by the supervisor including specific suggestions for corrective action, if appropriate. A copy shall be given to the nurse and a copy filed in the nurse's personnel file(s). No unfavorable reports shall be placed in a nurse's file(s) unless such report is made within ten (10) working days of the County's knowledge of the occurrence or incident which is the subject of this report. Provided no additional report has been issued during the intervening period, each report shall be removed from the nurse's file(s) at the end of two (2) years. Upon resignation, any such reports shall be removed from the nurse's file(s). Unfavorable reports may be removed from the nurse’s personnel file earlier than the regular removal schedule by mutual agreement between the Union, the Office of Labor

Relations and the CNO or his/her designee. Nurses shall have the right to grieve the factual content of such reports or attach a written response to the report for inclusion in their personnel file(s).

Section 6.6 - Return to Former Class

As an alternative to appointment from any employment list, any current regular nurse, upon recommendation of the appointing authority and approval by the Director of Personnel, may be appointed without further examination to a position in any class in which regular status had formerly been acquired, or to any related class on a comparable level with the former class.

Section 6.7 - Unclassified Appointment

No nurse, while holding a position in the unclassified service, shall be assigned to or occupy any classified position.

Section 6.8 - Rights Upon Promotion to Classified or Unclassified Service or Transfer to Unclassified Service

Any permanent nurse who receives a provisional or probationary promotion, or who is transferred or promoted to a position in the unclassified service shall retain all rights and benefits as a permanent nurse of the nurse's former class while in such provisional, probationary, or unclassified status. These include the right to participate in promotional examinations and the right to return to the nurse's former class if released while in such status. All such service shall count toward seniority credits in the nurse's former class in the event the layoff procedure is involved.

Any permanent nurse who receives a provisional promotion, or who is transferred or promoted to a position in the unclassified service, the duration of which is known to be for less than six (6) months, shall be considered to be on leave from the nurse's permanent position and departments are authorized to make substitute appointments to such vacated positions.

Section 6.9 - Transfers and Job Opportunities

Santa Clara Valley Health and Hospital System shall establish a system to facilitate transfers and career mobility of Registered Nurses.

a) All coded vacancies, transfer opportunities, and all special assignment positions created within existing job specifications, that the County intends to fill shall be posted on the work unit where the vacancy exists for a period of seven (7) calendar days. The County will transmit electronically to the RNPA all vacancies every payroll period.

b) Code and / or shift change requests within a unit shall be based on seniority within the unit subject to the following:

1) Nurses who have been issued an Unfavorable Report, suspension, subsequent probationary release or demotion within the past twelve (12) months may only transfer to a higher code status with management approval. T/A CP 1/13/31

2) The nurse is available to fulfill the position within six (6) weeks of the request.

c) If a vacant position exists after exhausting the above provisions, management shall post a notice of the vacancy for transfers of eligible nurses outside the work unit for seven calendar days. The vacancy may also be posted as promotional or open/competitive. Should the vacancy be posted as promotional or open/competitive, any nurse interested and eligible for transfer will be interviewed and considered prior to interviewing outside candidates. The vacancies will be posted on a bulletin board outside the Nursing Office and the Cafeteria at Valley Medical Center at least bi-weekly. In addition, the list shall be distributed to designated individuals in non-hospital locations for posting in nursing areas All Job postings may be accessed at the following websites: www.sccgovatwork.org and www.sccjobs.org.

Section 6.10 – Exchange of Shifts

Nurses may exchange shifts within the same code status and within the same work unit using the following process:

1. From February 1 through February 10 and August 1 through August 10 of each year, nurses desiring to change shifts within his/her same code status may submit in writing to management a request to change shifts. For example: day shift nurse holding a 3/5ths position requesting to exchange to night shift 3/5ths position.

2. Such requests shall be maintained in the schedule binder of each unit. Nursing management shall notify nurses of a viable shift change by February 15 and August 15 of each year.

3. If two or more requests to exchange to the same different shift are received, the nurse with the most seniority shall be granted shift exchange provided there is a staff member on the opposite shift in the same code status desiring to exchange. Seniority for the purposes

of shift exchange is defined as continuous date in the unit as a coded RN. Date of seniority for this purpose will be adjusted for unpaid leaves of absence.

4. Exchange of shifts will occur as soon as practical but not to exceed six weeks after notification to both parties.

ARTICLE 7 - PAY PRACTICES

Section 7.1 - Salaries

Effective on the dates listed all salaries shall be as listed in Appendix A attached hereto and made a part hereof. The parties agree that the rates of pay established by this Agreement are commensurate with those prevailing throughout the County for comparable work as required by the Charter for the County of Santa Clara.

Section 7.2 - Basic Pay Plan

The Basic Pay Plan consists of the salary ranges and the assignment of classes to such ranges as provided in this Section. Each nurse shall be paid within the range for the nurse's class according to the following provisions.

a) Step One

The first step in each range is the minimum rate and shall normally be the hiring rate for the class. In cases where it is difficult to secure qualified personnel or a person of unusual qualifications is engaged, the Director, with the approval of the County Executive, may approve appointment at the second, third, fourth or fifth step. If a nurse is hired under the difficult-to-secure-qualified- personnel clause, the County will move those nurses within that same class to the same salary step as that being received by the new nurse. The Association will receive a monthly listing of positions by class and department which list positions hired above the first salary step.

Effective April 11, 2005 Step 1 and Step 2 of the Clinical Nurse I wage scale shall be eliminated thereby making the entry wage for Clinical Nurse I to be at the Step 3 level.

b) Step Two

The second step shall be paid after the accumulation of six (6) months of competent service at the first step.

c) Step Three

The third step shall be paid after the accumulation of twelve (12) months of competent service at the second step.

d) Step Four

The fourth step shall be paid after the accumulation of twelve (12) months of competent service at the third step.

e) Step Five

The fifth step shall be paid after the accumulation of twelve (12) months of competent service at the fourth step.

f) Longevity Pay – Step Six

Effective August 7, 2000 a sixth step is established at approximately five percent (5%) above step five for the existing classifications of Clinical Nurse III, Psychiatric Nurse II, Nurse Coordinator, Staff Developer, Clinical Nurse Specialist, Infection Control Nurse, and Nurse Practitioner. The sixth step shall be paid after the accumulation of thirty-six (36) months of competent service at the fifth step. Beginning November 12, 2001 eligibility for sixth step shall be extended to the classifications of Assistant Nurse Manager and Certified Registered Nurse Anesthetist.

g) Longevity Pay – Step Seven

Effective August 7, 2000 a seventh step is established at approximately five percent (5%) above step six for the existing classifications of Clinical Nurse III, Psychiatric Nurse II, Nurse Coordinator, Staff Developer, Clinical Nurse Specialist, Infection Control Nurse and Nurse Practitioner. The seventh step shall be paid after the accumulation of one hundred and thirty two months (132) of competent service subsequent to attainment of step five of the nurse's current classification.

Effective August 7, 2000, former Clinical Nurse IVs and Clinical Nurse Vs, who are currently Clinical Nurse III's and had their salaries frozen, shall be eligible to be paid at step seven.

h) Longevity Pay Steps – Steps A, B and C

Effective November 8, 2004 pay steps A, B and C are established as sub-steps within a salary range at approximately two and one half percent (2.5%), five percent (5%) and seven and one half percent (7.5%) higher than a corresponding step (e.g. step 7, step 7A, step 7B and step 7C). The A step shall be paid during the 15th year through the 19th year of service in this bargaining unit. The B step shall be paid during the 20th year through the 24th year of service in this bargaining unit. The C step shall be paid during the 25th year and beyond of service in this bargaining unit.

i) Time for Salary Adjustments

Salary adjustments shall be made on the first day of the pay period in which the required accumulation of months of competent service occurs.

j) For nurses hired on or after February 4, 2013, the following salary steps shall apply:

1) Effective February 4, 2013, two lower sub-steps below step one shall be established for all classifications at 5% difference between each step. The first sub-step shall be

the hiring rate for all new nurses hired on or after February 4, 2013.

2) Sub step 98 is the minimum rate and shall normally be the hiring rate for the classification. In cases where it is difficult to secure qualified personnel or a person of unusual qualities is engaged, the County Executive may approve the appointment at step 99, one, two, three, four or five.

3) Sub step 99 shall be paid after the accumulation of twelve (12) months competent service at sub step ninety-eight.

4) Step one shall be paid after the accumulation of twelve months competent service at step ninety-nine.

5) Step two shall be paid after the accumulation of six months competent service at step one.

6) Step three shall be paid after the accumulation of twelve months competent service at step two.

7) Step four shall be paid after the accumulation of twelve months competent service at step three.

8) Step five shall be paid after the accumulation of twelve months competent service at step four.

9) Sub-step 98 and 99 Elimination:
Sub-steps 98 and 99 shall be eliminated effective November 10, 2014.

Nurses hired on or after February 4, 2013, into sub-step 98/99 and who remain in sub step 98/99 on November 10, 2014 shall be placed in step 1 effective November 10, 2014.

Nurses who remain in sub-step 98/99 on or after June 23, 2014, shall receive the difference between sub-step 98/99 and step 1 for all hours paid starting from June 23, 2014 through November 9, 2014.

Section 7.3 - Effect of Promotion, Demotion or Transfer on Salaries

a) Promotion

Upon promotion, a nurse's salary shall be adjusted as follows:

1. For a promotion of less than ten percent (10%) the salary shall be adjusted to the step in the new range which provides for a corresponding percentage increase in salary.

2. For a promotion of ten percent (10%) or more the salary shall be adjusted to the step in the new range which provides for ten percent (10%) increase in salary or to the first step in the new range, whichever is greater.

Any other promotion will be in accordance with regular County procedure.

b) Demotion

Notwithstanding the provisions of Section 7.2, upon demotion of a nurse with permanent status in the nurse's current class, the nurse's salary shall be adjusted to the highest step in the new class not exceeding the salary received in the former class.

c) Transfer

Upon transfer, the salary shall remain unchanged.

d) No Loss of Time-In-Step

Notwithstanding the provisions of Section 7.2, no salary adjustment upon promotion, demotion, or transfer shall effect a loss of time acquired in the former salary step, and such time as was acquired in the former salary step shall be included in computing the accumulation of the required months of service for eligibility of the employee for further salary increases.

e) Voluntary Demotion

In the event of a voluntary demotion required by a work-connected illness or injury and a resulting disability, the salary of the nurse shall be placed at the step in the salary range which corresponds most closely to the salary received by the nurse as of the time of injury. In the event that such voluntary demotion would result in a salary loss of more than ten percent (10%), the nurse's new salary shall be set at the rate closest to, but not less than ten percent (10%) below the nurse's salary as of the time of injury.

f) Lateral Transfers

When making a lateral transfer or demotion to another class, an application review by the Personnel Director shall be deemed as an appropriate qualifying examination for nurses in instances where a qualifying examination is required. If otherwise qualified under this provision, and the only prohibition to lateral transfer is the salary of the new class, it shall be deemed to be a lateral transfer if the move from one classification to another does not exceed twelve percent (12%) upward range movement.

Section 7.4 - Part-Time Salaries

a) Salary Ranges

The salary ranges provided in the attached Appendix are for full-time service in full-time positions, and are expressed in dollars per the number of working days in a bi-weekly pay period. If any position is established on any other time basis, the compensation for such position shall be adjusted proportionately.

b) Benefits

Beginning with the 1996 open enrollment period, part-time nurses may elect to be covered by either the County's health care package (medical, dental, vision, and life) or medical coverage only and shall authorize a payroll deduction for the appropriate prorated cost.

Nurses who become part-time nurses as a result of a layoff from full-time will continue to receive full-time benefits until such time as they are offered a full-time position in their current classification or higher.

Nurses may withdraw from the insurance package at any time. Nurses may enroll in the insurance package upon entering part-time, upon changing from any increment of part-time to any other increment of part-time or to full-time, or once per year during the County-wide insurance window.

Any nurse in a part-time status who pays for medical benefit coverage will be reimbursed in the following pay period the additional pro-rated premiums consistent with any hours worked above their code status the previous month. This shall begin with changes coinciding with the 1996 open enrollment period.

c) Split Codes

The County shall provide a minimum of fifty (50) full-time codes to be filled on a half-time basis at any one time. The location and choice of these codes will be determined on a departmental basis. Requests for split codes shall not unreasonably be denied. Reasonable denial shall include, but not be limited to, demonstration that the work is not divisible, demonstration that qualified partners, if needed, are not available, or that the fifty (50) available codes are filled. Nurses shall make a written request for a split code to their immediate supervisor. If the request is denied, it shall be reviewed by their Department Head and they shall receive a written response.

Section 7.5 - Work Out of Classification

a) Pay

Work out of classification assignments shall only be made if such assignment is 15 consecutive calendar days or more. When a nurse is temporarily assigned work out of classification to a vacant position or a position where the incumbent is unavailable for work due to an authorized leave, the nurse will receive pay consistent with the promotional pay procedure as set forth in Article 7.3. When such payment for higher level duties is appropriate under these terms and conditions, it will commence on the first day of the assignment and continue throughout the duration thereof. Any nurse assigned work out of classification must meet the minimum qualifications of the classification to which the nurse is assigned. The Association will be notified in writing of any work out of classification pay which continues beyond three (3) months.

Work out of classification to vacancies within the bargaining unit shall be posted within the unit for a period of five days. In order to be considered, nurses expressing interest in such assignment shall notify his/her Nurse Manager in writing. No nurse shall be assigned work out of classification in a vacancy within the bargaining unit for more than twelve (12) consecutive months per occurrence.

b) Application to Holiday and Sick Leave

Upon eligibility for pay in accordance with Section 7.5(a), a nurse temporarily assigned work out of classification shall receive the pay for:

1. Holidays when the nurse is assigned work out of classification the day prior to and following the holiday.

2. Sick leave absences when the nurse is assigned work out of classification and while absent is not relieved by the incumbent or by another nurse assigned work out of classification in the same position.

c) Vacant Regular Codes

Work out of classification may be assigned to cover vacant regular codes after ordinance code provisions for filling such vacancies have been followed and with approval of the Director of Personnel. The appointing authority shall consider appointment of nurses under work out of classification provision before making a provisional appointment.

Section 7.6 - Paychecks

a) Night Employees

The County agrees to provide paychecks for night nurses by 12:01 a.m. on payday.

b) Shortage Errors

Cash advance by the Controller's Department to cover a shortage error in a nurse's paycheck shall be provided to the nurse within one (1) working day after written notification of discrepancy by the department to Finance. The department will notify Finance within one (1) working day after verification of the shortage. This provision is to cover only those discrepancies above a net one hundred dollars ($100.00).

Shortage errors of less than a net one hundred dollars ($100.00) shall be adjusted within two (2) pay periods of when the department learns of the error.

c) Overpayment Errors

When a net twenty-five dollar ($25.00) or more overpayment error occurs, the nurse will repay the overpayment in the same amount and within the same number of pay periods in which the error occurred. In cases that necessitate pay back of overpayments totaling more than $200.00, the County shall notify the Association prior to implementing repayment action.

Section 7.7 - Automatic Check Deposit

All nurses hired after the effective date of this Agreement shall be paid by automatic check deposit. By March 1, 2008 all nurses hired prior to the effective date of this Agreement shall be paid by automatic check deposit unless the nurse certifies he/she does not have a bank account.

ARTICLE 8 - HOURS OF WORK, OVERTIME, PREMIUM PAY

Section 8.1 - Hours of Work

Eight (8) hours work shall constitute a full day's work and forty (40) hours work shall constitute a full week's work unless otherwise provided by law, code or other agreement. Nurses assigned to an eight (8) hour shift which is shortened to seven (7) hours due to daylight savings time shall be paid for eight (8) hours, and nurses assigned to an eight (8) hour shift which is lengthened to nine (9) hours due to daylight savings time, shall be paid overtime one (1) hour as defined in Section 8.2(b).

Section 8.2 - Overtime Work

a) Overtime Defined

1. Exempt Nurses

Overtime is defined as time worked beyond eighty (80) hours on a bi-weekly pay period, or beyond eight (8) hours in any work day except as mutually agreed upon between the County and the Association. Time for which pay is received but not worked such as vacation, sick leave, and authorized compensatory time off, will be counted towards the base period. The County Executive shall determine by administrative order those classes and positions which shall be eligible for overtime work and for cash payment.

2. Non-exempt Nurses

For non-exempt nurses all provisions regarding overtime shall be as set by the Fair Labor Standards Act. All disputes regarding that Act shall be within the sole jurisdiction of the U.S. Department of Labor and shall not be subject to grievance or arbitration under this contract. At least five (5) working days prior to filing any complaint regarding the Act with the U.S. Department of Labor, the Association shall give the County written notice. Such notice shall contain specific information so that the County can prepare a response.

b) Rate of Pay

When overtime work is assigned and is authorized by the appointing authority to be worked, compensation for such time worked shall be time off with pay computed as noted in 1. and 2. below, except that such overtime work shall be paid in cash for nurses where required by State or Federal law or when specifically authorized by administrative order of the County Executive.

1. Regular Overtime - one and one-half (1 1/2) hours for every hour of overtime worked.

2. Continuous Shift - one and one-half (1 1/2) hours for the first four (4) hours of overtime contiguous to their regular shift of a minimum of eight (8) hours and two (2) hours for any additional hours worked.

All compensatory time off must be taken within twelve (12) months of the date the overtime was worked, and failure to take the compensatory time off shall be deemed a waiver of the compensatory time by the nurse. In the event the appointing authority does not provide compensatory time off during the mandatory time period, the nurse may take compensatory time off as a matter of right immediately before the end of the pay period in which the compensatory time would be lost. Compensatory time balances shall be paid in cash on separation. A nurse may elect in advance to receive compensatory time-off credit in lieu of cash compensation for overtime where compensatory time off is allowed, if the appointing authority agrees.

c) Distribution of Overtime

In situations where the need for overtime work exists, coded nurses in the applicable work unit shall first be offered the overtime work. Overtime work shall be distributed among nurses in the applicable work unit as equally as practicable.

Section 8.3 - Meal Periods

a) Length

Nurses shall be granted a meal period not less than thirty (30) minutes nor more than one (1) hour, scheduled at approximately the mid-point of the work day. Nurses required to be at work stations for eight (8) or more consecutive work hours shall have their meal during work hours.

b) Overtime Meals

If a nurse is assigned two (2) or more hours of overtime work contiguous to the nurse's regular work shift or is called in within three (3) hours of the nurse's scheduled quitting time and then works two (2) or more hours of overtime work, the County will reimburse the cost of the meal actually purchased and consumed by the nurse on the nurse's own time to a maximum amount of nine dollars ($9.00). Nurses shall be provided additional meals as above for every seven (7) hour period of overtime completed thereafter. Nurses must present their claim for the reimbursement within fourteen (14) calendar days following the shift it was earned or the meal reimbursement is waived.

c) County Facilities

Whenever the duties or responsibilities of any County nurse require the nurse to be present and on duty during the serving of meals in a County facility and where such duty or responsibility occupies that nurse's meal period, such individual shall be entitled to that meal without charge.

d) Meal Rates

In each County dining facility where meals are served to nurses at the nurse's expense, the Department Head in charge of the operation of that facility shall prescribe the rates to be charged. The rates so prescribed shall, as a minimum, be sufficient to defray the costs of the food served.

Section 8.4 - Rest Periods

All nurses shall be granted and take a rest period of fifteen (15) minutes during each half shift of four (4) hours of work. Rest periods shall be considered as time worked for pay purposes. Should an individual nurse anticipate not being able to take his/her rest period due to patient care needs, he/she shall promptly notify his/her charge nurse or supervisor, or if unable to directly notify the charge nurse or supervisor, the nurse shall inform the relief nurse, in which case every effort shall be made to ensure the nurse is offered an alternate rest period during his/her shift. Any alternate rest period offered shall be considered a rest period and not a meal period.

If a nurse is not offered a rest period, the missed break shall be reported utilizing the Notice of Staffing Level Concerns form and process as listed in Section 18.10(d),(e), and (f).

Section 8.5 - Clean-Up Time

All nurses whose work causes their person or clothing to become soiled shall be provided with reasonable time and adequate facilities for wash-up purposes.

Section 8.6 - On-Call Pay

a) Definition

On-call is defined as the requirement to remain immediately available to report for duty to perform an essential service when assigned by the appointing authority, subject to approval by the County Executive. On-call duty is in addition to and distinct from the normal work week. This Section is only applicable to those situations where nurses are recalled to work when previously placed on an on-call status.

b) Classifications Eligible
Each Department Head, subject to approval by the County Executive, shall designate which class(es) of nurse(s) shall be subject to on-call duty.

c) Rates of Pay
Nurses assigned to on-call duty shall receive, in addition to their regular salary, one half (1/2) of their regular base rate of pay for each hour of assigned call duty. Nurses who are called into work while on-call will receive one and one-half (1 1/2) times their regular base rate of pay for each hour worked. Shift differentials shall be paid in accordance with Section 8.8.

d) Beepers
Beepers shall be provided to all nurses when placed on on-call status.

Section 8.7 - Call-Back Pay
If overtime work does not immediately follow or precede the regular work shift, a minimum of four (4) hours call-back time shall be credited the nurse. Call-back pay is subject to all provisions of Article 8, Section 2, Overtime Work.

The O.R. Nurse or Recovery Room Nurse may elect to receive compensatory time off credit in lieu of cash compensation for call-back time worked.

An O.R. Nurse or Recovery Room Nurse shall be granted a day charged to Paid Time Off, leave without pay, or compensatory time, on the O. R. or Recovery Room Nurse's normal work day following five (5) or more hours of call-back time.

Nurses will be credited for each call-back during a scheduled shift.

Section 8.8 – Call-In Pay
Availability does not constitute confirmation to work. Definite confirmation must be made by authorized personnel before the nurse reports to work. If staffing needs change and the nurse reports to work for a specific area, no work is available and no alternate assignment can be made, the nurse shall be reimbursed for a minimum of four (4) hours.

No work or pay is required under this provision if the employer has attempted to contact the nurse by phone (contact or attempted contact has been documented) at least one and one half (1.5) hours prior to the start of the shift to inform the nurse not to report. This provision is waived if the nurse declines an alternate assignment.

Section 8.9 - Shift Differentials

a) Definition of shifts:

1. DAY shift -- any scheduled shift of at least eight (8) hours beginning on or after 6:00 a.m. and ending on or before 6:00 p.m.

2. EVENING shift -- any scheduled shift of at least eight (8) hours beginning on or after 2:00 p.m. and ending on or before 2:00 a.m.

3. NIGHT shift -- any scheduled shift of at least eight (8) hours beginning on or after 10:00 p.m. and ending on or before 10:00 a.m.

b) Part Time/Overlapping Shifts:

1. For shifts of fewer than eight (8) hours, a differential will be paid on the hours worked only if at least half the hours fall between 5:00 p.m. and 6:00 a.m.

2. For shifts which fall across the shifts as defined above, a differential will be paid if at least half the hours fall between 5:00 p.m. and 6:00 a.m.

3. For shifts which fall across both the evening and night shifts as defined above, the differential will be paid according to which shift contains the majority of hours worked. If the split is half and half, the night shift differential will be paid.

c) Pay Rates:

1. The hourly rate for evening shift differential is $4.00.

2. The hourly rate for night shift differential is $7.25.

3. The above differentials are paid on productive hours worked only.

Section 8.10 - Split Shift Pay

A nurse who is performing services upon a split shift shall be paid an additional twelve dollars ($12.00) per day. "Split Shift" is defined as eight (8) hours of work which are not completed within any nine (9) consecutive hours in a work day.

Section 8.11 – Charge Nurse Differential

A Clinical Nurse I, II, or III, and Psychiatric Nurse I, or II who is assigned as a charge nurse shall receive an additional two dollars and seventy five cents ($2.75) per hour.

Section 8.12 – Weekend Off Provision

The County will attempt to grant every other weekend off and each nurse will not be required to work more than two (2) consecutive weekends in a row. The County guarantees that nurses will not be required to work more than twenty-six (26) weekends per year. If the County requires a nurse to work more than two (2) consecutive weekend days, or more than twenty-six (26) required above, the nurse will receive time and one-half for work in excess of that required. These penalties shall not be duplicated for the same weekend worked. Work as used in this section shall mean productive time. Weekend work required shall be prorated for newly coded nurses and for any nurse who is off the payroll due to an authorized leave of absence.

The above weekend off provisions may be waived on the written request of the individual nurse.

The weekend day a nurse is required to work must be the same day during consecutive weekends, e.g. a nurse who works the first Saturday, the second Saturday, and the third Saturday and Sunday would receive penalty pay at time and one half for the third Saturday. A nurse who works the first Saturday, the second Saturday, and the third Sunday would not receive penalty pay at time and one half for the third Sunday.

A nurse must pick up at least half of a scheduled shift on each weekend day worked to be eligible for penalty pay, e.g. a nurse working an eight hour shift who works the first Saturday for three hours, the second Saturday for eight hours, and the third Saturday for eight hours would not receive penalty pay at time and one half for the third Saturday. A nurse working an eight hour shift who works the first Saturday for four hours, the second Saturday for eight hours, and the third Saturday for eight hours would receive penalty pay at time and one half for eight hours the third Saturday. A nurse working an eight hour shift who works the first Saturday for eight hours, the second Saturday for three hours, and the third Saturday for eight hours would not receive penalty pay at time and one half for the third Saturday. A nurse working an eight hour shift who works the first Saturday for eight hours, the second Saturday for four hours, and the third Saturday for eight hours would receive penalty pay at time and one half for eight hours the third Saturday.

The examples listed are not exhaustive.

Section 8.13 – Weekend Shift Differential

A weekend differential of two dollars ($2.00) per hour will be paid to Registered Nurses for productive time worked on a Saturday and/or Sunday. For the Night Shift only, the weekend will begin at the start of the RN's regularly scheduled Saturday shift (i.e., 11:00 p.m. on Friday) and terminate at the end of his/her regularly scheduled shift on Sunday (i.e., 7:30 a.m. on Sunday).

This differential shall not be pyramided with other penalty premiums or paid on overtime shifts. The value of the weekend differential does not increase regardless of hours worked or rates of pay, etc.

Section 8.14 – Float Differential

The order of float shall be as follows:

a) Volunteers;
b) Extra help and per diem;
c) Coded nurses:
    1. All coded nurses working overtime will float prior to regularly scheduled coded unit nurses;
    2. All coded nurses working over-code will float prior to regularly scheduled coded unit nurses.

Each nurse will only float within areas as follows:

1. Medical-Surgical Units (3 Surgical, 4 Surgical, 4 Medical)
   Admission, Discharge, Transfer (ADT) Nurse

2. Neonatal ICU
   Pediatrics
   Pediatric Intensive Care Unit

3. Adult Intensive Care Units (MICU, CCU, SICU, TICU)
   Burn Unit
   Cardiac Cath Lab
   Interventional Radiology

4. Rehabilitation Unit 1 RHB
   Rehabilitation Unit 2 RHB
   Rehabilitation Trauma Unit RTC2

5. Labor and Delivery

6. Mother Infant Care Center (MICC)

7. Operating Room

8. Post Anesthesia Care Unit (PACU)
   Ambulatory Surgery Unit (ASU)

9. Transitional Care Neurosurgery Unit
   Medical Short Stay Unit

10. Drug and Alcohol

11. Psychiatric Inpatient
    Emergency Psychiatric Service

12. Custody Health Services

13. Ambulatory Care Clinics

14. Emergency Department
    (not to float except in emergency)

15. Renal Care Center/ Renal Dialysis Unit

16. Resource Nurse

17. Endoscopy

b) If a float assignment outside like areas is necessary, Management shall attempt to send volunteers from the unit to be floated from prior to making an involuntary assignment. If a coded nurse is required to float outside of one of the like areas, the nurse shall receive one dollar ($1.00) per hour for such assignment. A nurse who requests to float in order to broaden the nurse's experience may put the nurse's name on a list, maintained in the Nursing Office, indicating where the nurse requests to float. In this case, a differential shall not be paid.

Except in emergencies (emergency is defined as a situation when reasonable efforts to float from like areas fails), no nurse will be assigned to an area without having adequate orientation to that area. Adequate orientation will be determined by the Director of Nursing with input from the Nurse Manager, and Staff Developer.

Assignments shall include only those duties and responsibilities for which competency has been validated. A registered nurse with demonstrated competencies for the area shall be responsible for the nursing care, and shall be assigned as a resource to the

RN who has been assigned to the unlike area and who has not completed competencies for that area.

This Section will not apply when one of the units is temporarily closed.

c) The County will attempt to expand the float pool at Valley Medical Center. Coded Floats and Resource Nurses will be paid the current differential.

Section 8.15 - Temporary Work Location

When a nurse is assigned to work at a location different from the nurse's regularly assigned work location, the nurse shall be allowed to travel on County time to that work location. Time allotted for travel and mileage paid shall be based on actual miles traveled. Actual miles traveled shall be defined as all miles driven on County business. However, no mileage reimbursement shall be paid for miles traveled to the first field or work location of the day from the nurse's place of residence or from the last field or work location of the day to the nurse's place of residence, unless the miles traveled exceeds the distance normally traveled by the nurse during their normal home-to-work commute. In that case, the nurse may claim reimbursement for only the added mileage which exceeds their normal home-to-work location.

The County will either supply transportation for such travel or shall pay mileage based on the above distances. The County assumes no obligation to the nurse who for self-convenience voluntarily reports to other than the regularly assigned work location.

Section 8.16 - Bilingual Pay

On recommendation of the appointing authority and the Director of Personnel, the County may approve payments of one hundred fifty ($150.00) per month to a bilingual nurse whose abilities have been determined by the Director of Personnel as qualifying to fill positions requiring bilingual speaking and/or writing ability. Bilingual skill payments will be made when:

a) Public contact requires continual eliciting and explaining information in a language other than English; or

b) Where translation of written material in another language is a continuous assignment; or

c) The position is the only one in the work location where there is a demonstrated need for language translation in providing services to the public.

The County shall review positions covered by this Agreement not less than annually to determine the number and location of positions to be designated as requiring bilingual abilities. The County will post the names and language skills by work unit of those employees who are being paid a bilingual differential.

Differential may be removed when the criteria ceases to be met.

Section 8.17 - Hazard Duty

a) The work places covered and included in this Section are the JPD Ranches and the locked/secured sections of the following facilities:

The Main Jail
Elmwood
North County Jail
JPD Hall
Psychiatric Inpatient
Emergency Psychiatric Services

b) A premium for Hazard Duty of ninety-five cents ($.95) per hour shall be paid to coded classifications while in paid status whose entire assignment for the County is in a work place described in paragraph a). This payment shall be made irrespective of classification, pay level, overtime status, holiday work, or other wage variations. This hazard duty premium shall be included in the pay status time of the coded classifications described in this paragraph b).

c) A premium for hazard duty of ninety-five cents ($.95) per hour shall be paid to coded classifications, whose entire assignment is not in a work place described in paragraph a), for only the hours assigned and worked in a work place described in paragraph a). This payment shall be made irrespective of classification, pay level, overtime status, holiday work or other wage variations. This hazard duty premium shall not be included in the pay status time of the coded classification described in this paragraph c). A nurse must work a minimum of thirty (30) consecutive minutes per entry into a work place described in paragraph a) prior to being eligible for the hazard duty premium. Coded classifications shall receive an additional full hourly premium for time worked of more than six (6) minutes in any hour after the first hour of work.

d) The hazard duty premium shall not be allowed in computing payments at the time of termination.

Section 8.18 - Alternate Work Schedules

The only alternate shifts recognized are ten (10) and twelve (12) hour shifts. A nurse may elect to work an alternate work schedule based on eighty (80) hours per two (2) week period. Time worked in excess of eighty (80) hours bi-weekly shall be subject to overtime pay provisions of this Agreement. This schedule shall be a voluntary/optional alternative to a previous eight (8) hour per day schedule with mutual agreement of the nurse and management. A nurse working a regularly scheduled ten (10) or twelve (12) hour shift shall be compensated for each hour worked at the regular hourly base pay. Hours worked in excess of ten (10) or twelve (12) hours of a regularly scheduled ten (10) or twelve (12) hour shift, shall be subject to overtime provisions of Article 8, Section 2 (Overtime Pay).

Shift differential shall be paid for all hours worked as specified in Article 8, Section 8 (Shift Differentials).

Section 8.19 - Changes in Schedules

Except for emergencies, changes in a nurse's scheduled work unit, scheduled regular shift or scheduled regular number of hours in the work day will not be made unless the nurse is given advance notice of the change and is provided the opportunity to discuss the proposed change with the appropriate supervisor.

Section 8.20 - Additional Shift Work

Draft schedules shall be posted two weeks in advance of the posting of the final schedule. Nurses shall indicate availability for additional shift work in writing. Prior to posting of the final work schedule, nurses in part time codes will be given preference over Per Diem and Extra-Help nurses for available, additional shifts in their work unit. Additional shift work within a unit shall be distributed as equally as practicable among coded nurses in the following sequence:

a) Part time coded nurses within the work unit the additional shifts are available;
b) Part time coded nurses outside the work unit, provided such nurse can claim competency in the area the additional shifts are available.

Additional shifts do not result in overtime compensation or weekend off provision penalty pay unless pre-approved by Management.

Section 8.21 - Voluntary Reduced Work Hours Program

a) The County agrees to establish a Voluntary Reduced Work Hours Program for full-time nurses represented by the Association.

The purpose of the Program is to reduce work hours and a commensurate amount of pay on a voluntary basis.

b) Nurses may elect a two and one-half percent (2 1/2%), five percent (5%), ten percent (10%) or twenty percent (20%) reduction in pay for a commensurate amount of time off for a six (6) month period. Admission into the plan will be at six (6) month intervals.

c) All nurses in the Program will revert to their former status at the end of six (6) months. If a nurse transfers, promotes, demotes, terminates, or in any other way vacates or reduces the nurse's present code, the nurse will be removed from the Program for the balance of the six (6) month period.

d) Compensatory time shall accrue as earned and shall not be scheduled on any day considered as a County holiday. Nurses may use the reduced hours time in advance of accrual and will reimburse the County for hours taken in advance of accrual upon early termination from the Program.

e) Participation in this Program shall be by mutual agreement between the nurse and the Department/Agency Head. At no time will approval be given if it results in overtime. Restrictions by Department/ Agencies within work units shall be uniformly applied.

f) It is understood by the County that due to this Program there may be lower levels of service.

g) All nurses will be notified in writing regarding the Program specifics and the sign-up options. Such written notice to be mutually agreed upon by the parties.

h) Full and timely disclosure of actual sign-ups and any analysis developed will be made available to both the County and the Association.

i) This agreement governs as to the Voluntary Reduced Work Hours Program, but will in no way alter the meaning of the Association and County Agreements currently in effect. This will include any departmental, side letter agreements, etc.

Section 8.22 - National Certification Pay

Annual compensation of two hundred fifty dollars ($250.00) may be issued to a coded nurse who is certified or recertified in a clinical specialty. Each coded nurse may apply for National Certification Pay provided:

a) The certification is clinically relevant to the nurse's area of clinical specialty and will enhance the nurse's knowledge base and skill in providing expert patient care.
b) The certification is issued by a nationally recognized accrediting agency and applicable to current area of practice.
c) Certification that is required by the California Board of Registered Nursing (BRN) to meet certification or recertification requirements as a Certified Registered Nurse Anesthetist (CRNA) does not qualify for National Certification pay.
d) Certification that was used to meet the California Board of Registered Nursing credentialing requirements as a Nurse Practitioner or Clinical Nurse Specialist does not qualify for National Certification pay.
e) Verification of successful completion of such certification is submitted during the April submission month.

ARTICLE 9 - PAID TIME OFF

Section 9.1 - Purpose

Paid Time Off was developed to allow more flexibility in the use of nurse's time off. The following were taken into consideration in establishing the amount of time accrued each pay period:

3	Personal leave days
12	Holidays
1	Birthday
	Vacation

9.2 - Paid Time Off Accrual

a) Each nurse shall be entitled to annual Paid Time Off. Paid Time off is earned on an hourly basis. For purposes of this section, a day is defined as eight (8) work hours. Prior to February 16, 2003, the provisions of the prior contract will apply to PTO total yearly accrual, accrual factor, hourly accrual factor per pay period and maximum allowable balances.

Effective February 16, 2003, the accrual schedule shall be as follows:

SERVICE YEARS & WORK DAY EQUIVALENT	TOTAL YEARLY ACCRUAL IN WORK DAYS	ACCRUAL FACTOR PER HOUR	HOURLY ACCRUAL FACTOR PER PP	MAXIMUM ALLOWABLE BALANCE
1st year (1st through 261 days)	27	0.103846	8.307	81 work days
2nd through 4th year (262 through 1044 days)	29	0.111538	8.923	87 work days
5th through 9th year (1045 through 2349 days)	33	0.126923	10.153	99 work days
10th through 14th year (2350 through 3654 days)	35	0.134615	10.769	105 work days
15th through 19th year (3655 through 4959 days)	37	0.142307	11.384	111 work days
20th year and thereafter (4960 days and beyond)	39	0.150000	12.000	117 work days

Section 9.3 – Pre-Scheduled Usage

Paid Time Off may be used for any lawful purpose by the nurses; the time requested shall require the approval of management with due consideration of nurse convenience and administrative requirements. Requests for paid time off shall not be unreasonably denied. Approvals / denials shall be made in writing to the requesting nurse in accordance with Nursing Standards within thirty (30) days of the receipt of the request. All Paid Time Off hours must be exhausted before Leave Without Pay may be used with the exception of leaves of absence Where there are no earnings in one (1) full pay period. A nurse may be granted Leave Without Pay for less than one (1) pay Period upon the approval of the appointing authority or their designee.

Each unit shall maintain a vacation calendar effective June thirtieth (30) for the upcoming calendar year. The purpose of the calendar is to aid in vacation planning by the nurse and is not to be considered as an approval of a nurse's request. The scheduler will enter nurse's vacation requests(s) on such calendar as it is received.

Before denying a request, the employer will make all reasonable attempts to accommodate conflicts considering the utilization of over code work, scheduling extra help and per diem, and voluntary shift trades in support of vacation scheduling.

Upon request of a nurse denied vacation, management shall meet with the nurse on an individual basis no later than forty five (45) days before schedules are finalized in order to explore all reasonable options for resolving such conflicts. Requests for vacation shall be prioritized by submission date. Should two or more requests be submitted on the same date seniority, as defined in Section 5.1- Seniority Defined, will be used to resolve the conflict.

Section 9.4 - Paid Time Off Carry Over

In the event the nurse does not take all the paid time off to which he/she is entitled in the succeeding payroll year (twenty-six (26) or twenty-seven (27) pay periods), the nurse shall be allowed to carry over the unused portion, provided that the nurse may not accumulate more than three (3) years' earnings except:

a) When absent on full salary due to work-related compensation injury which prevents the nurse from reducing credits to the maximum allowable amount, or

b) In the case of inability to take paid time off because of extreme emergency, such as fire, flood or other similar

disaster, an additional accumulation may be approved by the County Executive.

Section 9.5 - Paid Time Off Pay-Off

Upon termination of employment a nurse shall be paid the monetary value of the earned Paid Time Off balance as of the actual date of termination of employment.

Section 9.6 - Nurse's Exit from Paid Time Off Program

In the event that a nurse covered by this section ceases to be covered by this section, the nurse shall revert back to Ordinance Section A25-693 "Vacations", A25-688 "Bereavement Leave", A25-694 "Sick Leave" and A25-664 "Holidays", or superseded agreement with a recognized employee organization. Any balance of paid time off shall be reconverted to vacation leave, and any paid time off accumulated over an amount allowed without reference to this section shall be credited as compensatory time off which must be used within one (1) year. Any balance in the Sick Leave Bank shall be converted to Sick Leave.

9.7 – Annual Cash Out of PTO

a) If a nurse has no more than two (2) occurrences of unscheduled absences, the nurse may cash out up to eighty hours of PTO. During the term of this agreement, a nurse may only cash out up to forty (40) hours under this subsection.

b) If the nurse has no more than four occurrences of unscheduled absences, the nurse may cash out up to forty hours of PTO.

Section 9.8 - Sick Leave Conversion to PTO

A nurse’s eligibility for sick leave conversion is determined by the number of occurrences of sick leave usage. Sick leave use attributed to Worker’s Compensation shall not be counted as an occurrence. The period for 2008 sick leave conversion eligibility begins December 17, 2007 and ends December 14, 2008. The period for 2009 sick leave conversion eligibility begins December 15, 2008, and ends December 27, 2009. The period for 2010 sick leave conversion eligibility begins December 28, 2009 and ends December 26, 2010. The conversion of sick leave to PTO will be for those nurses meeting the eligibility requirements below and upon the nurse’s request to the Health and Hospital Systems Human Resources Department. A nurse must identify any sick leave use attributed to Worker’s Compensation with the request in order for such leave to be disregarded as an occurrence. Requests for sick leave conversion for 2008 must be submitted in February 2009 and conversion to PTO shall be credited on March 9, 2009(paycheck of March 27, 2009). Requests for sick leave conversion

for 2009 must be submitted in February 2010 and conversion to PTO shall be credited on March 22, 2010 (paycheck of April 9, 2010). Requests for sick leave conversion for 2010 must be submitted in February 2011 and conversion to PTO shall be credited on March 21, 2011 (paycheck of April 8, 2011).

Sick leave may be converted annually on the following basis (prorated for nurses other than full time on the basis of code status):

a) If a nurse has no sick leave usage, seven (7) days of sick leave will be converted into PTO.

b) If a nurse has one (1) occurrence of sick leave usage, six (6) days of sick leave will be converted into PTO.

c) If a nurse has two (2) occurrences of sick leave usage, five (5) days of sick leave will be converted into PTO.

d) If a nurse has three (3) occurrences of sick leave usage, two (2) days of sick leave will be converted into PTO.

e) If a nurse has four (4) occurrences of sick leave usage, one (1) day of sick leave will be converted into PTO.

f) If a nurse has five (5) or more occurrences of sick leave usage, no sick leave shall be converted to PTO.

Section 9.9 - Usage of Paid Time Off on Holidays

a) The following shall apply to all holidays listed below:

1. Holiday falls on regularly scheduled day to work and nurse does not work -- Charge maximum eight (8) hours PTO.

2. Holiday falls on regularly scheduled day to work and nurse works -- Charge maximum eight (8) hours PTO and pay time and one-half for all hours worked.

3. Holiday falls on scheduled day off and nurse does not work -- Nothing is charged as holidays are in PTO accrual rate.

4. Holiday falls on scheduled day off and nurse works -- No charge to PTO Bank and pay time and one-half for all hours worked.

5. Half-time nurses who do not work the holiday may elect in advance to charge four (4) hours to PTO and the remainder to leave without pay.

b) The following shall be observed as legal holidays:

1. January 1st

2. Third Monday in January

3. Third Monday in February

4. March 31st

5 Last Monday in May

6. July 4th

7. First Monday in September

8. Second Monday in October

9. Veteran's Day to be observed on the date State of California workers observe the holiday

10. Fourth Thursday in November (Thanksgiving Day)

11. The Friday following Thanksgiving Day (Day After Thanksgiving)

12. December 25th

13. Other such holidays as may be designated by the Board of Supervisors.

All previous informal time off practices are eliminated and unauthorized.

c) Nurses shall enjoy the same number of holidays, regardless of variations in work weeks. For nurses who are assigned to positions which are not normally staffed on the weekends (Saturdays and Sundays, such as the clinics and Staff Development), holidays which fall on Sunday are observed on the following Monday and holidays which fall on Saturdays shall be observed on the preceding Friday. For employees who are assigned to positions which normally work on weekends (such as the Medical Units, ICU's, Institutional Units, etc.) the holiday shall be observed on the actual day listed in (b), supra.

d) The employer will use its best efforts to rotate equitably holiday time off among coded nurses for each unit for Thanksgiving, Christmas and New Year holidays.

e) A nurse may elect in advance to receive compensatory time off credit in lieu of cash compensation.

f) A nurse may elect in advance to use compensatory time off for a holiday in lieu of charging PTO.

Section 9.10 - Call Back From PTO

When a nurse is called back from PTO, which has been scheduled at least five (5) calendar days in advance of the first day of PTO, the nurse shall be paid at 1 1/2 times the nurse's base hourly rate.

Section 9.11 – PTO Illness Conversion

If a nurse on PTO becomes ill, the nurse may convert PTO to sick leave with pay. Such conversion must be supported by a statement from an accredited physician.

ARTICLE 10 - SICK LEAVE PROVISIONS

Section 10.1 - Sick Leave Bank Usage and Accrual

Each nurse shall be entitled to sick leave. Such leave may be used for personal illness or for medical consultation to preserve the nurse's health. Except for emergencies, all absences for medical consultation must be approved by the nurse's supervisor. Such leave shall be earned on an hourly basis and computed at the rate of ninety-six (96) hours per year and may be accrued without limitation. The accrual factor per hour is .045977 and the accrual factor per full pay period is 3.678.

Section 10.2 - Sick Leave Usage for Care of Immediate Family

A nurse who has acquired a sufficient right to sick leave with pay may be granted permission to use same not to exceed three (3) working days of such leave in order to care for a sick or injured member of the nurse's immediate family requiring care. "Immediate family" shall mean the mother, father, grandmother, grandfather of the nurse or of the spouse of the nurse and the spouse, son, son-in-law, daughter, daughter-in-law, brother, sister, grandchild, brother-in-law or sister-in-law of the nurse or any person living in the immediate household of the nurse.

Section 10.3 - Doctor's Notes

Request for sick leave with pay in excess of three (3) working days must be supported by a statement from a licensed medical practitioner who is eligible for third party reimbursement. Management may require such a supporting statement for absences of less than three (3) days when there is reasonable cause.

Section 10.4 - Bereavement Leave

Leaves of absence with pay shall be granted nurses in order that they may discharge the customary obligations arising from the death of a member of their immediate family. "Immediate family" shall mean the mother, father, grandmother, grandfather of the nurse or of the spouse of the nurse and the spouse, son, son-in-law, daughter, daughter-in-law, brother, sister, grandchild, brother-in-law, sister-in-law, registered domestic partner or step-parent of the nurse or any person living in the immediate household of the nurse. Up to forty (40) hours pay shall be granted which will consist of sixteen (16) hours not charged to any accumulated balance followed by twenty-four (24) hours chargeable to sick leave, if necessary. An additional twenty-four (24) hours, sixteen (16) chargeable to sick leave and eight (8) not charged to any accumulated balance, is authorized if out-of-state travel is required.

Section 10.5 - Sick Leave Bank Pay Off

For purposes of this paragraph, a day is defined as eight (8) work hours.

Upon death or retirement, up to sixty (60) days of accrued sick leave shall be paid off at a rate of fifty percent (50%) of the equivalent cash value. All accrued balances beyond sixty (60) days shall be paid off at the rate of twelve and one-half percent (12 1/2%) of the accrued cash value (one hour's pay for one day of accrual).

Upon resignation in good standing, nurses with ten (10) or more years' service shall be paid up to sixty (60) days of accrued sick leave at the rate of twenty-five percent (25%) of the equivalent cash value. All accrued balances beyond sixty (60) days will be paid off at the rate of twelve and one-half percent (12 1/2%) of the accrued cash value.

Section 10.6 - Reinstatement Pay Back

Nurses receiving a sick leave bank payoff in accordance with Section 10.5 may, if reinstated within one (1) year, repay the full amount of sick leave bank payoff received and have the former sick leave bank balance restored. Repayment in full must be made prior to reinstatement.

Section 10.7 - Sick Leave Conversion

A portion of unused sick leave may be converted to PTO in accordance with Section 9.8.

ARTICLE 11 - LEAVE PROVISIONS

Section 11.1 - Leave Without Pay

a) Reasons Granted

Leaves of absence without pay may be granted to nurses for up to one (1) year. Extensions to leaves approved for less than one (1) year shall not unreasonably be denied provided adequate advance notice is given. If a nurse wishes to return to work early from a leave of absence, the nurse shall provide reasonable advance notice to the appointing authority. Leaves beyond one (l) year may be granted due to unusual or special circumstances. The following are approved reasons for such leaves:

1. Illness beyond that covered by sick leave.

2. Education or training which will benefit the County, including advancement in nursing.

3. Other personal reasons which do not cause inconvenience on the department.

4. To accept other government agency employment.

5. Paternity leave, not to exceed six (6) months.

b) Leave for Association Business

Upon thirty (30) days' advance notice, a long term leave without pay to accept employment with the Association shall be granted by the appointing authority for a period of up to one (l) year. No more than three (3) nurses shall be granted a leave at any one time. A leave may only be denied if:

1. The notice requirement is not met.

2. The number of nurses on leave has reached the maximum of three (3).

3. The nurse has specialized skills and abilities which are necessary and could not be replaced.

With notice no less than thirty (30) days prior to the conclusion of the leave, such leave may be extended up to one (l) year upon approval of the appointing authority.

c) Revocation

A leave may be revoked by the Director of Personnel upon evidence that the cause for granting it was misrepresented or has ceased to exist.

d) Seniority Rights

Maternity leaves of more than thirteen (13) pay periods; leaves of absence of more than two (2) pay periods; and suspensions shall not be counted as time spent in a salary step in computing eligibility of the nurse for further salary increases. All time spent on industrial injury leave shall be counted.

Section 11.2 - Family Leave

a) Maternity and Adoptive Leave

1. Length

Upon request, maternity leave without pay shall be granted to natural or adoptive parents by the appointing authority for a period of up to six (6) months. With notice no less than one (1) month prior to the conclusion of the leave, such leave may be extended up to one (1) year upon approval of the appointing authority. A request for extension can only be denied for good cause. A nurse who is pregnant may continue to work as long as her physician approves with concurrence from the Department.

2. Sick Leave Use

If, during the pregnancy leave or following the birth of a child, the nurse's physician certifies that she is unable to perform the duties of her job, she may use her PTO or accumulated sick leave during the period certified by the physician. The authorized PTO or sick leave shall be charged either prior to or at the termination of the leave.

b) Paternity Leave

Upon request, paternity leave without pay shall be granted to natural or adoptive parents not to exceed six (6) months. All provisions of Section 11.1 shall apply to this paternity leave provision.

c) Other Family Leave

Upon request, family leave shall be granted for the placement of a foster child, or to attend to the serious illness of a family member in accordance with the Family and Medical Leave Act, and for the serious illness of a same sex domestic partner, for a period of up to six (6) months.

Section 11.3 - Leaves to Perform Jury Duty or to Respond to a Subpoena

a) Response to Summons

A nurse shall be allowed to take leave from the nurse's County duties without loss of wages, PTO, sick leave or nurse benefits for the purpose of responding to summons to jury selection or serving on a jury for which the nurse has been selected, subject to the limitation that a nurse shall receive paid leave to serve on a jury for which the nurse has been selected not more than once during a calendar year and provided that the nurse executes a written waiver of all compensation other than the mileage allowance, for which the nurse would otherwise receive compensation by virtue of the nurse's performance of such jury duty. No nurse shall be paid more than the nurse's regular shift pay or regular work week pay as a result of jury duty service. The nurse is required to notify the nurse's appointing authority when the nurse has received a jury summons and when the nurse's jury service is completed.

b) Jury Duty

Nothing in this Section shall prevent any County nurse from serving on a jury more than once per calendar year, provided, however, that such additional periods of absence from regular County duties as a result thereof shall be charged, at the option of such nurse, to either accrued Paid Time Off (PTO) or leave without pay.

c) Response to a Subpoena

No nurse shall suffer loss of wages or benefits in responding to a subpoena to testify in court if that nurse is not a party to the litigation.

d) Release Time

In the event a nurse is called to court under the above provision, the following shall apply:

1. Swing or PM shift shall have release time the day of court attendance; time spent in court shall be deducted from the regular shift on that day with no loss of wages or benefits.

2. Night or graveyard shift shall have release time on the shift prior to court attendance; and that nurse shall suffer no loss of wages or benefits.

3. When a nurse, whose regularly scheduled hours includes two (2) full shifts (16 hours) of scheduled duty between 11:00 p.m., Friday to 3:00 a.m., Monday, is selected for a jury

and is required to be in Court during his/her regular days off, the department will make every effort to provide the following Saturday or Sunday as a regularly scheduled day off. The weekend cannot count as a weekend worked for weekend off provisions.

e) Return to Work

For the purpose of this Section, a nurse who responds to a summons to jury duty and who is not selected as a juror shall not be deemed to have performed jury duty and shall return to work as soon as possible.

Section 11.4 - Compulsory Leave

a) Fitness for Duty Examination

If any non-probationary nurse is required by the appointing authority to take a fitness for duty examination not connected with preexisting or existing industrial injury to determine if the nurse is incapacitated for work, the following provisions will apply and will be given to the nurse in writing:

1. Before making a decision, the physician designated by the appointing authority will consult with the nurse's personal physician and will advise the nurse of this procedure.

2. If the nurse's personal physician agrees with the decision of the physician designated by the appointing authority, the decision is final.

3. If the physicians disagree, and the nurse so requests, they will select a third physician whose determination will be final. Cost for such examination by the selected physician will be equally shared by the nurse and the appointing authority.

b) Court Related

The appointing authority may require a nurse who has been formally charged in a court of competent jurisdiction with the commission of any felony or of a misdemeanor involving moral turpitude, provided said crime is related to the nurse's employment status, to take a compulsory leave of absence without pay pending determination by way of a plea, finding or verdict at the trial court level as to the guilt or innocence of such nurse.

1. Determination of Innocence

If there is a determination of innocence or the charges are dropped, the nurse shall be reinstated to the nurse's position with return of all benefits, including salary,

that were due for the period of compulsory leave if the nurse was available for work during this period. Despite reinstatement, the nurse remains subject to appropriate disciplinary action if warranted under the circumstances. Any such disciplinary action may be imposed effective as of the commencement date of the compulsory leave imposed under this Section.

2. Determination of Guilt

If there is a determination of guilt, the appointing authority may take appropriate disciplinary action. If the action is a suspension and the suspension is for a shorter duration than the compulsory leave, the nurse shall receive the difference between the compulsory leave and the suspension in salary and all benefits.

Section 11.5 - Military Leave

a) Governing Provision

The provisions of the Military and Veterans Code of the State of California and the County ordinance code shall govern the military leave of nurses of the County of Santa Clara.

b) Physical Examination

Any regular or provisional nurse shall be allowed time off with no loss in pay for the time required to receive a physical examination or re-examination as ordered by provisions of a national conscription act or by any branch of the National or State military services.

Section 11.6 - Educational Leave for Registered Nurses

a) Each July 1 a credit of forty (40) hours per year shall be granted for educational leave for all full-time nurses. Educational leave will be accumulative to a maximum of eighty (80) hours. Educational leave for part-time nurses will be prorated. There shall be a three (3) month waiting period for all nurses hired after the execution of this contract. However, each nurse who uses any time earned between three (3) and six (6) months must sign a note which states that the nurse will authorize a deduction from the nurse's last paycheck for the time used if the nurse leaves County employment within one (1) year of the date of hire.

b) The individual nurse shall decide the educational program in which they shall participate. It is understood that all use of educational leave shall be principally related to nursing practices within the County.

c) Details in the written application for educational leave shall include but not be limited to the course, institute, workshops, classes, or homestudy subjects, hours, faculty and purpose of taking the course, seminar, etc. The application shall be received by the Administration no less than ten (10) working days prior to the requested date of leave of absence. At least five (5) working days prior to the commencement of the leave of absence date, the Administration shall respond in writing to the nurse. When notification of a course is received less than ten (10) working days prior to the course date, Administration may consider approval.

d) In all instances set forth above, the leave request shall be subject to approval by the Department. Such leaves shall not unduly interfere with staffing requirements for patients' care or duplicate comparable training offered by the Department. The Department agrees that it shall not unreasonably withhold approval.

e) Proof of attendance may be requested by the Department. The nurse may be requested by the Department to report such activity in writing.

f) Every effort shall be made to arrange scheduling for the individual nurse's use of educational leave time.

g) If the educational leave falls on the nurse's day off, the nurse shall select one of the following:

1. The day will be charged to educational leave and the nurse will have a day added to the nurse's Paid Time Off balance, or

2. The day will be charged to educational leave and the nurse will be given another day off during the pay period, or

3. The day will not be charged to educational leave.

4. Educational leave granted for homestudy courses shall not be counted toward the base period in calculation of overtime.

h) Participation in the Registered Nurses Unit educational leave program shall not alter the RN's right to benefits included in the Professional Development Fund Section of this Agreement.

i) The County shall provide three (3) courses approved by the Board of Registered Nursing for continuing educational credit,

provided qualified instructors are available and interested. The County is under no obligation to hire additional instructors.

j) Educational leave for homestudy courses will be paid at the rate of one (1) hour for each contact hour completed. A copy of the certificate verifying successful completion is required for educational leave to be paid.

ARTICLE 12 - PROFESSIONAL DEVELOPMENT AND TUITION REIMBURSEMENT

Section 12.1 - Professional Development Fund

a) General

1. The County will fund, on a matching basis, up to eighty thousand dollars ($80,000) per fiscal year for group and individual professional development, California Board of Registered Nursing (BRN) Registered Nurse licensure, certification and recertification in a nursing specialty, and for education, as described in sections "b" and "c". An additional amount of fifteen thousand dollars ($15,000) per fiscal year shall be funded for the use by nurses in the classifications of Nurse Practitioner and Clinical Nurse Specialist for individual claims that are beyond the $300 annual matching limits. Funds not used for any period shall be carried over for use in the next period.

b) Individual

1. Funded on a matching basis: fifty percent (50%) by the nurse and fifty percent (50%) by the County, up to a maximum County contribution of three hundred dollars ($300) for nurses in the classifications of Clinical Nurse I, II, & III, Psychiatric Nurse I & II, Nurse Coordinator, Staff Developer, Infection Control Nurse, Assistant Nurse Manager, and Certified Registered Nurse Anesthetist per fiscal year. For nurses in the classifications of Nurse Practitioner and Clinical Nurse Specialist the matching cap is eight hundred dollars ($800) per fiscal year.

2. The requested expenditure must relate to the nurse's job or one to which the nurse could reasonably aspire within County service.

3. Requests will be processed on a "first come, first served" basis, but priority will be given to first requests by an individual for the current year.

4. At least five (5) working days must be allowed for prior approval in the amount of the estimated County contributions for authorized expenses other than licensure reimbursement.

5. Allowable expenses shall include but not be limited to: certifications and recertifications in a nursing specialty; conference and seminar registration fees; actual cost of California BRN Registered Nurse licensure fees; tuition not reimbursed under the tuition reimbursement program; books

and materials required for a conference, seminar or course; expenses for travel out of the county to attend a conference, seminar or course, including transportation, meals, lodging, car rental, etc., per County reimbursement policy, procedures and schedules.

6. An itemized statement of expenses for programs shall be submitted by the nurse for reimbursement or accounting as the case may be.

7. All nurses whose BRN licenses expire during the term of the agreement must present a receipt or other proof of payment and/or the renewed BRN license within sixty (60) calendar days after expiration of the BRN license in order to receive reimbursement. Requests must be submitted on a form provided by the County.

8. Substitute courses may be approved when approved courses are found to be unavailable.

c) Group

1. Funded on a matching basis: twenty-five percent (25%) by the participating nurses and/or the Association, and seventy-five percent (75%) by the County.

2. The Association will plan and budget group programs for review and approval by the County/Association Committee. Each proposed program will be considered separately on its own merits.

3. The Association will administer the approved programs, making all the necessary arrangements, etc.

d) Quarterly Financial Statement

A quarterly financial statement shall be forwarded to the Association on the status of the fund no later than two (2) weeks after the end of each quarter.

Section 12.2 - Tuition Reimbursement

a) Fund

The County shall maintain a tuition reimbursement program for the term of this Agreement. The total monies in this program will be administered at the County level. The fund will consist of two hundred thousand dollars ($200,000) per fiscal year. Effective July 1, 2008, the fund will increase to three hundred thousand ($300,000) per fiscal year. One quarter (1/4) of each year's fund will be available on the following quarterly dates:

Fiscal Year 14-15
2nd quarter - October 1, 2014
3rd quarter - January 1, 2015
4th quarter - April 1, 2015

Fiscal Year 15-16
1st quarter - July 1, 2015
2nd quarter - October 1, 2015
3rd quarter - January 1, 2016
4th quarter - April 1, 2016

Fiscal Year 16-17
1st quarter - July 1, 2016
2nd quarter - October 1, 2016
3rd quarter - January 1, 2017
4th quarter - April 1, 2017

Fiscal Year 17-18
1st quarter - July 1, 2017
2nd quarter - October 1, 2017
3rd quarter - January 1, 2018
4th quarter - April 1, 2018

Fiscal Year 18-19
1st quarter - July 1, 2018
2nd quarter - October 1, 2018
3rd quarter - January 1, 2019
4th quarter - April 1, 2019

Fiscal Year 19-20
1st quarter - July 1, 2019
2nd quarter - October 1, 2019

Funds not used for any period shall be carried over for use in the next period. Funds shall be encumbered to fifteen percent (15%) above the amount allotted for each funding period for the first one and one half fiscal years including any unused amount carried over from the prior funding period. This additional amount for encumbrance for the last one half fiscal year of this Agreement may be decreased based on the actual usage pattern. No amount may be approved or expended beyond funds available for the term of the Agreement.

b) Eligibility
Nurses are eligible to participate in the program provided:

1. The nurse is not receiving reimbursement from any other government agency or private source. (This applies to reimbursement only.)

2. The training undertaken is related to the nurse's occupational area or has demonstrated value to the County.

3. The application was filed with the appointing authority or their designee prior to the commencement of the course. Applications requiring time off must be filed with the appointing authority at least ten (10) days prior to the commencement of the course.

4. Substitute courses may be approved when approved courses are found to be unavailable.

5. There are sufficient funds available in the program.

c) Disapproval

Management may disapprove an application for tuition reimbursement provided:

1. Notice of disapproval is given to the nurse within ten (10) working days of the application.

2. The County alleges disapproval is necessary because any of the provisions above have not been met. When a nurse disagrees with the disapproval and files a grievance, they shall be allowed to continue the course with time off as provided for in this Section, except for denial based on paragraph b(5) above. If a final determination is made against the nurse, time off shall be made up by working, charging Paid Time Off (PTO) or comp time, or payroll deduction, and tuition reimbursement shall not be paid. If a final determination is made supporting the nurse, they shall be fully reimbursed in accordance with this Section.

d) Reimbursement

Total reimbursement for each nurse participating in the program will not exceed nine hundred dollars ($900.00) per fiscal year. Mileage and subsistence will not be authorized unless the training is required of the nurse. Within the above limit, nurses shall receive full immediate reimbursement for tuition, including approved home study courses and other required costs (including textbooks) upon presentation of a receipt showing such payment has been made.

e) Deduction Authorization

The nurse shall sign a note which states that, upon receipt of reimbursement, they authorize:

1. Deduction from their wages in the event they do not receive a passing grade of C or better.

2. Deduction of fifty percent (50%) of the amount of reimbursement if they leave County employment within one (1) year after satisfactory completion of the course.

3. Deduction of the full amount of reimbursement if they leave County employment before completion of the course.

4. Any monies deducted from nurses under this Section will be redeposited into the Tuition Reimbursement Fund.

f) Make-Up Time

Nurses taking a course only available during working hours must make up fifty percent (50%) of the time away from the job. Make-up time may be deducted from the nurse's accrued educational leave, Paid Time Off (PTO) or compensatory time balance. Make-up time will not be allowed when it results in the payment of overtime. The department will make every effort to allow the nurse time off except where the payment of overtime will result. A nurse and the appropriate level of management may mutually rearrange the duty shift beyond eight (8) hours but within the eighty (80) hour pay period for purposes of participating in non-duty education and/or training deemed by the County to be to the benefit of the nurse and the County and such arrangement will be considered a waiver of Section 8.2.

g) Quarterly Financial Statement

A quarterly financial statement shall be forwarded to the Association on the status of the fund no later than two (2) weeks after the end of each period.

ARTICLE 13 - BENEFIT PROGRAMS

Section 13.1 - Workers' Compensation

a) Eligibility

Every nurse shall be entitled to industrial injury leave when the nurse is unable to perform services because of any injury as defined in the Workers' Compensation Act.

b) Compensation

A nurse who is disabled as a result of an industrial injury shall be placed on leave, using as much of the nurse's accumulated compensable overtime, accrued sick leave, and PTO time as when added to any disability indemnity payable under the Workers' Compensation Act will result in a payment to the nurse of not more than the nurse's full salary unless at the time of the filing of the Supervisor's Report of Injury the nurse indicates on the form provided by the supervisor that he/she does not want such integration of payments to take place. This choice shall be binding for the entire period of each disability unless the employee later requests in writing that the Workers' Compensation Division begin integration. In such case, integration shall be implemented at the beginning of the next pay period.

If integration occurs, the first three (3) days are to be charged to the nurse's accrued but unused sick leave. If the temporary disability period exceeds fourteen (14) calendar days, temporary disability will be paid for the first three (3) days.

c) Industrially Injured Workers - Temporary Modified Work Program

The County has established a program to return workers with temporary disabling occupational injuries or illnesses to modified duty within the County as soon as medically practical. Pursuant to the program, the County will make every reasonable effort to provide meaningful work assignments to all such workers capable of performing modified work. The maximum length of such work program shall not exceed twelve (12) weeks. With the approval of the Worker’s Compensation Division, a temporary modified work assignment may be extended to no more than 16 weeks.

There are three kinds of "Temporary Modified Work" shown in order of preference:

1. Return to the worker's same job with some duties restricted.

2. Return to the same job, but for fewer hours per day or fewer hours per week. To be used if an injured worker cannot return on a full time basis.

3. Return temporarily to a different job. This is the least desirable and will only be attempted if the regular job cannot be reasonably modified to meet the injured worker's medical limitations.

d) Clothing Claims

Loss of, or damage to, a nurse's clothing resulting from an industrial injury which requires medical treatment will be replaced by the County through the following:

The Department will review and make a determination on all such incidents as submitted in writing by the nurse. Reimbursement will be limited to the lesser of:

1. Seventy-five percent (75%) of proven replacement cost, or

2. The repair cost.

However, both of the above are limited by a fifty dollar ($50.00) maximum. (Nothing in this Section is intended to replace or supersede Article 13.2 which provides for replacement of items damaged, lost or destroyed in the line of duty.)

e) Tracking of High Incidents of Industrial Injury

The County shall design and initiate a study/analysis of on-the-job injury/illness incidents to identify whether there are areas of unusually high injury and/or illness. The County may submit the report to the County-wide Safety Committee. The parties agree to review and determine what course of action, if any, may be required based on the findings.

Section 13.2 - Repair/Replace Claims

County shall provide the necessary protective clothing to nurses and classifications pursuant to such requests by the nurses affected as provided by law under Cal-OSHA, Title 8, Article 10. The County shall pay the cost of repairing or replacing the uniforms, clothing and equipment of County nurses which have been damaged, lost or destroyed in the line of duty when the following conditions exist:

a) The clothing, uniform or equipment is specifically required by the department or necessary to the nurses to perform the nurse's duty; and not adaptable for continued wear to the extent that they may be said to replace the nurse's regular clothing; or

b) The clothing, uniform or equipment has been damaged or destroyed in the course of making an arrest, or in the issuance of a citation, or in the legal restraint of persons being placed in custody or already in custody, or in the service of legal documents as part of the nurse's duties or in the saving of a human life; and

c) The nurse has not, through negligence or willful misconduct, contributed to such damage or destruction of said property.

Claims for reimbursement shall be reviewed and approved by the Department in accordance with procedures set forth by the County Executive.

Section 13.3 - Insurance Premiums

a) The HMO plan design will be $10 co-payments for office visits, $35 co-payment for emergency room visits, $5-$10 co-payment for prescriptions (30-day supply) and $10-$20 co-payment for prescriptions (100-day supply) and $100 copayment for hospital admission; the Point of Service plan design will be $15/$20/30% (Tier 1/2/3) for office visits, $50/$75/30% co-payment for emergency room visits, and $5/$15/$30 (generic/brand/formulary) co-payment for prescription (30-day supply) and $10/$30/$60 co-payment for prescription (90-day supply).

Hearing aid coverage, up to $1000 for 1 to 2 devices every 36 months, will be counted in all health plans.

Effective November 10, 2014 the County and employees will share in the cost of medical plan premiums. The County, in order to provide one health plan where there is not premium sharing, will continue to offer Valley Health Plan without premium sharing. For all other plans, the County will pay the cost of any premiums for "employee only" and "employee plus dependent" tiers that is not covered by the employee's share of the premium. The employee share shall be 2% of premium in effect as of November 10, 2014, converted to a flat rate.

Effective November-07-2016, and each November thereafter, for those plans and tiers where the employee pays a portion of the premium, the dollar amount of the then current employee contribution shall constitute the base onto which an additional amount equal to 10% of the increase in medical plan premiums rate for the plan year, if any, will be added to form the new total employee contribution. The County share of the premiums will decrease accordingly.

During the term of the agreement the employee contribution shall be capped at an amount equal to 10% of the increase. Employees shall not pay a higher share of the increase in medical plan premium rate than other bargaining units during the term of the agreement. Should a bargaining unit negotiate a lower term on a year for year basis during the term of this agreement, the share paid by RNPA members shall be adjusted accordingly.

Dual Coverage

Effective November 1, 1999, married couples and same sex domestic partners who are both County employees shall be eligible for coverage under one medical plan only with the County paying the full premium for dependent coverage. Married couples and registered domestic partners who had one dependent coverage and one single coverage will have the single coverage dropped effective November 1, 1999. If both employees have single coverage, one will be converted to dependent coverage. County employee couples are not eligible to participate in the Health Plan Bonus Waiver Program.

High Deductible Health Plan (HDHP)

The parties agree to investigate the feasibility of adding by mutual agreement a High Deductible Health Plan (HDHP) with or without Health Savings Account (HSA) or Health Reimbursement Account (HRA) as an option to current health plans.

Medical Premiums during Medical, Family, Maternity or Industrial Injury Leave of Absence

The County shall pay the nurse's premium subject to applicable co-payments in this Section as follows:

1. While on medical, maternity or industrial injury leave of absence without pay, up to thirteen (13) pay periods of employee only coverage. A portion of the leave may include dependent coverage in accordance with the Family and Medical Leave Act, The California Family Rights Act and the County's Family and Medical Leave Policy.

2. For a nurse on family leave without pay, in accordance with the County's Family and Medical Leave Policy, up to twelve (12) weeks of dependent coverage.

Registered Domestic Partners

a) County employees who have filed a Declaration of Registered Domestic Partnership in accordance with the provisions of

Family Code 297-297.5 shall have the same rights, and shall be subject to the same responsibilities and obligations as are granted to and imposed upon spouses. The term "spouse" in this contract shall apply to Registered Domestic Partners.

b) Tax Liability
Employees are solely responsible for paying any tax liability resulting from benefits provided as a result of their Domestic Partnership.

b) Dental Insurance
The County agrees to contribute the amount of the current monthly insurance premium to cover the nurse and full dependent contribution and to pick up inflationary costs during the term of this Agreement. The existing Delta Dental Plan coverage will be continued in accordance with the following schedule:

Basic and Prosthodontics:	75-25 - no deductible. $2,000 maximum per patient per calendar year.
Orthodontics:	60-40 - no deductible. $2000 lifetime maximum per patient (no age limit).

The County will continue to provide an alternative dental plan. The current alternate dental plan is Pacific Union Dental. The County will contribute up to the same dollar amount to this alternative dental plan premium as is paid to the Delta Dental Plan.

c) Life Insurance
The County agrees to increase the existing base group Life Insurance Plan to twenty-five thousand dollars ($25,000) per nurse for the term of the Agreement.

d) Social Security
Effective October 12, 1981, the County did cease payment of the nurses' portion of Social Security.

e) Vision Care Plan
The County agrees to provide a Vision Care Plan for all nurses and dependents. The Plan will be the Vision Service Plan - Plan A with benefits at 12/12/24 month intervals with twenty dollar ($20.00) deductible for examinations and twenty dollar ($20.00) deductible for materials. The County will fully pay the monthly

premium for nurse and dependents and pick up inflationary costs during the term of the agreement.

f) County-wide Benefits
The parties agree that, during the term of this Agreement, County-wide changes in benefits, such as medical, dental, life insurance or retirement, shall be applied to nurses in this Unit.

Section 13.4 - Training for Nurses With Disabilities

a) Vocational Rehabilitation
When a nurse is determined by the County to be unable to return to the classification in which the nurse held permanent status because of a work-connected illness or injury and does not elect a disability retirement, that nurse will be offered vocational rehabilitation.

b) Lateral Transfer/Demotion Openings
If the nurse meets all the qualifications for a particular position (this would take into account the nurse's medical limitations, prior work experience and skills) and an opening exists that involves a lateral transfer or demotion, the position shall be offered to the nurse.

c) Salary Level
In accordance with Chapter VI, Article 5, Section A25(e) of the Personnel Practices, "...the salary of the nurse shall be placed at the step in the salary range which corresponds most closely to the salary received by the nurse as of the time of injury. In the event that such a demotion would result in a salary loss of more than ten (10) percent, the nurse's new salary shall be set at the rate closest to but not less than ten percent (10%) below his/her salary as of the time of injury."

d) Training Program
In those cases where the nurse may not have the necessary prior experience or all the required skills but there is reasonable assurance that the nurse will be capable of obtaining them through a designated formal on-the-job training program, the County will make reasonable efforts to place the nurse in a training program.

e) Placement Review
If, after a period on the job, it is demonstrated that the nurse is unable to develop the required skills, knowledge and abilities and/or cannot meet the physical requirements to handle the new position, the nurse will be placed on a leave of absence and the placement process begins again.

f) Promotions

Any position which involves a promotion will call for the normal qualifying procedures, written and/or oral examination. However, if it is found that a nurse meets all the qualifications for a higher paying position and an eligibility list is already in existence, the nurse shall be allowed to take a written and/or oral examination, and, if the nurse qualifies, the nurse's name will be placed on the eligibility list commensurate with his/her score.

g) Referral to Accredited Rehabilitation Agency

In those cases where the County is unable, for one reason or another, to place a nurse in any occupation, that nurse's case will be referred to an accredited rehabilitation agency as approved by the Division of Industrial Accidents for testing, counseling and retraining at either the County's or State's expense.

h) State Legislation

The provisions of this Section shall not apply if State legislation removes from the County the control of training for disabled employees.

Section 13.5 - Short-Term Disability Program

The County shall provide a short-term disability plan at no expense to the County under the same terms and conditions as provided County-wide.

Section 13.6 - Retirement

The County will continue the present benefit contract with PERS which is the 2% at 55 Retirement Plan.

Effective April 11, 2005 the County ceased paying the employee's statutorily required contribution and adjusted the base pay of all employees upwards by 7.49% and implemented an employee self-pay PERS member contribution on a pre-tax basis pursuant to Internal Revenue Code 414(h)(2).

The County has amended its contract with PERS effective December 17, 2007 for the 2.5% at 55 Plan for Miscellaneous employees. In consideration for this amendment, the Association agrees for each nurse covered under this benefit to contribute to PERS, through payroll deduction effective December 17, 2007, an additional amount of 3.931% of PERS reportable gross pay added to the current self-pay member contribution of 7% through June 14, 2009.

Each nurse's payroll deduction of 3.931% includes the 1% member contribution and the 2.931% employer contribution. The 1% member contribution, in addition to the 7% member contribution, shall be deducted for the duration of the Agreement.

Effective June 15, 2009, each nurse, in addition to making the 8% member contribution, shall have a payroll deduction equal to the difference between the employer share for 2.5% at 55 and the employer share for 2% at 55 as computed by PERS for all Miscellaneous employees effective July 1, 2009 provided that the deduction for the employer share will not exceed 2.931%. This deduction shall continue for the duration of the Agreement.

Employees who are hired on or after January 1, 2013, and who are considered "new employees" and who are considered "new members" of PERS, as defined in Government Code section 7522.04 shall not be entitled to the benefits enumerated above. All such employees shall be in the Miscellaneous retirement tier of 2% at age 62 with a minimum retirement age of 52 and final compensation calculated on the highest average of pensionable compensation earned during a period of 36 consecutive months.

The employee contribution rate shall be 50% of the normal cost for the 2% @ age 62 PERS plan expressed as a percentage of payroll as defined in the Public Employees' Pension Reform Act of 2012. The County shall not pay any portion of the employee contribution rate (EMPC.) If the normal cost increases or decreases by more than one quarter of 1% of payroll the employee contribution rate will be adjusted accordingly.

Pursuant to the California Public Employees' Pension Reform Act of 2013 – Government Code Section 7522, employees convicted of certain felonies may be deemed to have forfeited accrued rights and benefits in any public retirement system in which he or she is a member.

Medical Benefits for Retirees

a) For Employees Hired before August 12, 1996:
The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of employees who have completed five (5) years service (1,305 days of accrued service) or more with the County and who retire on PERS directly from the County on or after December 5, 1983. Retirees over sixty-five (65) or otherwise eligible for Medicare Part B must be enrolled in such a plan, and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or the same sex domestic partner

of an employee eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

b) For Employees Hired on or after August 12, 1996:
The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of employees who have completed eight (8) years of service (2,088 days of accrued service) or more with the County and who retire on PERS directly from the County on or after December 5, 1983. Retirees over the age of sixty-five (65) or otherwise eligible for Medicare Part B must be enrolled in such a plan and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or the same sex domestic partner of an employee eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

c) For Employees hired on or after June 19, 2006:
The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of employee who have completed ten (10) years of service (2610 days of accrued service) or more with the County and who retire on PERS directly from the County. Retirees over 65 or otherwise eligible for Medicare Part B must be enrolled in such a plan, and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or same sex domestic partner of a employee eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

Continuous Years of Service
The years of service expressed in Section 13.6 a), b), c) and d) must be continuous service with the County and shall have been completed immediately preceding retirement directly on PERS from the County.

Delayed Enrollment in Retiree Medical Plan
A retiree who otherwise meets the requirements for retiree only medical coverage under the Sections above may choose to delay enrollment in retiree medical coverage. Application and coverage may begin each year at the annual medical insurance open enrollment period or within 30 days of a qualifying event after retirement.

Employee Contribution toward Retiree Medical Obligation Unfunded Liability

Effective with the pay period beginning February 4, 2013, all coded employees shall contribute on a biweekly basis an amount equivalent to 15% of the lowest cost early retiree premium rate. Effective with the pay period beginning June 24 2013, all coded employees shall contribute on a biweekly basis an amount equivalent to 7.5% of the lowest cost early retiree premium rate. Such contributions are to be made on a pre-tax basis, and employees shall have no vested right to the contributions made by the employees. Such contributions shall be used by the County exclusively to offset a portion of the County's annual required contribution amount to the California Employers Retirement Benefit Trust established for the express purpose of meeting the County's other post-employment benefits (OPEB) obligations and shall not be used for any other purpose.

Contributions made between June 23, 2014 and November 9, 2014 shall be rebated to each nurse.

d) For Employees Hired on or After December 08, 2014:

The County shall contribute an amount equal to the cost of Kaiser retiree-only medical plan premium to the cost of the medical plan of workers who have completed fifteen (15) years of service (3915 days of accrued service) or more with the County and who retire on PERS directly from the County. Retirees over 65 or otherwise eligible for Medicare Part B must be enrolled in such a plan, and the County shall reimburse the retiree for the cost of Medicare Part B premium on a quarterly basis. This reimbursement is subject to the maximum County contribution for retiree medical. The surviving spouse or registered domestic partner of a worker eligible for retiree medical benefits may continue to purchase medical coverage after the death of the retiree.

Section 13.7 - Deferred Compensation Plan

The County will continue the present deferred income plan. If the County proposes to change the plan, it shall provide appropriate notice to the Association and the parties shall meet and confer pursuant to Article 20 over said changes.

ARTICLE 14 - USE OF PRIVATE VEHICLES AND MILEAGE PAYMENT

Section 14.1 - Use of Private Vehicles

a) No Requirement

No nurse shall be required as a condition of obtaining or continuing County employment, to possess or provide a private vehicle for use in connection with her/his County employment. Use of County vehicles shall be in accordance with County policies and regulations.

b) Authorization of Use

Departments may authorize the use of private vehicles by their Department nurses, with each Department maintaining a continuous listing of those nurses authorized to use their private vehicles. Each nurse so authorized shall have completed applicable County authorization requirements governing County driver permits and insurance. Nurses not having completed such requirements and thereby not on the listing shall be neither required nor authorized to use their private vehicles.

c) Damage

A nurse whose vehicle is damaged in a collision with another vehicle while driving a personal vehicle on County business shall, following the approval of the Accident Review Board ESA Claims Division or if denied by ESA and subsequently approved on appeal to the Accident Review Board, be reimbursed for such damage not to exceed five hundred dollars ($500.00) provided:

1. The driver of the other vehicle is responsible for the accident as verified by a police report, and the damages shall be unrecoverable from the other party by reason of lack of liability insurance, or

2. The damage is caused by a hit-run or unidentified driver as verified by a police report, and/or

3. The amount of damage to be reimbursed by the County is not recoverable under any policy of insurance available to the nurse. The County shall be subrogated to the rights of recovery from the responsible party.

Section 14.2 - Mileage Reimbursement for Use of Private Vehicle

Effective September 1, 2000, the rate of reimbursement shall be equal to the "standard mileage rate" for auto expenses established by the Federal Government as the maximum tax-exempt mileage rate. Subsequent to September 2000, the County rate of reimbursement shall be adjusted on the first day of the month that any change by the Federal Government "standard mileage rate" is effective.

Section 14.3 - County Business Travel

Nurses who are required in the performance of their duties to travel shall receive business travel reimbursement in accordance with Santa Clara County Policy.

Section 14.4 - Parking Stickers for Nurses with Disabilities

All nurses determined by the County to be disabled in accordance with standards of the State of California Department of Motor Vehicles will be issued a disabled parking sticker for their private vehicle.

ARTICLE 15 - NURSES IN UNCLASSIFIED POSITIONS

a) Specially Funded Nurses

All nurses in unclassified coded positions within the Association's bargaining unit shall be subject to and protected by this Agreement and departmental agreements, except as otherwise provided.

b) Seniority

Time worked in such positions shall apply to seniority for the purposes of departmental agreements, salary increments and all other matters in the same manner for all other unclassified coded positions.

c) Examinations

Such nurses shall be allowed to participate in examinations in the classified service equivalent to the positions they occupy as well as all open and/or promotional examinations for which they qualify under Merit System Rules.

d) Career Opportunities

It is the County's intention to encourage and promote career opportunities for regular County nurses. In the interest of equitable treatment and to fulfill its contractual commitment, the County will not fill more than fifty percent (50%) of coded vacancies in a classification with unclassified nurses when regular County nurses are certifiable.

e) New Programs

Upon final approval by the County and the granting authority of new special programs funded from State and/or Federal sources which create full-time positions of one (1) year's duration or more, the parties agree to meet and confer on:

1. Coverage of such positions by all or any portion of the terms of this Agreement.

2. The impact the utilization of such positions may have on employees in positions currently covered by this Agreement.

ARTICLE 16 - GRIEVANCE PROCEDURE

County and the Association recognize early settlement of grievances is essential to sound employee-employer relations. The parties seek to establish a mutually satisfactory method for the settlement of grievances of nurses, the Association, or the County. In presenting a grievance, the aggrieved and/or the aggrieved's representative is assured freedom from restraint, interference, coercion, discrimination or reprisal.

Section 16.1 - Grievance Defined

a) Definition

A grievance is defined as an alleged violation, misinterpretation or misapplication of the provisions of this Memorandum of Agreement, Department Memoranda of Agreement and/or Understanding, Merit System Rules, or other County ordinances, resolutions, Policy and/or Procedure Manuals, or alleged infringement of an employee's personal rights (i.e., discrimination, harassment) affecting the working conditions of the nurses covered by this Agreement, except as excluded under Section 16.1(b).

b) Matters Excluded From Consideration Under the Grievance Procedure

1. Disciplinary actions taken under Section 708 of the County Charter except where nurses voluntarily waive their right to appeal such disciplinary actions to the Personnel Board.

2. Probationary release of nurses.

3. Position classification.

4. Merit System Examinations.

5. Items requiring capital expenditure.

6. Items within the scope of representation and subject to the meet and confer process.

Section 16.2 - Grievance Presentation

Nurses shall have the right to present their own grievance or do so through a representative of their own choice. Grievances may also be presented by a group of nurses, by the Association, or by the County. No grievance settlement may be made in violation of an existing rule, ordinance, memorandum of agreement or memorandum of understanding, nor shall any settlement may be made which affects the rights or conditions of other nurses represented by the Association without notification to and consultation with the Association.

The Association shall be provided copies of individual or group grievances and responses to same. Such grievances may not proceed beyond Step One without written concurrence of the Association at each step.

The Association shall have the right to appear and be heard in all individual or group grievances at any step. Upon request by County, the Association shall appear and be heard in such grievances at any step.

Section 16.3 - Procedural Compliance

Association grievances shall comply with all foregoing provisions and procedures. The County shall not be required to reconsider a grievance previously settled with a nurse if renewed by the Association, unless it is alleged that such grievance settlement is in violation of an existing rule, ordinance, memorandum of understanding, or memorandum of agreement.

A grievance is deemed to be presented or filed when it is either received by the Office of Labor Relations if presented in person or by facsimile or by electronic mail; or on the day it is postmarked, whichever occurs first.

A response by the County is deemed to be made when it is either received by the Association when presented in person or by facsimile or by electronic mail; or on the day it is postmarked, whichever occurs first.

Section 16.4 - Informal Resolution/Time Limits

It is agreed that nurses will be encouraged to act promptly through informal discussion with their immediate supervisor on any act, condition or circumstance which is causing nurse dissatisfaction and to seek action to remove the cause of dissatisfaction before it serves as the basis for a formal grievance. Time limits may be extended or waived only by written agreement of the parties.

If either party fails to comply with the grievance time limits, and the matter proceeds to arbitration, the party who missed the time limits, as determined by the arbitrator, shall pay the full cost of the arbitrator.

Section 16.5 - Formal Grievance

a) Step One

Within fifteen (15) working days of the occurrence or discovery of an alleged grievance, the grievance shall be presented in writing to the Office of Labor Relations. The grievance form shall contain information which identifies:

1. The aggrieved;

2. The specific nature of the grievance;

3. The time or place of its occurrence;

4. The rule, law, regulation, or policy alleged to have been violated, improperly interpreted, applied or misapplied;

5. The consideration given or steps taken to secure informal resolution;

6. The corrective action desired; and,

7. The name of any person or representative chosen by the nurse to enter the grievance.

A decision shall be made by the County in writing within fifteen (15) working days of receipt of the grievance. A copy of the decision shall be directed to the person identified in (7) above. A copy shall be sent to the Association and this copy shall dictate time limits.

b) Step Two

If the aggrieved continues to be dissatisfied, the aggrieved may, within fifteen (15) working days after receipt of the first step decision, present a written presentation to be directed to the County Executive's designated representative indicating the aggrieved wishes the grievance to be referred to an impartial arbitrator. The arbitrator shall be advised of and agree to the following provisions:

1. Within ten (10) working days of receipt of the grievance at step two, one (1) arbitrator shall be selected from the panel and a hearing scheduled within thirty (30) calendar days.

2. If the selected arbitrator cannot be scheduled within ninety (90) calendar days the parties will mutually agree to either another arbitrator or extend the time limit for the hearing.

3. Arbitration proceedings shall be recorded but not transcribed except at the request of either party or the arbitrator. Upon mutual agreement, the County and the Association may submit written briefs to the arbitrator for decision in lieu of a hearing.

The arbitrator's compensation and expenses shall be borne equally by the nurse or the Association and the County. Decisions of the arbitrator shall be final and binding.

Section 16.6 – Arbitrators

For the term of this agreement the County and the Union have agreed to the following panel:

Christopher D. Burdick	John Kagel
Katherine Thomson	Alexander Cohn
Matthew Goldberg	Catherine Harris
Barry Winograd	Luella Nelson
Robert Hirsch	

The parties may also mutually agree to choose another arbitrator not on the above list.

Section 16.7 - Arbitration Release Time

The following statement on nurse participation in grievance arbitration hearings is agreed to:

a) The nurse on whose behalf the grievance has been filed will be granted release time for the entire hearing. Release time to serve as a witness will be granted on a scheduled basis, i.e., when the nurse is scheduled to appear. In the case of a group grievance, release time will be granted for the designated spokesperson for the entire hearing. Release time also will be granted to the appropriate Unit Representative.

b) Other requests for leave for the purpose of participation in a grievance arbitration hearing will also be granted and charged to the nurse's own leave time - provided the absence does not unduly interfere with the performance of service.

ARTICLE 17 - CONFLICT OF INTEREST

Nurses are to abide by all applicable Federal, State and Local Statutes or contract requirements regarding conflict of interest in outside employment. Nurses intending to engage in outside employment shall file an advance statement of such intent for the approval of the appointing authority.

ARTICLE 18 - NURSING PRACTICE ISSUES

Section 18.1 - Supervision

All Interim Permitees will be directly supervised and will not assume team leader duties. A Clinical Nurse I will not work in charge position except as provided for in Section 8.10 of this Agreement.

Section 18.2 - Conscientious Objector Clause

The rights of patients to receive the necessary nursing care are to be respected. As individuals, licensed nurses hold certain moral, ethical, and religious beliefs and in good conscience may be compelled to refuse involvement with abortions. The licensed nurse must be free to exercise this right without being subjected to ridicule, harassment, coercion, censure, termination, or other forms of discipline. Emergency situations will arise where the immediate nature of the patient's needs will not allow for personnel substitutions. In such circumstances the patient's right to receive the necessary nursing care would take precedence over exercise of the nurse's individual beliefs and rights until other personnel can be provided.

Section 18.3 - Malpractice Protection

The County's obligation to defend and indemnify its officers and employees is prescribed by California Government Code 825 et seq. and 995 et seq. The County shall indemnify and defend nurses in this Unit in accordance with the applicable law when and if they are sued for errors or omissions (malpractice) within the course and scope of their duties, save and except where the applicable law excuses County's obligation to defend (e.g., fraud, malice, etc.). This paragraph and the terms and conditions thereof shall be enforceable, at law in accordance with the applicable law, but shall not be subject to the grievance provision of this Agreement.

Section 18.4 - Inservice Education Program For Nurses

a) While all nurses are responsible for their own professional growth, Santa Clara Valley Medical Center will maintain a Staff Development Program for nurses, including the following:

1. Provide an organized plan of orienting all newly hired nurses to the objectives, policies, goals, and procedures of the hospital and of nursing service at regularly scheduled intervals.

2. Provide an organized plan of orienting all nurses to the job descriptions, responsibilities, and work assignments for nursing classifications at regularly scheduled intervals.

3. Keep the nursing staff abreast on a continuing basis of new and expanding nursing care programs and of new techniques, equipment, facilities and concepts of care.

4. Each nurse must complete both (1) and (2) above before being permanently assigned to a unit and shift. Until completion of the formal orientation, the nurse will be considered as still in a structured learning experience and not part of the unit's regular nursing staff.

b) In each area, a clinical nurse(s) is responsible for coordinating inservice programs with the Nursing Staff Development. These programs shall be relevant to updating and upgrading skills particular to the unit in order to promote optimal nursing care to each patient.

It is understood that the department has the authority to approve all voluntary attendance at inservice education programs.

Section 18.5 - Staff Meetings

The date, time and location of regularly scheduled staff meetings will be posted seven calendar days in advance. Nurses assigned attendance at meetings, lectures, or inservice courses while off shift will be subject to all overtime provisions. Nurses on shift will be compensated at the regular rate.

Section 18.6 - Professional Performance Committee

a) The Valley Medical Center Professional Performance Committee shall be composed of nurses currently employed by the hospital. The Committee shall have a representative from each nursing unit, one (1) from each satellite clinic, and one (1) Institution Nurse elected by the nurses from that unit and clinic. All appointed and new positions will be filled by election by October 31 of each year.

b) Nurses employed by the County recognize their obligation to perform the highest level of nursing care for the patients. The Professional Performance Committee shall act as an advisory body to Nursing Service and Administration. The hospital will make a good faith effort to implement recommendations agreed to by the P.P.C. and the Director of Nursing.

c) The Committee shall not involve itself in grievances as defined and set forth in this Agreement. The purpose and function shall be as set forth in its bylaws and shall include the following:

1. Recommend nursing policies and procedures to the Nursing Administrator.

2. Review nursing policies and procedures prior to implementation, when possible, except in emergencies.

3. Maintain representative on Valley Medical Center Nursing Committees as designated by management.

d) The Nursing Administrator or representative will meet with the P.P.C. at their regularly scheduled meeting when requested. The Nursing Administrator will respond in writing to all written recommendations within thirty (30) days unless extended by mutual agreement.

e) Attendance at P.P.C. will be voluntary by the elected representative or an alternate. Committee members will be granted release time to attend the meetings. Those members who attend during other than duty time will be granted up to four (4) hours of compensatory time.

Meetings will be held monthly for three (3) hours or more as agreed to by the Nursing Administrator.

Section 18.7 Advanced Practice Professional Performance Committee

a) The Advanced Practice Professional Performance Committee (APPPC) shall be composed of Nurse Practitioners, Certified Registered Nurse Anesthetists and Clinical Nurse Specialists covered by the contract and employed by the County.

b) Each APRN within the employ of the County may attend APPPC meetings with prior management approval.

c) A minimum of (three)(3) Advanced Practice Professionals, (one)(1) RNPA representative and (one)(1) Nursing Administration representative shall make up the board of the APPPC. The position of Chairperson, Vice Chairperson and Secretary will be held by an APRN. All positions are to be elected by the APRN staff only. Necessity for additional seats on the board will be determined by the Chair and Vice-Chair. Duration of appointment to a particular board position shall be determined by the committee. All policies regarding the function of the APPPC shall be placed in writing and submitted to the Chief Nursing Officer and Deputy Director, ACHS/FQHC. A copy of these policies will be kept at the offices of RNPA. The agenda shall be determined and distributed one (1) week in advance. A copy of all minutes shall be forwarded to the Chief Nursing Officer, Deputy Director of ACHS/FQHC and RNPA.

d) The function of the APPPC shall be as follows:

1. To serve as a forum for discussion of administrative and medical practice issues which arise for APRNs within the SCVHHS.

2. The Chairperson, or designee, of this committee shall serve as a liaison between the committee and the Chief Nursing Officer, the Deputy Director, ACHS/FQHC and the Assistant Medical Director.

3. The development and review of APRN practice protocols prior to the submission of these protocols to the Interdisciplinary Care Committee/Medical Executive Committee.

4. To provide updates on state and federal legal changes to practice.

Section 18.8 - Safety

The County necessarily abides by safety standards established by the State Division of Industrial Safety and pursuant to the Occupational Safety and Health Act.

Section 18.9 - Nursing Practice

If a nurse objects to an assignment on the basis that it exceeds the nurse's professional qualifications and the nurse is unable to resolve the objection with the immediate supervisor, the objection will be noted, in writing utilizing the "Objection to Assignment" form, by the nurse and delivered to the Director of Nursing's office or the appropriate administrator prior to the nurse leaving at the end of the shift. A written response from the Director of Nursing or designee will be forwarded to the nurse.

Section 18.10 - Performance Evaluation

a) Each nurse shall be subject to a written appraisal of work performance. Performance evaluations are done:

   1. Annually;

   2. Prior to a promotion;

   3. During the probationary period.

Performance evaluations will not be used in the disciplinary process.

b) The evaluation shall consist of comparison of the nurse's performance against written standards established by Management for:

1. Work Unit competencies;

2. Job classification;

3. Unit role expectations;

4. Any appropriate legal or regulatory requirements.

18.11 – Staffing

The County shall maintain a staffing system for nurses based on the assessment of patient needs, to include the number and the acuity of the patient(s) assigned to a nurse in compliance with applicable state laws and regulations including AB 394 chaptered October 10, 1999. This assessment shall include meal and rest periods when determining staffing needs.

a) Assessment of Patient Acuity

During each shift, bedside nurses shall assess and determine patient acuity on an ongoing basis. The nurse shall consult with the charge nurse or manager as needed.

b) Staffing Decisions

In the absence of the Nurse Manager or Assistant Nurse Manager, the Charge Nurse shall have the authority to make necessary staffing decisions based upon patient acuity and census. Nurses involved in direct patient care are included in the calculation of nurse-to-patient ratios.

c) Staffing Report

Staffing reports shall be submitted by the Nurse Manager by shift and unit to nursing administration reflecting staffing levels for each shift, including beginning, middle and end of shift.

d) Notice of Staffing Levels Concerns

Nurses may report nurse to patient staffing levels that they believe are out of compliance by notifying the next level of management. Should a nurse believe staffing levels cannot be easily remedied, he/she may submit a Notice of Staffing Levels form. Such form shall be submitted to the nurse's charge nurse or immediate supervisor. The Charge nurse or supervisor who receives the form shall note the action(s) taken, if any, to resolve the staffing concern and shall forward the form to the Nurse Manager and the appropriate Nursing Director with a copy to the Chief Nursing Officer and RNPA. Notice of Staffing Levels forms shall be reviewed at the monthly Patient Acuity Task Force meeting. After review at the Patient Acuity Task Force meeting, the nurse reporting the concern shall be informed of the action taken to resolve the staffing concern, if any.

e) Patient Acuity Task Force

The Patient Acuity Task Force shall be comprised of an equal number of management, including the Nurse Manager of Nursing Systems, and RNPA representatives. The Patient Acuity Task Force shall meet on a monthly basis to assess and develop strategies for alleviating staffing concerns within nursing units. The Task Force shall also develop forms to be used as described in (c) and (d) above.

The Patient Classification Team shall include the Nurse Manager of Nursing Systems and one clinical nurse per shift/per unit to meet twice yearly to review inter-rater reliability of the patient classification system to determine whether the system accurately determines patient needs. Members of the Patient Classification Team shall then review and validate with each nurse in the unit that he/she is proficient. The Nurse Manager of Nursing System shall report the results of the twice yearly review to the Patient Acuity Task Force.

f) Dispute Resolution

In the event of a dispute regarding a staffing concern that is not able to be resolved in accordance with sub-section (d), such concern shall be subject to an internal review by the Management Audit Division for the Board of Supervisors when:

1) The staffing concern was not de minimis, (i.e. staffing concern was not cured within four (4) hours) and;
2) The staffing concern was not able to be resolved in accordance with sub-section (d) at the monthly meeting following the alleged violation and;
3) The staffing concern has not been resolved to the satisfaction of a majority of the Patient Acuity Task Force.

The Management Audit Division for the Board of Supervisors shall review the staffing concern and information provided by the Patient Acuity Task Force, Nursing Administration and RNPA and shall report his/her conclusions to the Patient Acuity Task Force and to Nursing Administration. Nursing Administration shall submit such report for the next scheduled Health and Hospital Committee meeting.

g) Section 18.10 is not subject to the grievance and arbitration procedures of this Agreement.

Section 18.12 – Safe Patient Handling

The County shall maintain a safe patient handling policy for all patient care units in acute care facilities in accordance with applicable state and or federal law, including AB1136, as applicable.

Such policy shall address providing nurses with appropriate equipment and staff assistance for moving patients, thereby eliminating, to the extent possible, manual lifting that may cause injuries.

Each nurse is responsible for the observation and direction of the lifting and mobilization of patients, and participates as needed in patient handling. The County will provide uniform training in the handling of patients on the appropriate use of lifting devices, equipment, and body mechanics on an annual basis.

ARTICLE 19 - STRIKES AND LOCKOUTS

During the term of this Agreement, the County agrees that it will not lock out nurses and the Association agrees that it will not engage in any concerted work stoppage. A violation of this Article will result in cessation of Association dues deduction by the County.

ARTICLE 20 - FULL AGREEMENT

It is understood this Agreement represents a complete and final understanding on all negotiable issues between the County and its Departments and the Association. This Agreement supersedes all previous memoranda of understanding or memoranda of agreement between the County and its Departments and the Association except as specifically referred to in this Agreement. All ordinances or rules covering any practice, subject or matter not specifically referred to in this Agreement shall not be superseded, modified or repealed by implication or otherwise by the provisions hereof. The parties, for the term of this Agreement, voluntarily and unqualifiedly agree to waive the obligation to negotiate with respect to any practice, subject or matter not specifically referred to or covered in this Agreement even though such practice, subject or matter may not have been within the knowledge of the parties at the time this Agreement was negotiated and signed. In the event any new practice, subject or matter arises during the term of this Agreement and an action is proposed by the County, the Association shall be afforded all possible notice and shall have the right to meet and confer upon request. In the absence of agreement on such a proposed action, the County reserves the right to take necessary action by management direction.

ARTICLE 21 - SAVINGS CLAUSE

If any provision of this Agreement should be held invalid by operation of law or by any court of competent jurisdiction, or if compliance with or enforcement of any provision should be restrained by any tribunal, the remainder of this Agreement shall not be affected thereby, and the parties shall enter into negotiations for the sole purpose of arriving at a mutually satisfactory replacement for such provision.

If the State of California notifies the County of Santa Clara that legislation has been implemented which assesses monetary penalties to local governments which settle wages and/or benefits with increases in excess of certain limits, those benefits and/or wages shall not be implemented or continue to be paid. The parties shall immediately enter into negotiations for the sole purpose of arriving at a mutually agreed upon alternative.

The County reserves the right to cease payment or seek repayment of wages and/or benefits upon which the State of California is basing the monetary penalty. The Union reserves the right to contest the legality of the payment cessation or repayment.

It is understood that the purpose of this Section is to ensure that the County does not incur any liability or penalties on either the original agreement provisions, or the negotiated alternate provisions.

ARTICLE 22 - IMPLEMENTATION

It is understood by the County and the Association that to fully implement this Agreement it will be necessary for the County to amend several existing County ordinances, some of which require the approval of the County Personnel Board, so that such ordinances will not conflict with the provisions of this Agreement. The County and the Association agree to cooperate to secure the enactment of such ordinances.

ARTICLE 23 - TERM OF AGREEMENT

This Agreement shall become effective only upon approval by the Board of Supervisors and upon the ratification by the Association, and shall remain in full force and effect to and including November 9, 2014 and from year to year thereafter; provided, however, that either party may serve written notice on the other at least sixty (60) days prior to October 20, 2019, or any subsequent October 19, of its desire to terminate this Agreement or amend any provision thereof.

DATED: 2/23/2015

COUNTY of SANTA CLARA

Lisa Dumanowski

Cynthia Mihulka

Matthew Cottrell

Jackie Lowther

Joyce Van De Pitte

Terry Edmonson

Kim Johnson

Francesco Germinario

REGISTERED NURSES PROFESSIONAL ASSOCIATION

Elizabeth LaRosa, RN
President

Jane Valdez, RN, CORN
Vice President

Daisy Brown, RN
Vice President

Katherine Volpe, RN
Negotiator

Zeniah Andres, RN
Alternate Negotiator

APPENDIX A – RNPA SALARIES

Effective November 10, 2014

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Assistant Nurse Manager - Extra Help	X1J	4682.64	4916.96	5162.72	5420.96	5692.16	---	---	10145.72	12333.01
Assistant Nurse Manager - Step A	S2A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Assistant Nurse Manager - Step B	S2B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Assistant Nurse Manager - Step C	S2C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01
Certified Registered Nurse Anesthetist	S1V	6887.60	7239.20	7608.96	7997.60	8406.00	8835.28	---	14923.13	19143.10
Certified Registered Nurse Anesthetist - Extra Help	X1K	6408.56	6734.80	7078.80	7440.40	7828.40	---	---	13885.21	16961.53
Certified Registered Nurse Anesthetist - Step A	Y1A	7059.76	7420.16	7799.12	8197.44	8616.16	9056.08	---	15296.14	19621.50
Certified Registered Nurse Anesthetist - Step B	Y1B	7232.08	7601.20	7989.52	8397.44	8826.24	9276.96	---	15669.50	20100.08
Certified Registered Nurse Anesthetist - Step C	Y1C	7404.32	7782.00	8179.60	8597.36	9036.40	9497.76	---	16042.69	20578.48
Clinical Nurse I	S89	3719.52	3905.44	4100.72	4306.64	4522.32	---	---	8058.96	9798.36
Clinical Nurse I - Extra Help	X1A	3445.04	3617.28	3815.20	4006.48	4207.20	---	---	7464.25	9115.60
Clinical Nurse I - Step A	C3A	---	---	4203.36	4414.08	4635.28	---	---	9107.28	10043.10
Clinical Nurse I - Step B	C3B	---	---	4305.92	4521.68	4748.40	---	---	9329.49	10288.20
Clinical Nurse I - Step C	C3C	---	---	4408.40	4629.44	4861.44	---	---	9551.53	10533.12
Clinical Nurse I - U	Q89	3719.52	3905.44	4100.72	4306.64	4522.32	---	---	8058.96	9798.36
Clinical Nurse II	S76	3942.24	4140.24	4347.60	4565.12	4793.52	---	---	8541.52	10385.96
Clinical Nurse II - Extra Help	X1H	3667.68	3851.76	4044.72	4247.12	4459.60	---	---	7946.64	9662.46
Clinical Nurse II - Step A	D0A	4040.88	4243.76	4456.32	4679.20	4913.20	---	---	8755.24	10645.26
Clinical Nurse II - Step B	D0B	4139.36	4347.12	4565.04	4793.44	5033.28	---	---	8968.61	10905.44
Clinical Nurse II - Step C	D0C	4237.92	4450.72	4673.76	4907.44	5152.88	---	---	9182.16	11164.57
Clinical Nurse II - U	Q87	3942.24	4140.24	4347.60	4565.12	4793.52	---	---	8541.52	10385.96
Clinical Nurse II - U - Step A	E1A	4040.88	4243.76	4456.32	4679.20	4913.20	---	---	8755.24	10645.26
Clinical Nurse II - U - Step B	E1B	4139.36	4347.12	4565.04	4793.44	5033.28	---	---	8968.61	10905.44
Clinical Nurse II - U - Step C	E1C	4237.92	4450.72	4673.76	4907.44	5152.88	---	---	9182.16	11164.57
Clinical Nurse III	S75	4347.60	4565.12	4793.52	5033.44	5285.28	5549.36	5826.88	9419.80	12624.90
Clinical Nurse III - Extra Help	X1I	4044.72	4247.12	4459.60	4682.64	4916.96	---	---	8763.56	10653.41
Clinical Nurse III - Step A	S7A	4456.32	4679.20	4913.20	5159.12	5417.20	5688.08	5972.48	9655.36	12940.37
Clinical Nurse III - Step B	S7B	4565.04	4793.44	5033.28	5285.20	5549.36	5826.80	6118.32	9890.92	13256.36
Clinical Nurse III - Step C	S7C	4673.76	4907.44	5152.88	5410.96	5691.52	5965.68	6263.76	10126.48	13571.48

Effective November 10, 2014										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Clinical Nurse III - U	Q86	4347.60	4565.12	4793.52	5033.44	5285.28	5549.36	5826.88	9419.80	12624.90
Clinical Nurse III - U - Step A	Q8A	4456.32	4679.20	4913.20	5159.12	5417.20	5688.08	5972.48	9655.36	12940.37
Clinical Nurse III - U - Step B	Q8B	4565.04	4793.44	5033.28	5285.20	5549.36	5826.80	6118.32	9890.92	13256.36
Clinical Nurse III - U - Step C	Q8C	4673.76	4907.44	5152.88	5410.96	5691.52	5965.68	6263.76	10126.48	13571.48
Clinical Nurse Specialist	S35	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Clinical Nurse Specialist - Extra Help	X1L	4682.64	4916.96	5162.72	5420.96	5692.16	---	---	10145.72	12333.01
Clinical Nurse Specialist - Step A	S4A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Clinical Nurse Specialist - Step B	S4B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Clinical Nurse Specialist - Step C	S4C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01
Infection Control Nurse	S04	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Infection Control Nurse - Extra Help	X1F	4682.64	4916.96	5162.72	5420.96	5692.16	---	---	10145.72	12333.01
Infection Control Nurse - Step A	S0A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Infection Control Nurse - Step B	S0B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Infection Control Nurse - Step C	S0C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01
Nurse Coordinator	S39	4793.52	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	10385.96	13919.53
Nurse Coordinator - Extra Help	X1M	4459.04	4682.32	4916.56	5162.24	5420.40	---	---	9661.25	11744.20
Nurse Coordinator - Step A	S3A	4913.20	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	10645.26	14267.58
Nurse Coordinator - Step B	S3B	5033.28	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	10905.44	14615.46
Nurse Coordinator - Step C	S3C	5152.88	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	11164.57	14963.69
Nurse Coordinator - U	Q39	4793.52	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	10385.96	13919.53
Nurse Coordinator - U Step A	Q4A	4913.20	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	10645.26	14267.58
Nurse Coordinator - U Step B	Q4B	5033.28	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	10905.44	14615.46
Nurse Coordinator - U Step C	Q4C	5152.88	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	11164.57	14963.69
Nurse Practitioner	S59	5549.36	5826.88	6118.48	6424.40	6752.00	7096.48	7459.12	12023.61	16161.42
Nurse Practitioner - Extra Help	X1N	5162.72	5420.88	5692.16	5976.80	6281.44	---	---	11185.89	13609.78
Nurse Practitioner - Step A	Y0A	5688.08	5972.48	6271.36	6585.04	6920.64	7273.76	7645.36	12324.17	16564.94
Nurse Practitioner - Step B	Y0B	5826.80	6118.32	6424.24	6745.60	7089.52	7451.28	7832.08	12624.73	16969.50
Nurse Practitioner - Step C	Y0C	5965.68	6263.76	6577.28	6906.32	7258.16	7628.64	8018.40	12925.64	17373.20
Per Diem Clinical Nurse	S99	---	63.18/Hrly	---	79.88/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	79.01/Hrly	---	99.89/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	63.18/Hrly	---	79.88/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	3904.96	4100.72	4306.64	4522.32	4748.48	---	---	8460.74	10288.37

Effective November 10, 2014										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Psychiatric Nurse I - Step A	D5A	4002.64	4203.36	4414.08	4635.28	4867.04	---	---	8672.38	10545.25
Psychiatric Nurse I - Step B	D5B	4100.24	4305.92	4521.68	4748.40	4985.84	---	---	8883.85	10802.65
Psychiatric Nurse I - Step C	D5C	4197.92	4408.40	4629.44	4861.44	5104.48	---	---	9095.49	11059.70
Psychiatric Nurse II	S57	4347.60	4565.12	4793.52	5033.44	5285.28	5549.36	5826.88	9419.80	12624.90
Psychiatric Nurse II - Extra Help	X1C	4044.72	4247.12	4459.60	4682.64	4916.96	---	---	8763.56	10653.41
Psychiatric Nurse II - Step A	E2A	4456.32	4679.20	4913.20	5159.12	5417.20	5688.08	5972.48	9655.36	12940.37
Psychiatric Nurse II - Step B	E2B	4565.04	4793.44	5033.28	5285.20	5549.36	5826.80	6118.32	9890.92	13256.36
Psychiatric Nurse II - Step C	E2C	4673.76	4907.44	5152.88	5410.96	5691.52	5965.68	6263.76	10126.48	13571.48
Staff Developer	S38	5033.44	5285.28	5549.36	5826.88	6118.48	6424.40	6752.00	10905.78	14629.33
Staff Developer - Extra Help	X1E	5008.72	5259.44	5522.40	5798.56	6088.72	---	---	10852.22	11693.06
Staff Developer - Step A	S5A	5159.12	5417.20	5688.08	5972.48	6271.36	6585.04	6920.64	11178.09	14994.72
Staff Developer - Step B	S5B	5285.20	5549.36	5826.80	6118.32	6424.24	6745.60	7089.52	11451.26	15360.62
Staff Developer - Step C	S5C	5410.96	5681.52	5965.68	6263.76	6577.28	6906.32	7258.16	11723.74	15726.01

APPENDIX A – RNPA SALARIES

Effective November 9, 2015

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Assistant Nurse Manager - Extra Help	X1J	4834.80	5076.72	5330.48	5597.12	5877.12	---	---	10475.40	12733.76
Assistant Nurse Manager - Step A	S2A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Assistant Nurse Manager - Step B	S2B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Assistant Nurse Manager - Step C	S2C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00
Certified Registered Nurse Anesthetist	S1V	7111.44	7474.40	7856.24	8257.52	8679.12	9122.40	---	15408.12	19765.20
Certified Registered Nurse Anesthetist - Extra Help	X1K	6616.80	6953.68	7308.80	7682.16	8082.80	---	---	14336.40	17512.73
Certified Registered Nurse Anesthetist - Step A	Y1A	7289.20	7661.28	8052.56	8463.84	8896.16	9350.40	---	15793.26	20259.20
Certified Registered Nurse Anesthetist - Step B	Y1B	7467.12	7848.16	8249.12	8670.32	9113.04	9578.40	---	16178.76	20753.20
Certified Registered Nurse Anesthetist - Step C	Y1C	7644.96	8034.88	8445.36	8876.72	9330.08	9806.40	---	16564.08	21247.20
Clinical Nurse I	S89	3840.40	4032.32	4233.92	4446.56	4669.28	---	---	8320.86	10116.77
Clinical Nurse I - Extra Help	X1A	3556.96	3734.80	3939.12	4136.64	4343.92	---	---	7706.74	9411.82
Clinical Nurse I - Step A	C3A	---	---	4339.92	4557.52	4785.92	---	---	9403.16	10369.49
Clinical Nurse I - Step B	C3B	---	---	4445.84	4668.56	4902.72	---	---	9632.65	10622.56
Clinical Nurse I - Step C	C3C	---	---	4551.60	4779.84	5019.36	---	---	9861.80	10875.28
Clinical Nurse I - U	Q89	3840.40	4032.32	4233.92	4446.56	4669.28	---	---	8320.86	10116.77
Clinical Nurse II	S76	4070.32	4274.72	4488.88	4713.44	4949.28	---	---	8819.02	10723.44
Clinical Nurse II - Extra Help	X1H	3786.80	3976.88	4176.16	4385.12	4604.48	---	---	8204.73	9976.37
Clinical Nurse II - Step A	D0A	4172.16	4381.68	4601.12	4831.20	5072.80	---	---	9039.68	10991.06
Clinical Nurse II - Step B	D0B	4273.84	4488.40	4713.36	4949.20	5196.80	---	---	9259.98	11259.73
Clinical Nurse II - Step C	D0C	4375.60	4595.36	4825.60	5066.88	5320.32	---	---	9480.46	11527.36
Clinical Nurse II - U	Q87	4070.32	4274.72	4488.88	4713.44	4949.28	---	---	8819.02	10723.44
Clinical Nurse II - U - Step A	E1A	4172.16	4381.68	4601.12	4831.20	5072.80	---	---	9039.68	10991.06
Clinical Nurse II - U - Step B	E1B	4273.84	4488.40	4713.36	4949.20	5196.80	---	---	9259.98	11259.73
Clinical Nurse II - U - Step C	E1C	4375.60	4595.36	4825.60	5066.88	5320.32	---	---	9480.46	11527.36
Clinical Nurse III	S75	4488.88	4713.44	4949.28	5196.96	5457.04	5729.68	6016.24	9725.90	13035.18
Clinical Nurse III - Extra Help	X1I	4176.16	4385.12	4604.48	4834.80	5076.72	---	---	9048.34	10999.56
Clinical Nurse III - Step A	S7A	4601.12	4831.20	5072.80	5326.72	5593.20	5872.88	6166.56	9969.09	13360.88
Clinical Nurse III - Step B	S7B	4713.36	4949.20	5196.80	5456.96	5729.68	6016.16	6317.12	10212.28	13687.09
Clinical Nurse III - Step C	S7C	4825.60	5066.88	5320.32	5586.80	5876.48	6159.52	6467.28	10455.46	14012.44
Clinical Nurse III - U	Q86	4488.88	4713.44	4949.28	5196.96	5457.04	5729.68	6016.24	9725.90	13035.18

Effective November 9, 2015										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Clinical Nurse III - U - Step B	Q8B	4713.36	4949.20	5196.80	5456.96	5729.68	6016.16	6317.12	10212.28	13687.09
Clinical Nurse III - U - Step C	Q8C	4825.60	5066.88	5320.32	5586.80	5876.48	6159.52	6467.28	10455.46	14012.44
Clinical Nurse Specialist	S35	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Clinical Nurse Specialist - Extra Help	X1L	4834.80	5076.72	5330.48	5597.12	5877.12	---	---	10475.40	12733.76
Clinical Nurse Specialist - Step A	S4A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Clinical Nurse Specialist - Step B	S4B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Clinical Nurse Specialist - Step C	S4C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00
Infection Control Nurse	S04	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Infection Control Nurse - Extra Help	X1F	4834.80	5076.72	5330.48	5597.12	5877.12	---	---	10475.40	12733.76
Infection Control Nurse - Step A	S0A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Infection Control Nurse - Step B	S0B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Infection Control Nurse - Step C	S0C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00
Nurse Coordinator	S39	4949.28	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	10723.44	14371.76
Nurse Coordinator - Extra Help	X1M	4603.92	4834.48	5076.32	5330.00	5596.56	---	---	9975.16	12125.88
Nurse Coordinator - Step A	S3A	5072.80	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	10991.06	14731.25
Nurse Coordinator - Step B	S3B	5196.80	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	11259.73	15090.40
Nurse Coordinator - Step C	S3C	5320.32	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	11527.36	15449.89
Nurse Coordinator - U	Q39	4949.28	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	10723.44	14371.76
Nurse Coordinator - U Step A	Q4A	5072.80	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	10991.06	14731.25
Nurse Coordinator - U Step B	Q4B	5196.80	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	11259.73	15090.40
Nurse Coordinator - U Step C	Q4C	5320.32	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	11527.36	15449.89
Nurse Practitioner	S59	5729.68	6016.24	6317.28	6633.12	6971.44	7327.04	7701.52	12414.30	16686.62
Nurse Practitioner - Extra Help	X1N	5330.48	5597.04	5877.12	6171.04	6485.52	---	---	11549.37	14051.96
Nurse Practitioner - Step A	Y0A	5872.88	6166.56	6475.12	6799.04	7145.52	7510.08	7893.76	12724.57	17103.14
Nurse Practitioner - Step B	Y0B	6016.16	6317.12	6632.96	6964.80	7319.92	7693.44	8086.56	13035.01	17520.88
Nurse Practitioner - Step C	Y0C	6159.52	6467.28	6791.04	7130.72	7494.00	7876.56	8278.96	13345.62	17937.74
Per Diem Clinical Nurse	S99	---	65.23/Hrly	---	82.48/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	81.58/Hrly	---	103.14/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	65.23/Hrly	---	82.48/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4031.84	4233.92	4446.56	4669.28	4902.80	---	---	8735.65	10622.73
Psychiatric Nurse I - Extra Help	X1B	3750.88	3939.12	4136.64	4343.92	4561.20	---	---	8126.90	9882.60
Psychiatric Nurse I - Step A	D5A	4132.72	4339.92	4557.52	4785.92	5025.20	---	---	8954.22	10887.93
Psychiatric Nurse I - Step B	D5B	4233.44	4445.84	4668.56	4902.72	5147.84	---	---	9172.45	11153.65
Psychiatric Nurse I - Step C	D5C	4334.32	4551.60	4779.84	5019.36	5270.32	---	---	9391.02	11419.02

Effective November 9, 2015										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Max**
Psychiatric Nurse II - Extra Help	X1C	4176.16	4385.12	4604.48	4834.80	5076.72	---	---	9048.34	10999.56
Psychiatric Nurse II - Step A	E2A	4601.12	4831.20	5072.80	5326.72	5593.20	5872.88	6166.56	9969.09	13360.88
Psychiatric Nurse II - Step B	E2B	4713.36	4949.20	5196.80	5456.96	5729.68	6016.16	6317.12	10212.28	13687.09
Psychiatric Nurse II - Step C	E2C	4825.60	5066.88	5320.32	5586.80	5876.48	6159.52	6467.28	10455.46	14012.44
Staff Developer	S38	5196.96	5457.04	5729.68	6016.24	6317.28	6633.12	6971.44	11260.08	15104.78
Staff Developer - Extra Help	X1E	4583.84	4813.28	5053.84	5306.64	5572.16	---	---	9931.65	12073.01
Staff Developer - Step A	S5A	5326.72	5593.20	5872.88	6166.56	6475.12	6799.04	7145.52	11541.22	15481.96
Staff Developer - Step B	S5B	5456.96	5729.68	6016.16	6317.12	6632.96	6964.80	7319.92	11823.41	15859.82
Staff Developer - Step C	S5C	5586.80	5866.16	6159.52	6467.28	6791.04	7130.72	7494.00	12104.73	16237.00

APPENDIX A – RNPA SALARIES

Effective October 24, 2016

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Min
Assistant Nurse Manager	S11	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Assistant Nurse Manager - Extra Help	X1J	4979.84	5228.96	5490.32	5764.96	6053.36	---	---	10789.65	13115.61
Assistant Nurse Manager - Step A	S2A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Assistant Nurse Manager - Step B	S2B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Assistant Nurse Manager - Step C	S2C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06
Certified Registered Nurse Anesthetist	S1V	7324.72	7698.56	8091.92	8505.20	8939.44	9396.00	---	15870.22	20358.00
Certified Registered Nurse Anesthetist - Extra Help	X1K	6815.28	7162.24	7528.00	7912.56	8325.28	---	---	14766.44	18038.10
Certified Registered Nurse Anesthetist - Step A	Y1A	7507.84	7891.04	8294.08	8717.68	9163.04	9630.88	---	16266.98	20866.90
Certified Registered Nurse Anesthetist - Step B	Y1B	7691.12	8083.60	8496.56	8930.40	9386.40	9865.68	---	16664.09	21375.64
Certified Registered Nurse Anesthetist - Step C	Y1C	7874.24	8275.92	8698.72	9142.96	9609.92	10100.56	---	17060.85	21884.54
Clinical Nurse I	S89	3955.60	4153.28	4360.88	4579.92	4809.28	---	---	8570.46	10420.10
Clinical Nurse I - Extra Help	X1A	3663.60	3846.80	4057.28	4260.72	4474.16	---	---	7937.80	9694.01
Clinical Nurse I - Step A	C3A	---	---	4470.08	4694.24	4929.44	---	---	9685.17	10680.45
Clinical Nurse I - Step B	C3B	---	---	4579.20	4808.56	5049.76	---	---	9921.60	10941.14
Clinical Nurse I - Step C	C3C	---	---	4688.08	4923.20	5169.92	---	---	10157.50	11201.49
Clinical Nurse I - U	Q89	3955.60	4153.28	4360.88	4579.92	4809.28	---	---	8570.46	10420.10
Clinical Nurse II	S76	4192.40	4402.96	4623.52	4854.80	5097.68	---	---	9083.53	11044.97
Clinical Nurse II - Extra Help	X1H	3900.40	4096.16	4301.44	4516.64	4742.56	---	---	8450.86	10275.54
Clinical Nurse II - Step A	D0A	4297.28	4513.12	4739.12	4976.08	5224.96	---	---	9310.77	11320.74
Clinical Nurse II - Step B	D0B	4402.00	4623.04	4854.72	5097.60	5352.64	---	---	9537.66	11597.38
Clinical Nurse II - Step C	D0C	4506.80	4733.20	4970.32	5218.88	5479.92	---	---	9764.73	11873.16
Clinical Nurse II - U	Q87	4192.40	4402.96	4623.52	4854.80	5097.68	---	---	9083.53	11044.97
Clinical Nurse II - U - Step A	E1A	4297.28	4513.12	4739.12	4976.08	5224.96	---	---	9310.77	11320.74
Clinical Nurse II - U - Step B	E1B	4402.00	4623.04	4854.72	5097.60	5352.64	---	---	9537.66	11597.38
Clinical Nurse II - U - Step C	E1C	4506.80	4733.20	4970.32	5218.88	5479.92	---	---	9764.73	11873.16
Clinical Nurse III	S75	4623.52	4854.80	5097.68	5352.80	5620.72	5901.52	6196.72	10017.62	13426.22
Clinical Nurse III - Extra Help	X1I	4301.44	4516.64	4742.56	4979.84	5228.96	---	---	9319.78	11329.41
Clinical Nurse III - Step A	S7A	4739.12	4976.08	5224.96	5486.48	5760.96	6049.04	6351.52	10268.09	13761.62
Clinical Nurse III - Step B	S7B	4854.72	5097.60	5352.64	5620.64	5901.52	6196.64	6506.56	10518.56	14097.54
Clinical Nurse III - Step C	S7C	4970.32	5218.88	5479.92	5754.40	6052.72	6344.24	6661.28	10769.02	14432.77

Effective October 24, 2016										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Clinical Nurse III - U	Q86	4623.52	4854.80	5097.68	5352.80	5620.72	5901.52	6196.72	10017.62	13426.22
Clinical Nurse III - U - Step A	Q8A	4739.12	4976.08	5224.96	5486.48	5760.96	6049.04	6351.52	10268.09	13761.62
Clinical Nurse III - U - Step B	Q8B	4854.72	5097.60	5352.64	5620.64	5901.52	6196.64	6506.56	10518.56	14097.54
Clinical Nurse III - U - Step C	Q8C	4970.32	5218.88	5479.92	5754.40	6052.72	6344.24	6661.28	10769.02	14432.77
Clinical Nurse Specialist	S35	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Clinical Nurse Specialist - Extra Help	X1L	4979.84	5228.96	5490.32	5764.96	6053.36	---	---	10789.65	13115.61
Clinical Nurse Specialist - Step A	S4A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Clinical Nurse Specialist - Step B	S4B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Clinical Nurse Specialist - Step C	S4C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06
Infection Control Nurse	S04	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Infection Control Nurse - Extra Help	X1F	4979.84	5228.96	5490.32	5764.96	6053.36	---	---	10789.65	13115.61
Infection Control Nurse - Step A	S0A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Infection Control Nurse - Step B	S0B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Infection Control Nurse - Step C	S0C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06
Nurse Coordinator	S39	5097.68	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	11044.97	14802.84
Nurse Coordinator - Extra Help	X1M	4742.00	4979.44	5228.56	5489.84	5764.40	---	---	10274.33	12489.53
Nurse Coordinator - Step A	S3A	5224.96	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	11320.74	15173.08
Nurse Coordinator - Step B	S3B	5352.64	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	11597.38	15542.97
Nurse Coordinator - Step C	S3C	5479.92	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	11873.16	15913.38
Nurse Coordinator - U	Q39	5097.68	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	11044.97	14802.84
Nurse Coordinator - U Step A	Q4A	5224.96	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	11320.74	15173.08
Nurse Coordinator - U Step B	Q4B	5352.64	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	11597.38	15542.97
Nurse Coordinator - U Step C	Q4C	5479.92	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	11873.16	15913.38
Nurse Practitioner	S59	5901.52	6196.72	6506.72	6832.08	7180.56	7546.80	7932.56	12786.62	17187.21
Nurse Practitioner - Extra Help	X1N	5490.32	5764.88	6053.36	6356.16	6680.08	---	---	11895.69	14473.50
Nurse Practitioner - Step A	Y0A	6049.04	6351.52	6669.36	7002.96	7359.84	7735.36	8130.56	13106.25	17616.21
Nurse Practitioner - Step B	Y0B	6196.64	6506.56	6831.92	7173.68	7539.44	7924.24	8329.12	13426.05	18046.42
Nurse Practitioner - Step C	Y0C	6344.24	6661.28	6994.72	7344.64	7718.80	8112.80	8527.28	13745.85	18475.77
Per Diem Clinical Nurse	S99	---	67.19/Hrly	---	84.95/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	84.02/Hrly	---	106.23/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	67.19/Hrly	---	84.95/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4152.72	4360.88	4579.92	4809.28	5049.84	---	---	8997.56	10941.32

Effective October 24, 2016										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Psychiatric Nurse I - Step A	D5A	4256.64	4470.08	4694.24	4929.44	5175.92	---	---	9222.72	11214.49
Psychiatric Nurse I - Step B	D5B	4360.40	4579.20	4808.56	5049.76	5302.24	---	---	9447.53	11488.18
Psychiatric Nurse I - Step C	D5C	4464.32	4688.08	4923.20	5169.92	5428.40	---	---	9672.69	11761.53
Psychiatric Nurse II	S57	4623.52	4854.80	5097.68	5352.80	5620.72	5901.52	6196.72	10017.62	13426.22
Psychiatric Nurse II - Extra Help	X1C	4301.44	4516.64	4742.56	4979.84	5228.96	---	---	9319.78	11329.41
Psychiatric Nurse II - Step A	E2A	4739.12	4976.08	5224.96	5486.48	5760.96	6049.04	6351.52	10268.09	13761.62
Psychiatric Nurse II - Step B	E2B	4854.72	5097.60	5352.64	5620.64	5901.52	6196.64	6506.56	10518.56	14097.54
Psychiatric Nurse II - Step C	E2C	4970.32	5218.88	5479.92	5754.40	6052.72	6344.24	6661.28	10769.02	14432.77
Staff Developer	S38	5352.80	5620.72	5901.52	6196.72	6506.72	6832.08	7180.56	11597.73	15557.88
Staff Developer - Extra Help	X1E	4721.28	4957.60	5205.44	5465.76	5739.28	---	---	10229.44	12435.10
Staff Developer - Step A	S5A	5486.48	5760.96	6049.04	6351.52	6669.36	7002.96	7359.84	11887.37	15946.32
Staff Developer - Step B	S5B	5620.64	5901.52	6196.64	6506.56	6831.92	7173.68	7539.44	12178.05	16335.45
Staff Developer - Step C	S5C	5754.40	6042.08	6344.24	6661.28	6994.72	7344.64	7718.80	12467.86	16724.06

APPENDIX A – RNPA SALARIES

Effective October 23, 2017

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Assistant Nurse Manager - Extra Help	X1J	5129.20	5385.76	5654.96	5937.84	6234.96	---	---	11113.26	14907.53
Assistant Nurse Manager - Step A	S2A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	13509.08
Assistant Nurse Manager - Step B	S2B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Assistant Nurse Manager - Step C	S2C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69
Certified Registered Nurse Anesthetist	S1V	7544.40	7929.44	8334.64	8760.32	9207.60	9677.84	---	16346.20	20968.65
Certified Registered Nurse Anesthetist - Extra Help	X1K	7019.68	7377.04	7753.84	8149.92	8574.96	---	---	15209.30	18579.08
Certified Registered Nurse Anesthetist - Step A	Y1A	7733.04	8127.76	8542.88	8979.20	9437.92	9919.76	---	16754.92	21492.81
Certified Registered Nurse Anesthetist - Step B	Y1B	7921.84	8326.08	8751.44	9198.24	9667.92	10161.60	---	17163.98	22016.80
Certified Registered Nurse Anesthetist - Step C	Y1C	8110.40	8524.16	8959.68	9417.20	9898.16	10403.52	---	17572.53	22540.96
Clinical Nurse I	S89	4074.24	4277.84	4491.68	4717.28	4953.52	---	---	8827.52	10732.62
Clinical Nurse I - Extra Help	X1A	3773.44	3962.16	4178.96	4388.48	4608.32	---	---	8175.78	9984.69
Clinical Nurse I - Step A	C3A	---	---	4604.16	4835.04	5077.28	---	---	9975.68	11000.77
Clinical Nurse I - Step B	C3B	---	---	4716.56	4952.80	5201.20	---	---	10219.21	11269.26
Clinical Nurse I - Step C	C3C	---	---	4828.72	5070.88	5324.96	---	---	10462.22	11537.41
Clinical Nurse I - U	Q89	4074.24	4277.84	4491.68	4717.28	4953.52	---	---	8827.52	10732.62
Clinical Nurse II	S76	4318.16	4535.04	4762.16	5000.40	5250.56	---	---	9356.01	11376.21
Clinical Nurse II - Extra Help	X1H	4017.36	4219.04	4430.48	4652.08	4884.80	---	---	8704.28	10583.73
Clinical Nurse II - Step A	D0A	4426.16	4648.48	4881.28	5125.36	5381.68	---	---	9590.01	11660.30
Clinical Nurse II - Step B	D0B	4534.00	4761.68	5000.32	5250.48	5513.20	---	---	9823.66	11945.26
Clinical Nurse II - Step C	D0C	4642.00	4875.12	5119.36	5375.44	5644.24	---	---	10057.66	12229.18
Clinical Nurse II - U	Q87	4318.16	4535.04	4762.16	5000.40	5250.56	---	---	9356.01	11376.21
Clinical Nurse II - U - Step A	E1A	4426.16	4648.48	4881.28	5125.36	5381.68	---	---	9590.01	11660.30
Clinical Nurse II - U - Step B	E1B	4534.00	4761.68	5000.32	5250.48	5513.20	---	---	9823.66	11945.26
Clinical Nurse II - U - Step C	E1C	4642.00	4875.12	5119.36	5375.44	5644.24	---	---	10057.66	12229.18
Clinical Nurse III	S75	4762.16	5000.40	5250.56	5513.36	5789.28	6078.56	6382.56	10318.01	13828.88
Clinical Nurse III - Extra Help	X1I	4430.48	4652.08	4884.80	5129.20	5385.76	---	---	9599.37	11669.14
Clinical Nurse III - Step A	S7A	4881.28	5125.36	5381.68	5651.04	5933.76	6230.48	6542.00	10576.10	14174.33
Clinical Nurse III - Step B	S7B	5000.32	5250.48	5513.20	5789.20	6078.56	6382.48	6701.68	10834.02	14520.30
Clinical Nurse III - Step C	S7C	5119.36	5375.44	5644.24	5926.96	6234.24	6534.56	6861.04	11091.94	14865.58

Effective October 23, 2017										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Clinical Nurse III - U	Q86	4762.16	5000.40	5250.56	5513.36	5789.28	6078.56	6382.56	10318.01	13828.88
Clinical Nurse III - U - Step A	Q8A	4881.28	5125.36	5381.68	5651.04	5933.76	6230.48	6542.00	10576.10	14174.33
Clinical Nurse III - U - Step B	Q8B	5000.32	5250.48	5513.20	5789.20	6078.56	6382.48	6701.68	10834.02	14520.30
Clinical Nurse III - U - Step C	Q8C	5119.36	5375.44	5644.24	5926.96	6234.24	6534.56	6861.04	11091.94	14865.58
Clinical Nurse Specialist	S35	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Clinical Nurse Specialist - Extra Help	X1L	5129.20	5385.76	5654.96	5937.84	6234.96	---	---	11113.26	13509.08
Clinical Nurse Specialist - Step A	S4A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	16424.54
Clinical Nurse Specialist - Step B	S4B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Clinical Nurse Specialist - Step C	S4C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69
Infection Control Nurse	S04	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Infection Control Nurse - Extra Help	X1F	5129.20	5385.76	5654.96	5937.84	6234.96	---	---	11113.26	13509.08
Infection Control Nurse - Step A	S0A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	16424.54
Infection Control Nurse - Step B	S0B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Infection Control Nurse - Step C	S0C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69
Nurse Coordinator	S39	5250.56	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	11376.21	15246.92
Nurse Coordinator - Extra Help	X1M	4884.24	5128.80	5385.36	5654.48	5937.28	---	---	10582.52	12864.10
Nurse Coordinator - Step A	S3A	5381.68	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	11660.30	15628.25
Nurse Coordinator - Step B	S3B	5513.20	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	11945.26	16009.24
Nurse Coordinator - Step C	S3C	5644.24	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	12229.18	16390.74
Nurse Coordinator - U	Q39	5250.56	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	11376.21	15246.92
Nurse Coordinator - U Step A	Q4A	5381.68	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	11660.30	15628.25
Nurse Coordinator - U Step B	Q4B	5513.20	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	11945.26	16009.24
Nurse Coordinator - U Step C	Q4C	5644.24	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	12229.18	16390.74
Nurse Practitioner	S59	6078.56	6382.56	6701.92	7037.04	7395.92	7773.20	8170.48	13170.21	17702.70
Nurse Practitioner - Extra Help	X1N	5654.96	5937.76	6234.96	6546.80	6880.48	---	---	12252.41	14907.70
Nurse Practitioner - Step A	Y0A	6230.48	6542.00	6869.44	7213.04	7580.56	7967.36	8374.40	13499.37	18144.53
Nurse Practitioner - Step B	Y0B	6382.48	6701.68	7036.80	7388.88	7765.60	8161.92	8578.96	13828.70	18587.74
Nurse Practitioner - Step C	Y0C	6534.56	6861.04	7204.56	7564.96	7950.32	8356.16	8783.04	14158.21	19029.92
Per Diem Clinical Nurse	S99	---	69.21/Hrly	---	87.50/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	86.54/Hrly	---	109.42/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	69.21/Hrly	---	87.50/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4277.28	4491.68	4717.28	4953.52	5201.28	---	---	9267.44	11269.44

Effective October 23, 2017										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Psychiatric Nurse I - Step A	D5A	4384.32	4604.16	4835.04	5077.28	5331.12	---	---	9499.36	11550.76
Psychiatric Nurse I - Step B	D5B	4491.20	4716.56	4952.80	5201.20	5461.28	---	---	9730.93	11832.77
Psychiatric Nurse I - Step C	D5C	4598.24	4828.72	5070.88	5324.96	5591.20	---	---	9962.85	12114.26
Psychiatric Nurse II	S57	4762.16	5000.40	5250.56	5513.36	5789.28	6078.56	6382.56	10318.01	13828.88
Psychiatric Nurse II - Extra Help	X1C	4430.48	4652.08	4884.80	5129.20	5385.76	---	---	9599.37	11669.14
Psychiatric Nurse II - Step A	E2A	4881.28	5125.36	5381.68	5651.04	5933.76	6230.48	6542.00	10576.10	14174.33
Psychiatric Nurse II - Step B	E2B	5000.32	5250.48	5513.20	5789.20	6078.56	6382.48	6701.68	10834.02	14520.30
Psychiatric Nurse II - Step C	E2C	5119.36	5375.44	5644.24	5926.96	6234.24	6534.56	6861.04	11091.94	14865.58
Staff Developer	S38	5513.36	5789.28	6078.56	6382.56	6701.92	7037.04	7395.92	11945.61	16024.49
Staff Developer - Extra Help	X1E	4862.88	5106.32	5361.60	5629.68	5911.44	---	---	10536.24	12808.12
Staff Developer - Step A	S5A	5651.04	5933.76	6230.48	6542.00	6869.44	7213.04	7580.56	12243.92	16424.54
Staff Developer - Step B	S5B	5789.20	6078.56	6382.48	6701.68	7036.80	7388.88	7765.60	12543.26	16825.46
Staff Developer - Step C	S5C	5926.96	6223.28	6534.56	6861.04	7204.56	7564.96	7950.32	12841.74	17225.69

APPENDIX A – RNPA SALARIES

Effective October 22, 2018

Job Title	Job Code	Biweekly Step 1	Biweekly Step 2	Biweekly Step 3	Biweekly Step 4	Biweekly Step 5	Biweekly Step 6	Biweekly Step 7	Monthly Min	Monthly Max
Assistant Nurse Manager	S11	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Assistant Nurse Manager - Extra Help	X1J	5283.04	5547.28	5824.56	6115.92	6422.00	---	---	11446.58	13914.33
Assistant Nurse Manager - Step A	S2A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Assistant Nurse Manager - Step B	S2B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Assistant Nurse Manager - Step C	S2C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40
Certified Registered Nurse Anesthetist	S1V	7770.72	8167.28	8584.64	9023.12	9483.76	9968.16	---	16836.56	21597.68
Certified Registered Nurse Anesthetist - Extra Help	X1K	7230.24	7598.32	7986.40	8394.40	8832.16	---	---	15665.52	19136.34
Certified Registered Nurse Anesthetist - Step A	Y1A	7964.96	8371.52	8799.12	9248.56	9721.04	10217.28	---	17257.41	22137.44
Certified Registered Nurse Anesthetist - Step B	Y1B	8159.44	8575.84	9013.92	9474.16	9957.92	10466.40	---	17678.78	22677.20
Certified Registered Nurse Anesthetist - Step C	Y1C	8353.68	8779.84	9228.40	9699.68	10195.04	10715.60	---	18099.64	23217.13
Clinical Nurse I	S89	4196.40	4406.16	4626.40	4858.72	5102.08	---	---	9092.20	11054.50
Clinical Nurse I - Extra Help	X1A	3886.64	4080.96	4304.32	4520.08	4746.56	---	---	8421.05	10284.21
Clinical Nurse I - Step A	C3A	---	---	4742.24	4980.08	5229.52	---	---	10274.85	11330.62
Clinical Nurse I - Step B	C3B	---	---	4858.00	5101.36	5357.20	---	---	10525.66	11607.26
Clinical Nurse I - Step C	C3C	---	---	4973.52	5222.96	5484.64	---	---	10775.96	11883.38
Clinical Nurse I - U	Q89	4196.40	4406.16	4626.40	4858.72	5102.08	---	---	9092.20	11054.50
Clinical Nurse II	S76	4447.68	4671.04	4904.96	5150.40	5408.00	---	---	9636.64	11717.33
Clinical Nurse II - Extra Help	X1H	4137.84	4345.60	4563.36	4791.60	5031.28	---	---	8965.32	10901.10
Clinical Nurse II - Step A	D0A	4558.88	4787.92	5027.68	5279.12	5543.12	---	---	9877.57	12010.09
Clinical Nurse II - Step B	D0B	4670.00	4904.48	5150.32	5407.92	5678.56	---	---	10118.33	12303.54
Clinical Nurse II - Step C	D0C	4781.20	5021.36	5272.88	5536.64	5813.52	---	---	10359.26	12595.96
Clinical Nurse II - U	Q87	4447.68	4671.04	4904.96	5150.40	5408.00	---	---	9636.64	11717.33
Clinical Nurse II - U - Step A	E1A	4558.88	4787.92	5027.68	5279.12	5543.12	---	---	9877.57	12010.09
Clinical Nurse II - U - Step B	E1B	4670.00	4904.48	5150.32	5407.92	5678.56	---	---	10118.33	12303.54
Clinical Nurse II - U - Step C	E1C	4781.20	5021.36	5272.88	5536.64	5813.52	---	---	10359.26	12595.96
Clinical Nurse III	S75	4904.96	5150.40	5408.00	5678.72	5962.88	6260.88	6574.00	10627.41	14243.66
Clinical Nurse III - Extra Help	X1I	4563.36	4791.60	5031.28	5283.04	5547.28	---	---	9887.28	12019.10
Clinical Nurse III - Step A	S7A	5027.68	5279.12	5543.12	5820.56	6111.76	6417.36	6738.24	10893.30	14599.52
Clinical Nurse III - Step B	S7B	5150.32	5407.92	5678.56	5962.80	6260.88	6573.92	6902.72	11159.02	14955.89
Clinical Nurse III - Step C	S7C	5272.88	5536.64	5813.52	6104.72	6421.20	6730.56	7066.80	11424.57	15311.40

Effective October 22, 2018										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Clinical Nurse III - U	Q86	4904.96	5150.40	5408.00	5678.72	5962.88	6260.88	6574.00	10627.41	14243.66
Clinical Nurse III - U - Step A	Q8A	5027.68	5279.12	5543.12	5820.56	6111.76	6417.36	6738.24	10893.30	14599.52
Clinical Nurse III - U - Step B	Q8B	5150.32	5407.92	5678.56	5962.80	6260.88	6573.92	6902.72	11159.02	14955.89
Clinical Nurse III - U - Step C	Q8C	5272.88	5536.64	5813.52	6104.72	6421.20	6730.56	7066.80	11424.57	15311.40
Clinical Nurse Specialist	S35	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Clinical Nurse Specialist - Extra Help	X1L	5283.04	5547.28	5824.56	6115.92	6422.00	---	---	11446.58	13914.33
Clinical Nurse Specialist - Step A	S4A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Clinical Nurse Specialist - Step B	S4B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Clinical Nurse Specialist - Step C	S4C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40
Infection Control Nurse	S04	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Infection Control Nurse - Extra Help	X1F	5283.04	5547.28	5824.56	6115.92	6422.00	---	---	11446.58	13914.33
Infection Control Nurse - Step A	S0A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Infection Control Nurse - Step B	S0B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Infection Control Nurse - Step C	S0C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40
Nurse Coordinator	S39	5408.00	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	11717.33	15704.17
Nurse Coordinator - Extra Help	X1M	5030.72	5282.64	5546.88	5824.08	6115.36	---	---	10899.89	13249.94
Nurse Coordinator - Step A	S3A	5543.12	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	12010.09	16096.94
Nurse Coordinator - Step B	S3B	5678.56	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	12303.54	16489.37
Nurse Coordinator - Step C	S3C	5813.52	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	12595.96	16882.32
Nurse Coordinator - U	Q39	5408.00	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	11717.33	15704.17
Nurse Coordinator - U Step A	Q4A	5543.12	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	12010.09	16096.94
Nurse Coordinator - U Step B	Q4B	5678.56	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	12303.54	16489.37
Nurse Coordinator - U Step C	Q4C	5813.52	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	12595.96	16882.32
Nurse Practitioner	S59	6260.88	6574.00	6902.96	7248.08	7617.76	8006.32	8415.52	13565.24	18233.62
Nurse Practitioner - Extra Help	X1N	5824.56	6115.84	6422.00	6743.20	7086.88	---	---	12619.88	15354.90
Nurse Practitioner - Step A	Y0A	6417.36	6738.24	7075.52	7429.36	7807.92	8206.32	8625.60	13904.28	18688.80
Nurse Practitioner - Step B	Y0B	6573.92	6902.72	7247.84	7610.48	7998.56	8406.72	8836.32	14243.49	19145.36
Nurse Practitioner - Step C	Y0C	6730.56	7066.80	7420.64	7791.84	8188.80	8606.80	9046.48	14582.88	19600.70
Per Diem Clinical Nurse	S99	---	71.28/Hrly	---	90.12/Hrly	---	---	---	---	---
Per Diem Nurse Practitioner	S41	---	89.14/Hrly	---	112.70/Hrly	---	---	---	---	---
Per Diem Psychiatric Nurse	S92	---	71.28/Hrly	---	90.12/Hrly	---	---	---	---	---
Psychiatric Nurse I	S58	4405.52	4626.40	4858.72	5102.08	5357.28	---	---	9545.29	11607.44

Effective October 22, 2018										
Job Title	**Job Code**	**Biweekly Step 1**	**Biweekly Step 2**	**Biweekly Step 3**	**Biweekly Step 4**	**Biweekly Step 5**	**Biweekly Step 6**	**Biweekly Step 7**	**Monthly Min**	**Monthly Min**
Psychiatric Nurse I - Step A	D5A	4515.84	4742.24	4980.08	5229.52	5491.04	---	---	9784.32	11897.25
Psychiatric Nurse I - Step B	D5B	4625.92	4858.00	5101.36	5357.20	5625.04	---	---	10022.82	12187.58
Psychiatric Nurse I - Step C	D5C	4736.16	4973.52	5222.96	5484.64	5758.88	---	---	10261.68	12477.57
Psychiatric Nurse II	S57	4904.96	5150.40	5408.00	5678.72	5962.88	6260.88	6574.00	10627.41	14243.66
Psychiatric Nurse II - Extra Help	X1C	4563.36	4791.60	5031.28	5283.04	5547.28	---	---	9887.28	12019.10
Psychiatric Nurse II - Step A	E2A	5027.68	5279.12	5543.12	5820.56	6111.76	6417.36	6738.24	10893.30	14599.52
Psychiatric Nurse II - Step B	E2B	5150.32	5407.92	5678.56	5962.80	6260.88	6573.92	6902.72	11159.02	14955.89
Psychiatric Nurse II - Step C	E2C	5272.88	5536.64	5813.52	6104.72	6421.20	6730.56	7066.80	11424.57	15311.40
Staff Developer	S38	5678.72	5962.88	6260.88	6574.00	6902.96	7248.08	7617.76	12303.89	16505.14
Staff Developer - Extra Help	X1E	5008.72	5259.44	5522.40	5798.56	6088.72	---	---	10852.22	13192.22
Staff Developer - Step A	S5A	5820.56	6111.76	6417.36	6738.24	7075.52	7429.36	7807.92	12611.21	16917.16
Staff Developer - Step B	S5B	5962.80	6260.88	6573.92	6902.72	7247.84	7610.48	7998.56	12919.40	17330.21
Staff Developer - Step C	S5C	6104.72	6409.92	6730.56	7066.80	7420.64	7791.84	8188.80	13226.89	17742.40

APPENDIX B - CLASSIFICATIONS AND AREAS OF COMPETENCY FOR LAYOFF PURPOSES ONLY

B.1 - Classifications

Assistant Nurse Manager

Areas of Competency

1. Medical/Surgical
2. Rehabilitation
3. Neonatal Intensive Care, Pediatrics, Pediatric Intensive Care
4. Critical Care
5. Post Anesthesia Care Unit(PACU), Ambulatory Surgery Unit (ASU)
6. Transitional Care Neurosurgery Unit, Medical Short Stay Unit
7. Labor and Delivery
8. Mother Infant Care Center (MICC)
9. Operating Room
10. Ambulatory Care
11. Renal Care Center
12. Psychiatry/Behavioral Health

Clinical Nurse Specialist

Areas of Competency

1. Enterostomal
2. Oncology
3. Psychiatry/Behavioral Health
4. Rehabilitation
5. Maternity
6. Neonatal
7. Pediatric

Staff Developer

Areas of Competency

1. Medical/Surgical
2. Rehabilitation
3. Neonatal Intensive Care, Pediatrics, Pediatric Intensive Care
4. Critical Care
5. Labor and Delivery
6. Mother Infant Care Center (MICC)
7. Operating Room
8. Ambulatory Care
9. Custody Health Services

10. Psychiatry/Behavioral Health
11. General

Infection Control Nurse

Area of Competency

1. Infection Control

Nurse Coordinator

Areas of Competency

1. HIV/AIDS Services
2. Diabetes Patient Education
3. Dialysis
4. Nursing Information Systems
5. Psychiatry/Behavioral Health, Drug and Alcohol
6. Comprehensive Perinatal Services Program (CPSP)
7. Endoscopy
8. SART
9. Mother Infant Care Center (MICC)
10. Lactation
11. Cardiovascular
12. Anticoagulant
13. Homeless Program
14. Oncology
15. Stroke Coordinator

Clinical Nurse I/II/III

Areas of Competency

1. Medical-Surgical Units
(3 Surgical, 4 Surgical, 4 Medical,
Admission, Discharge, Transfer (ADT) Nurse

2. Rehabilitation (1RHB,
2 RHB, Rehabilitation Trauma Unit RTC2)

3. Neonatal Intensive Care Unit,
Pediatrics, Pediatric Intensive Care Unit

4. Adult Intensive Care Units (MICU, TICU, CCU, SICU), Burn Unit, Emergency Department, Cardiac Cath Lab, Interventional Radiology, Resource Nurse, PICC Nurse

5. Post Anesthesia Care Unit (PACU),Ambulatory Surgery Unit (ASU)

6. Transitional Care Neurosurgery Unit, Medical Short Stay Unit

7. Labor and Delivery

8. Mother-Infant Care Center (MICC)

9. Operating Room

10. Ambulatory Care

11. Renal Care Center

12. Custody Health Services

13. Coded Float:
Competency areas for coded float nurses are determined based upon the greatest percentage of assignments within Appendix B, Clinical Nurse I, II, III Areas of Competency 1-13 in the preceding twelve (12) months.
In the event of a layoff, those coded floats determined to be competent in the area being laid off will be included in the layoff process.

Psychiatric Nurse I/II

Area of Competency

1. Psychiatry/Behavioral Health, Drug & Alcohol.

Nurse Practitioner

Areas of Competency

1. Family
2. Adult
3. Neonatal Care
4. Pediatric
5. Women's Health
6. Gerontology
7. Psychiatry/Behavioral Health
8. Oncology

B. 2. - Areas of Competency Not Covered

If an area is not covered by this appendix, the parties shall meet and confer on the related areas of competency.

B.3 - Certifications and Specialty Skills

County may retain less senior nurses or nurses in a lower class who have certifications or specialty skills as designated:

1. Chemotherapy Certification on 4 Medical and Infusion Center
2. Open Heart qualified in SICU
3. Intra-aortic Balloon Pump (IABP) Certification in the CCU
4. Cardiac Cath Lab qualified in the Cath Lab
5. Informatics Nurse Certification for Nursing Information Systems Nurse Coordinator positions.

Appendix C
Per Diem and Extra Help Nurses

1. Per Diem (PD) and Extra Help (EH) Nurses are appointments to non-permanent positions established to meet peak load or other unusual work situations.

   PD and EH nurses may access sccjobs.org and complete job interest notification(s) to be notified of coded nursing positions that are being posted on an open/competitive basis.

2. PD nurses are required to be available to work at least eight (8) shifts a month, two of which are weekend shifts(if applicable). Four (4) weekend shifts per month may be approved as an alternate schedule to the eight shifts per month work requirement.

   Each PD and EH nurse must be available to work one of the three major holidays: Thanksgiving, Christmas or New Year's Day on a rotating basis. Christmas Eve and New Year's Eve will be considered as meeting the holiday requirement for the evening shift. When assigned and worked, extra help and per diem nurses shall be paid at time and one half for all hours worked on two of the three major holidays as noted above.

3. EH nurses are required to be available to work a minimum of four (4) shifts per month, one of which will be a weekend shift.

4. Each PD and EH nurse is expected to float to units within their like area(s) as set forth in Section 8.14 b) however PD/EH nurses are not eligible for the premium pay.

5. No nurse may receive pay in an extra help capacity in the same classification in the same department for more than 1,040 hours in any fiscal year, unless otherwise approved by the Board of Supervisors.

   a) Should an extension of hours be requested, the County shall provide RNPA at least twenty (20) days' notice in advance of the scheduled Board of

Supervisors meeting. RNPA shall respond within five (5) days of receipt of notice to request to meet and discuss or such request is deemed to have been waived.

b) If a request to meet is made, the County and RNPA shall meet and discuss for not more than five (5) working days. If concerns are not alleviated or agreement not reached, the County may proceed.

c) The Board of Supervisors may proceed without meeting should they determine circumstances justify urgent action. Reasonable advance notice will be provided to the notice with intention to proceed on such basis.

6. Nurses who work as PD or EH shall be compensated on an hourly basis in accordance with the provisions of the County of Santa Clara Salary Ordinance Section B. (3).

7. Overtime is defined as time worked beyond eighty (80) hours on a bi-weekly pay period, or beyond eight (8) hours in any work day except as mutually agreed upon between the County and the Association. Compensation for regular overtime shall be paid in cash at the rate of one and one-half (1 ½) times the regular hourly rate. Compensation for continuous shift overtime shall be paid in cash at the rate of one and one-half (1 ½) times the regular hourly rate for the first four (4) hours of overtime contiguous to the regular shift of a minimum of eight (8) hours and two (2) times the regular hourly rate for any additional hours worked.

8. PD or EH nurses may elect to work an alternate work day of ten (10) or twelve (12) hour shift with mutual agreement of the nurse and management. This schedule shall be a voluntary/optional alternative to an eight (8) hour work day assignment. A PD or EH nurse working an alternate ten (10) or twelve (12) hour shift shall be compensated for each hour worked at the regular hourly base pay. Hours worked in excess of ten (10) or twelve (12) hours of the alternate ten (10) or twelve (12) hour shift, shall be subject to overtime provisions (Appendix C, #7).

9. PD and EH nurses shall be subject to all provisions of Article 1; Article 2; Section 3.1, 3.2, 3.4; Article 4; Section 6.3; Sections 7.1, 7.6, 7.7; Sections 8.3, 8.4, 8.5, 8.9, 8.14 a) 8.14 b) (except for differential); Section 13.7; Article 14; Article 16; Article 17; Sections 18.2, 18.3, 18.4, 18.5, 18.8, 18.9,

18.10 (except for e), 18.11; Article 19; Article 20; Article 21; Article 22 and Article 23 of the Agreement between the County and RNPA and this Appendix.

10. Each PD and EH nurse will be evaluated annually. The evaluation shall consist of a comparison of the nurse's performance against written standards established by Management for:

1) Work Unit competencies;
2) Job classification;
3) Unit role expectations;
4) Any appropriate legal or regulatory requirements.

The County and RNPA shall meet within 90 days of agreement to discuss options in assisting extra help and per diem nurses achieve employment in coded positions. Discussions shall include training for assisting extra help and per diem nurses be successful in the testing process and job advancement skills.

The County commits to train managers and supervisors on the effective use of eligible lists, filling temporary vacancies and using the recruitment process including the use of selective certification and alternatives to extra help and per diem including Provisional and Substitute Provisional appointments.

A PD nurse is eligible for and may request a performance salary increase, contingent upon achieving a rating of standard or above in all categories of the performance evaluation and provided that he/she has worked a minimum of 1,040 hours since the last performance increase. An evaluation used for salary increase shall not be older than 90 days. Each PD nurse may only receive one performance salary increase within a one year time frame.

11. The parties acknowledge the value of permanent positions in maintaining quality of patient care while recognizing the need to use an appropriate staffing mix. The staffing mix accounts for flexibility and fluctuations based on peak loads and unusual work situations.

On a monthly basis the County shall provide the Association with a list of all RNPA represented PD and EH nurses names, classification, department and hours worked. Each year during the month of July, the County shall provide the

Association with a summary of all RNPA represented PD and EH hours by name, classification, department, cost center, and hours for the entire preceding fiscal year.
On a quarterly basis the County shall provide the Association with a report on the aggregate staffing mix of permanent, extra help and per diem.

12. The County and the Association shall meet on a quarterly basis during the term of the agreement to review and discuss the use of PD and EH nurses.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

No. 19-cv-2916 NC

DECLARATION OF TONI TULLYS, M.P.A., DIRECTOR OF COUNTY OF SANTA CLARA BEHAVIORAL HEALTH SERVICES DEPARTMENT, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, TONI TULLYS, MPA, declare as follows

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

2. I am the Director of the County's Behavioral Health Services Department ("BHSD"), which is part of the County's broader Health System. I have held this position from December 2014 to the present. In this role, I provide leadership on behavioral health issues for all of Santa Clara County and oversee approximately 822 BHSD employees, full-time and part-time, who provide a wide array of services to safeguard and promote the health of the community. I also oversee over $500 million in behavioral health services delivered by County staff and contracted providers.

3. Prior to becoming the Director of Behavioral Health Services for the County, I was the Deputy Director of the Alameda County Behavioral Health Care Services Department. I have worked in various administrative and patient care capacities in public and private health care organizations for more than 30 years. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

4. The Behavioral Health Services Department's mission is

> "[t]o assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity."

5. BHSD is dedicated to improving the health and well-being of Santa Clara County residents and provides an array of behavioral health services to approximately 35,000 people annually. BHSD provides preventative mental health and substance use care and also serves individuals with mental health issues, serious mental illness, and substance use disorders. These services have been developed for every age group, from newborns to the elderly. BHSD provides treatment services to a wide range of residents including Medi-Cal beneficiaries, patients with a

sliding-fee option based on their ability to pay, and a small number of commercially insured patients that receive mild to moderate services.

6. BHSD provides prevention and treatment services for all persons struggling with substance use and mental health challenges, including at-risk youth, young adults, and families. For example, it provides individual counseling, group counseling, and case management services, which may include connecting youth to medical care, legal resources, transportation, job training, psychiatric services, and housing resources. Within BHSD, a dedicated Substance Use Treatment Services division provides prevention programs to children and youth and treatment services to persons struggling with substance abuse through services such as withdrawal management, outpatient treatment, recovery services, residential treatment, recovery residences, Medication-Assisted Treatment (MAT), perinatal services, and residential treatment services to assist County residents who struggle with substance abuse.

7. The County provides emergency psychiatric services at Santa Clara Valley Medical Center's Emergency Psychiatric Services (EPS) facility, the only 24-hour locked psychiatric emergency room in Santa Clara County. Nearly all patients at this facility are on involuntary psychiatric holds. In addition, BHSD operates Mental Health Urgent Care a walk-in crisis clinic with a psychiatrist on duty seven days a week for those seeking voluntary services. BHSD also provides post hospital services for patients who were served by the County's 48-bed acute inpatient psychiatric unit, and BHSD contracts with three additional community hospitals for inpatient mental health treatment.

8. Federal funding, either direct or indirect, from the U.S. Department of Health and Human Services is a major component of the budget for BHSD. Funding streams to BHSD, many of which flow through the State of California, include but are not limited to Medi-Cal and Medicare payments and several sources of funding from the Substance Abuse and Mental Health Administration, among many others. In total, in a typical fiscal year such as FY 2017-18, BHSD received approximately $112 million in federal funds, revenue that is a significant portion of the overall budget, which had overall gross expenditures of approximately $498 million. Without

those funds, the County Behavioral Health Services Department would have to dramatically reduce services even while the need for mental health services is growing in Santa Clara County and the County is planning to expand services provided through BHSD. The impact of any loss in federal funding would not be limited to services traditionally funded by federal dollars. A withdrawal of federal funding for the County would require a countywide realignment of funding and priorities, and money that is currently allocated from the County's General Fund to support programs that do not receive federal funding could be diverted to address the loss of federal funding.

9. The County Behavioral Health Services Department has a policy related to religious and moral objections to certain patient care, attached as **Exhibit A**. That policy requires BHSD staff and staff of all contracted service providers to inform BHSD prior to beginning work for BHSD, and annually thereafter, if there are certain services the provider does not offer due to religious or moral objections. BHSD will then inform beneficiaries and provide access to care through different providers.

10. BHSD's providers are expected to be competent to provide care for any patient and must not discriminate on the basis of health status or need for health care services, race, color, national origin, sex, gender, sexual orientation, gender identity, or disability. BHSD's providers also must offer culturally and linguistically competent, high-quality services to socially disadvantaged and ethnically diverse groups.

11. BHSD has a process for either patients or providers to voice concerns about their ability to continue in the treatment relationship, as building trust between the provider and patient is essential to the success of mental health treatment. When a provider is unable or unwilling to continue providing care for a patient, BHSD requires the provider to work with BHSD, which may include working directly with a new provider, to ensure continuity of care for the patient. That transition effort may also include following up with the patient to ensure they have scheduled necessary appointments and otherwise are receiving the treatments and services they need. Without timely notice of a refusal to provide care for religious or moral reasons and a

smooth transition to another provider, patients may not receive necessary and timely treatment, which could harm the patients and their communities and lead to additional healthcare needs and associated costs.

12. In my capacity as Director of Behavioral Health Services, I reviewed and am familiar with the model text for the "Notice of Rights under Federal Conscience and Anti-Discrimination Laws" from the Final Rule published by the U.S. Department of Health and Human Services, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."

13. Many of the clinics operated by and contracting with BHSD are physically small places where notices for employees would be in plain view of patients as well. The model text may give patients the impression that providers are able to object in the moment to providing care based on their conscience, religious beliefs, or moral convictions—potentially deterring patients from sharing sensitive information that is critical to their care. For example, to receive appropriate care, patients who are seeking mental health care may need to disclose to their provider sensitive information such as their medical history or plans to seek treatments such as abortion, sterilization, assisted suicide, or gender-affirming care. But the model notice may give the client an impression that revealing such information is unwelcome or even risky.

14. Given the vital importance in mental health care of trust between patients and providers, a notice such as this model text would unacceptably interfere with the patient-provider relationship, interrupting the continuum of care that the Behavioral Health Services Department is required to provide, interfering with the functioning of BHSD, and undermining BHSD's mission.

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

Dated: June 9, 2019

Respectfully submitted,

TONI TULLYS, M.P.A.

EXHIBIT A

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 2100

- [x] **BHSD County Staff**
- [x] **Contract Providers**
- [x] **Specialty Mental Health**
- [x] **Specialty Substance Use Treatment Services**

Title: LIMITATION ON MORAL OR RELIGIOUS GROUNDS

Approved/Issue Date:	**Behavioral Health Services Director:**	
Last Review/Revision Date:	**Next Review Date:**	**Inactive Date:**

REFERENCE:

- 42 CFR § 438.10 (e), (g). Information Requirements.
- 42 CFR § 438.52. Choice of MCO's, PIHPs, PAHPs, PCCMs and PCCM entities.
- 42 CFR § 438.100 (b). Enrollee Rights.
- 42 CFR § 438.102 (a)-(b). Provider-enrollee Communications.

POLICY:

Providers will not be required to deliver, reimburse for, or offer coverage of a counseling or referral service if the provider objects to the service on moral or religious grounds. Beneficiaries will know which providers have objections based on religious or moral grounds prior to referral or change.

DEFINITIONS:

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Provider. A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 2100

- [x] **BHSD County Staff**
- [x] **Contract Providers**
- [x] **Specialty Mental Health**
- [x] **Specialty Substance Use Treatment Services**

Title: LIMITATION ON MORAL OR RELIGIOUS GROUNDS

PROCEDURE	
Responsible Party	**Action Required**
Enrollees and Potential Enrollees	May contact the state to request information on how and where to obtains such services if BHSD chooses not to furnish the services because of moral or religious objections.
BHSD	1. Reimburses for counseling and referral services based on moral or religious grounds. 2. Notifies beneficiaries about providers that may not provide services based on moral or religious grounds at least 30 days prior to the effective date of the change. 3. Notifies enrollees at least 30 days in advance of BHSD implementing any new policy to discontinue the provision and reimbursement of counseling or referral services based on moral or religious grounds. 4. Furnishes the state with information on services it does not cover based on moral or religious grounds whenever it adopts this type of policy.
Providers	1. Prior to entering into a contract, providers will submit documentation to the BHSD about any services they do not cover because of moral or religious objections. 2. Providers will submit information to beneficiaries about any services they do not cover because of moral or religious objections. 3. Submit updates to BHSD annually or when there is a change in the services not covered due to moral or religious grounds.
Attachments:	

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF MODESTO VALLE, CHIEF EXECUTIVE OFFICE OF CENTER ON HALSTED, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Modesto Valle, declare as follows:

1. Center on Halsted is a 501(c)(3) non-profit organization based in Chicago and incorporated in Illinois. Center on Halsted is a comprehensive community center dedicated to securing the health and well-being of the LGBT people of the Chicago area. More than 1,400 community members walk through our doors each day for a range of social and/or direct service engagements.

2. As a comprehensive community center dedicated to advancing community and securing the health and well-being of LGBT people in Chicago, Center on Halsted provides programs and services for the LGBT community, including case management, lunches, job development, social programing, and housing for seniors; housing, meals, counseling, and leadership development for youth; and anti-violence services. Center on Halsted provides a wide range of behavioral-health services for all ages, including gender-transition-related counseling, individual and group therapy, anti-violence crisis counseling, and HIV-related healthcare, including HIV testing and linkage to Pre-Exposure Prophylaxis or PrEP, which is extremely effective at preventing HIV transmission. Center on Halsted will soon be expanding the breadth of healthcare services that it provides via the opening of its own Health and Wellness Clinic, likely within the next year.

3. Community members not only obtain services from Center on Halsted, they also access healthcare services from a range of other community based organizations and agencies, including religiously-affiliated organizations. For example, seniors who are served by Center on Halsted currently access services through Catholic Charities and religiously-owned hospitals and care facilities, organizations that receive federal financial support for their programs and services. When these seniors encounter problems with service agencies, including denial of healthcare services based on their LGBT status or identity, Center on Halsted intervenes to advocate on the

patrons' behalf. Center staff communicate with agencies informing them of their legal obligation to ensure that LGBT people who Center on Halsted serves have the ability to secure healthcare services on equal, nondiscriminatory terms. When agencies deny services to LGBT individuals, word spreads among community members, causing many of those who the Center on Halsted serves to be fearful of also being discriminated against by these organizations.

4. I have been the Chief Executive Officer of Center on Halsted since 2007 and have been instrumental in establishing many of the programs that are offered through the Center, including bringing several landmark efforts to the Center, such as the first LGBTQ-friendly affordable housing project for Seniors and the HIV/AIDS and STI Program. I attended DePaul University and Notre Dame's Seminary School. In addition, I hold certificates in nonprofit management from Harvard Business School and Northwestern University's Kellogg School of Management. I was recently appointed to the CenterLink Board of Directors and have served on the board of the NAMES Project Foundation, Equality Education Project, City of Chicago LGBT Health Council, Illinois Violence Prevention Authority Board, City of Chicago Employment Task Force, Welcoming Committee NATO, Illinois HIV/AIDS Advisory Council, Board Member of Horizons Community Services and the Chicago Children's Choir. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

5. Unless enjoined, the impact that the Denial-of-Care Rule will have on the patrons and clients whom Center on Halsted serves will be profound. People across nearly every demographic and along the entire spectrum from closeted to fully out come through Center on Halsted's doors to be in a space where they feel safe in the entirety of their authentic selves. What Center on Halsted provides is a space where judgement is not passed, nor services withheld based on personal prejudice. Center on Halsted is also a place where people do not have to sacrifice safety

or delay healthcare out of fear of being told that who they are does not meet someone's moral or religious standards. If there is one thing that the 1,400 people walking through our doors have in common, it is that they know they are welcomed, whether that is to join a community group, hear a lecture, receive mental-health services, participate in a family group, take in an art show, use a computer, get an HIV test, or just relax. From our experiences serving our community, the Denial-of-Care Rule will cause the people Center on Halsted serves to feel a greater need to hide their identities and same-sex relationships when accessing healthcare services from healthcare providers outside of Center on Halsted out of fear that the healthcare providers may have religious objections to serving LGBT people. Causing clients to omit potentially vital parts of their life history may result in a misdiagnosis and an incomplete or inappropriate treatment or recommendation. Staying in the closet may also lead to greater isolation, which is harmful in itself and negatively affects an individual's health and well-being.

6. The Denial-of-Care Rule will evoke trauma and fear among members of our community, resulting in increased demand for Center on Halsted's LGBT-affirming mental-health counseling. This will especially impact transgender and behavioral-health services that Center on Halsted currently provides. The additional demand for services and advocacy caused by discrimination resulting from the Rule will strain Center on Halsted's resources.

7. Center on Halsted will likely see an increased need for behavioral health services, especially for LGBT homeless youth who are particularly vulnerable, as many have been kicked out of their homes before encountering rejection or other discriminatory treatment by a healthcare provider. When at-risk youth experience additional rejections and denials of care by their healthcare providers, the very people whom they reach out to for support in their most vulnerable moments, they are more likely to engage in high-risk behaviors and will thus require Center on Halsted's services more often and in a greater state of trauma. With the Denial-of-Care Rule in

effect, Center on Halsted may have fewer ways to mentor these youth away from high-risk behaviors when the availability of complementary support, such as replacing the familial and community safety nets with ones using social services, is reduced by discriminatory denials of service.

8. The Rule will also cause added stress on LGBT clients for whom accessing social services will be like stepping into a minefield. This will mean that Center on Halsted will need to re-examine all referral linkages, which will become increasingly difficult as the Denial-of-Care Rule will empower individuals within agencies to discriminate. In effect, this reduces the already severely damaged trust that LGBT clients – especially young clients – have, which is troubling as trust is necessary for a client to reach out for help. For example, if a young client fears that a once trusted organization may have a healthcare provider or gatekeeper whose religious beliefs about the child's gender identity reflects those of the adults who abused and abandoned them, it keeps the young person in a state of heightened vulnerability.

9. Center on Halsted is also seeing a rise in the numbers of requests for gender transition letters from our behavioral-health department. Transition letters are written by qualified Behavioral Health staff on behalf of Transgender clients seeking gender confirmation surgery. The rise in requests is likely because some transgender clients are growing more afraid of harassment, denials of care, and elongated procedures intended only to obstruct their access to transition-related care. Center on Halsted's behavioral-health staff also anticipate that already disproportionately high suicide rates within the transgender community will climb if there is a return to more obstacles to transition-related options.

10. Center on Halsted will need to educate the community about the Denial-of-Care Rule in particular in order to inform clients of the additional steps clients may need to take in order to determine whether particular providers are competent and affirming. If the law takes effect, we

are likely to see an increase in reports of LGBT people being denied services. Between the Transgender Military Ban, the denial of gender self-determination for school children, and this Rule, LGBT people are negatively affected on multiple levels, which will require designing multi-level responses to address individual, interpersonal, systemic, and cultural impacts.

11. For instance, in addition to direct services, Center on Halsted provides training to healthcare professionals across fields. Due to increased stigma and discrimination, a lack of LGBT affirming healthcare options, and increased denials of care, the Denial-of-Care Rule will increase healthcare disparities affecting the LGBT community. For over a decade, Center on Halsted has invested heavily in training and providing technical assistance to the healthcare industry in Chicago related to learning to work toward ensuring equitable services to the LGBT community. The Denial-of-Care Rule will require us to re-write these training programs and any related materials as well as require us to reach out to healthcare organizations and businesses in the Chicago region to re-train their personnel. The Denial-of-Care Rule thus undermines our mission of maintaining nondiscriminatory healthcare environments at these institutions and forces us to redirect resources to retraining and ensuring that these healthcare organizations and businesses retain and reinforce their nondiscrimination requirements. Some of the training programs we have offered were funded through government grants such as the Victims of Crimes Act grant.

12. As a result of the Denial-of-Care Rule, LGBT people and people living with HIV in Illinois will be at a higher risk of lacking culturally competent healthcare providers who will not further traumatize them or exacerbate the reasons that they sought healthcare in the first place. Increased discrimination against LGBT clients creates a need for more and longer training engagements. In fiscal year 2017, Center on Halsted trainers provided twenty-five trainings to nearly 600 health and safety professionals. The Denial-of-Care Rule frustrates Center on Halsted's work in this area as it could prevent Center on Halsted from teaching and achieving its pillar

principles that are based on a client-centric, nondiscriminatory approach to healthcare, including teachings that religious-based objections to treating LGBT clients, and the negative treatment of LGBT clients and clients living with HIV, can significantly and adversely alter a client's health and well-being without potentially violating the Rule. When healthcare providers affirm negative messaging about clients' self-worth, particularly during clients' most vulnerable moments of need for health-related care, clients' confidence and trust in the medical care that they receive is eroded, negatively affecting their health and well-being because they are less likely to seek care for their medical needs and by the time they do seek care, their conditions are often more acute.

13. Related to gender transitions, Center on Halsted is concerned about the Denial-of-Care Rule's preamble that characterizes transgender-affirming care as "sterilization." Much of transgender-affirming care has no impact on reproductive function or may have merely an incidental impact on reproductive function. For many transgender individuals, gender confirmation surgery is a treatment for gender dysphoria, but it is not done for the purpose of preventing procreation. Bodily autonomy is of paramount importance to everyone, including transgender individuals. While impacts on reproduction may be an incidental effect of some transgender-affirming care, such treatment is *not* sterilization.

14. Center on Halsted is working on opening its own health and wellness clinic that will include behavioral health treatment, therapy, counseling, anti-violence and youth programming, HIV-related healthcare services, PrEP services and access, additional gender-transition-related care options, and referral services to outside organizations for clients seeking healthcare options that Center on Halsted does not provide. This will be another investment Center on Halsted makes in our community, one that is particularly important as more providers use religious-based objections to providing PrEP and other medications as a way to not serve the LGBT community.

15. The Denial-of-Care Rule will empower broad discrimination. We have heard from clients, for example, that their requests for prescriptions like PrEP were rejected because healthcare providers outside of Center on Halsted stated that providing such treatment was contrary to their moral beliefs and would, allegedly, promote "promiscuous" lifestyles and even 'gay sex' generally. Such denials of care could also lead to a rise in PTSD symptoms in those who survived the AIDS epidemic and watched friends and loved ones suffer and die when they were refused treatment within a milieu of fear which was in part perpetuated by the federal government. For clients who may have been reluctant to ask in the first place, being told that the provider morally opposes PrEP may lead the client to leave without the medication and not seek out another provider. This could impede realization of the state's Getting to Zero goal with respect to HIV transmission, which has been showing great promise, and increase the length of time and likelihood of seeing the end of the spread of HIV. This type of discrimination will increase as a result of the Denial-of-Care Rule.

16. In the weeks leading up to, and in anticipation of, the issuance of the Denial-of-Care Rule, Center on Halsted's staff devoted and since then continues to devote increased resources to strategize ways to combat negative effects from the Rule and to work with staff to develop community education options. Center on Halsted has already conducted additional "Know Your Rights" internal staff development sessions regarding discrimination against LGBT people; sent and prepared staff to attend meetings and events with other LGBT stakeholders in the city; and held internal training for staff to manage the added strains on the mental health of our clients. Center on Halsted needs to educate its community about the Denial-of-Care Rule, which erodes their confidence in the healthcare system and puts their lives and the lives of their loved ones in potential jeopardy. Center on Halsted needs to continue messaging the community about Center on Halsted's commitment to serving all clients in a non-discriminatory and welcoming manner and notify its clients that the Denial-of-Care Rule will not change Center on Halsted's commitment to providing

exceptional healthcare services to all members of the community. Center on Halsted will continue fighting for its clients' rights, including, for example, advocating with other entities on behalf of transgender clients who seek treatment for gender dysphoria, but who are denied such treatment due to providers' religious or moral objections to treating transgender clients. Center on Halsted must now devote more resources to working with outside providers and organizations to remind them of the importance of providing healthcare to all clients on non-discriminatory terms. Center on Halsted also must conduct additional internal, staff training to address and assist in managing the added strains that issuance of the Rule has already caused to Center on Halsted's staff and the people they serve. Further, Center on Halsted will ramp up its work at the intersections of identity and health, particularly focusing on transgender people of color, who already live in areas less likely to offer an array of healthcare options. The Denial-of-Care Rule thus already has required, and will further require, considerable diversion and additional expenditure of Center on Halsted's resources, and frustrates Center on Halsted's mission.

17. The Denial-of-Care Rule further adversely impacts Center on Halsted by necessitating the diversion and reallocation of resources in order to provide referrals to clients that it does not have the resources to treat either because Center on Halsted has reached its capacity for new clients (especially in the behavioral-health departments) or because the client requires treatment in a specialty that Center on Halsted does not have. These types of referrals are routine at Center on Halsted where our healthcare work focuses on behavioral health. The Denial-of-Care Rule will require Center on Halsted to expend more resources vetting healthcare providers within its referral network. Further, if a provider to whom we refer clients refuses to treat our referred clients, such a Denial-of-Care is gravely harmful to our reputation, a reputation that Center on Halsted invests heavily in with our clients, as it is essential to client trust. The Denial-of-Care Rule will make it significantly more difficult and resource-intensive for us to locate and monitor

appropriate referrals. With an increase in referral requests as a result of the Denial-of-Care Rule, Center on Halsted will need to allocate additional staff time to pre-screen service referrals to ensure that staff are sending clients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to Center on Halsted's clients. Moreover, Center on Halsted's staff will experience the indignity of discrimination themselves as they attempt to advocate for those whom Center on Halsted serves when healthcare providers interpret the Denial-of-Care Rule as permitting them to deny healthcare services to LGBT clients and refuse to even refer LGBT clients to other resources. The Rule will increase Center on Halsted's operating costs and will take a toll on the health and well-being of the LGBT community that it serves.

18. Center on Halsted's job-recruitment process will be adversely affected in terms of being able to best serve the LGBT communities of Chicago. Center on Halsted would have to devote both programmatic and human-resources time to re-writing job descriptions and interview protocols to adhere to requirements under the Denial-of-Care Rule. Center on Halsted's inability under the Rule to inquire about a job applicant's willingness to treat all clients with equal dignity and respect regardless of the clients' sexual orientation or gender identity will be extremely harmful to Center on Halsted's reputation and mission. The LGBT community is not monolithic. Similarly, for instance, to how the term "Asian" encompasses many identities and cultures, LGBT is used as an expedient way to describe an otherwise incredibly diverse population. There are, for instance, lesbians who deride transgender women. It is not inconceivable that such a lesbian would seek employment at Center on Halsted and, without appropriate policies to inquire about her alignment with Center on Halsted's mission, could be hired. This would erode the very mission of Center on Halsted. To not be able to ask an applicant if they object to any part of Center on Halsted's mission would leave our communities exposed to mental and physical harms, in direct opposition to Center on Halsted's mission. Currently, for instance, Center on Halsted asks "what about the Center"

attracts you as well as what experience the applicant may have working with LGBT communities. An inability to probe in connection with such questions would send a message that Center on Halsted is not interested in hiring and retaining a group of people committed to the LGBT community. Explaining this to our community would also divert already stretched resources. A similar issue of mission erosion would arise in working with volunteers.

19. One of the most disconcerting aspects of the Denial-of-Care Rule is the requirement to open confidential medical records to OCR upon its request and the fact that certain confidentiality requirements may not operate under the Rule. OCR's access to clients' medical records, especially given the recent creation of the "Conscience and Religious Freedom Division," sends a harmful signal to LGBT individuals that their medical records and well-being are vulnerable to discrimination and misuse. This will have a chilling effect on clients' decisions regarding whether to access Center on Halsted's services. Though it is good that LGBT rights have progressed so far so quickly, this means that many LGBT people remember when information was used by the government to harm individuals in the community. The Denial-of-Care Rule will erode the trust of our communities and could lead to a return to closeted life for some. Hiding out of fear of government intrusion in one's life is a far stretch from democratic ideals.

20. The impact on the behavioral-health department will be significant. Each year, the department receives nearly 150 applications for 8 internship positions because so many students want to learn how to provide the LGBT affirming therapeutic interventions that this anchor program has developed since the founding of Center on Halsted. The department also brings on new staff and contract staff. As part of their therapeutic practice, the behavioral health team asks a therapist if they are comfortable disclosing their sexual orientation and gender identity as this is an important and crucial way to establish trust. If asking this question is no longer an option, the model will be compromised.

21. Similarly, if the HIV/AIDS & STI department hires someone who refuses to offer services by not providing HIV/HCV tests to parts of the populations served by Center on Halsted, then that person's salary is in effect wasted, while other staff members, already overworked, will be burdened with having to make up the tests if that objector decides to remain with Center's testing services. Additionally, any reception staff that works on intake for behavioral health could try to use the Denial-of-Care Rule to opt out of working with a client. Given that people making religious-based objection to assisting clients may not be required to report their actions, Center on Halsted may never know if a new client was turned away or why a long-term engaged client stopped engaging. Furthermore, even if Center on Halsted could afford to hire duplicative staff to try to protect against clients being turned away, which it cannot, there would be no way of ensuring that even the duplicative, "extra" staff would not also discriminate against clients or deny them medically necessary treatment.

22. The absence of an emergency exception is also of deep concern. If, for instance, a behavioral-health client, a homeless youth, a senior from the Center's Town Hall Residence, or any other patron experiences an extreme situation requiring an ambulance, operations, reception, and direct-service staff are currently expected to respond immediately. Current staff understand it is their obligation to respond, but the Denial-of-Care Rule threatens that understanding. The absence of an emergency exception could mean that a client in crisis remains in a prolonged state of crisis, potentially causing greater harm to that person or persons around them. This could be as a result of emergency care services exercising religious objections to assisting clients at our Center or even Center staff refusing to abide by their mandated-reporter status that requires them under the Health Insurance Portability and Accountability Act to assist clients in need of emergency care, including calling an ambulance when necessary.

23. In addition to concerns about not being able to appropriately select and supervise staff who work directly with clients, we are also concerned about other personnel that we hire at Center on Halsted, including, for instance, custodial staff. Center on Halsted's Code of Conduct includes the requirements for anyone in the building, including staff, volunteers, interns, and patrons, to provide "considerate and respectful treatment and care" (devoid of "rude, discourteous or raucous behavior") from "experienced, professional, and responsive staff" who extend "participation in services and programs without regard to race, color, sex, gender identity, gender expression, age, religion, disability, national origin, ancestry, sexual orientation, marital status, parental status, military discharge status or source of income." The Denial-of-Care Rule invites behavior that would be contrary to Center on Halsted's Code of Conduct in that it invites discrimination against and mistreatment of LGBT clients. Center on Halsted has built its reputation on being a place where LGBT individuals can be their full, authentic selves. The Denial-of-Care Rule infringes upon our reputation and mission. The Rule could damage us to the point that the LGBT community may cease seeing Center on Halsted as a safe place for the community to go in clients' most vulnerable times of need.

24. Center on Halsted's funding may also be affected. Center on Halsted receives various forms of pass-through federal funding from HHS, including Ryan White funding and funding from the National Institutes of Health and the Centers for Disease Control and Prevention. Center on Halsted also benefits from programs governed by the Centers for Medicare through Medicare reimbursements. If Center on Halsted chooses to best serve its communities and to follow its mission, federal dollars, which comprise about a tenth of the budget, may be cut if we are found to be out of compliance with the Denial-of-Care Rule. Center on Halsted, therefore, has a reasonable fear that it could be sanctioned and lose vital federal funding as a result of our

nondiscrimination policies. The loss of such funding would result in massive service reduction and gut long standing signature programs that are the cornerstones of our work.

25. The daily administration of Center on Halsted will also be affected. When it started to become clear at the beginning of the current administration that LGBT people would experience a shift toward less support, fear and apprehension-based tensions within the community rose, particularly regarding safety concerns. At Center on Halsted, active shooter trainings have become part of all of our staff training rotations as well as part of the onboarding process for all new staff and interns. Not only are LGBT staff feeling the threat that accompanies the loss of support, they are also now on heightened alert because active shooter training is a reminder that they could very well be in harm's way if a shooter targets Center on Halsted. This, coupled with the growing number of ways that the federal government is creating laws that harm the LGBT community and dismantling the protections we worked so hard for, is creating the need for increased staff-supervision time and strategy sessions to help everyone at Center on Halsted understand, cope with, and handle the negative effects of the Denial-of-Care Rule.

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

Dated: June 9, 2019

Respectfully submitted,

/s/ Modesto Valle
Modesto Valle

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF HECTOR VARGAS, EXECUTIVE DIRECTOR OF GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Hector Vargas, declare as follows:

1. American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, ("GLMA") is a 501(c)(3) non-profit organization based in Washington, D.C., and incorporated in California. GLMA's mission is to ensure health equity for lesbian, gay, bisexual, transgender, queer (LGBTQ) and all sexual- and gender- minority (SGM) individuals, and equality for LGBTQ/SGM health professionals in their work and learning environments. To achieve this mission, GLMA utilizes the scientific expertise of its diverse multidisciplinary membership to inform and drive advocacy, education, and research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 and its initial mission focused on responding with policy advocacy and public-health research to the growing medical crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health concerns and issues affecting LGBTQ people, including ensuring that sound science and research inform health policy and practices for the LGBTQ community.

2. GLMA represents the interests of tens of thousands of LGBTQ health professionals, as well as millions of LGBTQ patients and families. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students and other health professionals. GLMA's members reside and work across the United States and in several other countries. Their practices represent the major healthcare disciplines and a wide range of health specialties, including internal medicine, family practice, psychiatry, pediatrics, obstetrics/gynecology, emergency medicine, neurology and infectious diseases.

3. I am the Executive Director of GLMA: Health Professionals Advancing LGBTQ Equality. I received my Bachelor of Arts degree in political science and Spanish in 1989 and law

degree in 1993 from the University of Georgia. I served on the Health Disparities Subcommittee of the Advisory Committee to the Director of the US Centers for Disease Control and Prevention (CDC) and served for four years on President Obama's Advisory Commission on Asian Americans and Pacific Islanders. I have more than 20 years of LGBTQ and civil rights advocacy experience, including on staff with Lambda Legal, the National LGBTQ Task Force and the American Bar Association's Section of Civil Rights and Social Justice. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the Denial-of-Care Rule from taking effect.

4. The Denial-of-Care Rule fosters greater discrimination against LGBTQ patients, who already experience widespread discrimination in obtaining healthcare and suffer significant health disparities in comparison to the general population. Research documents the history of this discrimination and the negative health outcomes that result. The majority of LGBTQ patients and patients living with HIV report having experienced providers refusing to touch them or using excessive precautions, providers using harsh or abusive language, providers being physically rough or abusive, and/or providers shaming LGBTQ patients and blaming these patients for their health status. A large percentage of transgender patients report having negative experiences related to their gender identity when seeking medical care, including being exposed to verbal harassment or refusals of care.

5. LGBTQ patients face significant health disparities—higher risk factors for poor physical and mental health, higher rates of HIV, decreased access to appropriate health insurance, insufficient access to preventative medicine, and higher risk of poor treatment by healthcare providers. Denials of care by healthcare providers asserting religious objections have been detrimental to the health of LGBTQ patients. LGBTQ patients are vulnerable in other ways as well, including higher rates of poverty and limited access to LGBTQ-specific services, that present

significant logistical and economic challenges to obtaining adequate healthcare. These harms are exacerbated by the Denial-of-Care Rule. The Rule will result in greater discrimination against LGBTQ patients and result in increased denials of services based not only on the medical services that patients seek, but on the patients' LGBTQ identities.

6. Among GLMA's strategic commitments is its ongoing collaboration with professional accreditation bodies, such as The Joint Commission, on the development, implementation, and enforcement of sexual-orientation and gender-identity nondiscrimination policies as well as cultural-competency standards of care for treatment of LGBTQ patients. GLMA worked with the Joint Commission and continues to work with similar professional bodies and health professional associations on standards, guidelines, and policies that address LGBTQ health, protecting individual patient health and public health in general.

7. The Denial-of-Care Rule presents a direct conflict with nondiscrimination standards adopted by The Joint Commission and all major health professional associations, who have recognized the need to ensure LGBTQ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other healthcare settings. Many of these efforts were prompted at least in part by GLMA's efforts through the years. For example, GLMA representatives, in coordination with other LGBTQ health experts, participated in the development and implementation of the hospital-accreditation nondiscrimination standards and guidelines developed by The Joint Commission to protect and ensure quality care for LGBTQ patients.

8. Similarly, GLMA has worked with the American Medical Association, among other health professional associations, over the last 15 years to ensure AMA policies prevent discrimination against LGBTQ patients and recognize the specific health needs of the LGBTQ community. All the leading health professional associations—including the AMA, American Osteopathic Association, American Academy of PAs, American Nurses Association, American

Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that healthcare providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity. By allowing discrimination against patients on the grounds of moral and religious freedom, the proposed rule obviates the ethical and medical standards of care that healthcare professionals are charged to uphold.

9. In order for a healthcare organization to participate in and receive federal payment from Medicare or Medicaid programs, the organization must meet certain requirements, including a certification of compliance with health and safety requirements, which is achieved based on a survey conducted either by a state agency on behalf of the federal government or by a federally-recognized national accrediting organization. Accreditation surveys include standards that healthcare organizations not discriminate based on sex, sexual orientation, or gender identity in the provision of services and in employment. A healthcare organization that discriminates on these bases in the provision of patient care or in employment, or that otherwise deviates from medical, professional and ethical standards of care is vulnerable to loss of accreditation. The Denial-of-Care Rule conflicts with these requirements.

10. If not enjoined, the Denial-of-Care Rule will harm GLMA members, LGBTQ patients whose interests GLMA also represents, and the patients who GLMA members treat. The Denial-of-Care Rule creates a safe haven for discrimination and prevents GLMA from achieving its goals with professional accreditation bodies because the Rule intimidates such bodies from holding healthcare providers accountable for discrimination against LGBTQ people and denials of care when the discriminatory conduct is justified on the basis of religious or moral beliefs. The Denial-

of-Care Rule would prevent agencies, to the extent allowed by law, from recognizing the loss of accreditation of a healthcare organization due to a specified anti-LGBTQ belief. The Rule, in turn, invites such facilities to discriminate against LGBTQ employees and patients without concern about the impact such discrimination will have on the organization's ability to continue receiving federal funding. The Rule, therefore, frustrates GLMA's mission of achieving and enforcing accreditation standards relating to nondiscrimination on the basis of sex, sexual orientation, and gender identity, and cultural-competency standards of care for treatment of LGBTQ patients. GLMA even works with medical organizations, like the American Academy of Dermatology, to create nondiscrimination policies and ensure their members understand and adhere to such standards. The Denial-of-Care Rule turns on its head all of the work that GLMA has accomplished in this arena.

11. Some members of GLMA are employed by religiously-affiliated healthcare organizations (for example, hospitals, hospices, or ambulatory care centers) that receive federal funds. These healthcare providers also treat LGBTQ patients. The Denial-of-Care Rule encourages religiously-affiliated healthcare employers to discriminate against employees who are GLMA members for adhering to and enforcing their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically-necessary care that is in patients' best interests. The Rule impinges on and conflicts with GLMA members' ethical and medical standards of care that healthcare providers are charged to uphold and harms the patients that they serve.

12. The Denial-of-Care Rule invites harassment and discriminatory treatment of GLMA members in the workforce by fellow employees who claim a right to accommodation for discriminatory behavior justified by the Rule. GLMA members and their LGBTQ patients are stigmatized and demeaned by the message, communicated by the Denial-of-Care Rule, that their

government privileges beliefs that result in the disapproval and disparagement of LGBTQ people in the healthcare context.

13. As an organization of health professionals who serve and care for patients from the LGBTQ community, GLMA knows that discrimination against LGBTQ individuals in healthcare access and coverage remains a pervasive problem and that often this discrimination is based in religious objections. GLMA members have reported numerous instances of discrimination in care based on religious grounds. GLMA members shared with GLMA the ways religious objections are used to the detriment of the healthcare of LGBTQ patients, including members who have said:

a. "I see patients nearly every day who have been treated poorly by providers with moral and religious objection. Patients with HIV who have been told that they somehow deserved this for not adhering to God's law. Patients who are transgender who have been told that 'we don't treat your kind here'. The psychological and physical damage is pervasive."

b. "[Some providers in my clinic] do not wish to have contact with transgender patients, mumbling religious incompatibilities when asked why. These people have made our transgender patients feel very uncomfortable and unwelcome at times, making them potentially more hesitant to use the health services they may need."

c. "The impact on my patients who were directly denied care was both psychological and physical. With regard to their mental wellbeing they clearly felt marginalized and disrespected. With regard to their physical wellbeing, they experienced delay in care, and in some cases disruption of their routine medication dosing or diagnostic assessment."

14. Based on what patients have told GLMA members about their history and fear of discriminatory treatment, it is clear that the Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid such discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. As a result of the Denial-of-Care Rule, GLMA is required to divert its resources to educate and assist its members and the LGBTQ patients its members serve to defend against the harms that the Rule causes. GLMA's staff and resources already have been diverted from other program activities to engage in advocacy, policy analysis, and program-development to address the ill-effects of the Denial-of-Care Rule. GLMA has worked tirelessly to get medical and other health associations to express their disapproval of the Denial-of-Care Rule, which has diverted large amounts of resources away from other proactive projects and outreach efforts that are core to GLMA's mission. GLMA also spends resources answering GLMA members' inquiries about the Denial-of-Care Rule given the pervasive concern that the Denial-of-Care Rule contradicts medical ethical requirements and standards of care. GLMA must spend resources educating its members and the general healthcare community about GLMA's position on the Denial-of-Care Rule and its effects on healthcare practices and providers.

16. The Denial-of-Care Rule will also adversely impact GLMA and its members by necessitating the diversion and reallocation of resources to maintain its online list of LGBTQ-affirming healthcare providers. As a result of the Denial-of-Care Rule, GLMA and its members expect to see increases in the use of this online service and must consider whether to allocate additional staff time to support this increase in website traffic. Patients have expressed concern

about traveling outside of their home cities for business because if they are ever in need of emergency medical assistance, they will not know where to go to ensure that they will receive nondiscriminatory, proper healthcare services. GLMA will need to be a resource for these patients.

17. The Denial-of-Care Rule empowers and incites religious-based discrimination against GLMA members and will contribute to discriminatory and even hostile work environments for GLMA members, LGBTQ healthcare providers, and LGBTQ-affirming healthcare providers. GLMA members who insist on treating patients equally and in accordance with medical and ethical standards of care are likely to be required to shoulder extra burdens as fellow employees decline to provide certain care. GLMA members also are likely to encounter push-back, hostility, and even adverse employment actions from their employers or fellow employees for trying to enforce nondiscrimination policies and provide appropriate care to patients. Because the vast majority of GLMA members are LGBTQ themselves, seeing LGBTQ patients treated in a discriminatory way by their colleagues and supported by their employers will have a profound impact on the environment in which they work, GLMA members will also fear that the discrimination faced by LGBTQ patients because of the Denial-of-Care Rule will also impact their own employment and ability to feel safe as LGBTQ employees. GLMA, in turn, sees and will continue seeing an increase in healthcare providers seeking its assistance with addressing such discrimination. The increased demand for such services will drain GLMA's resources and hamper other work, especially since GLMA already has a very limited bandwidth for such services.

18. As a membership organization comprising over a thousand LGBTQ health professionals, GLMA's members receive various forms of federal funding directly and indirectly via federal programs, including Public Health Service Act funding. GLMA's members may, therefore, be subject to the restrictions of the Denial-of-Care Rule. Without such funding, certain GLMA members could not provide proper treatment to their patients or proceed with their medical

research programs. GLMA's members, therefore, have a reasonable fear that they could be sanctioned and lose federal funding for the work that they do as a result of nondiscrimination policies, ethical requirements, and standards of care that they enforce in their healthcare practices, which are vital to providing proper care to their patients.

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

Dated: June 5, 2019

Respectfully submitted,

Hector Vargas

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF LEE H. RUBIN PURSUANT TO LOCAL CIVIL RULE 5-1(i)(3)

I, Lee H. Rubin, submit this declaration pursuant to Civil Local Rule 5-1(i)(3) in support of Plaintiffs' Motion for Preliminary Injunction. I have personal knowledge of the facts stated below, and if called upon to testify, I could and would testify competently thereto.

1. I hereby attest that I have on file all holographic signatures corresponding to any signatures indicated by a conformed signature (/s/) within the Declarations submitted as attachments to Plaintiffs' e-filed Motion for Preliminary Injunction.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 11th day of June, 2019 at Palo Alto, California.

By: */s/ Lee H. Rubin*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

vs.

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

Defendants.

Case No. 5:19-cv-2916

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

On June 11, 2019, Plaintiffs County of Santa Clara, Trust Women Seattle, Los Angeles LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Bradbury-Sullivan Center, Center On Halsted, Hartford Gyn Center, Mazzoni Center, Medical Students For Choice, AGLP: The Association of LGBTQ+ Psychiatrists, GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"), Colleen McNicholas, Robert Bolan, Ward Carpenter, Sarah Henn, and Randy Pumphrey (collectively, "Plaintiffs") filed a Motion for Nationwide Preliminary Injunction ("Motion") to enjoin Defendants from enforcing the Final Rule of the Department of Health and Human Services ("HHS") entitled Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. Pt. 88). A hearing on the motion was held on Wednesday, July 17, 2019 at 1:00 p.m.

The Court, having considered the Motion and the documents filed therewith, all of the papers on file in this action, and the evidence and arguments presented at the hearing, hereby

GRANTS Plaintiffs' Motion For Nationwide Preliminary Injunction.

IT IS HEREBY ORDERED that: Defendants HHS and Alex M. Azar II, in his official capacity as Secretary of HHS, and their officers, agents, servants, employees, and attorneys, and any other persons who are in active concert or participation with them, are enjoined from enforcing the HHS Final Rule entitled Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019).

IT IS SO ORDERED.

Date: _____

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HONORABLE NATHANAEL M. COUSINS
United States Magistrate Judge