STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

INDUSTRIAL WELFARE COMMISSION

Public Meeting

April 14, 2000

Oakland Federal Building

1301 Clay Street - Auditorium

Oakland, California

GOLDEN STATE REPORTING
P.O. BOX 5848
Monterey, CA 93944-0848
(831) 663-8851

P A R T I C I P A N T S

--o0o--

Industrial Welfare Commission

BILL DOMBROWSKI, Chair

DOUG BOSCO (arr. 10:16 a.m.)

BARRY BROAD

HAROLD ROSE

Staff

ANDREW R. BARON, Executive Officer

MARGUERITE C. STRICKLIN, Legal Counsel

MICHAEL MORENO, Principal Analyst

DONNA SCOTTI, Administrative Analyst

LISA CHIN, Analyst

I N D E X

--o0o--

INDEX (Continued) Page

INDEX (Continued) Page

INDEX (Continued) Page

P R O C E E D I N G S

--o0o--

(Time noted: 10:06 a.m.)

COMMISSIONER DOMBROWSKI: I'll call the meeting to order.

The first item on the agenda is we need to welcome and swear in our new commissioner, Mr. Harold Rose.

MR. BARON: I get a chance to read a formal oath. There are a few words in here I want you to think about very carefully before you say yes, that you do want to do this.

(Mr. Baron administers oath of office to Commissioner Rose.)

MR. BARON: Congratulations. It's great to have you.

COMMISSIONER ROSE: Thank you.

(Applause)

COMMISSIONER DOMBROWSKI: All right. The second item is I think we have to call the roll.

MR. BARON: Yes, we do.

Broad.

COMMISSIONER BROAD: Here.

MR. BARON: Dombrowski.

COMMISSIONER DOMBROWSKI: Here.

MR. BARON: Rose.

COMMISSIONER ROSE: Here.

MR. BARON: I'll note the others are absent.

COMMISSIONER DOMBROWSKI: Next item on the agenda is the approval of the minutes. Can I get a motion?

COMMISSIONER BROAD: So moved.

COMMISSIONER DOMBROWSKI: Second?

COMMISSIONER ROSE: Second.

COMMISSIONER DOMBROWSKI: All in favor, say "aye."

(Chorus of "ayes")

COMMISSIONER DOMBROWSKI: In order to try to move today's hearing along, let me just, for the record, recognize that we have received numerous comments from individuals in the healthcare industry, both in live testimony and in written communications. So, what we are going to try to do today is address the two agenda items with panels, and then, after each panel, let those individuals who wish to come up and address the commissioners to come up and address. But we're going to, number one, limit that individual testimony to approximately three minutes, and second, encourage you to

just, if you something to contribute that we haven't heard, to do that and not to be redundant with other people, because there is a volume of testimony and we don't need to hear more individual, I don't think, unless you feel very strongly about it.

With that, I would like to call up first the -- I guess I'd call up the hospital people to discuss the first item on the agenda and comments regarding the Wage Orders 4 and 5. And I have a list of speakers.

We are a little bit restricted in our set-up in the room, and I will just point out that the small hand-held microphone that you have, Don, is the live sound system for the room. The silver microphones are simply the recording devices for the transcript, so the silver microphones do not amplify. So whoever is speaking needs to use that small little hand-held microphone. And I, again, apologize for that.

We also have the first row of seats here for extra panelists, if you will, if you want to just rotate and go from there.

I'm not limiting the time of the panels, so whatever time period you think you need, please go ahead.

And with that, Don, I guess I'll let you kick it off.

And if individuals could identify themselves as we go through this, we'll go from there.

MR. MADDY: Good morning, Mr. Chairman, members of the Commission, staff.

COMMISSIONER DOMBROWSKI: Oh, excuse me. One other -- just for clarification, this is a meeting of the IWC. We are not taking any votes today on these issues, so it's simply testimony for the public record.

MR. MADDY: My name is Don Maddy. I'm employed by George Steffes, Incorporated. We represent the California Healthcare Association. And as our client, CHA is an organization with 450 members, represents California hospitals and large physician group organizations.

We are honored to present to you today our proposals for changes to Wage Orders 4 and 5 in light of the provisions of AB 60 and the authority of the IWC. The proposals are intended to preserve options available to healthcare workers that were in effect before January 1st, 1998, and to seek clarification regarding the impact of AB 60 on those previously existing standards.

We do recognize that this is a new era and that past actions of the IWC are not controlling on the IWC of today. Having said that, the 1993 wage orders evolved

over time to recognize both the health and welfare of employees working in healthcare as well as the special needs of the providers of healthcare services, which we believe are distinct from other types of employers. We believe the 1993 wage orders represent a good balance from a public policy perspective.

Although there are numerous issues this Commission will address with respect to the healthcare industry, the main issue, in our opinion, is to balance patient needs with worker wants and needs in a seven-day-a-week, 24-hour-a-day operation. To strike this balance, we believe that 12-hour shifts should be available to all employees because of the nature and uniqueness of hospital operations. In our opinion, patient care units depend upon support from a variety of employees all serving important roles in the eyes of the patient. These employees must interact with other members of the patient care team many times during a shift, and especially upon shift change. All employees also have personal needs that, in our opinion, make 12-hour shifts attractive: commuting times, going to school, family commitments, daycare costs. Healthcare employees are not that different from other employees where they will have advantages under a 12-hour shift.

Our proposal -- I'd like to read through the proposals that we have today. We have nine different proposals. Before we get into any type of dialogue, I'd appreciate just going through those very quickly so you get the whole scope of what we're proposing today.

Number one, allowing healthcare workers to work 12-hour shifts by preserving the flexible work arrangement provisions in Wage Orders 4 and 5 of '89, as amended in '93, and extending the protection for 12-hour shift arrangements implemented prior to 1998 beyond July 1st, 2000. That's number one. And that would be the same as before 1998.

Preserving the 8-80 overtime provisions available to healthcare employers under Wage Order 5-89, as amended in 1993. Again, the same as pre-1998.

Preserving the meal period provisions that allow healthcare employees who are scheduled to work shifts of up to 12 hours in a day to waive their second meal period, even if, as a result of an unplanned or unforeseeable event, they work more than 12 hours on a particular day. There's also language in the '93 that addresses that.

Number four, preserving the existing meal period provisions that allow employees to waive their meal

period where the nature of their job prevents them from taking 30 minutes off, or they voluntarily agree in writing to waive their meal period where they are compensated for the time -- actually, those are "ands" -- and they are compensated for the time they took off during the meal period.

Number five, preserving the white-collar exemptions for advanced practice nurses, such as nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. We're going to hear more from the second group of panelists on this, but that's our position as well, the hospitals' position, which is an important part of patient care.

Number six, clarification from the IWC of the exemptions to note the availability of the executive and administrative exemptions. Without reading the rest of this, I'll say that we want to know if the criteria for administrative and executive apply to nurses and pharmacists as they would to other employees. So, we need some clarification on that.

Seven, preserving the special standards relating to the definitions of "primarily" and "hours worked" that are in the '93 for healthcare employees. We want to

adopt the exact provisions that were in the prior order.

Preserving the personal attendant exemption that exists where a healthcare employer assigns a personal attendant or companion to a private household of a patient, which is -- we want, again, the exact language that's in 5 and 15 -- Wage Orders 5 and 15.

And finally, clarification that a flexible work arrangement established under the new rules contained in this proposal, or an alternate workweek arrangement established pursuant to the provisions of AB 60, may be adopted by a proper secret-ballot vote even though the employer does not disclose in advance the exact calendar days or hours of the day that must be working every week, as long as employees are told of the number of days and number of hours in the normal schedule. So, we'd like to adopt some language that addresses that.

I want to impress upon this Commission, before going through any reasons or questions on these proposals, that this balancing act that I speak of is not -- I think the healthcare industry is different, because I don't think the balancing act really is a matter of, you know, management and employees only, because patients are involved. And so, I think it's unique because of the patients.

When employees express their opinions about how our rules or your rules impact them, they often have to speak of personal situations that they're in so that you have a clear understanding of how it impacts them and looking at their problems with the rules or, you know, the benefits from rules. But I have -- I also have a personal story that I'd like to tell. And that's why I'd asked if I could testify today before this group for the hospitals.

We represent hospitals, but I wanted to testify today because I just had an experience in my life where -- it was two months ago, in fact, that my father was taken to the hospital, and he never left the hospital. And he was there for five days. And the whole notion of -- the whole notion of what a family goes through -- this is my personal experience because I had a family member in a hospital in a situation where there was a rotation and shifts, and where I saw the difference, probably, between one type of operation or one type of facility operating versus a hospital just having to take care of a patient.

And as a family member of a patient, I can tell you the anxiety level when we -- when we go into the -- when you're in the room, you know, with my dad and you're

going -- and you have to get to know the staff, the nurses, the others. You're trying to explain to them -- of course, that takes several hours and several different individual problems that come up during a period of hours that we need to explain. You know, they're communicating with you, the staff at Sutter General. They're a great staff. But it takes hours and hours and hours for us to -- and for my father to have explained what his situation was that would help with them to understand where he was.

And then the anxiety level -- I can tell you, the anxiety level goes up when new people walk in. There's, all of a sudden, a whole new group of people that you're dealing with over a period of time. And that's -- it's inevitable. There's going to be some new people that you're going to have to deal with when shifts change. But that anxiety level, as family members and watching, you know, my dad as a patient, went up extraordinarily.

And then, even though it wasn't an emergency, you know, when there's a need and there's a shift change going on, and there's something that has to be taken care of, in our view, because we want him comfortable, then there was a situation where, you know, there was nobody

to come in the room at that moment because they're going through and they're doing shift change and they're doing coordination.

And so that's -- you know, that's one of the reasons I wanted to testify today, is I see that it's a unique operation. I see that you have an extraordinary -- extraordinarily difficult task here when it comes to hospital and healthcare versus some other manufacturing or other type of operation. And I would urge to support at this time all of our proposals that we have today.

The next thing I want to do is introduce our panel. I don't know if you want to have questions first on the proposals.

COMMISSIONER DOMBROWSKI: No, we'll go to the panel first.

Let the record show that Commissioner Bosco has joined us.

Go ahead.

MR. MADDY: Okay. With me today, we have -- I'm going to name all the members that are here with us today -- Cathy White, a RN from Eisenhower Medical Center; Allen Outlaw, a respiratory therapist from Eisenhower; Amy Lowery, a RN from Mercy Hospital, Bakersfield; and we have Erin Pettengill, a RN from Sutter; Libby Prall, a RN

from Sutter; Darci Cimino, a LVN from Sutter; Melanie Walker, a respiratory therapist from John Muir Medical Center; and Tom Luevano, from Sutter Health; and Richard Simmons, who is CHA's legal counsel, from Sheppard, Mullin, Richter & Hampton, who's here to answer questions.

So, I'll hand it over to the others to testify now.

MS. PETTENGILL: Good morning, Mr. Chairman and members of the Commission. My name is Erin. I'm a registered nurse, and I'm here as a nurse and a mom and a wife. And I really want to express to you the importance of a 12-hour alternate work schedule.

Professionally speaking, it allows for wonderful continuity of care with my patients, allows me the opportunity to assess them in a full 12-hour workday, and the continuity between nursing staff, from one staff to the next, is amazing. And information doesn't get lost or misplaced. We know the telephone game where, by the time it reaches the twentieth person, what the first person said is never the same. And that's the same that goes with nursing care.

And personally, I have a child. And working 12 days a month as opposed to 20 days a month is amazing.

It allows me to be there for my child. I can be there as a mother, I can be there as a wife. It's the benefits of having a full-time wage and being a full-time mom. It cuts down on -- almost no daycare. I am raising my child, as opposed to a daycare. And to me, that's very important. It allows me the opportunity to volunteer outside of my home. It allows me the opportunity volunteer at my child's school. It's just amazing.

And if the 12-hour work schedules were not an opportunity for me, then the availability for my child for me to be there would be diminished dramatically. And I think, as evidenced in the newspapers and on the news, with, you know, drug use going up and violence going up, and I think the importance of having an adult figure and parent involvement in a child's life is overwhelming. And the fact that I would be there for her is a great advantage. And I think it would just be a shame if that was not available to me.

So, I think the professionalism is more than understood, of the benefits, and I think the advantages of having a mom at home is overwhelming. And that's all I'm going to say.

Thank you.

COMMISSIONER BROAD: Mr. Chairman, I have a

question.

COMMISSIONER DOMBROWSKI: Mr. Broad?

COMMISSIONER BROAD: Can you hear? Well, okay.

Do you -- what is your 12-hour-day schedule now?

MS. PETTENGILL: I work 7 p.m. to 7 a.m.

COMMISSIONER BROAD: Three days a week?

MS. PETTENGILL: Three days a week, that's correct.

COMMISSIONER BROAD: Okay. And you have only one job? I mean, you don't work a second job.

MS. PETTENGILL: Right.

COMMISSIONER BROAD: Okay. Does your employer ever ask you to work any overtime beyond the 12-hour day?

MS. PETTENGILL: I am asked, but not required. It's not mandatory at my job.

COMMISSIONER BROAD: Do you think that we should adopt a rule to require that it be voluntary as opposed to mandatory that you work overtime beyond 12 hours or 40 in a week, in that circumstance?

MS. PETTENGILL: Well --

COMMISSIONER BROAD: Do you think that's a good policy?

MS. PETTENGILL: I don't know that it's a necessary policy. Specifically, at my -- I can't speak

for other facilities, but at my -- at my facility, we don't need to work mandatory overtime because we generally have enough staff who will either voluntarily work overtime or we have a float pool that's available for extra staff to work. So, mandatory overtime has never really been an issue for us, although we've needed people to stay and they have voluntarily done so.

COMMISSIONER BROAD: So, do you believe there would be circumstances when someone working 12-hour shifts might be so tired that it would probably be better for patient care that they went home if they felt they shouldn't work any longer?

MS. PETTENGILL: Well, I think that after a 12-hour shift, in my experience -- I have stayed over on occasion. But I -- I think, as professionals, that we can make the decision if we're -- if it's an unsafe environment, that we won't stay.

COMMISSIONER BROAD: Okay.

MS. PETTENGILL: And I --

COMMISSIONER BROAD: So, you believe that you should be permitted to make that decision.

MS. PETTENGILL: Sure.

COMMISSIONER BROAD: Thank you.

MS. PETTENGILL: Any other questions?

(No response)

COMMISSIONER DOMBROWSKI: Next speaker.

MS. PRALL: Good morning, Mr. Chairman and commissioners. I'm Libby Prall, RN at Sutter General Hospital, also assistant nurse manager. I'm going to read my statement here.

I have been on 12-hour shifts since 1988. And speaking from my perspective, first as a bedside care RN on night shift, when I was commuting 100 miles round-trip, the alternative work schedule has enhanced the quality of my family life by providing more time to spend at home and less time commuting. The 12-hour shift continues to enhance my personal life with time to participate in family and church activities and personal interests. Trips and vacations can be taken on time off. All this contributes to reducing the stress in a stressful profession and enhances my ability to do the best I can when I'm at work.

The benefits of this flexibility in scheduling and its positive impact on many quality-of-life issues are immeasurable. And to lose this alternative work schedule would be a major negative impact on my daily life as well as many of the staff members on our unit. After working this since 1988, being forced to go to a

five-day, 8-hour-per-day would be a major disruption to my life and to the other staff. Many of our staff on the unit have young children with daycare issues similar to Erin, and some arrange their schedule to complement their husbands' so that they don't even have to use daycare. Others are able to attend schools to pursue their career goals.

Additionally, continuity of patient care is enhanced by having the same caregivers for longer periods. Shift-to-shift reports are more effective. Only two shifts are communicating with each other. Therefore, many times, the same nurses will report off to each other coming and going.

I believe strongly we should be able to continue to have the alternative work schedule 12-hour option. Those who work 12-hour shifts are doing so by choice. And I strongly urge you to allow us to continue to experience this excellent benefit.

COMMISSIONER DOMBROWSKI: Next speaker.

MS. CIMINO: My name is Darci Cimino, and I'm a LVN at Sutter. And I apologize ahead of time for any repetition, but we are all in the same field and a lot of the issues are the same.

I'm here to represent my co-workers at Sutter

General Hospital. I speak for myself, but also for them. Our floor approached our nurse manager independently and requested implementation of 12-hour shifts. At that point, she had a representative from HR come give us information. We voted on it, and it passed well above and beyond the required two-thirds vote. And for the past three years, the patients and nursing staff have reaped the benefits of the AWS, which are not limited to, but include enhanced continuity of care, because we care for our patients on the day shift from the time they start the day till the time they end the day. Any tests that they're having done, we're able to find out about the results of the tests instead of giving up the information to the next shift and notifying them, or they us, during the day. And the night shift is caring for their needs at night. They are not awakened by a third shift at 11:30, midnight, to be reassessed. And the communication is greatly improved since we've had the 12-hour shifts because we're only speaking to two shifts, and not three.

Talk of burn-out has been decreased markedly. And why? There are many reasons that -- in respect to the time constraints here, there are a few important points my fellow co-workers wish me to stress. Four days

off a week increases our productivity at work and at home. We have more time to spend with our families. Our children are cared for four days out of the week by us instead of outside caretakers. 12-hour shifts have allowed quite a few of the staff to eliminate completely outside childcare as the AWS makes it easier for them to rotate childcare with their spouses.

For those of us who commute to work, the AWS has made a huge difference in the time that we spend on the road. And the AWS has allowed precious time. As we all know, most of our life is spent in the workforce, and this allows precious time to pursue outside interests such as pursuing higher education, volunteering in our communities.

And on a personal note, as a member of the California workforce, I feel I have the right to choose my own work schedule.

Thank you.

COMMISSIONER DOMBROWSKI: Next speaker.

MR. MADDY: Let's take it down here, this way.

MS. CIMINO: Okay.

MS. WHITE: Good morning. My name is Cathy White. I'm a registered nurse in the Emergency Department at Eisenhower Hospital in Palm Springs. I am

also the advocate for our staff Empowerment Program for Professional Practice at Eisenhower.

I am proud to work for this nonprofit facility. I'm proud to work there, I'm proud of the community services my hospital provides. AB 60 puts all of this at risk. It is estimated it will cost Eisenhower an additional $2.4 million in next financial year just to continue 12-hour shifts for registered nurses and for respiratory therapists. In addition to the financial challenges we're already facing, having to move to 8-hour shifts is a real possibility for our organization.

A cross-section of the ER staff asked me to read their comments, and I promise I will be very brief and to the point. And I just wanted to read to you their names, if I may.

The first person is Susan Westphal. She's a RN. She says, "As a RN 26 years, I have worked for both 8- and 12-hour shifts. I personally find the 12-hour shifts for the patients superior in continuity of care. Some have had an improved, happier staff. And being a single-parent that works full-time, this time is extremely beneficial."

And this is also from Alexander Ramirez, a RN: "The ability to work three days a week has given me the

opportunity to obtain a bachelor's degree. I could not have accomplished my degree having to work five 8-hour shifts."

And this is from an emergency room technician. His name is Paul Wiese. "Please do not discontinue 12-hour shifts because it helps my family. We'd have to pay for this daycare."

As I say, in the emergency room, we work as an interdisciplinary team. If we were not all on 12-hour shifts, it would actually make it very difficult for us. I would hope that you will consider everyone on the healthcare team for the 12-hour shift exemption.

From -- this is from Lisa Stadler, RN. She is a RN 22 years, working 12-hour shifts since the mid-'80's. "I'm dedicated and devoted to this institution that I work for. However, returning to 8-hour shifts would not be an option for me. The impact that it would have on my family and social life would be unacceptable." She even stated that she would have to leave Eisenhower if we're going to 8-hour shifts. And she plans to stay on the 12-hour shifts under whatever exemption they could find.

This is a respiratory therapist, who says -- his name is Dennis Oeding: "In our department, we voted to keep our 12-hour shifts even though we were faced with a

cut in our gross income. This is how strongly we feel about our 12-hour shifts.

And this is from Daryl Swanson, a registered nurse: "12-hour shifts allow me to be at home and be more accessible to my children." And she also goes on about the flexibility -- right.

This is Trudy White. She's a registrar clerk. She does our insurance requirements and calls all the insurance companies. "I like my 12-hour shifts because I can spend more time with my family and more time with my duties at home."

This is from Sandra Bigwood, a registered nurse: "12-hour shifts at flat pay is my choice. Please don't try to fix what isn't broke."

(Laughter)

MS. WHITE: I just say this as a summary of some of the people who work in my department. Everybody wanted to have a say, so just a few of them -- and I have them included in a packet to give to you.

In answer to your question, to the panel -- excuse me -- of the panel member about the 12-hour shifts, yes, we certainly would like a choice as to whether we work overtime or not. However, I am duty-bound to provide patient care in the absence of any other

nurse, and I am very proud of that. I am a professional. I am proud of my rights to advocate for the patient. And I understand that you need to make sure that no employer abuses that, but I am very willing to stay for a few hours or however long it takes until they can get a replacement for me. I would not abandon my patients.

Also, to get -- there are more names.

(Ms. White hands documents to Commission.)

COMMISSIONER ROSE: I have a question, and it's of each of you that speak. When you mention your hospital, could you mention where it's at?

MS. PETTENGILL: I'm sorry. I'm --

COMMISSIONER ROSE: You did, Palm Springs. But Sutter?

MS. PRALL: Sacramento.

MS. PETTENGILL: Sacramento.

COMMISSIONER ROSE: Sacramento? Because we have a Sutter in San Diego. And the other thing is, could you mention your shift, what is -- are they all 7 hours -- I mean, like 7 p.m. to 7 a.m., or 7 a.m. to 7 p.m.?

MS. CIMINO: Yes.

MS. PRALL: Yes.

MS. PETTENGILL: Yes.

COMMISSIONER ROSE: They're all the same, in

every hospital?

MS. WHITE: Well, in the ER, we work staggered shifts. We work different 12-hour --

COMMISSIONER ROSE: Oh.

MS. WHITE: And it's taking your turn. We all share the different types of shifts.

COMMISSIONER ROSE: Thank you.

MS. WALKER: Hello. My name is Melanie Walker, and I work at John Muir Medical Center in Walnut Creek. We are the trauma center for Contra Costa County. I am a respiratory therapist that works full-time on the night shift. I'm here representing a lot of the respiratory therapists and some of the nursing staff that wish to continue working their 12-hour shifts.

Now, I've worked the 9-hour -- I mean the 12-hour shifts -- for the last nine years. Before that, I did work 8-hour shifts at another hospital. And I can tell you, between working an 8-hour shift and a 12-hour shift, it's like night and day. When I worked 8-hour shifts, I was constantly tired. The days off that you have off, you spend sleeping and catching up.

We used to work three days, have one day off, work two days, have one day off, work five days, and then have two days off. That is what your two-week period

would consist of, working an 8-hour shift, because you had to alternate weekends so that everybody could get weekends off. You wanted to pull your hair out. You were burnt out because you were sleep-deprived. Your patients, I think, suffered because patient continuity wasn't there. You had way too many people coming and going, a lot of people calling in sick. You would have to have more people come in from a registry or float pool that weren't as familiar with the hospitals and with the doctors and with the other nurses. So, your patients ultimately suffered by that.

Is it working?

MR. MADDY: The red light went off. Well, there it goes.

MS. WALKER: Can you hear me?

COMMISSIONER DOMBROWSKI: Yes.

MS. WALKER: Sorry.

Anyway --

COMMISSIONER DOMBROWSKI: That was not programmed, by the way.

(Laughter)

MS. WALKER: Anyways, I left the 8-hour-a-day hospital to work for the 12-hour facility, and I would gladly pay -- I would gladly work for straight pay for 12

hours because what it would cost me to work an 8-hour shift is going to be a lot more than the time and a half that I would get working -- being paid the time and a half for the last four hours.

I would have to have my children in daycare. I have three children. And I don't know if any of you all know how much it costs for daycare, but it's astronomical. I mean, it's bad enough if you have one child, but if you have -- multiply it by three, and it just gets crazy.

I also like to volunteer at my children's schools. With the way the school systems are now, the schools need all the help that they can get, and they cannot afford to be paying people to go in and helping them. Therefore, I spend a lot of time when I'm not at work helping at the school.

Now, currently I work a 36-hour workweek, which time I get paid straight time for the 36 hours.

MR. MADDY: The battery's gone.

MS. WALKER: It's not working?

MR. MADDY: Yeah, the battery's gone.

MS. WALKER: Can you hear me? Okay.

Anything after the 12 hours in one workday, I get paid double time, which I find satisfactory.

Anything after 40 hours in a workweek, I get paid time and a half. After the 44-hour -- if I work more than 44 hours in a workweek, I get paid double time for anything over the 44 hours. I find this reasonable.

It's -- you know -- I want -- and I did make the choice to work the 12-hour shifts. And a lot of the people that work the 12-hour shifts love it because they do have time to spend doing other things, and they don't feel as burnt out as they would working the 8's.

COMMISSIONER DOMBROWSKI: Thank you.

MS. WALKER: You're welcome.

MS. LOWERY: My name is Amy Lowery, and I'm --

THE REPORTER: You have to come to the table there to be recorded.

MS. LOWERY: I'm sorry.

MR. MADDY: Okay. We'll switch.

COMMISSIONER DOMBROWSKI: We need you to come to the table because the silver microphones are recording the transcript.

MS. LOWERY: Oh, sure. Okay.

My name is Amy Lowery, and I'm a RN from Mercy Healthcare in Bakersfield.

And it's extremely important to me personally, but also to my patients and the well-being of other

employees throughout the State of California, to maintain the 12-hour shifts as a choice. I also worked 8-hour shifts in another state, and I really see the difference of the continuity that has been explained already, that the patients have less faces to become familiar with, and the trust that they need to obtain from their staffing that they -- that they have, you know, can entrust that they're getting well taken care of and that all the information is passed on.

The other most important thing to me is, personally, my husband and I both have chosen industries for our careers that offer flexible scheduling. We have two small boys. And in order for us to have a very nice home, to provide for things that our children need to have, their baseball and everything, it all costs money these days.

And I am very grateful that I can work three days. I usually work two days in a row. I work 7 p.m. to 7 a.m. And then I'll have a couple days off, and then my husband will work on the days that I'm off. He works three 12's also, which -- in an area that's exempt. So, therefore, there's always one parent there with our kids every single day. We have no childcare expenses and there's someone there to supervise them, to go to their

school activities. And I'm able to also volunteer in my church and in my kids' school to see them do their Jog-a-thon at 9 a.m., but I will go to bed at 10 a.m. -- I mean, simple things that make a huge difference in our children's lives.

I'm also speaking for other single parents who I work with, a lot of young moms with three kids who work night shift. And it's, you know, easier to have someone like their grandma come and spend the night while they can go, you know, to work. And then they don't have that extra activity that the provider needs to do for them. So, she can come home from work in the morning, get the kids off to school, she can sleep for her six hours, and then she'll be awake when the kids get home, and have supper together. That is something that is so important these days, to really bring up our children to really value what families are all about, and that is to have a dinner together.

And these are just the things that everybody has told me that are so important. And it's a choice. I have not chosen an area that works 8 to 5, Monday through Friday. I have chosen to work something that is seven days a week, required to work weekends, which -- there is no childcare on weekends. My husband and I both are

required to work weekends. We wouldn't -- it would not be an option. I would have to go and work 8 to 5 in a day -- you know, a day surgery -- something that I don't want to do as a RN yet. I want to be at the bedside with these critically ill patients.

So, I'd just ask that you just really take these considerations.

Thank you.

COMMISSIONER BROAD: A question.

COMMISSIONER DOMBROWSKI: Mr. Broad?

COMMISSIONER BROAD: Do you ever work beyond 12 hours a day?

MS. LOWERY: I do not. And that is my choice.

COMMISSIONER BROAD: And you would like that to stay your choice?

MS. LOWERY: Exactly.

COMMISSIONER BROAD: So, there might be some times when you would be so tired or have family obligations that, if your employer asked you to stay, you really couldn't.

MS. LOWERY: Right.

COMMISSIONER BROAD: Thank you.

MR. OUTLAW: Hello. My name is Allen Outlaw. I'm a respiratory therapist out of Eisenhower Medical

Center in the Palm Springs area.

My concerns are pretty much what other people here have discussed already. But there are additional factors that I have seen because I have worked 8 hours and 12-hour shifts, and I've also participated in the registry pool, which allows us to go to different hospitals in order to supplement their staffing when they have shortages.

One of the things, though, I noticed about that is, with the 8-hour shifts, obviously you're looking at three people for every -- well, let's say, hypothetically, you have more people working. So, if you needed 10 people, you would now need an additional five people, because you would need one for that middle shift that would come in the PM. And one of the things that happens with that type of system that I always noticed was that it was harder to find replacements, which put more burden on us to work those days.

I noticed that you asked three times about -- thank you -- about having to work beyond 12 hours, whether it was voluntary. But when we were doing the 8's, we found that we were asked more often to work overtime. There was less call-offs on the 12-hour shifts. On the 8-hour shifts, people are committed, out

of 14 days, 10 days to the hospital. So, there was more times when people would need additional time off. We don't experience that as often with the 12-hour shifts because people are only committed to work 6 out of 14 days.

Also, from an own personal health issue, working in a hospital is very hard work, you know, working with patients, not just physical, but emotional. Dealing with people when they're sick, when their health is poor, has a strong drain on you, emotionally, physical. And one of the things I noticed is the days that we have off as a result of working 12 allows us to properly recoup, to come back to work so that we are able to give better service. Our quality of care is consistent as a result of that. I don't think that's necessarily the case when you work five straight days through. It does get more difficult to maintain your own health and your own mental well-being. You know, there's -- hospitals are not the first stressful job I've had -- I was a United States Marine for six years

-- I know how demanding it can be to have to give nonstop, you know. Obviously, the Marine Corps didn't have a panel like this, or else they wouldn't have had us do 24-hour guard duty.

(Laughter and applause)

MR. OUTLAW: But they have -- you know, and -- but I noticed that the performance does stay up among my co-workers. But their call-offs are less, and the patient jeopardy, I think, is less, and over the fact that they continue to see familiar faces. When I was working with the registry, I was showing up at a hospital that was an unfamiliar environment. I would come there and I would go to work, and the patients are mad they're having to deal with persons unfamiliar with that hospital. You know, when you have consistent staff that's available, you know, or your own hospital internal float crew, where they have a per-diem staff, you have people that are well trained, they know their level, they're trained and able to better perform.

And I thank you.

COMMISSIONER DOMBROWSKI: Thank you.

MR. LUEVANO: Good morning, Mr. Chairman, commissioners, and staff of the IWC. My name is Tom Luevano. I'm the chief labor and employee relations officer for Sutter Health Central. My primary responsibilities are around the administration and management of labor contracts, as well as the employee relations programs for those non-represented employees.

To give you a little bit of background about Sutter, we have approximately 35 facilities. There are approximately 35,000 employees in the system. And we have less than 15 percent of those employees who are represented.

A while back, we conducted a study to determine how many of our employees were actually working alternative schedules, and it was quite surprising. Well over 75 to almost 80 percent, when you take -- and it's a little higher when you take into account the 10-hour workdays -- are working some form of 12-hour workdays.

Over the last couple of weeks, I've been asked to meet with those who are working 12-hour workdays in various units, ICU, CCU, ER, OR, med-surg, respiratory therapy, IV therapy, infusion therapy, and a couple of the clerical offices, the central billing office and the medical records department. And I finished up my last series of meetings last night at about 1:30.

It's difficult to explain to you how emotional these people are over the issue of 12-hour workdays. Many of them have focused their entire lives, their social lives, their professional lives, their educational lives, their church lives, around 12-hour workdays. And to negate that would be extremely, extremely difficult on

many of them. They have expressed many of the sentiments that you've heard already from people who have testified here, who are on the lines, if you will, with our patients. And they have asked me to say to all of you that, one, they were encouraged by the Interim Wage Order 2000, which appeared to give us an indication as to where the Commission was headed with the issue of 12-hour workdays. They hoped that that was a sign that the 12-hour workday was going to continue.

Many of them are very concerned, though, that if the 12-hour workdays are not retained, how are they going to be able to manage their lives? They have, over the last several months -- actually, since the passage of AB 60, this whole notion of alternative work schedules came up -- have been looking at alternative careers. And that's difficult for us in the industry. At a time when we are struggling with many shortages in a lot of the professional areas, to have very trained, experienced people look outside of our industry for other career opportunities is not something that we relish at all.

Sutter continues to offer alternative work schedules under the provisions of Wage Orders 4- and 5-89. Also, it does it on a voluntary basis. It always has been. We have -- I manage five collective bargaining

agreements, and it's kind of interesting, last month -- I apologize -- this is April -- in March of this year, I was approached by a representative from the California Nurses Association who has a contract with Santa Rosa Medical Center. That facility has a provision in it for 12-hour workdays. The provision says that only 40 percent of certain units can work 12-hour workdays. And they have approached me to ask if we'd be willing to enter into a side letter agreement which would increase from 40 percent to an unknown percentage. That came not from CNA, it came from their own membership, our employees. And we are finding more and more people are interested in these alternative work schedules.

We're also finding that a couple of the other unions who heretofore have not been very supportive of alternative schedules, whether they be 10-hour days or any combination thereof, or 12-hour days, they -- their employees as well have been asking us if we would be interested in reopening contracts to address this issue.

Now, it's interesting to note that it doesn't affect every employee. It may affect only a few employees who would like to work alternative schedules. But the provision before us today in the interim wage order is that, you know -- with the exception of the

grace period -- is that we would have to have two-thirds vote of the affected employees in a defined unit, which is the whole reason that the previous wage order, 98, allowed for the flexibility, in other words, the individual to enter into an agreement with their employer. So, we're kind of going backwards in time.

It makes it difficult, and it's hard to explain to employees, "Look, you're a representative group of twelve; two-thirds of you have to vote. And if you vote in the affirmative, then, in fact, you can have the alternative schedule." Somebody gets hurt one way or the other in a scheme like that. However, if that's the direction that we are headed, they would much rather have that than nothing at all.

So, to leave you with the comment, we at Sutter, or those facilities who have the alternative work schedules, which there are a number of them, would like for this Commission to continue with this deliberation, and we hope that you do find in favor of continuing the alternative work schedule up to 12 hours in a day for all classifications of employees.

And I thank you.

COMMISSIONER BOSCO: Can I ask a question? Do you -- have you ever taken -- you say about 75 percent of

your employees do some form of flexible scheduling. That would appear that you'd easily qualify for the two-thirds vote, assuming those people want to be done that flexible scheduling. Have you ever like polled your employees to -- I mean, what do you foresee as your problem in just simply having these elections?

MR. LUEVANO: I'm not suggesting -- well, let me back up, to answer your question.

First of all, I'm not advocating that we don't have the election. I would love for us not to have it, only because what I'm expressing to you is that are individuals who would like to engage in an agreement with their employee without having to negatively affect the rest of their employees. The balance of those employees may not want 12-hour workdays, but this individual would like to do that. Why would I then force the rest of those employees to go through this whole process? It gets voted down, I'm out, I don't get 12-hour workdays. Or the reverse, I'm the one who doesn't want to work 12 hours, everybody else does, two-thirds vote in favor of it, we try to accommodate you -- and I can assure you that we will find -- we'll figure out a way to accommodate you because healthcare workers are very difficult to find -- but it makes it difficult. And

that's the only thing that I want to express to you, Commissioner Bosco.

If the two-thirds vote is the direction that the Commission goes, we're going to live with that and we're going to make it work. But it was a lot easier when we dealt with individual requests.

COMMISSIONER BOSCO: As it is now, a person that wants to work an 8-hour, standard 8-hour-day workweek, you accommodate them?

MR. LUEVANO: Yes. Yes.

COMMISSIONER BOSCO: So, you don't force someone that wants to work an 8-hour day to work a 12-hour day and vice versa?

MR. LUEVANO: That's correct. There -- it's just far too difficult to find healthcare workers, qualified healthcare workers. We are not going to turn qualified healthcare people away. We will find someplace in our facility. And if it's not in that one particular facility, the way Sutter runs, we have a job bank, we know of other facilities that have openings. We will ask them to go there and to apply there. We will find a place for them.

COMMISSIONER BOSCO: Do the people that work 8-hour days, do they usually receive overtime if they work

past the 8-hour day, or do you do it in such a way that they very seldom would receive -- or very seldom work past an 8-hour day?

MR. LUEVANO: If an employee works an 8-hour day and it's not an alternative work schedule employee, they will get overtime.

COMMISSIONER BOSCO: But as a practical matter, do those people ordinarily work past 8 hours a day?

MR. LUEVANO: I wouldn't be able to -- that would be difficult for me to answer.

COMMISSIONER BOSCO: I guess what I'm asking is do you find that you're paying a substantial amount of overtime?

MR. LUEVANO: I -- I can only speak for certain units within the facility, so it may not be -- it may be a distorted picture. But we don't find that our 8-hour employees work a lot of overtime, partly because we are very cognizant of the fact that it costs us, as a facility, a lot of money to pay the OT. So, we would rather bring in the part-time employees for, let's say, another 4 hours, if that be the case. In other words, if the volume is there, we'll add the staff. But if it needs -- you know, the billing needs to get out today and it's the end of the month, and it takes a couple more

hours of everybody's time, we'll ask for people to volunteer. And usually that's not an issue, because it's so infrequent. If it does become a frequent issue, then we look at the staffing and determine if it's appropriate to the volume of the work. And if it's not, we add the staff to ensure that that work is taken care of.

COMMISSIONER BOSCO: Thank you.

MR. LUEVANO: You're welcome.

COMMISSIONER DOMBROWSKI: Commissioner Broad?

COMMISSIONER BROAD: Mr. Luevano, is it your understanding that anything in AB 60 prohibits an employer from accommodating, where longer alternative workweeks are established, from accommodating employees who wish to remain on 8-hour shifts?

MR. LUEVANO: No.

COMMISSIONER BROAD: So -- okay, so that's really -- nobody's forcing you to force them to work the longer shift if they don't want to.

MR. LUEVANO: That's correct.

COMMISSIONER BROAD: Okay. Secondly, is it your sense that AB 60 in any way permits this Commission to dispense with the requirement that alternative workweeks be ratified by a two-thirds vote of the affected employees?

MR. LUEVANO: You're asking for an interpretation of AB 60.

COMMISSIONER BROAD: Yeah. I -- it's sort of novel to me that there is any -- that there is any discretion for this Commission to dispense with that two-thirds vote. That's in the statute, as I understand it. So, it's really sort of beyond -- it may be something you want, but it's nothing we can give.

MR. LUEVANO: I think you've answered my question.

MR. MADDY: Richard, you want to answer it? Will you answer the question, Richard? Maybe we'll ask our counsel.

MR. SIMMONS: Well, I think they're both accurate, that, in fact, if you want to implement an alternative work schedule arrangement within the contours of AB 60, you have to go through the requisite group-wide election process.

COMMISSIONER BROAD: Okay. Now, I asked several of your witnesses about compulsory overtime for people that would be on 12-hour shifts, should we permit that? Do you have any problem with us establishing as a condition for those 12-hour shifts that employees who wish to go home at the end of their 12-hour shift may do

so?

MR. LUEVANO: I think it would be inappropriate for me to answer that question. You're asking me to -- you're asking me to respond to a circumstance that neither you nor I know what is occurring.

The staff nurse on schedule at that time, with their volume of patients and the issues related to those patients, are the only people that can answer that question.

COMMISSIONER BROAD: Well, I guess that's my question. If, in their judgment, they're too tired to continue working, that it might somehow endanger patient safety, should it be within their discretion to determine whether they continue working or should they be forced to continue to work in those circumstances?

MR. LUEVANO: I think that's an issue that needs to be addressed with the manager and the employee.

COMMISSIONER BROAD: Should they be able to be forced to continue working beyond that point? That's my question.

MR. LUEVANO: And my answer to you is that I think it needs to be addressed with the manager and the employee, because I don't know what the circumstances are. You're asking for a blanket "yes" or "no" to an

issue that I don't know and I can't really address.

COMMISSIONER BROAD: No, I --

MR. LUEVANO: If you have a critically ill patient, critically ill, your mother or father is on an ICU unit, and that person's just worked 12 hours and they're short-staffed, would you appreciate that person saying, "I'm sorry, but I'm leaving"?

COMMISSIONER BROAD: I guess if that person reached the conclusion that they were so tired that they might endanger the health and safety of my father or mother in that circumstance, I think that probably would be appropriate, and that you would have to find somebody that wasn't tired to do that work.

MR. LUEVANO: Okay. And that issue would be left with the individual who is caring for your mother and father, and with the manager who is responsible for all of those patients and employees at the time, not me.

MR. MADDY: Mr. Broad, from our perspective, there is no simple sentence in a regulation that is going to cure the problem. And I think that's what Mr. Luevano is saying, is that these are judgment calls made by those who are held accountable and responsible for the care of the patient. And we just don't see a simple answer, that it's just "yes," "yes," every time an employees says that

they need to go, that they can go, versus every time an employer says, "You need to stay." And I don't know what -- you know, I don't know how many sentences it would take to figure all that out.

But I think, in this industry, since the primary goal and motivation is to care for the patients, that there has to be some kind of trust that that arrangement will work out between management and employees. And it's hard -- it's hard when you take it into every single circumstance, to say that, I know, because you can -- you can talk about one circumstance that seems -- "Boy, that doesn't seem like there would be really any problem there," but -- you know, "There's nothing critical going on there, but there's something critical going on here." But I don't know how you'd come up with -- you know, I don't know how you'd come up with a blanket provision. I think that's -- I think that's the problem.

And we can work with you. We can work with the Commission to try to come up -- kind of on case-by-case type of notions, that this situation probably means that there -- that we could write something that would protect, you know, the employee more than the -- you know, when the patient's not involved, but I don't see how we'd do it universally. And I think that's what Mr.

Luevano's trying to say, and I think a lot of the witnesses we've had today are trying to say the same thing. But that's not a -- that's not a simple matter.

COMMISSIONER BROAD: No, it's not a simple matter. But I'm disturbed by this issue because the standard we have is 8 hours a day, and we're talking about extending it to 12 hours a day.

I received a call in my office two or three weeks ago from a pharmacist who had been required on successive occasions, after a 12-hour day, to work an additional 8 hours.

(Audience murmuring)

COMMISSIONER BROAD: Now, to me, that is absolutely unacceptable, and that this Commission should by regulation prohibit an employer from doing that.

That employee said to me, "I was so tired I could barely function." And the employer said, "If you don't work those shifts, you are going to be disciplined, because we're short-handed." Somebody got sick.

Now, I'm greatly disturbed by that. And I would hope that your industry would consider empowering workers that are going to choose these 12-hour shifts -- and all -- there's all this talk about it's voluntary and that they want to do it -- that if, in their judgment, they

reach the point where they are so tired that they are endangering patient safety, that they can go home after that shift, irrespective of the other economic needs or staffing needs. 12 hours is half the day. After that, by the time they get home, they're getting very little sleep. And it's of great concern to me. I don't know how my fellow commissioners feel, but I'm concerned about it.

And I believe that if we're going to permit 12-hour days -- and I am sympathetic to it in this industry in certain circumstances -- that we also should make sure that we're really providing some extra protection for these employees from abuses that might occur in that circumstance.

MR. MADDY: I would say that there is -- there is no doubt that if there is a -- if a patient or a person preparing, you know, prescriptions or anything else that's going on is endangering people, that we don't share your same view. I mean, we absolutely share the view that if someone is endangering patients or if someone is too tired to perform their function in a healthcare environment, we totally share your view.

I'm just saying that I don't think that just saying it's employee choice for whether they work or not

on, you know, mandatory overtime, that it's just yes or no, the employee gets to decide, is a solution. That's all I'm saying. And as I say, I would -- we'll be happy to work with you on trying to figure out how to -- how to craft something that would address your concerns with people, you know, having these extraordinary circumstances happening to them. But I think it's extraordinary on the other side too. I think it's extraordinary if an employee says, "I don't want to work overtime," and the patient gets left without care.

So, yes, there's two sides to this. They're way over here. The language is not just a couple sentences, it's not. And that's all we just want to impart to you, is it's not that -- we don't find it to be simple.

And you don't either, but I'm just saying we don't find it to be --

MR. LUEVANO: One of our staff members would like to respond to that as well, if you would.

MS. CIMINO: I would like to respond to that.

In the years that I've been working the 12-hour shifts, I have four days off a week. Rarely, rarely is anybody asked to work overtime. Number one is the monetary reasons, and, number two, they can bring a staff person in to work 4 hours without paying overtime, and

that staff person is going to -- we have always been more than willing to do that, because we work in the environment and we know that that work is there. We will come in to work those 4 hours at straight time because we have four days off a week.

This was different when we worked the 8-hour shifts. When we worked the 8-hour shifts and we were required to come in on our day off to offset somebody else having to work longer hours that day, there was reluctance to do that because of the limited amount of free time that we had due to being required to work every other weekend and only getting two days off in a row every two weeks. It was precious to us.

But with the 12-hour shifts, we are more than willing to come in and work that 4 hours to eliminate the need for them to even request some -- the first thing that our nurse manager does is call staff that are not working, before they ever ask a staff member to stay. And that has been the way it has been consistently. I've never seen it being handled any other way.

COMMISSIONER BROAD: Well, I -- that's the way, it sounds to me, like it ought to be handled.

MS. CIMINO: That is the way it's handled.

COMMISSIONER BROAD: But the question is -- I

was presented with a case where it was handled very differently.

MS. CIMINO: That's was -- that's never. And I never heard that happen, ever in my career of doing this. However, when there were 8-hour shifts, you would find people who were very resistant to come in on their day off, very resistant. You don't have that any more.

MS. LOWERY: Another comment, if I might say, when I did those 8-hour shifts nights, I was the lead therapist at night, and the lead therapists were supposed to stay over if the staffing needs weren't met in the morning. And there was a lot of mandatory overtime working the 8-hour shifts.

(Applause)

MS. LOWERY: Working 12-hours, I haven't had the mandatory overtime.

(Applause)

COMMISSIONER DOMBROWSKI: Let's not go there.

MS. LOWERY: Yeah. On the 8-hour -- like I'm saying, on the 8-hour shifts, I was mandated on several occasions to work the overtime. And frankly, there was a lot of times that I was tired. But there was nobody there to deal with the patients.

So, being if it's an 8-hour or a 12-hour, if you

are mandated, you know -- a patient -- you know, you have the right to tell your employer, "Listen, it's not safe for me to be there." You do have the right to do that. And if they don't do anything, your manager doesn't do anything, then you go above them and -- you know, and speak until somebody hears you, and say -- and say, "Listen, I can't do it; it's not safe for me and it's not safe for my patient." And --

COMMISSIONER DOMBROWSKI: Okay. I think I hear grounds for negotiation for a settlement here, a conciliation. So, let's move this along.

Mr. Simmons.

MR. SIMMONS: I'm actually here simply to respond to any technical questions that may be raised.

COMMISSIONER DOMBROWSKI: Okay. Any other questions?

COMMISSIONER BROAD: Yeah. I have a couple questions. Mr. Simmons, these are more in your area of legal questions.

As I understood Mr. Maddy, he was suggesting that we reinstate the definition of "primary" that was contained in Order 5-89, which, as I read it, contains a primary duty test component. And it's my understanding that our interim wage order, complying with the

provisions of AB 60, eliminated this provision within the restored Order 5-89. Is it your view that we have the legal ability to effectuate a primary duty test for exempting managers?

MR. SIMMONS: Yes, I think you do. I, frankly, believe that the provision that was adopted in 1993 with respect to the term "primarily" is, in effect, restored under AB 60. And I think the IWC has the legal authority to preserve that provision in the healthcare industry as it was adopted in 1993.

COMMISSIONER BROAD: Okay. Secondly, in December when you testified, you and I had a little colloquy about the circumstance by which a number of healthcare institutions reduced people's base wages after the passage of AB 60 and before January 1, in order to maintain 12-hour shifts with the payment of overtime, in order that the amount of pay be retained at the same level pending action by this Commission. At that time, I asked you whether it was the position of the industry that should we permit 12-hour days, would there be any objection were we to require that employees whose base wages were reduced, that those base wages be increased to what they were, as a precondition to going to 12-hour days. And I wonder if you could respond, what the

position of your industry is on that question.

MR. SIMMONS: I believe the position is, as I thought it would be when we did have that colloquy back in December, and the fact of the matter is that I am confident that the industry would be more than happy to readjust the rates of pay to those that were in effect prior to the adjustments, because the entire system was devised to maintain pay parity. And they would be happy to go back to pay parity by restoring any adjustments that were made at the time.

COMMISSIONER BROAD: Well, there's one issue that's resolved.

(Laughter)

COMMISSIONER BROAD: Thank you.

MR. SIMMONS: You're welcome.

COMMISSIONER DOMBROWSKI: I'm now going to have Mr. Rankin bring up his panel.

MR. MADDY: Thank you, members.

COMMISSIONER BROAD: Mr. Chairman, while they're coming up, can I take care of a couple of issues?

COMMISSIONER DOMBROWSKI: I just want to make sure --

COMMISSIONER BROAD: Okay.

COMMISSIONER DOMBROWSKI: -- people understand.

After Mr. Rankin's panel, then I'm going to go through the cards here. I'm not quite on all these, if the people want to talk about this issue, the 12-hour day, or if they want to talk about the advanced practice nurses, so I'm going to call names in order. If you want to talk on this issue, you can come up. If you want to wait and defer, that's your choice.

COMMISSIONER BROAD: Mr. Chairman, a couple of issues arising out of last month's meeting -- hearing.

At that time, when we empaneled the members of the wage order for the on-site industries, you had requested that I read all of the nominees. And it has been brought to my attention that I inadvertently left two off the list, although the list in its completed form was part of the record. I would like to mention these two appointees just for the record, that we cross our "t's" and dot our "i's," that they be -- that it be clear that they were intended to be at that time, and are included, on that wage board.

And they are the two employer representatives from the mining industry, Gil Crosthwaite, and Lynn Kraemer.

Do we need any sort of motion for that, of any sort?

Okay. The second thing, Mr. Chairman, is I'd like to notice reconsideration of the action by which we voted to establish a wage board for certain employees in the -- highly paid employees in the computer industry, and request that we would take up consideration of reconsidering that at our next public hearing.

COMMISSIONER DOMBROWSKI: We'll put that on the May 5th agenda.

COMMISSIONER BROAD: Thank you.

COMMISSIONER DOMBROWSKI: Mr. Rankin, if you could identify or --

MR. RANKIN: Sure.

COMMISSIONER DOMBROWSKI: -- make sure that your witnesses identify themselves so I can sort through the --

MR. RANKIN: Right. I'm Tom Rankin, with the California Labor Federation. And we have several nurses and representatives of nurses with us today. And I would -- you want me to go through them now or --

COMMISSIONER DOMBROWSKI: Just as a group.

MR. RANKIN: -- as they speak? Okay.

COMMISSIONER DOMBROWSKI: I can't keep up that fast.

MR. RANKIN: All right. Very good. Well, we

have folks here representing three different organizations, labor organizations, the United Nurses, an AFSCME affiliate, the Service Employees Union, I think mostly with Local 535, and the California Nurses Association.

So, let us just begin to my right here. And I will pass this down.

We have with us Leila Valdivia from -- who is a Kaiser nurse and a member of SEIU Local 535.

MS. VALDIVIA: Hi. My name is Leila Valdivia. I'm a registered nurse and I work at Kaiser Los Angeles Medical Center, and I am a member of SEIU Local 535, American Federation of Nurses.

I am not a manager. I give direct patient care every day. I work three 12-hour shift every week, and each week I take a loss in pay. I support the healthcare -- I support the idea that healthcare workers who put in 36 hours be paid 40. The current practice allows hospitals to make incredible profits while healthcare workers like me lose 4 hours of pay each week. Many of my co-workers have found that they need to work extra hours to compensate for the loss.

These abuses, along with others you will hear today, are some of the major reasons why people leave the

healthcare industry and why we have such a serious shortage. Continuity of care is great, if you have enough people to give the care.

You have the authority to help change a very imbalanced culture, a culture where the front-line healthcare worker is put last. While we care for you and your families, who will care for us?

The recommended 4 hours will help us receive a fair day's pay for a fair day's work.

And I'd just like to add that I would like to thank all of the hospital administrators who took their time out from their busy schedules today to express their compassion and concern for their employees. I am quite impressed.

MR. RANKIN: Next we have Joyce Gray, another nurse, from Encino Hospital.

MS. GRAY: My name is Joyce Gray. I'm a registered nurse at Encino Tarzana Medical Center in Encino, California. I work 12-hour shifts, night shift, on a medical-surgical unit.

The abuses of 12-hour shifts are making hospitals increasingly more unsafe for both patients and nurses. Hospital nurses need some protections from overwork and fatigue to facilitate making safe decisions

for patient care.

I regularly work overtime and without breaks in order to meet basic patient needs and complete required documentation of care given at my facility. Some nurses have worked 24 hours straight, on several occasions. According to state law, this is not illegal. Both patients and staff need protection to limit the amount of work hours today, with mandated rest periods during and between shifts.

Frequently hospitals are understaffed to the point that lunch and rest breaks are not possible. Complicated nursing decisions and interventions for seriously ill patients under such conditions are unsafe, to both patient and nursing personnel.

On behalf of my patients and co-workers, I am asking for modest regulations of the 12-hour shifts with regard to hours of work, rest periods, and meal breaks. These regulations should be upheld and rigorously enforced in hospitals.

Thank you.

MR. RANKIN: Thank you. Next we have Deborah Bayer, with the California Nurses Association, who works at Children's Hospital in Oakland.

MS. BAYER: Hello. My name is Deborah Bayer. I

work in the pediatric intensive care unit at Children's. And I'm here to speak, really, in support of maintaining the 8-hour day as a standard.

When we talk about 12-hour shifts, we talk about -- well, we talk about flexible, being flexible, being alternative. And I am not opposed to 12-hour shifts. I realize that those work well for some people, and I think it's great if we have an election, a two-thirds election, which is returning to kind of the status quo we had a couple years ago, and allow people who want to to work those shifts. But it is an alternative shift to what is standard, which is 8 hours, which, for many people, is as much energy as they have to be at work and also provide them with ability to live their life outside of work.

So, I think that the proposal of 36 for 40 is reasonable, is fair. Employers always want -- it's not surprise that all these managers are up here talking about how wonderful it is to work -- have their people work 12 hours at straight time. It's the cheapest way to staff any 24-hour industry. So, of course they're going to be in favor of that.

But I think that if people are working those 12-hour shifts for the employers, they do deserve some premium pay. And 36 for 40 is a compromise agreement

between time and a half and straight time, and I think that that's reasonable, because they are onerous to work.

As many people who came up and spoke and said how desperate they are to maintain their 12-hour shifts and how proud they are to be working 12-hour shifts, we can have people coming up and saying the same thing for 8 hours. If you think about 12 hours, it takes like an hour before work, an hour after work. We're really talking 14 hours. If you have children or if you want any kind of a home life, that's a big chunk out of your day.

I mean, I can topple all those arguments. They talk about continuity of care, but then they say how many days they're away from the hospital. Well, there goes the continuity of care, where, if you're working 8 hours, you're here day after day. I mean, we can go on and on about it.

And I'm not here to speak for 12-hour shifts, you know -- against, 12-hour shifts. It's a reasonable shift to work if you want to do it. What I'm here to really talk about is protecting the 8-hour day and -- so that if people want to work 12 hours, okay. But nurses, especially, is an aging workforce. People get sick. Often you are medically unable to work more than 8 hours.

And I think that -- I'm 50. I've been doing this work for a long time, and I think I can keep working for another fifteen years. I can't do that. I can't work 12 hours. You know, I'm tired at the end of 8 hours. And so, I really want to stress that.

And, in fact, that Sutter manager from Roseville who said that, oh, yes, he accommodates anybody who wants to work 8 hours, I'd like to see him put that in writing. And I don't think people especially want to go to a different hospital or take a different job in order to find an 8-hour shift, which is what he was -- what he ended up saying.

And then I also want to talk a little bit about forced overtime. What hospitals have done is instituted just-in-time staffing. They can talk about a nursing shortage, but it's a shortage of their own making, because they engaged in massive layoffs. At my hospital, Children's Hospital, we never had mandatory overtime until they laid nurses off in 1992. They got rid of 20 percent of the nursing staff and acute care employees. All of the sudden we had a nursing shortage, and we were expected to stay over. And mandatory overtime became a big problem for quite a few years. We proved the point successfully enough that the hospitals backed down. And

they only backed down when nurses, en masse, started to refuse. Since then, we have been getting no mandatory overtime in our contracts. I think it's a right that should be extended to all workers, that you're not slaves. We have a right to know when we've had enough.

And this whole talk about nurses, what we have done is we have --

COMMISSIONER DOMBROWSKI: Could you hold on a second? Commissioner Bosco has a question.

COMMISSIONER BOSCO: Well, I can wait till she's finished.

MS. BAYER: Okay. What we basically -- the language that we mostly have adopted where we have negotiated this in our contract, what we've done is, the nurses have said, "This is a strike issue; we're going to go on strike if we don't have no mandatory overtime," because we needed relief. The language we negotiated said, in most cases, no mandatory overtime unless there's a civil emergency, you know.

And no nurse is going to walk out on their patient because their 8 hours is done or their 12 hours is done. But we have the right to say -- and we put in hundreds of hours of overtime at our hospital voluntarily -- but we have the right to say that we know when it's

time to go home, okay, because our children are home needing us or because we're too tired, either way.

And there was one other -- I know I -- oh, I know. I just wanted to mention that in Worcester, Massachusetts, the nurses have been on strike for several weeks now, and they're striking over mandatory overtime. It's the only issue. This is a big issue. And people say, "Oh, no, it's impossible for the pharmacists to work 20 hours." Several years ago, mandatory overtime was like uncontrolled at our hospital, and the hospital was using it as a staffing tool. We had nurses forced to work 20 hours. It does happen, and we do need some controls.

Thank you.

COMMISSIONER BOSCO: Could I ask -- I'm very interested in what actually is happening out there. And obviously, I don't have personal experience, aside from occasionally visiting the hospital for one reason or another. But rather than theorizing on what could happen, I'm sort of interested in this question of what does happen. And I asked the gentleman that was here before whether, for the most part, people who had chosen to work an 8-hour day were able to, and the people that wanted to work a 12-hour day were able to. Now you have

testified that -- I think -- that that doesn't happen.

In your experience, do you -- I assume that you work in a facility that some people have 12-hour days and some people have 8-hour days. Is that true?

MS. BAYER: Well, we used to have -- in the nursing staff, we used to have both 8 and 12, when we had a 36 for 40 agreement. When the hospital wanted to have us work 12 hours at straight time, we took a vote. And by a two-thirds majority, we voted no.

And we used to have -- go to 12, because the nurses said, "We are not going to give -- we're not going to work those horrible shifts." And some people really felt bad about losing their 12-hour shifts, but this was a democratic decision. And a few people, you know, said, "Oh, we mind we're going to lose the 12-hour shifts, but we don't want to work them at straight time." And then, within a few weeks, they were just sort of blissed out. They said, "Oh, my God, it was like getting off a treadmill, not to have to work 12."

COMMISSIONER BOSCO: Okay. No, that wasn't what I was asking.

MS. BAYER: But in -- so, we had passed, because we have a contract, we had -- we had protections. We negotiated a 40 percent cap -- we're going to have a 40

percent cap on 12-hour shifts on the floors. In hospitals where there are no regulations, many hospitals -- many hospitals in southern California and many nonunion hospitals, at UC, they are all 12's. It's very, very difficult to get an 8-hour job, because management, in union hospitals or nonunion hospitals, management has control over posting shifts. So, once you get -- unless there are controls, unless there are regulations providing for the availability of an 8-hour shift, management can post all 12's, if they want to.

COMMISSIONER BOSCO: No -- well --

MS. BAYER: Was that your question?

COMMISSIONER BOSCO: That was my question, but you're giving me the theory. I understand that management could do that if it wanted to. I'm saying, in practice, is that what happens --

MS. BAYER: Yes.

COMMISSIONER BOSCO: -- or is more what's happening that the gentleman --

AUDIENCE MEMBERS: (Not using microphone) No! No!

COMMISSIONER DOMBROWSKI: Audience, please.

COMMISSIONER BOSCO: I mean, you don't work in a facility that that's the case, do you?

MS. BAYER: Well, I guess, the respiratory therapists from Children's Hospital here, they all work 12-hour shifts. They voted two-thirds for the 12-hour shifts, and some people wanted to work 8. Everybody now works 12. No 8-hour shifts have been posted since the election, which took place a long time ago.

COMMISSIONER BOSCO: And that's in the Children's --

MS. BAYER: That's at my hospital. Those are non-represented employees. So, they all work 12-hour shifts at straight time. They want to do it. But they're out, if you wanted to work 8 hours. You can't apply for a respiratory therapist's because --

COMMISSIONER BOSCO: So, in your experience, then, that this -- that it isn't true that people who want to work 8-hour shifts are still able to, even though a lot of other people are working 12 hours, that that is not your experience.

MS. BAYER: It's not my experience. Unless there are written agreements providing for the ability of the people who want to work 8 hours to continue to work 8 hours, or the posting of 8-hour positions. I mean, what I would prefer is if we allow this two-thirds vote to go through and 12-hour shifts, which I think is reasonable,

what I would prefer is that anyone who wanted to work an 8-hour shift would be accommodated, because I think that it's the standard.

But I don't know if other people have had experiences like that.

COMMISSIONER DOMBROWSKI: All right. Next speaker.

MS. BLOOM: My name is Wendy Bloom. I am a registered nurse at Children's Hospital, Oakland, working the PM shift, which is the 3-to-11 shift.

And I had not planned to speak today, but I feel very strongly on this issue. And with the previous group of speakers, I thought you would think that all nurses support the 12-hour shift. I'm satisfied as an 8-hour shift worker. I do not want to work 12-hour shifts.

I work a pediatric hematology oncology unit, and we work very hard there. Often we don't even have dinner breaks during our 8-hour shifts. And when we did have the 12-hour shifts that we spoke about before and the 8-hour shifts, and, in fact, the 12-hour workers' productivity definitely decreased after the 8 hours.

I am also a single parent of three, and I find working 8-hour PM's works well for me. I have to time to volunteer to school, do laundry, grocery shopping,

housecleaning, and also to maintain my own mental health with this schedule with my mornings off.

I really think that glorifying the 12-hour day for nurses as a way to improve patient care is a falsehood. I think workers are too tired working 12-hour shifts. Also, we need to find a way to recruit and retain workers and not fall back on the 12-hour shift as a solution to the staffing problems. I speak for many of my co-workers for the need to maintain the 8-hour shift as being the standard shift.

Thank you.

MR. RANKIN: We have Michael Zackos, who is a Kaiser nurse with UNAC.

MR. ZACKOS: Good morning, Mr. Chairman. My name is Michael Zackos -- and commissioners -- my name is Michael Zackos, and I'm a staff nurse at Kaiser Permanente in Los Angeles, and also a member of the United Nurses Association of California/AFSCME.

I've been in the nursing profession for 22 years. Today I am representing myself, as a staff nurse, and fellow nurses at the work site who actually are composed of a mix of 8-hours and 12-hour shifts. I'm supporting the labor proposal regarding 12-hour shifts, emphasizing, however, that those safeguards indicated be

stringently followed, more specifically, a reasonable effort and accommodation made for those individuals unable to work 12-hour shifts in instances such as family restrictions, healthcare reasons, or a critical admission on the part of employees that they would be a patient risk if they worked beyond the 8-hour day.

My sister mentioned those nurses who make up an aging workforce, which I thought was pretty creative. Those people cannot physically maintain a consistent 12-hour shift. Other instances are an absence of intimidation or coercion by the employer in order to force healthcare workers to work or vote for a 12-hour shift, and again, no mandatory overtime after 12 hours.

The previous speakers had mentioned my personal opinion in reference to reasonable effort and accommodation. I certainly don't believe it's reasonable effort and accommodation when you have -- facilities have multiple hospital locations. And I myself, who have been working at a facility for twenty years and being advised that I would have to work a 12-hour shift, and if I don't, if I want to maintain my 8 hours, I'll have to go work at another facility, I think that is not reasonable accommodations. And I think those people that want to work the 12-hour shifts should be allowed to voluntarily,

and those who cannot do it, maintain their 8-hour.

Thank you.

COMMISSIONER BROAD: Can I ask him a question?

COMMISSIONER DOMBROWSKI: Sure.

COMMISSIONER BROAD: Following up on Commissioner Bosco's question about reality and what's the reality, obviously, for us, you know, we're in the hospital -- somebody said, you know, we had a surgery or we're visiting someone or, you know, in my case, there's a couple of children that got born, or whatever -- I recall spending a lot of time alone in the room on those occasions, without the presence of anyone on staff.

But I guess my question goes to -- I, of course, raised this issue about mandatory overtime, and you've addressed it. But I'm wondering what is the reality. I mean, how often do you have situations that come up and what situations are they where people don't just go home at the end of their shift in a hospital, an emergency or whatever?

MR. ZACKOS: Situations come up when a nurse is approached -- it could be an hour, 30 minutes before the end of the shift, and they say, "You have to stay." And they may say, "I'm physically not able to, I have family commitments at home," and they're being threatened with

discipline. They're being threatened with abandonment of patients, or any other creative approach that a supervisor will do. And that happens frequently.

And I have members and fellow workers who complain of that, so that's a reality that consistently happens.

COMMISSIONER BROAD: Why does it happen?

MR. ZACKOS: Well, it could be --

COMMISSIONER BROAD: I mean, from the --

MR. ZACKOS: -- from the hospital's perspective, multiple reasons, maybe not enough effort in meeting those staffing needs for the oncoming shift, or it could be -- and I have to certainly give them the consideration that there may be last-minute call-ins, but certainly more effort has to be made, and certainly if someone cannot physically work past that 8 hours, they should not be threatened with disciplinary action or, again, abandonment of patients.

COMMISSIONER BROAD: What about -- and I guess any of you on this panel can answer this question -- what emergencies come up, and how often do they come up, and in what circumstances that a patient is in such dire need that there's nobody there to take care of them if you go home?

MS. OBASIH-WILLIAMS: My name is Cheryl Obasih-Williams, and I work for the Tenet facilities. And I work L&D. I'm a L&D nurse. I work 12 hours.

COMMISSIONER BROAD: What's -- excuse me. What's L&D?

MS. OBASIH-WILLIAMS: Labor and delivery.

COMMISSIONER BROAD: Oh. Oh, yeah. Okay.

COMMISSIONER BOSCO: Where you were.

COMMISSIONER BROAD: Yeah, one place I have been.

COMMISSIONER BOSCO: As a spectator, I assume.

(Laughter)

COMMISSIONER BROAD: Definitely.

MS. OBASIH-WILLIAMS: And a situation just happened where I'd worked 12 hours, the unit is beginning to get crowded, the employer has not perceived that we're going to have "x" amount of patients walking in. The physicians are sending patients from their office to have NST's or whatever done, have further evaluations that cannot be done in the office, which impacts the union, because you have laboring patients there. And maybe an hour before you're to leave, the employer says, "We don't have anybody to replace you. We're trying to get a replacement. We can't get anybody until 11 o'clock. Can

you stay over?" Well, you've got a patient who may be 8 or 9 centimeters, where she's going to deliver in a couple of hours, and you don't mind staying over a couple hours, but the employer has promised you that they're going to try to get you somebody there by 11 o'clock. And hopefully, they will. Sometimes they don't. You have to stay until maybe 12, 12:30. But I'm tired, and I would like to go home. But I'm not going to leave this patient because I've bonded with that patient, and I want to continue continuity of care.

And that is one -- that is one instance, for myself, where the employer has waited until the last minute to come and say, "Can you stay over?," or "Can anybody stay over?"

MS. BLAKE: My name is Barbara Blake. I'm the state secretary of United Nursing Associations of California.

You asked about what type of emergencies might come up where someone would be required to stay. I think hospitals are staffing, because of economic issues, staffing to the bare bones these days. And what we used to call core staffing was the minimum number of people that would be provided on a floor to provide safe staffing. A lot of times, the core staffing has been cut

so low that you just don't have any reserve to be flexible in case you start getting a lot of patients in the emergency room or whatever. And the supervisors are also stretched as far as they can be. And oftentimes, it's the easiest thing to do to turn around and get staff nurses and say, "Sorry," you know, "it's five minutes till the shift starts and I don't have enough people to cover the patients; you're expected to stay."

I recently spoke with a nurse whose supervisor told her that she didn't care that the nurse's child was at the park and expecting the mother, the nurse, to pick the child up, that the supervisor was demanding that the woman stay at the hospital. And if she was to leave, she would have been charged with abandonment.

I mean, there's a lot of fear and intimidation that was going on in that situation.

The other situation that I've recently been informed of was in a unit where people went to 12-hour shifts. They said they were going to try to accommodate those people that chose to work an 8-hour shift, and the management came back and said that they were not able to accommodate that. The only option that was open was that the nurses be moved to another unit where they would have suffered a wage reduction. So, it was a unit that was

not paid as highly as the unit that they were on. And then they were forced to sign statements that said that they were volunteering to do the 12-hour shifts, because the other option was to take a lower paying job. And the employer was saying, "You've gone into this voluntarily, and we now want a statement from you saying that you're entering into this 12-hour shift on a voluntary basis."

So, there are some perfect worlds out there, from what we've heard this morning, and I wish there were more of them, but there are also some worlds out there that are not quite so perfect as that.

MR. RANKIN: Herb Steinkrans, a respiratory therapist.

MR. STEINKRANS: Hello. How's this?

My name is Herb Steinkrans. I'm a respiratory therapist at Seton Medical Center in Daly City, across the Bay from here. I've been a respiratory therapist for approximately thirty years, the last fifteen with Seton Medical Center. I have been, for the last twelve -- ten years, I have been on a 12-hour shift, after they brought it in by a two-thirds majority.

I want to speak -- speak for myself and my colleagues at my sister hospitals, St. Mary's and St. Francis, who have just recently voted in the SEIU this

last fall. I've been in contact with them, and I called them just prior to coming down here asking if I may speak for them, and they said, "Please do."

I want to say briefly that when we first voted our 12-hour shift, management had promised us 40 hours of pay and benefits. Later on, they kind of went through a unilateral decision and stripped us of those, and we went back to the 36 hours of straight pay. This was appalling to us. It's one of the reasons why we decided to get some more support and organize, one of the issues.

Mandatory overtime was temporarily ordered this last winter when, due to a shortage of staffing, not only in hospital, but all the registries and everybody else was impacted, so we couldn't get anybody from anywhere. So, they required us to do mandatory overtime in the sense of having to work an extra shift. Rather than the three 12-hours, we had to work an extra 12-hour shift. This was soon, after many of the staff had made an issue of it and made a complaint about it, it was soon rescinded. And we went back to the standard three shifts.

But I wanted to say that in order to perform at maximum performance, it is important that the people on these shifts have adequate rest periods. Talking to my

colleagues at the two hospitals, St. Francis has a very good program, which 12-hours are allowed, and they have two half-hour meal periods and three fifteen-minute rest periods. Half-hour rest periods were -- if half-hour meal periods were interrupted, this could be put down on our timecard as overtime. Seton night nurses often used their half-hour periods to sleep -- these are 8-hour nurses usually -- and they have adequate staffing to cover each other to do this.

Respiratory therapists on the night shift at Seton are minimally staffed and are only allowed one thirty-minute meal period and two fifteen-minute breaks. This meal time is often interrupted, and at times, back-up is unavailable and no lunch is taken.

At St. Mary's, the way they -- the St. Mary's staff is on 8-hour shifts, so I'm just going to speak -- mention one thing for them, is that they have unbelievable staffing. They don't do -- they only have one therapist on nights and sometimes one therapist on PM's. Now, how can you take a break or have anybody cover patients when that one therapist is on a break? You can't. So, this is totally unrealistic. And they're trying to institute a minimum staff of two therapists.

I wanted just to add on one more comment here,

and that is, at Seton it is common for day staff to ask to work an extra six hours to fill in staffing needs on evenings. It is not mandatory. And it is not uncommon for those RN's who have worked 8 hours to be asked to work a double, or an additional 8 hours, for a total of 16.

So, I think that working an extra -- we try to let those people who do work extra 6 hours -- not an extra 12 hours, but an extra 6 hours from -- like I work from 6 p.m. to 6:30 a.m. If the day therapist works an extra 6 hours to help us through the evening shift, we try to make it available that as soon as their work is caught up and as soon as our workloads lighten up, that they get home -- a chance to go home as early as possible. But occasionally our workload is not that way. They have to work until midnight, at least.

It has never happened, that I know of, that anybody works beyond midnight through the morning session. They usually just suck it up and prioritize care to take care of whatever they have to do to get the work done.

I think that's about all I had to say about working a 12-hour shift, except that if I wanted to say anything more, it would be about my differential. I wish

that they would never have cut us on that, because that is the worst thing you ever -- we work so hard on nights and we have so poor -- so little time to catch up on our regular home life that it's sometimes important that we get the maximum benefit out of it. This is where I'm adding my two cents now.

Thank you very much.

MR. RANKIN: Leila would like to answer one of the questions that was raised.

MS. VALDIVIA: Yes. Before that, though, a lot of the problems that we've described today are problems that were available. If we -- if we adequately put into our labor force that work in the healthcare industry and adequately take care of the minimum standards, then we wouldn't be having a lot of these shortage problems and we wouldn't have to be addressing how do we accommodate, to have safe staffing or to have somebody to relieve another nurse. That wouldn't be a problem if it wasn't for that thinking in the first place. So maybe we should start thinking long-term instead of short-term.

The other thing, about the mandatory overtime, it does happen, too many times. And I know that you've all read the newspapers and when they started reporting about how many medication errors really do happen in a

hospital. I can tell you so many more stories. I mean, it really happens. And I'm talking about reality. I'm not talking about an administrator's point of view from the office. This happens.

The reason it happens is because of fatigue, too many times. The reason it happens is because there's not enough of us to adequately take care of these patients. Why isn't there enough of us to adequately take care of the patients? Because a lot of us are leaving the industry or the hospitals did do -- as my sister over here mentioned earlier, about layoffs, because they're so into cutting to the bare bones, they're so into the bottom line, they're so into short-term thinking. And that's the point I wanted to make.

MR. RANKIN: Thank you. Allen Davenport, with the Service Employees Union.

Before we get to Allen, Cheryl wants to say one more word about the wage question.

MS. OBASIH-WILLIAMS: I have a statement from -- my name is Cheryl Obasih-Williams, and I'm from Fountain Valley Medical Center.

In my sister hospital, there is a group of nurses who have a statement that they wanted me to read in.

"We, the undersigned nurses of Lakewood Regional Medical Center would like the following considerations: to have our hourly wage restored to its previous level and provide us with retroactive pay for those nurses affected; number two, nurses who work three 12-hour shifts have made financial sacrifice for the employer's benefit and should be compensated for 40 hours of pay instead of losing 4 hours each week; nurses should have a vote on 12-hour shifts, and those nurses who opt not to work 12-hour shifts should not be mandated to do so; they should be allowed to work 8 hours and accommodations made for them."

And these are the nurses who have signed their statement to these three objectives, and I have it here.

COMMISSIONER DOMBROWSKI: Thank you.

Allen.

MR. DAVENPORT: Hello. I'm Allen Davenport. I work for the Service Employees International Union, and we are a union of nurses and other healthcare workers in all the healthcare settings across California.

We know that the best protections for patients and healthcare workers are in a union contract, and -- as

you see here, even on these 12-hour shifts that we have under union contracts, these things are difficult to enforce, and there are stresses in the system. All right?

But one of the things that we have done in the course of our organizing is go out and talk to workers who work 12-hour shifts who are not in unions, but who would like to be in unions. And the documents that I've submitted to you are 26 letters from nonunion healthcare workers who have concerns about -- real stories, Mr. Bosco -- about what goes on in 12-hour shifts in hospitals where there is no unionization. And they talk about fatigue, they talk about understaffing, they talk about forced overtime. These are nurses who we asked to write to you, and those are your letters. They're -- you'll find that they are all remarkably different and unique, but they are real stories.

I would like to relate one of them. This is a nurse at St. John's Regional Medical Center. She says, "I worked in ICU, CCU, and ER for twenty years. I got burned out from rarely taking a break, maybe squeezed out a twenty-minute lunch break, tried to limit my liquid intake so I wouldn't have spend so much time to visit the bathroom. For years it almost seemed normal to work

while extremely exhausted, overwhelmed, and unable to care for my patients as they deserved. After many long physically and emotionally exhausting 12 hours in the ER, I would drive home in tears knowing my patients and my fellow nurses' patients did not get the care that they should have."

This is the concern that we have here, is that if we're going to do this 12 hours, that we do this in a way that there's adequate staffing, that there's adequate rest periods, that -- and that these decisions are made on behalf of all of the workers through fairly conducted elections. And I think that's the proposal that -- the kind of proposal that we could support in this area.

But these concerns are real and they need to be taken account of.

MR. RANKIN: Kay McVay, with the California Nurses Association.

COMMISSIONER DOMBROWSKI: I'm sorry. I didn't get the name.

MR. RANKIN: Kay McVay, I believe president of the Nurses Association.

MS. McVAY: Hello. My name is Kay McVay, and I'm the president of the California Nurses Association. And we, as a board, discussed the issues before you and

we propose that there would be a ban on mandatory overtime after any shift worked by a registered nurse, regardless of the length of that shift, be it 8 hours, 10 hours, or 12 hours. We feel that mandatory usually indicates that there has been a lack of planning on the part of the manager to try and make sure that there is relief for those RN's. And I can cite several instances that have occurred in the Kaisers, at Doctors Pinole, and at Riverside and other facilities.

We also definitely want to recognize the 8-hour day as a standard for the work shift. My grandfather actually was on some of the lines to try and get an 8-hour day, along with every other weekend.

I want to support allowing the waiver of time and one half after 8 hours for alternative work schedules such as 10- or 12-hour shifts, provided that there is a minimum two-thirds vote, so that it would be the affected nurses on a unit-by-unit basis, and that it would be supervised by a neutral party so nobody could feel that they were being intimidated.

We recommended that those nurses affected by a waiver be paid 40 hours for 36 hours worked.

We oppose the bumping of an 8-hour nurse from their shift position, unit, or department as a result of

the two-thirds vote to grant the waiver. And I have experienced that position, because I maintained an 8-hour shift and there was no one else to offset that 8 hours. Therefore, I would either go to the night shift or I would become a 12-hour nurse. That is an example of what goes on.

Support for a revote on the waiver after a year, which would be triggered by a petition signed by one third of the nurses in the affected unit. What we are asking for is democracy and respect. We wouldn't have a nursing shortage if we had a little more respect.

Thank you.

MR. RANKIN: Thank you.

We now have Patty Gates, who is an attorney with the Van Bourg law firm, who will speak to us about a situation where pay was reduced in order to adopt a 12-hour day and what we should do about that.

MS. GATES: Thanks, Tom.

Good morning, commissioners. My name is Patty Gates, and the office that I work for represents, I guess, over two million men and women across the country. And one of the things that we provide in terms of legal counsel is we provide -- every day there is an attorney who's on duty, and the attorneys on duty take telephone

calls. And these are calls that come in from working people. And they give you a pretty good indication of what kind of issues working people face in the workplace. And even though, in the office, duty call isn't always the favorite job, it's the job where you find out what's happening in the workplace.

And sometimes it troubles me to hear people who make light of what is a very serious inequality that exists between an employee and an employer. And while I would like to believe that all employers are as enlightened as some of the ones on your earlier panel, my job experience and my life experience tells me otherwise.

Recently, we have received a rash of phone calls from employees in the healthcare industry at our law office. And these calls have reported to us unilateral, coerced reductions in a base rate of pay so that, in anticipation -- these reductions occurred after the governor approved AB 60 but prior to the implementation date of the law -- and these reductions were done in order to secure the economic safety -- it was basically an insurance policy -- for the hospitals that put these in place. And this insurance policy was paid for by the workers.

And the testimony that I submitted to you today,

if you look at Appendixes A and B, those two appendixes show the entire strategy that was put in place. First of all, the employer misinformed the employees about the effect of AB 60 and never bothered to mention that, under the terms of AB 60, the 12-hour day was actually secure until July. So, in December, during the month of December, these two hospitals, St. Vincent Medical Center in southern California, which is part of -- I think it's called Catholic Healthcare West -- and Doctors Medical Center in Modesto, California, both sent memorandums to their 12-hour-shift employees telling them that they would try to keep them as whole as possible, but in the meantime, they would receive a 14 to 16 percent reduction in base pay.

And if you look at the -- if you look at the documents that the workers were required to sign, there's nobody that can tell me that this was not a coerced agreement. At the bottom of the page -- people were told on December 10th that on December 19th, they could either take this reduction in pay or they would have to go to five 8-hour work shifts. And I think the people in this room who testified in favor of the 12-hour day made the case for how hard that would be for an individual to make that shift in their life, with sometimes less than ten

days' notice. Yet people agreed to this because they trusted their employer and they trusted that their employer would make them whole, as economically whole as possible.

And, in fact, they came up with a system for how they were going to do payroll. And this system is included as Appendix B. And that system took twelve pages to explain. And I've read it nine times. I had two other people in my office read it with me. And the -- I mean, it requires things called flex differential charts. In order to understand what you're paid, you actually had to interpret -- for instance, if you got sent home an hour early, the kind of machinations that the employer had to go through to figure that out, because they were paying you time and a half based on your reduced rate of pay, but they had a double time based upon 2.43 percent, which was a voluntary double time arrangement. But if you were using time off, if you were using time off, it complicated the situation and required yet another chart to figure that out.

But in the end, what happened is these workers were incredibly troubled because lots of things are tied to your base rate of pay. And these things that are tied to your base -- whether you qualify for a car loan,

whether you qualify for a home mortgage -- your base rate of pay is a really important part of your financial and your economic stability.

And these two hospital employers are two employers who, in my opinion, don't deserve the kind of trust that I've heard expressed here today by some of the witnesses.

One of the witnesses in favor of the -- sent a message to the Commission in favor of the 12-hour day, and that worker sent a message that he liked his 12-hour days so much, he was willing to take the pay cut that the hospital dealt him in order to get that 12-hour day. And I think that people forget how hard it was for protection to be put in place. And when I hear people laughing at union leaders and union activists who work hard to create a floor of rights underneath all of what -- and we all benefit from this floor of rights. The people in this room all benefit from that floor of rights.

And then, when I think about all of the phone calls that we receive at our office explaining to us how employers really use the clout that they have -- and they do have clout, because people signed agreements to take these pay cuts, but these were, in my opinion, coerced agreements. I think these pay cuts are illegal. I think

they violate probably the Fair Labor Standards Act as well as California law. And I think that all of the employers, if they're going to get a 12-hour day at this stage, they should first have to go back to where they were in -- it was probably early December where a rash of these were signed. And they should have to go back and reinstate the base pay that these workers had prior to the reduction.

(Applause)

COMMISSIONER BROAD: Can I ask a question?

COMMISSIONER DOMBROWSKI: Sure.

COMMISSIONER BROAD: Mr. Simmons testified that the intention of this was to keep people whole. And in a theoretical way, I suppose that that could have happened. The question is, in your experience, did it happen? I mean, did they actually lose pay over what they would have had, had they -- had they remained at the same base pay level?

MS. GATES: The way the formulas were designed, if a worker works exactly what he or she was scheduled to work, they had the -- they had the figures to come out so one -- so point -- I think it's almost to a thousandth, or at least a hundredth of a cent. And if the worker worked exactly what shift they were scheduled, yes, they

could -- they could -- using -- applying this formula and bringing back in, in California, the differential is what they called it -- they basically are 16 percent or 14 percent off the wage. And then they put it back in. But they only put it back in for certain circumstances, not for calculating overtime on the four hours.

So, the way it worked out, if you had to leave early, that -- or if you stayed over, that hour that you stayed over or left early started to slip and the wages that were actually -- came home in the paychecks were less. But they were not significantly less. But they would be -- they could be much more significantly less if the employer stopped voluntarily paying 2.34 times the base rate of pay, if they went back to just what's required by law, which is two times the base rate of pay.

But we did -- we were able to determine that some employees received -- and some were between -- not -- they didn't lose the full 14 to 16 percent, but they would lose somewhere between 2 and 4 percent of real income, particularly in the healthcare industry, where workers, as you heard, often don't work what they're scheduled to work. They work extra or they work less, depending on patient census.

COMMISSIONER BROAD: Okay. Well, I've looked through this, and I probably could spend hours going through that big long chart. What I thought they were trying to do was, they would reduce your base rate of pay, and after 8 hours a day, they'd pay at time and a half, right?

MS. GATES: Correct. Correct.

COMMISSIONER BROAD: So, what's all this times 2.4 percent? What is that about?

MS. GATES: Well, that's because -- well, they -- it's because they made this up in the manipulation, and it manipulated overtime at time and a half and double time is two times the rate of pay. But if you took double time the new reduced base rate, that wouldn't really get you where you had to be to keep the wages on parity. So, it was this process by which they called in, you know, their accountants and figured it out so that they wouldn't lose. And if anybody lost, it would be the employee, because they shifted the burden of AB 60 overtime onto the employees and protected themselves, all of this, of course, being unnecessary since they had the 12-hour exemption through July, under the terms of the law.

COMMISSIONER BOSCO: Well, could I ask -- you

receive these calls because you're a law firm that represents these people or people who are in similar circumstances. And apparently -- I don't have a calculator here, and I don't even know advanced math, which I think you'd have to, to figure out what you were talking about. But -- and you say that these people probably have a remedy under any number of statutes. And have you pursued that?

MS. GATES: Yes. Some people have filed their claims with the Labor Commissioner. The ones that can identify the actual wage differential, they have filed claims with the Labor Commissioner.

COMMISSIONER BOSCO: Well, what I'm wondering is why is it relevant here, then? I mean, if an illegal action were taken and they have a remedy at law, what does that mean to us?

MS. GATES: Well, because this Commission is considering, based on this same industry's representations to you that they're doing what their employees want and asking for a 12-hour day. And I guess I also brought it to your attention because I thought you'd want to know that when they set up the balloting -- and they refer to it as balloting -- to get employees to, by a majority, to vote in favor of this reduced pay

scheme, they set up a system, and in doing it, they did not give any notice of the election to the employees, they provided the employees with inaccurate information, they didn't tell the employees that AB 60 extended the 12-hour-day exemption until July of 2000. The employer didn't provide for an impartial party to tally the votes. The employer did not provide for the participation of employees who could not be present --

COMMISSIONER BOSCO: And all those things violate the law?

MS. GATES: Well, all of these things are things that this Commission has considered when it's considering adopting regulations for -- for employer application of the alternative workweek schedules. So, I thought you'd want to know about that.

COMMISSIONER BOSCO: So, it's your testimony, then, that in addition to this broad issue, we should also look at how these elections are conducted and such things.

MS. GATES: Yes.

COMMISSIONER BOSCO: Okay.

MR. RANKIN: I'm Tom Rankin, of the California Labor Federation. And we have been looking long and hard at this difficult issue of 12-hour days in the healthcare

industry and have come up with a proposal, which I just passed out to you, which accommodates the wishes of many of the employees -- and I guess all of the employers -- to provide for the possibility of 12-hour days for certain classifications in this industry. And we believe that it should be limited to licensed or certified healthcare personnel. There's no real reason why we should have janitors in the hospital industry working different hours from janitors anywhere else. The rationale is different for the classifications involved in direct patient care. So, our proposal to allow a 12-hour day would be limited to those classifications.

And I don't want to go through all of this in great detail because I know you're going to be having another hearing to deal with it. But I do want to highlight some of the points.

Several of the workers have talked about the election. I think you have to have an election. What we've done in this proposal is to deal with the specifics of the election, the voting units, the classification -- vote by classification, how the election is conducted. We believe it should be conducted by a neutral third party, given all the shenanigans that have happened in this industry over the last few months. So, there are a

number of -- a couple pages here that deal with the election provisions.

The second issue is to accommodate employees who are unable to work 12-hour shifts. And I think, again, we have sort of agreement here, judging from the testimony of the hospitals, especially the nurses who testified in the first panel, that they all believe in accommodation. Well, if that's the case, then we shouldn't have problems making it clear that hospitals do have to make reasonable efforts to accommodate those who want to continue working an 8-hour shift.

The question which was just discussed on the rate of pay, number four under our provisions, the last provision there, deals with the question of reinstating pay. Employers who reduced hourly wage rates would have to reinstate the base rate of pay in order to go through this election procedure. And we think that's only fair. The law, of course, requires that once it passed, it was illegal -- clearly illegal to reduce the regular hourly rate of pay in conjunction with an election.

The proposal that you've heard from many of the witnesses regarding 12-hour shifts, three 12-hour shifts, should involve 40 hours of pay so that the people who are being required to go to 12-hour shifts are not losing

pay, not losing four hours of pay a week.

And as was also brought up, we want to make sure -- and this has to do with, I think, from my experience in being a patient, better patient care and with protection of the lives of the employees -- they should not be required to work more than 12 hours a day. It's simply not good for either the patient or the employee. So, we would, under "C" here, provide that any work over that would be voluntary, not mandatory. And I think if this can be done in hospitals with union contracts, it can be done in all hospitals. And we know that once in a while there might be a civil emergency. We didn't put emergency provisions in here because we think that's taken care of elsewhere in the law. We all remember what happened to overtime when we had the Northridge earthquake and Governor Wilson declared an emergency, and people within a certain radius were not given overtime pay for a period of time. So, that can be taken care of in other ways.

We also want to make sure that people who are working 12-hour days have their meal periods. We think that's very important. That's a necessary rest period in order for them to provide the kind of care that they should be providing.

And I think that's basically it. As I said, we can -- we'll be happy to answer questions on it. I know you've -- this is something you're going to have to take a closer look at.

But I think it's only fair that if we are going to take the big step -- and as you may or may not remember, because some of you weren't involved in the legislation -- originally, AB 60 took away 12 hours for hospital employees, and in the end, a compromise was reached to give this issue to you to look at again, because of the complications with the issue and the feelings of the people involved. So, it's a very serious matter that you're dealing with. And I'd like to remind you of the basic premise of AB 60, which was the 8-hour day. And the Legislature reaffirmed -- and you all know the language that was in the bill, but I'd like to go through it once more. And the Legislature reaffirmed the state's unwavering commitment to upholding the 8-hour workday as a fundamental protection for working people.

So, if we're going to vary from the 8-hour workday, it's a very serious matter, and it's a matter that requires you, in your role as protector of the workers of the State of California, to adopt a rule that carries with it protections. If you're going to do an

exception, we really need to have extra protections for those workers, which, in this case, are also going to be protections for all those patients in the hospitals in the State of California.

One of the things you might also consider doing, in your role as protector, is the statute gives you authority to make studies. And I would suggest you might want to do a long-term study of the effects of the 12-hour day on the personnel in hospital, and even broaden it to the effects on patients, because we are very concerned, as a labor movement, about what happens in our healthcare system. We've seen a lot of problems because of understaffing. You all know the medication -- the study was mentioned about hospital -- about medical mistakes. That may well be connected -- some of those, a lot of those mistakes may well be connected to fatigue.

It's some -- this is a very serious matter, and you have to treat it as such and take our proposal seriously. And we would suggest that it is a very reasonable compromise proposal in terms of allowing 12-hour days under prescribed circumstances, with closely supervised elections, and no mandatory overtime under those circumstances.

I'd be happy to answer any questions.

COMMISSIONER DOMBROWSKI: Commissioner Bosco.

COMMISSIONER BOSCO: Yeah, I have a question.

I think there's no doubt that the law requires elections to be held and two thirds of the affected employees would have to vote in favor of having a 12-hour workday. But I'm concerned about the other people, the ones that don't want to work the 12-hour workday. And the way the law reads, at least my reading of it, is that employers would have to make reasonable accommodations for people who were unable to work the 12-hour workday. And I'm a little bit concerned with "unable." Does that mean physically unable or -- do you have ideas on that, as to what we might put in the regulation to define "unable to work"?

MR. RANKIN: Well, I would suggest that "unable" should be defined by the employee. I came across an interesting situation a number of years ago when I represented a union here in the East Bay Park District, and we had an issue involving time off to vote. And basically, the statute said that, you know, if an employee was unable to vote during working hours, they could take time off to -- I mean, during nonworking hours -- they could take time off work, up to, I think it was two hours, to vote. We actually didn't go to court on

it. We went to an arbitrator. We had Joe Grodin, who is a former Supreme Court justice, as an arbitrator. And his decision was -- and I think the same logic would apply here -- that the employee is the one who determines whether or not he or she is unable to work.

COMMISSIONER BOSCO: So, I think that this just requires a reasonable effort. And you would attach to that that any employee, in effect, that has his or her own reason for not wanting a 12-hour workday, that would be the standard that we would use, that the employee would have to -- employer would have to make a reasonable effort to accommodate.

MR. RANKIN: Yes.

COMMISSIONER BOSCO: Okay.

COMMISSIONER BROAD: Yeah. I actually have just a couple of technical questions.

The first is, in your proposed language, you refer to "licensed hospitals." And are all licensed hospitals 24-hour facilities, by definition?

AUDIENCE MEMBERS: (Not using microphone) Yes.

COMMISSIONER BROAD: Okay. So, we wouldn't need -- the audience responded "yes."

MS. BLAKE: Somebody needs to --

MR. RANKIN: I'm out of my league on some of

these, so --

COMMISSIONER BROAD: Okay.

MR. RANKIN: -- we have our experts here. Would you mind?

COMMISSIONER BROAD: Yeah. Well, I mean, could they identify themselves so it gets on the record and we get some --

MR. RANKIN: Barbara, do you want to --

MS. BLAKE: Yes. Barbara Blake, UNAC. Yes.

COMMISSIONER BROAD: Okay. So, we wouldn't have to say "operating 24 hours a day" in order to mean that they're operating 24 hours a day.

MS. BLAKE: Right, yes.

COMMISSIONER BROAD: Obviously, the rationale disappears if we're not operating 24 hours a day.

Now, let me ask this question. "Licensed or certified healthcare personnel," what classifications of healthcare personnel would that refer to?

MS. BLAKE: Certified nurses, nursing assistants, respiratory -- certified respiratory therapists, licensed vocational nurses, registered nurses, people involved with direct patient care.

COMMISSIONER BROAD: Okay. And a "designated patient care unit," is that a term of art in the

healthcare industry?

MS. BLAKE: Somewhat. Under the prior wage orders, they found "unit" to be interpreted a variety of ways. And that's what we were asking them to look at, the community of interests of the particular unit, that the intensive care nurses be considered together. But I do know that in the past -- as I said, in the past, "unit" was -- I was told at one point in time that a "unit" was all of the full-time staff, all of the part-time staff, and all of the per-diem staff, was what the hospital was considering to be a "unit," another situation where they have said the fifth floor, even though there was a pediatric and oncology unit on that floor, they didn't share staff at all, they had no common interests, but the hospital considered that to be one unit. So, we ask you to look at the community interests.

COMMISSIONER BROAD: Okay. So, I guess the answer to my question is the term "designated patient care unit" has no legal meaning, like defined in the Business and Professions Code?

MR. DAVENPORT: What I'm told by my experts, who are down teaching a class today, is "designated patient care unit" is something that is done by the Department of Health Services, okay? And so, we thought that that was

a logical, rational way for you to create the appropriate universe here, because, I think, it gets defined in some other way.

COMMISSIONER BROAD: So, we might be able to cross-reference, then, a -- call it a "designated patient care unit" within the meaning of such-and-such regulation or statute?

MR. DAVENPORT: That's our intent.

COMMISSIONER BROAD: Okay. Because, obviously, I don't want to create a rule that invites more, you know, confusion than it solves or whatever. And to the extent that we have these terms like "licensed hospital," "licensed or certified healthcare personnel," "designated patient care unit," I would like to ensure that we have those definitions absolutely as tight as we can so everybody on every side of these issues understands exactly what we mean by it, should we adopt regulations along those lines.

COMMISSIONER DOMBROWSKI: Okay. Any other questions?

(No response)

COMMISSIONER DOMBROWSKI: Okay. Could I just get a show of hands of anyone else in the audience who wants to talk about the 12-hour shift?

(Show of hands)

COMMISSIONER DOMBROWSKI: Okay. All right. Thank you.

We're going to take a lunch break. I show about twenty after twelve. We'll come back at one o'clock.

(Thereupon, at 12:20 p.m., a lunch recess was taken.)

--o0o--

1

2

3

4

5

6

7

A F T E R N O O N S E S S I O N

--o0o--

(Time noted: 1:08 p.m.)

COMMISSIONER DOMBROWSKI: We'll reconvene and have the record show that Commissioner Bosco has left. He's left the room.

COMMISSIONER BROAD: Fled the building.

COMMISSIONER DOMBROWSKI: Okay. Now, who wants to talk about the 12-hour day?

(Show of hands)

COMMISSIONER DOMBROWSKI: Why don't you all come up?

AUDIENCE MEMBER: (Not using microphone) Are you serious?

COMMISSIONER DOMBROWSKI: Come up. Those who can't fit at the table, take the first row.

What we'd like is that you identify yourself for the record and try to keep your comments to the point.

MS. MESSER: My name is Kerry Rodriguez Messer, and I'm with the California Association of Health Facilities. And we represent 1,600 licensed long-term healthcare facilities. This includes skilled nursing facilities for the chronically ill or aged; sub-acute facilities focusing on treatment, rehabilitation, and

post-surgical recovery for residents of all ages; facilities for the developmentally disabled; and assisted living facilities for the elderly. These facilities range from home-like settings that are six-bed facilities, which actually are private homes in neighborhoods, to the 100-bed facilities.

The kind of care that's given includes skilled nursing care as well as assistance with activities of daily living, whether that's bathing, dressing, just daily functioning activities. And our members employ licensed, certified, and specially trained -- on-the-job-trained employees. In the developmentally disabled arena as well as in the residential care facility for the elderly facilities, it is all on-the-job-trained caregivers. And those are all direct caregivers.

And I stress that point in response to the union's proposition, which, from your response and questions, I think just addressed licensed hospitals. But certainly, we look forward to seeing that and seeing whether or not we're going to be part of what is considered within that proposal.

It should be noted that in the facilities we represent, the long-term care industry, a lot of the payment stream comes from MediCal and Medicare and some

SSI. So, there is not currently the option within those payment streams to accommodate overtime. And developmentally disabled are almost 100 percent paid for by the MediCal. In skilled nursing, it's like 60 or 70 percent. And right now, the rate does not accommodate overtime. In residential care facilities for the elderly or assisted living, that's all paid privately by the elderly. So, any -- anything we do beyond the 12-hour day, if we remove that option at those facilities where the employees do want to vote for it, it's going to increase the labor cost. And that's just one consideration.

I want to introduce one of our members, Paul Tennell. He's the director of operations for northern California for Vencor, who operates skilled nursing facilities. We were going to have some other members with us to represent our other membership, but they're right now in southern California negotiating an union contract, which ran late. So, here's Paul.

MR. TENNELL: Thank you. My name is Paul Tennell. And as she said, I work for Vencor, which owns skilled nursing facilities across the country. I'm also the secretary-treasurer for the California Association of Health Facilities.

And I'd like to comment, basically, on this issue from personal experience. I have run a nursing home for the last 22 years. And we do have a unit, a -- one floor in one unit, in one skilled nursing facility, that runs 12-hour shifts.

The Health Department does not designate units, to answer Mr. Broad's question. If you're talking about a nursing home, you can have an Alzheimer's unit on one floor, a sub-acute unit on another floor, and a regular long-term care facility on another floor. I have a six-story facility in San Francisco with different levels of care in that facility on every single floor.

So, if I was going to do a 12-hour shift, I would want that entire floor to do that because, for continuity of care, you couldn't have a 12-hour person work a 12-hour shift and an 8-hour person with an 8-hour shift because there would be no time for them to report to each other.

So, the way it works is the sub-acute unit, for instance, they work 12-hour shifts. So, you have everybody that works on a unit works 12-hour shifts. Everybody who works on the other units works an 8-hour shift. And that's pretty much the way we run that facility. So, it's actually unit-specific.

Another thing about our care is that it really also depends on the kinds of patients that we're taking care of. Alzheimer's, for instance, is a dementia disorder which actually has a sundown syndrome, which happens between three and seven o'clock in the afternoon. If you have a break in their entity, if you have a break in their staff during that period of time, it causes confusion. So, a lot of people who run special care units for Alzheimer's or dementia actually choose to work 12-hour shifts based on the fact that it provides better quality care for the Alzheimer's patient so you're not disturbing them earlier than what they normally are disturbed.

The other major issue about the developmentally disabled, which are members that we represent, is their clients are -- range from all ages, three years old up to however long they live, in the forties or fifties. And they also have the same issue. And every time they have a change of staff, they have a disruption in their live. So, they choose to be -- most of -- all of the six-bed facilities choose 12-hour shifts.

The other thing about those employees who work in those facilities, none of them are licensed, none of them are certified. So, if you only -- if you include

the licensed and certified employees in this regulation, you will completely eliminate them. It will increase their cost 37 percent, and they will probably all have to go out of business. And there are -- almost 90 percent of the developmentally abled (sic) who are in institutions are in these six-bed homes. And it would raise their costs 37 percent to have to pay overtime for that additional time.

COMMISSIONER DOMBROWSKI: Did you say 90?

MR. TENNELL: 90 percent of the developmentally able (sic) are in these six-bed units, in the State of California.

COMMISSIONER BROAD: Can I just ask you a question?

MR. TENNELL: Yes.

COMMISSIONER BROAD: Excuse me. Okay. Who exactly are you talking about are staffed by -- there's no certified or licensed personnel? Where is that?

MR. TENNELL: Developmentally abled (sic) facilities.

COMMISSIONER BROAD: Okay.

MR. TENNELL: That is a licensed --

COMMISSIONER BROAD: Maybe it's the term. What is a "developmentally abled facility"?

MR. TENNELL: A developmentally disabled patient is somebody who is exactly that, he's been -- you know --

COMMISSIONER BROAD: Right, I understand that. I thought you said "abled."

MR. TENNELL: No.

COMMISSIONER BROAD: You said "disabled."

MR. TENNELL: "Disabled."

COMMISSIONER BROAD: Okay. And it's a facility that has six or fewer people living in it?

MR. TENNELL: Correct.

COMMISSIONER BROAD: So, is this -- is this like a group home?

MR. TENNELL: Yes.

COMMISSIONER BROAD: Is that what we're talking about, in layman's terms?

MR. TENNELL: They can be -- they can be bigger facilities. They can be up to 100 beds. But 90 percent of them are in six-bed homes.

COMMISSIONER BROAD: And the people that staff those are not --

MR. TENNELL: None of them are certified or licensed. The state does not require their licensure or certification.

COMMISSIONER BROAD: Okay. So, describe who the

-- what the -- they're just caregivers?

MR. TENNELL: Well, what actually happens is that each unit has to have a QMRP, which is a qualified manager, and that is the state requirement. That is not certified, that is not licensed. That is just a person who has attended a QMRP class.

COMMISSIONER DOMBROWSKI: What does QMRP stand for?

MS. MESSER: Quality mental retardation professional.

MR. TENNELL: That's what it stands for. Did you get that?

So -- and that's kind of like a 40-hour class. But they are not certified and they are not licensed.

So -- and the aides that work with those people. So, each one of these six-bed houses or twelve-bed houses, depending on how big of a house they get, has one of these people, this QMRP. The aides who actually help these patients -- a lot of these patients go to daycare. For instance, they'll go to a daycare program in the town that the house is located in. But you don't break their schedule. And so, almost all of these facilities use the 12-hour shift so that they don't have three breaks in their routine. And that's the basic issue for them,

because every break in their return causes them confusion. So, that's a major issue for that group of people. So I'd really like for you to consider that.

And I want to say another thing that was said earlier by labor, that, you know, all of us are making money off this deal. I'd like for you all to take a look at the nursing home stock. About 30 percent of the nursing home beds in the country are bankrupt, and so we're not making a lot of money on this business. So, everything that we can do to recruit staff, get staff, really helps us take care of the people who can't take care of themselves. So I'd really like for you to take it into consideration.

Thank you.

MS. LAUBACHER: Good afternoon. I come here on a bit of a different --

COMMISSIONER DOMBROWSKI: Your name, please?

MS. LAUBACHER: Oh, I'm sorry. Cindy Laubacher. I'm employed by Wilke, Fleury, Hoffelt, Gould & Birney law firm in Sacramento, and I'm here today on behalf of my client, the California Veterinary Medical Association.

We're here in support of a 12-hour exemption for licensed hospitals. However, we would like to have veterinary hospitals included within the definition of a

licensed hospital.

Our facilities -- we represent approximately 4,500 registered veterinary technicians and veterinarians. And those -- they own and work in some 2,200 hospitals, clinics, and independent practices. Of those 2,200 hospitals, clinics, and independent practices, approximately 50 percent of them are 24-hour hospitals that provide emergency care, critical care for the patients that come in. It operates basically on the same -- in the same manner in which a regular -- a human hospital works. We have lab techs, we have X-ray techs, we have -- we do prescriptions, we do surgery, we do, you know, any levels of treatment and then any monitoring that's required.

So, again, we would -- we believe that it would -- for all of the reasons raised by the hospitals, we have issues of continuity of care, we have issues of staff shortages, we have issues where, basically, we have staff -- 95 percent of our RVT's are women. And the bulk of them are women with children. So they have the same kinds of childcare issues. And they would like to have the same kind of flexibility available to them that is available to -- that would be available in other hospital settings.

With me is Dr. Bob Sahara, who's a licensed veterinarian and one of our members, to answer any technical questions you might have with regard to how we operate.

Thank you.

COMMISSIONER DOMBROWSKI: Questions?

(No response)

MS. KOWALEWSKI: Commissioners, my name is Denyne Kowalewski, and I represent the California Association for Health Services at Home. We are seeking an exemption from the provisions of Assembly Bill AB 60.

And interim home care, particularly home health and respite care, is to give attentive and consistent care to persons who are facing end-of-life issues as well as those with a long-term debility and condition that requires consistent care in a way to stay home and not in institutional settings. I'm speaking also on behalf of CAHSH today is Marilyn Baker-Venturini, with Self-Help HomeCare & Hospice; Mary Jo Kelly; and Holly Swiger, with Vitas Hospice Care.

MS. BAKER-VENTURINI: Good afternoon. My name is Marilyn Baker-Venturini. I'm the administrator of Self-Help HomeCare & Hospice. We're a division of Self-Help for the Elderly. We are a licensed health facility

in California.

We do not operate out of one facility. Home health -- the nature of home health is that our caregivers, be they registered nurses, physical occupational speech therapists, medical social workers, certified home health aides, go to individual patients' homes and care for them.

In our scheduling process, case managers, who are usually registered nurses or physical therapists, schedule their own caseload. The treatment, the care that is developed, is in conjunction with the medical director of the patient's care, which is their attending physician. The care may involve all six disciplines, or it may involve only one discipline. The care is seven days a week, 24 hours a day.

Each day, each person's schedule is very different. One patient may need daily care seven days a week, one patient, for example, fasting blood sugar, where you go and you assess the level of sugar in the patient's blood before they are administered their insulin. Another patient maybe is only for rehabilitation and they only need care three days a week. Many things impact the level of these schedules and the level of this care.

I guess my whole point of my testimony today is really to make the point that home health care, be it hospice or home health agencies or private-duty nursing or home care aide, is like putting a square peg in a round hole. We don't fit in that 8-hour model. I'd respectfully request a permanent exemption for the home care industry from the 8-hour overday (sic).

MS. KELLY: Good afternoon. My name is Mary Jo Kelly, and I am a parent of a child who has received home care for nearly seventeen years. I am concerned with the current overtime laws that are already coupled with the nursing shortage, that is very real, going on.

My son, Bradley, already has multiple shifts a week missing from our staffing. He is supposed to be having 24-hours, around-the-clock care. I am a single parent. I work full-time, and I have another child at home to care for as well. For me and my son Bradley, this could be the difference in being able to continue working or to be forced into making a decision that I don't want to make.

We were one of the first families in Sacramento to come home with a child on a ventilator, with such strong medical needs. The only opportunities before that were to be institutionalized in a state facility. These

children didn't survive because they didn't have the kind of care that they needed. Bradley survives today because of the care that we have given him and because of the continuity of care he's received from his nurses.

My home care nurses are a great bunch of people. They've been with him, some of them, for seven, eight years, so -- one of them has been with him for nearly sixteen years, has followed him from a different agency. What they wish to have the right to decide whether they have an 8-hour shift or a 12-hour shift. There are some of them who have special needs children of their own. And a 12-hour shift three times a week, for them, would be perfect.

So, what I'm asking is that this Commission assist in helping us not go backwards. We don't want to be forced into putting our children in institutions, our loved ones. I don't want to be forced not to work in order to have to stay home to care for my child. I want to be able to provide the best for my -- for all my family.

Thank you.

MS. SWIGER: Hello. My name is Holly Swiger. And I work with Vitas Healthcare Corporation, which is the largest provider of hospice care in southern

California.

I'm extremely concerned about the impact of AB 60 and the interim wage order on hospice programs and patients in California. We're asking for a permanent exemption from the 8-hour workday for hospice employees in order to protect the quality and the continuity of care that's so desperately needed for the people that are dying in California.

When people are dying, there's so much change that's going on in their life and loss and confusion. And so, we try to provide a compassionate environment where there's a minimal set of circumstances where change is occurring. And we need to address both the patients and the families' needs, their physical, psychosocial, emotional, and spiritual concerns. And in order to do that, we need to provide a whole team of people that do that. Those are physicians and social workers and certified home health aides, chaplains. And one of the things I heard you mention is that you were looking at certified and licensed personnel. Well, our social workers are masters-prepared, but there's no licensure or certification category. And yet it would be important for them to be included in this exemption, as well as our chaplains. Although our home health aides would be

certified, those that have maybe gone through a masters- or doctorate-prepared coursework wouldn't meet that criteria. So, it's important for you to note that.

Also, people really just want to remain at home as best they can when this is happening. And in order for us to do that, we need this team that works together and has the flexibility to meet the needs. People don't die according to the clock. And if a nurse or social worker or chaplain or home health aide are out there and the patient is actively dying, and it's the end of their 8-hour shift, we don't want them to have to either leave the bedside and call their supervisor to get approval for overtime, or we don't want them to have to call in an on-call staff member who's never met this patient, doesn't have the intimate relationship that they've built over the course of time with them, to have to leave them at this important time.

We see our interdisciplinary team as a set of professionals that manage the care of patients and families going through this transition, and trust them to make the decisions about whether they stay or they leave.

And, obviously, prior to this when they had the flexible workweek, they were able to make that decision

and then call their supervisor the next morning and say they were up late with the family and say, "I need help, I can't work my, you know, full 8 hours today; I need to have some compensatory time today," or work their schedule during the week to meet their needs and to meet the patient and families' needs as well.

For the patient that's in crisis with hospice, we are able to provide 24-hour shift care. For this shift care, there's a huge difference in providing 12-hour shifts or providing 8-hour shifts. If we're providing 8-hour shifts in the home, that means we're keeping a family either up until 11:00 p.m. or whenever, in order to have our shift change, and then getting them up again early in the morning, at six or seven, versus having 12-hour shifts where people can have a normal sleep pattern, families can get the rest they need that are so involved in this care. So, it's really essential that we have the opportunity to provide the 12-hour shifts, again, for the benefit of the patients and the families.

I'd have to say it's also the benefit of the staff, and that's what my staff keep talking to me about in regard, because it does provide them the flexibility to only have to work three days instead of five during

the course of a week. And I can tell you how difficult it is right now, in recruiting staff. We are having to actually call other agencies to take patients because we don't have the staffing capacity. And that's how the shortage is hitting home health and hospice out there.

Finally, our industry is very concerned about the added overtime cost. And this goes without saying. Our company alone, at this point in time, is incurring about a million dollars in overtime costs, because we are not, at this point in time -- we are praying that you'll make an appropriate decision on an exemption by July 1st, and we've continued to let our staff provide the care they need to without stopping care and requesting permission to stay at a very critical moment. However, we can't continue to do that. So we hope that there's -- that you make the appropriate decisions in regard to hospice and home health and provide us an exemption from the interim wage order.

Thank you very much.

I guess you have a question?

COMMISSIONER DOMBROWSKI: I have a question, whoever can answer it. I'm a little confused. You're talking about caregivers, a mixture of caregivers, some of whom are not licensed, certified, who are working 12-

hour shifts, correct, or have been working 12-hour shifts?

MS. SWIGER: Well, we have a category -- as you might determine, a work unit that would be shift care, but we also have visit staff, so that in home health, you might find shift work with private-duty nursing, with hospice respite care, with continuous --

COMMISSIONER DOMBROWSKI: Well, I guess my question is, the 8-hour day was repealed in 1998. What was -- how were these people who are not nurses or -- what kind of shifts were they working before that?

MS. BAKER-VENTURINI: Before January of 1998, they would work within the 8 hours. They would work -- be it 40 hours or 32 hours.

I think, for our organization, I can speak for it, and I think my staff as well -- in January of 1998 when the 8-hour overtime law was eliminated and they had a 40-hour week, they thought they had gone to heaven. For the first time, they were able to manage their patient loads, they were able to manage their documentation loads, they were able to manage their personal lives.

For example, they may schedule -- the goal would always be to schedule an 8-hour day, and, again, a 40- or

a 32- or a 24-hour.

I think one of the myths we have is that, when we look at specially home health staff, one of the conversations that I've had with my staff was, you know, this is -- "Why was this changed?" And it's like, "To protect you," because I guess there were employers who would force their employees to work overtime or require mandatory overtime. They laughed in my face. I can't require them to do anything because there's such a shortage. They're so committed to their work, they're not interested in working overtime. I don't want them to work overtime. But together we could manage that.

There's productivity standards for each of the different disciplines that are employed under the home health or hospice. For example, a registered nurse might see five or six patients in a day, the medical social worker might see three to four patients a day, and they would manage that schedule. So if a patient became in crisis and they worked over 8 hours one day, then -- before 1998, we paid them overtime -- the next day, they might work less than that. But they consistently tried to work the 8-hour day.

After January of 1998, that flexibility became built in, and it was like it should have been there

forever, because this is not an industry that fits into a little box. It can't be defined. There's no -- it's not that there's not a standard, but every day is not the same. You never know if your patient is going to be hospitalized. We're dealing with a frail population.

Perhaps the patient you saw on Monday that you planned to see on Wednesday had a heart attack. They may not -- the family may not get around to telling us until we show up at the door. Then there's no patient for that staff to see. That shortens their day.

By the same token, on Friday maybe the patient that was hospitalized the week before is being redischarged. You want that patient continuity, you want that same case manager to readmit that patient.

MS. KELLY: I just wanted to say one more thing.

In home care nursing, and with the shortage that's going on, if you've got a nurse or several nurses that you have that staff your particular case, one doing a 12-hour shift and another one doing an 8-hour shift, then at least you've got 20 out of the 24 hours taken care of.

And personally, since I work full-time and try to do -- take care of my daughter and her activities, that makes it much easier for me to manage. But if I've

got an 8-hour shift open -- and currently my agency has been paying me overtime, but they're not going to be able to keep that up -- they can't afford to -- then I'm going to have to make some decisions or try to cut back my work time. It just doesn't work. You can't work eight to five and expect to be home by three.

MS. SWIGER: One other point I know we've talked a lot about, making sure that we don't take advantage of employees, and I think that's really important, but I had a chaplain that came to me and said, "You know, Holly, this has made it so difficult for me to work because I have to do -- you know, I have families that I'm responsible for and I have relationships with, and I can only provide support over the phone to the caregivers at night, when they get off work. I can't call them during the day when they're at work, so I have to try to somehow anticipate how much time that's going to take in the evening. And sometimes I'll call and they just say, 'This isn't a good time.' Well, I've only worked seven hours, and now I've lost an hour because what I thought I was going to do and work in the evening, I can't do."

In the past, then, they would just make that up the next day, you know, and get their call schedule later in the week or whatever. But they've lost that

opportunity as well.

COMMISSIONER DOMBROWSKI: You said a chaplain, right? A chaplain?

MS. SWIGER: Yes, chaplains. In hospice we have chaplains, we have social workers, home health aides --

COMMISSIONER DOMBROWSKI: Okay.

MS. ACKER: Hi. My name is Roberta Acker. I'm a respiratory care practitioner at Children's Hospital of Oakland. I speak for my colleagues and myself today.

We are requesting an extension of the enactment deadline for Assembly Bill 60, for the following reasons. We currently choose to work 12-hour shifts. The respiratory care practitioners at Children's Hospital have worked 12-hour shifts for the last ten years. During that time, our department has twice voted and approved the use of 12-hour shifts by a greater than two-thirds majority.

We are disheartened that this legislation was passed without full consideration of all the workers it would affect. It is clear that the proponents of Assembly Bill 60 did not speak for all workers. We are asking for an equal voice.

We understand that AB 60 was designed to protect those employees who are at risk of exploitation.

However, not all employees are exploited by their employers, and we strongly feel that companies and/or individuals that choose to work longer hours should have the opportunity to do so.

Converting to 8-hour shifts will require more staff. The field of respiratory care is already burdened by the lack of trained professionals. This is especially true for competent pediatric and neonatal respiratory care practitioners. Converting to 8-hour shifts will undoubtedly cause a further manpower shortage in our field.

As respiratory care practitioners at Children's Hospital, a manpower shortage will be felt throughout the facility because we provide specialized care in both the neonatal and pediatric respiratory intensive care units. We cover the transporting of children to our facility, the ER, and trauma. These shortages will adversely affect patient care, especially during the flu season when most hospital admissions are respiratory-related.

The 12-hour shift provides the worker and the hospital with several benefits. We commute less frequently, there's less traffic, less fuel consumption, cleaner air. We have more days off during the week to be with our families and more time to be involved in our

children's activities. We have a lower cost for and depend less on childcare.

Healthcare in the hospital operates 24 hours a day, seven days a week, similar to several other professions who have been exempted from AB 60. Inclusion of healthcare workers in this exemption will not alter the intent of AB 60; rather, it will allow freedom of choice for employees who choose to work 12-hour shifts.

On a personal note, I've worked at Children's Hospital for the past nineteen years, and I can still say that I love what I do. I'm a very involved member of our transport team at our hospital and our pediatric intensive care unit. And the flexibility of the 12-hour schedule allows me the ability to work very hard, provide very consistent care, and have time off to relax so that I come back to work and want to do a good job, because I never have to work more than two days in a row and I have two days off, and I come back.

And I know that's true for all -- I mean, that's all we've talked about at my job, and I know that I'm speaking for all the other 39 therapists that I work with at Children's Hospital.

The nature of what we do is extremely stressful, and it necessitates time to rejuvenate. Working 12-hour

shifts allows us to work -- to return to work relaxed so we can continue with our job.

We request an extension to allow Assembly Bill 2056 to progress. Please note that this bill has already been offered to amend Bill 60, and this should serve as evidence that there is resistance to Assembly Bill 60. Assembly Bill 2056 offers language that includes the freedom of workers to choose to work their 12-hour shifts without exploitation of others.

Thank you very much.

MS. SABATO: My name is Katie Sabato, and I am a supervisor at Children's Hospital for the respiratory care department. I've been in that supervisory position for thirteen years, and I've managed 12-hour shifts for the last ten hours -- ten years -- I'm sorry.

But first of all, what I'd like to say is I believe we're all here and the concern is that our freedom to choose has been violated here, and that is, is that we need to offer employees the option to offer either 8- or 12-hours. And we can never, ever accommodate all -- everybody's whim. I think if there -- a group has voted and there has been, you know, a two-thirds majority, then that should preside -- that should preside.

COMMISSIONER DOMBROWSKI: Hold the mike still.

MS. SABATO: I'm sorry.

And if there are employers that are choosing to abuse their employees in terms of requesting overtime on 8- and 12-hour shifts, that's something that needs to be dealt with on an individual basis by everybody on your board.

I think we have listened to a lot of individual issues. But again, I think we choose to work in a democracy, and that's what we're offering here. What we're saying is that we have been -- our democracy rights have been violated in terms of the freedom to choose between an 8- and 12-hour shift.

As far as our experience with 12-hour shifts at Children's Hospital, we do accommodate requests for 8-hour shifts, and it works fairly well in our department for that. We have a system for, should there be a request -- need for overtime to staff additional therapists that we don't have, and that we can call registries. We also -- as a manager, I have taken the choice to be on call and available to come into work should there have to be a necessity to have someone replace someone that we can't replace. So, we have a system to work with to avoid this request for overtime.

And then again, on a personal note, we have -- in respiratory care practice, there are very, very highly trained individuals to work at Children's Hospital. It takes years and years to train those individuals to work within a highly specialized field in neonatal or pediatric respiratory care. And should we have to change back to 8-hour shifts, we are going to lose therapists like Roberta that we really, really cannot replace. We have a severe shortage in our profession already. And it will compromise our department severely, which will compromise care throughout Children's Hospital, Oakland, because we are very visible and very involved in the care of children there.

And I think it all boils down to the fact that we have a large contingency here in support of 12 hours. It's worked at Children's Hospital, the 12-hour shifts. And I do hope that you consider us when you make your decision.

COMMISSIONER BROAD: Wait. Excuse me. I have a couple questions for you.

Actually, let me ask a question to you. Was it Roberta?

MS. ACKER: Yes.

COMMISSIONER BROAD: I'm sorry.

MS. ACKER: That's all right.

COMMISSIONER BROAD: Do you believe that we can trust you to know whether, at the end of a 12-hour shift, you need to stay with your patient or go home, or you're too tired to go home?

MS. ACKER: Yes.

COMMISSIONER BROAD: We can trust your judgment?

MS. ACKER: Yes.

COMMISSIONER BROAD: And that you would not abandon your patient in that circumstance and would stay voluntarily if it was important for your patient?

MS. ACKER: Yes.

COMMISSIONER BROAD: Could we also trust your judgment that if you were too tired to work and, in fact, there was sufficient staffing, for you to be able to go home at that point?

MS. ACKER: Yes. And I'd like to give you an example of that. I've been on the transport team for the past eighteen years, and it has had many incarnations in the time that I've been there. We've had an out-of-house system, in-house systems. And I have been out on several transports in a row, and I have gone to my managers -- two of them are here today -- and I've said, "I've done three of these in a row; I'm too tired to go on the next

one," and I have never not been accommodated, to say, "We're going to call someone in an hour early," "We're going to ask the second call person to go out on this call." I've never not been accommodated in an eighteen-year period of time at my institution.

COMMISSIONER BROAD: So that you would support a rule -- let's just assume for a moment that we were to vote to permit 12-hour days -- and considering that organized labor has come forth with a proposal that includes 12-hour days, I think there's a reasonable likelihood that something could happen in that area -- would you support a rule that said it was within your discretion whether to work beyond 12 hours a day if you were on 12-hour shifts?

MS. ACKER: Yes.

COMMISSIONER BROAD: Thank you.

Actually, that's all my questions.

COMMISSIONER DOMBROWSKI: Next speaker.

MR. WOODFALL: Hi. My name is Chris Woodfall. I'm a respiratory therapist at the Stanford University Hospital. I've been working there for about ten years.

I think you guys can see that the healthcare industry is a unique industry out there with very special needs for all the different healthcare workers who are

out there. And all we're asking is that you provide the opportunity for us to work 8- or 12-hour shifts. I'm here in support of the 12-hour shifts. I believe it does help with continuity of care.

It's important for me on a personal level because my wife and I both work 12-hour shifts. We have two children, and we're able to keep those children out of daycare, and we're also able to commute to work on the days that we do work together.

But also, I think, as far as the amount of congestion with traffic in the Bay Area, it helps us to keep our cars off the road, at least for three days of the workweek, and then to commute before and after peak commute times when we are actually going in to work.

So, I'd just like to ask you, just in closing, just to consider the 12-hour shift.

Thank you.

MS. SMITH: Hi. My name is Susan Smith. I'm a respiratory care practitioner at Stanford Hospital, and I've worked 12-hour shifts for the past eight years. And I am here today to implore you to allow respiratory care practitioners to continue to have that choice.

As a full-time employee, I am still able to be a full-time mother four days per week. Governor Gray Davis

said that working men and women need options to juggle family and career responsibilities. AB 60 takes away the options I have to balance my family life and career.

I ask that you please consider Governor Davis' statement as you hear my story and make your decision regarding 12-hour shifts for healthcare workers.

My husband works the four days that I have off, and because of this arrangement we do not have someone else raising our child. If I have to work 8-hour shifts, my son will require daycare, meaning less quality time with his parents, and we'll also incur daycare expenses.

This is my child, Nathaniel. He's four years old. He and I enjoy lots of activities together, and many of these would be impossible if I worked five days per week. He has been taking tai kwan do for the past year and will be testing for his black stripe this summer. I also take my son to gymnastics classes and swimming lessons. We go roller-skating and have picnics in the park. He has not yet started school, but he's already reading. And I ask you, who will nurture my child when I have to be away from him an additional two days per week?

A year ago my husband was diagnosed with cancer. If he ever becomes unable to work, I will need to work

more hours to support our family. Eight-hour shifts makes this impossible to accomplish and still have days off to care for my husband. I am sure that there are many who face the same dilemma caring for ill family members and needing 12-hour shifts to do so.

Currently, my total work commitment, including travel, is 42 hours per week. With 8-hour shifts, I would travel during peak commute times, increasing my commitment to more than 55 hours per week. Section 2(e) of AB 60 states that, "Family life suffers when parents are kept away from home for an extended period of time." It is ironic that AB 60 pretends to care about families being kept apart, when it actually guarantees that more parents will spend greater amounts of time away from their families.

The IWC stated, in the "Statement as to the Basis" for Interim Wage Order 2000 that it received testimony supporting the elimination of 12-hour workdays. The only reason given is that in the last four hours, there's greater inclination to make mistakes. I ask the Commission to consider these two questions: One, if the last four hours of 12-hour shifts is unsafe, then why is there no concern about the last two hours of the 10-hour workday or the last three hours of the 11-hour make-up

day? And, two, are employees who work under a collective bargaining agreement safer? I find it strange that the exemption for healthcare workers is pending further investigation while this Commission found no evidence to make any changes to the collective bargaining agreement exemption. I raise these questions to demonstrate that AB 60 is biased and is discriminatory in its application to those not belonging to a union.

I agree that 8-hour shift employees should be paid overtime after 8 hours. But I ask you to remember that I, along with many others, chose to work these 12-hour shifts. 12-hour shifts allow an improved family life and increased flexibility without the loss of income. Please let us keep this choice.

Thank you.

COMMISSIONER DOMBROWSKI: Thank you.

MS. ANDERSON: Hello. My name is Jan Anderson. I'm here representing the California Dialysis Council, which represents about 500 dialysis facilities throughout the State of California.

There about 25,000 California citizens who have had the misfortune to experience irreversible kidney failure. Those individuals have to be dialyzed three times a week. And I feel it's necessary to give you a

brief sense in the way in which dialysis is yet again different from all the other particular types of healthcare providers, because it's necessary to understand that to understand the particular impact that AB 60 would have on dialysis facilities and their employees.

Because dialysis patients have to be treated three times a week to sustain life, every dialysis facility ends up having two groups of patients. We have one group of patients who are treated Mondays, Wednesdays, and Fridays, and we have a second group of patients who are treated Tuesdays, Thursdays, and Saturdays. Because of the nature of that kind of therapy, sort of by default we end up with, often, groups of employees who, similarly, work three 12-hour days and tend to work Monday, Wednesday, Friday with that group of patients, or Tuesday, Thursday, Saturday with the other group of patients.

One of the ways -- or one of the things that frequently happens in dialysis facilities, we have yet another classification of certified healthcare worker, in that we use, in addition to registered nurses, a group of employees that are called certified hemodialysis technicians, which is a program that is managed and

overseen by the California Department of Health Service that's specific to dialysis facilities.

Because I work in northern California, the Bay Area here, and because of the very high cost of living here, we find that many dialysis employees who work three days in one dialysis facility choose to work in another dialysis facility on their alternate days to obtain the extra income that that affords them. Truthfully, they have more stamina than I have. I'm not sure how some of them manage to do it, but they do.

So, what would happen if 12-hour shifts are no longer readily available to the dialysis community, there would be a negative impact both on the dialysis employees and on the facilities themselves. For the employees, if facilities are -- find it necessary to shift to five 8-hour days or four 10-hour days, it means that the many employees who choose to work at two different jobs are going to have to pick one of those two jobs because they aren't going to be able to work at the other facility because there going to be at one more days of the week than they are now. That's going to end up resulting in a decrease in income to those patient care technicians because they won't have the option of working for two employers.

And the other fallout to that would be that if facilities have to go to 8- or 10-hour days, then there suddenly is going to be a shortage of qualified dialysis staff available because the employee who works for me Monday, Wednesday, Friday, and then works down the street at another dialysis facility on Tuesday, Thursday, Saturday, if the other provider decides to go to five 8-hour days and they choose that provider, then I'm suddenly less one employee.

And if you visualize that on a broad level throughout the state, it would have a very large impact on dialysis providers and employees, as I explained. So we very much are in favor of a 12-hour work shift with the appropriate vote and election by employees. We have many staff who work 12's and like that pattern very much.

We have, the Association, submitted comments before, so I'm not going to repeat those.

And I would stress to Mr. Broad that while I very much -- I know I mean this genuinely, that I not only commend, but I am so appreciative of your desire to end up with whatever language comes out of this process being as clear as possible, because often it's not.

But I would remind you that our facilities, for example, are very different from hospitals, in that we

are not open 24 hours a day and we are not open seven days a week. And as you have heard from many of the other individuals testifying after lunch this afternoon who represent types of healthcare providers other than acute-care hospitals, there are many of us that don't fall into the same definitions and the same categories. So please keep that in mind as you develop your language. Sometimes it ends up -- if all the language is based around hospital requirements, it ends up causing problems for non-hospital healthcare providers.

So, I would ask, one, that you keep that in mind.

COMMISSIONER DOMBROWSKI: We will.

MS. ANDERSON: Okay. Thank you.

COMMISSIONER DOMBROWSKI: Questions?

COMMISSIONER ROSE: My question of you is how long is the dialysis treatment per day?

MS. ANDERSON: Most dialysis patients in treatment runs around three and a half hours, on average.

COMMISSIONER ROSE: So, in an 8-hour shift, you get two; in a 12, you could get three.

MS. ANDERSON: Yes. Yeah. And there are exceptions, but as a general rule most facilities do work 12-hour days and treat three shifts of patients in that

12-hour day. Sometimes more, sometimes less, but that's a common rule. It's a very efficient operating schedule, so that's the most common pattern you will find.

COMMISSIONER ROSE: Thank you.

COMMISSIONER BROAD: I just have one question.

So it's very common for people -- these technicians -- to work five 12-hour days over two employers?

MS. ANDERSON: It is not uncommon. I mean, they're certainly not all staff who are doing that. I agree. I don't know how they manage to do it, some of them, but some want the extra income. Some feel that they have to have that to afford the cost of living in the Bay Area.

And so, yes. It's not true of every staff member, but it's true of a surprisingly large number of them.

COMMISSIONER BROAD: Are you unduly concerned that your facility might be getting the person on their fifth 12-hour shift?

MS. ANDERSON: Well, every facility is concerned of that, just depending on the day and the time of the week. I think that -- I can't speak for every dialysis provider, but the safety is overwhelmingly the number one

concern in our facilities because it is, in fact -- dialysis is very technical, of medical treatment, and it is possible to do harm to a patient in the dialysis facility. There are many, many, both state and federal, regulations designed to ensure safety, and that is the primary concern of every dialysis provider that I know.

So, yeah, there's a concern, and we watch for that. And if we felt that there was a real concern about the safety of a particular employee, we would talk to them about that.

COMMISSIONER DOMBROWSKI: Anybody else?

(No response)

MR. WINN: My name is Timothy Winn. I'm a manager of respiratory care for Children's, Oakland. You've already heard from several of my staff, and probably one additional one. I'm not going to reiterate a lot --

COMMISSIONER DOMBROWSKI: We would appreciate that.

MR. WINN: -- of what's already been said today.

(Laughter)

MR. WINN: Other than that I am going to reiterate two words, and those are choice and flexibility. I think those are the paramount discussion

here today.

I will say that it will be an undue hardship on the healthcare industry, and particularly my department, to have to accommodate 8-hour shifts. I will lose staff members, and it currently takes more people to accommodate an 8-hour format than a 12-hour format.

You've heard today that there are limited resources and workforce and all that out there, which is very true.

The other is, is I wanted to comment on a lot of what's been discussed here by Mr. Broad with the additional overtime and whether we accommodate someone's wish not to work overtime and acknowledge their decision. And that's absolutely true. A lot of times, I will make the decision that, you know, there won't be any overtime, "You've been here for 12 hours; even if you wanted to stay overtime, you need to go home." And I just wanted to make that point.

So, thank you very much.

MR. WATTS: My name is Brent Watts, and I'm a respiratory therapist at Children's, Oakland.

My comments have already been stated multiple times.

I actually found it interesting that some

institutions in the state decided to somehow circumvent the law or try to do so by, you know, these very interesting maneuvers they did in the twelfth hour of last year, not to comply with the law.

In my institution, we have been on 12-hour days for like ten years, eleven years, and it's worked very well in my department as a whole. And the decision to become 12-hour staff people was made twice, as other individuals have already stated.

So, it would become difficult for us to switch back to the 8-hour format, one, because of our -- we work in every department in the -- most every department in the hospital. And we do the transport role and other activities that don't really lend themselves to a strict adherence to a timetable for completion of our duties. And that's never been a problem before; there's always been the flexibility to finish a task that was very necessary to be completed, whatever time we were doing that.

That's all I have to say.

COMMISSIONER DOMBROWSKI: Thank you.

Anybody else on the 12-hour day?

(No response)

COMMISSIONER DOMBROWSKI: Okay. Let's

transition to the advanced practice nurses. And again, I'll say as I said this morning, we do not need to hear a number of personal stories. It's now two o'clock in the afternoon. So, if we could keep this on point to the proposal as opposed to people's individual lives, that would be very helpful, I think, from the commissioners' viewpoint.

Let's see. I'm going to take a little guessing here about who wants to be on this. Malcolm Trifon, Naomi Newhouse, Sandra Schmit, Laurie Tright, Linda Terabasi, Terry Biehl, Ken Sulzer. Have I missed anybody?

MR. SULZER: We have, on a separate panel, advanced practice nurses.

COMMISSIONER DOMBROWSKI: This is the advanced practice nurses.

MR. SULZER: We'll be on a separate panel from the healthcare providers.

COMMISSIONER DOMBROWSKI: Well, they're both -- you're both going to be up here at the same time.

Tom?

MR. RANKIN: Yeah. I just have a favor to ask, because, actually, I've got --

COMMISSIONER DOMBROWSKI: Do you want to go

first?

MR. RANKIN: I would, yes. And my statement's about two minutes.

COMMISSIONER DOMBROWSKI: That's fine. That's fine.

Just like -- yeah.

MR. RANKIN: Tom Rankin, California Labor Federation.

We've been through this issue in many areas, and I just want to once more state our position to you, that you have absolutely no statutory authority to create exemptions here. The statute is very clear. These folks are registered nurses. There is no exemption that can be created except by the Legislature.

And we made the rule to reach agreement on some classifications. We've had long discussions on this.

You said you don't have the authority to do it, so I don't quite understand why you're taking up this issue.

Thank you.

MR. TRIFON: My name is Malcolm Trifon. I'm a senior counsel with Kaiser Permanente, and today I'm representing Kaiser Permanente as well as the California Healthcare Association. We are members of the

Association and our views are consistent with the other members of the Association on this issue of advanced practice nurses.

And I think it's -- I want to make it very clear at the beginning that we're not asking the Commission to create new law or to do something that is not authorized by AB 60. All we're asking you to do is to interpret the provisions of AB 60, which we believe does not change the application of the professional exemption to advanced practice nurses.

The language in AB 60 that registered nurses "employed to engage in the practice of nursing" are not exempt from the coverage under the wage orders was intended to apply to registered nurses performing the basic functions of registered nurses within their scope of practice under the Business and Professions Code. And I think it's very important to look at the prior law as well as the history of AB 60.

Basically, pursuant to AB 60, Section 515(f) of the Labor Code, and the interim -- IWC Interim Wage Order 2000, Section 3(B), states that registered nurses employed to engage in the practice of nursing may not be considered exempt professional employees unless they individually meet the criteria established for the

exemption as executive or administrative employees. This represents only a very slight change from the prior law, encompassed in Wage Order Number 5-89, which provided that registered nurses could not be considered exempt professional employees unless they individually met the administrative, executive, or professional criteria described in that wage order. And what happened with AB 60 was to remove that language about professional criteria for individual nurses.

And the legal interpretation of Wage Order 5-89 is that regular registered nurses were not exempt professional employees unless they so qualified on an individual nurses, but that advanced practice nurses did qualify for that professional exemption.

So, our position is that the effect of AB 60 was to codify Wage Order 5-89 and preclude registered nurses working within their registered nurse license from qualifying for the professional exemption in any manner.

And it's important to note that AB 60, as introduced by Assemblyman Wally Knox, used the term "registered nurses" in the subsection dealing with the registered nurse exemption issue. Thus it seems apparent that the Legislature's subsequent addition of the words "registered nurses employed to engage in the practice of

nursing" was intended to limit the professional exemption preclusion to registered nurses engaged in basic nursing practices, but not to change the law with respect to nurses engaged in the advanced practices pursuant to other sections of the Business and Professions Code. And this applies to nurse anesthetists, nurse midwives, clinical nurse specialists, and nurse practitioners. Otherwise, there would have been no reason for the Legislature to add to Labor Code Section 515(f) the limiting words "registered nurses employed to engage in the practice of nursing."

And we contend that this interpretation is consistent with the Labor Commissioner's interpretation of the professional exemption, as set forth in the chief counsel for the Commission's -- in his memo of December 13, 1999, in which he states, on Page 21, as was the case under the IWC orders, "Section 515(f) provides that the professional exemption section shall not apply to registered nurses." However, that memo does not make any reference to any change in the exempt status of advanced practice nurses by reason of AB 60.

And I think that evidence that advanced practice nurses are not engaged in the practice of nursing within the meaning of Section 515(f) is evident from a

comparison of the work performed by registered nurses and the work performed by advanced practice nurses. And you're going to hear from others who are actually engaged in advanced practice nursing duties more on basically what they do.

And very briefly, a registered nurse is limited by the Business and Professions Code to a scope of practice that involves providing for basic nursing care. And that's outlined in our submission to you, and it's in Code Section 2725. And these duties are generally performed under the direction and orders of physicians or other licensed healthcare providers. It typically, very briefly, involves monitoring patients' vital signs; ensuring the safety, comfort, personal hygiene, and protection of patients; the administration of medication; performance of certain kinds of tests, including blood-drawing; and basically observation of signs and symptoms of illness, reactions to treatment, general behavior, physical condition, and appropriate follow-up care.

But, in contrast, while advanced practice nurses are registered nurses, their scope of practice far exceeds the basic practice of nursing described above, based on their advanced education, training, and certification. Essentially, advanced practice nurses'

duties more closely resemble and overlap the services provided by physicians and other clearly exempt professional healthcare providers than those provided by registered nurses. And importantly, a registered nurse license does not permit a registered nurse to perform the functions of an advanced practice nurse. And the Business and Professions Code specifically prohibits a registered nurse from performing the services provided by advanced practice nurses without the required certifications specified in the Code.

And essentially, a nurse anesthetist is certified to administer anesthesia in the same manner as an anesthesiologist, and that's her primary duty. A nurse-midwife is certified to deliver babies and provide prenatal and post-partum care that normally would be provided by a physician. Clinical nurse specialists are certified to provide expert clinical practice and other care, and they must meet advanced education requirements at the graduate level, just as the other advanced nurses are required to do. And nurse practitioners are certified to provide primary and urgent care to patients. And they are -- in their absence, the work that they do would be provided by a physician or a physician assistant.

Additional distinctions between registered nurses and advanced practice nurses include recognition that their services are considered professional services that are eligible for Medicare reimbursement, the requirement that advanced practice nurses be privileged and credentialed in the same manner as a physician in order to practice in healthcare facilities, and the coverage of advanced practice nurses by reporting requirements of federal law for reporting to the National Practitioner Data Bank. And furthermore, advanced practice nurses, like physicians, give orders to registered nurses.

And it's our position that it's clear from the above differences in practice specified in the Business and Professions Code that advanced practice nurses do not "engage in the practice of nursing" within the meaning of Section 515(f). Rather, they're engaged in delivering medical services that cannot by law be provided by a registered nurse, and in the absence of an advanced practice nurse, would have to provided by a physician.

And finally, one additional basis for our position that advanced practice nurses were not intended to be considered to fall within the scope of the 515(f) provision that there's no professional exemption for

registered nurses, is that physician assistants, who perform essentially the same work as nurse practitioners, and licensed midwives who perform the same work as nurse-midwives, are not covered by Labor Code Section 515(f), and both qualify for the professional exemption. It would make no sense for the Legislature to deny the application of the professional exemption to nurse practitioners and nurse-midwives, based solely on the fact that they happen to be registered nurses, and allow the professional exemption for physician assistants and licensed midwives who are not registered nurses but perform the same basic functions under different licensure and under different provisions of the Business and Professions Code.

And finally, I want to say that Kaiser Permanente is the largest employer in the State of California of advanced practice nurses. And the impact of any kind of a conclusion that advanced practice nurses are not exempt as professionals could quickly affect the cost-efficient quality of care that Kaiser Permanente provides and could lead to the substitution of their services by having to use physicians.

Thank you.

COMMISSIONER DOMBROWSKI: I want to just make --

we've heard, obviously, Mr. Rankin speaking at this point. So, from the chair's position, I'm just going to direct counsel to find out and give us her opinion on the legal question of this before we take any action.

So -- okay. Go ahead.

MR. SULZER: Good afternoon, Chairman Dombrowski and members of the Commission. I'm Ken Sulzer. I'm partner with Seyfarth, Shaw, Fairweather & Geraldson. Today I represent the California Association of Nurse Anesthetists, the California Nurse Midwives Association, and the California Coalition of Nurse Practitioners, as well as Clinical Nurse Specialists. With me to answer any questions from the Commission are Deborah Haight, from the Nurse Anesthetists; B.J. Snell, from the Nurse Midwives; Susie Philips, from the Coalition of Nurse Practitioners; and Laurie Twight, from the Clinical Nurse Specialists.

Rather than go over again some of the legal points Mr. Trilon (sic) made, I'd like to address real quickly a couple of points made by Mr. Rankin.

We disagree on the process. The IWC has every power and is enabled to certainly say something in its "Statement as to the Basis," or even, if necessary, in a wage order to clarify what "registered nurses engaged in

the practice of nursing" means.

The IWC has already made very similar clarifications of statutory language. A couple examples: The seventh day in the workday was supposed to be paid at double time. Well, it meant seventh consecutive day. It didn't say that in the statute; the IWC clarified it correctly. The collective bargaining agreements, they were supposed to have premium pay for every overtime hour worked. Well, "every overtime hour worked" under AB 60 meant over 8 hours. Obviously, that isn't what it meant, and the IWC clarified it and said it's whatever the collective bargaining agreement says is overtime hours. Now, it's a union issue, a no-brainer. There was in manufacturing a -- whether you could have -- incur overtime after 10 hours and still have the benefit of the four 10's. That was a clarification made by the Commission.

This is the same type of clarification of statutory language that is clearly within the purview and exactly what the IWC is supposed to do. That's not to say we are not, as Tom Rankin said, in discussions with various labor organizations regarding this issue.

A couple of quick points on nurse anesthetists, to tell you who we are. They require two and a half

years of specialized training. They require a master's degree. They have to take a national nurse anesthetist certification exam. They make about -- average about $90,000 a year. They don't fall into that class of overworked, exploited employees whom the IWC is charged with protecting. They're governed by Article 7 of the Business and Professions Code. Article 6, which talks about registered nurses, doesn't talk about nurse anesthetists. It doesn't talk about nurse midwives, it doesn't talk about nurse practitioners or what they do: anesthesia services, primary and urgent care, for the nurse practitioners, and delivering babies. None of those are within the traditional definition of nursing. If you look it up in the dictionary, it doesn't say delivering anesthesia, when you look up "nursing" or "nurses."

And that's the common meaning of this statutory language, and I don't think anybody thinks that the Legislature meant to include these people, just like they didn't mean the seventh day in a workweek, if that's the only day you worked, you were supposed to get double time. I think it falls in that same category.

The APN's are different for additional reasons. They can have their own practices. Registered nurses

don't have their own practices. They can't set up a practice. APN's get direct third-party insurance reimbursement; registered nurses don't. APN's are more like doctors and medical -- direct medical providers, which they are. APN's must also report to the National Practitioner Data Bank. RN's, regular registered nurse with a regular registered nursing license do not have to do that, because they're doing different things.

To expand a little bit on what Mr. Trilon (sic) said, the Legislature did use the limited term "registered nurses." It could have used other terms if it meant to include these people, who are, obviously, set forth in our Business and Professions Code. They didn't do that.

If it's, at a minimum, unclear, the IWC certainly has the power to clarify it one way or the other. I think the obvious clarification would be that the APN's are not meant to be included.

And typically, when people have conversations in the industry, when they say, "What are you?," they don't say, "I'm a registered nurse." They say, "I'm a nurse anesthetist." There's a difference in the way the industry talks about these people. You can use that to interpret the language of the statute very, very easily.

A related point to one thing Mr. Trilon (sic) is, the services are beyond what registered nurses give. In fact, with respect to nurse anesthetists, nurse practitioners, and nurse midwives, there's very little overlap to what they do with regular registered nurses. They do different things that physicians -- that normally physicians do. Physicians deliver babies, physicians deliver anesthesia services, and physicals do direct primary and urgent care. They are replacements for those people; registered nurses are not. That's why they are different and different types of regulation is justified. And, in fact, that was the state of the law before.

And nothing that the Legislature did in 515(f) says that should change. The advanced practice nurse system wasn't broke. Nobody in the Legislature decided to fix it or change it. And we simply need the IWC to clarify it, like other things that are a little bit unclear in AB 60.

The practical effect on my clients, the Coalition of the Nurse Practitioners, Nurse Anesthetics, Nurse Midwives, and CNS's themselves is the job market. Hospitals and healthcare providers fear these massive overtime liabilities for violating the overtime laws. The answer to that has been nurse midwives and nurse

practitioners have already have their jobs cut. Some of them have already been replaced. Nurse anesthetists understand and have been told that, absent clarification of this issue, they will be replaced, because the other people who deliver anesthesia services, anesthesiologists, are exempt. Other people who do primary care like a nurse practitioner, physicians assistants, are exempt. Other people who deliver babies, licensed midwives who happen not to be nurses, are exempt professionals. To do otherwise would lead to an absurd result, and the Legislature just didn't intend that. And this is exactly the sort of thing that the IWC can clarify very, very easily, without -- without fear of violating AB 60.

And another point to make for my clients, but the nurses themselves are -- the advanced practice nurses themselves -- is this doesn't affect -- it's not a union issue, it's not a nonunion issue. It doesn't -- whether they're professional or not doesn't effect their ability to unionize or organize a union if they so choose. It does not affect the rights of their labor organization to organize or attempt to organize any advanced practice nurse group at all, one way or the other. And it's not an issue that has any of that at play. And that -- I'm

saying that for the edification of some folks whom we talked to who think that would have some legal effect on their ability to organize. It does not, and I don't think anyone on the Commission thinks that it does.

The last point -- I'll be brief, because you've heard a lot about patient care and continuity of care -- these people do need -- they are, quite frankly, above your regular healthcare providers. Sometimes they're there instead of a doctor, there just isn't a doctor that's available. And they're the head cheese dealing with this medical crisis. They can't go home when their 8-hour shift is over or their 10-hour shift is over or their 12-hour shift is over. It's even more critical that these people be available. And while it's infrequent that people would work generally more than 12 hours, it is regular and it is necessary.

And if the IWC or whatever restricts them, they will basically be priced out of the market and replaced by physicians' assistants, anesthesiologists, or licensed midwives or OB-GYN doctors.

So, they're in a different situation than registered nurses. I think the term "registered nurses," as used in AB 60, is pretty clear that it means Article 6 registered nurses and nobody else.

And I've got a good anecdote, but we've heard some, so I'll save it. I'll put it in writing. You'll get it.

And I just want to thank you for your indulgence and urge you to consider very closely our comments.

COMMISSIONER BROAD: Mr. Sulzer, you and Mr. Trifon both made the point that prior to the passage of AB 60, advanced practice nurses were treated as exempt.

MR. SULZER: Yes, sir.

COMMISSIONER BROAD: Under what authority were they treated as exempt? Was there a court case? Was there an interpretation of the Labor Commissioner? How did you arrive at that conclusion?

MR. SULZER: I don't know the answer, but that's how they were treated, as professionals, under the professional exemption. I don't know if there's a case that says they are professionals.

But one thing to add, that there is a context to this. There's a federal -- you know, analogous federal law. I realize it's different, but the analogy is, both the federal law, the Department of Labor, and the state law think that registered nurses, basic registered nurses, are a close question. The State of California says registered nurses are not exempt, and they're not.

The statute's clear on that, no question about it. Federal law made that a close call the other way and said that they are, they're professionals. Neither of them suggested that advanced practice nurses were even a close question, that they should qualify for the professional exemption.

I can't cite it for you. I'll try to do it in some supplemental written materials. There's some law suggesting, you know, advanced practice qualify for the professional exemption. And they're treated that way generally in the industry.

COMMISSIONER BROAD: Mr. Chairman, I would just ask, because I know Mr. Locker is here, chief counsel at DLSE, that perhaps after the witnesses are through testifying on this, that he might come forward and just say what the -- how they did treat these people prior --

COMMISSIONER DOMBROWSKI: One of the things -- you were out -- I asked our counsel to take the question of what's our authority in this area. And maybe we could just put that with their -- and get that information all to the Commission --

COMMISSIONER BROAD: Okay.

COMMISSIONER DOMBROWSKI: -- if that's all right.

COMMISSIONER BROAD: So we'll ask Mr. Locker to send us a letter on that?

COMMISSIONER DOMBROWSKI: Well, he can do that or from Marguerite, whichever way it works best for both of you, just to get the information to the commissioners.

MR. SULZER: Yeah. And additionally, on the IWC point, when AB 60 was being formulated -- you can ask some of the clients, but they were told by legislators that, you know, we can't change the language, but it doesn't mean the advanced practice nurses, that the IWC is the appropriate body to bring this before. And that's what our clients were told, and that's why -- that's one reason why we are here.

COMMISSIONER BROAD: Before we leave your testimony, Mr. Sulzer, let me just run through a little bit of the legal analysis here.

The section that you're referring to, 515(f) --

MR. SULZER: (f).

COMMISSIONER BROAD: -- says that in addition to the other requirements to be treated as exempt, you're not exempt, however, if you're a registered nurse engaged in the practice of nursing. Were we to interpret that section to not include advanced practice nurses, would you agree with me that advanced practice nurses would

then have to qualify as exempt professionals under some other provision of the wage orders?

MR. SULZER: Yes.

COMMISSIONER BROAD: They're not automatically exempt.

MR. SULZER: Yes.

COMMISSIONER BROAD: Okay. So, that would be the provision of the wage orders that refers to learned professionals. Is that correct?

MR. SULZER: That's right.

COMMISSIONER BROAD: All right. So, therefore, in order for them to be treated as exempt, there would, under

-- well, let me withdraw that for a second -- that language defining "learned professionals" remains the same in the wage orders now and was not affected by AB 60. Is that correct?

MR. SULZER: Just -- is that a question?

COMMISSIONER BROAD: Yes.

MR. SULZER: Well, what is the answer? You --

COMMISSIONER BROAD: Well, I don't --

MR. SULZER: I don't have it in front of me. I don't think so.

COMMISSIONER BROAD: I don't think so either.

So, the real question is, it all boils down to -- even if we did this -- is how has the Division of Labor Standards Enforcement interpreted that same section in the past. And if they've come to the conclusion that they're not exempt, then doing what you ask us to do will actually not accomplish anything because they'll still remain not exempt, but under a different analysis. And that's -- that's the point I want to leave you with.

MR. TRIFON: I'd like to respond.

I think the way I would interpret 515(f) is that it is intended to apply only to registered nurses engaged in nursing. And I think that under -- and I -- again, like Mr. Sulzer, I can't cite you right now any cases where there was a finding specifically that advanced practice nurses are exempt or not. I'm not aware of any cases. I would be glad to do some research on that and provide it -- provide it to you. But it was never something that was -- I'm aware of, in my practice of employment law -- was ever challenged under federal or state law, that advanced practice nurses were exempt.

But I think that 515(f) was always intended to deal with registered nurses, and AB 60 is an attempt to clarify that there's just no way a registered nurse engaged in the practice of nursing can get the

professional exemption. And I think that was the full focus of it.

So, I would think that advanced practice nurses are exempt under other provisions of the law, as professionals. This -- we're just dealing with registered nurses engaged in nursing, and they would fit within the other definitions of the exemption.

COMMISSIONER BROAD: Thank you.

MS. SCHMIT: Hi. My name is Sandra Schmit, and I'm a certified registered nurse anesthetist. I work at the Kaiser Oakland Medical Center.

It's important for me to maintain my professional status and essential for me to keep my exempt status. Although my practice was built on nursing, the services that I provide are beyond the basic scope of the basic practice of nursing. I have advanced education which permits to exercise independent judgment in managing patient care. I was hired to provide anesthesia services. The services I provide are considered professional service. In my practice, I am exempt and I'm used interchangeably with physician anesthesiologists. We work a lot of different shifts, depending on the clinical setting. A nurse cannot replace me, only another nurse anesthetist or an

anesthesiologist is qualified to perform the services that I provide.

Physicians are afforded a professional exemption, and it's essential that I be able to maintain my professionally exempt status. If I were to lose my professional exemption, premium pay for overtime hours worked will require that my employer limit my flexible work schedule. And additionally, I'll lose the economic advantage that I have over physicians, which would thereby create an impetus for my employer to hire physicians instead of nurse anesthetists.

MS. NEWHOUSE: I won't bore you -- you've heard this a hundred times -- but I wanted to make a couple points about the nurse midwives.

COMMISSIONER DOMBROWSKI: Please identify yourself.

MS. NEWHOUSE: Naomi Newhouse, certified nurse midwife, chair of the peer group for northern California nurse midwives at Kaiser Permanente Medical Group.

We have several avenues to the profession that would -- does not include a nursing track. And that is something we need to make sure you understand. We have professional people that will walk into a graduate program at UCSF, for example. A student right now that I

have is also in this program. She has a bachelor's and master's degree in business and has entered this program to become a nurse midwife. And when she's done, she will have an RN that is only accessible if she finishes the program, only it will be applied to her practice of midwifery. It's one of nursing school and two years of graduate training in nurse midwifery and OB-GYN nurse practitioner training. So when she's done, she's a nurse midwife.

Licensed midwives can go to a program for a bachelor's degree and become midwives without the requirement of a nursing degree. So, we do not feel that we have been prepared and we are not engaged in the practice of nursing. We're not employed for that, as well. We are employed to deliver babies in a hospital in lieu of physician care. When I'm sick, a doctor replaces me.

DR. VAN MEURS: My name is Krisa Van Meurs. I'm a newborn intensive care doctor at Lucile Salter Packard Children's Hospital at Stanford. I want to speak in support of the exemption of advanced practice nurses from AB 60. I have worked with neonatal nurse practitioners for the last eighteen years, for about eight years in Washington, D.C., and the last ten years here in

California. I see neonatal nurse practitioners as fellow professionals caring for critically ill babies.

The intensive care nursery is a very labor-intensive field as the care of infants has become more complex and technical over the last years. Nurse practitioners have become important as physician extenders. They assess, diagnose, write orders, prescribe medication, and treat patients in an interchangeable manner with physicians. You will see them in the delivery room resuscitating newborn infants, doing the same technical procedures that a physician would do, putting in chest tubes, intubating babies, managing a breathing machine. They also diagnose and treat infants.

If neonatal nurse practitioners were not exempt from AB 60, they would be unable to continue to function in the same manner. In our attempts at Packard to conform with AB 60, the MD nursing -- nurse practitioner staffing pattern of our unit would change drastically, with a major impact on patient continuity and quality of care.

I perceive that if the exemption of advanced practice nurses from AB 60 does not occur, many nurse practitioners will either seek employment in state or

county institutions that are exempt from AB 60 or leave the state. And there -- we have nine nurse practitioners in our institution right now. Several of them previously lived out of state and are investigating leaving the state so they can continue the same kind of practice.

In summary, I see neonatal nurse practitioners as fellow professionals who perform a critical service to intensive care units across the state. AB 60 threatens to disrupt the high quality medical care that we're able to deliver right now.

MS. SCHNEIDER-BIEHL: My name is Terri Schneider-Biehl. I'm a neonatal nurse practitioner down in San Diego, at Children's Hospital and Health Center. I'm a neonatal coordinator for the NNT group. As you can tell, we do more medical care than we do nursing care. I have not actually done nursing care in over seven years.

We provide medical management during a 10-hour day shift, but we also provide emergency medical management during a 14-hour night shift, which means we don't actually have to be up and in the unit. We have the possibility of sleeping if the unit is quiet, but we are there for emergency back-up. We also provide on-call status for emergency neonatal transport.

And one of the other things that differentiates

us from bedside nursing is that we provide education for the nursing staff, for other hospital staff. We speak at national conferences and also internationally.

We try to provide, at least at Children's Hospital, the flexibility of putting us into our regular hours of week. We try to keep a 40-hour workweek. Sometimes that's not possible when you're speaking internationally and you're gone for two weeks. We just pay whatever we need to. With -- currently right now, we are short of physicians and nurse practitioners, and we don't require mandatory overtime. But if you're called out at 6:00 a.m. to go on a transport where you have a fixed wing up to Spokane, Washington, for a cardiac kid, you will not be back until you've worked 24 hours. What we offer is that we'll either pay them overtime, or, when they get back, they can have what would be the overtime hours but taken off, that amount of time off, the next workday. So, we provide flexibility based on an exemption, not based on an 8-hour workday.

MS. KING: Hi. I'm Donna King. I'm a pediatric nurse practitioner from Children's, San Diego.

My role is a little bit different than Terri's in neonatal. However, we do -- again, as you've heard already a couple of times -- follow the medical model, in

that we work with the physicians as supervisors, but we also do many other procedures and management that physicians do. Another registered nurse would not replace me. When I leave my 12-hour shift, a physician replaces me, basically.

If I'm asked to do overtime -- nobody really asks me to do overtime -- if I'm in the middle of a patient work-up and I need to stay, I do that, and then I flex my hours accordingly.

Primarily, we're licensed, certified annually as nurse practitioners. And the role is totally different than with a registered nurse in that we do -- we are not directly involved in nursing care.

Thank you.

MR. LOOSE: Good afternoon, Mr. Chairman and commissioners. My name is David Loose. I represent the Association of California Nurse Leaders, an organization that represents nurse executives that hire CNS's.

We respectfully request you to reauthorize the professional exemption eligibility for advanced practice nurses, including CNS's, clinical nurse specialists.

Historically, prior to AB 60, CNS's, like other advanced practice nurses, were eligible for professional exemption from wage and hour requirements under both

federal and California law due to advanced preparation and education, certification, and level of patient care services. A clinical nurse specialist is a registered nurse who has received advanced education and functions in the role of expert nurse clinician, educator, researcher, consultant, and clinical leader. Clinical nurse specialists may manage individual patients or specific patient populations. CNS's may be experts in managing age-specific populations such as pediatrics, adult, or geriatric populations, or specific body systems or disease processes such as diabetes, orthopedics, respiratory, or cardiovascular. Regardless of the population, the CNS applies advanced clinical knowledge and expertise to their practice.

On July 1st, 1998, the Board of Registered Nursing adopted regulations mandating all individuals holding themselves out as CNS's to be certified by the Board. The certification requirements include that the CNS possess a master's degree in nursing or a related clinical field. This educational requirement exceeds that of other APN's by the Board of Registered Nursing. Currently, there are 1,298 certified clinical nurse specialists in the State of California. And this number will continue to grow, as the certification process has

been in effect for only a year and a half.

As an expert nurse clinician, the CNS performs advanced assessment and utilizes advanced critical thinking skills while working collaboratively with a variety of interdisciplinary team members. The CNS acts as a resource to the nursing staff, patients, and families. The CNS provides clinical leadership to the healthcare team through the application of this advanced knowledge and clinical expertise. This clinical leadership may take the form of individual patient management, patient population or system management. A clinical nurse specialist works closely with physicians yet functions in an independent capacity in providing direction and case management for many aspects of patient care.

Flexibility in the day-to-day work schedule is crucial to allowing the clinical nurse specialist to be responsive to the changing and sometimes unpredictable needs of patients, families, staff, and physicians. The need of a patient or family member for the advanced knowledge and clinical skills of a clinical nurse specialist does not, by its very nature, come on a routine scheduled basis. CNS's must be able to intervene when critical or urgent patient care needs arise. The

flexibility of scheduling which accompanies the professional exemption allows for expansion and contraction of work hours based on these changing needs.

The clinical nurse specialist role evolved out of this need for flexible application of advanced nursing knowledge and advanced clinical skills to patient care. The compensation that accompanies this role is commensurate with the flexibility and professional nature of the role and puts CNS's on an equal level with other mid-level providers and other advanced practice nurses. Clinical nurse specialists are advanced practice nurses. Advanced practice nurses are recognized as professionals providing professional services in federal law, allowing the CNS to obtain reimbursement from Medicare for specific patient care services. In many states, CNS's also have regulatory endorsement for prescribing of pharmaceuticals.

As the CNS role in the State of California continues to become defined by the Legislature and the Board of Registered Nursing, furnishing privileges currently held by other advanced practice nurses in the State of California may expand to the CNS role.

On behalf of the Association of California Nurse Leaders, I appreciate your consideration of this

testimony in support of reauthorization of the professional exemption eligibility for advanced practice nurses, including clinical nurse specialists.

Thank you.

COMMISSIONER DOMBROWSKI: Any other witnesses?

Barbara Blake.

MS. BLAKE: Yes. Good afternoon. I am Barbara Blake, the state secretary for UNAC. We represent 11,000 registered nurses, advanced practice nurses, and physician assistants in southern California. Our largest employer is the Kaiser system.

We did a survey of our registered nurse practitioners at the beginning of the year, and they voted overwhelmingly that they did not want to be exempt from AB 60 or whatever overtime provisions are provided for them.

We took the position at the January 28th meeting that if you are looking at advanced practice nurses, you should take them on a certification-by-certification basis. The Board of Nursing recognizes them as each individually separate areas of practice and grants them separate certification.

And if they are not nurses, I question why they're under the Board of Nursing.

But aside from that, I think that there are some of the advanced practice nurses that may have different areas of practice, like the nurse midwives, that make it appropriate to pull them out from the overtime provisions, but definitely not the RNP's. And that is the position for my organization.

MS. HUNTER: Hello. My name is Tricia Hunter. I represent the American Nurses Association, California, am a registered nurse, former Assemblywoman, and also had the opportunity to serve on the Board of Registered Nursing for eight years.

Our Association does actually support the exemption for the advanced practice nurses, but I need to clarify some comments that have been made in testimony that need to be considered as you proceed in this. And again, if this is not the appropriate body to receive this exemption, we are going to be working with them for legislative relief.

We are very proud of the fact that advanced practice nurses are registered nurses. And we believe it is -- you have to be a registered nurse first to be a nurse practitioner, and you have to be a registered nurse to be a certified nurse midwife, you have to be a registered nurse to be a nurse anesthetist.

I also want to clarify that there is no such thing as a basic registered nurse, that we're all licensed under Section 2725 of the Nurse Practice Act, and that the Practice Act goes on to describe an independent and dependent role, that, yes, there are many functions that we function under with doctors' orders, but that a registered nurse, as they go through their education role, learns to function independently, because we believe nursing care is an independent practice from medicine.

We also believe that the advanced practice nurses do, many times, take the role of a physician, that their positions, especially as a nurse anesthetist, interact directly with the physician, that a nurse anesthetist is the only nurse that has statutory authority to give anesthesia, the only professional that has the statutory authority to give anesthesia, beyond a physician, and so that they absolutely interchange in their roles.

We also recognize that a certified nurse midwife, who is the only advanced practice nurse that has a separate scope of practice, practices definitely outside the practice of a registered nurse, because they have a separate scope of practice that clearly defines

what they do.

We also recognize that advanced practice nurses, nurse practitioners in particular, have fought very hard, and we've helped them in that fight, to be able to prescribe and dispense medication. We call it "furnishing" in California.

And I actually carried the bill that allowed them to be primary care providers, which are both unique things that a nurse practitioner can do.

But we all function under standardized procedure. And under standardized procedure as an operating room nurse, I was able to function as a first assistant. The process of standardized procedure allows me to advance my practice as a registered nurse. When the Nurse Practice Act was passed in 1974, it gave all of us the opportunity to have our practice expand as our careers changed and as our activities changed.

And so, again, I want to say that we believe that based on the -- especially the fact that they do step into positions that clearly could be filled by physicians and they interact between those, that they should have an exemption. And it should have been in AB 60, if it isn't clear that they have it now.

If you determine that you can't give them that

exemption, we will help them legislatively. But we strongly believe they are registered nurses and are proud to have them within our rolls.

COMMISSIONER BROAD: Bill, can I just ask one question?

COMMISSIONER DOMBROWSKI: Yes.

COMMISSIONER BROAD: Tricia, I just sort of read through the materials that we have in preparation, and it's very clear to me what nurse anesthetists do, and it's very clear to me what nurse midwives, and it's a little less clear what nurse practitioners do. It's not clear at all to me what clinical -- what the other one -- nurse specialists do.

I mean, as a practical matter, what do they do? Where are they in the system, in terms that we can understand? They were described, but in ways that could describe, you know, three quarters of the workforce.

MS. HUNTER: I actually haven't gone through the certification process, so I cannot call myself a certified nurse -- clinical specialist. But that is what my degree is.

Certified nurse clinical specialists function in all kinds of arenas. One that I'm very familiar with is, frequently, they are on victim teams, where they go out

and provide mental health care and interventions for victims after there has been some kind of trauma. They function in hospitals in an advanced role, oftentimes in neonatal units, where they are working in replacement of the physician when the physician is gone, actually working with the nursing staff to make sure that the nursing staff is familiar with different medications or treatments or activities that need to be done. They provide treatment that would generally be considered medical treatment. They're definitely an advanced practice. They definitely have the education.

When I was going through the training, the biggest difference that we defined, although I think it's evolved even farther than that, was that I chose a clinical nurse specialist degree because I wanted to work in acute care, and that, at that time, generally nurse practitioners worked in private practice or in primary care. That isn't true any more. I mean, there are nurse practitioners in acute care that function as -- for instance, in surgery, with a surgeon, doing the post-op care, the pre-op care, the rest of it. There are certified nurse clinical specialists that do the same thing.

Do you want to answer that question?

MS. TWIGHT: Hi. I'm Laurie Twight. I am a clinical nurse specialist, and I've been one for ten years.

I would agree with you, it is kind of a hard role to get your hands around, in terms of verbiage and words. But really, the best way I can describe it is that we do practice nursing at an advanced level and bridge the gap between nursing and medicine that sometimes exists.

So, our assessment skills are at an advanced level, through education and extra clinical hours and mentorship with advanced practitioners like physicians -- could be nurse practitioners, could be other people with advanced practice assessment skills.

Another thing, you'll see most of us -- and this is a generalization -- most of us traditionally practice in an in-patient hospital setting. And we do flex our hours in terms of working with patients and families. Often our physician colleagues are quite busy with office rounds, surgery, seeing patients that are within their scope of practice to see, and we have patients and families who need explanations about their diagnoses, education about how to manage their disease that often they would get in a physician office. But we as advanced

practice nurses provide that education for the patients and their families, which is something that sometimes gets left out of -- when you think of physician practice, you often think you go in, you get diagnosed, you get a prescription. A lot of what happens in there is also education regarding your disease process and what you can do to manage it and counteract it, prevent it, improve it, whatever the condition.

But that's the field a little bit -- there's a lot more to it than that, a lot more to it than that.

MS. KING: I have one --

COMMISSIONER BROAD: Sure.

MS. KING: You did a nice job. I wasn't going to undermine you.

I've been both a clinical nurse specialist and I'm now currently a nurse practitioner, both in Children's Hospital in San Diego, a nurse practitioner -- or a clinical specialist for about five years, going back to school to get advanced practice specifically in assessment of patients and management of patients. So, what I do now varies quite a bit from what I did as a clinical specialist, although the role overlaps somewhat as to education of staff and families.

But if your child's going to the hospital, for

example, I may be the one to come into the room and say, "Hi, Mr. Broad, I'm the nurse practitioner. I work with Dr. Stuckey." I will examine your child, give you my assessment of what kind of management is needed, along with the pediatrician, and even write the orders, perform some procedures that might be done, and plan for discharge, write a prescription for discharge, and, again, always in collaboration with the pediatrician, and the pediatrician also seeing that patient at least once during the course of the day.

At six o'clock at night, if your baby has had a renal ultrasound and the physician is home having dinner, I'm the one that's there to say, "Mr. Broad, the renal ultrasound was negative." You don't have to wait till morning to find that out -- those kinds of things that are valuable to me to be in the hospital for 12 hours.

Does that help a little bit as far as role differentiation?

COMMISSIONER BROAD: Yeah, but isn't that what a nurse practitioner does?

MS. KING: Yes. That's what I do as a nurse practitioner now. But I didn't do that as a clinical specialist.

COMMISSIONER BROAD: So, what you were

describing is what you did then?

MS. KING: What I -- I was describing what I did now. As a clinical nurse specialist --

COMMISSIONER BROAD: Okay.

MS. KING: -- primarily I did teaching, I did some education with families, providing specific kinds of education on procedures, also filling in families, but less medically oriented, as far as I never wrote orders as a clinical nurse specialist. I wasn't able to write -- to furnish medications or write prescriptions.

Does that help a little bit?

COMMISSIONER DOMBROWSKI: He really wasn't --

MS. KING: It's very confusing now.

COMMISSIONER BROAD: Thank you.

MS. HUNTER: Mr. Broad, the profession has actually debated -- the profession actually has debated whether we did a disservice by creating another category and didn't instead try to blend it into nurse -- the nurse practitioner role with all the requirements that a nurse practitioner is required to do, because we've had confusion with defining the role. We think we know what the role is, but we've had confusion in the public since it's -- it's the newest advanced practice role.

There is literature that clearly defines what it

is, within the five roles that were described by testimony that was given earlier. And we can get that to you.

COMMISSIONER BROAD: Well -- here's my question. Does a clinical nurse specialist spend a fair amount of his or her day engaging in regular nursing duties?

MS. HUNTER: No, only in collaborating and helping with the staff in development, in specialty cases, where you would have a client that needed additional help and support at the level of the clinical nurse specialist. The clinical nurse specialist would not be given a patient load. They would be coming in and helping the staff with that patient load if there were clients and disease processes or family needs that were beyond the regular role.

MS. TWIGHT: We all operationalize the role a little differently, but a good example would be that I, as a clinical nurse specialist, round with my nurses, physicians, find out about the patients, provide critical thinking, advanced assessment into what that patient needs from a nursing perspective and somewhat of a medical perspective, and work indirectly through the other care providers in getting that accomplished for the patient.

Does that make it a little clearer?

So, if I identify a need, I would say to the clinical staff nurse, "Have you thought about this? What does it look like? This is what the patient needs," with my advanced assessment skills. And either she -- she goes about to get it, depending on that need, or I seek out to get it for the patient.

COMMISSIONER BROAD: I understand what you're saying. From my vantage point, what I'm hearing, it sounds very much like you are highly skilled nurses that are engaged in supervisorial duties or mentoring kind of duties, or some -- it doesn't sound to me like it's a separate scope of practice.

I get delivering a baby as a -- you know, in other words, a registered nurse cannot deliver a baby. The question is, can a registered nurse do many of the things that you can do? And from our view, the fact that this is a new area and there's sort of mushy distinctions between categories is not helpful. It actually makes this process more difficult for us.

MS. TWIGHT: A registered nurse can do parts of what I do, portions. She is not qualified and trained and meet the requirements to do all the role functions as it's encompassed as a whole.

Does that -- you can have a registered nurse who's an expert practitioner but doesn't have the consultant skills and training to provide that in a -- the research skills, the education skills, et cetera, for providing for the patient at the advanced level.

COMMISSIONER DOMBROWSKI: Is there something in writing --

MS. HUNTER: Yes.

MS. TWIGHT: Yes.

COMMISSIONER DOMBROWSKI: -- that we could read, instead of having five people come up and answer?

MS. HUNTER: Yes.

COMMISSIONER DOMBROWSKI: All right. Anyone else on the advanced practice nurses issue?

DR. VAN MEURS: Since there was -- has been some confusion between the CNS --

COMMISSIONER DOMBROWSKI: You're not going to let me close this down, are you?

(Laughter)

DR. VAN MEURS: One more minute.

The nurse practitioners are -- I'm working with neonatal nurse practitioners -- function interchangeably with physicians in intensive care units. If we lose our nurse practitioners, for whatever reason, from the

nursery, they would be replaced by physicians in doing -- working the exact same hours and exactly the same job.

So, I went -- when I went to medical school, I sat beside nurse practitioners who had already finished their RN degree, and we simultaneously went through the next two years of medical school. They received the same training I did after -- you know, after they had already finished their RN degree, and go on to do a lot of very similar activities.

They are in the delivery room resuscitating babies, assigning Apgars at birth, calling the babies into the unit and doing all the medical procedures that a physician would do.

Thank you.

MS. BLAKE: Barbara Blake. I just wanted -- I submitted all of the five certifications from the Board of Nursing in the January 28th testimony and would be happy to supply them once again to the Commission as necessary. I think that is really what's most helpful, is to look at the descriptions from the Board.

Thank you.

COMMISSIONER DOMBROWSKI: We will take those comments under advisement.

We have another item that Mr. Baron wants to

bring up.

MR. BARON: I wanted to clarify a situation relative to some of the occupations that are listed in Wage Order 5. I wanted to note that when, as a result of AB 60, that we reverted to an earlier version of Order 5, that language came into play which was -- came back into play -- which is in 3(D) of that order, which had been deleted in the '98 version, that allows for up to 54-hour workweeks without overtime payments for specified personal attendants, resident managers, and employees for children under 24-hour care.

In light of discussions with representatives from the federal Department of Labor and a review of relevant federal regulations, there appears to be a conflict here, as the federal regulations call for only up to a 40-hour workweek for these employees without their having to be paid overtime. As the federal standard would prevail, we would be obliged to conform with the federal standards, which is exactly what was done a couple of years ago. But now that we're going back to an earlier version of orders, we're back to where it was before that change was made.

We had a similar situation at a previous meeting relative to stable employees, where it was exactly the

same type of thing, where they also had 54 hours. And then, again, under FLSA, which we are obliged to work within, the federal law, again, these delineated professions are not exempt from that 40-hour federal standard.

So I wanted to put that out there now. And it's something that we will be aware of as the Commission drafts wage orders.

COMMISSIONER DOMBROWSKI: Okay. Item 3 on the agenda is public comment on provisions of Labor Code Section 517(a) that require us to adopt regulations to provide assurances of fairness in the conduct of employee elections to adopt or to repeal alternative workweek schedules, procedures for the implementation of alternative workweek schedules, the conditions that must exist before employers can repeal alternative workweek schedules adopted by their employees, employee disclosures, designations of work, and processing of workweek election petitions.

I have one card of somebody who wishes to speak, and I don't see her in the audience.

Do you want to speak, Allen?

MR. DAVENPORT: I won't take long.

COMMISSIONER DOMBROWSKI: You know, I thought we

were going to have a record here where we get an item on the agenda and nobody spoke. And now you're going to blow it.

(Laughter)

MR. DAVENPORT: Allen Davenport, with the Service Employees.

We submitted to you earlier today, in the previous discussion on the 12-hour day, a design for elections that we think would be applicable under those and other circumstances as may occur.

We do find -- and I think you have on record from previous hearings -- given the confusion about the implementation of the 12-hour day exemption -- or the 12-hour day exemptions -- that there are a lot of untoward practices that go on in these elections. And we do think that they need to be done by neutral parties in neutral circumstances, in a very official way.

The potential for these things to be manipulated, for the information to be manipulated, is overwhelming. And I think the -- you've seen enough evidence of that in previous hearings. But we certainly -- that's why we put some thought into those procedures that you have in front of you.

MR. COOPER: Peter Cooper, with the California

Labor Federation.

And we also would just ask that you -- we believe that the provisions for the elections, as outlined in our proposal, would be also applicable to other wage orders, with some -- maybe some altering slightly of language for specific wages orders, and appreciate you looking at that proposal in detail.

Thank you.

COMMISSIONER DOMBROWSKI: Wasn't the neutral third party in an earlier draft of AB 60? Do you remember?

COMMISSIONER BROAD: Pardon me.

COMMISSIONER DOMBROWSKI: Yeah, a neutral -- was there a provision in an earlier draft of AB 60 --

MR. BARON: Yes.

COMMISSIONER DOMBROWSKI: -- that had a neutral third party? And then it was -- come out?

MR. BARON: Yes, that's correct.

COMMISSIONER DOMBROWSKI: That was in an earlier --

MR. BARON: It was in an earlier.

COMMISSIONER DOMBROWSKI: I thought there was a provision in there about that.

MS. BLAKE: Barbara Blake, United Nurses

Associations of California, AFSCME. And we're in support of the state labor's proposal on the neutral party and the guidance on the election procedure for 12 -- or for alternative workweeks.

COMMISSIONER DOMBROWSKI: Anyone else?

(No response)

COMMISSIONER DOMBROWSKI: We'll take those comments under advisement.

Any other business people want to bring before the Commission?

(No response)

COMMISSIONER DOMBROWSKI: Okay. That being the case, can I get a motion to adjourn?

COMMISSIONER ROSE: I move we adjourn.

COMMISSIONER BROAD: Second.

COMMISSIONER DOMBROWSKI: All in favor?

(Chorus of "ayes")

COMMISSIONER DOMBROWSKI: We are adjourned.

(Thereupon, at 3:05 p.m., the public meeting was adjourned.)

--o0o--

CERTIFICATE OF REPORTER/TRANSCRIBER

--o0o--

I, Cynthia M. Judy, a duly designated reporter and transcriber, do hereby declare and certify under penalty of perjury under the laws of the State of California that I transcribed the four tapes recorded at the Public Meeting of the Industrial Welfare Commission,

held on April 14, 2000, in Oakland, California, and that the foregoing pages constitute a true, accurate, and complete transcription of the aforementioned tapes, to the best of my abilities.

Dated: May 7, 2000

_____

CYNTHIA M. JUDY

Reporter/Transcriber