Six Negotiation Sessions Completed

With six of our ten scheduled sessions complete our team agrees we have made some significant improvements to the contract. We have negotiated new language which will empower nurses to have more input into staffing and scheduling decisions at the unit level which will also require unit approval. We are also very close on language regarding open position notice and requests for schedule trade language. We will keep the Task Force and maintain current Earned Time Off (ETO) as well as Earned Sick Time (EST) accrual rate. We still have issues to resolve regarding break/lunch issues which will be addressed next week.

Preparation for Economic Issues

We are preparing for negotiation on economic issues. Those discussions will start on Monday June 23. We will begin the bargaining session around 1000 a.m., however there are a couple of final language issues to discuss prior to diving into the money issues.

In our opening economic proposal our team proposed differential increases in very few areas. Our purpose is to focus the money where the greatest number of nurses will see a benefit.

Our proposals included increase to preceptor pay, certification differential, charge nurse/ OR team leader/Hospice case manager (in 2015) and across the board wage increases for all ONA represented Registered Nurses in the amounts of 10 percent in 2014 and 6 percent in 2015.

When we formulated these proposals we looked at publicly available information regarding our wages and differentials from similar in size and services offered hospitals within Oregon. We discovered that many of our current differentials are nearly equivalent with the exceptions of those areas highlighted in our proposals.

While the usual practice for negotiations is to start VERY high with economic proposals that is not what our team has
Preparation for Economic Issues (continued from page 1)
done. Our opening proposal was a little higher than we expect to land as we want to make the most of our limited remaining negotiation dates.

Using our ONA comparators for wages, we are currently an average of 6 percent behind our colleagues around the state which does not account for those facilities that are also currently in negotiation.

The hospital representatives have acknowledged that our last contract concessions on wage increases allowed the hospital to secure financial security during a time when such security was potentially in peril. It needs to be noted that during the term of our current contract Asante has maintained an Operating Margin (OM) which in the 75th percentile in comparison to other hospitals throughout Oregon.

Most hospitals strive to have an OM greater than 3 percent, RRMC’s OM for the years 2009-2012 has been 7.9 percent, 8.05 percent, 5.5 percent and 8.6 percent respectively. For fiscal year 2013 the current OM is 6.3 percent.

We also know that our spending power has decreased by nearly 7 percent in the past three years. We understood that the hospitals opening proposal was just that, an opening proposal and it is not where they or we will end for wages in these negotiations.

NICU Update

Nurses in the Neonatal Intensive Care Unit (NICU) have been experiencing an enormous amount of Mandatory Call Off (MCO) which has significantly increased in the past six months or so. Nurses met with ONA leaders to discuss all of the issues, including how we got to this point, and what are possible solutions now? A large group of nurses met on June 18 to discuss possible remedies which would allow all of the nurses to have the opportunity to use Earned Time Off (ETO) for vacations rather than to simply ensure they have a full paycheck.

The attendees at the meeting brainstormed some great solutions which will be shared with the hospital administration in the very near future. The goal is to keep RRMC nurses working at RRMC.

Nurse Staffing

The Oregon Nurse Staffing Law ensures that our citizens, when hospitalized in an acute care facility, will receive safe patient care based on sufficient, safe nurse staffing.

Additionally, this law is similar to what other states have and are doing related to nurse staffing.

Important Requirements of Oregon’s Hospital Nurse Staffing Law:

- The staffing plan must be based on the individual and aggregate needs of the patients and their requirements for nursing care.
- The plan must delineate specialized qualifications and competencies required of the nursing staff.
- The plan must be based upon nationally recognized specialty standards.
- Each staffing plan must be developed through a collaborative partnership between direct care nurses and nurse managers.
- Committee developing the staffing plan must be composed of equal numbers of direct care RNs and nurse managers.

A hospital may not require RNs, LPNs or CNAs to work (with a few exceptions – including voluntary overtime):

- Beyond the agreed-upon shift
- More than 48 hours in any hospital-defined work week
- More than 12 consecutive hours in a 24-hour period
| Article | ONA Counter-Proposals May 27/28  
| *June 10  
| *Indicated by italics | RRMC Proposals May 27  
| * June 10  
| *Indicated by italics |
| --- | --- | --- |
| 1.2. | Updated definition of Preceptor/Mentor.  
* Tentative Agreement (T/A) 6/17/14. | An RN who agrees and is assigned by management to assist new graduate nurses; or to provide orientation to an RN new hire or to RN transferees to a unit; or to mentor student nurses in a recognized integrative practicum, not reflective practice. Where possible preceptors/mentors will be assigned a reduced patient load. |
| 4.1 | We disagree with this language and offer no counter proposal.6/17/14, | Altered this language to read: In any arbitration the ONA will not challenge the validity of Hospital policies; it may challenge the fairness of the application of the policy in a just cause corrective action arbitration, or challenge them as unlawful or in violation of the contract, but will not challenge policies themselves as being unfair or unreasonable. The ONA will not challenge the Hospital policy of requiring an RN to have an active and current license, solely according to the date on the license itself to work at the Hospital. |
| 6.1 | Agree, only if weekend compensation will now be from 1900-1900 Friday-Sunday (economic) | Add new sentence as follows: The consecutive weekend overtime ends Sunday at 7:00 p.m. No counter as of June 17. |
| 6.2 | Meal Break. The hospital will provide relief nurses, unencumbered by other patient assignments to provide meal and break relief.  
• Any RN who is scheduled to work and works six (6) hours or more and misses his/her meal break will be paid double time (2xs) for the missed meal break.  
Maintained our proposal (economic) | No to additional nurse or additional pay. |
| 6.3 | For each uninterrupted rest break that a nurse does not receive, he/she will be paid double (2x) the regular hourly wage for one-fourth (1/4) of an hour for the missed rest break. (economic)  
Proposed additional language to the Hospital’s recent proposal and reached a T/A on the language only.  
Compensation issues remain open.  
6/17/14. | No to additional pay.  
Nurse Managers will not instruct RNs not to report missed breaks or lunches, and will encourage and support them in all such reports. There will be no public or publicized criticism for individual RNs for missing their breaks or reporting such. The goal is to work collaboratively to try to find a way to solve the problem of missed breaks or lunches, not to necessarily allocate blame for the problem. The RN retains personal responsibility to proactively and appropriately communicate regarding coverage with the charge nurse to take breaks and lunches whenever offered or possible. |
### Summary (continued from page 3)

<table>
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<th>Article</th>
<th>ONA Counter-Proposals May 27/28 * June 10</th>
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<td></td>
<td>T/A 6/17/14</td>
<td>The PNCC will focus on all mandatory overtime/staffing situations. RNs mandated to work overtime will have the option to be involved in such PNCC discussions. The Hospital will provide to the PNCC monthly RN overtime figures, and the same reports received under Article 6.12.C above. T/A this language.</td>
</tr>
<tr>
<td>7.5</td>
<td>Nursing Resource Team. Each Resource Team RN will be assigned a &quot;home unit&quot; other than the resource float pool itself for purposes of MCO rotation, job bidding and layoff under Article 8. The home unit will be the Resource Team Service line for which they were hired. T/A 6/17/14</td>
<td>Each nursing resource pool team RN will have a &quot;home unit&quot; other than the nursing resource pool team itself. The home unit for MCO rotation, job bidding, and layoff will be assigned and designated to each resource team RN within the operational division, for example, critical care, med-surgery.</td>
</tr>
<tr>
<td>8.1</td>
<td>Equitable MCO rotation will attempt to ensure that no single nurse receives MCO more than once in a payperiod before each nurse on the shift has also received MCO. Scheduling by Mandatory Call Off (MCO) Work units may allow MCO to be pre-scheduled on a voluntary basis for shifts when census is expected to be low. Each individual unit will determine how much or if voluntary MCO is counted toward equitable rotation. The MCO rotation list will be reset by each individual unit according to the method they agree upon. For nurses with the same amount of MCO accruals, the rotation will be based on seniority. When a nurse is hired into a unit (after orientation) he/she will receive credit equal to one less measurement than the nurse with the least accrued MCO. It is recognized that this sort of MCO rotation system will be complex to administer and that mistakes may be made. When mistakes are made regarding MCO between Code 1 and Code 2 nurse such mistakes shall be remedied by addition of MCO credits for the nurse in question. However if the MCO layoff procedure as outlined in 8.1 A-D in is not followed then the financial resolution and grievance procedure will apply. T/A 6/17/14</td>
<td>Would only allow nurses to move to Code 3 position with manger approval.</td>
</tr>
<tr>
<td>8.4.D</td>
<td>No counter proposal 6/17/14.</td>
<td></td>
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(continued on page 5)
### Article 8.5

We asked for supporting information how often have nurses bid out after 6 months and where did they go.

Information received, no counter yet. 6/17/14.

When a fixed RN position becomes available it will be put up for bid and assigned by seniority. Any RN may bid on all or a portion of the position. If an RN is granted a portion of the position, the remaining portion of both positions shall go through the same process.

*We are still working on this language 6/17/14*

### Article 9.4 B

Proposed language that would allow units to decide for themselves, with suggested guidelines as identified in Article 15.5

T/A for the new language in that article. 6/17/14.

### Article 9.5

Each nursing unit staffing committee as identified in Article 15.5 will develop a process to allocate ETO utilization among unit RNs. Each nurse will be granted ETO up to a maximum of two uninterrupted weeks, consecutive if possible requested (subject to available ETO), before any nurse will be granted more than two weeks.

T/A 6 17 14.

### Article 9.7

ETO Guidelines and Unit Maximum ETO Scheduled Days Dispute Procedure. Whenever these decisions cannot be worked out on the nursing unit level itself, the dispute will be submitted to the Department Director for investigation, mediation, and resolution.

If the dispute remains unresolved, it will be submitted to the Vice President of Nursing or a designee. If this procedure is not followed, the grievance procedure will apply. Moved this language to Article 15.5
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<td>9.7. O</td>
<td>T/A this language. 6/17/14.</td>
<td>RN Request for Code 2 or 3 RNs to “Cover” for Scheduled Time. RNs may request Code 2 RNs to cover for their normal scheduled shifts before the schedule is posted and final. No other change to current language.</td>
</tr>
<tr>
<td>11.3</td>
<td>Added language which would allow Code 3 B to use frozen EST. <em>(economic)</em></td>
<td>No counter proposal offered <em>(economic issue).</em></td>
</tr>
<tr>
<td>12.5</td>
<td>Proposed new language which would allow nurses who work 20-24 hours/week to qualify for leave equal to FMLA/OFLA requirements including benefit compensation for those hours. <em>(economic)</em></td>
<td>No counterproposal at this time <em>(economic issue).</em></td>
</tr>
<tr>
<td>13.4. A.</td>
<td>Agree to effective date of changes 6/17/14.</td>
<td>Amend language that would allow benefit eligibility and cost sharing changes would be effective first of month rather than first day of pay-period.</td>
</tr>
<tr>
<td>13.4. B</td>
<td>To be further discussed as part of economics.</td>
<td>Add: A nurse may also become eligible for health benefits due to the application of the rules under the Affordable Care Act. Such Code 3 RNs who accepts offered coverage will not be eligible for the fifteen</td>
</tr>
<tr>
<td>13.4. C</td>
<td>Counter proposal 6% cap to premiums each year of contract. 6/17/14.</td>
<td>Proposed 12% cap to premium increase per calendar year.</td>
</tr>
<tr>
<td>14.3</td>
<td>T/A 6/17/14</td>
<td>Amend language to clarify fiscal year.</td>
</tr>
<tr>
<td>14.3. B</td>
<td>Increased education fund from $400.00 to $800.00 per year with 4 year carry over. <em>(economic)</em></td>
<td>Increase fund to $600 per year. No annual carryover.</td>
</tr>
<tr>
<td>14.3. F</td>
<td>Increased education fund from $400.00 to $800.00 for Code 3 nurses who have worked a minimum of 1040 hours in prior fiscal year. <em>(economic)</em></td>
<td>Increase fund to $600 per year, no annual carryover.</td>
</tr>
<tr>
<td>15.3</td>
<td>Propose keep pay for alternates who attend <em>(economic)</em></td>
<td>Only allow pay for Hospital staffing committee alternate if regular member is not present.</td>
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### Summary (continued from page 6)

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<tr>
<td>15.5</td>
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It is the responsibility of each nursing unit to turn in a balanced schedule, and to develop and implement decisions, protocols, communications, guidelines, and rules to accomplish this responsibility. Each unit shall elect a Scheduling Committee bi-annually who will work collaboratively with the unit manager to accomplish this goal. The Housewide Staffing Committee representative shall be a member of this committee. The duties shall include oversight of schedule changes, determination of bedside hours, review of average acuity, intensity and case mix index for the unit, developing equitable floating, MCO and ETO guidelines. All such recommendations shall be approved by a majority vote of RNs on the unit. In addition, the committees shall report their findings and recommendations annually to the House-wide Staffing Committee.

Each nursing unit with 2 or more scheduled nurses will have a committee of elected staff nurses review their unit level staffing to include:

- a) Accurate description of (how) individual and aggregate patient needs and requirements for nurse care are used to staff the unit.
- b) A system for recognizing differences in acuity and intensity of patients, except in those units where National Standards exist and are being utilized.
- c) A description of the specialized qualifications and competencies of the nursing staff on the unit and how this is related to the staffing plan.
- d) A description of how the skill mix and competency qualifications ensure that nursing care needs of all the patients on the unit are met.
- e) Consistency with nationally recognized evidence-based standards in the specialty. The requirement here is to determine if the unit-level plan is below, at, or above the national standards from specialty nursing organizations. Wherever the unit level staffing plan falls below national standards, an explanation needs to be given for that level.
- f) A description of minimum number of nursing staff personnel (including licensed practical nurses and certified nursing assistants) required on specified shift with no fewer than one RN and one other nursing care staff person on duty in a unit when a patient is present.
- g) Identification of criteria that a direct care registered nurse would use to indicate the inability to meet patient care needs or where a risk of harm would exist if patients were admitted to the unit. (This links to the hospital-wide policy for limitation of admission or diversion of the patients)

Verbal proposal that there be unit based committees to develop guidelines and protocols related to equitable rotation of MCO and Float hours, staffing and scheduling issues as well as ETO issues and requests will be made in collaboration with manager. Committee would be paid time. Issues which are unable to be resolved would be referred to VP of nursing or designee. If unresolved at that level would go to Hospital Staffing Committee. Committee will follow Hospital wide staffing guidelines for decision making.

(continued on page 8)
### Summary (continued from page 7)

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<th>Article</th>
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<td>15.5</td>
<td>H) Description of a process for reporting (verbal, written) when safe patient care does not occur. This will include notification of Clinical Manager/House Supervisor and response to these concerns. I) Description of an annual quality evaluation process to determine whether the staffing plan is accurately reflecting patient needs over time. Nurse members shall be paid for all approved committee work time. Nurse members will work collaboratively with nursing management on all issues. In case of dispute(s) about MCO, float, ETO guidelines and staffing or scheduling issues that cannot be resolved at the unit level by unit RNs and the manager, the Vice President for Nursing or designee, will mediate in attempt to resolve the issue. If the dispute(s) remains unresolved at this step, a decision will be made by a majority vote of the Housewide Staffing Committee. Any violations of this procedure will be resolved through the grievance process, article 17. T/A 6 17 14.</td>
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<td>20</td>
<td>We proposed a 2-year contract. (economic)</td>
<td>3-year contract.</td>
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<td>A.3</td>
<td>Increase charge, hospice case mgr, operating room (OR) team leader pay to $3.35 per hour in 2015. Increase preceptor/mentor pay to $2.00 per hour effective 2014.</td>
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<tr>
<td>A.4</td>
<td>Increase certification differential to $2.00 per hour effective 2014.</td>
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<td>A.5</td>
<td>Added language to clarify additional night shift premium increases and rates. Added language to secure additional differential for night shift staff who work hours other than night shift for the good of the unit or required education. Added language which would allow a nurse who occasionally works a shift other than nights to not lose the entire differential for years of service on night shift.</td>
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<td>A.7 3</td>
<td>Callbacks to Work. After being placed on standby, the RN will only be required to report to work if called during standby hours. When an RN is called back to work during the standby hours, (absent overtime being required by some other provision of this Agreement), he/she will be paid at time and one-half (1 1/2x) for the hours of work. (With a 2 hour minimum)</td>
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<td>Add “Majority of hours” to current language. Add language as follows: A nurse who changes regular work shifts so as to lose the consecutive years night shift differential, but who returns to night shift for a majority of workweek hours within twelve (12) months, will again be eligible for the same level of consecutive years night shift differential and retain prior accrual credits toward the next consecutive years differential level, if applicable.</td>
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<td>A.11</td>
<td>Removed this article which allowed the hospital to withhold wage advancement based on merit.</td>
<td>Verbal agreement 6/10/14.</td>
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<tr>
<td>A.12</td>
<td>Eliminate clinical ladder language. Revert to current A.12 language.</td>
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<tr>
<td>A.13</td>
<td>Nurses can voluntarily waive CNI/ASI (would get preference for those shifts)</td>
<td>No counter</td>
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</table>
| A.14    | Proposed new language as follows: Short-Staff Shifts Designation of Short-Staff shifts. A shift shall be designated a short-staff shift and will be compensated with CNI differential for all RNs working on a unit under any of the following circumstances:  
   c. (Where baseline staffing is ten or less), when staffing on the unit is one nurse below the appropriate staffing level, adjusted for census and acuity, as determined by the daily matrix or charge nurse.  
   d. (Where baseline staffing is more than ten), when staffing on the unit is two nurses below the appropriate staffing level, adjusted for census and acuity, as determined by the daily matrix or charge nurse.  | |
| A.15    | Attendance Bonus.  
   Full time nurses who have worked twelve (12) months with no unscheduled absences will receive a bonus of 12 hours of ETO.  
   Part time nurses who have worked twelve (12) months with no unscheduled absences will receive 8 hours.  
   Full time nurses who have worked twelve (12) months with 1-2 unscheduled absences will receive a bonus of 6 hours of ETO.  
   Part time nurses who have worked twelve (12) months with 1-2 unscheduled absences will receive 4 hours of ETO.  | No counter |
| Exhibit C | Hospice agreement  
Increase to cell phone contract reimbursement.  
Increase to Assessment pager time pay. | No counter proposal. |
| Exhibit D | 10% across the board wage increase for all steps in 2014.  
6% across the board wage increase for all steps in 2015. | 2% across the board increase 2014.  
1% across the board increase 2015.  
1% across the board increase 2016. |
Congratulations to the following ONA members elected to ONA leadership positions.

President
• Katy Cooper, BSN, RN, CCRN - Oregon Health & Science University (OHSU)

Secretary
• Diane Hedrick, RN - Retired

Director
• James Sims, ARNP, MSN, RN - Peace Health Medical Group

Cabinet on Health Policy
• Erin Shawn, MSN, FNP, RN – Mid County Health Center

Cabinet on Education
• Janet Killen, MSN, BSN, RN - Sacred Heart Medical Center (SHMC)
• Patricia Bellamy, RN - Retired

Cabinet on Nursing Practice & Research
• Charity Pape, BSN, RN, HNB-BC – OHSU, State of Oregon

Profile – Katy Cooper, BSN, RN, CCRN – ONA’s new President

Katy is a dedicated registered nurse (RN) with 32 years specialty critical care nursing experience in cardiology, adult and pediatric neonatal cardiac surgery, interventional cardiology and electrophysiology, complex medical/surgical intensive care, progressive care, and burn care.

Throughout her career Cooper has developed strong management and communication skills, serving as a unit supervisor of a progressive care unit and ongoing affiliation with professional nursing organizations. She has knowledge of acute coronary syndrome, heart failure, valve disease, congenital heart anomalies, unstable angina, aortic aneurysm, anti-arrhythmic and hemodynamic emergency medication administration, patient care management and training.

Katy has proven her ability to build positive relationships with patients and their family members, co-workers, physicians and other medical professionals. Congratulations Katy Cooper!

Cabinet on Economic & Welfare
• Susan V. Johnson, BSN, RN – Samaritan Albany General Hospital (SAGH)

American Nurses Association (ANA)
• Steve Rooney, RN – St. Charles Medical Center Bend
• Becky McCay, BSN, RN - St. Anthony Hospital (STA), ONA Relations Representative

Last ANA Alternate
• Susan King, MS, RN, CEN, FAAN, Executive Director, ONA

National Federation of Nurses (NFN)
• George Haefling, BSN, RN – Rogue Regional Medical Center (RRMC)
• Clarice Gerlach, BS, BSN, RN, CCRN – OHSU
• Bobbi Turnipseed, RN, CCRN - St. Alphonsus Medical Center – Ontario (SAO)

NFN Director
• Lynda Pond, RNC – SHMC

AFT
• Becky McCay, BSN, RN - STA, ONA Relations Representative
• George Haefling, BSN, RN – RRMC
• Carolyn Starnes, RN – Mercy Medical Center
• Susan King, MS, RN, CEN, FAAN, Executive Director, ONA
• Katy Cooper, BSN, RN, CCRN - OHSU
• Paul Goldberg, BSN, RN - ONA Assistant Executive Director Labor Relations
• Ann Carlson, RN – RRMC
• Lynda Pond, RNC – SHMC
• Bobbi Turnipseed, RN, CCRN - SAO
• Clarice Gerlach, BS, BSN, RN, CCRN – OHSU
• Susan V. Johnson, BSN, RN – SAGH

ONA welcomes and thanks all our dedicated professionals who stepped up to take leadership positions.