CMH MANAGEMENT’S Q&A WITH RESPONSES FROM CMH NURSES

In response to administration’s assertions, many nurses have requested clarification. Please see below. Responses by CMH administration are in black, responses by nurses are italicized in red.

FAQS ABOUT NEGOTIATIONS BETWEEN CMH AND ONA

1. Why won’t the hospital agree to include a reference to the staffing law in the ONA contract?

The contract between CMH and ONA covers wages, hours, and terms and conditions of employment. The Oregon Nurse Staffing Law is a separate statute that requires us to have a hospital-wide staffing committee. The Oregon Health Authority (OHA) enforces this law. Under the law, the ONA’s only role is to determine the process for appointing the nurse members of the staffing committee, but ONA’s proposal would make the union the guardians of the law. CMH feels this is neither appropriate nor necessary.

**FALSE:** Embedding the law in the contract does not make the union the guardians of the law. It makes us, direct care nurses at CMH, the guardians of how the hospital is staffed. And we put quality care before record-breaking profit margins and executive bonuses. Enforcement from OHA has not been adequate; they have yet to respond to a complaint we filed in 2016. Facilities that commit to following the law are not opposed to putting it in the contract. In fact, 19 facilities across the state have the staffing law, or components of it, in their collective bargaining agreements. CMH is opposed to fulfilling their duty to staff us as mandated in our agreed upon staffing plans!

2. How are staffing decisions currently handled?

CMH has been, and remains, committed to following the Oregon Nurse Staffing Law. We have an active and collaborative hospital-wide staffing committee co-chaired by Kelsey Betts and Judy Geiger. It is functioning well. There has only been one complaint filed against CMH related to staffing. (It was investigated by the state in October of 2016). The committee reviews data, staffing plans, Staffing Request and Documentation Forms (SRDF), and staffing model trials. It recently approved a CNA trial for CCU. When there is an immediate staffing concern, the Nursing Supervisor calls a staffing huddle to determine the best course of action to assure patient safety.

Our unit-based committees are also designed to enhance communications between management and nurses about nurse practice issues, including staffing. The changes ONA has suggested would put the union in the middle of that communication, thereby making addressing nurses’ concerns related to staffing an adversarial process. This does not make sense to us and is not in-line with the practice environment we are working with nurses to create.

**FALSE:** CMH is not committed to following the Oregon Nurse Staffing Law. The week of our picket management attempted to increase patient loads without approval of the hospital-wide staffing committee. And then again last week in the days leading up to our Town Hall, management tried to
coerce brand new nurses to go above their staffing matrix to accept more patients. More senior nurses were forced to work more than 16 hours that day to avoid leaving newer nurses with huge patient loads beyond what is safe. When questioned on this, management told nurses in the department and our nurse staffing co-chair that the safe staffing matrix is just a guideline, not a requirement! This is false, it is a nurse staffing law, not a recommendation! With these types of weekly threats to patient safety and our nursing licenses, it is clear this needs to be in our collective bargaining agreement. Nineteen other hospitals around Oregon aren’t scared to put it in the contract!

3. Are the current staffing levels in the hospital nursing departments sufficient?

Yes. CMH is committed to safe patient care and we have good staffing levels in every unit. Each nursing unit has a staffing plan that was collaboratively developed by the nurse manager and department staff and approved by the Hospital-wide Staffing Committee. They take into consideration any existing national standards on patient types, acuity and care needs. A few examples of the nurse staffing models at CMH are:

<table>
<thead>
<tr>
<th>Unit</th>
<th>Staffing Model</th>
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</thead>
<tbody>
<tr>
<td>Family Birthing Center</td>
<td>Uses Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) standards. Nurse to patient ratio varies by where patients are in the labor and delivery process.</td>
</tr>
<tr>
<td>Critical Care Unit</td>
<td>No national standards developed by Critical Care Nursing Organizations. CMH staffs 1 nurse for 1-2 critical care patients on all shifts. This is in-line with national averages.</td>
</tr>
<tr>
<td>Medical/Surgical Unit</td>
<td>No national standards developed by Medical-Surgical Nursing Organizations. CMH averages 1 nurse to 3 patients. National averages are 1 nurse to 4-6 patients on day shift, and 1 nurse to 5-7 patients on night shift. Ratios of certified nursing assistants (CNAs) to patients are in-line with national averages.</td>
</tr>
<tr>
<td>Surgical Services, PACU, Same Day Services</td>
<td>Uses American Society of Peri-Anesthesia Nurses (ASPN) guidelines and AORN standards in their position statement on Perioperative Safe Staffing and On-Call Practices.</td>
</tr>
</tbody>
</table>

**FALSE:** The American Association of Critical Care nurses has designed comprehensive acuity tools and has been publishing critical care staffing guidelines for well over a decade. This error demonstrates why staffing can’t be left to management; they aren’t up to date on the latest nursing practice research.
Management believes they can do a lot to improve our staffing by making nurses take more patients, thus increasing profits. They have attempted multiple times to increase patient loads and pressure nurses to agree to new staffing plans with larger patient loads, most recently last week. Their numbers are based on national benchmarking data, and the law specifically states staffing plans will not be based solely on benchmark data. The intent of the law is that direct care nurses know best what the facility and the community needs.

Large medical centers have large teams of specialists to help with time consuming tasks like procedures, IVs, patient mobility, admissions, discharges, and care coordination. We do not have that same level of support. As a critical access hospital, Medicaid reimburses us at higher rates to deal with increased costs. We believe that money belongs at the bedside, not in executive bonuses. Enforcing staffing levels that allow us to provide quality care is critical for this community.

The law mandates staffing plans are made by the nurses and managers of a unit and then voted on by the hospital nurse staffing committee made of equal numbers of managers and direct care nurses. We did this, management passed these plans, and now they don’t want to follow them. This community can’t wait for OHA, we need this in our contract. If CMH executives intend to follow the letter of the law and our agreed upon staffing plans, why not just put it in the contract?

4. How does CMH’s turnover rate for nurses compare to other hospitals?

Some units have been impacted more by nurse turnover than others, but CMH’s total nurse turnover rate is good compared to other hospitals. In the past 12 months, 20 RNs left CMH. Of those, seven (or 35%) were relief/intermittent nurses. Here’s how we compare with averages among other hospitals over the past 12 months:

<table>
<thead>
<tr>
<th>Hospital Type/Location</th>
<th>Turnover Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia Memorial Hospital</td>
<td>13.2%</td>
</tr>
<tr>
<td>Medical Center/Acute Care*</td>
<td>13.4%</td>
</tr>
<tr>
<td>Other Non-Portland/Seattle/Puget Sound*</td>
<td>15.4%</td>
</tr>
<tr>
<td>National Average**</td>
<td>17.2%</td>
</tr>
</tbody>
</table>

*Source: 2019 Northwest Healthcare Compensation Survey

**Source: NSI Nursing Solutions 2019 National Health Care Retention & RN Staffing Report

**FALSE:** Losing 20 out of 135 RNs is almost 15 percent, not 13.2 percent. Additionally, losing 20 nurses at a very small hospital outside of a major metropolitan region is very difficult to overcome. Sadly, we are hearing from an increasing number of nurses who have applied for jobs elsewhere. Every week that we do not reach an agreement we risk losing more and more nurses. Trying to fill
open positions by convincing nurses to move away from Portland or other locations has been incredibly difficult when they can’t be guaranteed hours. Most hospitals only have 25 percent of their nurses at part-time status, while we have 75 percent at part-time. Part-time nurses lack economic security. If they aren’t guaranteed more set hours, they know they won’t be able to pay their bills and will not accept work at CMH. As a result, nurses in some units have been working incredibly stressful hours to make up for the lack of staff and inability to recruit replacements. Some nurses report hearing “good job!” and “here’s some pizza” as management’s response to the lack of staffing and nurses stepping up day after day to work non-stop shifts. We find management’s response shows a lack of compassion and how out of touch management is with this community. Pizza doesn’t make up for working 14 hours and coming back in during the middle of the night after four hours of sleep because there is no one else to call. A fair contract can help recruit more nurses!

5. What is CMH doing to recruit and retain nurses?

We have been actively planning and implementing several new processes to recruit and retain nursing staff. These include:

| Wages (proposed) | 4% wage increase for nurses upon ratification of the contract. Unfortunately, until nurses approve the contract including this raise, our ability to recruit nurses can be challenging because our hourly rates are currently lower than neighboring hospitals.  
**FALSE:** For 2019, management is only proposing effectively a 2 percent increase because they are refusing to pay wage increases that were due back in June. If management genuinely wanted to get these raises in place, they would guarantee safe staffing and protections for schedules. At this moment, CMH administration is refusing to meet with a federal mediator. Your bargaining team believes this is a stall tactic, so they will not have to pay us what we are due and keep more for themselves. |
| --- | --- |
| Tuition Support (proposed) | Increasing tuition reimbursement from $2,000/year to $4,000/year for nurses seeking their BSN.  
**FALSE:** While we would like to be excited about this and were willing to accept it, management already has a program that provides $2,000 a year that is not in our contract but is unclear how often they approve submitted reimbursements. Agreeing to provide a benefit that already exists is not a huge improvement. |
### Certification Differential (proposed)

Changing the flat certification bonus to an hourly differential. Nurses would receive a $1/hour differential for obtaining one or more approved national nursing certifications relevant to their current role.

**FALSE:** While this would be beneficial for some nurses, nurses who work fewer hours may see the total dollar amount of their certification compensation decrease.

### Float Process (proposed)

Improving the float process to assure competency so nurses can float to other units rather than being docked. We have proposed 3 levels of floating:

- Fill a CNA role, if there is a need that cannot be filled by a CNA.
- Partner with a unit nurse to share a patient load larger than what one nurse would typically take, but less than two whole assignments. The nurses would work together to assure safe patient care is provided.
- Take on a full patient load in another unit with proper orientation for some of the patient diagnoses cared for on that unit.

**FALSE:** This process is not appealing to potential recruits. Nurses are very passionate about the specialties they have focused on in their career. Focusing on floating does not help us recruit and retain nurses – it does quite the opposite.

### Affordable Health Insurance (current)

At the beginning of 2019, CMH reduced employee-paid health insurance premiums significantly for the high-deductible plan. Families on the plan pay just $100/month, which is an annual savings of more than $3,200 over 2018. They will also receive $1,500 in employer contributions to the HSA.

**FALSE:** Any plan that has a $10,000 deductible for families is completely unacceptable. It doesn’t matter what discount exists to get services at CMH when your child goes to Doernbecher’s and you are forced to pay $10,000 before CMH will pay anything. The health insurance at CMH is not acceptable and nothing to brag about. Perhaps for the highly paid CMH executives, a $10,000 deductible is not a big deal, but to working folks like us it can be financially devastating.
### High Deductible Health Plan/Health Savings Account (HDHP/HSA)

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>2018 employee-paid premiums</th>
<th>2019 employee-paid premiums</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$243.66/mo.</td>
<td>$50/mo.</td>
<td>$2,323.92/yr.</td>
</tr>
<tr>
<td>Family</td>
<td>$367.20/mo.</td>
<td>$100/mo.</td>
<td>$3,206.40/yr.</td>
</tr>
</tbody>
</table>

**Shift Length (current)**

In accordance with the Collective Bargaining Agreement, when a nurse wants to move from the traditional 8-hour shifts to a 12-hour shift schedule, and it is mutually agreed upon with the unit manager, nurses have been moving to 12-hour shifts. This has been a staff-satisfier for these nurses.

**FALSE:** After talking with our colleagues in Surgical Services, you will learn that the process for changing shift lengths is not a “staff-satisfier.” It is an utter failure. We need protections for the hours that part-time employees’ hours can be scheduled along with a doc cap as we face more attempts to change shift lengths as the hospital attempts many different structural changes to patient flows and hours of operation.

**Supporting Students (current)**

CMH is continually looking at our future workforce. Each year, we provide opportunities for nursing students to do their clinicals and preceptorship experience at the end of their program. We also work with high school students interested in the healthcare profession. This year, FBC hosted a summer intern who helped with administrative tasks and was able to see what nursing in Labor and Delivery is like by shadowing some of our nurses.

**FALSE:** Nursing students won’t accept jobs to work here because we can’t offer them dependable hours and guarantees on safe staffing.
| **Nurse Residency Program** *(developing)* | Starting in October, our new graduate nurses will be placed in a Nurse Residency Program. Nurses in the Residency will receive support for their first year of employment to help them transition to the practice of nursing. They’ll have a mentor and get additional time learning skills such as critical thinking, communication with team members, prioritization, and time management.  

**FALSE:** Even though this program has yet to start, we are skeptical that it will be as described. Just last week, three of our newer nurses were being pressured by management to take unsafe staffing loads. This type of behavior and the lack of protections in our contract does not support newer nurses. |
|---|---|
| **Supporting New Caregivers** *(developing)* | VP of Patient Care Services, Judy Geiger, will meet with newly hired nurses twice in their first year of employment to hear feedback on what is going well and what they would like to see improved at CMH.  

**FALSE:** Again, we are skeptical about this plan. Judy Geiger claiming to want feedback is disingenuous when the rest of management refuses to hear the feedback they have already received in letters, pickets, town hall, and from every nurse who has continued to call for a fair contract with protections for schedules, doc caps, and safe staffing. |
| **PNCC** *(developing)* | PNCC is being refreshed with a focus on collaborative projects between the Unit Based Nurse Practice Council Chairs and Nurse Managers using evidence-based practice to guide us.  

**FALSE:** When we do not have a fair contract, it makes it impossible for Unit Based Nurse Practice Councils (UBNPC) to collaborate in productive ways with nurse managers. |
| **Charge Nurse** *(developing)* | CMH is beginning work to strengthen the Charge Nurse role so that nurses have additional clinical and leadership support during their shift.  

**FALSE:** Charge nurses are faced with an increasingly difficult role when management is actively seeking to change hours of operation, violate the safe staffing law, and increase patient loads. |