Recruitment and retention is our top priority. We are dedicated to our mission to deliver excellent patient care in our community, and we know that we can best ensure great care when we recruit and retain quality staff. An overwhelming majority of us signed a petition to let the Multnomah County Health Department (MCHD) know our priorities. We’ve told our stories, attended meetings, and wore stickers at work to show our public unity. As the nurses on the frontline in our community, we know best what we need.

Management’s response has been, “show us data.” During our October 24 bargaining session, we did a presentation on data, and showed management that just throwing numbers around is not useful.

Data is not evidence. We walked MCHD’s team through a scientific perspective on data and demonstrated that the narratives of ONA members are the best data we have for answering the questions about how to better recruit and retain staff. See full data presentation on pages 3 & 4.

Other items in the presentation included:

- A systematic literature review recently published in a high impact peer-reviewed journal about the cost of nurse turnover. (see page 2).
- A way to estimate the true cost of NP/PA turnover (see pages 2 & 3).

**MCHD Package Counterproposal**

MCHD responded to our latest package with one of their own, with a bit of movement on some items, which included:

- A slight increase in vacation accrual for new hires
- Acknowledging that providing breaks is MCHD’s responsibility
- The 3.6 percentage COLA retroactive to July 1, 2018—paid out in a lump sum.
- Employees shall not be a step lower than where they would be as an incoming new hire
- Three-hour notice for all mandates

We are not there yet. MCHD still says they are not interested in addressing NP/PA workloads in the contract. They still want to give CHNs another market adjustment (moving everyone down the scale) right away. They still want to give Corrections nurses bonuses instead of increasing differentials. (More on that on page 2 & 3)

**Results of Corrections Health Survey**

Currently at Corrections Health, for every nurse hired, two are lost to resignation or transfer, which affects the morale of remaining staff. Vacant posts result in extra
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shifts and mandated overtime, which further negatively affects morale and increases the attrition rate.

Since recruitment and retention is the theme of our current ONA contract campaign, our bargaining team made Corrections Health a priority.

In order to address this, our bargaining team proposed changing the Corrections Nursing Premium from dollar amounts (currently $1.75 for CHNs, $3.00 for NP/PAs) to a percentage. The current proposal is a 17 percentage premium over the hourly rate, based on a national average of corrections nursing differentials.

In response, Multnomah County proposed giving Corrections Health Nurses two one-time bonuses:

- One year after ratifying the new contract, all Corrections Health nurses will receive $2,000. (Pro-rated for FTEs below .8 in latest proposal.)
- Three years after ratification, all nurses continuously working in Corrections Health will receive $3,000. (Pro-rated for FTEs below .8 in latest proposal.)

Corrections nurses were asked:

Do we accept the retention bonus that MCHD proposed? or Do we reject the bonus and fight for a higher premium?

Out of 38 responses (around 66 percentage of Corrections nurses) only one person wanted to accept the retention bonus.

They also responded to the following statements

**What is the true cost of nurse turnover?**

When asked, MCHD said they do not have estimates for turnover costs of nurses, and it is not reflected in the annual budget. We did more research to figure out an estimate, but the reality is, there is not a great deal of scientific literature on this topic anywhere. **We should ask why this isn’t studied more.**

We did find a systematic literature review recently published in a high impact peer-reviewed journal. In the scientific hierarchy of evidence, a systematic review is considered the sources of the most reliable information that we have.


The conclusions of the literature review were:

- Few studies have been done to answer the question of the economic cost of nurse turnover.
- The studies that have been done vary widely in the methods that were used and this makes it difficult to draw larger conclusions.
- The authors of the review showed that in all of the studies in which the economic cost of turnover was rigorously measured, there was a significant association between turnover and cost.
- For example, one of the largest studies included in the review found that the cost of turnover among RNs is estimated to be *at least* 120 percentage-130 percentage of their salary.

The authors concluded that all existing studies are likely to underestimate the true financial cost of turnover.

This was to show MCHD that with all their number crunching to show the cost of our proposals, there are many variables that are unknown to them. Moreover, we maintain that the biggest costs of turnover are non-financial. We think the non-financial costs of turnover to the community we serve is the most substantial component of all, and that’s why we demand a contract that addresses recruitment and retention.

**Estimates on cost of NP/PA turnover**

Based on data received from MCHD, NP/PA turnover is approximately twice the rate of aggregate for Health Department (24 percentage vs. 12.7 percentage).

- 30 NP’s quit in the past three years — that’s an
average of 10 a year.

♦ The turnover rate at Mid-County clinic alone is 34 percentage!

To our best estimation:

♦ The average NP/PA at 0.8 FTE generates $618,588 a year in revenue. (Billable encounters $261,468 + $357,120 in OHP APM monthly payments)

♦ The average cost of an NP/PA: $111,120 and year with salary and benefits

♦ Net: $507,468 per year per NP/PA

This means that NP/PA’s generate far more revenue than cost. The following items contribute to the cost of NP turnover:

♦ Recruiting and Training costs

♦ Lost revenue during time of vacancy

♦ Lost revenue as new-hire NP is less productive in first year

Each month an NP/PA position is vacant, the County does not generate billable encounters, although they have the facilities/support staff in place.

♦ Average time of vacancy for NP/PA is 187 days (around 6 months)

♦ Our estimation is that the average monthly billable revenue is $21,789*

♦ $21,789 x 6 Months = $130,734

♦ Subtract a half year’s average salary: $55,560 (salary/benefits)

♦ This would mean a potential loss of $75,174 in revenue

*Average of 4 experienced NP’s at Rockwood Clinic, which has an insured rate close to MCHD average

Another factor is that experienced providers see more patients, use higher billing codes, and do more procedures.

We attempted to estimate, based on revenue reports, the difference in productivity between average experienced provider vs. inexperienced new-hire:

♦ $261,000 (experienced)

♦ $135,200 (new hire)

♦ Which means a potential loss of $125,800 in revenue

Add up the estimates:

♦ Lost revenue during time of vacancy: $75,174

♦ Lost revenue as new-hire NP is less productive in first year: $125,800

♦ This means our estimated cost of an NP departure is: $200,974

♦ Multiply that by the average of 10 a year: $2,009,740!!

Our best estimation, using the data we have available, is that NP turnover may cost MCHD over TWO MILLION DOLLARS a year.

As shown in the literature review, we can’t know the true cost of turnover. This is a estimation of what the costs may be and it’s likely that these numbers are an underestimation.

“Show me the data”

Here is the scientific perspective of data that we presented to MCHD.

Data is information gathered in a consistent and reliable way and presented as either:

♦ Quantitative: numbers

♦ Qualitative: words

Both kinds of data are valid and necessary, and different kinds of data are needed to answer different kinds of questions.

Since we can’t answer most questions with 100 percentage certainty, we have to find the best answer, and that means:

♦ It should come from a sample that is representative of the population you are studying.

♦ It should be appropriate for the state of knowledge in the field you are working in, appropriate for the inferences you are trying to make, and from the standpoint of the stakeholders you are making inferences about.

Example:

If a drug company wanted to show that a drug worked, they could test it in a different population that they knew it would work for. The data they got would be “good data” but not the “right data” to answer this question. Thus, data is only as good as it’s fit for the question you
In order to know how drug X will affect people with heart disease, you need to study the drug in people with heart disease.

If you try to make a prediction about drug X by studying it in people with cancer, the data you get will not tell you anything about heart disease.

This is the problem of transferability and has been responsible for all kinds of problems.

There is also an issue of representation.

It is very dangerous to make inferences about one population based on data from another.

Financially and politically powerful entities like pharmaceutical companies, political parties, large employers, etc. do this all the time.

It is always possible to find some data to show what you want to predict, often that means using data that is not appropriate for the population you are working with.

Example:

For a long time, “evidence-based” drugs and medical procedures developed to treat cardiovascular disease have been used the same way for men and women of all different ethnic backgrounds. Unfortunately, the evidence for the efficacy of these drugs and procedures was derived from samples made up almost entirely of white men. It was good data, and good evidence for white men, but these data were not transferable to women and some people of color, who can have differences in physiology, culture, and behavior which impact the efficacy of these interventions.

Understanding state of knowledge is also critical.

For instance, the state of knowledge about community-based nursing labor is very limited. There is very little research done in this population.

In cases like these, qualitative methods, like interviews and open-ended questioning and simple quantitative methods like surveys are far more powerful than complex large-scale measurement.

Until the state of knowledge has progressed to a certain point of consensus, reliable measurements cannot be made because we do not know what variables are important.

Inferences are what we do with data.

Raw data are not useful until we analyze them to make inferences.

Complex inferences about human behavior, such as “why are so many nurses quitting their jobs at this institution?” need to be answered using multiple sources of data.

The most important data always comes from the standpoint of the stakeholders you are making inferences about.

If you want to know why nurses are leaving their jobs at a particular institution, the best data comes directly from nurses at that institution.

As much as possible, this information should be generated by, with, and for the stakeholders about which inferences are made.

The purpose of fleshing all this out is because MCHD has thrown a lot of numbers at us, and in turn say they need more data from us before considering our proposals. But we have posited that the narratives of ONA nurses at MCHD are the best data we have right now, like why are so many employees dissatisfied and what would need to change to keep them. Our narratives can yield predictive inferences about the efficacy of the changes we are proposing to our contract.

We are union nurses, we stand united to advocate for better patient care. As nurses working on the front lines of community health every day, we already know we can better recruit and retain nurses if we meet these priorities:

- Better Wages
- Great Health Insurance
- Higher Differentials for Corrections Nurses
- Addressing NP/PA Workload Issues
- More Vacation Accrual
- Better Inclement Weather Language
- Enabling Nurses to Work up to their Full Scope of Practice

Our next bargaining session is November 8.