We open our letter to you, our members, to say thank you for your patience while waiting for this update. We wanted to make sure we had a clean version of the tentative agreement (TA) for you to see along with our summary and recommendation here.

It took a few weeks and there were some unanticipated delays, but the end result is a clean version of our contract we feel is solid for a vote.

After another long day at the table on May 2, we arrived at a TA on our contract! The greatest challenge of the day was the mandatory day off (MDO) cap. The hospital was not able to offer us a cap that we felt met our needs for limiting MDO in the units that are hit hard (ICU, Birthplace, and to some extent OR). We agreed that the hospital has a responsibility to curb the MDO burden across the hospital and we had a lot of discussion about the strategies outside of an MDO cap the hospital has at its disposal.

There are several factors that affect the units that experience high levels of MDO; core staffing that exceeds census or cases, the drop in the national birth rate, and the process for admitting patients who need intensive care all contribute to increased MDO. In order to avoid layoffs, the hospital made it clear they want to spend the next year looking at core staffing and gather data on MDO in the process.

We both agreed that layoffs are not the route anyone wants in order to tackle the problems around MDO, so we worked toward a cap that would work. The MDO cap proposed by the hospital was no more than 24 hours in a 4-week scheduling period but no annual cap. This amounts to a shift per pay period and 312 hours annually; this is the amount of MDO sustained by the nurses in the units who are hurting and we felt this fell short of a cap that would meet our needs. Their proposal also did not count voluntary low census hours or hours spent floating out as “helping hands” toward the MDO cap. Without these two contingencies, we felt their MDO cap proposal was not a sufficient remedy and could not agree to it.

We didn’t want our commitment to addressing this problem to be lost, so both parties agreed to continue our work on an MDO cap through an MOU over the next year. The hospital has committed to gathering data on voluntary versus mandatory low census and helping hands utilization in order for both sides to come together and design an MDO cap that works for everyone.

Here is an overview of the TAs we made with the greatest impact:

**Article 3 - Definitions**

Agreed to a charge definition that is accurate for the current role and responsibilities. Agreed to a resource nurse definition with language based on job as set forth in the original MOU, and kept the sign-on bonus.

**Article 8—Management Rights**

Included language that states “determining staffing requirements” is “in accordance with the Oregon Nurse Staffing Laws.” This adds strength to our contract to ensure the hospital adheres to the Oregon nurse staffing laws.

**Article 11—Wages, Overtime, and Other Economic Items**

We agreed to keep original language for reporting time for call back—45 minutes (30 minutes for surgical services). This was a big win for the birthplace nurses who the hospital wanted to include in the 30-minute reporting time.

There were many disappointments in this article. We were not able to get agreement on separating call-back time from over time premiums. The hospital continues contract after contract to push back on this. We fought hard for both a resource nurse (RRN) differential and a resuscitation nurse (R-nurse) differential. The hospital pushed back repeatedly on
the RRN differential, stating the wages they earn includes consideration for the education and competency validation requirements. While they were not willing to recognize the increased responsibility and training requirements for the R-nurse through a differential, the hospital did propose a $500 sign-on bonus for the R-nurses who are currently in the role and to extend that bonus to anyone who is designated as an R-nurse for the duration of the contract. We agreed to this proposal.

In the end, we did get increases in these differentials:

- Standby call rate: $4.75
- Core charge diff. to $3.50
- Relief charge diff. to $2.50
- Preceptor diff. to $2.15

**Article 12—Basic Medical/Dental Coverage**

Includes EPO plan as the third plan option in connection with HMO plan if included.

**Article 14—Hours of Work and Scheduling**

Introduction of the staffing committee section in 14.3. This adds strength to our contract to ensure the hospital adheres to the Oregon nurse staffing laws. Incorporation of more specific rest and meal breaks language MOU from the grievance agreement. Includes that management partners with a bargaining nurse on unit scheduling.

**Article 19—Seniority**

New hires can float out as helping hands at four months if full-time and six months if part-time.

**Article 21—Paid Time Off**

We worked toward creating more transparency and clarity on 21.3 through 21.6 for time off request procedures. We also agreed to unit-level holiday scheduling practices that aim for creating equity and the ability to plan ahead.

The agreement made at Providence Portland Medical Center (PPMC) regarding extended illness time (EIT), paid time off (PTO) accrual, and the short-term disability insurance (STDI) was hard fought. While we would have liked to have greater increases in PTO accrual rates, we are tied to the agreements made through PPMC.

Here is a summary of those agreements:

- STDI as proposed by Employer
- RNs keep and use accrued amount through December 31, 2021 (top up or otherwise).
- Between January 1, 2020 and December 31, 2021:
  - Use EIT as it currently exists for absences shorter than 7 days
  - For absences longer than 7 days, use EIT for scheduled shifts missed during the 7-calendar day waiting period for short term disability benefits (regardless of whether STDI is approved or denied)
  - Use for approved OFLA/FMLA to care for a family member after the 24 hour elimination period.

- PTO accrual rates:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Current Accrual Rate—before April 19, 2011</th>
<th>Current Accrual Rate—after April 19, 2011</th>
<th>New Accrual Rate 2019-2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 years</td>
<td>0.09231</td>
<td>0.0924</td>
<td>0.1004</td>
</tr>
<tr>
<td>3 to less than 5 years (NEW)</td>
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<td>---</td>
<td>0.1122</td>
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<td>0.1197</td>
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<tr>
<td>15 or more years</td>
<td>0.13461</td>
<td>---</td>
<td>0.1389</td>
</tr>
</tbody>
</table>

continued on page 3
Tentative Agreement (continued from page 2)

Article 24—Employment Status
Disciplinary action will be removed from a nurse’s file after four years after consideration by the CNO and HR.

Article 28—Duration
Three-year contract that expires December 2021. This way the concerns with MDO, PTO, EIT, and wages can be addressed sooner than later (hospital had proposed a four-year contract). This also puts us on track to bargain along with Providence St. Vincent Medical Center (PSVMC) and Providence Milwaukie Hospital (PMH).

Appendix A
- Jan 1, 2019 — 2.75%
- Jan 1, 2020 — 2.5%
- Jan 1, 2021 — 2.5%
- Evening shift to $2.65
- Night shift to $5.85
- Certification to $2.50
- Extra shift at $15.50
- Weekend $1.35 (current), due to agreement on agreed upon weekend duration to be from Friday at 1500 to Monday at 0600.
- Shift differential is paid out for PTO taken out for MDO.
- Shift differential is paid out for hours scheduled not worked.
- CCRN certification for PACU.

Appendix B
- Incorporation of more granular breakdown of call-off order.
- Incorporation of language for alterations in call-off order:
  ◦ Specify “specialty nurse” language.
  ◦ Incorporates helping hands algorithm.
- Drop MDO cap and agree to work on an MDO cap through detailed MOU through an appointed work group; PWF to collect data on volunteer versus mandatory low census and helping hands utilization over the next year (May 2019 – May 2020) and any data collection that is pertinent to the work group (see MDO MOU at the end of the contract).

We appreciate everyone’s support and encouragement during this negotiation cycle. Your bargaining team set the record for longest time at the bargaining table—85.5 hours! This beat out 84 hours for our first contract with Providence in 2011. We know how much having a strong contract means to all of you—it’s important to us that we be your voice at the table!

RECOMMEND: VOTE YES
Your bargaining team recommends you vote YES on this contract. We feel strong that we did our best on a tough negotiation and came to a fair agreement on the issues that mattered most to you.

You can access the full redline TA on the ONA/PWFMC website at: www.OregonRN.org/99.

Voting information is on page 4 of this update.
Staffing Education & Advocacy Training

Have you recently been elected to your hospital’s staffing committee or do you desire to be a more prepared and effective staffing advocate? If so, we encourage you to take a SEAT with ONA for our online Staffing Education & Advocacy Training (SEAT). This is the only comprehensive staffing law training in Oregon and is available online through our OCEAN platform. It is available 24/7 and can be taken at your own pace. It is free for ONA members and available to non-members at a discounted price.

Nurses can earn 2.25 continuing nursing education contact hours for completion of the entire SEAT series.

Visit www.OregonRN.org/OnlineCE to get started.

VOTE TO RATIFY THE NEW TA

ONLINE:
- Opens - Monday, June 3 at 0000
- Closes - Friday, June 7 at 2359
- A link to vote will be sent to your email address on file with ONA when the vote opens

IN-PERSON:
- Thursday, June 6 1030-1600, Conference Room 2 at PWFMC
- A printed copy of the TA redline will be available at the in-person vote

Review the TA redline online on the ONA/PWFMC website at: www.OregonRN.org/99

Part 1: Oregon’s Nurse Staffing Law
Part 2: How to Write a Better Nurse Staffing Committee Charter
Part 3: How to Write a Better Staffing Plan
Part 4: Staffing Committee Orientation

Oregon Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.