AGREEMENT BY AND BETWEEN

OREGON NURSES ASSOCIATION

AND

ASANTE ROGUE REGIONAL MEDICAL CENTER

OCTOBER 1st, 2023 through October 1st, 2026

Note: This contract is effective the first full pay period starting after ratification, except as otherwise noted. All wage and benefit increases are effective the first full pay period of the month referenced.
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AGREEMENT BY AND BETWEEN
ASANTE ROGUE REGIONAL MEDICAL CENTER
AND
OREGON NURSES ASSOCIATION, INC.

PREAMBLE

THIS EMPLOYMENT AGREEMENT is made by and between ASANTE ROGUE REGIONAL MEDICAL CENTER (ARRMC), hereinafter the "Hospital," "ARRMC," and/or "Facility," and the OREGON NURSES ASSOCIATION (ONA), hereinafter the "Association" and/or the "ONA."

This Agreement will be effective, except as otherwise indicated.

For, and in consideration of, the mutual covenants and undertakings herein contained, Hospital and Association do hereby agree as follows:
ARTICLE 1 – RECOGNITION AND DEFINITIONS

1.1 Recognition: ARRMC recognizes the Association as the exclusive bargaining representative with respect to the rates of pay, hours of pay, hours of work and working conditions. The bargaining unit is composed of all registered nurses employed by ARRMC who are providing direct patient care duties in the Hospital, including charge nurses and staff RNs who also have educational responsibilities, or Hospice Services, excluding supervisors, and educator RNs while working solely in an educator code.

1.2 Definitions:

A. Nurse: A Registered professional Nurse (RN) currently licensed to practice professional nursing in Oregon. (For the remainder of this document, “RN” and “Nurses” will be synonymous in reference to this definition.)

B. New Hire/Probationary Nurse: A nurse will be on probationary status for six months from the date of hire as a nurse. The purpose of the probationary period is for the Hospital to determine if the employee can satisfy the Hospital’s performance expectations in all areas of skill, knowledge, work ethic and all other aspects of quality patient care. The probationary period of a nurse may be extended by the Association, the nurse, and the Hospital up to sixty (60) additional days.

C. Flexible Status Nurse: The following designations define a Flexible Status employee:

1. Temporary: A nurse working as an interim replacement or on a temporary work schedule.

2. On-Call: A nurse assigned on a recurring basis as needed, with no fixed schedule.

3. Bid: A nurse who has successfully bid one or more positions with regularly scheduled hours between .1 and .5 FTE per pay period.

Flexible status RNs will sign up with the individual unit schedulers or the Staffing office to
cover Regular RNs’ pre-planned ETO/ESDP requests or other pre-planned absences such as jury duty, FMLA leave, educational leave, etc., as well as urgent unexpected staffing needs. Flexible status RNs’ availability is to the Hospital. It is acceptable for regular staff RNs to request that a Flexible status RN work for them, to cover for shifts where the regular status RN has been denied ETO or educational leave due to staffing issues, pursuant to Article 9.7.R procedures.

Flexible status RNs will work in direct patient care a minimum of 96 hours each calendar quarter, on shifts designed by Hospital schedulers subject to Clinical Managers' discretion to decide on some lower minimum hours requirement (as measured over two (2) consecutive calendar quarters). The Hospital also may modify this requirement in individual circumstances, for example, when an RN meets competency requirements in other ways than ARRMC work, or when the RN is eligible for full social security benefits only if he or she works fewer hours. The goal is to assure Flexible RNs have core competencies, not to enforce a rigid ninety-six (96) hour per quarter work requirement in all situations. This may will include at least one weekend shift per four-week period and one major Hospital holiday a year as defined in Article 10.1 of the Agreement. Each Flexible status RN will be assigned a primary nursing unit on which the RN will normally be scheduled.

Flexible status Bid RNs will be scheduled time off per ETO-type approval process.

D. Clinical Resource Nurse: An RN required to float to a work unit where they are not adequately educated or oriented.

E. Nursing Resource Team Nurse: A nurse assigned to the Nursing Resource Team, which is a team of nurses dedicated to a service line and routinely assigned to work in the various units within that service line.

F. Critical Care Outreach Nurse: A nurse who acts as a clinical resource to the health care team to assist with high risk patients and promote optimal patient outcomes. The Hospital will make every effort to maintain the Critical Care Outreach Nurses in their regular assignment, unless there is an emergency that will compromise patient outcome or on a voluntary basis.
G. **Regular Status Nurse:** A nurse who is hired into one of the following:

1. **Full-time Nurse:** Any nurse hired to work forty (40) hours every workweek or eighty (80) hours per fourteen (14) day pay period on a regularly scheduled basis (1.0 FTE). A nurse regularly scheduled to work three (3) twelve (12) hour shifts in a workweek or seventy-two (72) hours per fourteen (14) day pay period will also be regarded as full-time (0.9 FTE).

   An RN will be considered full-time if they successfully bids one or more positions with regularly scheduled hours which total at least 0.9 FTE (72-hours) per pay period.

   This applies even if one position is non-bargaining unit, for example, educators.

2. **Part-time Nurse:** Any nurse hired to work twenty (20) or more hours every workweek or forty (40) hours per fourteen (14) day pay period on a regularly scheduled basis.

   An RN will be considered part-time if they successfully bids one or more positions with regularly scheduled hours which total at least 0.5, but less than 0.9 FTE (forty (40) to seventy-one (71) hours) per pay period.

   This applies even if one position is non-bargaining unit, for example, educator.

3. **Variable Days Coverage Nurse:** A Regular Status nurse who has bid into a variable pattern of days schedule on a specific unit and shift. Such positions will be limited to the number needed to cover predicted absences on the unit.

   Such positions will not be used to permanently replace core staff however they will be counted as core positions for the purpose of fair and equitable rotation for call off and floating.

4. **Voluntary Hours Reduction:** ARRM will consider requests for nurses to reduce FTE to accommodate an incumbent RN’s desire for lesser hours. The
requesting nurse will first meet with the clinical manager and request such reduction in hours. A committee of one Association appointed representative and one Hospital-appointed representative will facilitate consideration of such transitions and propose creative solutions if the RN and their clinical manager cannot agree. This procedure will not be subject to the grievance and arbitration process.

H. **The Workweek:** The workweek begins as of 7:00 a.m. on Sunday of each week.

I. **The Workday:** The workday will be defined as the twenty-four (24) hour period commencing with the time the nurse first reports for work.

J. **Hourly Rate:** Base pay plus all differentials.

K. **Operating Room Team Leader:** An Operating Room (OR) nurse, assigned by the OR clinical manager, who coordinates the surgical activities for one of the following specialty surgical areas, including but not limited to: ENT/Plastics, Neurology/Podiatry, Orthopedics, Cardio-thoracic, Urology/GYN, and General-Vascular. OR team leaders do not carry twenty-four (24) hour responsibility.

L. **Continuous/Service Employment:** All nurses in the bargaining unit will be considered continuously employed from the most recent date of hire as a nurse in the bargaining unit.

M. **Charge Nurse:** A bargaining unit nurse designated or appointed to assist the clinical manager in the operation of a nursing unit, but who does not carry 24-hour responsibility for the unit in the absence of the clinical manager.

An RN will not be regularly assigned charge nurse duties or continue in charge nurse status involuntarily, unless no other qualified RN is available or willing to perform such duties. ARRM&C retains the sole right to select charge nurses. Once selected, a nurse will not be removed from a charge nurse position without advance notice of, and opportunity to correct, perceived performance failings. Charge nurses will be removed from such positions for failure to meet the charge nurse job requirements.
only, but such removal will not itself be considered discipline.

N. **Organized Nursing Unit:** As designated by ARRMC, will have a clinical manager or charge nurse on each shift, except where the Hospital determines such staffing is not required.

O. **Compensable Hours:** All hours for which the nurse is paid by the Hospital excluding standby hours not worked only.

P. **Seniority:** Seniority is the total length of continuous service/ employment of any nurse, from his/her date of hire as a nurse in the bargaining unit, as measured by hours compensated and months worked.

**Guidelines are as follows:**

1. Each nursing unit will have an updated seniority list for the nurses in that established unit every six (6) months, which is to be kept in a convenient location for nurses in the unit to refer to.

2. Seniority is based on total months of service for all bargaining unit nurses employed at ARRMC/Facility. Bargaining unit seniority, not Facility or departmental seniority, will be used in all instances where seniority is applicable under this Agreement (except if this Agreement specifically provides to the contrary).

3. Eighty-six (86) compensated hours equals one month’s seniority accrual. This figure is established in recognition of a part-time minimum regular work schedule. Additional compensated time such as scheduling, education, and overtime will count for seniority accrual purposes.

4. Non-Workers’ Compensation leaves of absence of up to twelve (12) weeks will count towards hours worked.

5. Workers’ Compensation and military leaves will count towards seniority in
accordance with law.

6. A nurse will accrue no more than twelve (12) months’ seniority per calendar year.

A printout of nurse seniority will be placed in Human Resources and the staffing office. These lists will be updated annually by July 1. Absent protest by September 1, the list will be considered final and accurate.

Q. Preceptor/Mentor: 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 transferee to a unit; or to mentor student nurses in a recognized integrative practicum. Where possible, preceptors/mentors will be assigned a reduced patient load.

R. Care Partner Nurse: A nurse who is a regular staff member on the unit who is able to demonstrate clinical competency for a specific patient population. The Care Partner Nurse will make themselves available to the CRN or Float nurse throughout the shift to assist with patient care and/or answer questions as needed.

S. Hospice Case Manager: The Hospice Case Manager is a bargaining unit nurse that is designated as the coordinator of the plan of care. The Hospice Case Manager is a core member of the Interdisciplinary Group (IDG), develops the plan of care, coordinates with other disciplines and members of the IDG, implements interventions, and evaluates the patient/family outcomes.

T. Travel/Agency: A nurse employed as an interim replacement or for temporary work on a predetermined basis whose employment does not extend beyond twelve (12) cumulative months per eighteen (18) month period.

- Travel/Agency RNs who work beyond twelve (12) cumulative months per eighteen (18) month period providing direct patient care duties in the Hospital will be required to accept a staff position and will be held to the membership of collective agreement.
• This provision will not apply to International Nurses.

• The number of international nurses shall not exceed the equivalent of 10% of the total of the collective bargaining unit.

• Upon request, the Medical Center will provide a list of nurses working in a temporary capacity beyond six months, as well as the unit/department in which they are working.
ARTICLE 2 – NONDISCRIMINATION

2.1 Nondiscrimination Generally: In accordance with state or federal law, ARRMC and the Association will not discriminate against nurses because of race, religion, color, sex, age, national origin, marital status, sexual orientation, gender identity, or physical or mental disability as defined by law. An RN’s personal lifestyle choices, which have no work-related consequences, are not grounds for Hospital decisions relating to employment, and ARRMC will not discriminate against RNs on the basis of such choices.

2.2 Disability and Reasonable Accommodation. It is recognized that the Association and ARRMC are each obligated to comply with the Americans With Disabilities Act, and to provide the protections granted in that Act to disabled employees. The employer, the Association, and affected RNs will jointly discuss reasonable accommodation and/or disability discrimination issue and attempt to resolve them amicably, whenever contractual provisions are involved in a particular situation. Whenever an RN’s medical condition or medical fitness to work is in question for any purpose under this Agreement, ARRMC may request an independent medical examination at its own expense.
ARTICLE 3 – ASSOCIATION

3.1 Association Membership Generally: ARRMC recognizes the right of any nurse to become a member of the Association and will not discourage, discriminate or in any way interfere with the right of any nurse to become and remain a member of the Association. The Association recognizes the right of any nurse to refrain from becoming a member of the Association as provided hereunder, and the Association will not discriminate on account of the exercise of such right.

3.2 Association Membership or Fair Share Payments: Nurses who, as of June 30, 1999, are members of the Association and those paying a "fair share" fee to the Association in lieu of dues will continue to do so as a condition of employment.

Nurses hired on or after July 1, 1999, will join the Association or pay a "fair share" to the Association in lieu of dues as a condition of employment.

Nurses who as of June 30, 1999, are not members of the Association or who do not pay a "fair share" fee to the Association in lieu of dues will not be required to join or pay a "fair share" fee; however, those nurses who do join or elect to pay a "fair share" fee to the Association in lieu of dues will thereafter maintain that status as a condition of employment.

A. Notification to New Hire Employees: New Hire RNs will acknowledge in writing the receipt of information regarding Association membership options and designate their choice in writing no later than the 31st day after the date of hire. The Association, upon request, may inspect such documents. Hospital officials will provide information to new hires and applicants about Association membership options in a neutral manner, without attempting to influence a nurse’s choice. Hospital officials shall will explain in writing and have the new hire nurses sign a statement of agreement/acknowledgement of their obligation to fulfill and maintain one of the options presented to them as a condition of employment at ARRMC. One copy of this statement shall will be placed in the personnel file of the nurse and a copy sent to the Association.

B. Termination Clause: If a nurse required to maintain Association membership or
1 fair share payments is in non-compliance, the Association will notify the nurse in
2 writing that he/she is delinquent in the satisfaction of his/her obligations and
3 provide a copy of this notice to the Hospital. The Association will allow the
delinquent nurse thirty (30) calendar days to come into compliance. If the nurse
remains delinquent, termination from employment by the Hospital will occur
within seven (7) calendar days.

3.3 **Charitable Payments in Lieu of Full Membership/Fair Share:** A nurse who is a
member of and adherent to teachings of a bona fide religion, body or sect which has
historically held conscientious objection to joining or supporting a labor organization, or
an RN who does not desire to join or pay fair share for personal reasons, will not be
required to join or financially support the Association, but will in lieu of such financial
support pay sums equal to “fair share” dues to Asante Foundation to the ONA
scholarship fund for Registered Nurses, founded to develop and support RN students
and new grads, or to the Children’s Miracle Network and will provide the Association with
proof of payment on request. Funds collected by the Asante Foundation as a "fair-share"
payment will be used to establish an educational fund for Registered Nurses employed
by Asante Rogue Regional Medical Center. In the event this class of exemption will at
any time be interpreted by any court or government agency of competent jurisdiction,
such interpretation will be controlling in the application of this exemption.

3.4 **Collection:** ARRMC will deduct Association membership dues, “fair share” dues, ONA
Scholarship Fund Asante Foundation contributions, or Children’s Miracle Network
contributions from the wages of each nurse who voluntarily agrees to such deductions
and who submits an appropriately written authorization.

New hire RNs who elect such automatic deductions will have appropriate deductions
made beginning the first pay period of the month following the first full month of
employment and continuing thereafter. The Association will inform the Hospital each
year of the amount of monthly dues and fair share contributions. The Hospital will remit
the aggregate deduction monthly, together with an itemized statement of all RNs and all
deductions, to the Association and to the ARRMC Association chair.

3.5 **Information to the Association:** The Hospital will provide the unit chairperson and the
Association written notice within fourteen (14) calendar days of the nurse’s first day on
the job, specifying: name, unit of initial assignment, shift assignment, address, and
telephone numbers. Within thirty (30) days after the execution date of this Agreement,
ARRMC will provide the bargaining unit membership chairperson with a master list of
covered nurses showing the nurse’s name, address, and date of continuous
employment.
ARRMC will provide an updated quarterly list, to the bargaining unit chairperson, the
bargaining unit membership chairperson, and to the Association, of all bargaining unit
RNs which indicates his/her current unit and shift, address, and telephone numbers.
This list will also indicate new hires, retirees, voluntary resignations, terminations and
code changes of RNs subsequent to the prior list. The list will be delivered during the
first weeks of October, January, April and July of each year.
ARRMC agrees to provide to the designated Association representative, on a monthly
basis, in an Excel spreadsheet, the full names, address (street name and number, city, state, and zip code), phone number, full-time equivalency (FTE), unique employee identifier, primary shift and unit, seniority date, and termination date, if any.

A nurse must notify the Association Member Services Department, in
writing, of any desire to change membership status or membership option at the following email, phone number and/or physical address:

Member Services Department
Phone: 503-293-0011
Email: memberservices@oregonrn.org

Oregon Nurses Association
18765 SW Boones Ferry Road, Suite 200
Tualatin, OR 97062
Attn: Membership Services Coordinator

If the bargaining unit nurse has elected a payroll deduction option, the Association will
notify the Hospital of the change to begin deducting the proper amount for changed
membership options.
3.6 **Association Access/Meetings at the Hospital:** The Association may hold bargaining unit meetings in the Facility to deal with matters related to the administration of this Agreement by scheduling such meetings with the appropriate scheduling office at mutually agreeable times and places. The Association will give ARRMC reasonable advance notice of scheduled Association meetings at the Facility. Normally such meetings will not be conducted in nursing unit lunchrooms or break rooms.

1. **Association Representative:** The Association will inform the Medical Center as to its official representative for purposes of representation. The parties acknowledge their respective obligations under the National Labor Relations Act to negotiate with one another only through official representatives.

2. **Access to Premises:** Without interrupting normal Hospital work and patient care routine, the duly authorized representative of the Association shall be permitted at reasonable times with prior written or emailed notice to the Director of Employee Relations to enter the facilities operated by the Hospital for the purposes of administering this Agreement and observing conditions under which bargaining unit nurses are employed.

Effective May 28, 2008, the Association may place easels with signs indicating the location of ONA meetings and activities at the Hospital, at the Hospital entry points and at meeting locations.

3.6.7 **Association Bulletin Boards:** The Hospital will provide a 20x20 inch, visible and accessible Association Bulletin Board: (1) in each unit break room and/or common area as mutually agreed between the Vice President for Nursing or designee and the unit representative chairperson; (2) inside third floor nursing complex; (3) in the employee cafeteria (36x36 inch). Posted Association communications will be confined to Association Bulletin Boards only, and only Association postings will be put on these boards.

3.7.3.8 **Association and PNCC Mailbox:** ARRMC will place a lockable mailbox affixed to the wall in the employee cafeteria, for Association correspondence and PNCC communications. (Keys to be provided to the Association chairperson.)
3.83.9 **Association New Hire Orientation:** The Association membership representative will have up to thirty (30) minutes to meet with newly hired RNs during weekly orientation at a mutually agreed day and time. ARRMC will announce that an Association representative will be available during the paid orientation for thirty (30) minutes to address the RNs and to respond to questions about the Association and that RN attendance is required. The Association representative(s) will not be paid for time spent in the Association’s informational meeting. New hire RNs who choose to attend will be paid for thirty (30) minutes. *If orientation is done virtually, the ONA presentation will be at a mutually agreed upon day and time.* ARRMC will provide the Association membership representative advance notice if there is no new hire RN at a particular orientation session. In addition, ARRMC will place an Association prepared information sheet in the new hire information package it hands out to new hire bargaining unit RNs prior to each orientation. The Association will also be given a thirty (30) minute time slot just prior to the lunch break at the Hospital New Grad orientation dates on day one (1) of the mandatory orientation schedule.

3.9 **New Non-Bargaining Position Postings Requiring RN License:** ARRMC will provide the Association with written notice of new non-bargaining unit position job titles or codes, and the new job description, for which an RN license is required. Such notice will be given at least fourteen (14) days before the new position is posted.
ARTICLE 4 – NEGOTIATIONS/CONTRACT TERM AND RETAINED RIGHTS

4.1 Retained Rights. ARRMC retains all of the rights, powers and authorities exercised or had by it prior to the execution of this Agreement, except as expressly limited by a specific provision of this Agreement.

It is agreed that the operation of the Hospital and the direction of the nurses, including the making and enacting of rules to assure orderly, safe and efficient operation; the right to hire, to transfer, to promote, to demote; to establish, discontinue or modify either non-contractual past practices or work rules (after full negotiations with the Association on changes in mandatory subjects); to set work schedules and staffing levels (not including changes in overtime status under Article 6.5); and to lay off for lack of work are rights vested exclusively to ARRMC and are subject to its sole discretion except as abridged by this Agreement. The above listing is not all-inclusive but indicates the types of matters which belong to or are inherent to management.

Such “full negotiations” on mandatory subjects shall occur for a maximum of thirty (30) calendar days from the first meeting of the parties, after which the Hospital will be entitled to implement the change in question as it may be modified after such negotiations.

The grievance procedure, Article 17, is available for the Association to challenge any ARRMC policy. The Association may challenge any such policy in arbitration through Article 18 as being in violation of the contract, as being unfairly, inconsistently, or improperly applied, or for other valid reason as determined by the arbitrator but will not challenge in arbitration any ARRMC policy on the sole grounds that different content is preferred.

It is the responsibility of each nurse to renew their license before it expires. ARRMC may discipline a nurse that fails to renew their license before it expires. Prior to disciplining such a nurse, ARRMC will consider all mitigating factors to determine whether discipline is appropriate and the level of discipline that may be appropriate. Nurses who timely renew their licenses will not be subject to discipline and will be allowed to work even if their license is “active pending.” Such nurses will be required to notify their managers once their status changes (for example, changing from “active pending” to “active”).
Notwithstanding the foregoing, the Hospital generally will provide reminders to nurses regarding the status of their license through its automated system, with the understanding that a failure of the automatic system does not impact a nurse’s responsibility for his/her license renewal.

4.2 Entire Agreement. This Agreement constitutes the entire Agreement and understanding arrived at by the parties after negotiations. During said negotiations which resulted in this Agreement, the Association and ARRMC had the unlimited right and opportunity to make demands and proposals with respect to all proper subjects of collective bargaining.

The final resolution of pay practice disputes under the 2002-2005 contract will continue during this renewal contract.

4.3 Substance Abuse Policy. ARRMC will not develop, modify, or implement a substance abuse policy that violates the terms and conditions of the contract. The Association will meet with ARRMC administrative officials to determine mutually agreeable amendments to the current policy, subject to the procedure outlined in Article 4.1 hereof. The policy and any changes thereto will be applicable to all ARRMC employees.
ARTICLE 5 – AMICABLE RELATIONS DURING CONTRACT TERM

In view of the importance of the operation of the Hospital facility to the health and welfare of the community, ARRMC and the Association agree that there will be no picketing, strikes, or other interruptions of work by the Association or nurses either department-wide or ARRMC-wide during the term of this Agreement. There will be no lockouts by ARRMC during the term of this Agreement.
ARTICLE 6 – HOURS OF WORK

6.1 Weekend Schedules: Nurses will be granted at least every other weekend off. This requirement may be waived on the request of an individual nurse and with the agreement of the nurse's supervisor. Such request for waiver will be in writing and will indicate the time period in which such waiver will be in effect. ARRMC will furnish a copy of such written waiver to the nurse representative designated by the Association for such purpose. A nurse who works on a non-scheduled weekend at the request of management will be paid at one and one-half (1 ½) times the nurse's regular rate of pay for all weekend hours worked. Flexible status RNs will also be eligible for consecutive weekend premiums. This premium rate will not apply to nurses whose weekend work results from a waiver or from a schedule change requested by a nurse who has traded a scheduled weekend with another nurse.

6.2 Meal Break: Each shift worked by a nurse will include one one-half hour meal break on the nurse's own time at a site away from the nurse's work unit if the nurse prefers. The meal break will be as near as practically possible to the middle of the shift.

If an RN misses a meal period, that time (thirty (30) minutes) will be paid as worked hours.

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 for the missed meal break.

6.3 Rest Breaks: RNs working eight- or ten-hour shifts will receive two 15-minute breaks, during which they will be relieved of all duties. RNs working twelve (12) hour shifts will receive three (3) fifteen (15) minute breaks. Breaks will be taken each four hours whenever possible. Breaks may be combined (for example, a second and third break for a twelve (12) hour RN taken together for a thirty (30) minute break) by agreement of the charge nurse or clinical manager and the nurse, in light of unit preferences and patient care needs. In addition, breaks may be pre-scheduled using a sign-up sheet whenever possible. If scheduled breaks need to be adjusted due to patient care requirements, every effort will be made to facilitate breaks later in the shift. It is understood that this is a dynamic procedure requiring the best efforts of all unit staff.
If an RN misses a break period, they will be paid the regular hourly wage for an additional one-fourth (1/4) of an hour for the missed break period.

A nurse who misses a meal or rest break will accurately record this fact in their time record. It is understood that a missed break or meal period due to patient care requirements is not a basis for disciplinary action.

Nurse managers will encourage RNs to report missed breaks or meals and will support them in all such reports. There will be no public or publicized criticism of individual RNs for missing their meals/breaks or reporting such. The goal is to work collaboratively to find a way to solve the problem of missed breaks or meals, not necessarily to allocate blame for the problem. The RN and charge nurse will communicate proactively and appropriately regarding coverage for breaks and meals. The RN retains personal responsibility to take breaks and meals when offered and reasonable as long as patient care is not compromised.

ARRMC will provide training on the importance of taking meal and rest periods, use of the time-recording system for recording missed meal and rest periods, non-retaliation for reporting missed meal and rest periods, personal responsibility for taking meal and rest periods, and methods for proactive communication with the charge nurse regarding scheduling meal and rest periods.

ARRMC will continue to maintain an electronic means for tracking missed meal and rest periods at the end of an employee’s shift. This will not relieve a nurse from the requirement to proactively communicate with the charge nurse regarding meal and rest periods.

The Hospital Nurse Staffing Committee will be provided with missed meal and rest period reports on a quarterly basis.

Each Unit-Based Staffing and Scheduling Committee will develop a written plan, in accordance with the procedures provided in Section 15.5 of this Agreement, to provide meal and rest periods on their unit, which may include the use of a relief nurse.
6.4 **Break for Expression of Milk:** Lactating employees at work Nursing mothers who return to work post-maternity leave and who are breastfeeding will be provided reasonable rest periods each time the employee has a need to express milk up to 30 minute rest periods (during normal break times) in a private location for children up to 24 months of age, except in situations where circumstances make it impossible (i.e. emergent situations). To receive this accommodation, employees must notify Employee Relations and/or their manager of their need to express milk, and the hospital will not discipline any employee who has received this accommodation.

6.5 **Overtime Compensation Generally:** Overtime will be paid at one and one-half times the nurse's regular rate of pay as defined under the Federal Fair Labor Standards Act. Overtime will be paid under the following conditions:

A. **8 & 80 Rule** – Overtime will be paid for those hours worked in excess of eighty (80) hours per pay period and/or in excess of eight (8) hours in any workday.

B. **40 Hour Extended Rule** – For nurses who routinely work more than eight (8) hours per day overtime will be paid for hours worked in excess of forty (40) hours per seven (7) day workweek and any additional hours worked in excess of the nurse’s scheduled ten (10) or twelve (12) hour shift.

C. **40 Hour Rule** – RNs will receive overtime pay for hours worked over forty (40) in a workweek only, regardless of hours worked on a particular shift. except that all work time over twelve (12) continuous hours on a shift will be compensated at a double time rate. By mutual agreement between ARRMC and the individual nurse involved, the parties may agree to some shift other than eight (8) hours in a pay period of forty (40) hours which also alters the above overtime provisions. Any such agreement will be reduced to writing and signed by both the nurse and ARRMC. The written agreement between ARRMC and the nurse concerning an alternative shift other than eight (8) hours will also confirm any impact of such alternative schedule on differentials or eligibility for fringe benefits. Within thirty (30) days of execution, ARRMC will forward a copy of the agreement to the Association.
A. **Eligibility:** A nurse who works more than five (5) consecutive full shifts (12-hour scheduled RNs) or six (6) consecutive full shifts (eight (8) or ten (10) hour scheduled RNs) without a day off will be eligible for continuous days of work premium.

A full shift for eligibility shall be the number of hours a nurse is normally scheduled to work. If a nurse is normally scheduled to work shifts of varying lengths, a full shift will be the length of the shortest scheduled shift (minimum of 8 hours).

When an RN is called in from scheduled standby on Saturday or Sunday, and the call-in hours paid equal or exceed the lowest hours of the nurse’s regularly scheduled shifts, the day will be considered a full shift for purposes of this Section.

B. **Premium Pay:** Once eligible for continuous days of work premium, a nurse will be compensated at the rate of time-and-a-half for each day worked or portion thereof worked after such fifth (5th) or sixth (6th) consecutive shift until granted a day off. Hours worked over forty (40) in a workweek that also qualify for the consecutive day’s premium will be paid at double time.

C. **Waiver:** This requirement may be waived on the request of an individual nurse and the agreement of the nurse’s supervisor. Such request or waiver will be in writing and will indicate the time period in which such a waiver will be in effect. ARRMC will furnish a copy of such written waiver to the nurse representative designated by the association for such purpose. This Section can be waived by using the procedure in Article 6.1.

Time scheduled but not worked on standby does not count as time worked under this Article. Staff requested/voluntary in-service or paid educational days off (outside the Hospital) will not count as consecutive days of work regardless of length. When this consecutive day premium is operative, it will no longer apply after the date of a day off offered to the RN by the Hospital.
6.67 **In-Service Programs and Overtime:** When a variety of mandatory in-service program times are offered, the RN is encouraged to attend the in-service that will not result in overtime, if at all reasonably possible. This Section is designed to prevent overtime abuse; not intended to require attendance at in-services at times which conflict with patient care responsibilities or an RN’s reasonable time off for rest. It is all nurses’ responsibility to work with scheduling to place any mandatory in-service programs on their schedule. Nurses will not be subject to discipline when they have made good faith efforts to schedule education.

6.76.8 **Overtime Review:** All overtime actually worked will be paid at the appropriate overtime rate and subject to management review.

6.86.9 **Non-Duplication of Overtime/Premium Pay:** There will be no duplication of overtime or payments and other time paid but not worked (sick leave, funeral leave, vacations, etc.) for the same hours worked or paid under any one of the provisions of this Agreement. To the extent that hours are compensated at overtime or premium rates under one provision, they will not be counted as hours worked in determining overtime under the same or any other provision; provided, however, that if more than one provision is applicable, the higher rate will apply. This non-duplication of overtime/premium rates rule does not apply to CNI, ASI, standby, or shift differential.

6.9

6.10 **Holiday Pay and Hours Overtime Calculation:** Holiday hours worked, even though paid at the rate of time and a half, will count as straight time hours for purposes of computing eligibility for overtime. Only holiday hours worked and ETO hours taken on a holiday will count as straight time hours for purposes of overtime pay eligibility calculations. Notwithstanding any prior practice, for calculating overtime pay eligibility in holiday or non-holiday weeks, no other paid non-working time counts as straight time hours for this purpose.

6.11 **Equitable Rotation of Overtime:** ARRMC will attempt to distribute overtime among nurses on each unit and on each shift on an equitable basis while also recognizing the dictates of sound patient care.

6.12 **Unit Scheduling:** Nurses will not be involuntarily regularly scheduled to work different
shifts (day, evening or night), and will not be involuntarily regularly scheduled to work a shift length different from their bid shift length. The Hospital may change a bid shift start time by up to two (2) hours before or after the normal start time. When a nurse volunteers for a new permanent start time, that new time will be considered their new bid shift start time. This definition will not be interpreted to change or modify any other provisions of this contract with respect to shifts, for example, shift premium provisions. After a unit schedule is posted, an RN will not be involuntarily replaced on the schedule and an RN's scheduled start time will not be changed absent emergency or mutual agreement.

The Hospital will not schedule RNs involuntarily over forty (40) hours on consecutive days, regardless if over two (2) workweeks.

A non-variable shift RN may trade days with another RN on the same unit and shift, on a permanent basis, as long as there is no change in current unit balance and there is no cost increase to the Hospital and seniority is respected. There will be at least fourteen (14) days electronic notice and posting by the involved RNs on a unit of a proposed trade to allow the senior nurse to exercise seniority rights.

It is the responsibility of each nursing unit to post a four (4) week balanced schedule, a minimum of four (4) weeks in advance. The unit will also develop and implement decisions, protocols, communications, guidelines, and rules to accomplish this responsibility, pursuant to Article 15.5 procedures and protocols. Hospital management will audit such units to ensure compliance with this schedule posting requirement, with audit results provided to the Labor Management Committee.

In addition, RN seniority and status will be considered in scheduling, as follows: When a scheduling conflict arises, regular status and bid flexible status seniority will be used to prioritize desirable schedules up to the RN's budgeted FTEs. On units with established schedules, regular status and bid flexible status nurses cannot be bumped out of their regular schedule by another nurse.

Nurses’ regularly scheduled days will not be changed without mutual consent prior to schedule posting, as long as the schedule can be balanced by available staff. The
rotational list will be posted on each unit. In balancing schedules prior to posting, the Hospital will not flex nurses if it will result in staffing that is below core.

The Hospital will maintain its program to facilitate higher seniority RNs to move to lower hour scheduled shifts.

**Island Days:** Starting October 2024, full-time night shift RNs who have been on night shift for more than two (2) years will not be required to work island days as part of their regular schedule, provided the RN agrees to schedule alterations that may include the following: 1) agreement to a schedule pattern where the RN is routinely scheduled for over forty (40) hours on consecutive days, or 2) agreement to a schedule where the RN is routinely scheduled on consecutive weekends. These schedules will be considered “voluntary for purposes of waiving otherwise applicable premium pay. Island days are defined as single days of work not contiguous to other scheduled work days. The Unit Scheduling Committees may present patterns to achieve this goal of eliminating island days.

**6.13 Use of Travelers in Scheduling and Overtime/Extra Shifts:** The following order will be utilized in scheduling travelers on the regular schedule, and when there are additional shifts available:

1. Bargaining unit RNs on the unit will be scheduled in accordance with 6.12 above.
2. Traveler RNs will be tentatively scheduled.
3. Bargaining unit RNs will be offered additional available shifts and to fill holes.
4. Traveler RN schedules will be adjusted to accommodate bargaining unit RN requests when possible.
5. Bargaining unit RNs will be offered any applicable ASI shifts.
6. Traveler RNs will be offered any remaining open shifts after bargaining unit RNs have been granted ASI.

**6.14 Scheduling Mandatory Standby or Overtime:** Mandatory overtime is defined as any overtime for which a nurse is required to stay over their schedule without right of refusal. Mandatory standby (defined in Exhibit A.6.1) or overtime is not intended to substitute for adequate staffing of nursing units. It is understood that mandatory overtime is not to be
used to resolve routine inadequate staffing, and that continuing or persistent overtime
indicates a need for additional staff. Mandatory overtime will be required of on-duty RNs
only in the following circumstances:

A. Work time over an RN’s scheduled shift will be required only in accordance with
current Oregon law. (See Exhibit E, Oregon Nurse Staffing Law.)

B. Overtime work in such situations will not be required absent discussion with the
charge nurse and approval by clinical manager or management designee.

C. The Hospital Nurse Staffing Committee will review all mandatory overtime
situations (of any sort) at least annually in an attempt to set guidelines for the
future to minimize such incidents.

D. Work time (voluntary or mandatory) over twelve (12) continuous hours on a shift
will be compensated at a double time rate.

E. No work over twelve (12) hours in a twenty-four (24) hour period will be required,
except in accordance with applicable the current Oregon Law Staffing Law. (See
Exhibit E, Oregon Nurse Staffing Law).

F. No work over sixteen (16) continuous hours will be required, absent instituting the
disaster protocol. In such event, the above procedures/rules will also apply.

6.15 No Hours Guarantee: Nothing contained in this Agreement will be construed as a
limitation on or a guarantee of hours of work available during the workweek.

6.16 Payroll Accountability: The hospital may form a committee with the goal of meeting the
following goals by the end of the contract:

• By the end of business day Tuesday, following the payroll ending week, the
timekeeping system will have the timecards finalized including missed punches,
unaccounted hours, etc.
By noon on Thursday following the payroll ending week, pay stubs will be in the HRIS system and accessible for employees. A payroll representative will be available and live during regular business hours to engage nurses regarding their paychecks, Timekeeping system issues, and other issues related to payroll. A hospital payroll representative will have the power to edit payroll and enforce payroll corrections subject to internal Asante Procedures.

Note: the referenced time-frames may be adjusted as a result of recognized holidays.
ARTICLE 7 – WORK ASSIGNMENTS AND FLOATING

7.1 Assignments Generally: The parties agree that nurses should be assigned to nursing units in which they have been oriented and possess the necessary education, experience, and qualifications. See Article 15.4 for staffing guidelines.

7.2 Scheduled RN Work Preferences: Scheduled nurses will have preference in assignments over nurses who are called in. Bargaining unit RN’s will have preference in assignments over travel/agency RNs. This policy will be subject to review every six (6) months to ensure that its enforcement does not create staffing problems. If such problems occur, the parties will meet to modify this requirement. The Association agrees that it will not unreasonably withhold agreement to modify.

7.3 Volunteers to Float: When a need for floating arises outside of the clinical groupings provided in Section 7.4, Travel/Agency RN’s will be floated prior to any Bargaining Unit nurses. If staffing needs cannot be filled by Traveler/Agency RN’s, NRT’s will be placed in any remaining holes. If further staffing needs exist, which cannot be filled from the Nursing Resource Team or on-duty RNs on shift, volunteers will be solicited from the shift subject to qualifications. If staffing needs cannot be filled by volunteers on the shift, or Agency RNs, followed by regular and flexible status nurses on the shift may be floated by rotation on an equitable basis. In light of the requirements of the particular nursing situation, qualifications for floating assignments will be determined by the Hospital. Qualifications for floating assignments will be based on unit requirements within clinical groupings, developed as part of the staffing plans pursuant to article 15.3. In making such assignments, the Hospital will follow Section 7.4.

RNs, when asked to work on an unscheduled day, including same day CNI, (not a standby day), will be informed if there is a float possibility, and if so, to what unit(s), so that the RN can make a fully informed choice as to accepting the requested call to work. If an RN accepts a call into work without being so informed of such a float possibility:

A. The RN may insist on home unit, including buddy unit float, work only for the entire call and shift; or

B. If not put to work on the home unit, may decline to work, go home, and receive
two (2) hours minimum call-in pay.

Absent mutual agreement, an RN will only be required to float to one other nursing unit per shift (return to home unit from a float assignment is not a separate second float).

7.4 Floating Assignment Guidelines: In situations where nursing needs cannot be met from the Nursing Resource Team or on duty RNs or volunteers on shift, the Hospital will make floating assignments under the following guidelines.

When float assignments are necessary, considerations will be made for services, clinical groupings, and stand-alone units. Services will include clinical groupings with similar competencies but differing patient populations/acuity. Clinical groupings, within services, will include units that have similar competencies and similar patient populations/acuity. Stand-alone units have unique competencies and patient populations that are not like another unit.

A. Clinical Groupings within Services:
   • Adult Inpatient Services
   • Critical Care Units (Closed):
     o CVICU/CCU/ICU/IMCU (These units include Critical Care patients boarded in alternate care areas and Cardiac Step-Down Unit designated patients)
   • Medical Surgical Units:
     o General Medicine
     o Medical Oncology
     o Post-Surgical
     o Orthopedics-Neuroscience
     o Cardiac Center
     (These units include Medical-Surgical patients boarded in alternate care areas)
   • Behavioral Health Services:
     o Behavioral Health
     o PCU
   • Women’s and Children’s Services:
     o Women’s Departments: (See Exhibit E; MOU on WCS Closed Service
Family Birth Center

- OB Emergency Department
- Family Newborn (Maternal Child)

Children’s Departments:
- NICU
- Pediatrics
- Outpatient Pediatrics Infusion

Emergency Services:
- Emergency Department
- CDU
- Asante Immediate Care (Black Oak)

B. Stand Alone Units:
- Cath Lab
- CVR
- Emergency Room
- EFR
- Endoscopy
- Imaging
- Infusion Services (This includes the Heimann Cancer Center)
- Inpatient Rehab
- MRI
- Nuclear Medicine
- Operating Room
- PACU
- Radiation Oncology
- Short Stay Unit
- Vascular Access
- Wound Care

NOTE: the timeline for closing the Critical Care and Womens and Childrens service lines is as follows:
A. **February 2024:** close service line.

B. **July 2024:** Service Line Council will be formed and begin meeting to develop a competency/education plan. Will meet monthly until orientation/education begins with plans to meet quarterly thereafter to assess for needed changes.

C. **January 2025:** Orientation and education requirements set forth by the Service Line Council will begin. Orientation order will be determined by the Service Line Council.

The Labor-Management Committee, in cooperation with the Staffing Committee, may reconfigure stand alone and clinical groupings during the contract term.

Floating assignments will be made with appropriate regard for the orientation of available nurses, excess staff in units, and patient care needs. RN's floating within a clinical grouping will take a regular patient assignment. RN's floating outside of their clinical grouping but within the service will be considered a CRN and given a modified patient assignment. RN's floating outside their service/stand-alone unit will be utilized as a CRN in a limited capacity as described below. RN's who float will do so in accordance with Staffing Committee guidelines, subject to the nurse's professional judgment as to the patient care responsibilities that can safely be assumed.

When making floating assignments, nurses will not be floated outside of their service/stand-alone unit except in the following circumstances:

A. **There are no traveler RN's available to be assigned.**

B. **There are no staff RN's available to float within the clinical grouping.**

C. **Additional staff offered critical needs incentive have not volunteered to work.**

D. **There are no staff RN's available to float from another clinical grouping in the service.**
Critical Care RNs who desire to float outside of their service line may submit their name to a voluntary float list that shall be available to hospital leadership and charge nurses on each unit. Each unit will develop a process to keep an up-to-date volunteer float list to communicate with the staffing office.

When all other attempts have been made to meet the staffing needs, (including CNA's or patient safety monitors), an RN may be required to float to another service if additional RNs are available and not needed within their own clinical grouping/service. When doing so, they will not be required to take a regular patient care assignment.

1. Appropriate assignments will be provided and may include the sitter role or providing assistance to other RN’s in completing tasks. For RN’s from Women and Children’s service line, an appropriate assignment typically shall be serving as a sitter in an observer role only, with the understanding that additional emergent intervention may be necessary.

Each RN defines their own scope of practice based on the RN’s education, knowledge, competencies, and experience.

2. Nurses floating outside their service will be paired with a core RN who will be the primary care nurse for any patient assigned.

Each nursing unit scheduling committee will decide equitable Float Rotation procedures pursuant to Article 15.5 procedures, and such unit decisions will not be subject to the grievance and arbitration procedure. It is understood that ARRMC retains the basic management right to require RNs to float subject to specific restrictions in the labor agreement.

Nursing personnel are requested to float, in judgment of clinical managers and charge nurses, when patient care and safety requires additional personnel in a particular unit. When a RN is not adequately cross-trained or oriented in a specific nursing unit, the RN will float to that unit only as a clinical resource nurse, will inform the charge nurse, or clinical manager, or nursing supervisor, and will receive a modified patient care assignment.
Nurses to be floated must have demonstrated competency for the
tasks/assignments they are given and can provide care within the scope of
their license and/or capabilities. The nurse who is floated functions under the
supervision of a regular nurse who is assigned as his/her “Care Partner”
resource. The charge nurse will assign a Care Partner to all CRNs and float
2 nurses.

Any nurse required to float may refuse any specific component of an
assignment that the nurse, in his/her professional judgment, does not assess
is appropriate. In such case, alternate nursing care duties will be assigned in
the unit. All assignments of nursing care will be consistent with licensure
requirements for registered nurses licensed in Oregon.

The parties are committed to cooperate in establishing floating policies which
are mutually satisfactory while ensuring good patient care. If the guidelines
outlined above prove unsatisfactory, ARRMC may modify the procedures
followed in making floating assignments after prior notice to and consultation
with bargaining unit representatives.

7.5 Nursing Resource Team (NRT): The purpose of NRT is to provide internal staffing
within the hospital units to cover anticipated and short-term absences of core staff. NRT
nurses are a valuable and highly skilled resource for the Hospital. Nurses shall
demonstrate and maintain competency, skills and certifications required to work within
their clinical grouping service. NRT clinical grouping services currently include:

- Med-Surg:
  - Cardiac Center
  - Ortho-Neuro
  - Med Oncology
  - Post-Surgical and
  - General Medicine
    (Including boarded Med-Surg patients)

- Critical Care:
  - ICU, IMCU, CVICU CCE and ED
(Including boarded Critical Care patients and Cardiac Step-Down Unit designated patients)

- Women’s and Children’s:
  - Peds
  - Family Newborn (Maternal Child)
  - Special Care Nursery
  - NICU

The Hospital may add to or reconfigure clinical grouping services, or add additional services, after prior notice to and consultation with bargaining unit representatives.

NRT RNs will cover open charge nurse shifts within their service line that are not able to be covered by other trained RNs within the service line.

7.5.1 Each NRT RN will be assigned a primary unit within their clinical grouping service for purposes of Staffing Standby rotation, job bidding, and layoff under Article 8.

7.5.2 As with other positions in the bargaining unit, the Hospital may post NRT positions as full time or part time, in its discretion. In addition, an NRT RN may request a reduction in hours in accordance with Section 1.2(G)(4).

7.5.3 Daily staffing assignments while on shift will be designated in accordance with the following:

1. Assignments will generally follow four-hour blocks with equitable rotation throughout the clinical grouping service.

2. An NRT nurse will be assigned to a unit outside of their primary clinical grouping service only when a Travel/Agency RNs or an NRT in that clinical grouping service is unavailable, and patient needs require the assignment. An NRT required to float outside of their clinical grouping service may request and receive a modified assignment consistent with their skill set. If an NRT nurse, in their professional judgment, determines that they do not possess the skills or experience required for the assignment, the nurse’s judgment will
3. An NRT nurse shall have the option to reorient to any unit within their clinical grouping service if it has been more than six months since their last rotation to that unit. If an NRT nurse identifies a need for further training to maintain a skill or competency in a specific department, they can make that request to their clinical leader. Upon this request, the NRT nurse will receive the training within ninety (90) days.

7.6 **Boarding:** When boarding of patients is required secondary to excessive patient volume for bed availability, the following guidelines will apply to staffing for boarding:

7.6.1 Travel/Agency RNs within the applicable Clinical Grouping within Services (See Section 7.4) will be the primary resource responsible for boarding assignments.

7.6.2 In the absence of available and qualified traveler RNs, NRT within the applicable Clinical Grouping will continue to be the primary unit responsible for boarded patients due to their extensive training across multiple units.

7.6.3 Inpatient and Emergency Department nurses will act as additional alternate personnel for boarding, if needed.

7.6.4 There will be an NRT nurse assigned as Charge Nurse for boarding assignments. The NRT charge nurse will be implemented once the boarding population in SSU or ED reaches a total of 4 patients or more.

7.6.4 To ensure appropriate patient safety, Boarding will be included in the Unit-Based Staffing and Scheduling Committee for NRT.

By June 2024, the NRT Unit-Based Staffing and Scheduling Committee will present their recommended staffing guidelines meeting the needs of Boarding patients to the ARRMC Hospital Nurse Staffing Committee for approval.
ARTICLE 8 – LAYOFF AND JOB BIDDING

8.1 Short-Term Layoff/Staffing Standby: These are adjustments that are made for low
census, or other temporary adjustments of less than twenty-one (21) out of every thirty
(30) calendar days in a work unit. A short-term layoff/Staffing Standby will occur in the
following order:

A. Volunteers from the shift and work unit.

B. Agency and traveler nurses within the Staffing Standby unit or its clinical grouping
service

C. Nurses working at ASI or CNI or other premium, or at overtime rate. A nurse on ASI
or CNI who has been placed on short-term layoff may not be required to be on
Staffing Standby. Rather such a nurse has the right to voluntarily go home and not
remain on standby during ASI or CNI incentive shifts. An ASI/CNI nurse who agrees
to stay on standby and is called back will receive both incentive and call-back pay.

D. Flexible status nurses from the shift and work unit in the following order:

1. Temporary and On Call
2. Bid

E. Regular status nurses, from the shift and work unit.

There will be fair and equitable distribution of Staffing Standby hours based on
scheduled hours within the work unit. Each work unit will be responsible for maintaining
a current documentation of Staffing Standby hours lost, beginning with the least senior
nurse. ETO may be used for any Staffing Standby hours at the nurse’s discretion.

A nurse may be placed on mandatory Staffing Standby out of rotation if ARRMC
determines the nurse is not qualified (with reasonable orientation/education) to perform
the work of the unit during the layoff or does not possess special skills required in the unit
which are possessed by another nurse. The Hospital's determination will not be arbitrary
or capricious.
If a nursing unit experiences more than twenty-one (21) out of a rolling thirty (30) calendar days of rotating Staffing Standbys, the Association or Administration may request a meeting to discuss whether or not a formal short term layoff, or long-term layoff, or other solution is appropriate.

8.1.1 Scheduling by Staffing Standby: Work units may allow Staffing Standby to be pre-scheduled on a voluntary basis for shifts when census is expected to be low. A nurse who voluntarily signs up for Staffing Standby may use ETO at the nurse’s discretion.

Equitable Staffing Standby rotation will attempt to ensure that no single nurse receives Staffing Standby more than once in a pay period before each nurse on the shift has also received Staffing Standby. Each individual unit will determine how much or if voluntary Staffing Standby is counted toward equitable rotation. The Staffing Standby rotation list will be reset by each individual unit according to the method unit RNs agree upon. For nurses with the same amount of Staffing Standby accrual, the rotation will be based on seniority. When a nurse is hired into a unit (after orientation), they will receive credit equal to one (1) less measurement than the nurse with the least accrued Staffing Standby.

It is recognized that this sort of Staffing Standby rotation system will be complex to administer and that mistakes may be made. When mistakes are made regarding Staffing Standby between regular status nurses, such mistakes shall be remedied by addition of Staffing Standby credits for the nurse in question. However, if the Staffing Standby layoff procedure as outlined in Article 8.1, subparagraphs A-D is not followed, then the financial resolution and grievance procedure will apply.

An RN will have no duty to be on standby (whether scheduled in advance or in a Staffing Standby situation) unless the nurse is specifically told to be on standby. The nurse will also have a standby obligation only for the hours they are specifically told to be on standby. For example, if an RN is told to be on standby for the first four (4) hours of a scheduled shift in a Staffing Standby situation, the nurse does not have an obligation to be on standby or be available to return to
work after the expiration of that four hours, absent a call back within that four (4) hours, or an extension of the standby during that four (4) hours. Extensions of a four (4) hour standby will always be made for the entire remainder of the scheduled shift. See also Exhibit A.7.2.

8.2 Long-Term Layoffs: Layoffs of a permanent nature which are expected to exceed twenty-one (21) consecutive calendar days in a work unit or permanent reductions of work force in a work unit will occur in the following manner:

A. When the need for long-term layoffs is foreseen by ARRMC, at least twenty-one (21) calendar days prior to the effective date of such reduction or elimination, ARRMC will deliver notice to the Association and the Association unit chairperson, in writing, specifying the number and description of positions to be reduced and the reasons therefore.

B. ARRMC and Association officials, and affected nurses, will meet to explore and discuss alternatives to layoffs within seven (7) days of such notification. If discussions do not produce full agreement on alternatives, then long-term layoffs will proceed as follows:
   1. Volunteers from the shift and work unit.
   2. Agency and traveler nurses.
   3. Probationary nurses (all status).

C. Other flexible status nurses in the following order:
   1. Temporary and On Call
   2. Bid

D. Regular status, full-time and part-time RNs by inverse seniority.

In staffing the reduced work unit, displaced nurses will be offered the vacated positions within the work unit according to their seniority consistent with the standards set forth in the next sentence. A more senior nurse may be laid off, out of seniority, if the Hospital determines the nurse is not qualified (with reasonable orientation/ education) to perform the work of the unit during the layoff or does not possess special skills required in the
unit, which are possessed by a less senior nurse. The Hospital's determination will not
be arbitrary or capricious. A laid off nurse will be entitled to use the procedures under
the “displaced nurses” provisions of this Section.

E. Layoff Status: If seniority is not exercised in this manner, the nurse will be placed
on layoff. Nurses may remain on layoff for up to two (2) years and will not lose
previously accrued credit for seniority while on layoff.

F. Meetings to Resolve Long – Term Layoff Issues: The parties will meet in
advance of long -term layoff situations to try to minimize problems and issues. The
Hospital will provide a seniority list to all nurses notified of pending layoff within three
(3) days (Monday - Friday) of such notice, as well as a list of all vacant positions in
all Hospital units. Both negotiating parties shall have authority to and must agree to
specific layoff, bid, and/or bump/displacement rules and priorities, different than
those under this Article 8, based on unique fact circumstances of a particular long -
term layoff situation. Absent such agreement, contract language will apply. A nurse
eligible to bump (see “Displaced Nurses” section below) will have fourteen (14)
calendar days from the time of receipt of such list to exercise seniority in the above
manner by delivery of written notice to Human Resources.

G. Displaced Nurses: Displaced nurses may exercise these options in the following
order:

1. A nurse laid off may choose to utilize available ETO in lieu of layoff (layoff will
occur after ETO is depleted).
2. A nurse temporarily working with an increased FTE may revert to his/her
previous FTE, when available.
3. A nurse may take a temporary, voluntary reduction in FTE, when available.
4. A nurse may explore alternate work share arrangements among nurses.
   Work share arrangements must be agreed upon by those nurses involved in
   the work share, Hospital Administration, and the Association.
5. Fill a vacant position for which the nurse is qualified, under normal bid rules,
   without the right to displace/bump any other nurse, from among the list of
   available positions to be provided by Human Resources.
6. If numbers 1. – 5. above are not or cannot be utilized, the laid off nurse may
displace/bump the least senior nurse in the same status, or in a lower status if
the laid off RN so chooses, in that work unit or another. The nurse displaced
by this process may also exercise such seniority displacement rights, if any.
To exercise such displacement rights, an RN must be qualified in the new
position, or capable of becoming qualified, within six (6) weeks.

8.3 **Recall:** Nurses will be recalled to work in their shift and work unit in the reverse order of
layoffs. Upon return, the nurse will retain seniority, step wage, and benefit accrual level
including unused ETO and ESDP, in effect at the time of layoff. A nurse that is laid off
will have priority over new hires for vacant positions.

8.4 **Bidding for Available Positions:** Nurses in the bargaining unit may apply for posted
positions, and these positions will be filled on the following basis:

A. Qualified senior nurses who apply will be given preference for vacancies, provided
that on the basis of skill, training, certification, and experience, the senior nurse
meets the job standards required by ARRMC. ARRMC will be the judge of the
nurse's ability to meet its standards, which will be posted when the vacancy is
posted; provided, the Hospital's judgment will not be arbitrary or capricious.

B. A nurse's transfer to a position may be delayed for only up to two months from the
date the bid is accepted. If further delay is requested until a capable replacement is
available, it may be extended by mutual consent between the manager and the
nurse.

C. A nurse may return to their previous position within one (1) month if the position
remains open; e.g., the manager intends to refill it, but it has not been posted or the
schedule awarded to another nurse.

D. ARRMC will be entitled to place an inexperienced RN into a shift and unit temporarily
for training purposes to maintain skills, or for short staff periods.

E. A regular status nurse may change to a flexible status RN with management
approval but is not eligible to bid a regular status position for six months absent
exceptional circumstances approved by the Hospital, and denials shall not be
arbitrary or capricious.

F. To encourage professional development and cross-training, a nurse may voluntarily
request to shadow a nurse in an agreed-upon department. The nurse who is
shadowing will not be paid for their time and will not be expected or allowed to
perform any nursing tasks while shadowing.

8.5 Bidding for Available Positions: Procedure and Priority. Recognizing that a position
may be filled temporarily during the posting period, nurse managers will notify all unit
RNs via email, electronic, and bulletin board posting, and ARRMC will post electronically
all vacant and newly created positions in the bargaining unit for a minimum period of
seven (7) calendar days, with the exclusions noted below:
A. On-Call or Temporary positions;

B. Positions modified by mutual agreement to accommodate nurses wishing to
decrease their hours of work on the same shift and work unit; and

C. Positions for nurses exercising their rights to return to a previous position under the
final paragraph of this Article 8.5.

Position postings will specify the FTE, shift(s) (day, evening, night), start times, and
job requirements. The Hospital will indicate the range of anticipated variation, to the
best of its knowledge, in days of work and shifts (for example, “This position is for
two nights, and will not normally involve Sunday work.”), but such will not be
considered a guarantee.

Human Resources will keep a copy of all bid postings and awards indefinitely and will
also provide a copy to the successful bidder. All unsuccessful bidders will be notified
in writing of this fact within fourteen (14) calendar days of the date the posting is
taken down. When positions change over time due to voluntary agreements, such
will be documented on the unit and a copy kept in a master file in Human Resources.

When a nurse bids on several posted vacancies at once, the nurse will prioritize the
bids. If a regular status nurse bids on a posted position for a permanent vacancy and is appointed to the position, the nurse may not bid on any other position (except to increase FTE status while remaining in the current position) outside the current unit for nine (9) months from the nurse's transfer date unless mutually agreeable between the nurse and the Hospital.

A regular status nurse working in the unit will have first priority to bid openings, under contract standards, in that unit, before nurses in other units wishing to bid, and the seven (7) day notice posting will state this priority. (Nurses in the Family Birth Center and Post-Partum care units will have seniority accrual count equally for both departments, regardless which of these departments the hours were actually worked.) Flexible status nurses will have equal bid priority to that of regular status nurses if they have worked in the nursing unit in any RN status position:

- Three (3) years, and
- A minimum average of 384 hours worked in that unit per year.

A nurse returning from a leave of absence for a period of less than three (3) months will return to the nurse's previous position. If the nurse is absent three (3) months or longer, the nurse will have the right to the first available position for which the nurse meets the qualifications. In the event State or Federal leave laws are more generous to the nurse on leave, the Hospital will apply the applicable law.

All job postings will normally be for one shift (day, evening, or night) only for the posted position. A nurse may voluntarily bid for two job postings with different shifts. In addition, the Hospital may post a single bid for two different shifts in order to cover for a nurse who is temporarily (three months maximum) absent due to State or Federal law leaves of absence, workers’ compensation leave, or other illness or injury absence.

The Hospital may post non-temporary variable days coverage positions based on predictable nursing unit absences, and such positions will be regular status. The variable days coverage positions in each unit will be reported quarterly to the Labor Management Committee.
If a nurse who returns after a leave of absence is not returned to the nurse's previous position, the nurse will be returned to the previous position when, and if, vacant at the first opportunity which occurs, within eighteen (18) months from the time the nurse first returned to work.

8.6 **Unit Consolidation:** Nurses from both units will be placed in available jobs in the consolidated unit according to qualifications, on the same shift and status, with seniority controlling placement in cases of conflict. If there are not enough positions for all affected nurses, lay-off rules will apply.

8.7 **Unit Eliminations:** Affected nurses will retain their right to bid into available open jobs based upon normal contractual factors. If bidding into available open positions is not successful, lay-off rules will apply. If a position is only available directly because of the unit elimination, the nurses in the eliminated unit will have first priority over nurses in other units in bidding on the available job.

8.8 **Termination of Seniority:** Seniority will be considered terminated by any of the following:

A. Involuntary termination;

B. Layoff for lack of work or leave of absence for a period of two (2) years or more (except where a longer period is required by law, for example, workers’ compensation leaves); or

C. Resignation from the Hospital.

A nurse who leaves the bargaining unit to accept a non-bargaining unit position with ARRMC will retain, for a maximum of two (2) years from the date of leaving the bargaining unit, which will count when a non-bargaining unit nurse bids for an open position to return to the bargaining unit, and also if/when the nurse returns to the bargaining unit.

A nurse who is rehired within two (2) years of voluntary resignation from ARRMC will be rehired at his/her most recent wage step and have seniority that was accrued at time of resignation restored.
ARTICLE 9 – EARNED TIME OFF (ETO)

9.1 **Purpose:** Earned time off (ETO) is provided to enable nurses to plan time off more effectively to meet both their needs and the staffing needs of their departments. Since ETO removes the accrual distinction between holiday, sick time, and vacation, it provides greater flexibility in the use of time off, provides a special reward for nurses who work holidays and provides an adequate amount of time off for illness. ETO compensates nurses at their hourly rate when they are absent from work for such purposes as vacation, illness, holidays, family emergencies, religious observances, dental care, and other personal time off.

9.2 **Eligibility:** This policy covers all full-time and part-time nurses who are otherwise eligible to participate in the ETO program. This policy excludes flexible status nurses.

9.3 **Accrual:** Effective December 20, 2020, regular full-time and part-time RNs will accrue ETO from the first day on the job as follows:

<table>
<thead>
<tr>
<th>Completed Years of Continuous Service</th>
<th>ETO Accrued Per Hour Worked</th>
<th>Maximum Accrual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accrual Rate</td>
<td>Hours</td>
</tr>
<tr>
<td>0-4</td>
<td>.09829</td>
<td>306.7</td>
</tr>
<tr>
<td>5-9</td>
<td>.11966</td>
<td>373.3</td>
</tr>
<tr>
<td>10-14</td>
<td>.14103</td>
<td>440.0</td>
</tr>
<tr>
<td>15+</td>
<td>.16239</td>
<td>506.7</td>
</tr>
</tbody>
</table>

A. **Exceptions to ETO Accrual:** No ETO benefit will accrue during the following absences: (1) layoff and (2) unpaid absences in excess of 14 days.

Additional ETO Accruals: Through December 19, 2020, ETO will also accrue on hours worked above 2,080 hours per calendar year.

These ETO accruals will be calculated and credited to an RN's account each January.
for the prior calendar year.

B. ETO will accrue on all Hospital-compensated hours (excludes standby except as provided below). It will also accrue on mandatory call off hours from regularly scheduled FTE shift, regardless whether the RN elects to use ETO for such hours, and regardless whether the RN is placed on standby for these mandatory call-off hours. There will be no double ETO accrual for the same hours.

C. Oregon Sick Leave Law: The ETO accrual outlined above meets the Hospital’s obligation as outlined under SB 454, Oregon Sick Leave Law, for regular status RNs. Nurses categorized as Flexible status are eligible for the Hospital’s Oregon Paid Time Off Plan (OPTO) (policy 400-CORP-0112).

9.4 ETO Use:

A. No Waiting Period: ETO hours may be used as soon as they are accrued.

B. Scheduling: Requests for ETO will be submitted in writing no later than January 31 each year, for ETO to be taken between the subsequent June 1 to May 31. ARRMC will grant or deny such requests on or before February 28 of the year in question according to the guidelines listed below. At other times, such requests will be submitted in writing, and at least two (2) weeks before the schedule is posted, again, according to the guidelines listed below. The unit scheduler will respond in writing within fourteen (14) days after the request is received.

Each nursing unit will develop a process to allocate ETO utilization among unit RNs on a calendar year basis, pursuant to Article 15.5. Each nurse will be granted ETO up to a maximum of two (2) uninterrupted weeks, consecutive if possible (subject to available ETO), before any nurse will be granted more than two (2) weeks.

C. Guidelines:

- Respect for RN bargaining unit seniority.
- Fairness to all RNs regardless of seniority.
- Equitable rotation of ETO during most popular ETO times, including ETO requests for days during holiday weeks, school spring break, and summer
Desire of RNs for occasional extended periods of ETO time.

Schedulers may request flexible status RNs to work for purposes of vacation relief as well as filling vacancies.

The parties agree that the scheduling process must include:

- Ability of a nurse to prioritize at least three periods of ETO during popular ETO times, and to state whether the nurse will accept granting of a partial period of requested ETO.
- Allowance for re-submitting an ETO request that had been previously denied during the annual ETO request process, which may be granted if one of the approved nurses return their granted ETO (i.e., a “second chance” policy).
- Allowance for requesting ETO before the schedule is posted for a day when no one has made a request for the day off.

Notwithstanding these guidelines, once every two years, a nurse may exercise seniority on a scheduled ETO request received before March 15 to obtain a preference over a junior nurse selecting a competing scheduled ETO period.

When requested and possible, full workweek ETO will be granted. The Hospital will work with RNs to avoid partial or “broken” ETO weeks. Extended week or additional day(s) ETO requests, made after the March 15 challenge period, will be evaluated on a first come, first served basis.

The above guidelines will be weighed and analyzed at in management's discretion. The overriding considerations will be staffing and patient care requirements. To ensure safe patient care, each unit will determine the availability of ETO time, for a maximum number of RNs to be granted ETO, at any given time for specific nursing units.

In order to minimize scheduling problems due to an RNs use of ETO for illness or injury, ARMC will:

1. Apply its absenteeism policy in injury or illness absences.
2. Not approve requests for authorized unpaid time off (for example, vacation) when an RN does not have sufficient ETO accumulation due to use of ETO for illness or injury, unless mutually agreed due to special circumstances. Use of ETO in Staffing Standby ("Mandatory Call Off") situations will not be cause for vacation disqualification.

Once approved, ETO is not subject to cancellation after schedules have been posted, unless by mutual agreement. In addition, it is understood that an RN must actually have a sufficient ETO bank at the actual time of the ETO to cover the ETO hours under Hospital policy. Where the RN does not have sufficient available ETO hours at the time of the scheduled ETO, the Hospital will work with the RN to maintain scheduled time off in this situation based on all circumstances.

The system described above is to assist both ARRMC and the nurses in scheduling ETO. It will not prevent a nurse from making an ETO request on shorter notice, which ARRMC will consider on the basis of staffing and patient care requirements.

9.5 ETO Unit Scheduling Guidelines: The unit scheduling committee, under Article 15.5, shall set ETO scheduling guidelines. Each such committee may establish a subcommittee for the purpose of granting ETO per the unit scheduling committee and contract guidelines. These guidelines will address, at a minimum:

- The definition of "prime time" for that unit.
- The number of staff that can be scheduled off at any time, including "prime-time."
- A fair and equitable system of assigning holidays including New Year’s Eve.

These guidelines must be in compliance with this Article, they are intended to supplement, but not replace, the provisions of this Agreement.

9.6 ETO Scheduling Dispute Resolution Procedure: Whenever ETO scheduling decisions involving two (2) or more RNs wanting the same ETO day(s) cannot be worked out on the nursing unit level itself, ETO scheduling decisions by ARRMC may be challenged by an affected RN through the following procedure:
• Challenges to ETO schedule decisions must be initiated within ten (10) days of vacation schedule decisions.

• Within ten (10) days thereafter, a committee of one management official, one Association representative, and one RN from the affected nursing unit selected by nursing unit RNs, will hear and make recommendations on the dispute. Committee members will be selected each April and will serve on a one-year basis thereafter.

• The committee’s recommendation will be accepted by management unless clearly inconsistent with patient care requirements, as determined by the Vice President for Nursing.

If the procedures under Articles 9.4, 9.5, and 9.6 are not followed, the grievance procedure will apply.

9.7 **Specific ETO Utilization Rules:** Time off with pay is provided so nurses may enjoy a period of rest and relaxation and be better prepared to meet the physical and emotional demands of patient care. For this reason, nurses are encouraged to utilize fully ETO on a scheduled basis as outlined above. In addition, other rules apply, as follows:

A. **Maximum Accrual and Cash Out:** Earned time off may not be accrued in excess of a nurse's ETO benefit amount for a one and one half (1 ½) year period. If a nurse requests ETO in a timely manner *(at least two weeks before a schedule is posted as stated in 9.4)* and it is not granted, the non-accrual provision of this paragraph will not apply until the nurse is able to use accrued ETO. **Up to sixty (60) hours (part-time) and one hundred twenty (120) hours (full-time) of ETO may be cashed out each year at the RN's option per Hospital policy. Up to two hundred forty (240) hours (i.e., up to sixty (60) four times per year) of ETO may be cashed out each year at the RN's option per Hospital policy.**

B. **Maximum Utilization:** A nurse may not take more than one year's ETO accrual at any one time without mutual agreement between the nurse and management.

C. **Personal Illness or Injury:** ETO benefits will be used in case of personal illness or injury or unscheduled absence, **except where provided to the contrary in this**
Agreement, provided, however, that an RN will not be required to use ETO for extra scheduled hours or extra shifts beyond their regularly scheduled shifts, as long as they have worked their full FTE in the workweek. If the RN has not worked their full FTE in the workweek, then they will be required to use ETO for extra scheduled hours or extra shifts up to their FTE.

D. Oregon Sick Leave Law: Up to forty (40) hours (or 48 hours for 12-hour nurses) of ETO benefits accrued each calendar year will be used for absences covered by the Oregon Sick Leave Law, including reasons covered by the Oregon Family Medical Leave Act (OFLA), Oregon’s domestic violence and stalking law, and in the event of a public health emergency.

E. Unpaid Personal Leaves of Absence: Available ETO or ESDP benefits must be utilized for personal leaves of absence, unless there are extenuating circumstances. ESDP leave under Hospital policy may not be used for time off work due to dependent care, or parental, educational, or military leaves. It is recognized that a spouse or dependent illness, accident, or death may be sufficiently serious to cause a medical condition to an RN that would qualify the RN for ESDP use (medical verification may be required.

Nurses returning from a personal medical leave of absence may be requested to have a medical examination by a physician designated by the Hospital and at the Hospital’s expense.

After two (2) years seniority and once every two (2) years thereafter, a regular status nurse may request a maximum of five (5) weeks personal leave of absence where staffing permits. This personal leave may be extended up to an additional eight (8) weeks by mutual agreement of the Hospital and nurse. A flexible status RN may request a leave of absence under similar terms as regular status RNs.

Articles 9.6 and 12.1 apply to such leaves.

A short-term disability plan, which includes coverage for pregnancy-related disabilities as well as other disabilities, is available to eligible employees. The
employee pays the full premium for this option plan. Contact ARRMC Human Resources Benefits and Compensation Department for further information regarding leaves of absence and coverage under short- or long-term disability plans.

F. **Workers’ Compensation:** Accrued ETO benefits may be used for scheduled workdays missed due to an on-the-job accident or illness if the workday is not paid by workers' compensation.

G. **Staffing Standby:** ETO benefits may be used, but will not be considered mandatory, for scheduled workdays missed when a nurse is called off, mandated to unschedule their shift or part thereof, or given the option to go off the schedule any time within the nurse’s shift due to low census, nursing unit closures (for example, on a holiday) or low acuity. This includes nurses who may also receive stand-by pay.

H. **Trades:** When an RN trades shifts with another RN, ETO may be used but will not be considered mandatory.

I. **Association Business:** When an RN schedules off for Association business, ETO may be used but will not be considered mandatory.

J. **Jury Duty and Bereavement:** Jury duty and bereavement absence taken under Article 12 will be paid separately from ETO.

K. **Part-time RNs:** Part-time nurses may not take ETO over a longer period of time than the same period of ETO taken by full-time nurses.

L. **Military Duty:** Nurses who are members of the military reserve or National Guard who are ordered to either active duty or annual training (but not weekend drills) will provide their clinical manager a copy of their written orders within seven (7) days after they have been received by the nurse if the nurse intends to use ETO time for military leave.

M. **Scheduled Hours:** ETO hours when utilized by a nurse will be paid up to the amount of the scheduled hours for the day in question. If an RN is scheduled above
his or her FTE status, and then canceled, ETO will be available.

N. **Holidays:** If a holiday falls during a nurse’s first sixty (60) days of employment and if the holiday is a customary workday, but the nurse is not scheduled to work, the nurse may use ETO whether accrued or not for the holiday. ETO hours paid on any one of the actual holidays listed in Article 10 count as straight-time hours worked in calculations for overtime.

O. **Transfer to Flexible Status:** Upon transfer to flexible status, ETO hours accrued will be paid if the nurse is eligible.

P. **RN Terminations:** ETO accruals are paid to the nurse upon termination, at the nurse’s then current base rate.

- **Suspensions:** ETO hours may not be used to cover absences due to a disciplinary suspension but may be used during investigatory suspensions.

Q. **RN Request for Part-time or Flexible Status RNs to “Cover” for Scheduled Time:** RNs may request part-time RNs to cover for their normal scheduled shifts before the schedule is posted and final. After schedules are balanced (including utilization of all available staff, including part-time and flexible status RNs), and schedules are posted and final, an RN who has requested but who has been denied ETO for some part of the period covered by the schedule may request an available flexible status RN to work the shift(s) in question, so that the RN can take the ETO requested but denied. Once ETO is granted based on flexible status RN acceptance of such request to cover, and the flexible status RN’s availability for such shift(s), it will not be rescinded. This flexible status RN coverage option to obtain previously denied ETO may be utilized regardless of which calendar days of the year are involved.

9.8 **ETO Payment Calculations:** At the nurse’s option, all hours actually worked above the nurses FTE may be considered for purposes of compensating RNs for ETO, and such hours will be calculated on the basis of the prior six (6) pay periods.
Example 1 – Calculation of Weekly Optional ETO:
A full-time RN is regularly scheduled thirty-six (36) hours (three (3) twelve (12) hour shifts) a week, but actually works an average of forty (40) hours over the prior six (6) payroll periods. The nurse who requests, will receive forty (40) (not thirty-six (36)) hours of accrued ETO payment for one week’s vacation.

Example 2 – Calculation of Daily Optional ETO:

Step 1: Calculate the total hours worked in the immediately preceding six (6) pay periods.
Step 2: Calculate the total regularly scheduled shifts up to the RNs FTE for the same period.
Step 3: Divide Step 1 by Step 2 to determine the RN’s average hours worked per regularly scheduled shift for the same period.
Step 4: Pay a single day ETO based on such average hours.

9.9 Prime-Time ETO Scheduling Incentive: The Hospital and the Association agree to implement the Prime-Time ETO Bonus Program described below. “Prime Time ETO” is defined as a three consecutive month period of time during which there is a high demand for ETO and/or a historically high patient volume. Each unit will designate the three-month period of time during which this Prime-Time ETO Bonus Program will be available to nurse(s) on that unit.

A. Bargaining unit nurses who are interested in being considered for the Prime-Time ETO Bonus Program in a particular year must notify their manager by January 1 of that year.

B. A bargaining unit nurse who meets the following requirements will receive a bonus up to $1500. The bargaining unit employee must:

1. Have been informed by their manager that they are eligible to participate in the Prime-Time ETO Bonus Program.
2. Not take more than two (2) consecutive scheduled shifts as ETO during the period Prime Time ETO scheduling period
3. Not take more than a total of three (3) days of ETO during the Prime-Time
ETO scheduling period.

C. Hours worked calculation:
1. Hours worked is based on shifts agreed upon at the time of the schedule posting (not ASI/CNI short term agreements for shifts)
2. Hours worked will be calculated starting in the first full pay period of the prime-time period through the last full pay period of the prime-time period.
3. Hours worked will be calculated week by week rather than by pay period.
4. Partial ETO shifts qualify as a full shift missed for calculations for B. 3.
5. If 3 shifts of ETO are taken consecutively over a two-week period, it will not disqualify them from the program but will count as maximum allowed in the program.
6. Must be an active bargaining unit nurse during the time of payout.
7. Approved leave hours that are in excess of Section B above, will disqualify the nurse from those weeks, but not the program.
8. Bereavement and jury duty hours will not disqualify participant from the program but will not count as hours worked and may result in a prorated bonus.
9. Part Time participants will not qualify for ASI/CNI up to 36 hours/wk. Additional hours beyond that will qualify for ASI/CNI.
10. Hours worked: Reg MCO, MSB, USB, Call back hours worked (periop/procedural areas).

D. In addition:
1. This $1500 bonus is based on bargaining unit employees who have worked 72 or more hours per pay period during the Prime-Time ETO scheduling period.
2. Bargaining unit nurses who work less than 72 hours per pay period during the Prime-Time ETO scheduling period will have the ETO Bonus payout prorated, based on a 72-hour pay period.
3. ETO hours taken in compliance with Section 2 above will count as hours worked for purposes of subparagraphs 1 and 2 in section 3.
4. For every ten (10) bargaining unit FTEs in a unit, the Hospital will offer a minimum of one (1) FTE for Prime-Time ETO bonus eligibility; however,
based on unusual circumstances, the Hospital and the ONA can mutually
agree to increase the number of bargaining unit employees of a particular unit
for the Prime-Time ETO Bonus program. Examples of unusual circumstances
include but are not limited to high unit vacancy rate, large number of nurses
needing precepting on a unit, and/or nurses out on leave on a unit.

E. During periods of low census occurring during the Prime-Time ETO scheduling
period, a nurse may be asked to take time off. If a nurse manager or designee sends
a bargaining unit nurse home, and that bargaining unit nurse is on the Prime-Time
ETO Bonus Program, those lost hours will not be counted against the total ETO
taken during these months, for purposes of calculating qualification for the Prime-
Time ETO Bonus Program payout.

F. The payment for the Prime-Time ETO Bonus Program will be made no later than
forty-five (45) days after the conclusion of the Prime-Time ETO scheduling period.

G. Part-time Prime-Time Bonus:
   1. Part-time will be defined as .5-.89 FTE and will qualify if they meet all the
      requirements designated under sections B, C and D as well as:
   2. Work above designated FTE to qualify for the full bonus, which would include
      the requirement of signing up for 36 hours weekly prior to the posted
      schedule.
   3. Bargaining unit nurses who reduce their FTE after being accepted to the
      program will not be disqualified to receive the bonus. Staff will need to meet
      the minimum required hours.

9.10 Weekend Differential: Weekend differential will be added to the ETO payment for
regularly patterned weekend work. Regularly patterned weekend work refers to a
weekend shift between the hours of 11:00 pm Friday to 11:00 pm Sunday as outlined in
Exhibit A.5 that is part of the nurses regularly scheduled hours.
ARTICLE 10 – HOLIDAYS

10.1 Recognized Identified Holidays: Holidays are a built-in component of ETO. However, nurses who are required to work on any of the following holidays will be paid premium pay:

<table>
<thead>
<tr>
<th>New Years Day</th>
<th>Easter Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Day</td>
<td>Independence Day</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td>Christmas Eve Day</td>
<td>Christmas Day</td>
</tr>
</tbody>
</table>

If Asante adds any additional recognized holidays for non-represented nurses, the Hospital agrees that it will add the same additional holidays to this agreement.

10.2 Pay for Holiday Work: Nurses who work on a designated holiday will receive time and one-half hourly pay if the hours are not otherwise covered at the overtime rate.

The holidays are celebrated on a twenty-four (24) hour basis as follows:

- The holiday starts at 11:00 p.m. on the day before the holiday

10.3 Scheduling Holidays Off: Because of patient care requirements, it is not possible for all nurses to take these holidays off at the regularly scheduled times. The Hospital will schedule time off on holidays in accordance with the work unit's need for coverage. Within each work unit an effort will be made to schedule holidays on a rotating basis among all full-time and part-time nurses.

10.4 Standby Call In on Recognized Select Holidays: A nurse who is called in from scheduled standby on any recognized holiday Thanksgiving, Christmas or New Year's Day holidays will be paid at a double time rate. This pay rate will apply in the following nursing units only: Operating Room, Cath Lab, PACU, and Endoscopy, and other nursing units which regularly schedule standby when the unit is closed in order to provide for 24/7 staffing coverage.
ARTICLE 11 – EMPLOYER SPONSORED DISABILITY PLAN (ESDP)

11.1 **Purpose:** ARRMC provides an Employer Sponsored Disability Plan (ESDP), which is a short-term disability benefit to provide for protection against loss of income sustained because of the RN's personal illness (injury or sickness) sufficiently severe to cause a nurse to miss more than twenty-four (24) consecutive hours of scheduled work.

11.2 **Accrual:**

A. Beginning with the first day of employment, regular status nurses will begin accruing ESDP.

B. Full-time nurses who are paid for sixty-four (64) or more hours in a two-week payroll period will accrue a full ESDP benefit of 2.15384 hours; nurses who work less than sixty-four (64) paid hours will accrue a pro rata share of ESDP.

C. Part-time nurses will accrue ESDP on scheduled hours plus excess hours worked to a maximum of eighty (80) hours per fourteen (14) day pay period; provided, where scheduled hours are changed or an AA (Approved Absence) day is granted at the request of the nurse, ESDP will not accrue on scheduled but unworked hours. Part-time nurses will accrue ESDP hours at the rate of .026923 hours for each scheduled hour.

D. ESDP hours may be accrued to a maximum of 1,040 hours. Each year in December, RNs who have reached this maximum will receive pay for fifty percent (50%) of ESDP hours they would have accrued (absent this cap) in the prior twelve (12) month period (December to November).

11.3 **Using ESDP:**

A. **Waiting Period after Hire:** ESDP can be used as soon as it is accrued. ESDP benefits must be used for all unscheduled absences related to a nurse’s medical condition.

B. **Waiting Period/Each Occurrence:** Accrued ESDP shall be used starting with the 25th consecutive scheduled hour missed, or the fourth scheduled workday missed regardless of hours, whichever comes first, due to personal illness when the illness is
sufficiently severe to require the nurse to miss work. However, first hour immediate
ESDP access will be provided if the RN is hospitalized either in-patient or for short-
stay surgery when surgery time and the recovery period equals at least twenty-four
(24) scheduled hours, and in connection with injuries or illness covered by workers’
compensation, as described in Article 11.3(D) hereof. In addition, first hour ESDP
access will be granted for an absence due to the recurrence, within a seven (7) day
period of return to work, of the same injury/illness for which the twenty-four (24) hour
waiting period has already been satisfied. There will be only one (1) twenty-four (24)
hour waiting period each rolling twelve (12) month period for the same medical
condition before an RN on intermittent FMLA leave can access ESDP benefits on a
first hour basis.

C. Medical Verification: If deemed necessary by ARRMC, a nurse may be required to
obtain a physician clearance before returning to work. In situations of suspected
misuse of ESDP, as a condition of access to ESDP for the episode claimed, ARRMC
may require the nurse to provide a doctor’s certificate that the nurse was unable to
work because of the claimed illness. This requirement is subject to state and federal
laws on leaves of absence, which can be accessed in Human Resources.

D. Workers’ Compensation: Accrued ESDP benefits may be used to cover the three
(3) day waiting period for workers’ compensation time loss coverage, as soon as it is
determined that the three (3) days are not otherwise covered by workers’
compensation. Accrued ESDP benefits will also be used for missed shifts due to
workers’ compensation leave of absence, up to twenty percent (20%) of the RN’s
FTE status (e.g., 1.6 ESDP hours a day, eight (8) ESDP hours a week for five (5)
day, forty (40) hours a week, full-time RNs), after fourteen (14) days of workers’
compensation leave.

E. Return to Work: When a nurse can return to work from ESDP leave with
restrictions, ARRMC and the nurse will make every reasonable effort to
accommodate such return, provided the nurse can perform a productive and
available job. Such job can be a temporary placement into a vacant position without
bidding. When such accommodation is not possible, the release must be without
restrictions. This is not intended to modify ARRMC’s obligations under the Americans
with Disabilities Act. ARRMC will work with RNs to maximize the opportunities for return to productive work from ESDP status.

F. Payment of ESDP Benefits: ESDP hours will be paid according to the nurse’s regularly scheduled hours of work. ESDP hours will not be paid upon termination or transfer. Where a nurse transfers to an ineligible status (e.g. flexible status) accrued ESDP will be frozen and held for future use when the nurse returns to an eligible status.

G. ESDP Payment Calculations: At the nurse’s option, all hours actually worked above the nurse’s FTE may be considered for purposes of compensating RNs for ESDP, and such hours will be calculated on the basis of the prior six (6) pay periods. Example: A part-time RN is regularly scheduled twenty-four (24) hours (two (2) twelve (12) hour days) a week, but actually works on average of thirty-two (32) hours a week over six (6) payroll periods. The nurse who requests will receive thirty-two (32) hours (not twenty-four (24)) ESDP for a missed week of work due to illness.

H. Flexible Status Bid RN ESDP: Flexible Status Bid RNs may access their “frozen” (as of the time of transfer from full-time or part-time status to flexible status) ESDP accounts as follows: Only bid shifts count for the twenty-four (24) hour waiting period or for ESDP eligibility and payments. Flexible Status Bid RNs will not accrue additional ESDP benefits while on flexible status. All other Article 11.3 eligibility rules apply.

Daily optional ESDP calculations will be the same as for ETO under Article 9.8.

11.4 Oregon Paid Family and Medical Leave Act (OPFMLA): When paid leave becomes available under the OPFMLA, the parties agree that paid leave will be made available to employees in the following order:

1. OPFMLA
2. ESDP
3. ETO, subject to applicable eligibility requirements for each type of paid leave. ESDP and ETO may be used to replace a nurse’s wages up to 100% of the nurse’s regular earnings.
ARTICLE 12 – LEAVES OF ABSENCE

12.1 Personal Leaves of Absence: Personal leaves of absence may be granted to regular status nurses at the Hospital’s discretion, for up to twelve (12) consecutive weeks, independent of any leaves provided for by law.

A leave of absence must be requested in writing and approved by the nurse’s clinical manager. See also Article 9.7.E regarding ETO/ESDP utilization rules. Article 9.6 will apply if there is a conflict with respect to ETO scheduling in the event a personal leave is denied.

After two (2) years seniority and once every two (2) years thereafter, a regular status nurse may request a maximum of five (5) weeks unpaid personal leave of absence where staffing permits. This unpaid personal leave may be extended up to an additional seven (7) eight (8) weeks by mutual agreement of the Hospital and nurse. A flexible status RN may request an unpaid leave of absence under similar terms as regular status RNs.

Article 9.6 applies to such leaves.

12.2 Bereavement Leave: When a death occurs in the immediate family, including a domestic partner or children of a domestic partner of a full-time nurse, the nurse will be entitled to three (3) shifts off with pay at the hourly rate. A part-time nurse will be entitled to two (2) shifts off with pay at the hourly rate. Bereavement leave must be taken within six (6) months of the death or the knowledge thereof. Paid bereavement leave will not be included in calculations for overtime. Paid bereavement leave taken under this Article 12 will run concurrently with any bereavement leave to which an employee may be entitled under the Oregon Family Leave Act (OFLA). Paid bereavement leave taken under this Article 12 will not count as “sick time” against a nurse’s Oregon Paid Sick Leave, ETO or ESDP balance or entitlement.

12.3 Immediate Family: For purposes of this Article 12, immediate family shall be the nurse’s spouse, parents, children (natural, foster, or adopted), domestic partner, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, brothers, sisters, grandparents, grandchildren, and current step-parent, step-child, step-brother and step-
sister, and shall also include a non-relative living in the RN’s household with a close personal relationship with the RN similar to that of a family member.

12.4 **Jury Duty:** A nurse who is required to perform jury duty will be permitted the necessary time off to perform such service and will be paid the difference between the nurse’s hourly rate for the scheduled work hours missed and the jury pay received, provided arrangements for the time off are made with the nurse’s supervisor in advance. The nurse must furnish a signed statement from a responsible officer of the court as proof of jury service and jury duty pay received.

Jury duty pay is limited to the RNs scheduled hours missed up to the budgeted FTE hours per workweek and will not be included in calculations for overtime.

If the nurse reports to jury duty and actually serves on a jury, such nurse will not be required to report back to work on that day. If the nurse reports for jury duty but is released for the day, the nurse will return to the Hospital for remaining contingent shift hours. A nurse scheduled for the night shift immediately prior to a day of jury duty will be taken off the night shift schedule and given a contingent day shift schedule. The nurse will be available for normal weekend rotation in any workweek the nurse does not serve a minimum of four days on jury.

12.5 **Paid Administrative Leave:** Paid administrative leave is defined as the Hospital removing an employee from work, with or without notice, in accordance with the following. Paid administrative leave is used when an employee is under an investigation for misconduct, or for other reasons specifically approved by HR leadership, in writing. Paid Administrative leave is outside of applicable leave or paid time off policies (i.e. ETO, ESDP, Leaves of Absence, Accommodations, Worker’s Compensation, etc.), and those policies will control wherever applicable. When the Hospital, in its discretion, places a nurse on paid administrative leave, the Hospital shall pay the RN their base pay based upon their regularly scheduled FTE hours. ETO, ESDP, and Seniority accrual will continue while a nurse is on paid administrative leave.
ARTICLE 13 – BENEFITS

13.1 Disability Insurance: ARRMC agrees to continue its current long-term disability insurance or a substantially equivalent program for nurses who meet the eligibility requirements of said plan. ARRMC will pay the full premium.

Part-time nurses will be eligible for pro-rated long-term disability benefits according to hours worked.

A short-term disability plan, which includes coverage for pregnancy-related disabilities, is available to eligible employees. The employee pays the full premium for this optional plan. Nurses may access the details of this plan in the Human Resources office.

13.2 Group Life Insurance: ARRMC agrees to continue its group life insurance or a substantially equivalent program for nurses who meet the eligibility requirements of said plan. ARRMC will pay the full premium for the $50,000 maximum plan coverage. Additional insurance coverage may be purchased by employees.

13.3 Retirement Plan: The Hospital agrees to continue the existing retirement plan or a substantially equivalent plan for all nurses who meet the eligibility requirements of the plan. Asante will continue to contribute 3% of gross salary to all eligible employees.

13.4 Health Insurance Coverage: Asante currently offers three (3) medical insurance plans to bargaining unit RNs, as follows:

- Asante PPO Health Plan
- Asante Saving Health Plan
- Asante Reimbursement Health Plan

It is understood that Asante Health Plans have a pharmacy component which will be considered part of the Asante Health Insurance Plan(s) for all purposes under this Article 13.

A. Premium Plan Cost, and Redesign: Premiums for the three (3) Asante medical plans will be shared between the eligible employee and the Hospital based on full
time; part time (scheduled minimum of fifty-six (56) hours per pay period), or part
time (scheduled forty to fifty-five (40-55) hours per pay period) status, and based
on four tiers of available coverage.

The individual RN premium will not increase above eight percent (8%) per calendar
year.

Plan premiums will be allocated between the Hospital and the registered nurse,
exactly the same as between the Hospital and other comparable employees covered
by Asante medical plans. Comparable employees are those with similar family status
tier and scheduled hours status, wellness plan participation, care management, and
other consistently applied, specific identifiable factors. Such factors will be first
negotiated under Article 13.4.C, will be applied equally to all comparable plan
participants, and will be based on objective criteria.

There will be no distinction made between salaried and hourly Hospital employees
for purposes of health insurance benefits and premiums.

Health benefits eligibility and cost sharing will change as of the first of the month
after the effective date of a formal scheduled hour status change, except as provided
otherwise by law.

B. Eligibility: A nurse is "full-time" for purposes of eligibility for health benefits if the
nurse is regularly scheduled to work at least seventy-two (72) hours a pay period,
with scheduled ETO counting as time worked. A nurse is "part-time" for the
purpose of eligibility for health benefits if the nurse is regularly scheduled to work
forty (40) to seventy-one (71) hours a pay period, with scheduled ETO counting
as time worked. A flexible status nurse may also become eligible for health
benefits due to the application of the rules under the Affordable Care Act. Such
flexible RNs who accept offered coverage will not be eligible for the fifteen
percent (15%) wage premium during all coverage periods.
C. Plan Modification: The Hospital will offer bargaining unit nurses the same plan(s) it offers to all other comparable eligible Asante employees, that is, the same deductibles, co-insurance, premium sharing, benefits, and eligibility.

It is recognized that regulation of health insurance on both the Federal and State of Oregon levels will likely continue to occur. In order to meet new mandates, the Hospital may need to modify its health insurance plans to comply with law and to avoid penalties and taxes for maintaining practices or plans which are disfavored by such new laws and regulations. Plan modifications may also be made in light of annual cost increases.

When changes in any aspect of Asante health insurance plans are proposed by the Hospital, the following negotiation procedure will take place:

1. The hospital will give the ONA at least sixty (60) days advance notice and opportunity to negotiate about proposed changes. This sixty (60) day period will be shortened only if required by legal implementation deadlines. This sixty (60) day period will supersede and replace the thirty (30) day period (prior to final Hospital action) in Article 4 hereof. No plan changes will be made until this negotiating period has expired.

2. The parties in such negotiations will consider and analyze the proposed changes. The goal will be to modify the plans in such a way as to retain the best and most acceptable plan benefits possible, in light of legal requirements, the adequacy and sufficiency of providers, and the cost to both the hospital and nurses. The following factors will be considered when determining whether there are "adequate and sufficient" providers in the AHN network: (1) whether there are choices of providers and provider groups, recognizing that there may only be one provider or group for certain specialties in the area; and (2) whether the AHN network includes providers who have privileges at the Hospital; and (3) the ability of providers in the AHN network to provide timely appointments.

To facilitate collaboration, the Hospital shall provide updated data on
usage in each Category. In addition, the Hospital shall provide the
Association with a list of provider groups and individual providers by
specialty who are within the AHN network. This information shall be
provided at LMC on a quarterly basis.

3. Changes in plan benefits and premiums for an upcoming year will be
finalized no later than September 15 of each year, and negotiations will
start at a sufficiently early date to meet this goal (no later than July 15).
The Hospital shall obtain actuarial premium projections as soon as
possible for an upcoming plan year; share all such information with the
Association; and expeditiously negotiate with the Association regarding
benefit and premium reconfigurations. Information about proposed
upcoming plan year changes will be provided one (1) week in advance of
meetings on such changes. Additionally, the Hospital and the Association
will meet at least once, prior to July 15, to review plan performance during
the plan year.

4. Strategic planning for health care benefit and premium changes will be an
ongoing process, and part of an Association-Hospital partnership tasked
with analyzing short-term (annual) and long-term (multiple year) legal,
cost, and strategic health insurance initiatives and actions. This process
will involve, at least three (3) meetings per year (unless otherwise agreed
between the parties) to discuss strategic plans for all health insurance
issues, and to obtain input on such issues from unit RNs as health care
professionals. Up to five (5) RN participants will be compensated at their
regular straight time rate at such annual meetings. The above sixty (60)-
day negotiating time limit will only apply to health insurance changes to
be implemented promptly by the Hospital, not long-term strategic health
insurance issues, to effect plans for the upcoming enrollment period.

5. If significant modifications to the plan are required through legislation, or
judicial decision, executive order, or administrative regulations during the
contract term, the Hospital and the ARRMC ONA will bargain over the
D. **Medical Benefits Advisory Committee:** Strategic planning for medical benefits will be an ongoing process, which will include an Asante-wide Medical Benefits Advisory Committee. ONA may appoint up to five (5) RNs from the bargaining unit to participate on this advisory committee. All nurse representatives on the committee will be paid at their straight time rate for time spent in scheduled meetings. This committee will meet quarterly to review the current medical plan, anticipated cost increases, significant design changes, access concerns, as well as data on utilization of the plan. The committee may also provide recommendations regarding plan design and cost controls, including, but not limited to, the prescription drug program, premiums, co-pays, and provider accessibility provided under the plan.

E. **Infectious Disease Fund:** An infectious disease Fund will remain in place with the Asante Foundation as the independent administrator that will be authorized to receive direct nurse contributions and matching Hospital contributions, the latter not to exceed $10,000 per calendar year, to be used to pay nurses who contract an infectious disease from their duties at ARRMC and are eligible thereby for workers’ compensation. A lump sum payment of up to $1,000 will be provided to nurses who request it, depending on the balance in the fund.

F. **Non-Coverage Option:** A nurse who certifies to ARRMC in writing with adequate substantiating documents that the nurse is covered by another health insurance plan may elect to have no health benefit coverage through ARRMC. Such election to withdraw from coverage must comply with state and federal law and be without penalty or tax to the Hospital.

G. **The Hospital will maintain a hotline at 541-789-1234 which may be used by employees and those covered by their plan, to establish with an APP Primary Care Provider. It will also allow those covered by a plan who are established with an APP clinic to make appointments for appropriate acute care needs for either the same day or next business day at the clinic where they are established.**
Physical examinations: At the beginning of employment ARRMC will provide a comprehensive employment physical for full-time and part-time nurses. ARRMC will provide full-time and part-time nurses, once every two (2) years and at ARRMC’s expense, the following tests when ordered by the nurse’s primary care provider:

- A Complete Blood Count
- Chemistry screen
- Pap Smear
- Chest X-ray
- An EKG (For nurses age forty (40) or older)
- A Mammogram (For female nurses age thirty-five (35) or older)
- Colonoscopies every five years at age 45+, or younger if family history warrants such early detection protocols.

Laboratory Examinations: When directed by ARRMC’s infection committee, a laboratory examination will be provided by ARRMC at no cost to the nurse.

Dental Benefits: ARRMC agrees to continue its dental benefits or a substantially equivalent program for all nurses who meet the eligibility requirements of said plan. ARRMC will contribute a minimum of 80 percent for single-party coverage and a minimum of 70 percent for two-party and family coverage.

Leaves of Absence: Except as described below, nurses may continue their enrollment in the medical health and dental benefit program during approved leaves of absence as listed in Article 12.1 by paying the full monthly premiums. With respect to leaves for personal or family illness as covered by the Family & Medical Leave Act of 1993, ARRMC will make premium payments under this Article for the required number of months in connection with such leaves. ARRMC may require such illness to be certified by a physician.

Flexible Spending Accounts: To provide nurses the opportunity to maximize take-home pay by paying certain predictable expenses with pretax dollars, ARRMC will continue its current flexible spending accounts which qualify under Sections 125 and 129 of the Internal Revenue Code.
13.10 **Infection Control Protocol:** When ARRMC requires an asymptomatic RN, who is apparently healthy and capable of working to miss scheduled work pursuant to ARRMC identification of a potential communicable disease, and ARRMC initiation of infection control protocol:

A. The RN will be offered available and suitable work to make up the lost scheduled hours, if this can be done without risk of infection to other employees.

B. Alternatively, ARRMC will pay the RN for the lost scheduled hours at the RN’s base rate.

C. ARRMC will pay for testing and treatment expenses.

This Section is not designed to become operative when an RN is actually sick or injured. In such event, normal ESDP and ETO utilization and eligibility for workers’ compensation will apply.
ARTICLE 14 – PROFESSIONAL DEVELOPMENT

14.1 Performance Reviews: Hospital will provide evaluations of the work performance of each nurse covered by this Agreement.

Bargaining unit nurses will be requested to provide feedback on other employees for purposes of peer reviews. (The bargaining unit RN who provides such feedback will not be part of the performance review unless the employee requests.)

14.2 Compensation for Required Education: In the event a nurse is required by ARRMC to attend educational functions outside the nurse's normal shift, the nurse will be compensated for the time spent at such functions at the nurse’s hourly rate. RNs on an extended (ten (10) or twelve (12) hour) night shift will be compensated at the straight-time rate plus applicable shift differentials they would normally be paid if they are required to miss a scheduled shift to attend a required eight-hour educational function during day shift hours. When feasible, an extended shift RN working nights may choose to return to work for some part of the remaining shift hours following such a required educational function. Other than the above, night shift nurses will not be scheduled an additional shift to make up for the canceled shift in such situation. Extended twelve (12) hour day shift RNs will be compensated at the straight time rate plus applicable differentials they would normally be paid if they are required to miss a scheduled shift to attend a required eight (8) hour educational function during day shift hours. When feasible, an extended shift RN may, but is not required to, work some part of their normally scheduled shift after an eight (8) hour education class or function. The term “education” will include ARRMC-requested individual training in specialty as well as other educational training.

Procedure for extended night shift RNs to attend day shift mandatory educational classes:

**Step 1:** Determine if the class is available on a day outside of regularly scheduled night shifts. If so, schedule on that day.

**Step 2:** If not, engage in interactive communications to determine possible voluntary alternate days of scheduled work – up to FTE status – in the workweek in question to help facilitate attendance.

**Step 3:** If, based on all circumstances and with manager approval, a mandatory
education class must be scheduled on a day shift falling between two consecutive regularly scheduled night extended shifts, the Hospital will take the RN off the night shift schedule and pay twenty-four (24) hours straight time to the affected RN, to be allocated as follows:

Twenty-four (24) hours pay for the eight (8) hour educational course and missed night shift no. 1 and no. 2.

When a regularly scheduled twelve (12) hour shift starts between 1500 and 1800 hours, and the RN on such a scheduled shift is required to attend an eight-hour educational program during day hours (typically 0600 to 1700 hours), any extra four hours work will be scheduled contiguous to the educational program and within normal scheduled shift hours.

14.3 **Voluntary Paid Educational Leave:** Continuing education and accompanying educational leave for RNs is an important part of the Hospital’s patient care mission, and therefore should be a priority component of unit-based scheduling.

Except as provided in Article 14.2 above with respect to night shift RNs, mandatory education courses and/or leaves shall not affect voluntary educational leave allowances.

The Hospital will provide the Association reports on RN voluntary educational leave utilization on Association request, such requests to be made no more frequently than every six (6) months.

After each year of employment, regular status nurses will be eligible for thirty-six (36) hours paid education leave per fiscal year October 1 through September 30. An annual maximum of 3,200 hours (of which a maximum of 1,600 hours will be granted during the first six (6) months of the fiscal year) paid education leave will be provided by ARRMC for this purpose. The RN must show proof of attending the educational course or activity or will forfeit this paid educational leave. The RN will receive pay for the hours missed due to the educational leave, not to exceed the nurse’s regular FTE, at the RN’s normal rate of pay, calculated in the same manner as ETO pay. Voluntary paid education leave will not count towards overtime or any other premium payment. The Hospital will work
with RNs requesting paid educational leave to minimize lost work hours, or to reschedule
hours. In particular, the nurse and their clinical manager will agree on the scheduled
shift(s) to be missed in connection with deciding upon an educational leave request and
paid educational leave will be available for all such hours if the request is granted.
Normally no work at the Hospital will be required on educational leave days.

This thirty-six (36) hour annual paid educational leave is the maximum Hospital
management may award an eligible RN. It is not a guarantee or entitlement.

A. Eligible Programs: Education leave will be available for programs sponsored by
hospitals, education institutions, government agencies or professional
associations. RNs will be eligible for paid educational leave for programs related
to current or future RN patient care responsibilities, and which will benefit both
the RN and ARRMC.

ARRMC will pay twelve (12) hours of educational leave to RNs who are granted
leave for the Association conference/convention by the Hospital without review of
program content.

B. Reimbursement: Each nurse who successfully completes such seminar or
program is entitled to reimbursement of expenses, including, but not limited to,
tuition, CEU costs, travel, mileage, lodging, exam fees, books, and meals of up to
One Thousand Six Hundred Dollars ($1,600.00) per fiscal year,
accumulating over two (2) years if not fully used, up to One Two Thousand Two-
Hundred Dollars ($1,200.00 2,000.00).

C. Requesting Educational Leave: Requests for such leave will be made in writing
to the department clinical manager with a copy to the PNCC Co-chairs, on a
record made available by ARRMC. The request will set forth the details and
purpose of the program. Approval of education leave will not be unreasonably
denied. It is understood by the parties that the Hospital will not be required to
grant approval for a request of education leave if such leave would seriously
interfere with staffing.
D. **Unused Educational Leave:** A nurse entitled to apply for education leave and who does not apply waives it for that year. However, unused leave will accumulate if a nurse applies for and does not receive leave in a year for which she/he is qualified but cannot be accumulated for more than three years.

E. **Allocating Educational Leave:** Scheduling for educational leave and funds will be subject to equitable rotation among RNs in a department. Nurses who have been denied educational leave in one instance will have priority, on an equitable basis, for scheduling educational leaves for the next requested event or program. All denied leave requests will be sent to the applicant with a letter of explanation. If the educational leave has been denied because of staffing issues and the nurse finds a replacement, educational leave will not be arbitrarily denied. It is also the intent of the parties that educational leave will be available to nurses on all shifts on an equitable basis.

Nurses need to keep records of denials and make clinical managers aware of their priority, upon the next educational leave request, to ensure priority is given over nurses who were granted, or who did not apply for, educational leave in the prior instance.

F. **Reports:** The nurse may be requested by ARRMC to make a report regarding the education experience.

G. **Scheduling Educational Leave:** ARRMC will make reasonable work schedule accommodations for nurses scheduled to work on the day of an education program.

H. **Overtime Pay:** Overtime pay will not be a reason to deny voluntary educational leave, but the only overtime qualifier for such educational leave overtime pay is hours over forty (40) per workweek, that is, consecutive days, consecutive weekend, twenty-four (24) hour rule, etc. overtime rules do not apply to voluntary educational leave hours.
I. **Eligibility:** Nurses will be eligible for the benefit on their continuous Asante employment anniversary date.

14.4 **Mandatory Initial and Renewal Certifications:** For certifications that are a mandatory job requirement for a position, including but not limited to: BLS, PALS, TNCC, ACLS and Fetal Monitoring, the Hospital will pay for renewal of such certifications. The Hospital will pay for initial required certification(s) for nurses participating in the New Graduate RN Program or Nurse Residency Program. Nurses who wish to obtain required certification for other departments will first use their contractual ONA Education funds and if such funds are exhausted and a nurse is awarded a position for which such certification is mandatory, the Hospital will pay for the initial certification.

14.5 **Tuition Reimbursement – Institutes of Higher Learning:** ARRMC will provide reimbursement for tuition, fees, and books to regular status nurses who complete approved education programs.

A. **Relevance of Course:** The course must relate to the nurse’s current hospital work or future hospital positions, and constitute undergraduate or graduate course work, or seminars, for which credit is offered through an institute of higher learning. This determination will be made at the discretion of the Hospital.

B. **Approval by ARRMC:** Nurses must request reimbursement on form P 56, which will be readily accessible through Asante.net (intranet) and the Asante HRIS system, and receive authorization in writing prior to the start of the program. The written request which should include goals to be obtained and must be submitted to the nurse’s department director. Approval of tuition reimbursement will be made by the Vice President for Nursing ARRMC upon the recommendation of the nurse’s clinical manager, and a copy of the approval sent to the PNCC Co-Chairs.

C. **Satisfactory Performance:** For reimbursement the nurse must receive a "C" or higher grade or for pass/fail courses the nurse must pass.
D. **Reimbursement:** Regular status RNS will be reimbursed for courses completed as follows:

After completion of one (1) year of continuous service, one hundred percent (100%) tuition reimbursement to a maximum of $2,000 per fiscal year, or to a maximum reimbursement as specified in Hospital policy if a higher amount, subject to any Hospital policy requirements. (Such higher policy reimbursement will be subject to policy restrictions, for example, RN has no final written warning, no book reimbursement, etc.).

E. **Increases in Reimbursement:** ARRMC may in its discretion increase tuition reimbursement benefits above those set forth in this Section.

F. **Flexible Status Nurse Reimbursement:** The One Thousand six hundred Dollars ($1,000.00) annual fiscal year reimbursement (accumulating over two (2) years if not fully used, up to One Two Thousand Two Hundred Dollars ($2,000.00)) will be made available to flexible status nurses who work a minimum of 1,040 hours in the prior fiscal year October 1 through September 30.

14.6 **In-Service Education:** ARRMC, in making decisions on paid educational leave, will generally consider the RN’s attendance at in-service meetings and staff meetings (with reference to ability to attend in light of shifts worked and patient care needs), participation in ARRMC educational programs and review of policies or medical literature.

Short in-service programs during which an RN retains patient care responsibilities will be considered patient care hours worked for purposes of Article 6.13 double time.

14.7 **Staff Meetings:** It is recognized that ARRMC in-service programs and staff meetings are an important part of professional development, and attendance is expected. Nurses must attend a minimum of four (4) staff meetings per year, **in-person**. For any additional staff meetings that a nurse is unable to attend, the nurse is expected to read and initial minutes, if available. Staff meetings will be scheduled proportionally during day shift and night shift hours to ease attendance. All staff meetings will offer attendance by phone or electronic method; however, attendance by phone or electronic method will not count.
toward the minimum requirement of four (4) staff meetings per year. A schedule of meeting dates and times will be posted annually in each unit to facilitate ease of scheduling. Each unit will schedule a minimum of eight (8) staff meetings per year. The minimum meeting requirement may be waived or adjusted for a nurse who has been on an approved leave of absence.
ARTICLE 15 – COMMITTEES

The committees in this Article serve a valuable patient care purpose. The committees shall schedule regular and predictable meetings as early in advance as possible, at times which will facilitate maximum attendance. Schedulers and managers will plan for coverage, to allow committee member RNs release time from work for such committee meetings, understanding that patient care is dynamic and that staffing needs at times may prevent such release. All RN committee members’ time shall be compensated.

The Hospital and the Association will agree on schedules for the following committees that allow participation, to the maximum extent possible, of nurses on all shifts.

The Hospital and the Association will each attempt to select committee members to minimize work schedule/committee meeting conflicts.

All committee members will make reasonable efforts to attend all meetings.

Release time for RNs on the Staffing Committee will be provided, in accordance with law.

If a committee member has to miss a meeting, the chair(s) will request a volunteer to brief that individual on the committee’s discussions.

15.1 Professional Nursing Care Committee: The Association will elect from its membership at least five (5) members of the bargaining unit who will constitute the Professional Nursing Care Committee (PNCC). The Association may elect or appoint additional members. The Committee will prepare an agenda and keep minutes and a roster of all of its meetings. ARRMC will provide paid release time (estimated two hours per month) for each of the five (5) members of the Committee when the monthly meeting occurs during duty time. Administration will also provide a PNCC mailbox in the employee cafeteria. Administration members of the PNCC will attend the PNCC meeting every other month. For meetings that the Administration members do not attend, the Association members will be responsible to complete and provide minutes and a roster to the Administration members within seven calendar days of the meeting.

The Committee will consider those matters regarding patient care and nursing practice
which are not proper subjects to be processed through the grievance procedure.

The Committee will partner with the Hospital to promote excellence in clinical practice and engagement through a mutually agreed upon Nursing Clinical Ladder Program. The Clinical Ladder is a program to recognize and reward Registered Nurses who actively engage in professional role development, advancement and redesign of clinical practice, and a positive work environment/culture. These actions take place through professional development, continuous learning, teamwork, leadership and innovation, shared governance, and/or community outreach. The ARRMC Nursing Clinical Ladder establishes the recognition that everyone is personally accountable for his or her professional practice, professional growth, and positive contribution to the workplace.

**Responsibilities of the PNCC:**

1. Collaborate with the Hospital to develop and implement a mutually agreed upon ARRMC Nursing Clinical Ladder.

2. Assist staff nurses to maintain professional standards, examine issues, and make recommendations regarding improved nursing practices and patient care outcomes.

3. **Route Address** clinical practice issues **within ARRMC to appropriate Asante Nursing Council,** or research evidence based best practice and solutions in the context of the Clinical Ladder process. **Recommendations that impact other Asante locations will be routed to the appropriate system-wide committee.**

4. Have access to and be able to evaluate data related to the quality of nursing care, except statutorily protected confidential information.

5. Review and provide recommendations for use of Voluntary Paid Education Leave and Reimbursement provided under Article 14.3.
6. Review and provide recommendations relating to the Hospital’s plan to address equity, diversity, and inclusion, as developed by the hospital-wide steering committee.

Membership/Activities/Actions and Reporting:

1. There will be a chairperson and secretary elected by the members of the Committee.

2. There will be two management members of the Committee (6th and 7th members) appointed by Administration. Administration may appoint up to two (2) additional participants.

3. The chairpersons will prepare and distribute an agenda for each meeting.

4. The approved minutes of each meeting will be distributed to the Vice President for Nursing, and to the Labor-Management Committee. The ONA Co-Chair also will provide the minutes to the ONA Executive Committee. PNCC activities will be reported to the bargaining unit members quarterly.

5. The five (5) formal PNCC members appointed by the Association will receive straight time pay (normally two (2) hours) for attendance at PNCC meetings. The secretary will receive additional straight time pay when required to prepare minutes, reports, or correspondence (normally one (1) hour’s pay).

6. The committee will develop a yearly calendar of activities consistent with the goals of the Committee. Committee will be developed.

15.2 Labor-Management Committee: The Labor-Management Committee is an advisory committee created to provide a forum for regular ongoing communication between the ONA and Hospital administration regarding issues of mutual interest. This Committee shall meet a minimum of six (6) times during the course of the calendar year. Meeting dates and times will be established by the Committee to best accommodate work schedules of Committee members. Typically, the Labor-Management Committee will
meet every other month, in months in which the Administration members of the PNCC are not attending the PNCC meeting.

The Labor-Management Committee shall discuss new or existing work rules, policies, and other non-contractual issues as a means to minimize these issues and create an atmosphere conducive to positive resolution and cooperation.

This Committee is not intended to replace the collective bargaining process or the grievance procedure that is outlined in Article 17 of this Agreement. The Committee, however, may discuss Hospital practices or policies which have led to grievances. No individual employee grievance or contract language changes will be discussed. The Labor-Management Committee may confer with PNCC when appropriate to address nursing practice issues, which are primarily assigned to the PNCC. It is expected that increased communication between Hospital representatives and ONA representatives will reduce the necessity for formal grievances. The Labor-Management Committee has not been created to replace other Hospital committees, but rather to address non-contractual issues related to policy application and general working conditions, RN concerns, and morale.

The Hospital will select three members, of which one shall be a Patient Care Services representative. The ONA Committee membership shall consist of the ONA Field Representative and three nurses to be selected by the bargaining unit. The Labor-Management Committee is considered a Hospital committee and employees will be paid for time spent in Committee meetings. A member of the Board of Directors and a representative of the ARRMC medical staff will be invited to attend the LMC on a quarterly basis. The purpose of this meeting is to share information about existing issues affecting nursing practice and professional standards, including recommendations made by the PNCC. Minutes and meeting materials of this quarterly meeting shall be provided to the participating Board member and medical staff representative.

After ratification of this Agreement, the Hospital will provide patient care supervisors and managers with an in-person training to review the current collective bargaining agreement. This training will be facilitated by the Hospital based on content agreed-upon by the LMC.
15.3 **Hospital Nurse Staffing Committee:** The Hospital Nurse Staffing Committee shall be composed of an equal number of nurse managers and bedside registered nurses, including at least one (1) direct care registered nurse from each unit or specialty area as defined by the Hospital, to be selected by the Association and one direct care staff member who is not a Registered nurse and whose services are covered by the written hospital wide staffing plan. The Union will actively promote a goal of attendance by the primary or secondary bedside representative of at least 50% of ARRMC recognized nursing units at each Hospital Nurse Staffing Committee meeting. Pursuant to current Oregon staffing laws, the Committee shall have as its primary goal the provision of safe patient care, and adequate nurse staffing, and the development, monitoring, evaluation, and modification of the staffing plan for nursing services. The Hospital Nurse Staffing Committee shall meet at 08:00 to allow participation of day shift and night shift nurses.

In developing the staffing plan, the Hospital Nurse Staffing Committee may consider will be based on:

- **A.** The specialized qualifications and competencies of the nursing staff and the skill mix and level of competency needed to ensure that the hospital is staffed to meet the health care needs of patients;
- **B.** The size of the hospital and a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;
- **C.** The unit’s general and predominant patient population as defined by the Medicare Severity Diagnosis-Related Groups adopted by the Centers for Medicare and Medicaid Services, or by other measures for patients who are not classified in the Medicare Severity Diagnosis-Related Groups;
- **D.** Nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations, if any;
- **E.** Differences in patient acuity;
- **F.** Tasks not related to providing direct care.

Patient acuity, intensity, and census, with the ultimate goal of safe, quality care;
National specialty standards and guidelines and other Hospital comparative data); and

Patient outcome indicators, including but not limited to American Nurses Association quality indicators and ONA staffing and documentation request data.

Bedside nurse members will be released from duty for Committee meetings as well as subcommittee meetings and other duties related to Committee work as requested by the Committee. Alternate members will be released from duty when replacing a regular member. Nurse members and alternates will be paid their hourly wage, plus appropriate differentials, for time spent in the above Committee activities. Association members who oversee the selection of the registered nurse members and alternates will also be entitled to be paid for hours spent in activities requested by the Committee. In the event the provisions of the current Oregon staffing laws are changed, the provisions of this Article will be deemed modified in accordance with such changes.

**Shared Information:** On a quarterly basis, the Hospital will provide the following information to the Hospital Nurse Staffing Committee, separated by department/unit:

- Department FTE, overtime hours worked, standby hours worked, shadow vacancy rate, ASI/CNI hours worked, hours worked by contract/agency nurses.
- **The percentage of shifts which deviated from the approved staffing plan by unit and shift.**
- **The number of meals and rest breaks missed by direct care staff by unit.**

**15.4 Unit-Based Staffing and Scheduling Committees:** It is the responsibility of each nursing unit to **A) create unit-based staffing and scheduling guidelines; and B) develop the unit’s staffing plan to be presented to the Hospital Nurse Staffing Committee turn in a balanced schedule and staffing plan.**

Each unit shall elect a **Staffing and Scheduling committee bi-annually.**

This unit committee will work collaboratively with the unit manager to develop consensus on protocols, communications, guidelines, and rules to accomplish a balanced staffing plan.

The Unit-Based Staffing and Scheduling Committee membership will be composed of department RNs and department leadership. Staff RN members will be elected bi-
Unit-Based Staffing and Scheduling Guidelines: This unit committee will work collaboratively with the unit manager to develop consensus on protocols, communications, guidelines, and rules to accomplish a balanced schedule. The committee will be responsible for developing Staffing and Scheduling guidelines that will be voted on at minimum every two years and when changes are made. A valid vote shall have a majority of the department’s RN’s participation and a majority vote in favor or against (50% + 1 RN). All recommendations and/or guidelines of the unit committee shall be approved by a majority vote of RNs on the unit, including any changes thereto. All recommendations shall be consistent with the ONA-ARRMC collective bargaining agreement, and with the procedures and protocols of the Hospital Nurse Staffing Committee.

Unit-Based Staffing and Scheduling guidelines should address:

- Procedure for fair and equitable float rotation, including how floating is tracked.
- Procedure for fair and equitable granting of voluntary standby, mandatory call off, and mandatory standby.
- Procedure for requesting, tracking, and granting schedule pattern requests.
- Procedure for providing a balanced schedule prior to the schedule being posted. This includes a fair and equitable rotation for schedule changes to achieve a balanced schedule.
- Definition of prime-time months for purposes of ETO granting.
- Procedure for granting ETO requests fairly. This includes annual ETO requests and ongoing requests throughout the year.

Unit Nurse Staffing Plan: The Hospital Nurse Staffing Committee representative for the unit shall coordinate and communicate with each Unit-Based Staffing and Scheduling committee on the unit they represent, as requested. The unit’s recommended Nurse Staffing Plan will be developed collaboratively with unit leadership and the unit-based Staffing and Scheduling Committee, ensuring all legal requirements are fulfilled, including consideration of those items listed in Section 15.3, A-F, above, which are the criteria the Hospital Nurse Staffing Committee may consider in approving each unit’s...
Nurse Staffing Plan. All RNs on the unit will have an opportunity to provide feedback on the unit’s Nurse Staffing Plan prior to presenting it to the Hospital Nurse Staffing Committee.

The unit-based representative of the Hospital Nurse Staffing Committee will be responsible to co-present the unit’s recommended Nurse Staffing Plan with the unit’s leadership at least annually. Each unit committee will consider bedside hours, acuity, intensity, and case mix index for the unit. The unit committee, in collaboration with the unit manager, will also develop consensus on equitable floating, Staffing Standby, and ETO guidelines. All recommendations and/or guidelines of the unit committee shall be approved by a majority vote of RNs on the unit. All recommendations shall be consistent with the ONA-ARRMC collective bargaining agreement, and with the procedures and protocols of the Hospital Nurse Staffing Committee. The unit committee shall report findings and recommendations annually to the Hospital Nurse Staffing Committee. If the unit committee identifies concerns with unbalanced schedules, including skill mix, it will bring patterns of concern to the Hospital Nurse Staffing Committee.

Each nursing unit scheduling committee will review its 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 acuteness 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 must be
provided for that level.

F. A description of the minimum number of registered nursing staff personnel
required on a specified shift, with no fewer than one (1) RN and one (1) 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.

H. Description of a process for reporting (verbal and written) when safe patient care
does not occur. This will include notification of the 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 of the unit scheduling committee 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 Staffing Standby, float, staffing,
ETO guidelines, 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 an
attempt to resolve the issue. If the dispute(s) cannot be resolved at this step, the final
decision will be made by a majority vote of the Hospital Nurse Staffing Committee. Any
violations of this procedure will be resolved through the Article 17 grievance process.

15.5 Code Triage Incident Command: Upon initiation of Code Triage Level 1, one ONA
representative, designated by the ONA, in writing to the hospital, shall have the right to
may attend Incident Command.
ARTICLE 16 – EMPLOYMENT STATUS AND DISCIPLINE

16.1 **Probationary period:** Asante has a formal introductory period. An employee’s first six months as a new employee, or as an employee transferred to another unit during the first six months, are intended to give their opportunity to demonstrate the ability to achieve a satisfactory level of performance and to determine whether the new position meets expectations. Asante uses this period to evaluate the employee’s capabilities, work habits and overall performance. If Asante determines that the designated introductory period is insufficient to thoroughly evaluate the employee’s performance, the introductory period may be extended for a specified time.

During a nurse’s probationary period, disciplinary action shall not be subject to the grievance procedure. A nurse who has completed his/her probationary period and feels he/she has been disciplined, suspended, demoted, or discharged without just cause may present the matter for consideration under the grievance procedure.

16.2 **Resignation Notice:** A nurse will give ARRMCh written notice not less than two (2) weeks prior to the time of intended resignation.

16.3 **Notice of Involuntary Termination:** ARRMCh will give a nurse who has completed the new hire/probationary period not less than two (2) weeks’ notice of termination, or pay in lieu thereof, unless the nurse is terminated for cause or matters which constitute a violation of professional nursing ethics, scope of practice, or gross misconduct. In such cases, there would be no two (2) week notice of termination or pay in lieu thereof, and to the extent allowed by law, ARRMCh would be entitled to set off against any accrued benefits or wages an amount equal to the damages sustained by ARRMCh as a result of the nurse’s conduct.

16.4 **Exit Interviews:** Nurses will receive an anonymous electronic exit interview upon voluntary termination. Upon request, a nurse shall be granted an exit interview conducted by the Human Resources department or another leader as designated by Human Resources when transferring to a different unit or upon discharge/resignation of employment. A summarized copy of the interview will be provided to the Association upon written authorization of the exiting nurse.
16.5 **Pre-Discipline Investigatory Meetings:** A nurse will be provided with advance notice of an investigatory meeting over any issue that may lead to discipline of the nurse, including the general subject matter of the investigation. Except in situations where immediate action is needed, the manager will work with the nurse to determine an appropriate time for the meeting, taking into account the manager’s and nurse’s schedule, and the staffing needs of the nurse’s unit. A nurse shall have the right to have an Association representative accompany them when there is a formal investigation pending possible disciplinary action, upon the nurse’s request.

16.6 **Progressive Discipline:** Coaching/corrective action is undertaken to clarify policy and performance expectations in a problem-solving, collaborative manner. Coaching/corrective action for most behavior or performance problems is usually handled in a progressive manner, with the level of counseling advancing from a minor action (such as a discussion) up to termination if problems persist. However, some infractions may be of such a serious nature that some or all of the normal progressive steps are skipped, and some infractions can result in immediate termination for the first infraction. Additionally, some or all of the normal progressive steps may be skipped for employees within their introductory period.

16.1.1 The following steps are considered general guidelines for situations requiring progressive corrective action related to work performance, attendance violations or unacceptable employee conduct. A fair and appropriate investigation is conducted, which includes listening to the employee’s side of the story. Each situation is ultimately handled at the discretion of the manager involved.

1. **Documented Verbal or Written Coaching**
2. **Written corrective action**
3. **Final written corrective action**
4. **Termination**

16.7 **Discipline:** Asante shall have the right to discipline, suspend, demote to a lower classification, or discharge a nurse for just cause. A nurse may be disciplined only for just cause. A nurse, who in the nurse’s opinion has been disciplined without just cause, may present the matter for settlement under the grievance procedure outlined in Article 17. Nurses who are absent from work without authorization are subject to discipline,
including discharge. Generally, ARRMC will not impose discipline suspensions
administrative leave of more than three (3) days, provided however that ARRMC may
impose a longer period of time as necessary to conduct a thorough investigation, which
may be converted to a discipline and/or termination depending on the circumstances. In
some cases, such as leave suspension for investigation of incidents such as fit-for-duty,
ETO may be used, that may exceed three (3) days, which may be converted to a
depending on the circumstances. Suspensions for investigation of incidents which do not
lead to a disciplinary suspension or termination will be paid time. All discipline
documents will be clearly labeled as such, and dated, and will be invalid after one (1)
year (except to show RN knowledge of a rule or policy). All discipline documents are
subject to the grievance and arbitration procedure.

ARRMC will not impose discipline based solely on data obtained from random systems
audits or electronic nurse locator or tracking devices without separate and independent
investigation of the facts.

Extreme proven dishonesty, patient abuse or endangerment, or violence, when the
behavior is akin to criminal offense, at an Asante affiliate of ARRMC resulting in
discharge, may constitute just cause for dismissal from ARRMC as well. The Grievance
and Arbitration Procedures of this Agreement apply to such situation

16.7.1 Reports to OSBN: The Chief Nursing Officer Vice President for Nursing will
review and analyze all corrective actions before any Hospital report to the Board of
Nursing and notify investigated RN that the report has been made.

16.8 Personnel Files: Nurses will have access to their personnel files in accordance with
Oregon Revised Statute 652.750(2)(3). No written notice of discipline or evaluation will
be placed in a nurse's personnel file or any anecdotal file without a copy first having
been given to the nurse.

16.9 Coaching: Coaching is a problem-solving process focused on improving performance.
Coaching (discussions or discussion notes about ARRMC policy or performance
expectations) will not be used for or considered discipline subject to the grievance or
arbitration process and will likewise not be considered to be any step of the progressive
Examples of inappropriate coaching documents: Any coaching documentation which is disciplinary in nature, which is prepared without appropriate investigation (which will always include, and may appropriately be limited to, a direct conversation with the affected RN), or which is pre-written prior to the direct conversation. These discussions or notes will solely and exclusively be used by ARRMC to show that prior communications about ARRMC policy and performance expectations have taken place, and to show RN awareness of the same.

ARRMC clinical managers may or may not prepare documentation of coaching sessions, after the coaching discussion has occurred. If such documentation is prepared, such discussion notes will be provided to the RN in question within seven (7) calendar days of the discussion or later, as mutually agreed with the clinical manager and nurse. Space will be provided on the discussion notes for the nurse’s response, which will be due within seven (7) calendar days of receipt. These seven (7) day periods will be suspended during any period when the nurse or the clinical manager is absent from work due to illness, approved leave, etc., or if there is mutual agreement to do so between the nurse and clinical manager.

Coaching Guidelines:

- Coaching is a problem-solving process focused on improving performance.
- Coaching typically is a two-way communication. RNs should be given the opportunity to provide input. In some instances, coaching may include email or other reminders, informing a nurse of policy expectations.
- Clinical leadership typically should investigate the facts prior to coaching unless the situation requires immediate action; this does not apply to auto-generated reminders of policy expectations.
- The investigation can be personal observation by a supervisor or part of the coaching meeting itself.
- Coaching should take place as soon as possible after an event occurs which shows the need for coaching—normally within seven (7) days of the event.
- Coaching is not discipline and should not be considered such by either the RN or clinical manager.
- Because coaching is not discipline, it is not subject to the grievance procedure.
16.10 **Evaluations:** Evaluations will not be considered discipline and are not subject to Article 18, Arbitration Procedure, unless an evaluation results in no step increase or other financial penalty.
ARTICLE 17 – GRIEVANCE PROCEDURE

17.1 **Time Limits Generally:** All time limits in this Article will be Monday through Friday only and may be extended by mutual consent, confirmed in writing.

17.2 **Grievance Defined:** A grievance is a dispute arising out of the interpretation or application of this Agreement. Each grievance must identify the Articles and Sections of the contract which have allegedly been violated, specifically outline the facts and events on which it is based and the requested remedy. A grievance may be filed by the Association or a nurse under the following procedure regarding disputes which arise during the term of this employment agreement. A probationary new hire RN may use the grievance procedure to contest discipline, or other alleged contract violations, but will not be entitled to process a grievance to arbitration, or to continue a grievance on discipline post-termination.

17.3 **Procedure for Processing Grievances:** Except in unusual circumstances (for example, when a problem directly relates to a supervisor’s perceived misconduct, when the supervisor has issued the discipline being grieved, or when it relates to an issue a supervisor has no involvement with or no authority over), an RN should present problems which may generate a grievance to their immediate supervisor for resolution before filing a formal grievance. The Association grievance officials will communicate this responsibility to all potential RN grievants. Grievances shall not be heard at Step 1 or Step 2 by any Hospital official who had a decision-making role with respect to the particular discipline being grieved. The parties recognize that it is best to fully resolve issues through such discussions whenever possible.

**Informal Fact-Finding Resolution of Potential or Actual Grievances:** Prior to the Step 1 hearing (or the Step 2 hearing with respect to grievance issues that may be presented initially at Step 2), the parties may choose to meet in a fact-finding meeting, and/or to determine possible resolution of a grievance. The same sort of meeting may occur with respect to an issue that may, but has not yet, given rise to the filing of a formal grievance. The Hospital will agree to suspend the ten (10) day grievance filing time restrictions (specified in the Step 1 procedures) when the ONA timely requests such a meeting on such an issue.

The Step 1 and Step 2 Hospital official’s obligation is to take a fresh, unbiased look at all
grievance issues, exercising neutrality and fairness. If a pre-hearing investigation of a
fact or issue is deemed appropriate by such official, both management and the ONA will
be asked about the fact or issue.

At either Step 1 or Step 2, the Hospital may conduct further factual investigation. When
this occurs, the Association will be notified of the results, and be provided an opportunity
for input, rebuttal, or challenge with respect to the newly discovered information before
the Step 1 or Step 2 written decision is finalized.

Step 1:  **Vice President for Nursing ARRMC:** If a nurse or the Association
decides that the problem should be treated as a grievance, the grievant
and an Association representative will submit the grievance in writing to
the supervisor, whom the nurse understands to be the “immediate
supervisor” and the Vice President for Nursing ARRMC or designee.

The nurse has ten (10) days from the date that they had knowledge of, or
should have been aware of, a contract violation upon which the grievance
is based, to file the grievance. The immediate supervisor and the Vice
President for Nursing ARRMC, or a designee, will meet with the grievant
and Association representative within ten (10) days to hear the grievance.

All filed grievances will receive a Step 1 hearing, with the Hospital
reserving the right to question whether the matter is a proper (for
example, under Article 16.4) or timely grievance. A written response will
be rendered to the grievant and the Association within ten (10) days.

***Association grievances will be submitted within the times described above
to the supervisor whom the nurse understood to be the immediate
supervisor involved in the dispute with a copy to the Vice President for
Nursing ARRMC.***

**Association Grievance:** A grievance, relating to occurrences involving
three (3) or more nurses, may be initiated by the Association at Step 1 of
the above-mentioned procedure by the filing of a written grievance,
signed by one of the affected nurses or a representative of the
Association, within ten (10) calendar days from the date of occurrence.

Such a grievance shall describe the problem and the contract provisions alleged to be violated.

**Step 2:**  
**Human Resources:** If the nurse is dissatisfied with the response under Step 1, the grievance may be presented to the Vice President of Human Resources or designee. The grievance, with a written outline detailing the matter, will be delivered or mailed to the Vice President of Human Resources or designee within ten (10) days of the receipt of the “Step 1” response or within ten (10) days from the expiration of time allowed for response. The requested remedy will be added to the written grievance by the Association before submitting the grievance to the Vice President of Human Resources. The Vice President of Human Resources or designee and the same representative for Patient Care Services present at the “Step 1” hearing will meet with the grievant, local bargaining unit representative and Association representative within ten (10) days from the receipt of the grievance with remedy. Together, they will attempt to resolve the grievance. The Vice President of Human Resources will render a written decision within ten (10) days from such a meeting.

When a nurse is terminated and presents a grievance of the matter to be considered, the grievance hearing may, at the discretion of the Association, be conducted at “Step 2.”

Either party may bring additional individuals (limited to Hospital employees or Association officials) to a Step 1 or Step 2 meeting whom either party believes may contribute to the investigation or resolution of the grievance, for example, witnesses, persons involved in making prior decisions with respect to the incident being grieved, etc. The parties will communicate in advance to identify the individuals who will attend such meetings. Association or management officials may also attend such meetings in order to learn how the grievance process works with mutual consent, including consent of the grievant.
Step 3.  **Arbitration:** If the issue is not settled on the basis of the foregoing procedure, the Association may submit the issue to arbitration by notifying the other party in writing within ten (10) days from receipt of the written response in Step 2, or if the written response is not received within that time period, within ten (10) days from the expiration of time allocated in Step 2 for the response.

17.4  **Resolution of Physician-RN Conflicts:** The appropriate clinical manager will try to resolve professional or interpersonal conflicts between RNs and physicians in an amicable way.
ARTICLE 18 – ARBITRATION PROCEDURE

18.1 Selection of Arbitrator. ARRMC and Association or their designees will meet as soon as possible after the grievance is submitted at Step 3 to select a mutually agreeable arbitrator. In the event ARRMC and Association are unable to agree on the selection of a third party within ten (10) days from the date the grievance is tendered in Step 4, the Federal Mediation and Conciliation Service will be jointly requested to submit a list of seven proposed arbitrators. The Association and ARRMC will each alternately strike from this list one name at a time until only one name remains on the list. The party striking first will be determined by the flip of a coin. The name of the arbitrator remaining on the list will be selected to arbitrate the matter.

18.2 Association and ARRMC Responsibilities. The parties will stipulate to the arbitrator, whenever possible, the issue or issues to be decided. The parties will jointly request that the arbitrator render a written decision within thirty (30) days from the hearing. The expenses of the arbitration will be borne equally by both ARRMC and the Association.

18.3 Authority of the Arbitrator. The jurisdiction of the arbitrator will be confined in all cases exclusively to questions involving the interpretation and application of existing clauses or provisions of this Agreement. The arbitrator will not have authority to modify, add to, alter or detract from provisions of this Agreement or to impose any obligation on Hospital or Association not expressly agreed to by the terms of this Agreement.

The decision or decisions of the arbitrator will be announced in writing to the parties and will be final and binding on both parties. It is further understood and agreed that the arbitrator’s decision may provide retroactivity not to exceed thirty (30) days from the date of the initial filing of the grievance as defined in this Article.

18.4 Arbitration of Discrimination Issues. In the event a grievance arises under Article 2 (Nondiscrimination), and such grievance is not resolved or otherwise terminated before arbitration, ARRMC and Association will stipulate on the record that the arbitrator, in deciding the Article 17 issue, may apply settled law under the Oregon Discrimination Laws, Title VII of the Civil Rights Act of 1964, or the Civil Rights Act of 1886. It is the understanding that the settled law which will be applied by the arbitrator usually will be found in decisions of the Supreme Courts of the United States or the State of Oregon.
Decisions of the Circuit Court of Appeals or the Oregon Court of Appeals will be utilized if the Supreme Courts have not decided the issue and there is no conflict in the decision of the Court of Appeals. In the event that an Article 17 issue is raised for the first time in the arbitration hearing, the parties agree to enter into the above stipulation without prejudice to the position of either or both that the issue should have been raised in the grievance procedure.
ARTICLE 19 – SEPARABILITY

In the event that any provision of this Agreement will at any time be declared invalid by any court or government agency of competent jurisdiction, such decision will not invalidate the entire Agreement, it being the express intention of the parties hereto that all other provisions not declared invalid will remain in full force and effect.
ARTICLE 20 – DURATION

Except as otherwise provided, this Agreement will be effective through September 30, 2026, and from year to year thereafter if no notice is served as hereinafter provided. If either party wishes to modify or terminate this Agreement, it will serve notice of such intention upon the other party no more than one hundred twenty (120) days and no less than ninety (90) days prior to the expiration or subsequent anniversary date.
IN WITNESS WHEREOF, ARRMC AND ASSOCIATION

Have Executed This Agreement as of [Insert Date Here]

OREGON NURSES ASSOCIATION

Fred Katz

Andrew Farina

Keith Coddington

Meagan Pereira

Joeseph Sasser

Misha Hernandez

ASANTE ROGUE REGIONAL MEDICAL CENTER

Amanda Kotler

Alicia Lorenz

Sarah Hillyer

Staci Sparks

Jackie Damm
EXHIBIT A – ECONOMICS

A.1 Future Gain Share or Incentive Program: Notwithstanding anything else specified in this Exhibit, the Hospital may implement any gainshare or incentive program above and beyond contract minimums during the contract term as long as the changes are implemented Hospital-wide, and the Hospital provides 30-day advance notice and opportunity for discussion/input to the Association.

A.2 Wages and Steps: The minimum base wages for nurses in the bargaining unit will be as specified on Exhibit D hereof.

A.3 Premiums: (effective the first full pay period following upon ratification).

<table>
<thead>
<tr>
<th></th>
<th>Per Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge Nurse</td>
<td>$6.003-50/hr.</td>
</tr>
<tr>
<td>Hospice Case Manager</td>
<td>$6.003-50/hr.</td>
</tr>
<tr>
<td>Operating Room Team Leaders</td>
<td>$6.003-50/hr.</td>
</tr>
<tr>
<td>Preceptor/Mentor</td>
<td>$2.501-90/hr.</td>
</tr>
<tr>
<td>BSN</td>
<td>$1.5025/hr.</td>
</tr>
<tr>
<td>Critical Care Outreach Nurse</td>
<td>$6.003-50/hr.</td>
</tr>
<tr>
<td>Nursing Resource Team</td>
<td>$6.003-50/hr.</td>
</tr>
</tbody>
</table>

A.4 Certification Bonus: Each nursing unit will identify and publicize at least one preferred, not required, advanced certification. There will be no payment for multiple certifications or re-certifications.

RNs with certification(s) as described above will receive $1.5025 per hour certification differential (regular status and flexible status RNs eligible).

A.5 Shift Differentials:

Days: No shift differential will be paid for hours worked between 7 A.M. and 3 P.M.

Evenings: A nurse will receive an evening shift differential of $2.50/hr on all hours worked between 3 P.M. and 11 P.M.

Nights: A nurse will receive a night shift differential of $10.004-75/hr on all hours worked.
between 11 P.M. and 7 A.M.

Consecutive Years Night Shift Work Enhanced Differential: Regular RNs with at least twelve (12) months of consecutive regularly scheduled night work (at least fifty percent (50%) of scheduled FTE hours on night shift) will receive $1.0050 increase, applicable as long as RN stays regularly scheduled (fifty percent (50%) test) on night shift ($11.00525/hr total night shift premium)

- Three (3) consecutive twelve (12) month periods regularly scheduled night shift – additional $1.0035c ($12.00560/hr total night shift premium)
- Five (5) consecutive twelve (12) month periods regularly scheduled night shift – additional $2.0035c ($14.00595/hr total night shift premium)
- All twelve (12) month periods will be evaluated four (4) times per year, on the first (1st) of January, April, July, and October of each year, with increases paid prospectively only.

A nurse who changes regular work shifts so as to lose the consecutive years night shift differential, but who returns to night shift for at least fifty percent (50%) of scheduled FTE 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.

Weekends: The nurse will receive a weekend differential of $2.5025/hr. The “weekend” is from 11:00 P.M. Friday to 11:00 P.M. Sunday.

An RN must work at least one (1) hour in a differential period to be eligible for the shift differential specified in Exhibit A.5.

A.6 Standby:

1. Standby Definitions:

- Scheduled/Procedural Standby: Standby regularly scheduled as a normal part of staffing a 24/7 procedural or procedural support unit. When on scheduled standby, the RN is required to report to work if called-in during standby hours. Required response times vary by unit.
• **Staffing Standby:** Standby assigned to a nurse who has been called off a normally scheduled shift. Staffing Standby is assigned at the request of the Hospital, and typically is assigned to volunteers. If there are no volunteers, the Hospital may assign mandatory staffing standby.

• **Mandatory Standby:** Mandatory standby is any standby for which a nurse has not volunteered. Mandatory standby is not intended to substitute for adequate staffing of nursing units. The parties agree that long-term, continuous mandatory standby needs to be addressed through staffing adjustments. The Hospital accepts its responsibility to determine staffing contingency requirements and the exact nature and length of standby time.

2. **Scheduled/Procedural Standby:**

   - Each nursing unit that requires scheduled/procedural standby may elect to schedule standby coverage under one of the two following options. The decision on which option to use will be determined by unit leadership, after first submitting it to the unit-based staffing and scheduling committee. In the event a department changes from one Option to the other, it will do so in accordance with the regular scheduling cadence.

   **Option 1 – Traditional Voluntary Rotation**

   **A. Scheduling of Scheduled/Procedural Standby:**

   *ARRMC will:*

   1. First attempt to solicit volunteers for such scheduled standby.
   2. In situations where there are not enough volunteers for scheduled standby, ARRMC may implement a fair rotational system for distribution of required standby among the nurses in the involved work unit in inverse seniority order.
   3. Mandatory standby will not be imposed unless other reasonable alternatives for adequate staffing are explored and are not successful for adequate staffing. Such reasonable alternatives include volunteers, floating employees from other units, utilizing available flexible employees, etc.
   4. Prior to any imposition of a mandatory standby system in a unit, the Hospital will discuss the situation with the Association and attempt to resolve problems in advance.
5. After twenty-five (25) years of service in any ARRMC job category (from date of hire) mandatory standby will not be required.

6. Up to two (2) primary charge nurses may be exempt from the traditional voluntary call rotation if the unit-based staffing and scheduling committee approves.

B. Additional Provisions for Callbacks to work while on Scheduled/Procedural Standby:

1. Standby After 1:00 a.m. for Day Shift Employees: When a nurse works at the Hospital while on standby after 1:00 a.m., the nurse will be given the opportunity to decline to work all or part of his or her regularly scheduled shift on that same day.

   Example: Nurse’s regular start time is 8:00 a.m. The nurse is called back from standby and works from midnight to 2:00 a.m. The nurse can either decline to work the scheduled shift or return to work at 10:00 a.m. Under no circumstances may a nurse be required to work more than sixteen (16) continuous hours, absent instituting the disaster protocol.

2. 10-Hour Rest: In addition, an RN who does not work call hours after 1:00 a.m. still retains the right to ten (10) hours rest before reporting to work.

   Example: Nurse’s regular start time is 6:00 a.m. Nurse works call hours 10:00 p.m. to midnight the day before. The nurse can report to work at 10:00 a.m.

3. Notice of 1:00 am or 10-Hour Rest Need: A nurse exercising either the “1:00 a.m.” or “10-hour rest” options must so inform the appropriate supervisor as soon as possible.
C. Scheduled/Procedural Standby Pay under Option 1:

1. Option 1 Standby Pay Rate: Nurses will receive $12.00 per scheduled standby hour. Nurses will receive the following tiered pay based upon the total amount of scheduled standby per month:

<table>
<thead>
<tr>
<th>Scheduled Standby Hours per Month</th>
<th>Standby Rate of Pay per Hour</th>
</tr>
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<tbody>
<tr>
<td>0 – 30 hours</td>
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<tr>
<td>61 – 90 hours</td>
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<tr>
<td>91 – 120 hours</td>
<td>$15</td>
</tr>
<tr>
<td>120+ hours</td>
<td>$16</td>
</tr>
</tbody>
</table>

2. Callback Pay Rate: Each time a nurse on standby is called to the Hospital, the nurse will be paid callback pay at the applicable rate for the actual time worked, but in no event for less than two (2) hours. Standby pay will continue during time worked while on standby status. Callback pay will include evening, night, and weekend differentials. Callback pay will include Charge differential, as applicable.

3. Short Notice Standby Call-back Pay: If an RN is placed on mandatory standby within forty-eight (48) hours, or volunteers to take a vacant standby shift within forty-eight (48) hours of the start time of the standby, the nurse will be paid double time if called back to work. In such situation, the RN placed on standby may agree with another nurse on the list to replace the nurse for such mandatory standby, and the double time rate will likewise apply if this nurse is actually called back to work. Alternatively, the RN may solicit a volunteer replacement nurse not on the list, who will be paid at the rate appropriate to that nurse if called back to work.

Option 2 – Rotating Weekly Call Schedule.
A unit may elect Option 2, a rotating weekly call schedule. This option may be elected by unit leadership after consultation with the unit-based staffing and scheduling committee.
A. Nurses will be scheduled to be on call for one week (seven days) at a time, to correspond with the “workweek” for overtime purposes. These “call nurses” will not be scheduled to work any other hours, except on a volunteer basis, which will be documented in writing. Nurses volunteering for such scheduled shifts will be paid their straight-time rate of pay and any applicable incentive pay for such shifts, in addition to the standby compensation provided in paragraph b, below.

B. Nurses on standby in Option 2 will be compensated for forty (40) hours of regular time, regardless of hours worked. Nurses will not receive any traditional standby pay. Any hours worked while on standby during Monday through Friday will not be additionally compensated, up to forty (40) hours worked while on standby.

C. Any hours worked over forty (40) Monday through Friday will be compensated at overtime (1.5 times the nurse’s regular rate of pay) and/or premium time as otherwise provided in Article 6.5 of this Agreement.

D. Any hours worked while on standby from 11:00 pm Friday to 11 pm Sunday (the traditional “weekend”) will be compensated at the overtime rate (1.5 times the nurse’s regular rate of pay).

E. Nurses will be scheduled for weekly call rotation on an equitable rotation basis.

F. Nurses with twenty-five (25) years of service in any ARRMC job category (from date of hire) may be exempt from the weekly call rotation.

G. Up to two (2) primary charge nurses may be exempt from the weekly call rotation.

**Staffing Standby:**

1. **Pay:**
   - RNs placed on Staffing Standby will receive $5.00 per hour for scheduled standby pay.
• After being placed on Staffing Standby, the RN will only be required to report
to work if called during standby hours. If an RN is placed on Staffing Standby,
and then prior to the originally scheduled start time of the shift is called to
report to work, he or she will receive straight time pay for third (3rd) and
subsequent hours actually worked (absent overtime being required by some
other provision of this Agreement), and will be paid at time and one-half (1½)
for the first two (2) hours of work. If an RN is called back to work during
standby hours, the RN will receive time and one-half (1½) for all hours
worked during the standby time (with a two (2) hour minimum), and otherwise
will receive straight time pay (absent overtime being required by some other
part of this Agreement). Standby pay will continue during time worked while
on standby status.

• **Scheduling:** The Hospital will use its best efforts to give at least two hours
advance notice of shift cancellation and staffing standby status. If the Hospital
does not provide at least one (1) hour notice of shift cancellation, the nurses
shall be offered two (2) hours of work or regular pay, in addition to any
applicable standby pay. A nurse will have no duty to be on staffing standby
unless the nurse is specifically told to be on standby. The nurse will also have
a staffing standby obligation only for the hours he or she is specifically told to
be on standby. Upon providing notice of staffing standby status, the Hospital
will place nurses on staffing standby for either four (4) or eight (8) hours. If
the staffing standby is extended beyond the initial four (4) or eight (8) hours, it
must be extended for the remainder of the scheduled shift.

A.7  **Transport Pay:** Nurses on transport will receive an additional pay as follows:

• Neonatal or Maternal transport - $250 transport pay plus straight time pay for all
hours a nurse works on transport that would otherwise be part of the RN’s
regularly scheduled hours, and an overtime premium rate of one and one-half
(1.5) times the RN’s regular rate for all other transport hours. The Hospital will
provide nurses who are members of the transport team an additional $200,000 of
accidental death and dismemberment insurance coverage applicable to transport
work. Each of these types of transport pay will apply regardless of whether or not
the RN is called to transport duty from regular duty or from standby or off-duty
time. An RN called to transport from on-duty time will be replaced on the unit if
staffing allows.

- If the Hospital requires uniforms for transport RNs, it shall provide up to two (2)
  uniforms per calendar year either free of charge or reimburse the RN for their
cost.

A.8 **Flexible Status Nurses:** Flexible status nurses will receive fifteen percent (15%) above
their base rate for each hour worked in lieu of all benefits provided to full-time and part-
time nurses under this contract. Any RN, regardless of status, who is eligible for benefits
paid to full- or part-time employees under this contract, is not entitled to this fifteen
percent (15%) payment.

A.9 **Base Pay Wage and Step Increases:** Nurses will be granted a base pay wage increase
on their eligibility date provided the nurse's performance is satisfactory by meeting or
exceeding performance standards. The times when nurses are eligible for pay increase
will be computed as follows:

1. Annually on the nurse's continuous employment anniversary provided 1,040 hours or
   more compensable hours have been completed since the nurse’s date of continuous
   employment or immediate prior step increase until the nurse has reached the top
   step. If on the above date 1,040 compensable hours have not been reached,
   advancement will be upon completion of 1,040 compensable hours.

2. The Step VIII rate is for all nurses who have been compensated at least 1,040 hours annually for at least ten (10) years. Otherwise, nurses will be eligible for the
   Step VIII rate after they have been compensated at least 1,040 hours annually
   for four (4) years following their Step VI increase.

   The Step IX rate is for all nurses who have been compensated at least 3,120 hours and three (3) years at Step VIII, whichever comes last.

   The Step X rate is for RNs who have been compensated at least 2,080 hours
   and two (2) years at Step IX, whichever comes last.
The Step XI rate is for RNs who have worked at least three (3) years at Step X and who have been compensated at least 3,120,4500 hours at Step X, whichever comes last.

The Step XII rate is for RNs who have worked three (3) years at Step XI and who have been compensated at least 3,120,4500 hours at Step XI, whichever comes last.

The Step XIII rate is for RNs who have worked three (3) years at Step XII and who have been compensated at least 3,120,4500 hours at Step XII, whichever comes last.

See wage schedule in Exhibit D

<table>
<thead>
<tr>
<th>Step</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (I)</td>
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</tr>
<tr>
<td>2 (II)</td>
<td>1 year and 1,040,4500 hours since previous RN anniversary</td>
</tr>
<tr>
<td>3 (III)</td>
<td>1 year and 1,040,4500 hours since change to Step 2</td>
</tr>
<tr>
<td>4 (IV)</td>
<td>1 year and 1,040,4500 hours since change to Step 3</td>
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<td>5 (V)</td>
<td>1 year and 1,040,4500 hours since change to Step 4</td>
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<tr>
<td>6 (VI)</td>
<td>1 year and 1,040,4500 hours since change to Step 5</td>
</tr>
<tr>
<td>7 (VII)</td>
<td>1 year and 1,040,4500 hours since change to Step 6</td>
</tr>
<tr>
<td>8 (VIII)</td>
<td>3 years* and 3,120,4500 hours since change to Step 7</td>
</tr>
<tr>
<td>9 (IX)</td>
<td>3 years* and 3,120,4500 hours since change to Step 8</td>
</tr>
<tr>
<td>10 (X)</td>
<td>2 years* and 2,080,3000 hours since change to Step 9</td>
</tr>
<tr>
<td>11 (XI)</td>
<td>3 years* and 3,120,4500 hours since change to Step 10</td>
</tr>
<tr>
<td>12 (XII)</td>
<td>3 years* and 3,120,4500 hours since change to Step 11</td>
</tr>
<tr>
<td>13 (XIII)</td>
<td>3 years* and 3,120,4500 hours since change to Step 12</td>
</tr>
</tbody>
</table>

A.10 **Minimum Standards:** The Association recognizes this contract to be the minimum standards of employment. This contract should not be construed to limit management's right to reward an individual nurse's performance or prior experience over and above the prescribed conditions called for in this Agreement. In recognition of pending business developments, the Hospital may propose and/or implement above contract conditions for certain classifications or units, after discussions with the Association.
Recognizing that the minimum pay rates set forth in Exhibit D will be observed, the Hospital may implement a clinical ladder program to provide additional pay based on special nursing skills.

The parties commit to work together in the implementation of a clinical ladder program in consultation with other Hospital/ONA committees or officials.

A.11 Incentive Shifts:

1. There are currently two (2) levels of incentive pay for extra work.

2. Advanced Shift Incentive Seven (ASI-7) for sign-up for shifts of four (4) hours minimum length seven (7) days in advance. This ASI-7 incentive will continue when an RN works over scheduled shift hours.

3. Critical Needs Incentive Shifts (“CNI Shifts”) for agreement to work extra shifts or above shift hours inside of seven (7) days.

4. ASI-7 shift payment is $30.00/hr. CNI hours’ payment is $25.00/hr.

5. ASI-7 applies to staffing vacancies which remain after the schedule has been posted as balanced and vacancies filled as much as possible, including offering any holes in the schedule to part-time and flexible status nurses, and/or core unit travelers, prior to the schedule being posted.

6. ASI-7 Shifts can be paid for any hours worked, can be less than a minimum of four (4) hours if approved by Clinical Manager. ASI-7 shifts may be posted in any department, including OR.

7. Nurses on ASI-7 or CNI Shifts will be designated for first call off before regularly scheduled RNs and paid the shift incentive for all hours worked. A nurse on ASI-7 or CNI who has been called off may volunteer to be on standby but cannot be required to take mandatory standby.
8. The goal of this incentive shift program is not to incentivize regular status RNs to drop below current FTE status. Except as provided in No. 17 below, any RN who drops below current (as of ratification) FTE status will be ineligible for either type of shift incentive for six (6) nine (9) months.

9. Except as provided otherwise in No. 17, only regular status RNs are eligible for these incentive payments, and only if they actually work (including Staffing Standby, MCO and ETO hours) their FTE status for the workweek in question, in addition to the ASI-7 or CNI hours.

10. No nurse who has been regularly scheduled to work the shift or hours in question as part of his or her FTEs, or who is on standby for the shift or hours, will be eligible for either type of incentive pay. RNs on standby will receive applicable standby pay.

11. The ASI-7 and CNI payments are themselves premium rates, they are not part of the wage rate for calculation of overtime.

12. New graduates are eligible after completion of orientation.

13. Nurses on CNI Shifts shall also receive overtime for over 40 hours worked in a workweek, other premium pay and differentials to which they would otherwise be entitled.

14. These incentive shifts are paid for actual patient care hours only.

15. CNI hours will be paid for nurses working on extra shifts for which they have signed up, and for extra continuous hours worked above their scheduled shifts.

16. Continuous worked hours above a shift that are paid with an ASI-7 incentive will continue to be paid as an ASI-7 incentive.

17. Continuous worked hours above a scheduled shift will be paid CNI, regardless of whether the shift is straight time or overtime, and regardless of whether the nurse
working the shift is regular or flexible status (including reduced FTE RNs under No. 8
above.)

18. ASI-7 shifts will be scheduled in an equitable rotation per unit-based scheduling
guidelines.

19. ASI-7 and CNI Shifts may ultimately be incorporated into shift bidding software.

20. Cross-trained nurses will be allowed to sign up for ASI-7 and CNI shifts in
accordance with the receiving unit’s guidelines.

21. NRT nurses will be allowed to sign up for ASI-7 and CNI shifts in units in which they
are cross-trained, in accordance with the receiving unit’s guidelines and with no
obligation as an NRT while working that shift.

The goals of this program are to incentivize RNs to sign up in advance for vacancies in
the schedule, to reduce the amount of time support staff spends trying to achieve
adequate staff for last minute vacancies, to reduce travelers, to be a consistent and
simple Hospital-wide system, to reward and recognize extra work by RNs, and to lower
the stress levels of all staff, management and schedulers.
EXHIBIT B – OVERTIME CALCULATION RULES

(Please check the applicable option box(es) and obtain the required signatures at the bottom of this form. Forward completed form to Human Resources.)

8- & 80-HOUR RULE

1. I understand and agree to work under the 8- & 80-HOUR RULE for purposes of overtime pay calculations. Overtime will be paid for those hours worked in excess of eighty (80) hours in a fourteen (14) day work period and/or in excess of eight (8) hours in any workday. *

40 HOUR RULE

2. I understand that only those hours worked in excess of FORTY (40) HOURS in a seven (7) day period of time will be paid as overtime. This rule permits the scheduling and working of more than eight (8) hours in a workday without payment of overtime. **

EXTENDED SHIFT RULE

3. I understand and agree that, if I work EXTENDED SHIFTS (more than eight (8) hour shifts), I will be paid overtime on the basis of the 40 Hour Rule. The 40 Hour Rule states, in part, that only those hours worked in excess of forty (40) in a seven (7) day period of time** will be paid as overtime. In addition, the Medical Center will pay me (extended shift employee) overtime for additional hours worked in excess of my scheduled 10 or 12 hour shifts within 24 hours of my original start time on that shift.

IN ADDITION TO SELECTING ONE OF THE THREE OPTIONS LISTED ABOVE, YOU MAY ALSO WANT TO SELECT THE FOLLOWING WAIVER:

4. If ARRMC requires you to work 5 consecutive full shifts (12 hours) or 6 consecutive full shifts (8 or 10 hours), the consecutive days thereafter will be paid as overtime, if the hours are not already subject to overtime payment. However, this provision can be waived by checking this box. If you check this box, ARRMC will apply your straight time rate, if you work the above number of days in a row.

5. I understand the position I have accepted is exempt from overtime under the wage & hour law.

6. I agree to waive the payment of overtime when I work the weekends.
Notes:

* Each pay period normally begins at 7:00 a.m. on Sunday of each week and continues for fourteen (14) days.

** A seven (7) day period is normally 7:00 a.m. on Sunday of each week and continues for seven (7) days.
EXHIBIT C – HOSPICE AGREEMENT

1. Full-time/part-time field staff nurses will be paid the amount of the cell phone contract up to $50.00 per month. On-call nurses will be paid the amount of the cell phone contract up to $40.00 per month. Cell phone reimbursement for field staff no longer applies if alternate communications technology is developed, in which case reimbursement for such alternate communications technology will be negotiated, if necessary, during the contract term.

2. In addition to other shifts, there will be a regular shift from 1700 to 0130. A nurse working this regular shift will be paid the hourly rate of pay (as defined in Exhibit A) for those hours worked, regardless of volume of patient calls and visits. This will include an unpaid 30-minute lunch period. The lunch period will typically be scheduled toward the middle of the shift, in collaboration with the other assessment nurse working that night, so that any incoming calls can be taken by the other nurse during the lunch period. It is understood that occasionally patient needs may require the nurse to work through the lunch period. If that occurs, the nurse will be paid for that time.

3. The evening shift premium for hours worked will be $2.50 between 1800 and 2300, the night shift premium for hours worked will be $10.00 and will be paid between 2300 and 0700.

4. For the remainder of the typical 15-hour shift, from 0130 to 0800, Scheduled Standby pay of $5.00 will be paid. There will be a minimum of 15 minutes of pay at time-and-a-half for any calls or visits that occur during this scheduled standby time. No other changes will be made to the pay practice after 0130.

5. The above shift will be used to calculate the FTE status of a nurse. For example, a nurse who is regularly scheduled for ten of the above 8-hour shifts during a two week pay period would be considered 1.0 FTE; a nurse scheduled to work for seven of the above shifts would be considered 0.7 FTE for benefits purposes.

6. Case Manager differential will be paid as specified in Exhibit A.
EXHIBIT D – WAGE RATES

September 30, 2023 through September 30, 2026

October 1, 2023 through October 1, 2026

Job Code 516 Wage Rates

<table>
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</table>

Effective dates indicate first full pay period of month listed.
EXHIBIT E – WOMEN’S AND CHILDREN’S SERVICES – CLOSED SERVICE LINE

The following provisions as they relate to the floating for registered nurses (RNs) with positions in Women’s and Children’s Services (WCS).

E.1 Floating Outside Service Line: Nurses within WCS will not be required, but may volunteer, to float outside of the service areas of NICU, Pediatrics, FBC, and Maternal Child. Specialty populations within this service line include labor and delivery, postpartum, neonatal, and inpatient pediatrics. Nurses working in the WC service line who desire to float outside of their service line may submit their name to a voluntary float list that shall be available to hospital leadership and charge nurses in each unit. If an RN floats outside of the service line, an appropriate assignment shall be serving as a sitter in an observer role only. An RN must give reasonable notice before removing their name from the float list. Each unit will develop a process to keep an up-to-date volunteer float list to communicate with the staffing office.

E.2 Floating Within WCS: Starting in January 2025, all nurses within WCS, after successful completion of their introductory period on their home department and specialty patient population, will maintain one secondary specialty within WCS for the purpose of safely staffing these specialty departments / patient populations, particularly during times of increased patient volumes in one specialty. To adequately fulfill the orientation requirement to the secondary specialty, the RN must be competent to care for the average (medium) acuity of the patient population and must complete the requirements set forth by the service line council.

Each nurse will be required to maintain the skills to allow them to be safely reassigned to another WCS unit. Floating will be done in an equitable rotation, based on skill mix, between the specialty areas of WCS. Each nurse will be required to maintain the skills to allow them to be safely reassigned to another WCS unit. Nurses within WCS cluster may be used as sitters for patients within MCS but will not be utilized for sitter assignments for patients from other departments. Nurse managers, designee, or charge RNs may mandate an out of turn float/assignment for skill mix and/or patient safety; every effort will be made to respect float rotations, and any deviation from normal rotation will be in exceptional circumstances.
E.3  **Timeline for Implementation:**

- **February 2024:** Closed Service Line
- **July 2024:** Service line council will form, meet to develop competency education plan. Will meet monthly until orientation/education begins with plans to meet quarterly thereafter to assess for needed changes.
- **January 2025:** Orientation and education requirements set forth by the Service Line Council will begin. Orientation order will be determined by the Service Line Council.

E.4  **Service Line Council:**

- The Service Line Council will consist of at least two (2) RNs from each Women’s and Children’s unit with up to four (4) RNs from each unit. The RNs on the council may volunteer to join and the units will vote if more than four (4) RNs have agreed to serve.
- The Service Line Council will submit their final requirements to the designee appointed by the hospital for implementation.

E.5  **Goals of Service Line Council:**

- Identify patient populations in each department that could be assigned to an RN with a secondary specialty.
- Identify specific competencies needed to care for these patient populations.
- Identify education and/or orientation needs to support competency, including content and modality of education and/or orientation.

EXHIBIT E — OREGON NURSE STAFFING LAW

“The text of the current Oregon Nurse Staffing Law, in effect in August 2017, is included below, for reference only. It is not incorporated into this Agreement and is subject to change by the Oregon legislature.”

Chapter 441—Health Care Facilities
ORS sections in this chapter were amended or repealed by the Legislative Assembly during its 2016 regular session. See the table of ORS sections amended or repealed during the 2016 regular session: 2016 A&R Tables.

New sections of law were enacted by the Legislative Assembly during its 2016 regular session and pertain to or are likely to be compiled in this ORS chapter. See sections in the following 2016 Oregon Laws chapters: 2016 Session Laws 0106

441.151 “Hospital” defined for ORS 441.152 to 441.177. As used in ORS 441.152 to 441.177, “hospital” includes a hospital as described in ORS 442.015 and an acute inpatient care facility as defined in ORS 442.470. [Formerly 441.160]

Note: 441.151 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 441 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

- 

441.152 Nurse Staffing Advisory Board.

(1)(a) The Nurse Staffing Advisory Board is established within the Oregon Health Authority, consisting of 12 members appointed by the Governor.

(b) Of the 12 members of the board:

(A) Six must be hospital nurse managers;

(B) Five must be direct care registered nurses who work in hospitals; and

(C) One must be either a direct care registered nurse who works in a hospital or a direct care staff member who is not a registered nurse and whose services are covered by a written hospital-wide staffing plan that meets the requirements of ORS 441.155.

(e) To the extent practicable, board members shall be appointed to ensure that the board is represented by members from hospitals where direct care staff are represented under a collective bargaining agreement and hospitals where direct care staff are not represented by a collective bargaining agreement and by hospitals of different sizes, types and geographic location.

(d) The term of office of each board member is three years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins January 1 next following. A member is eligible for reappointment but may not serve more than two consecutive terms. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(2) The board shall:
(a) Provide advice to the authority on the administration of ORS 441.152 to 441.177;
(b) Identify trends, opportunities and concerns related to nurse staffing;
(c) Make recommendations to the authority on the basis of those trends, opportunities and concerns; and
(d) Review the authority’s enforcement powers and processes under ORS 441.157, 441.171 and 441.177.

(3)(a) Upon request, the authority shall provide the board with written hospital-wide staffing plans implemented under ORS 441.155, reviews conducted under ORS 441.156, information obtained during an audit under ORS 441.157 and complaints filed and investigations conducted as described in ORS 441.171.
(b) The authority may not provide the board with any information under paragraph (a) of this subsection that is identifiable with a specific hospital unless the information is publicly available.
(c) Hospital-wide staffing plans provided to the board under this section are confidential and not subject to public disclosure.

(4) A majority of the members of the board constitutes a quorum for the transaction of business.
(5) The board shall have two cochairs selected by the Governor. One cochair shall be a hospital nurse manager and one cochair shall be a direct care registered nurse.
(6) Official action by the board requires the approval of a majority of the members of the board.
(7) The board shall meet:
(a) At least once every three months; and
(b) At any time and place specified by the call of both cochairs.
(8) The board may adopt rules necessary to for the operation of the board.
(9) The board shall submit a report on the administration of ORS 441.152 to 441.177 in the manner provided in ORS 192.245 to an interim committee of the Legislative Assembly related to health no later than September 15 of each year. The board may include in its report recommendations for legislation.
(10) Members of the board are not entitled to compensation but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the authority for purposes of the board. [2015 c.669 §2]

Note: 441.152 to 441.177 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 441 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.
Note: Section 3, chapter 699, Oregon Laws 2015, provides:
Sec. 3. Notwithstanding the term of office specified by section 2 of this Act [441.152], of the members first appointed to the Nurse Staffing Advisory Board:
(1) Four shall serve for a term ending January 1, 2017;
(2) Four shall serve for a term ending January 1, 2018; and
(3) Four shall serve for a term ending January 1, 2019. [2015 c.669 §3]

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Sec. 3. Notwithstanding the term of office specified by section 2 of this Act [441.152], of the members first appointed to the Nurse Staffing Advisory Board:
(1) Four shall serve for a term ending January 1, 2017;
(2) Four shall serve for a term ending January 1, 2018; and
(3) Four shall serve for a term ending January 1, 2019. [2015 c.669 §3]

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Sec. 3. Notwithstanding the term of office specified by section 2 of this Act [441.152], of the members first appointed to the Nurse Staffing Advisory Board:
(1) Four shall serve for a term ending January 1, 2017;
(2) Four shall serve for a term ending January 1, 2018; and
(3) Four shall serve for a term ending January 1, 2019. [2015 c.669 §3]

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Sec. 3. Notwithstanding the term of office specified by section 2 of this Act [441.152], of the members first appointed to the Nurse Staffing Advisory Board:
(1) Four shall serve for a term ending January 1, 2017;
(2) Four shall serve for a term ending January 1, 2018; and
(3) Four shall serve for a term ending January 1, 2019. [2015 c.669 §3]
(3) A majority of the members of a hospital nurse staffing committee constitutes a quorum for the transaction of business.

(4) A hospital nurse staffing committee shall have two cochairs. One cochair shall be a hospital nurse manager elected by the members of the committee who are hospital nurse managers and one cochair shall be a direct care registered nurse elected by the members of the committee who are direct care staff.

(5)(a) A decision made by a hospital nurse staffing committee must be made by a vote of a majority of the members of the committee. If a quorum of members comprises an unequal number of hospital nurse managers and direct care staff, only an equal number of hospital nurse managers and direct care staff may vote.

(b) If the committee is unable to reach an agreement on the staffing plan, either cochair of the committee may invoke a 30-day period during which the committee shall continue to develop the staffing plan. During the 30-day period, the hospital shall respond in a timely manner to reasonable requests from members of the committee for data that will enable the committee to reach a resolution. If at the end of the 30-day period, the committee remains unable to reach an agreement on the staffing plan, one of the cochairs shall notify the Oregon Health Authority of the impasse.

(c) Upon receiving notification under paragraph (b) of this subsection, the authority shall provide the committee with a mediator to assist the committee in reaching an agreement on the staffing plan. Mediation conducted under this paragraph must be consistent with the requirements for implementing and reviewing staffing plans under ORS 441.155 (Written staffing plan for nursing services) and 441.156 (Annual review of nurse staffing plan).

(d) If the committee is unable to reach an agreement on the staffing plan after 90 days of mediation, the authority may impose a penalty against the hospital as described in ORS 441.175 (Civil penalties).

(6) A hospital nurse staffing committee shall meet:

(a) At least once every three months; and

(b) At any time and place specified by either cochair.

(7)(a) Subject to paragraph (b) of this subsection, a hospital nurse staffing committee meeting must be open to:

(A) The hospital nursing staff as observers; and

(B) Upon invitation by either cochair, other observers or presenters.

(b) At any time, either cochair may exclude persons described in paragraph (a) of this subsection from a committee meeting for purposes related to deliberation and voting.
Minutes of hospital nurse staffing committee meetings must:
(a) Include motions made and outcomes of votes taken;
(b) Summarize discussions; and
(c) Be made available in a timely manner to hospital nursing staff and other hospital staff upon request.

A hospital shall release a member of a hospital nurse staffing committee described in subsection (1)(a) of this section from the member’s assignment, and provide the member with paid time, to attend committee meetings. [2015 c.669 §1]—

Note: See note under 441.152 (Nurse Staffing Advisory Board).

Note: Sections 17 and 18 (2), chapter 669, Oregon Laws 2015, provide:

Sec. 17.
(1) For purposes of this section, “hospital” has the meaning given that term in ORS 441.160 [renumbered 441.151 ("Hospital" defined for ORS 441.152 to 441.177)].

(2) A hospital nurse staffing committee shall be established for each hospital in accordance with section 1 of this 2015 Act [441.154 (Hospital nurse staffing committee)] on or before January 1, 2016.

(3) Each hospital shall post material as described in section 7 of this 2015 Act [441.169 (Public notice)] on or before January 1, 2016.

(4) The Oregon Health Authority shall adopt rules required by section 8 of this 2015 Act [441.173 (Hospital to maintain records)] on or before July 1, 2016.

(5) Each hospital nurse staffing committee established pursuant to section 1 of this 2015 Act shall develop a written hospital-wide staffing plan in accordance with ORS 441.162 [renumbered 441.155 (Written staffing plan for nursing services)] as amended by section 4 of this 2015 Act on or before January 1, 2017. [2015 c.669 §17]

Sec. 18. (2) A hospital-wide staffing plan for nursing services implemented under ORS 441.162 [renumbered 441.155 (Written staffing plan for nursing services)] before the effective date of this 2015 Act [July 6, 2015] shall continue to be in effect until a hospital nurse staffing committee established under section 1 of this 2015 Act [441.154 (Hospital nurse staffing committee)] implements a new written hospital-wide staffing plan for nursing services pursuant to ORS 441.162 as amended by section 4 of this 2015 Act. [2015 c.669 §18(2)]

441.155 Written staffing plan for nursing services. (1) Each hospital shall implement the written hospital-wide staffing plan for nursing services that has been developed and approved by the hospital nurse staffing committee under ORS 441.154.

(2) The staffing plan:
(a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients;

(b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;

(c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses;

(d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations;

(e) Must recognize differences in patient acuity;

(f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts, provided that at least one registered nurse and one other nursing staff member is on duty in a unit when a patient is present;

(g) Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgment of a direct care registered nurse or a nurse manager, there is an inability to meet patient care needs or a risk of harm to patients;

(h) Must consider tasks not related to providing direct care, including meal breaks and rest breaks; and

(i) May not base nursing staff requirements solely on external benchmarking data.

(3) A hospital must maintain and post a list of on-call nursing staff or staffing agencies to provide replacement nursing staff in the event of a vacancy. The list of on-call nursing staff or staffing agencies must be sufficient to provide for replacement nursing staff.

(4)(a) An employer may not impose upon unionized nursing staff any changes in wages, hours or other terms and conditions of employment pursuant to a staffing plan unless the employer first provides notice to and, upon request, bargains with the union as the exclusive collective bargaining representative of the nursing staff in the bargaining unit.

(b) A staffing plan does not create, preempt or modify a collective bargaining agreement or require a union or employer to bargain over the staffing plan while a collective bargaining agreement is in effect. [Formerly 441.162]

Note: See note under 441.152.

441.156 Annual review of nurse staffing plan. (1) A hospital nurse staffing committee established pursuant to ORS 441.154 shall review the written hospital-wide staffing plan.
developed by the committee under ORS 441.155:
(a) At least once every year; and
(b) At any other date and time specified by either cochair of the committee.
(2) In reviewing a staffing plan, a hospital nurse staffing committee shall consider:
(a) Patient outcomes;
(b) Complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;
(c) The number of hours of nursing care provided through a hospital unit compared with the number of patients served by the hospital unit during a 24-hour period;
(d) The aggregate hours of mandatory overtime worked by the nursing staff;
(e) The aggregate hours of voluntary overtime worked by the nursing staff;
(f) The percentage of shifts for each hospital unit for which staffing differed from what is required by the staffing plan; and
(g) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients.
(3) Upon reviewing a staffing plan, a hospital nurse staffing committee shall:
(a) Report whether the staffing plan ensures that the hospital is staffed to meet the health care needs of patients; and
(b) Modify the staffing plan as necessary to ensure that the hospital is staffed to meet the health care needs of patients. [2015 c.669 §5]
Note: See note under 441.152.
441.157 Audits. (1) For the sole purpose of verifying compliance with the requirements of ORS 441.152 to 441.177 and 441.192, the Oregon Health Authority shall audit each hospital in this state once every three years, at the time of conducting an on-site inspection of the hospital under ORS 441.025.
(2) When conducting an audit pursuant to this section, the authority shall:
(a) If the authority provides notice of the audit to the hospital, provide notice of the audit to the cochairs of the hospital nurse staffing committee established pursuant to ORS 441.154;
(b) Interview both cochairs of the hospital nurse staffing committee;
(c) Review any other hospital record and conduct any other interview or site visit that is necessary to verify that the hospital is in compliance with the requirements of ORS 441.152 to 441.177 and 441.192; and
(d) Within 60 days after issuing an order requiring a hospital to implement a plan to correct a violation of ORS 441.152 to 441.177 or 441.192, conduct an investigation of the hospital to—
ensure compliance with the order.

(3) Following an investigation conducted pursuant to subsection (2) of this section, the authority shall provide in writing a report of the authority’s findings to the hospital and the cochairs of the hospital nurse staffing committee.

(4) The authority shall compile and maintain for public inspection an annual report of audits and investigations conducted pursuant to this section.

(5) The costs of audits required by this section may be paid out of funds from licensing fees paid by hospitals under ORS 441.020. [2015 c.669 §9]

Note: See note under 441.152.

441.160 [2001 c.609 §1; renumbered 441.151 in 2015]

441.162 [2001 c.609 §2; 2005 c.665 §2; 2015 c.669 §4; renumbered 441.155 in 2015]

441.164 Variances to staffing plan requirements. Upon request of a hospital, the Oregon Health Authority may grant a variance to the written hospital-wide staffing plan requirements described in ORS 441.155 if the variance is necessary to ensure that the hospital is staffed to meet the health care needs of patients. [2001 c.609 §3; 2009 c.595 §733; 2015 c.669 §12]

Note: See note under 441.152.

441.165 Modification of nurse staffing plan in case of emergency or epidemic. (1) For purposes of this subsection, “epidemic” means the occurrence of a group of similar conditions of public health importance in a community or region that are in excess of normal expectancy and that are from a common or propagated source.

(2) Notwithstanding ORS 441.155 and 441.156, a hospital is not required to follow a written hospital-wide staffing plan developed and approved by the hospital nurse staffing committee under ORS 441.154 upon the occurrence of a national or state emergency requiring the implementation of a facility disaster plan, or upon the occurrence of sudden unforeseen adverse weather conditions or an infectious disease epidemic suffered by hospital staff.

(3) Upon the occurrence of an emergency circumstance not described in subsection (2) of this section, either cochair of the hospital nurse staffing committee may require the hospital nurse staffing committee to meet to review and potentially modify the staffing plan in response to the emergency circumstance. [2015 c.669 §5a]

Note: See note under 441.152.
441.166 Need for replacement staff. (1) For purposes of this section, “nursing staff” includes registered nurses, licensed practical nurses, certified nursing assistants and other hospital nursing staff members as defined by the Oregon Health Authority by rule.

(2) When a hospital learns about the need for replacement staff, the hospital shall make every reasonable effort to obtain nursing staff for unfilled hours or shifts before requiring a nursing staff member to work overtime.

(3) (a) Except as provided in subsection (4) of this section, a hospital may not require a nursing staff member to work:

(A) Beyond the agreed-upon and prearranged shift, regardless of the length of the shift;

(B) More than 48 hours in any hospital-defined work week;

(C) More than 12 hours in a 24-hour period; or

(D) During the 10-hour period immediately following the 12th hour worked during a 24-hour period.

(b) For purposes of paragraph (a)(D) of this subsection, a nursing staff member begins to work when the nursing staff member begins a shift.

(4) A hospital may require an additional hour of work beyond the work authorized under subsection (3) of this section if:

(a) A staff vacancy for the next shift becomes known at the end of the current shift; or

(b) There is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another nursing staff member.

(5) If a nursing staff member agrees to work overtime, the nursing staff member is accountable for the nursing staff member’s competency in practice and is responsible for notifying the nursing staff member’s supervisor when the nursing staff member’s ability to safely provide care is compromised.

(6) (a) Time spent in required meetings or receiving education or training shall be included as hours worked for purposes of subsection (3) of this section.

(b) Time spent on call or on standby when the nursing staff member is required to be at the premises of the employer shall be included as hours worked for purposes of subsection (3) of this section.

(c) Time spent on call but away from the premises of the employer may not be included as hours worked for purposes of subsection (3) of this section.

(7) If a nursing staff member believes that a hospital unit is engaging in a pattern of requiring direct care nursing staff to work overtime for nonemergency care, the nursing staff member may report that information to the hospital nurse staffing committee established for the hospital.
pursuant to ORS 441.154. The hospital nurse staffing committee shall consider the information when reviewing the written hospital-wide staffing plan as required by ORS 441.156.

(8) The provisions of this section do not apply to nursing staff needs:
(a) In the event of a national or state emergency or circumstances requiring the implementation of a facility disaster plan; or
(b) In emergency circumstances identified by the authority by rule. [2001 c.609 §4; 2005 c.665-§1; 2009 c.595 §734; 2015 c.669 §6]

Note: See note under 441.152.

441.168 Leaving a patient care assignment. A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon shift or an agreed upon extended shift without authorization from the appropriate supervisory personnel. [2001 c.609 §5]

Note: See note under 441.152.

441.169 Public notice. On each hospital unit, a hospital shall post a notice summarizing the provisions of ORS 441.152 to 441.177 in a place that is clearly visible to the public that includes a phone number for purposes of reporting a violation of the laws. [2015 c.669 §7]

Note: See note under 441.152.

441.170 [2001 c.609 §6; 2009 c.595 §735; 2015 c.669 §13; renumbered 441.175 in 2016]

441.171 Complaint investigations. (1) For purposes of ensuring compliance with ORS 441.152 to 441.177, the Oregon Health Authority shall:
(a) Within 60 days after receiving a complaint against a hospital for violating a provision of ORS 441.152 to 441.177, conduct an on-site investigation of the hospital; and
(b) Within 60 days after issuing an order requiring a hospital to implement a plan to correct a violation of ORS 441.152 to 441.177, conduct an investigation of the hospital to ensure compliance with the plan.

(2) When conducting an investigation of a hospital to ensure compliance with ORS 441.152 to 441.177, the authority shall, if the authority provides notice of the investigation to the hospital, provide notice of the investigation to the cochairs of the hospital nurse staffing committee established pursuant to ORS 441.154.

(3) Following an investigation conducted pursuant to this section, the authority shall provide in writing a report of the authority’s findings to the hospital and the cochairs of the hospital nurse-
staffing committee.
(4) When conducting an investigation of a hospital to ensure compliance with ORS 441.152 to 441.177, the authority may:
(a) Take evidence;
(b) Take the depositions of witnesses in the manner provided by law in civil cases;
(c) Compel the appearance of witnesses in the manner provided by law in civil cases;
(d) Require answers to interrogatories; and
(e) Compel the production of books, papers, accounts, documents and testimony pertaining to the matter under investigation. [2015 c.669 §10]

Note: See note under 441.152.
441.172 [2001 c.609 §9; renumbered 441.179 in 2015]
441.173 Hospital to maintain records; rules. A hospital shall keep and maintain records necessary to demonstrate compliance with ORS 441.152 to 441.177. For purposes of this section, the Oregon Health Authority shall adopt rules specifying the content of the records and the form and manner of keeping, maintaining and disposing of the records. A hospital must provide records kept and maintained under this section to the authority upon request. [2015 c.669 §8]

Note: See note under 441.152.
441.174 [2001 c.609 §10; renumbered 441.181 in 2015]
441.175 Civil penalties; suspension or revocation of license; rules; records. (1) The Oregon Health Authority may impose civil penalties in the manner provided in ORS 183.745 or suspend or revoke a license of a hospital for a violation of any provision of ORS 441.152 to 441.177. The authority shall adopt by rule a schedule establishing the amount of civil penalty that may be imposed for a violation of ORS 441.152 to 441.177 when there is a reasonable belief that safe patient care has been or may be negatively impacted, except that a civil penalty may not exceed $5,000. Each violation of a written hospital-wide staffing plan shall be considered a separate violation. Any license that is suspended or revoked under this subsection shall be suspended or revoked as provided in ORS 441.030.
(2) The authority shall maintain for public inspection records of any civil penalties or license suspensions or revocations imposed on hospitals penalized under subsection (1) of this section. [Formerly 441.170].
441.177 Posting of audit reports and civil penalties. The Oregon Health Authority shall post on a website maintained by the authority:

(1) Reports of audits described in ORS 441.157;

(2) Any report made pursuant to an investigation of whether a hospital is in compliance with ORS 441.152 to 441.177;

(3) Any order requiring a hospital to implement a plan to correct a violation of ORS 441.152 to 441.177;

(4) Any order imposing a civil penalty against a hospital or suspending or revoking the license of a hospital pursuant to ORS 441.175; and

(5) Any other matter recommended by the Nurse Staffing Advisory Board established under ORS 441.152. [2015 c.669 §11]
EXHIBIT F – NURSE RESIDENCY PROGRAM

DEFINITIONS

- **New Graduate Nurse:** currently licensed with less than 12 months of nursing licensure or relevant experience.

- **Nurse Residency:** a planned, comprehensive program with identified start dates through which currently licensed RNs with less than 12 months of nursing licensure or relevant experience demonstrate the knowledge, skills, and behaviors required to meet defined standards of practice and performance.

- **Fellowship:** A currently licensed nurse with more than 12 months of nursing licensure but less than 1 year of experience in a clinical grouping service /specialty area.

The Asante Nurse Residency Program will serve new graduate residents. Residency start dates will be clearly identified by the Hospital. Residency typically spans the first 12 months of employment and provides a comprehensive infrastructure to support the new nurse’s transition into clinical practice with the goal of developing knowledge, skills, and behaviors required to move from entry level competence towards proficiency and expertise.

The Asante Residency program provides the nurse with comprehensive, structured clinical and didactic training. Training progresses from the fundamentals to complex concepts of knowledge, technical skill, ability, ethical principle, and clinical reasoning which are relevant to the practice role/unit, recognized standards of practice, and patient safety. The residency fosters professional development, practice improvement, and the development of mentoring relationships.

Review and completion status of outlined residency components will be included in the new hire/probationary nurse performance review initially at residency midpoint, at 6 months, and at the next yearly performance review.

In the event identified residency education, competencies, or performance standards are not met, or if the resident requests transfer from the department, the manager and resident will identify an action plan to address learning and/or performance opportunities or request for transfer.
Resident RNs may be eligible for a retention bonus in accordance with the Asante Residency Bonus Procedure. Resident RNs may be required to make a time commitment, in accordance with Asante policy.

In addition to the Nurse Residency Program, Asante anticipates developing a Fellowship Program to allow experienced nurses to train in new specialty areas.