After 16 Hours, TA was Reached

We were able to reach a tentative agreement (TA) at 1:00 a.m. (0100) on Oct. 14. Below is a summary of the changes to the current collective bargaining agreement.

We will be holding the contract ratification vote on Saturday, Oct. 24 from 12:01 p.m. (0001) through 11:59 p.m. (2359). Voting will be completely electronic and a link will be sent out later this week.

We appreciate all of the support for the negotiation team and the solidarity you have shown which was critical to achieving the improvements to this upcoming contract.

If you have questions please reach out to any of the negotiation team members.

Thank you again for your support.

In solidarity,
Fred Katz, Juniper Arthurs, Susan Speaks, Rob Campbell, Meagan Pereira, Keith Coddington, Tonsina Wells, David Baca and Susan Bruce

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<table>
<thead>
<tr>
<th>Issue</th>
<th>Changes</th>
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<tr>
<td>Dedication</td>
<td>1.1 – Hospice as part of BU&lt;br&gt;1.2.c – Change name of code 3&lt;br&gt;1.2.c – Eliminate return RN program&lt;br&gt;1.2.g – Change code 1 to full time&lt;br&gt;1.2.g – Change code 2 to part time&lt;br&gt;1.2.s – Add word hospice&lt;br&gt;2.1 – Add &quot;gender identity&quot;&lt;br&gt;4.1 – Eliminate hospital responsibility to notify nurse of upcoming licensure renewal need.&lt;br&gt;6.4 – Lactation break added limit to child age 24 months.&lt;br&gt;6.5 – 2x for &gt;12 continuous hours&lt;br&gt;6.6 – Change word overtime to premium&lt;br&gt;6.6 – Clarify rate of pay for consecutive days is 1.5x per hour for each day worked.&lt;br&gt;6.6 – Hours worked in excess of 40 hours in a workweek that also qualify for consecutive days premium will be paid a double time (2x)&lt;br&gt;6.7 – Nurses encouraged to work with staffing to ensure scheduling for mandatory education hours are included in their schedules. Nurses will not be disciplined when they have made good faith efforts to schedule education.&lt;br&gt;6.9 – This non-duplication of overtime/premium rates rule does not apply to CNI, ASI, standby, or shift differential.</td>
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6.12 – Added clarification that nurses will not be involuntarily regularly scheduled to different shift length different from their bid shift length.

6.12 – Add: in balancing schedules prior to posting, the Hospital will not flex nurses if it will result in staffing that is below core.

6.13 c – Review of mandatory OT changed to annually and by staffing committee.

6.13.e – Agree to eliminate PNCC review language and renumber remaining sections of 6.13

7.1 – Assignments Generally. The parties agree it is the desire of both ARRMC and the bargaining unit that nurses should be assigned to nursing units in which they have been oriented and possess the necessary education, experience and qualifications or in which they have prior education or experience. See Article 15.4 for staffing guidelines.

7.3 – Volunteers to Float. When a need for floating arises which cannot be filled from the Nursing Resource Team or on-duty RNs on shift, volunteers will be solicited from the shift. Agency RNs will be floated prior to regular and flexible status RNs, subject to qualifications. If staffing needs cannot be filled by volunteers on the shift, or Agency RNs, regular and flexible status nurses on the shift may be floated by rotation on an equitable basis. Agency RNs and Code 3 RNs (except Code 3B RNs) are to be floated prior to regular status RNs (Code 1 or 2) or bid Code 3 RNs, subject to qualifications. 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.

7.4 – Floating guidelines. Add 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/acute. Clinical groupings, within services, will include units that have similar competencies and similar populations/acute. Stand alone units have unique competencies and patient populations that are not line another unit. Clinical groupings (formerly buddy units) include Adult inpatient services: Critical Care Units, Med-surg units including General Medicine, Medical Oncology, Post-surgical, Orthopedics, Neuroscience and Cardiac Center; Behavioral health services; Women's and Children services.

7.4 – 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 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: 1. There are no traveler RN's available to be assigned 2. There are no staff RN's available to float within the clinical grouping. 3. Additional staff offered critical need incentive have not volunteered to work. 4. There are no staff RN's available to float from another clinical grouping into the service. 5. 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 RN's are available and not needed within their own clinical grouping/service. When doing so, they will not be required to task a regular patient care assignments. a.) 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 their RN's education, knowledge, competencies and experience. b.) Nurses floating outside their service will be paired with a core RN who will be the primary care nurse for any patient assigned.

7.5 – NRT are assigned to service lines: Reconfigure or Additional areas will be included with notice to Assoc Rep.; repeat orientation option if not worked in that unit for more than 6 months.

7.5.2 – NRT positions may be posted as full or part time and NRT nurses may request a reduction in hours in accordance with Section 1.2.g.4.
7.5.3 – a.) Assignments will generally follow four-hour blocks with equitable rotation throughout the Service line. b.) An NRT nurse will be assigned to a unit outside of their primary Service Line only when an NRT in that Service Line is unavailable, and patient needs require the assignment. An NRT required to float outside of their Service Line 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 nurses' judgment will be respected. c.) An NRT nurse shall have the option to reorient to any unit within their Service Line if it has been more than six months since their last rotation to that unit.

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

7.6.1 – NRT will continue as primary unit responsible for boarding patients due to their extensive training across multiple units;

7.6.2 – Inpatient and Emergency dept. nurses will act as alternate personnel for boarding.

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

7.6.4 – Boarding to be included in the unit-based staffing and scheduling committee and NRT

8.1 – Staffing standby rotation: volunteers, agency, ASI/CNI , code 3, regular status.

8.1.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.

8.4.a – Added that certification to the list of preferences for job bidding.

8.4.c – Nurse may return to their previous position within 1 mo if position remains open; e.g. the manager intends to refill it, but it has not been posted or the schedule has not been awarded to another nurse.

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

8.5 – 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.

8.5 – Code 3 bid priority requirement reduced to 3 years.

8.8.c – Add resignation from RRMC

8.8 – Allows nurse out of BU less than 2 years but who remains in RRMC to count seniority for purpose of job bidding back into BU position.

9.2 – Change short hour to flexible

9.3 – Effective December 25, 2020, ETO accrual rates: 0-4 years 0.09829/hrs worked; 5-9 years 0.11966/hrs worked; 10-14 0.14103/hrs worked; 15+ 0.16239/hrs worked. Max accrual: 0-4 years 306.7 hrs/year; 5-9 years 373.3 hrs/year; 10-14 years 440.0 hrs/year; 15+ years 506.7 hrs/year.

9.3 d – Eliminate restriction to accrue ETO on 2200 hour worked.

9.4 – Scheduling guidelines respect; Process: prioritize 3 periods of leave during popular ETO times and whether nurse will accept partial granting of leave. Allow resubmission as second chance if dates become available. Allow request for ETO before schedule is posted for a day where no one has made request for a day off;

9.7.d – Oregon Sick Leave Law 40 hours (48 hours for 12 hour nurses) of ETO will be used to cover absences for covered by OSL law.

9.7.e – Change use of ETO to after use of ESDP

9.7.p – Eliminate clause to lose eto if fired for misconduct

9.9 – Add weekend diff will be include on ETO payment for regular weekend schedule.

9.9 – Include Primetime MOU language

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 p.m. Friday to 11:00 p.m. Sunday as outlined in Exhibit A.5 that is part of the nurses regularly scheduled hours.
11.4 – New OPFMLA language; pay order OPFMLA, ESDP, ETO. Clarification that ESDP and ETO may be used to replace a nurse's wages up to 100% of the nurse's regular earnings.

12.2 – 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.

13.4 – Rename health plan options

13.4.a. – Reduce premium increase cap from 10% each year to 8% each year.

13.4 – Add scheduled hour status

13.4.c. – 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.

13.4.c.1 – Increased the common review period for insurance changes from 45 to 60 days.

13.4.c.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 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 Union 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.

13.4.d – Infections disease fund name change an increased hospital match amount from $4800 to $10000. allows lump sum amount up to $1000 upon request depending on funds available.

14.3 – RN will receive pay for the hours missed due to educational leave, not to exceed the nurses FTE. Voluntary paid education leave will not count towards overtime or any other premium payment.

14.4 – Eliminate ability to use Asante Tuition reimbursement funds for certification fees.

14.6 – In service education reimbursement or "education" changed from "tuition" will consider attendance and meeting participation.

15 – The hospital and Assoc will agree on schedules for the following committees that allow participation, to the maximum extent possible of nurses on all shifts.

15.1 – PNCC 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 active 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.

15.1 1. – 1.) Collaborate with Hospital to develop and implement a mutually agreed upon ARRMC Nursing clinical Ladder, subject to approval by the Bargaining unit. 2.) Assist staff nurses to maintain professional standards, examine issues, and make recommendations regarding improved nursing practices and patient care outcomes. 3.) Route clinical practice issues to appropriate Asante Nursing Council, or research evidence based best practice and solutions into he context of the Clinical Ladder process. 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.

PNCC membership increased to two management members appointed by Administration and the ability for Administration to appoint up to 2 additional participants.

15.2 – Eliminate task force

15.3 – LMC may confer with PNCC when appropriate to discuss nurse practice issues discussed at PNCC from LMC. Invite BOD member to meeting quarterly.

15.3 – Add annual contract training for supervisors

15.5 – Procedural units decide which standby model to use. Manager has final approval.

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16.4 – RRMC will not impose discipline suspensions of more than three days, provided however that ARRMC may impose suspensions for investigation of incidents such as fit for duty that may exceed three days which may be converted to a disciplinary suspension depending on the circumstances. Eliminate restriction of 3 days suspension for discipline. Eliminate opportunity for nurse reported to OSBN opportunity to meet with VP of nursing prior to report being filed.

17.3 – Change Chief People Officer to VP of HR

20 – Expires 09/30/2023

Exhibit A. 2 – Effective upon Pay period including October 1, 2020

A.3 – Premium increase effective upon ratification

Charge: $3.50/hr.
Preceptor: $1.90/hr.
BSN: $1.25/hr.
Critical Outreach: $3.35/hr.
NRT: $3.50/hr.
Eve: $2.50/hr.
NOC $4.75/$5.25/$5.60/$5.95
weekend: $2.25/hr.

A.6 – Add procedural support areas to scheduled /procedural standby

A.6.2 – Traditional voluntary rotation or weeklong rotation as determined by unit members with manager approval.

A.6.2 – New language that allows up to two primary charge nurses may be exempt from the traditional voluntary call rotation if the unit staffing committee approves.

A.6.2.8.a – Procedural standby rate $12.00/hr.

A.6.2.8.c – Procedural standby short hour notice call back of less than 48 hours will be double time when called back into work in addition to all differentials and premiums applicable.

A.6.2.9.b – Option 2 weekly rotation call schedule To facilitate the predictable and fair scheduling of procedural standby in a manner that enhances patient safety and minimizes the disruption to nurses when on standby status, a unit may elect the to schedule standby in weekly blocks as follows:

1. The Hospital shall schedule nurses to be on call for one week (seven days) at a time, to correspond with the “workweek” for overtime purposes,” the start and stop to be determined by the Unit Scheduling Committee. These “Call Nurses” shall not be scheduled to work any other hours, except on a volunteer basis, which will to be documented in writing.

2. Nurses shall be compensated for forty (40) hours of regular time, regardless of hours worked. Nurses will not receive any other standby pay.

3. Any hours worked on the weekend (from 11:00 P.M. Friday to 11:00 P.M. Sunday) shall be compensated at overtime rate (1.5 times the nurse’s regular rate of pay).

4. Any hours worked over forty (40) will be compensated at overtime and/or premium time as otherwise provided in Article 6.5 of this Agreement.

5. If called to work, the Nurse shall receive an additional ½ time pay, up to 40 actual hours worked.

6. Nurses shall be scheduled for weekly call on a fair and equitable rotation basis.

A.6.3.1 – Staffing standby $5.00/hr.

A.6.3 – If the Hospital does not provide at least one hour notice of shift cancellation, the nurse shall be offered two hours of work at regular pay in additional to any applicable standby pay.

A.8 – Transport pay increase flat rate to $250 + straight time.

A.9.1 – Change continuous employment anniversary to prior step increase.

A.10 – Step advancement occurs on employment anniversary provided 1500 compensable hours have been completed since the nurse's date of continuous employment or immediate prior step increase until the nurses has reached the top step.

A. 10 – Across the board increases every 6 months. First is effective pay period starting September 28 and is 2%, the remaining increases occur the first full pay period of April and October of each year. April 2021 1%; October 2021 1.5%; April 2022 1.5%; October 2022 1.5%; April 2023 1.5%
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A. 11.5 – 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 nurses, an or/or core unit traveler, prior to the schedule being posted.

A. 11.7 – Added: 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.

A. 11.9 – Eligible for incentive if they actually work (staffing standby, MCO and ETO hours) their FTE.

A. 11.13 – Nurses on CNI shifts shall also receive overtime for over 40 hours worked in a workweek other premium pay and differential which they would otherwise be entitled.

A. 11.15 – CNI continues for all extra shifts and hours worked above their scheduled shifts.

A. 11.16 – Add continuous hours worked to beginning of section.

A. 11.17 – Add continuous.

Exhibit C – Add MOU language

Exhibit C – Increase phone stipend to $50/mo and $40/mo.

Exhibit D – ATB increases every in October and April of each year. Starting October 1, 2020 2%; April 2021 1%; October 2021 1.5%; April 2022 1.5%; October 2022 1.5%; April 2023 1.5%.

Exhibit F – Clarifies 3 year commitment

Exhibit F – The program will be reviewed at quarterly intervals to ensure adequate advancement and appropriateness of placement for the new graduate. In the instance where the new graduate nurse has difficulties completing the delineated training in their chosen area of work, the situation will be reviewed by the Staff Development Specialist, Management and ONA with input from the nurse, to determine the best course of action, including additional training or relocating to a different specialty, as appropriate. This will not be considered a disciplinary action or failure on behalf of the nurse.

Training times will be adjusted accordingly, but overall contracted commitment will not be extended beyond three (3) years.

ANA Resilience Nurse Resources

The American Nurses Association (ANA) is committed to meeting the needs of nurses and has launched a NEW Nurse Suicide Prevention and Resilience Resource site to provide information and tools to address the critical issue of suicide prevention.

Research indicates that nurses are at a much higher risk of suicide than the general public. During this unprecedented time, nurses are struggling with mental health issues like fear, anxiety, depression, and post-traumatic stress as they respond to COVID-19 and continue to care for all patients.

Effectively managing these mental health issues is essential in nurse suicide prevention.

ANA’s Resilience and Nurse Suicide Prevention Resource site provides information and tools to:

- Build resilience
- Assist in active crises
- Support suicide survivors
- Offer grief and bereavement coping strategies
- Honor a nurse’s memory

We encourage all nurses to check out the site, bookmark the pages, and share the resources with a colleague or a friend in need.

Nurses, you are not alone. Help is available. Learn more here.