“While we are exploring and experimenting with new models of care, the fact that health care is a human endeavor must be respected and supported.”

Our Patients Today

As we progress through Oregon’s health care transformation, the emphasis of conversation includes reducing hospitalizations, enhancing primary care, coordinating care and managing costs, while improving quality and the patient’s experience. All are good goals. ONA as an organization supports them. So do I as a nurse, with a caveat. That is, while we are exploring and experimenting with new models of care, the fact that health care is a human endeavor must be respected and supported. That means, attention has to be paid to ensuring that there is a provider available to the patient to meet his or her needs. Nothing much has changed about that over my career or during our previous attempts to reform our very broken system.

Let’s talk about hospitals. Hospital care is expensive and the United States’ population depends too much on this level of care. Reducing the number of emergency department visits for non-emergent problems is important, as is avoiding the need for hospitalization in the first place, if possible. But patients in hospitals need nursing care which is delivered by RNs and others such as CNAs, with support from other disciplines, when appropriate. Of course it is important that we reserve the RN’s time for those aspects of care delivery such as teaching, complication surveillance and prevention, discharge planning and coordination. It is also important that we test ways of providing high quality care for less cost. But some of the care delivery models currently under consideration promise little in the way of coordinated and efficient care and can result in more fragmentation, when too many types of caregivers are involved with one patient.

The “sky is falling” argument unfortunately permeates many discussions about care delivery these days. Such an attitude leads to hasty decisions with ill-considered effects. We are seeing some Oregon systems returning to seeking advice from expensive consulting firms instead of relying on the expertise that is already paid for within their own walls. And failing to take an honest view of what patients need, those consultants, not surprisingly, dust off the old recommendations to cut staff at the patient’s side. On what basis, besides budget, their recommendations are made is rarely made transparent. And frequently the recommendations are either never implemented or are reversed when found to be inappropriate. By then, of course, the consultants have collected their fees and are on their way to the next site.

This current reality compels ONA leaders and staff to evaluate what interventions are necessary to provide balance in the current process of decision making used by some facility and system administrators. Balance is needed to allow good decisions to be made – decisions that will endure and benefit both our patients and support providers, while improving the system overall.

Our staffing law is a good example of an intervention that was necessary in 2001 and 2005, it is likely that the legislature will need to consider additional changes to this law in the future. While the staffing law’s collaboration and partnership goals are still priorities for ONA, more specific direction will help to ensure that patients receive the care they need.
The situation at the hospital where I practice provides a good illustration of some issues that are nearly universal to acute care facilities in Oregon and across the country.

In 2012, we experienced difficult negotiations, with administrators proposing the hospital save money by shifting resources from the bedside. As a result, we saw reductions in both RN staffing and hospital support staff. Thankfully, our ONA team worked with the Staffing Committee, and was effective at forestalling the worst of the proposals.

Next, the St. Charles’ Board of Directors hired a consultant whose verdict was: “Your culture is broken”. This is the exact message our bargaining unit leaders, ONA staff, PNCC and the Staffing Committee have been telling administrators for years. On this we all agree.

The consultant’s solution, just underway, is called the “Cultural Evolution”. Our first project is attending classes that teach us that caring is healing. It is called “The Soul and Science of Caring”. Class one featured recent physician research that asserted medicine is not providing a healing environment – that if we started caring, our patients would do better. To a room of nurses (and others) this message was hardly new. In fact, many of us were dumbfounded that a speaker should suggest such a long standing value and practice of nursing had been “discovered” by medicine. The entire “Soul and Science of Caring” project is scheduled to last 18 months and will include bi-weekly small group meetings as well as four weekend retreats. Its evolution will be interesting to follow.

So what are the big picture points?

Health care facilities have amazing resources in their army of front line caregivers – nurses. If administrators would seek and adhere to the advice of their nurses and reallocate resources, we would devise a system that delivers better outcomes at lower cost.

We know how to care and we bring about healing in our patients. We also know that caring doesn’t stop at the bedside. Caring means RNs standing up and fighting for the proper resources needed to provide effective care.

Another important point, historically, is our voice. Nurses have done the research showing caring is healing, dating back to Florence Nightingale. Unfortunately, unless a physician completes the same research, the results go unheard outside the nursing community.

This same thing is happening in our efforts to reform health care. Physicians and administrators have voices that dominate. Government staff, writing new health care regulations, often defer to them. Nurses’ voices, which represent the largest group of health care workers, are all too often not heard – or worse, heard and not heeded. If nurses are to affect lasting change, we must become full professional partners with physicians and administration in our new health care environment.

One solution is: join together with your fellow nurses in your professional association and union, the Oregon Nurses Association (ONA). Collectively, your voice is powerful on the issues that matter to our patients. It is only through collective action that we will be able to shape the future of health care.

Join me. We’ll make the difference.
New Roles for Traditional Health Workers

Sarah Baessler, BS, BA, Director of Health Policy and Government Relations

As Oregon continues to explore new models of health care, nurses will begin seeing, and in some cases, working with, different types of health care workers as participants in care teams. These “new” non-medical workers can provide skilled outreach to populations that historically have not been well-served by health care systems and can help address health disparities within some communities.

Many of these roles, including community health workers, peer wellness specialists, personal health navigators, doulas, and peer support specialists, have been around for a long time, but have not been fully integrated into our health care system and were not previously eligible for Medicaid reimbursement.

Under Oregon’s agreement with the Centers for Medicare & Medicaid Services (CMS), which allowed the creation of Coordinated Care Organizations (CCOs), traditional health workers are now eligible for Medicaid reimbursement and Oregon has committed to train 300 traditional health workers, a designation which includes many of the roles mentioned above. A steering committee is currently in the process of developing new rules and criteria for traditional health worker training programs.

ONA has been engaged in this work in the Oregon Legislature and with the steering committee, aiming to ensure that traditional health workers and nurses are able to work together and offer complementary services, while ensuring that patients receive the best possible care.

Recently, ONA submitted formal comments on the steering committee’s proposed traditional health worker training rules and presented testimony for the committee. Our comments and advocacy have emphasized the following themes:

Understanding Roles on Teams: It is critical for all workers, whether nurses, community health workers, social workers, or others, to understand the role, responsibilities, and competencies of the other workers on their team. While many nurses at county health departments have experience working with traditional health workers, most hospital nurses do not.

As we transition to a community-based care setting, it is imperative that nurses understand a traditional health workers’ role on a care team, and vice versa. This mutual understanding will serve to improve patient care. Certain tasks, like care coordination and assessment, will remain within nurses’ scope of practice, and both groups will need to work together to ensure that the right team members are doing the right work.

Supervision: Oregon’s agreement with CMS makes it clear that traditional health workers will be supervised by licensed health care providers. In most cases, nurses will take on that supervisory role. Training for traditional health workers needs to include discussion and understanding of the supervisory relationship and the State should continue to refine a shared understanding of traditional health workers’ supervision. Clarity in this area benefits nurses, traditional health workers and patients.

The rules for the training programs are nearly complete. At the end of the year, the current steering committee will dissolve, and the Traditional Health Workers Commission, created during the 2013 legislative session by House Bill 3407, will take its place. One member of this group will be a representative from ONA. The commission will oversee any future changes to training requirements, and will approve new training programs.

ONA will continue to partner with the Traditional Health Workers Commission and other stakeholders as we work together to find ways to best serve our patients, while seeking to ensure that nurses continue to have an important role in community health settings.
The Affordable Care Act: Where Are We Now?

Kevin Mealy, BA, Political Communications Liaison

Cover Oregon

This fall Cover Oregon, Oregon’s new health insurance exchange, got off to a disappointing start. Due to technical problems, CoverOregon.com, along with the federal government’s exchange, Healthcare.gov, and several other state exchanges, were forced to delay certain online functions, move back deadlines, and, in some cases, switch to offline enrollment. Because of these ongoing technical challenges, Oregonians may not be able to use Cover Oregon’s website for full online enrollment until 2014 and some applicants may not be enrolled in coverage that begins on January 1, 2014. If you or someone you know have already submitted a Cover Oregon application and have questions about its status, please contact Cover Oregon’s customer service team at 1-855-268-3767, info@coveroregon.com or visit their application frequently asked questions (FAQ) page. https://www.coveroregon.com/learn-more/faq.

Despite these challenges, uninsured or under insured Oregonians should not wait to apply for health insurance. Cover Oregon is currently helping many people apply for health insurance using paper forms, which can be filled out and sent to Cover Oregon directly by mail, fax or through a special online application. Cover Oregon has hired an additional 400 workers to help process paper applications, and is encouraging Oregonians to apply for health insurance now, to make sure they receive coverage as soon as possible.

Oregonians can fill out an application today by visiting www.CoverOregon.com and clicking “Apply Now” to fill out an online application, or print an application to fill out and send back by mail or fax.

Oregonians can also visit www.CoverOregon.com to find local community organizations and insurance agents who offer free help for Oregonians who apply for health insurance through Cover Oregon.

While the paper application process takes longer than full online enrollment, there is no change in the insurance plans offered or in individual’s or families’ eligibility for tax credits. The offline process is a different way to access the same health coverage.

Medicaid Expansion

While health insurance websites have stolen the spotlight this fall, one of the nation’s biggest health care success stories is happening right here in Oregon. Thanks to new Medicaid expansion provisions in the Affordable Care Act (ACA) that took effect on October 1, 2013, Oregon reduced its uninsured population by more than 10 percent in October alone, and more than 90,000 Oregonians have gained coverage as of mid-December.

Under the ACA, states were allowed to increase income eligibility limits for Medicaid programs, allowing Oregon to offer the Oregon Health Plan (OHP) to more than 260,000 newly eligible Oregonians. So far, more than 90,000 have been enrolled in OHP insurance, which covers common health benefits like primary care visits, mental health care and basic dental care.

By using previously reported income levels for federal programs like the Supplemental Nutrition and Assistance Program (SNAP) Oregon was able to quickly identify and pre-qualify Oregonians whose income was below the new eligibility limits, allowing them to access the Oregon Health Plan.

Oregon was one of the only states to get federal approval for this unique “fast-track” enrollment.

While some elements of the ACA have run into problems, others are working well and some have yet to be implemented. With such a large and complex law, in a large and complex field, growing pains are to be expected. Health care providers and consumers should monitor developments and offer constructive critiques as well as positive encouragement as we work to improve all our health. Throughout this process, ONA will continue updating you on new developments at Cover Oregon, in Coordinated Care Organizations (CCOs) and in hospitals, clinics and home health locations around the state. We hope you’ll continue to follow these developments with us and we look forward to continuing to improve how Oregonians access and receive health care.

Cover Oregon by the numbers:
- 11 insurance carriers
- More than 100 health insurance plans
- Approximately 65,000 applications (as of 12/10/13)
So What About ACOs and CCOs?

Connie Miyao RN, BSN, Nursing Practice Consultant

In expanding access to health insurance coverage, the Patient Protection and Affordable Care Act (ACA) encourages the adoption of innovative models of care and payment, such as Accountable Care Organizations (ACOs) that deliver care for Medicare beneficiaries. ACOs are also being launched in many areas of the country as a way to deliver care to Americans of all ages who have private health insurance.

An ACO generally consists of an interrelated system of providers that may comprise hospitals, home care and long-term care agencies, and other health care entities. The ACO assumes responsibility for managing the care of the patient as well as the delivery of services across the continuum of care. Its emphasis is primary care and prevention. The goal of an ACO is improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. This is known as the Institute for Health Improvement Triple Aim. (see illustration page 7)

In July 2012, CMS approved Oregon’s 1115 Medicaid Demonstration Waiver that was necessary to implement health system transformation. The waiver established Coordinated Care Organizations (CCOs) as Oregon’s delivery system for Medicaid health care.

Oregon’s CCOs are community-based organizations and ACO-like systems. They deliver health care for all Medicaid clients by bringing together various providers of services to transform the care delivery. CCOs are designed to improve patients’ health, by delivering better care at lower costs. Each CCO is responsible for the full integration of physical, behavioral and oral health, with a goal to eliminate fragmentation of health care delivery. They operate on a global budget that allows innovative approaches to care, with opportunities for shared savings among the providers of that care. Accountability is created through measures of health outcomes, patient experience and use of resources.

Unlike the predominant fee for service payment system that rewards health care providers for providing more health services even when they’re not always necessary, the CCO will pay providers a set amount to cover all aspects of the patient’s health care – then reward those providers if certain quality goals are met.

In addition, Oregon’s CCOs will receive strong incentives when they coordinate care that reduces medical errors, improves patient outcomes and exceeds benchmark values set by the Oregon Health Authority (OHA) Metrics & Scoring Committee, against data from 2011. Oregon will track 17 measures, across seven improvement-focus areas. They include metrics that evaluate performance in access to care, member satisfaction with care, and quality of care. The seven improvement focus areas are:

1) Improving behavioral health/physical health coordination
2) Improving perinatal and maternity care
3) Reducing preventable re-hospitalizations
4) Ensuring care is delivered in appropriate settings
5) Improving primary care
6) Deploying care teams to reduce unnecessary and costly utilization by super-utilizers
7) Addressing population health issues

Funds from a quality pool will be awarded to CCOs based on their performance on these 17 CCO Incentive Measures. The first incentive awards for improving quality are expected June 2014.

(continued on page 19)
The Role of the Nurse Practitioner in Oregon’s Health Care Reform

Tara Gregory, MSNHA, FNP-BC
Nursing Practice Consultant

Nurse Practitioners (NPs) have been providing both comprehensive primary care and specialty care services in Oregon, since the 1970’s. However, there has never been a more critical time to look to nurse practitioners as a key resource to help meet the growing demand for health care services as a result of health care reform. Nurse practitioners are well-equipped to meet new challenges and provide their services to the thousands of Oregonians who did not have access to a primary care provider in the past.

Because Oregon is on the cutting-edge in both its health care transformation efforts and its innovations in care delivery models, the opportunities for nurse practitioners are great. Many NPs are opening their own primary care practices in both rural and urban communities. They are also joining care delivery systems such as Coordinated Care Organizations (CCOs) and becoming part of the medical staff at hospitals.

CCOs are central to Oregon’s health care reform. They are groups of providers from various disciplines who have come together to provide care to a population of patients who have chosen to affiliate with one of the Patient Centered Primary Care Homes or PCPCHs in their “patient neighborhood.” The patient neighborhood is comprised of providers that are either directly affiliated with the CCO or have contracted with the CCO to provide services not generally available in the primary care environment. An NP’s role in specialty care could be providing services in areas such as cardiology, neurology, orthopedics or dermatology.

Several PCPCH practices have begun to integrate behavioral health services in their models, either by co-locating a behavioral health provider on-site or by contracting with a provider nearby. Many NPs around our state operate their own behavioral health practices and serve as a behavioral health provider in a CCO.

Soon you will be able to find a nurse practitioner located in almost any type of primary care of specialty care role!

Design of a Triple Aim Enterprise

(see article page 6)

Oregon Nurse - Winter 2014
ONA has a long history with nurse staffing. In 2001, we passed the first safe nurse staffing law in the state, and updated it significantly in 2005. This law established the collaborative structure that is in place today, where staff nurses and nurse managers set staffing for their facility at a unit-based or hospital-wide staffing committee. This law gave staff nurses a voice in the process.

In recent years, it’s become clear that it is time to update our law again. At the ONA House of Delegates in 2012, ONA members overwhelming passed a resolution aimed at enhancing and expanding the law. In 2013, ONA nurses submitted a record number of Staffing Request Documentation Forms (SRDFs), which indicate a shift on which staffing was inadequate.

Aside from the volume of SRDFs, the information they present is alarming, both in terms of patient care and in the impacts of inadequate staffing on nurses.

According to a recent study of SRDF submissions led by Sue B. Davidson, PhD, RN, CNS and Dave Cadiz, MBA, PhD, with the Oregon Nurses Foundation, more than 80 percent of SRDFs indicate that care was either delayed or omitted. High intensity, high acuity and inappropriate staff mix all increased the likelihood that patient care would be delayed or omitted.1

Clearly, inadequate nurse staffing has a negative impact on the patient, but it also has a negative impact on the nurse. Eighty percent of SRDF reports indicate that inadequate staffing prevented a nurse from taking a rest break and more than 50 percent of reports show a nurse missed a meal break.2

Through the years, ONA’s work on nurse staffing has focused on patient safety, and rightly so. In the late 1990s, there was insufficient research available documenting the impact nurse staffing has on patient safety. Since then, this area has been increasingly studied and the conclusions are clear: insufficient nurse staffing negatively impacts patient safety and nurse well-being.

Studies published in the Journal of the American Medical Association and the New England Journal of Medicine, among others, have shown that insufficient nursing care has been linked to lower quality patient care, increased medical errors and increased patient mortality.3 In some studies, increasing the amount of RN time in the total skill mix was associated with a decrease in the rate of hospital acquired infections.4

As evidence of the negative impact inadequate nurse staffing has on both nurses and patients mounts, ONA will work to further improve our nurse staffing law.

With your help, ONA anticipates introducing safe nurse staffing legislation during the 2015 legislative session. The goal of this legislation is to strengthen our current collaborative structure, and to enhance the tools the state has to investigate violations and enforce the law.

Prompted by the House of Delegate’s 2012 action report, a group of ONA members has met twice with leadership from our nursing colleagues at the Oregon Federation of Nurses and Health Professionals (OFNHP) to conduct a detailed review of the current law and to identify areas that need to be improved.

Using those discussions and other nurses’ input, we’re in the process of developing a framework for legislation. Throughout spring, summer, and fall 2014, we’ll be working with nurses around Oregon to learn about their experiences and begin the discussion with legislators on legislation for 2015.

Oregon’s health transformation aims to improve the patient experience, improve health, and decrease costs. That will not happen in a vacuum. Appropriate hospital nurse staffing is one tool that will help us meet these goals.

The 2013 legislature passed numerous bills which included provisions for new work groups, task forces, or commissions. Several of these new groups deal with issues that are important to nursing. The following briefs will help keep you up-to-date on new developments in groups whose work will impact nurses and their patients.

**Mental Health and Primary Care Reimbursement Task Force:** This task force was created by House Bill 2902, the NP/PA Payment Parity Bill. The group is charged with exploring existing mental health and primary care reimbursement structures and making recommendations to Oregon’s legislature in 2014 and 2015. Any recommendations should preserve or enhance Oregon’s existing health care workforce and treat providers fairly. Former chair of NPO and president of ONA, Mary Grant, RN, MS, ANP, was appointed by the Governor to co-chair this group as ONA’s representative to the task force.

**Common Credentialing Advisory Group:** During the 2013 legislative session, the state moved ahead with plans to create a common credentialing process and application for multiple health care provider types, including all nurses who need credentialing. This new shared process and application will be used to minimize redundancy, costs and hassle for both providers and employers. NPO’s Conference Committee Chair, Larlene Dunsmuir, FNP, was appointed to serve as a member of this group. The new common credentialing system is due to be implemented in 2016.

**Future of Public Health Task Force:** This task force was created by House Bill 2348 to study regionalization and consolidation of public health services. This task force is responsible for making recommendations to the legislature on how to prepare Oregon’s public health system for the future, find ways for public health systems to operate more efficiently and explore regionalization. The group had its first meeting in November and will continue meeting monthly. This group will have robust discussions on the role of public health departments in the future, and to what extent that role should include clinics and other health care delivery models. They are also expected to explore best practices from public health models around the nation and seek input from regionally recognized public health experts.

**Oregon Retirement Savings Task Force:** The Oregon Retirement Savings Task Force was created by House Bill 3432 to bring together employers, representatives from the financial services industry, the public and the State Treasurer, to recommend ways to increase the percentage of Oregonians saving for retirement and study the feasibility of a statewide retirement savings option for private employees. Members of the task force have been appointed. The group will report to the legislature in 2014 and 2015. ONA and our partner organizations will track the work of this task force and continue to advocate for legislation that promotes greater retirement savings for Oregonians.

**Earned Sick Days Task Force:** ONA, along with other stakeholders, has been participating in an informal task force designed to bring together opposing groups to identify and address concerns about potential statewide earned sick days legislation. In March 2013, the City of Portland unanimously passed an earned sick days policy that allows private employees to earn time off work they can use when they are sick. Similar legislation was also introduced at the state level in 2013. Many of the concerns raised by opponents at the city level have resurfaced in conversations about the possibility of a statewide policy.

The task force has reached agreement on some aspects of potential earned sick days legislation, including simplified implementation rules and aligning any proposal with current labor standards, such as the Oregon Family Leave Act. However, there are many areas where the two sides disagree, such as whether small employers should be exempt. For the good of individuals and the public health, ONA has advocated that all employees deserve the opportunity to earn sick time at work.

While statewide talks are ongoing, proponents of the law are also exploring other cities in Oregon that may be interested in passing local earned sick days ordinances.

Oregon’s 2014 Legislative Session will begin on February 3. Contact Kevin at mealy@oregonrn.org to get involved and support ONA’s legislative priorities in 2014.
Join ONA and the Keep Oregon Working coalition to send a clear message to the out-of-state interests behind IP 9. Corporate CEOs and out-of-state entities don’t have your interests at heart.

Over the past few years, we’ve seen the beginning of a disturbing national trend. States that have traditionally been home to strong labor movements, like Michigan, Indiana and Wisconsin, have fallen victim to agendas being pushed by corporate CEOs and billionaires whose ideas are out of touch with average Americans and wrong for working and middle class families. Now, these same corporate CEOs and billionaires are setting their sights on Oregon.

In 2014, the same groups who pushed paycheck deception and other anti-worker measures onto Oregon’s ballot are gathering signatures for Initiative Petition 9 (IP 9), a measure that would take away nurses’ and other workers’ ability to advocate for better staffing levels, safe working conditions and reasonable working hours.

IP 9 takes the worst of Bill Sizemore’s old ideas and brings them back again, backed by the same out-of-state corporate interests who have funded Sizemore’s agenda in the past.

This initiative is another in a series of political attacks by large corporations and billionaires who want to make sure the rich keep getting richer while everyone else pays the bills.

IP 9 undermines nurses’ ability to advocate for their patients as well as their ability to come together and collectively bargain issues including wages, benefits and safe working conditions. IP 9 would lower living standards for working Oregonians and reduce your voice in the political process.

Time and time again, nurses are voted one of the most trusted professional groups in America. This is because your friends, family and community know you do what’s best for your patients and yourself.

Help ensure that you maintain the ability to come together and effectively advocate for your patients and your coworkers. Let your family, friends and community know that IP 9 will negatively impact your patients and your work. Your voice is key in helping win this fight to keep Oregon working.

November 2014
Vote NO on IP 9

Like the Keep Oregon Working Facebook page to learn more and get critical updates.

Start standing up for working Oregonians today by ensuring your coworkers, family and friends know that IP 9 is wrong for nurses, wrong for patients and wrong for Oregonians.
Why I’m Running for State Representative

Rob Nosse, ONA

Over the past nine years, I have had the privilege of working directly with nurses as an ONA Labor Representative and I have enjoyed getting to know many of you personally. I’m excited to share my decision to run for state representative in House District 42 (inner SE and NE Portland) with you. I am honored to have earned ONA’s endorsement in my race and to begin this campaign with your support.

My husband, Jim, and I have lived in Southeast Portland for nearly twenty years and share many of the same concerns I hear from nurses every day. Today the middle class is disappearing and opportunities for Oregonians to move up are fewer and fewer. We are witnessing an unprecedented shift of wealth in America and we need representatives who understand these challenges and will fight for workers’ rights.

In my position as an ONA labor representative, I’ve worked hard every day to help bring nurses together and ensure you have the strong, united voice you need to advocate for the patients you care for and ensure safe working conditions for you and your coworkers. As a state representative I will put my health care knowledge and experience to work increasing patients’ access to health care, improving Oregon’s safe nurse staffing law, and working on the issues Oregon’s nurses care about.

As a former executive director of the Oregon Student Association (OSA), I have experience fighting for lower tuition, more student aid and better access to college for all Oregon students. Today, as the father of two children in Portland Public Schools, I know class sizes are too big and that we’re losing too many high quality teachers. The legislature took important steps this session to reverse the devastating cuts our schools all across the state have faced in past years, but I believe more needs to be done. As a State Representative, I will work to invest in high quality public education from pre-K through college. I will also support innovative ideas to open up our public universities and community colleges to more Oregonians and increase funding for the Oregon Opportunity Grant.

If elected, I will continue to work with you on the issues that have been at the heart of my professional and personal life. I am honored to have spent my entire professional career advocating for nurses, students, and working families who share the same concerns. You deserve a representative in Salem who understands these struggles firsthand and who has the experience necessary to make these issues a priority. You deserve someone who is willing to fight for you and your family every day. I believe I can be that representative and am honored to have the support of ONA and look forward to working with you on the campaign trail.

Please contact me at rob@robnosse.com to find out how you can get involved with the campaign.

In Unity,

Rob Nosse
Profile:
Seth Merritt, RN, FNP, LMT, CATOM, CLS

Seth Merritt, RN, FNP, LMT, CATOM, CLS, who operates his own practice as a family nurse practitioner offering comprehensive health care to patients of all ages, has just achieved the designation of “Patient Centered Primary Care Home-Tier 3” which is currently the highest level of achievement. This allows Merritt to provide full scope primary care at his clinic, Merritt Health & Wellness, LLC, within the climate of the Affordable Care Act (ACA) and health care reform in Oregon.

Merritt specializes in preventive medicine, long-term weight loss, weight management for children, adolescents and adults, management of all types of cholesterol and triglyceride management, and diabetes management. A self-described “professional nerd” who enjoys learning, Merritt holds certifications in lipid (cholesterol) management, exercise and nutrition, and is completing a certification in personal training.

“I have focused on weight management through educating life-long dietary and exercise changes with behavior assistance for over four years. I obtained the specialty in Obesity Medicine because too many of my patients were having many problems with hypertension, high cholesterol, high blood sugars, and mental health issues – and the source for them really was their ongoing weight issue,” explains Merritt. “It is very rewarding getting to the root of the issue. I feel empowered to make change and I infect patients with that same sense of empowerment that we can make a change and although it can be hard, nothing will be as potent a medication or treatment option as weight loss.”

While other providers can offer services for specific medical issues, Merritt offers additional services, emphasizing health and wellness in addition to use of targeted prescription medications and specialized laboratory testing to assist patient in the achievement and maintenance of optimal health. “My small micro practice is a Tier 3 PCPCH which I obtained this year. I am very proud to say that I am doing more than just helping people lose weight,” said Merritt. “I want to be transparent about the care I provide and hold myself to the best standards for primary care. This designation allows patients and insurance companies to know about my commitment toward excellent care by meeting and beating standards of patient care and patient satisfaction.”

Merritt approaches health care with a focus on the patient and their overall care, not just treating the symptoms the patient may be displaying at the time. “I became a nurse practitioner because it opened a lot of doors for me to be involved in a patient’s holistic care. I like learning the ins and outs of a specific whole person or whole environment,” said Merritt. “When I can wrap my head around the entire problem and the entire person, I feel I then can help guide patients toward ideal health.”

You can learn more about Seth Merritt and his practice by visiting the Merritt Health & Wellness, LLC, website, www.merritthw.com
ONA is both happy and sad to announce that Shirley Seat is retiring from her position as Program Assistant in Labor Relations. Shirley has been with ONA since 1985.

Throughout the years, Shirley has been responsible for updating all of ONA’s bargaining unit leadership records when advised of changes, maintaining check sheets of facility roster updates, contract ratification votes, and BU bylaws. Shirley also kept the wage comparison check sheet current, and tracked and completed contract reopeners.

ONA held a retirement party for Shirley on December 17. Staff enjoyed the party in honor of our valuable employee, friend, and long-term colleague.

Shirley, we wish you all the best and hope you enjoy a happy, healthy, well-deserved extended vacation!

Spotlight: Rich App, RN

Rich App, RN, works in a unique nursing position, performing apheresis on blood donors at the American Red Cross (ARC). Apheresis is a complex process involving a machine that separates donors’ red blood cells, platelets and plasma. This separation allows platelets or plasma to be donated, while red blood cells, and unused platelets or plasma, are returned to the donor. This process can take several hours and requires close monitoring and care from nurses like Rich, as well as Apheresis technicians.

As Executive Committee and Bargaining Unit Chair for Oregon’s ARC nurses, Rich has helped ensure that nurses continue to play an important role in blood drives even as the blood collection industry tries to reduce the number and role of nurses in the blood donation process.

Outside of work, Rich volunteers his time to help political candidates whose policies benefit nurses and their patients. In 2012, he was awarded ONA’s Internal Organizing Award for his work developing his local bargaining unit.

How did you decide to be a nurse advocate?

“Historically when you think of the Red Cross, you think of nurses, but that has changed significantly in the last few years as the Red Cross has moved away from using RNs on blood drives. A lot of people don’t know that unlicensed personnel are the main workers on Red Cross blood drives in Oregon and the number of nurses working on blood drives is shrinking. Nationally, there’s been a strong push to remove RNs from the blood donation process entirely.

This is a serious problem, because the Red Cross and other blood donation organizations are asking more and more of our donors, so those donors need a higher level of care that only health care professionals, like nurses can provide.”

What advice would you offer to other nurses?

“In smaller bargaining units like the ARC, nurses need to work together to stand up for their profession. When a single nurse is the only health care professional at a donation site, we need to make sure we’re advocating for our patients’ safety and showing them the value registered nurses bring to the blood donation process.”

What have you learned from your advocacy?

“There is a great future in nursing, but only if we advocate for ourselves, for our patients and for our donors. If we don’t stand united for patients we run the risk of losing our sense of pride in our work and forgetting the value of the care we provide for our patients.”

We’ll miss you, Shirley!
Rising Star Award

This award recognizes one who is relatively new to collective bargaining but has dived into the sometimes murky water to become involved and show great promise of future leadership.

Phil Zichino, RN, Sacred Heart Medical Center, Eugene

Phil has become a very active member of the Executive and Bargaining team at Sacred Heart Home Care Services (SH-HH) and has excelled in his role, as Bargaining Unit (BU) Chair, advocating for nurses since 2011.

During his tenure, Phil helped negotiate both the 2012 Sacred Heart Medical Center (SHHCS) and the current Sacred Heart Home Care Services contracts.

Phil has also become involved at the state, regional and national levels. He attended the 2013 National Federation of Nurses (NFN) Labor Academy in Washington DC. Phil has served as a delegate to the NFN Assembly and lobbied members of Congress on issues important to nurses, and he has participated in the ONA Lobby Day at the Oregon State Legislature.

We thank Phil for his dedication to improving the quality of life for the nurses and the patients they serve.

Adversity Award

This award is given to a nurse member who has gone forward to success despite terrible odds.

Cynthia Kistler, RN Tuality Community Hospital

Cindy is the bargaining unit chair at a facility that is an open shop and discourages nurses from joining ONA. Despite the obstacles, Cindy remains tireless in engaging her colleagues in membership drives.

And, despite having a heavy night shift schedule, Cindy is always active in taking calls from nurses. She utilizes her thorough knowledge of the Tuality contract to work proactively, keeping a positive attitude. Cindy knows that by utilizing an interactive, non-aggressive approach as she continues to work with the hospital’s administration, relationships are improved and difficult issues are resolved.

ONA, values Cindy’s many contributions, both as Chair and a member of her negotiation team.

Outstanding Local Bargaining Unit Chairperson Award

The award is presented to an individual for working to develop the local bargaining unit through a variety of activities under difficult conditions.

Katy Cooper, RN, OHSU

Kathy has served as the Bargaining Unit Chairperson at OHSU for three years. During that time she led the team to negotiate successful contracts in 2010 and 2013.
In the interim, Katy has concentrated her efforts on improving the infrastructure of her bargaining unit so it has a greater impact going forward. She has initiated a complete rework of the unit’s bylaws, advocated for, and recruited greater diversity within the unit, and worked tirelessly on the Grievance Committee, Labor-Management Committee, Policy Advisory Committee, and Employee Benefits Councils.

Katy has also been able to develop a good rapport working with OHSU administration, including initiating one-on-one monthly meetings with the Chief Nursing Officer.

Thank you Katy, for all your contributions.

2013 Internal Organizing Award

The award is presented to an individual who has worked to develop the local bargaining unit through activities such as membership recruitment, development of a telephone tree, fund raising, community public relations for ONA and the local bargaining unit, and for other projects which promote the bargaining unit.

Juliann Underwood, RN, Sky Lakes Medical Center

Juliann is the bargaining unit chair and serves on the Grievance Committee at Sky Lakes Medical Center. She’s an operating room (OR) nurse who works diligently to improve ONA’s union voice at her facility.

Juliann is also a tireless advocate for nursing education, organizing and development at the local, state and national levels. Continually reaching out to colleagues in order to improve and educate the staffing committee at Sky Lakes Medical Center. She has created a strong, unified team.

Thank you, Juliann, for your commitment and dedication to nursing and ONA’s labor relations.

Outstanding Grievance Chairperson Award

This award is presented to a nurse member who assists nurses in the bargaining unit to understand the rights within the contract; and effectively represents the bargaining unit nurses.

Janine Tebeau-Jemerson, RN

Janine has been an RN with Multnomah County for 32 years. Prior to joining the county, Janine was an army nurse, serving during the Desert Storm initiative. She works with children in the County’s school-based health centers and is currently ONA’s bargaining unit chair on the Multnomah County team.

Janine is one of our most active leaders. She has been tireless, engaging the county on many issues, regardless of applicable contract language.

Over the last eight months, Janine has addressed a particularly involved issue, regarding a potentially hostile work environment at one of the county’s units. Although no contract language covers these issues, the County has great respect for Janine and has acted upon these issues, at her recommendation. They have held a number of meetings, interviewed nurses, and hired outside consultants to conduct trainings that build positive working relationships.

Thank you Janine, for your continued advocacy and support for nurses.
Outstanding Union Leader Award

This award is given to a member who through unique contributions has strengthened the local unit and provided leadership for nurses on a state and national level.

**Julie Shuff, Bay Area Hospital**

June 13, 2013 marked the end of Julie Shuff’s term of office as the chair of ONA’s Cabinet on Economic & General Welfare (E&GW). ONA is grateful for Julie’s contributions and outstanding work on behalf of Oregon nurses during her multiple terms. Julie’s vision was to strengthen ONA by joining forces with the national labor movement, envisioning a new national union for nurses. She was one of the key players in writing the National Federation of Nurses (NFN) constitution and the formation of NFN in 2008. Julie was elected as the NFN vice president through 2015 and carries out her duties with professionalism and energy, never forgetting her commitment to ONA.

Julie was integral in the affiliation agreement between NFN and the American Federation of Teachers (AFT). She is immensely talented and wholly committed to the nursing profession and labor relations. Her talents and positive attitude will be missed on the cabinet. While her term as E&GW chair is over, Julie will continue to be a powerful advocate for nurses, both locally and nationally. Thank you Julie, for everything you have done and continue to do for ONA and nurses across the country.

### Value-Based Nurse Staffing Conference

**Julie Serrano, RN**

On November 14 and 15, the ONA Professional Services Department and the Oregon Nurse Staffing Collaborative presented the Value-Based Nurse Staffing Conference in Bend, Oregon. The two-day conference was developed to increase nurses’ knowledge of the staffing law as well as the unique process that was created by ONA and Oregon’s nurses to ensure safe staffing levels are met.

Nurses from all over Oregon attended the conference. Attendees came from up and down I-5, Southern Oregon to Portland, the Oregon Coast and Central Oregon. Each came to increase their knowledge and understand the impact of the Oregon staffing law on the staffing plans at different facilities.

Attendees at the conference were provided with valuable resource documents to use in helping develop and strengthen staffing committees at their facilities. Guest speakers Wendy Edwards and Chris Campbell from the Health Care Regulation and Quality Improvement Department of Oregon, provided details on how, as surveyors, they help support the nurse staffing law. They provided the tool that they use to help guide them through a survey of a facility.

A panel of both nursing executives and staff nurses working on staffing committees was opened for questions. The panel addressed both areas that were successes and struggles at various facilities. Difficult subjects were broached including how to change the environment at a facility to be one of interest and trust from intimidation and fear, when nurses are reporting staffing concerns with the Staffing Request and Documentation Form (SRDF).

One of the key messages emphasized, over and over, was that nurses must be able to confidently use data to support staffing decisions to create a safe environment for quality, safe patient care. Nurses are a vital part of the staffing decision because they are the patients’ advocate. ONA must ensure their safe journey through our health care systems.
At the recent Nurse Practitioner of Oregon (NPO) Annual Conference, we had the opportunity to honor two important leaders who have contributed to our practice for many years.

Larlene Dunsmuir has been a member of ONA since 1985 and has served in a variety of roles within the leadership of NPO since 1992, when she was an NP student. Those positions are Secretary, Treasurer, Nominating Chair, Chair Elect and Chair. She has served as the Co-Chair, and then Chair of the NPO Education Committee for the last seven years, working to offer high quality educational programs to NPs from Oregon and other states.

Larlene advocated for NPO’s involvement in Project Access Now, an organization dedicated to providing access to care for those without resources. This is an example of Larlene’s leadership and contribution to not only our focus on advocating for nurse practitioners but to the community as well.

Larlene has exemplified the role of an NP leader in the state of Oregon by being an active member in her state professional organization.

Larlene is in a Doctor of Nursing Practice (DNP) program at Chatham University located in Pittsburg, Pennsylvania.

Brian Delashmutt Says Good Bye

“I want to thank ONA for having faith in me as a 26-year-old, 35 years ago in 1979, and for giving me the opportunity to work with and for the ONA and NPO members.

We have achieved much in these nearly 35 years and we did it together. We had many successes in the legislature starting with NP independent practice and third party billing, the ability to bill insurance directly. We took on the OMA and insurance companies when many said it could not be done and we succeeded.

Do not ever forget that it takes dedicated members who are willing to work to achieve goals, especially when dealing with the legislature. In 1979 we had a core group of RN’s and NP’s who took on the task. Because it was a team effort, you have the ability to practice as you do today.

The work is never over – whether it concerns Workers Comp issues or equal pay for equal work – both of which we corrected this past legislative session.

Legislative gains in protecting both Home Health and staff RNs from violence in the workplace as well as staffing legislation took efforts over several sessions, but in the end ONA was successful.

Changes in the Nurse Practice Act over the years such as barring facilities from submitting mass RN license applications from out of state RNs who were recruited to be strikebreakers, protected striking RNs and provided a balance in the negotiations process.

I can look back at the past 35 years with pride in what we accomplished each and every session. After the 1979 session, Senate President Jason Boe referred to ONA and said “a sleeping giant has awoken”. Looking back now I think his remarks were understated.

Again thank you, I am not going far and you know how to reach me.”
The Annual Samaritan Leadership Strategic Retreat took place on November 8, 2013 at the Corvallis Country Club. This year’s agenda included reports from the four Samaritan facilities, a presentation on IP 9 legislation, and a keynote presentation by Rick Kuplinski, Deputy Director AFT Department of Organization and Field Services.

The focus of Rick’s presentation was utilizing strategies to better engage with members and potential members. During open discussion all hospital representatives committed to helping each other by identifying and sharing common events that occur during both negotiation and non-negotiation times.

Attendees from all four Samaritan facilities also agreed to meetings on a quarterly basis. As part of the agreement to continue the discussions of working together, our nurses decided to design a new set of targets for all four hospitals. A current example is the Samaritan grievance process, which now is the same at all four hospitals.

Nurses have agreed to work on internal organizing, to build strong labor relations within the four Samaritan hospitals and to increase the community contacts and engagements. Examples here were strategic meetings, greeting all new hires and hosting blood pressure drives at community events. With all these new ideas, nurses were energized and step forward into the busy year ahead.
Amedisys, Inc., Portland, 2-year agreement, 6/1/13 – 3%,
add new Step 23, 4/1/14 – 3%
Clatsop County, Astoria, 2-year agreement, 7/1/13 – 2.5%,
7/1/14 – 2.5 to 4.5 – CPI-U, 7/1/15 – 2.5 to 4.5 – CPI-U
Columbia Memorial Hospital, Astoria, 2-year agreement,
7/1/13 – 2.5%, 7/1/14 – 2.5 to 4.5 – CPI-U, 7/1/15 – 2.5 to 4.5 – CPI-U
Coquille Valley Hospital, Coquille, 3-year agreement
7/1/13 – 16-24%, 7/1/14 – 1.75%, 7/1/15 – 1.75%
Good Samaritan Regional Medical Center, Corvallis, 3-year agreement
7/1/13 – 1%, 7/1/14 – 2%, 7/1/15 – 2%
Good Shepherd Medical Center, Hermiston, 1-year agreement
10/1/13 – 1.5%
Harney County, Burns, 3-year agreement
7/1/13 – 2%, 7/1/14 – 2%, 7/1/15 – 2%
Klamath County, Klamath Falls, 3-year agreement
New pay scale (with at least 6.6% increase – placed at closest rate & if less, paid the same
Mercy Medical Center, Roseburg, 3-year agreement, 10/1/13 – 2%,
10/1/14 – 2%, 10/1/15 – 2%
Oregon Health & Science University, Portland, 3.5 year agreement
11/9/13 – 2.25%, 10/1/14 – 2.25%, 10/1/15 – 2.5%, 4/1/16 – 2.5%
12/20/13 - Lump sum bonuses
ProvRN, Portland, 2.5 year agreement, 11/1/13 – wage scale
1/1/14 – 1%, 7/1/14 – 1%, 7/1/15 – 2%
Samaritan Lebanon Community Hospital, Lebanon, 3-year agreement
7/1/13 – 1%, 7/1/14 – 2%, 7/15 – 2%
Silverton Hospital, Silverton, 3-year agreement, 7/1/13 – 1% Step freeze – lst yr,
7/1/15 – 1.5%, 7/1/16 – 2%
State of Oregon, 2-year agreement
12/1/13 – 1.5% 12/1/14 – 1.5%
St. Charles Medical Center-Redmond, 3-year agreement, 12/1/13 – 1%,
6/1/14 – 1%, 12/1/14 – 2%, 12/1/15 – 2%
In Negotiation
American Red Cross, Portland
Expiration date 6/29/13
Peace Harbor Hospital, Florence
Expiration 12/31/13
Providence Hood River, Hood River
Expiration 12/31/13
Providence Medford Medical Center, Medford, Expiration 12/30/13
Providence St. Vincent Medical Center Portland, Expiration 12/30/13
Washington County Health, Hillsboro
Expiration 6/30/14
Coming Up
Marion County Health, Salem
Expiration 6/29/14
St. Alphonsus Medical Center, Baker City
Expiration 3/31/14

So What About ACOs and CCOs?
continued from page 6

Arm Yourself.

As the largest single group of clinical health care professionals within the health system, registered nurses are educated and practice within a holistic framework that views the individual, family and community as an interconnected system that can keep us well and help us heal.

Registered nurses are fundamental to the critical shift needed in health services delivery, with the goal of transforming the current “sick care” system into a true “health care” system.

Nursing Again Named Most Honest and Ethical Profession

Just In: According to the 2013 Gallup Poll of Honesty and Ethics, nursing topped the list, for the twelfth straight year, as the most ethical and honest profession in America.

This year, 82 percent of Americans rated nurses’ honesty and ethical standards as “very high” or “high,” a full twelve percentage points above any other profession.

“Nurses are on the front lines of health care. We advocate on patients’ behalf whether we are at the bedside or in the boardroom,” said American Nurses Association President Karen A. Daley, PhD, RN, FAAN. “Patients understand that nurses are committed to improving the quality of their care, and this poll reflects the high regard they have for the profession.”

“Patients understand that nurses are committed to improving the quality of their care, and this poll reflects the high regard they have for the profession.”
Upcoming ONA Elections

ONA will be conducting statewide elections for officers and cabinet members. The ONA Nominating Committee is currently soliciting ONA members and leaders to self-nominate for openings. The deadline for self-announcement is January 17, 2014. Elections open on February 3, 2014 and close on March 7, 2014.

Any member who is interested should be encouraged to self-announce their candidacy. Online forms are available on the website. Kathy Gannett is the committee staff person and will assist nurses in completing the process. Should a nurse wish to speak to a committee member about the various open positions and their duties, or about the nomination/election process in general, please contact Kathy Gannett at gannett@ona.org.

Open Positions: 2014 Elections

- President
- Secretary
- Director (4)
- Cabinet on Health Policy (1)
- Cabinet on Education (4)
- Cabinet on Nursing Practice & Research (1)
- Cabinet on Economic & General Welfare (1)
- Nominating Committee (3)
- Elections Committee (3)
- ANA Delegates (2)
- NFN Delegates (3)
- NFN Director (1)
- AFT Delegates

For More Information, call Kathy Gannett, 503-229-0011 ext. 309 gannett@oregonrn.org.

Portland Monthly Magazine Names 2014’s Top NPs

The 2014 edition of Portland Monthly’s “Top Docs & Nurses” is now available across the state. ONA would like to congratulate our NPO members who were featured! It is rewarding to see your hard work and dedication to your patients being recognized. We at ONA and Nurse Practitioners of Oregon (NPO) are proud to have Oregon’s nursing profession so well represented.

Congratulations to: Rebecca Christensen, ANP; Michelle Grove, ANP, BC-ADM, CDE; Laurie Beeson, FNP; Kristin Case, FNP; Shelda Holmes, FNP; JC Provost, DNP, FNP; Lynn West, MSN, ANP; Agnes White, FNP; Carole Gaglione, PNP; and Larisa Jeffreys, PMHNP.

Flu Season is Here, Time to Get Vaccinated!

The Oregon Nurses Association (ONA) believes that all nurses and other health care workers should be vaccinated against seasonal influenza. Vaccination is a key method of protecting health care workers from influenza and helping to prevent the spread of influenza among patients and the public.

ONA encourages nurses to be vaccinated and is working to provide education to Oregon’s nursing professionals and student nurses and assist them in making informed choices about receiving annual influenza vaccines.

However, ONA opposes requiring influenza vaccinations of nurses and other health care workers as a condition of employment. Rather, education and access to vaccinations, when combined with other methods to prevent influenza transmission, are sufficient and effective in protecting patients and workers.

You can learn more about ONA’s position on seasonal influenza vaccination for health care workers, and find resources from the Centers for Disease Control, the American Nurses Association and the state of Oregon regarding the flu season at ONA’s Flu Resource Center on the front page of the ONA website, www.OregonRN.org.
New ONA Constituent Associations Replace ONA Districts

Kathy Gannett, Associate Director of Operations, ONA

ONA Constituent Associations (CAs) are geographic areas in which all ONA members participate. ONA members are elected to the ONA House of Delegates from CAs. Thus, nurses from different practice settings have the opportunity to serve in the highest policy making body of the association. ONA members typically join the CA where they work or live, although some areas of the state do not have a CA. Members in those areas belong to the “At-Large CA” which provides them a vehicle for election to the House of Delegates.

The ONA Board declared the following bargaining units as Constituent Associations Bargaining Units (CA-BUs):

1. Mid-Columbia Medical Center CA-BU
2. Good Samaritan Regional Medical Center CA-BU
3. St. Anthony Hospital CA-BU
4. Harney District Hospital CA-BU
5. Sky Lakes CA-BU
6. St. Alphonsus Medical Center Baker City CA-BU
7. Grande Ronde Hospital CA-BU
8. Samaritan Pacific Communities Hospital CA-BU
9. St. Alphonsus Medical Center Ontario CA-BU
10. Good Shepherd Medical Center – SHMC CA-BU
11. Providence Hood River Memorial Hospital – HRM CA-BU
12. Providence Willamette Falls Medical Center – PWFMC CA-BU
13. Providence Milwaukie – PMIL CA-BU

All members in a dissolved CA who are not members of the new CA-BU have been placed in the At-Large CA.

1. CA 6 dissolved
2. CA 7 dissolved
3. CA 8 dissolved
4. CA 9 dissolved
5. CA 12 dissolved
6. CA 13 dissolved
7. CA 19 dissolved
8. CA 20 dissolved
9. CA 22 dissolved
10. CA 26 dissolved

In addition, these CAs remain active:

1. CA 1: Columbia, Multnomah
2. CA 3: Polk, Marion
3. CA 4: Josephine, Jackson
4. CA 5: Lane
5. CA 10: Coos
6. CA 14: Jefferson, Crook, Deschutes
7. CA 23: Linn
8. CA 24: Washington
9. CA 51: Kaiser, Portland
10. CA 52: OHSU, Portland

In 2012 the ONA Bylaws were amended which changed CAs in their definition, function and responsibilities (ARTICLE VIII: CONSTITUENT ASSOCIATIONS).

Highlights of the Changes

Definition
An active CA exists where current CA members meet as a group at least semi-annually, one of which may be attendance at the House of Delegates, and complies with Section 3 of this Article.

Where there is no active CA, the following may be become constituent associations:

1. ONA collective-bargaining units as defined by the recognition clauses in the collective bargaining agreements; or
2. Special interest groups; or
3. All members designated “at-large” will be considered one (1) constituent association.

Formation, Alteration

Members wanting to alter an active CA, considered a constituent association for the purposes of these Bylaws, will present to the ONA Board of Directors an official petition with the signatures of at least seven percent (7%) of the affected members in good standing.

Where there is no active CA the ONA Board of Directors will designate as a constituent association an ONA collective-bargaining unit after receiving an official petition with the signatures of at least seven percent (7%) of the members in good standing in the bargaining unit or a unanimous written request by the bargaining unit’s executive team. All members of the bargaining unit will then become a member of the bargaining unit’s constituent association for all matters related to the House of Delegates.

Members wanting to form or alter a special interest group will present to the ONA Board of Directors an official petition with the signatures of at least seven percent (7%) of the affected members in good standing.

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New Constituent Associations

Members that do not belong to one of the three (3) types of constituent associations above or are part of a constituent association that has been dissolved will automatically be placed in the At-Large Constituent Association.

Responsibilities

Constituent associations must:

– Adopt and maintain Bylaws that are consistent with these Bylaws and adopted policies. These Bylaws and adopted policies will supersede any inconsistent Bylaws or policies of a constituent association.

– Elect officers by secret ballot from its members in good standing.

– Select a delegation to the House of Delegates.

– Submit to the ONA Board of Directors copies of all governing body and committee minutes, financial reports and communications and such reports as may be required by these Bylaws, adopted policies, and/or governing documents, or as requested by the ONA Board.

– Submit a report to the House of Delegates.

– Funds from a dissolved constituent association will be put into ONA’s General Fund and allocated pursuant to adopted policies.

At-Large Constituent Association

The ONA Board of Directors will serve as the Executive Committee by default for the At-Large Constituent Association and will be responsible for such things as conducting the nominations and elections of delegates, filling any vacancies in the delegation, and administering and allocating funds for delegate expenses.

The following BUs reside in the At-Large CA and could petition to become CA-BUs:

- Benton County Health Dept.
- Clatsop County Health Dept.
- Columbia Memorial Hospital
- Klamath County Health Dept.
- Lake District Hospital
- Mercy Medical Center
- Prov. Seaside Hospital

All CAs and CA-BUs have been mailed a letter with 2014 convention timelines and House of Delegates information including delegate count. The At-Large CA has been mailed a “Call for Nominations” form to begin the process of electing delegates to the House. The total potential number of delegates at the 2014 House of Delegates is 392. Below is the delegate count for the 2014 House of Delegates.

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<th>Totals</th>
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