Nurses rally in D.C. for patient safety reforms
Quality nurse staffing through single-payer

By Marilyn Albert, RN
Labor/Political Organizer, NNU

Nurse union builders struggle with the need to build a broad movement of nurses that welcomes RNs of all political stripes, and our belief that a single payer system is the only reform that will work. To some, building a broad movement and fighting for single payer may seem contradictory, or at least difficult.

Talking to nurses about how a single payer system would transform hospitals and their financing, opening the way for health care workers and communities to be decisive in the budgeting priorities of hospitals and health systems, is something on which we might place more attention.

As nurses, we are tempted to think that the way hospitals operate and the way hospital care is paid for has always been the way it is now, and will always be that way. But many of us remember when hospitals were reimbursed for anything they billed for, then when prospective payment via DRGs came into effect in the early 1980s, and some of us even remember when Medicare and Medicaid transformed hospital financing in the 1960s, a giant step in recognizing health care as a human right.

As corporate medicine and the drive for profits grew in the 1990s, managed care made cutting costs the focus of hospital budgeters and administrators. Since nurses were the largest labor cost for hospitals, nurses were the first to be cut. In the mid 1990s, the re-engineering of nursing took place, eradicating primary care nursing and leading to layoffs, downsizing, displacement, and a shortage of nurses willing to work at the hospital bedside. All of this endangered patients’ lives, which has been well documented by respected researchers.

Hospital financing has changed before and it can change again.

We campaign for mandatory nurse-to-patient ratios under the current system of hospital financing in which patient care is not the priority. One of the first questions politicians ask is “what will ratios cost?” Our position is that saving patients’ lives cannot be submitted to cost/benefit analysis, and that ratios are affordable, even under the current hospital financing system. According to the former editor of the New England Journal of Medicine, only 50 cents of the health care dollar reaches health providers under today’s system dominated by the for-profit insurance industry. However, suppose the prevailing system eliminated the private insurance industry, thereby saving at least 30 percent of the health care dollar and redirecting that funding to direct patient care? Instead we have become used to hospitals prioritizing:

- Marketing their services to the well insured
- Employing huge numbers of staff dedicated to billing, aimed at high reimbursement
- Employing huge numbers of administrators dedicated to cost cutting
- Refusing to admit patients without insurance and discharging patients quicker

Under a single payer financing system, the substantially enriched funding for direct patient care would be budgeted with strong input from health care workers and unions.

Single payer legislative proposals have in common a concept of a democratically designated public entity that would budget according to the public health needs, plan health services, distribute technology rationally and eliminate duplications, and make decisions based on input from all real stakeholders. Such an entity would function at the national level, regional, state and local levels, and could be developed on a community basis to determine budgets for hospitals. There is a rich history in the U.S. of community health planning which can be tapped to transform the new health care system down to the neighborhood level.

Single payer advocates call this global or negotiated budgeting. Health workers, professionals, and community and patient advocates would negotiate with the health planning entity for their hospital’s annual budget.

Good staffing practices with nurses’ and health worker unions having a strong say and staffing ratios are budgeted as a top priority.

The hospital’s areas of medical and research expertise, determined objectively, would be funded appropriately.

Unnecessary surgeries, hospitalizations and treatments would end.

Patients would be hospitalized for as long as their physicians and members of the health care team determine is necessary, with appropriate follow-up care carefully planned.

With equitable hospital care policies and equitable health access, many of the persistent health disparities among the medically underserved would end. The special needs of deserving patients, such as the chronically ill, the frail elderly, the disabled, etc., can be given the special attention they deserve and can be funded accordingly.

Public health systems would be fully funded and no longer be the “last resort” for patients rejected by private hospitals.

A single payer system that eliminates the private insurance industry is the only reform that can meet the above needs, and should be supported by RNs whose main concern is safe patient care. This is realistic and winnable if the most trusted profession raises our collective voice!
A major new study led by one of the nation’s most eminent nurse researchers provides compelling new evidence that California’s landmark RN-to-patient staffing law reduces patient mortality, assures nurses more time to spend with patients, and substantially promotes retention of experienced RNs. The study is the latest—and most conclusive—piece of scientific evidence to bolster the case for increasing RN staffing in hospitals and for limiting the number of patients assigned to a nurse at one time and is being proposed now in pending legislation, the Patient Safety Act (H.3912/S.890), currently before the Massachusetts Legislature.

“This research effectively closes the case in the debate for long sought legislation in the commonwealth, which would provide patients with safe staffing standards to save lives and improve patient care,” said Donna Kelly-Williams, RN and president of the MNA. “The California law works, and every day we wait to pass a similar law here in Massachusetts, more and more of our patients suffer preventable complications, and some of them die as a result.”

The study, published online in the prestigious policy journal, Health Services Research, was conducted by a team of researchers led by Linda Aiken, RN, Ph.D. and director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing. The researchers surveyed 22,336 RNs in California and two comparable states, Pennsylvania and New Jersey, with striking results, including:

- If they matched California ratios in medical and surgical units, New Jersey hospitals would have 13.9 percent fewer patient deaths and Pennsylvania 10.6 percent fewer deaths.
- California RNs report substantially more time to spend with patients, and their hospitals are far more likely to have enough RNs on staff to provide quality patient care.
- Fewer California RNs say their workload caused them to miss changes in patient conditions than New Jersey or Pennsylvania RNs.
- In California, hospitals with better compliance with the staffing limits, RNs cite fewer complaints from patients and families and the nurses have more confidence that patients can manage their own care after discharge.
- California RNs are substantially more likely to stay in their jobs because of the staffing limits, and less likely to report burnout than nurses in New Jersey or Pennsylvania.

“In these two states alone, 468 lives might have been saved over the two year period just among general surgery patients if the California nurse staffing levels were adopted,” said Aiken. “Because all hospitalized patients are likely to benefit from improved nurse staffing, not just general surgery patients, the potential number of lives that could be saved by improving nurse staffing in hospitals nationally is likely to be many thousands a year,” said Aiken.

Two years after implementation of the California staffing law—which mandate minimum staffing levels by hospital unit—“nurse workloads in California were significantly lower” than Pennsylvania and New Jersey. “Most California nurses, bedside nurses as well as managers, believe the ratio legislation achieved its goals of reducing nurse workloads, improving recruitment and retention of nurses, and having a favorable impact on quality of care,” the authors write.

“From a policy perspective, our findings are revealing. The California experience may inform other states that are currently debating nurse ratio legislation including Massachusetts,” the study concluded.

The Patient Safety Act, which is co-sponsored by Rep. Christine Canavan (D-Brockton) and Sen. Marc R. Pacheco (D-Taunton), calls upon the Massachusetts Department of Public Health to set safe limits on the number of hospital patients a nurse is forced to care for at one time. The limits would be based on scientific research and testimony from public hearings and, once established, could be adjusted in accordance with patient needs and requirements using a standardized, DPH-approved system. The bill would also prohibit mandatory overtime, such as forcing RNs to work extra hours or double shifts, and protects against the reduction in the number of other members of the health care team including LPNs, aides and technicians. Patients would have the right to know and demand safe limits.

A hearing on the bill was held in November by the Joint Committee on Public Health. A similar bill passed the House of Representatives by overwhelming margins during the last two legislative sessions, but failed to win passage in the Senate.

“In the past, some legislators and our opponents pointed to California, claiming they first needed to see if the law would work there,” Kelly-Williams said, “Well now we have the answer. It’s time to act.”
Making a difference: Ellen Farley stands tall for all nurses

By Barbara “Cookie” Cooke
Region 3 Community Organizer

For four years Ellen Farley, a registered nurse at Taunton State Hospital, battled for change. Farley was the victim of an attack by one of the patients at Taunton State Hospital and she was determined to make things different. Taunton State Hospital is a step-down facility for the criminally insane released from Bridgewater State Hospital, as well as for clients sent directly from the courts. These clients have severe psychiatric illnesses and are in need of hospital-level care. Farley was attacked by one of the court case clients, an individual who committed numerous violent attacks on others, so she decided to file assault charges against him.

After filing charges, the patient’s behavior temporarily improved. As the case dragged on in court and decisions were postponed again and again, the violent behavior of Farley’s attacker resumed. “I could see that his behavior was purposeful and intentional,” she explained. “Right after I filed the charges, his behavior improved, and this only proved to me that I needed to follow through if he was to ever realize that there were consequences to his assaultive behavior. The drawn-out procedural delays did not work well for either of us. I really wanted something done but wondered if I could make it happen.”

In February, at an unrelated political event, Farley’s Taunton State co-workers Colleen Bissonette and Karen Coughlin met Sam Sutter, the Bristol County district attorney. Coughlin, executive vice president of Unit 7 and vice president of the MNA, recalls the meeting as a turning point. “I was frustrated with nothing happening and conveyed my aggravation to the DA. I told him about these violent occurrences—56 episodes in a one-year period perpetrated by this single individual. The DA should have been aware of this situation. I also made him aware of Ellen’s prolonged assault court case and I was insistent that he needed to do something.”

Sutter and assistant DA Brandon Ferris agreed to a meeting with Farley, Coughlin and Barbara “Cookie” Cooke, Region 3 community organizer. Sutter was thankful to Farley for bringing the situation to light and he made a promise that the approach to this case would change, and that it would be resolved without further delay. Sutter kept his promise. On April 1, Farley again found herself at the Taunton District Court, but this time was different. In addition to the co-workers, friends and MNA staff who accompanied Farley, Sutter was there even though he was not directly handling the case, and the issue was resolved that day.

“I really believed that my attacker would be found mentally ill,” said Farley, “and I explained to anyone who would listen that in the past there had been a difficult-to-manage unit where assaultive clients in need of treatment could go and receive more intensive treatment. Due to budget cuts, that unit was dissolved. Consequently, this client would return to Taunton State Hospital after each court appearance, where he would resume his assaultive behavior.” Farley’s assessment of the case proved to be correct. The judge found the defendant innocent by reason of mental defect, but sent him to Bridgewater State for an evaluation before he could return to Taunton State. “I did feel there was justice with that ruling,” Farley said. “I really want the client to do better and I hope that it works that way. I also want my co-workers to know that we need to send a strong message to clinical staff, administration, police and court officers that violence towards health care workers should not be part of the job.”

Farley would have never found any justice if she hadn’t been so persistent, and also did not have the support of her co-workers throughout the ordeal. But the story also demonstrates the value of political contacts and political activity. It was at a political event that MNA members were able to speak with Sutter personally and effect some change in how the case was being handled. You never know how political activism will help you!

Update: MNA assault bill takes the next step

On April 15, the Massachusetts Senate voted unanimously in favor of S.2383, An Act Relative to Assault and Battery of Health Care Providers, sponsored by Sen. Michael Moore (D-Millbury). This bill would increase the penalties faced by patients, family members or others who assault a nurse or other health care worker while they are providing care. The successful Senate vote followed a unanimous House vote on March 31 in favor of a similar bill.

The MNA is now working to reconcile the two versions of the bill and is looking to have the legislation on the governor’s desk in the coming weeks.

Thank you to all the nurses and health care professionals who lobbied their legislators over the past six months on this important bill and on the issue of violence against health care providers. This campaign has only been successful because of your hard work.
MNA members: politically active across Massachusetts

On March 15, a group of Region 4 members braved the rain and flooding to meet with state Rep. Barbara L’Italien in North Andover. The group shared personal stories and had a great discussion about the MNA’s workplace violence prevention legislation. Pictured above (from left), Kathy Renzi from Merrimack Valley Hospital, Terry Melnikas from Lawrence General Hospital, L’Italien, Lori Donovan from Anna Jaques Hospital and Jeanine Hickey, RN, an organizer for the MNA.

Region 4 nurses continued their lobbying efforts on March 16, when a group traveled to the State House to bring information on S.988, An Act Requiring Health Care Employers to Develop and Implement Programs to Prevent Workplace Violence, to members of the Legislature. Above, from left, Kay Marshall and Marsha Froburg from Anna Jaques Hospital, Helen French from the Chelsea Soldier’s Home, Peggy O’Malley, and MNA member Tina Russell visited legislators from Region 4.

MNA members from left Gary Kellenberger, Sandy Eaton, Tina Russell, MNA President Donna Kelly-Williams and MNA Vice President Karen Coughlin with Rep. David Sullivan (D-Fall River) talk about the MNA violence prevention legislation on March 24 at the State House.

MNA members and constituents with Sen. Jack Hart at Amrhein’s restaurant in South Boston to discuss violence prevention bills. From left, Tom Keaney, Andrea Green, Hart, Renee Bothwell and Kim DeLeon.

MNA President Donna Kelly-Williams (right) and Vice President Karen Coughlin (center) met with (from left) Reps. Patricia Haddad (D-Somerset), Jim Fagan (D-Taunton) and Steve Canessa (D-New Bedford) to discuss preventing violence against nurses.

MNA members and constituents with Rep. Linda Dorcena Forry at Dot2dot Café in Dorchester on April 9 to discuss violence prevention bills. From left: Jane Farricy, Kim DeLeon, Dorcena Forry and Tonia King. Standing are Petra Bruno Morson (left) and Maribeth Diener.
Why do unions make endorsements in political races?

By Maryanne McHugh

Many RNs and health care professionals are surprised when told that it is critically important for them to be involved in politics. After all, they got into the health care profession because they wanted to help sick people get well, not because they wanted to be politically active. But political activism is an important part of patient advocacy.

The Mass Nurses PAC endorses candidates running for elected office who it believes will best represent the MNA and its issues at city/county halls, the State House and the U.S. Capitol.

Why is political activism so important for nurses?

Because a huge percentage of dollars spent on health care services are taxpayer dollars.

Almost 50 percent of the Massachusetts state budget is spent on health care.

Elected officials influence almost every aspect of nursing and health care, including licensing; hospital finance and regulation; nursing education and practice; staffing levels; medical errors; whistleblowing protections; hospital closures and conversions; issues related to insurance, etc. In other words, your elected officials have a tremendous influence over your workplace and your ability to care for your patients.

When so much public money is spent in a single policy area, you can be sure that elected officials will exert their influence. As a result, if you are not talking to elected officials about health care issues and nursing be assured that other entities will be talking with them, including the hospital industry, the insurance/HMO industry, and the pharmaceutical industry. Do you really want elected officials making decisions that affect your profession when it very well may be the hospital industry that is speaking for you?

Nurses need to speak for themselves!

Here are just a few actual examples of how elected officials have recently affected the work of some of your fellow nurses, as well as examples of how nurses have successfully advocated for the nursing profession and their patients.

On a local level

Last April—literally a few hours before the swine flu outbreak made global headlines—Worcester’s city manager, mayor and city council made a shocking announcement: They would be implementing budget cuts and layoffs that would ultimately eliminate virtually all services provided by the city’s public health department.

Five public health nurses were laid off, leaving only two to cover the city—Worcester being the second largest city in Massachusetts. The MNA sprinted into action and worked with local officials to save these services. We are still actively engaged in preserving public health services in Worcester, which remain under threat of elimination.

On a state level

This spring, the MNA’s legislative division scheduled numerous meetings with both representatives and senators to address the level of violence against nurses and other health care workers in hospitals.

Members from all over the state sat with their individual elected officials in their districts and shared their own personal stories of verbal and physical abuse at their workplace. Legislators were outraged to learn that there was not a law in place that protected nurses, and in March and April both the House and the Senate voted unanimously to pass a bill that would more severely punish individuals who assaulted nurses and health care professionals on the job. Many legislators spoke passionately during the debate and quoted the stories they had heard from MNA nurses during these meetings.

On a federal level

An example of the importance of political involvement at the federal level is the impact of the NLRB’s Kentucky River decision. As you may know, Kentucky River expanded the definition of supervisor to include charge nurses. In doing so, it not only affected the ability of many nurses to be part of a bargaining unit, but also opened the door to employers seeking to deny union rights to millions of other workers. The NLRB is comprised of five members, all of whom are appointed by the President and approved by the Senate. Just a few months ago, the Senate used a procedural maneuver to reject two good nominees appointed by President Obama. Senator John Kerry voted in favor of against had a

Politics allows you to use that power to help yourself and your patients.

To get involved in the Mass Nurses PAC, or for more information, please contact Maryanne McHugh at 781-830-5713.
Use your MNA Webmail Account Today
for a chance to WIN

10 weeks worth of amazing prizes available

Did you know that as an MNA member you have access to a free MNA Webmail account? Did you also know that you could win great prizes just by using this account?

Here is how it works

- Activate your MNA Webmail account by using the personal username and password sent to you previously. Need them again? Call 781-821-4625 (9 a.m. to 4 p.m.) and ask to speak with member services.

- When activation is complete, log in to your personal MNA Webmail account and open the e-mail message titled “MNA E-mail Contest.”

- This message will include a simple trivia question, directions on how and when to submit your answer, and a complete summary of both the contest rules and prize details.

- Check your MNA Webmail account weekly. A new trivia question will be sent each Friday until the end of the contest.

- Weekly winners will be selected randomly from all the correct submissions and will be notified in an e-mail message sent to their MNA Webmail account.

- All participants will be entered in the drawing for a grand prize at the end of the contest.

Some available prizes:

(2) $25 BEST BUY GIFT CARDS
(2) $50 FRIDAY’S GIFT CARDS
(1) $50 CRATE&BARREL GIFT CARD
(1) Motorola Universal Bluetooth headset H270
(1) Denon in-ear Headphones
(1) AT&T Phone

Pictures shown may not accurately reflect actual prize.

Complete contest rules available at massnurses.org
Morton Hospital RNs and health professionals ratify agreement

After six months and 22 negotiating sessions, the registered nurses and health professionals of Morton Hospital ratified a tentative agreement on May 4. The pact includes strong language to limit mandatory overtime, protection of the defined benefit pension plan, a salary increase to allow Morton’s professional staff to keep pace with other hospitals in the market and pay parity for Morton’s home care nurses.

“We are thrilled to have achieved this settlement, which is a victory for all of us—nurses, health professionals, management, and most important of all, our patients, who will benefit from nurses having safer practice conditions,” said Joyce Wilkins, RN and chair of the nurses’ local bargaining unit of the MNA. “This agreement also maintains a benefits package that will allow this hospital to continue to recruit and retain the excellent professional staff our community expects and deserves.”

Highlights of the agreement, which will run from Jan. 1, 2010 to Dec. 31, 2012 include:

- **Mandatory overtime protections**, including a written commitment to keep mandatory overtime to a minimum, a provision that no nurse or health professional will be required to work beyond 12 hours, and that no nurse or health professional can be mandated to work mandatory overtime more than two times each quarter. In support of this commitment, the hospital is already increasing contingency staff positions to provide staffing support to help alleviate this problem.

- **Pension protection** that maintains the current defined pension benefit with no changes. In recognition of the tenuous economic climate, the nurses and health professionals have agreed to form a joint committee with management to evaluate the pension issue. In addition, the contract could be reopened in 2011 to evaluate the pension benefit based on the hospital’s financial status. Any changes to the pension will need to be negotiated and approved by the bargaining unit members.

- **Wage increases**, including 1 percent across-the-board retroactive to Jan 1, 2010, 1 percent on July 1, 2010; 1 percent on Jan. 1, 2011, with a 2 percent increase to the top step of the pay scale making it a full 4 percent step and another 1 percent across-the-board raise on July 1, 2011. In addition, home care nurses will be granted parity with other nurses in the bargaining unit and “on call” pay will be increased from $4.25 per hour to $5 on July 1, 2010. The contract also includes a reopener for salary, differentials, health insurance and pension benefits in January 2012.

- **Health insurance**: The nurses and health care professionals agreed to discontinue a grandfathering provision granting nurses hired before 1998 to pay a lower health insurance premium contribution, meaning all employees will now pay 20-30 percent (20 percent full-time 32-40 hours, 30 percent part-time) of their health insurance premium. The union also agreed to modest increases in co-pays for office visits for primary care, specialist and ED visits.

The 400 nurses and health professionals began negotiations for a new contract on Oct. 15, 2009. The last eight of the 22 sessions were held with a federal mediator. The existing contract expired on Jan. 1.

Tufts pays $5,000 OSHA fine for violations in tracking nurse injuries

Management at Tufts Medical Center was recently forced to pay a $5,000 fine to the Occupational Health and Safety Administration for numerous lapses in its efforts to track injuries to nurses. These injuries included a significant number of needle stick injuries that could have exposed nurses to life threatening pathogens, including HIV and hepatitis C. In addition, management was forced to post a public notice for its nurses that detailed the lapses.

The settlement agreement with OSHA was reached after it issued a letter detailing a number of instances where the hospital failed to document and track injuries to staff. Under federal law, all workplace injuries must be tracked on what are commonly known as “OSHA 300 logs.” The logs are a vital tool used to monitor the type and frequency of workplace injuries, and for identifying ongoing workplace safety issues that may need to be addressed.

The investigation by OSHA resulted from a complaint filed by the MNA, which discovered the lack of proper injury tracking while doing its own investigation of unreported incidents of workplace violence at the facility in 2009.

According to the OSHA investigation, Tufts Medical Center did not prepare an annual summary of work-related injuries and illnesses for 2007 or 2008. It also failed to track the days employees were not able to work due to injuries (even when an employee was out for over 180 days), to keep the employees name private as is mandated by law, and to document sharp and needle stick injuries and illnesses (this happened 67 times in 2007, 90 times in 2008 and 59 times in 2009). Needle stick injuries are a serious concern for health care workers. Such injuries can expose nurses to blood borne pathogens, like HIV and hepatitis C. It is vitally important to track these injuries to help identify trends and potential causes of these injuries.

“For a hospital, particularly a major teaching hospital, to show such a lack of concern for the health and safety of its workers is a travesty,” said Barbara Tiller, RN, a clinical resource nurse at the facility and chair of the MNA’s local bargaining unit at Tufts. “Any health care provider knows that documenting the existence of a problem is the first and most important step in being able to address it. We see this as part of a pattern of behavior on the part of this administration to disregard their obligations, not only to its staff, but also to the patients under our care. We hope this fine and penalty send a message to our administration that they need to be accountable for the conditions they create for their workforce.”

The OSHA investigation over problems with worker safety is the latest in a series of ongoing issues the nurses have had with the hospital in recent years. Nurses staged a picket outside the hospital on February 11 to protest dangerous staffing conditions at the facility resulting from a change in the nurse’s staffing pattern, which the nurses claim violated the hospital’s obligation to negotiate those changes as stipulated in the their union contract. Since the new model of care has gone into effect, there have been hundreds of official reports filed by nurses documenting unsafe staffing incidents. In fact, there were 132 such reports filed over a 179-day period through March.

As with the problem of the OSHA logs, the hospital has failed to address any of the nurses staffing and patient safety concerns.

The nurses at Tufts have continued to document their concerns and are preparing to reach out to the hospital’s board of trustees as well as to local public officials for support in their efforts to improve conditions at the facility.
Quincy Medical Center holds picket after management ceases negotiations

Carrying signs that read, “Negotiate Don’t Dictate,” “Safe Staffing Now,” and “Be Fair to Those Who Care,” more than 200 registered nurses at Quincy Medical Center conducted an informational picket outside the entrance to the facility on April 13.

RNs picketed after the MNA filed an unfair labor practice charge with the NLRB against the hospital for their appalling decision to cease negotiations for a new contract and to declare impasse after only six sessions. Citing the hospital’s financial instability, QMC management is demanding that the nurses cut their wages by 3 percent, increase their health insurance by 5 percent, and freeze their pension along with other benefit cuts—all of which were implemented on April 4.

“We are outraged by management’s decision to declare impasse,” said Paula Ryan, an RN and chair of the MNA bargaining unit at Quincy. “This move is unprecedented and we also believe it is illegal. Negotiating is meant to be a good faith process of reaching a fair settlement that protects the hospital and nurses alike.”

“They are demanding that nurses make significant sacrifices, without providing us the opportunity to negotiate over those changes,” added Ryan. “For management, it is ‘take it or leave it.’ They are stomping on our legal rights and we will not be bullied, we will not be intimidated.”

For their part, the nurses have stated they could agree to some concessions, providing the hospital reciprocates by agreeing to make the staffing improvements that were promised in the last round of contract negotiations, and that the concessions/cuts “sunset” (i.e., be automatically restored) at the end of the new contract. The nurses are also seeking a non-voting seat on the hospital’s board of trustees, which will allow them to provide input into the hospital’s “transformation” plan.

“The nurses are fully aware of the hospital’s financial situation, and we are not opposed to making sacrifices. We have done this before in fact,” said Ryan. “However, we also have a greater responsibility to our patients and we cannot accept a contract that fails to ensure that we have the staff and resources to keep our patients safe. We all have a stake in supporting this hospital, but we cannot do so at the expense of our patients.”

Negotiations for a new contract began on Feb. 18 with six sessions held so far. The contract expired on March 31.

The MNA charge against the hospital contends that the hospital’s declaration of impasse was premature, coming only after six bargaining sessions—only one of which was with a federal mediator. Both parties called in the mediator for the March 24 session to help the parties move the process forward.

Marching with the QMC nurses were their colleagues from a number of MNA local bargaining units, including nurses from Cambridge Health Alliance, Caritas Norwood Hospital, Caritas St. Elizabeth’s Medical Center, Unit 7, Jordan Hospital, Brockton Hospital, Faulkner Hospital, Tufts Medical Center and Boston Medical Center. The nurses also had the support of the local labor community, including the AFL-CIO’s president, Robert Haynes; the AFL-CIO’s secretary, James Howard; Robert Rizzi, president of the Norfolk County Central Labor Council; James Pinkham, president of the Plymouth/Bristol County Central Labor Council; and members from NEMSA. Also offering their support at the picket were members from Teamsters Local 25, Local 103 IBEW, IAM Local 264 Machinists, Local 17 Sheet Metal Workers, Local 2222 IBEW, Laborers Local 133, Boston Mailers Local 1 and Laborers Local 367.

Public officials in attendance included State Sen. Michael Morrissey (D-Quincy), Quincy School Committee member Elaine Dwyer, former Quincy City Council member Marty Aikes and, candidate for state representative Tackey Chan.
Rebutting the refrain, ‘What has my union done for me lately?’

By Tom Breslin
Associate Director of Labor Education

How many times have we all overheard a fellow union member declare the following: “I’m sick and tired of my darned union! All I get for my monthly dues is (insert complaint here).”

But what DO unionized workers actually get with their monthly dues? At the very least, unionized workers get:

- Good medical and dental benefits, paid for mostly by their employer
- Reporting pay when called into work
- Vacation time with vacation pay
- Seniority rights that provide benefits and layoff/recall protections
- Access to grievance procedures that culminate with binding arbitration if you disagree with your employer
- Contractual health and safety language that requires your employer to maintain a safe work environment

One of the hazards we all face is that sometimes we take our union and the work it does for granted. After all, what else guarantees that the employer will have to negotiate with us, or even talk to us at all? What else brings a voice and a sense of democracy to the workplace unless it is a union?

It is easy to forget that the language we have, the pay scale with steps, the grievance procedure with binding arbitration and the other protections we have is all due to active union members before us fighting to win it for their bargaining unit, and ultimately, for the rest of us. These things did not appear simply due to the benevolence of the employer. In addition, what protects these and other benefits from unilateral change by the employer?

Why should we care about this now? More than ever, employers are taking advantage of working people when they can. Even in health care, which is supposed to be resistant from the economic pressures of job losses; we are seeing layoffs of health care workers in general and registered nurses in particular. We are seeing increases in workloads harm patients. It can’t be enough for nurses to get involved with the union only when the contract is open and the committee begins negotiations.

We need only look at the actions taken by nurses at Boston Medical Center and Tufts Medical Center and their supporters who picketed in the snow and cold in February not because they wanted better wages or benefits, but because the staffing in their facility puts patients at risk. There are also examples at other facilities of how we can stand up to the outrageous and unreasonable demands of the hospital industry.

Nurses at Morton Hospital were recently in the contract fight of their lives to preserve their pension and prohibit the dangerous use of mandatory overtime. Similarly, nurses at Quincy Medical Center have filed an unfair labor practice charge and are fighting back after their employer unilaterally imposed wage and benefit cuts.

A few years ago I was speaking with a staff person from another nurses’ union about the mandatory overtime language in an MNA contract. She responded that nurses “were lucky to have this language.” I was shocked by this reaction and told her that luck had nothing to do with it. These nurses won this language because they thought it was important, they educated the membership on the issue, developed a plan and together they fought for it.

The same applies today. Once we identify what is important and what is worth fighting for, we have to work together to achieve it. It will not happen simply because we want it or because we think we deserve it. Whether it’s trying to achieve new contract language or the fight to preserve the language we already have, the fight is the same.

It is time for nurses to work together within and across bargaining units and within corporations to address issues that unite us all. The tactics may change, but the most important component of any successful campaign is an educated, motivated and mobilized bargaining unit.

Does any of this sound familiar? Does it sound like the last round of work restructuring in the 1990s? It should. Hospitals did exactly the same things in their attempt to reduce the number of registered nurses and replace them with unlicensed personnel. Many nurses left the profession or found work in non-hospital settings.

Organized nursing’s response in the 90s when nurses refused to permit their practice to be decimated in this manner is the same response that is required today. MNA nurses were a model for nurses across the country in the manner in which they responded to restructuring initiatives. Nurses must become active once again to show both the employer and the community the hospital serves that speedups and increasing workloads harm patients. It can’t be enough for nurses to get involved with the union only when the contract is open and the committee begins negotiations.

Coming next month:
More on the Washington rally

More than 1,000 registered nurses from across the country rallied in Washington, D.C., in May, raising an unprecedented, unified voice for patient safety reforms and new, national standards for patient care conditions and standards for nurses. The event was sponsored by the nation’s largest nurses’ union and professional association, the 155,000-member National Nurses United, which came to Washington to press the case for quality of care legislation that was not part of the national health care bill enacted earlier this year, and to build on the unity of RNs who are NNU members from coast to coast. See next month’s issue for more coverage of this important event.

Providence Hospital reaches agreement

After several months of negotiations, the nurses at Providence Behavioral Hospital in Holyoke recently reached a two-year agreement with management. Under the agreement the nurses will receive an across-the-board 2 percent increase in each year.

The hospital recently switched to a biweekly pay system and language was added to the contract to protect the nurses in case of management mistakes. The RNs were able to gain increases in differentials for the evening shift and charge nurse. Under the new contract only nurses with two years experience at the hospital will be eligible to orient new nurses and they also gained language that any record of disciplinary action against a nurse will be expunged after one year.

In terms of staffing, management agreed that, except in areas that are staffed by one RN, no staff RN will work without another RN. Hospital management also agreed it would not randomly review security camera videos for the sole purpose of monitoring RN performance.

Tom Breslin

May 2010  Massachusetts Nurse
A group of MNA members from across Massachusetts attended the first National Nurses United (NNU) Organizing Institute held in California in March. The institute was an opportunity for nurses to learn more about how to build national RN power by organizing unorganized nurses.

The organizing training included workshops on one-on-one communications, network and coalition building, and how to deal with “union busting” behavior and tactics. In addition, attendees also had the opportunity to participate throughout the conference in role playing activities to practice their new organizing skills.

The organizing institute included presentations on “Organizing for RN Power,” “Building Collective RN Organization,” “Strategy to Win Fair Organizing Agreements,” “Corporatization of Health Care” and “Post Election Organizing.”

The training also gave MNA members the opportunity to network and socialize with NNU nurses from across the country. Members who completed the institute will be able to use their training in helping with organizing drives as well as in mobilization efforts in their bargaining units.

Following are some comments from MNA members who completed the training:

“I attended the first NNU Organizing Institute in California and learned many skills and techniques that I can apply in my bargaining unit at Caritas St. Elizabeth’s Hospital, to strengthen and unify my facility. I would like to help MNA organize unorganized nurses especially at Caritas facilities and to help my peers understand how a union can help them. I thank the MNA and NNU for this amazing learning opportunity.”

— Betsy Prescott, Caritas St. Elizabeth’s Medical Center

“It is truly amazing to see RNs from all over the U.S. working together in unity for the greater good of our profession and even more importantly for the greater good of our patients. I feel honored to be a part of history in the making.”

— Debra Vescera, MNA Board of Directors

“Everyone was so nice. You could sense the ‘graceful militancy’ in the air.”

— Patty Sullivan, Lawrence General Hospital, MNA BOD

MNA members from Region 2 joined with the Central Massachusetts labor community at Shaw’s supermarket in Shrewsbury to protest against Shaw’s corporate greed and to support more than 300 employees at the Shaw’s warehouse in Methuen who went on strike in March over company demands to drastically increase health care costs and eliminate jobs. MNA Region 2 members from left: Nora Watts, RN; Mary Colby, RN; Colleen Wolfe, RN; Mike D’Intinosanto, RN; and Lynne Starbard, RN.

MNA member Shannon Sherman (left), chair of the Cape Cod Hospital bargaining unit, state Rep. Cleon Turner, and MNA member Beth Piknick attended the Democratic Party kick off event on April 11.
Hospitals under order to grant same-sex couples visitation rights

Hospitals must now clearly allow gay and lesbian couples to have non-family visitors and cooperate on issues relating to partners having medical power of attorney. This has been the law in Massachusetts, but a presidential memorandum signed by President Barack Obama on April 15 orders the Department of Health and Human Services to prohibit discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability in hospital visitation policies and practice. The future rule will affect any hospital that receives Medicare or Medicaid funding.

The announcement establishes that in the future, hospitals can no longer insist that only family members by blood or marriage be allowed to visit patients. New rules will ensure that hospitals “respect the rights of patients to designate visitors.”

MNA receives periodic inquiries from nurses over gender issues arising in their nursing practice, such as dealing with visitation policies, rooming policies for transgendering patients, use of pharmaceuticals “off label” by transsexual (transgendering) patients, liability for abiding by discrimination laws when hospital policies or management directives do not, etc. There are a myriad of insurance, discrimination and access-to-care problems that affect the GBLT (gay, bisexual, lesbian, transgendered) community which are relevant for health professionals.

We are interested to know the extent to which these issues affect your practice and what resources, education or information might be helpful. Please contact Mary Crotty with your thoughts and suggestions by e-mail at mcrotty@mnarn.org or by phone at 781-830-5743.

Background

One explanation of terms and issues is found in a Journal of Emergency Nursing article “Transgender Patients: Implications for Emergency Department Policy and Practice.”

“Transgender” is an umbrella term for several distinct but related groups, which include cross-dressers, gender-variant individuals and transsexuals (TS). Transsexuals often express the feeling of being “trapped inside the wrong body,” and they may undergo medical and surgical treatments (sexual reassignment/transition) to align their outer appearance with their gender identity. “Gender identity” refers to the internal sense of feeling male or female, regardless of biologic sex, and it may be firmly expressed by even very young children. Some TG persons do not completely identify with either gender. Gender expression and gender identity are unrelated to sexual orientation. Transgender people may define themselves as heterosexual, gay, lesbian or bisexual.

Public policy and legislation affecting TG status and rights vary. To date, six states, 62 cities, and 10 counties have passed laws prohibiting discrimination on the basis of gender identity or expression. Eight states have transgender-inclusive hate crime laws. However, most health insurance policies specifically exclude all procedures related to being TS. In fact, transsexual people are routinely denied health policy coverage solely because they are TS. Even those who have insurance coverage may be denied payment for essential health screenings, such as prostate examinations for male-to-female persons and pelvic examinations for female-to-male persons.

According to a recent study, TG persons frequently encountered humiliating treatment, widespread insensitivity and discrimination when seeking health care. There was a lack of provider knowledge necessary to adequately treat the routine health issues of TG individuals, who may remain silent about health issues they fear could lead to further stigmatization or loss of insurance. Another study found that male-to-female persons were more likely to seek care and adhere to human immunodeficiency virus (HIV) antiretroviral therapies when health care providers were perceived to be aware and accepting of sexual and social identity.

Web sources for more information

Advancing gay and lesbian health: A report from the Gay and Lesbian Health Roundtable: lgbthealth.net/downloads/research/LAGLCRoundTable2000.pdf

Health risks of gay teens: jeramy.t.org/gay/gayteenhealth.html


Examples of problems with access to healthcare encountered by the LGBT community: mergerwatch.org/lgbt_health_care.html

Information needs of LGBT healthcare professionals: pubmedcentral.nih.gov/articlerender.fcgi?artid=314103

Ongoing medico-legal issues facing LGBTs: washblade.com/2004/5-7/news/healthnews/HIBS.cfm

A library site with links to numerous articles on LGBT health issues: nmsu.edu/~ebosman/trannurs/glb.shtml

Medical and mental health concerns of transgendered: gayhealthchannel.com/transgender/index.shtml#mental

Cultural competency in mental health care for LGBT: gima.org/policy/hp2010/index.shtml
Notice to members and non-members regarding MNA agency fee status

In private employment under the National Labor Relations Act

This notice contains important information relating to your membership or agency fee status. Please read it carefully.

Section 7 of the National Labor Relations Act gives employees these rights:
- To organize
- To form, join or assist any union
- To bargain collectively through representatives of their choice
- To act together for other mutual aid or protection
- To choose not to engage in any of these protected activities

You have the right under Section 7 to decide for yourself whether to be a member of MNA. If you choose not to be a member, you may still be required to pay an agency fee to cover the cost of MNA’s efforts on your behalf. If you choose to pay an agency fee rather than membership dues, you are not entitled to attend union meetings; you cannot vote on ratification of contracts or other agreements between the employer and the union; you will not have a voice in union elections or other internal affairs of the union and you will not enjoy “members only” benefits.

Section 8(a)(3) of the National Labor Relations Act provides, in pertinent part:

It shall be an unfair labor practice for an employer –
(3) by discrimination in regard to hire or tenure of employment or any term or condition of employment to encourage or discourage membership in any labor organization: Provided, that nothing in this Act, or in any other statute of the United States, shall preclude an employer from making an agreement with a labor organization … to require as a condition of employment membership therein on or after the thirtieth day following the beginning of such employment or the effective date of such agreement, whichever is the later. If such labor organization is the representative of the employees as provided in Section 9(a), in the appropriate collective bargaining unit covered by such agreement when made…

Under Section 8(a)(3), payment of membership dues or an agency fee can lawfully be made as a condition of your employment under a “union security” clause. If you fail to make such payment, MNA may lawfully require your employer to terminate you.

This year, the agency fee payable by non-members is 95 percent of the regular MNA membership dues for chargeable expenditures. Non-members are not charged for expenses, if any, which are paid from dues which support or contribute to political organizations or candidates; voter registration or get-out-the-vote campaigns; support for ideological causes not germane to the collective bargaining work of the union; and certain lobbying efforts.

MNA has established the following procedure for non-members who wish to exercise their right to object to the accounting of chargeable expenditures:

1. When to object

Employees covered by an MNA union security clause will receive this notice of their rights annually in the Mass Nurse. If an employee wishes to object to MNA’s designation of chargeable expenses, he or she must do so within thirty days of receipt of this notice. Receipt shall be presumed to have occurred no later than three days after the notice is mailed to the employee’s address as shown in MNA’s records.

Employees who newly become subject to a contractual union security clause after September 1, or who otherwise do not receive this notice, must file any objection within thirty days after receipt of notice of their rights.

MNA members are responsible for full membership dues and may not object under this procedure. MNA members who resign their membership after September 1 must object, if at all, within 30 days of the postmark or receipt by MNA of their individual resignation, whichever is earlier.

Objections must be renewed each year by filing an objection during the appropriate period. The same procedure applies to initial objections and to renewed objections.

2. How to object

Objections must be received at the following address within the thirty-day period set forth above:

Massachusetts Nurses Association
Fee Objections
340 Turnpike Street
Canton, MA 02021

Objections not sent or delivered to the above address are void.

To be valid, objections must contain the following information:
- The objector’s name
- The objector’s address
- The name of the objector’s employer
- The non-member’s employee identification number
- Objections must also be signed by the objector.

Objections will be processed as they are received. All non-members who file a valid objection shall receive a detailed report containing an accounting and explanation of the agency fee. Depending on available information, the accounting and explanation may use the previous year’s information.

3. How to challenge MNA’s accounting

If a non-member is not satisfied that the agency fee is solely for chargeable activities, he or she may file a challenge to MNA’s accounting. Such a challenge must be filed within 30 days of receipt of MNA’s accounting. Receipt shall be presumed to have occurred no later than three days after the notice is mailed to the employee’s address as shown in MNA’s records.

Challenges must be specific, and must be made in writing. Challenges must be received by MNA at the same address listed above in section 2 within the 30-day period to be valid. Challenges not sent or delivered to that address are void.

Valid challenges, if any, will be submitted jointly to an impartial arbitrator appointed by the American Arbitration Association. MNA will bear the cost of such a consolidated arbitration; challengers are responsible for their other costs, such as their travel expenses, lost time, and legal expenses, if any. Specifically challenged portions of the agency fee may be placed in escrow during the resolution of a challenge. MNA may, at its option, waive an objector’s agency fee rather than provide an accounting or process a challenge.

Notice to Members

This notice is to remind all MNA members that the dues rate will increase on July 1, 2010. For more information, contact the MNA’s division of membership at 781-821-4625 or send an e-mail message to mnainfo@mnarn.org.

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H1N1 report: looking back, thinking ahead

By Sandra Landry, RN
Plymouth County Public Health/Emergency Preparedness Coalition

With the onset of this past calendar year’s flu season and the alarming news that swine flu was likely to spread to pandemic proportions, the health care community and the media told U.S. citizens to take the situation seriously and get vaccinated. But the vaccination process was slow to get moving for many reasons, resulting in numerous stops and starts that frustrated both the public and public health nurses.

The vaccination process: protocols

Each clinic varied in its procedures to dispense medication but each clinic’s goal was the same: to vaccinate as many people as possible. Some clinics were more successful at accomplishing that goal than others. The clinics were available if the public wanted the medication; it was up to the public to receive it. The goal of reaching as many children (school age, preschool, and babies over 6 months) as possible was realized.

When it was first announced that children were going to be vaccinated, school nurses, as well as other RNs and LPNs, balked at the thought of actually dispensing the medication to the children. As many of the nurses had no actual pediatric experience, they perceived dispensing medication to this group as being a daunting task. After the Massachusetts Department of Public Health provided vaccination review courses, attitudes changed and everyone seemed to step up to the plate to accomplish the goal of getting the children vaccinated. Clinics were held at schools (some identified as emergency dispensing sites), boards of health offices, town halls, etc.

The DPH clearly stressed there would be no liability, as long as protocols were followed and participants in the clinics were trained in their respective roles.

One major problem I observed at one town clinic (while I was there for Medical Reserve Corps recruitment) was the lack of protocols. The town did not use its public health nurses, but used a local doctor’s office personnel to vaccinate. These nurses did not follow the protocol. There was no screening mechanism available, either before forming dispensing lines, or at the actual time of vaccinating. The public was never asked about whether they felt well or ill; or if they had allergies to eggs, etc.; or if they had ever had reactions to previous flu vaccines. The nurses, when questioned about the standing orders (from the DPH), were not familiar with those protocols. When this was mentioned to the board of health director, the response was, “There is no liability.” The need to follow protocol was reiterated.

Just-in-time training was carried out at many clinics. Standing orders were distributed to the vaccinators and screeners, or reviewed with them. Many clinic vaccinators and screeners had never seen the standing orders prior to the clinic. At some, but not all clinics, copies of the standing orders were provided.

Other variations: gloves to syringes

Whether to wear gloves was a big issue. Guidelines from the DPH state that it is not necessary to wear gloves, so it was left as a personal preference. Many residents did ask why gloves were not worn and seemed concerned that it was not required. Some clinics actually posted laminated signs stating gloves were not required.

Wearing gloves was encouraged when dispensing the nasal vaccine due to the risk of vaccine on opened skin that could burn. Again, this was a guideline and not a requirement.

Syringes also varied from clinic to clinic. The orange top syringes proved to be problematic with many vaccinators. The plunger was already at the .5cc mark, leading some nurses to give air thinking the syringe was already filled. The orange top syringe made the removal of air more difficult.

Sanofi-Pasteur multi-dose vials were easier to extract solution from than the Novartis multi-dose vials, which leaked after three or four extractions.

TB syringes with 1¼-inch needles worked well; they were easier to fill, expel air from and to vaccinate with. Some clinics made ¾-inch syringes available, but most did not. These smaller syringes would have made vaccinating thin people and children less traumatic.

A simple item like a Band-Aid also caused problems. Most nurses did not realize that the Band-Aid needed to be pulled apart from each end instead of tearing it open and trying to remove the Band-Aid, which took unnecessary time. This issue was eventually dealt with by including it in the just-in-time training.

Which vaccine and how to screen

Some clinics had seasonal flu vaccine on the same table with the H1N1 multi-dose vial injectable vaccines. Other clinics had separate stations for seasonal flu vaccine, pregnant women needing pre-filled vaccine, families with children under a certain age, families with children over a certain age, nasal vaccine, and adults. By setting up the different stations, it was easier to perform just-in-time training for the nurses who were not as familiar with the specific administering procedures.

The screening process varied greatly among clinics, from more to less information. In some clinics, the only screening performed was by the vaccinator following protocols for side effects, contraindications etc, which did not take any more time for the vaccinator. As people took off jackets and pulled up sleeves, the necessary questions were asked and answered.

Other scenarios

One clinic used paramedics as vaccinators and felt that worked better than using nurses. The health agent stated, “The nurses wasted time by re-screening prior to the vaccination.” (There were several instances where re-screening at the time of administering the medication resulted in different answers in many clinics.)

Just-in-time training was performed to show vaccinators where to administer the shot, as several vaccinators were administering the vaccine too low on the upper arm.

Many vaccinators were reminded frequently to shake vials as well as the syringes that they had previously filled. Many did not know this as the standing orders had not been reviewed or the vaccinator did not read the information.

One town, in particular, had a screening process where an RN and the director of medical services for that town screened and determined who would receive the nasal (due to the restrictions) or the multi-dose vial. As a result, and the lines grew shorter at other clinics.

Summary

Having participated in 16 H1N1 clinics, I was amazed to see how each clinic functioned to accomplish the same results. The procedures for the clinics varied as much as the people varied from town to town.

It was good to see the emergency dispensing sites being utilized. Due to the delay in the arrival of the vaccine, plans for clinics were already set up and ready to go. When the vaccine did arrive, however, there was a rush to get the public vaccinated as quickly as possible, and last minute changes and training had to be altered. ■
Haiti relief nurse volunteers
While the earthquake in Haiti has fallen off the world stage, the need for nurses to help those injured remains. Since January, MNA nurses have volunteered in huge numbers for relief work in Haiti. We salute the following:

Susan Blouin, Caritas St. Elizabeth’s Medical Center
Maura Brennan, UMass Medical Center
Patricia Caruso, St. Vincent Hospital
Tom Curran, Caritas Good Samaritan Medical Center
Karen Dalton, Caritas Norwood
Amy Desmaris, Mercy Medical Center
Regina Kennedy, Caritas Carney
Jan Leary, UMass Memorial
Regina Mackenzie, Caritas Norwood
Deborah Perry, Lawrence General Hospital
William Pierce, St. Vincent Hospital
David Powers, Mercy Medical Center
Trish Powers, Brigham & Women’s
Kathy Reardon, Caritas Norwood
Pam Reilly, Caritas Norwood
Michael Savoy, Brigham & Women’s
Betty Sparks, Newton-Wellesley Hospital
Tim Stratton, Caritas St. Elizabeth’s Medical Center
Marie Ventimiglia, St. Vincent Hospital

The work in Haiti is ongoing, so contact the MNA at 781-830-5743 or via massnurses.org for details on how to volunteer.
**MNA election and campaign rules**

**Constitution and bylaws**

The nominations and election of MNA officers will be conducted in accordance with the MNA Bylaws and policies, as well as the Labor-Management Reporting and Disclosure Act of 1959, as amended.

**Term of office**

As defined by MNA Bylaws.

**Eligibility to hold office**

As provided in the MNA Bylaws, any MNA and/or MNA Labor program member who is current in dues who is in good standing and eligible to run for office.

**Nomination notice**

A nomination notice and consent to serve forms will be posted in the Massachusetts Nurses Association’s official newsletter mailed to all members and posted on the MNA official website.

**Nominations**

Nominations for vacant offices will be made in writing to the Nominations and Elections Committee and must be postmarked and received by June 1.

**Nomination acceptances**

A candidate must accept nomination in writing to the Nominations and Elections Committee by completing a consent to serve form received no later than June 1 of the relevant election period. A statement from each candidate, if provided will be printed in The Massachusetts Nurse Association’s official newsletter. Such statements should be limited to 250 words.

**Candidate eligibility**

The Nominations and Elections Committee will review MNA dues and membership records to determine eligibility of all nominees. Eligible nominees will be notified of their eligibility for office(s), mailed a copy of the MNA nomination and elections rules, and asked how they wish their names to appear on the ballot. Ineligible nominees will be advised of the reason(s) they are not eligible to run for office.

If a nominee has not received confirmation from the Nominations and Elections Committee that her/his consent to serve form has been received within seven (7) days of sending the Consent to Serve form, it is the nominee’s responsibility to contact the Nominations and Elections Committee regarding the state of his/her nomination.

**Inspection of the member list**

Each candidate may inspect (not copy) the MNA membership list once within 30 days prior to the election. No candidate is entitled to receive a copy of the list.

The membership list will be available for inspection at the MNA office between 8:30 a.m. and 4:30 p.m., Monday through Friday. Any candidate who wishes to inspect the list should contact the Director of the Division of Membership between June 15 and July 15 of the election year.

**Distribution of campaign literature**

MNA will honor any reasonable request by a candidate to distribute campaign literature to members at the candidate’s expense. Requests will be honored in the order received. Campaign literature must be provided to the Nominations and Elections Committee ready for mailing. The cost of postage will be paid by the candidate. MNA will make arrangements for office staff to address the campaign literature. Candidates are solely responsible for any and all materials contained in their campaign literature.

Ad space in the official newsletter of the Massachusetts Nurses Association will be at a specific advertising rate.

Candidates may not utilize any “personal” mailing list which was created or obtained as a result of a candidate or a supporter serving or employed in an MNA position. Candidates should contact the Nominations and Elections Committee and the Director of the Division of Membership to arrange for mailing campaign literature.

**Campaign restrictions**

Federal law prohibits the use of any MNA, MNA structural units (Regional Councils, Local Bargaining Units, Committees or any other entity recognized by MNA bylaws or policies) or employer funds to promote the candidacy of any person in an MNA officer election. This prohibition applies to cash, facilities, equipment, vehicles, office supplies, etc., of MNA, MNA structural units and any other union, and of employers whether or not they employ MNA members. MNA officers and employees may not campaign on time paid for by the MNA.

Federal law also provides that candidates must be treated equally regarding the opportunity to campaign and that all members may support the candidates of their choice without being subject to penalty, discipline, or reprisal of any kind. Members may endorse candidates, however no endorsement may carry the identification of the MNA office or position held by the endorser or the MNA logo. The use of MNA, MNA structural units or employer funds or facilities is a violation of federal law even if MNA or the employer do not know about or approve the use.

Request from candidates for campaign time on structural units must be in writing to the Nominations and Elections Committee. The Nominations and Elections Committee will notify the Labor Associate Director assigned to the unit, Division Director and chair of such request within 5 business days of receiving the request, and will also notify all other candidates for the same office that they are eligible for the same opportunity upon request. All candidates for specific office must be provided with equal access and time.

MNA Structural units may invite candidates to speak at a meeting, by submitting such request in writing to the Nominations and Elections Committee. All candidates for a specific office must be provided with equal access and time. The Nominations and Elections Committee will then notify all candidates for the same office(s) that they are invited to speak at a meeting of the requesting structural unit(s), and will notify all candidates of the date, time and location of the meeting.

**Voter eligibility**

Any member in good standing as of seven (7) days prior to the date of ballots being mailed will be eligible to vote.

**Election**

Ballots will be mailed to the last known home address of each eligible MNA member, at least fifteen (15) days prior to the date which it must be received by the election administrator. Members are responsible for mailing ballots in sufficient time to be received by the administrator.

Eligible voters are permitted to vote for any candidate per the instructions on the ballot. However, write-in votes are not valid and will not be counted. Ballots should not be marked outside of the identified areas.

Ballots must be completed (as per the instructions on the form) and enclosed in an envelope (marked BALLOT RETURN ENVELOPE), which does not identify the voter in any way, in order to assure secret ballot voting. Only one ballot may be placed in the envelope. The ballot return envelope must be returned in an outer envelope addressed to MNA Secretary, c/o Contracted Election Administrator (address)

In the upper left-hand corner of this envelope you must:

Print your name

Sign your name (signature required)

Write your address and zip.

If this information is not on the mailing ballot, the secret ballot inside is invalid and will not be counted.

If the mailing envelope has been misplaced, another mailing envelope can be substituted provided that all the required information is provided by the voter in the return envelope.

All returned mailing envelopes will be separated from the inner envelope containing the ballot before the ballots are removed, to assure that a ballot can in no way be identified with an individual voter. Mailing envelopes containing
voter’s name and address will be checked off on a master membership list.

Ballots must be at the office of the election administrator no later than the end of business day of the date indicated by the election administrator.

Observers
Each candidate or her/his designee who is an MNA and/or Labor Relations Program member in good standing may be permitted to be present at the stuffing of the ballots, observe delivery to the post office and be present on the day(s) of the opening and counting of the ballots. Notification of the intent to be present or have an observer present must be received in writing or electronic message to the Nominations and Elections Committee from the candidate five (5) working days prior to the ballot counting date for space allocation purposes.

The observer must provide current MNA membership identification to election officials and authorization from the candidate.

No observer shall be allowed to touch or handle any ballot or ballot envelope. During all phases of the election process, the single copy of the voter eligibility list will be present for inspection.

All observers and candidates will keep election results confidential for 72 hours after the ballot procedure is certified.

Tally of ballots
Ballot counting will be overseen by the contracted election administrator.

Election results
Results of the MNA Election will be made available to candidates (or their designee) within 72 hours after completion of the ballot counting. Hard copies of the election results shall be sent to each candidate. Results of the MNA election will be kept confidential until all candidates are notified. Results will include the number of total ballots cast for the office in question; the number of ballots cast for the candidate in question and the election status of the candidate (elected/not elected). Any MNA member may access these numbers by written request to the Nominations and Elections Committee.

Only the names of those elected will be posted on the MNA website when all candidates have been notified after the ballot procedure is completed and certified. The election outcome will be posted at the annual meeting. The Department of Public Communications shall check the information on file for accuracy/currency with elected candidate status.

Questions/ problems
Candidates and members with questions about the nomination or election procedures should contact a member of the Nominations and Elections Committee or appropriate staff at MNA. Any violation of these rules should be reported promptly to the Nominations and Election Committee and Director of Division of Membership so that corrective action can be taken, if necessary.

Protests
Per MNA Bylaw any member may challenge an election by filing a protest in writing with the Nominations and Elections Committee within 10 days after election results are posted.

Contacting the Nominations and Election Committee
All correspondence to the Nominations and Elections Committee should sent to:

Mail: MNA Nomination and Election Committee, 340 Turnpike St., Canton MA 02021
Fax: MNA Nominations and Elections Committee, 781-821-4445
Email: Nominations and Elections Committee, TBA
Phone: MNA Nominations and Elections Committee, TBA

Approved: BOD 3/18/10

### MNA Preliminary Ballot, 2010

<table>
<thead>
<tr>
<th>Position</th>
<th>Region(s)</th>
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</thead>
<tbody>
<tr>
<td>Vice President, Labor*, 1 for 2 years</td>
<td>Region 3, Region 4, Region 5</td>
</tr>
<tr>
<td>Treasurer, Labor*, 1 for 2 years</td>
<td>Region 3, Region 4, Region 5</td>
</tr>
<tr>
<td>Director, Labor*, 5 for 2 years (1 per Region)</td>
<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
</tr>
<tr>
<td>Director At-Large, Labor*, 3 for 2 years</td>
<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
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<tr>
<td>Director At-Large, General*, 4 for 2 years</td>
<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
</tr>
<tr>
<td>Nominations Committee, 5 for 2 years (1 per Region)</td>
<td>Region 1, Region 2</td>
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<tr>
<td>Bylaws Committee, 5 for 2 years</td>
<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
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<tr>
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<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
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<tr>
<td>Congress on Health Policy, 4 for 2 years</td>
<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
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<tr>
<td>Congress on Health and Safety, 6 for 2 years</td>
<td>Region 1, Region 2, Region 3, Region 4, Region 5</td>
</tr>
<tr>
<td>Center for Nursing Ethics &amp; Human Rights, 2 for 2 years</td>
<td>Region 1, Region 2</td>
</tr>
</tbody>
</table>

At-Large Position in Regional Council, 2 for 2 years
- Region 1
- Region 2
- Tami Hale
- Debra Holmes
- Region 3
- Peggy Kilroy
- Stephanie Stevens
- Region 4
- Marie Freeman
- Mary Wignall
- Region 5

*General means an MNA member in good standing and does not have to be a member of the labor program. Labor means an MNA member in good standing who is also a labor program member. Labor Program Member means a non-RN Healthcare Professional who is a member in good standing of the labor program.
I am interested in active participation in Massachusetts Nurses Association.

MNA General Election

- Vice President, Labor*, 1 for 2 years
- Treasurer, Labor*, 1 for 2 years
- Director, Labor*, (5 for two years) [1 per Region]
- Director At-Large, Labor*, (3 for 2 years)
- Director At-Large, General*, (4 for 2 years)
- Nominations Committee, (5 for 2 years) [1 per region]

* “General” means an MNA member in good standing and does not have to be a member of the labor program. “Labor” means an MNA member in good standing who is also a labor program member. “Labor Program Member” means a non-RN health care professional who is member in good standing of the labor program.

Please type or print — Do not abbreviate

Name & credentials
(as you wish them to appear in candidate biography)

Work Title ___________________________ Employer ___________________________

MNA Membership Number ___________________________ MNA Region _____________

Address ______________________________________________________________________

City ___________________________________ State ______________________ Zip _________

Home Phone ___________________________ Work Phone __________________________

Educational Preparation

<table>
<thead>
<tr>
<th>School</th>
<th>Degree</th>
<th>Year</th>
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</tbody>
</table>

Present or Past MNA Offices/Association Activities (Cabinet, Council, Committee, Congress, Unit, etc.) Past 5 years only.

<table>
<thead>
<tr>
<th>MNA Offices</th>
<th>Regional Council Offices</th>
</tr>
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<tbody>
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Candidates may submit a typed statement not to exceed 250 words. Briefly state your personal views on nursing, health care and current issues, including, if elected, what your major contribution(s) would be to the MNA and in particular to the position which you seek. This statement will be used in the candidate biography and published in the Massachusetts Nurse Advocate. Statements, if used, must be submitted with this consent-to-serve form.

Signature of Member ___________________________ Signature of Nominator (leave blank if self-nomination) ___________________________

Postmarked Deadline: Preliminary Ballot: March 31, 2010
Final Ballot: June 1, 2010

Return To: Nominations and Elections Committee
Massachusetts Nurses Association
340 Turnpike Street, Canton, MA 02021

• Hand delivery of material must be to the MNA staff person for Nominations and Elections Committee only.
• Expect a letter of acknowledgment (call by June 1 if none is received)
• Retain a copy of this form for your records.
• Form also available on MNA Web site: www.massnurses.org
2010 Consent to Serve for the MNA Regional Council

I am interested in active participation in MNA Regional Council

☐ At-Large Position in Regional Council (2-year term; 2 per Region)
   I am a member of Regional Council
   ☐ Region 1  ☐ Region 2  ☐ Region 3  ☐ Region 4  ☐ Region 5

General members, labor members and labor program members are eligible to run. “General” means an MNA member in good standing and does not have to be a member of the labor program. “Labor member” means an MNA member in good standing who is also a labor program member. “Labor program member” means a non-RN health care professional who is a member in good standing of the labor program.

Please type or print — Do not abbreviate

Name & credentials ___________________________________________
   (as you wish them to appear in candidate biography)

Work Title ___________________________ Employer ___________________________

MNA Membership Number ___________________________ MNA Region ___________________________

Address ________________________________________________________________
City ___________________________ State ___________________________ Zip ___________________________

Home Phone ___________________________ Work Phone ___________________________

Educational Preparation

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Signature of Member            Signature of Nominator (leave blank if self-nomination)

Postmarked Deadline: Preliminary Ballot: March 31, 2010
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Return To: Nominations and Elections Committee
Massachusetts Nurses Association
340 Turnpike Street, Canton, MA 02021

Massachusetts Nurse May 2010
### Track 1: MNA Overview and Structure

<table>
<thead>
<tr>
<th>Week 1: Overview of the MNA</th>
<th>Region 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisions</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>By-laws</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>How policies, decisions are made</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>One member, one vote</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
</tbody>
</table>

### Region 1 2 3 4 5

<table>
<thead>
<tr>
<th>Track 2: Role of the Floor Rep., Grievances and Arbitration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1: Role of the MNA rep</td>
</tr>
<tr>
<td>Identifying grievances</td>
</tr>
<tr>
<td>What is grievable</td>
</tr>
<tr>
<td>Grievances vs. complaints — how to tell the difference, how to work with the member</td>
</tr>
<tr>
<td>3/23</td>
</tr>
<tr>
<td>Week 2: Components of the grievance procedure</td>
</tr>
<tr>
<td>Time lines and steps</td>
</tr>
<tr>
<td>When/how to settle grievances</td>
</tr>
<tr>
<td>Discipline vs. contract interpretation grievances</td>
</tr>
<tr>
<td>Burden of proof, just cause, due process, seven tests of just cause</td>
</tr>
<tr>
<td>Past practice</td>
</tr>
<tr>
<td>• Definition</td>
</tr>
<tr>
<td>• Difficulty in proving a practice</td>
</tr>
<tr>
<td>• Burden in proving a practice</td>
</tr>
<tr>
<td>4/6</td>
</tr>
<tr>
<td>Week 3: How to file grievances</td>
</tr>
<tr>
<td>How to write a grievance</td>
</tr>
<tr>
<td>Investigation/identifying sources of information</td>
</tr>
<tr>
<td>Right to information</td>
</tr>
<tr>
<td>Information requests</td>
</tr>
<tr>
<td>Constructing the case</td>
</tr>
<tr>
<td>4/20</td>
</tr>
<tr>
<td>Week 4: Presenting the grievance</td>
</tr>
<tr>
<td>Dealing with management</td>
</tr>
<tr>
<td>Settling the grievance</td>
</tr>
<tr>
<td>5/4</td>
</tr>
<tr>
<td>Week 5: Arbitration</td>
</tr>
<tr>
<td>Why it’s good for the members</td>
</tr>
<tr>
<td>Why it’s bad for the members</td>
</tr>
<tr>
<td>Unfair labor practices</td>
</tr>
<tr>
<td>Weingarten rights</td>
</tr>
<tr>
<td>Organizing around grievances</td>
</tr>
<tr>
<td>5/18</td>
</tr>
</tbody>
</table>

### Track 3: Collective Bargaining

| Week 1: Negotiations and the Legal Basis                   |
| Process overview                                           |
| Bargaining ground rules                                    |
| C                                                           |
| Week 2: Preparing for Bargaining                           |
| Importance of internal organizing                          |
| Contract action team                                       |
| Contract calendar, planning events                         |
| Surveys, meetings, other methods of gathering proposals from members |
| Setting priorities                                         |
| Developing a campaign                                      |
| O                                                           |
| Week 3: Committee Decision Making                          |
| Conduct at the table                                       |
| Dates, location, etc                                       |
| Open bargaining. Pros & cons                               |
| Opening statements                                          |
| Proposal exchange                                           |
| P                                                           |
| Week 4: Table Tactics/Reading Signals                      |
| Implementing the contract campaign                         |
| The contract action team                                   |
| Writing contract language                                  |
| E                                                           |
| Week 5: Costing the Contract                              |
| Bargaining video                                           |
| Picketing and strikes                                      |
| Bargaining unit job actions                                |
| Impasse/contract extensions                                |
| T                                                           |
| Week 6: Use of the Media                                   |
| Reaching agreement, writing final language                 |
| Committee recommendation                                   |
| Ratification process                                       |
| Midterm bargaining                                         |
| E                                                           |

### Track 4: Computer Training

| Week 1: Excel 1                                             |
| 4/7                                                         |
| Week 2: Excel 2                                             |
| 4/14                                                        |
| Week 3: Excel 3 graphs & application                        |
| 4/28                                                        |
| Week 4: Word 1                                              |
| 5/5                                                         |
| Week 5: Word 2                                              |
| 5/19                                                        |
| Week 6: Publisher 1                                         |
| 5/26                                                        |
After a very successful first year, the MNA Labor School has been expanded and restructured. It now consists of six separate tracks of classes in each Region running five to seven weeks each, depending on the track. Two new tracks have been added. One focuses on the MNA structure and divisions, and the second track on computer training (Excel, Word and Publisher). Classes are standardized, so if one particular class is missed in one region, it can be picked up in any other region.

At the conclusion of each track, participants receive a certificate of completion. Any MNA member who completes any two tracks will receive an MNA Labor School blue jacket. There are no prerequisites to attend any track—members are free to attend any track they choose and need not follow them in order. Each track is self-contained, focusing on a specific area of interest.

Preregistration through the Regional office is necessary. Classes generally run from 5–7:30 p.m., with a light meal included. All courses are free and open to any MNA member. Classes in red will be held from 10 a.m.–noon.

For further details: massnurses.org 781-830-5757

**Track 5: Building the Unit, Building the Union**

<table>
<thead>
<tr>
<th>Week 1: Member Participation/Basic Foundation</th>
<th>Region 1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of a union</td>
<td>C C C C C</td>
</tr>
<tr>
<td>Bargaining unit structure &amp; officers</td>
<td>O O O O O</td>
</tr>
<tr>
<td>By-laws, why they’re important</td>
<td>M M M M M</td>
</tr>
<tr>
<td>Organizing model, internal organizing</td>
<td>P P P P P</td>
</tr>
<tr>
<td>Week 2: Organizing the Workplace</td>
<td>L L L L L</td>
</tr>
<tr>
<td>Mapping the workplace</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Using contract action teams outside of</td>
<td>T T T T T</td>
</tr>
<tr>
<td>bargaining</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Organizing around grievances</td>
<td>D D D D D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 3: Attacking Member Apathy</th>
<th>Region 1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective union meetings</td>
<td>C C C C C</td>
</tr>
<tr>
<td>Internal communication structure</td>
<td>O O O O O</td>
</tr>
<tr>
<td>Member feedback</td>
<td>M M M M M</td>
</tr>
<tr>
<td>Intervention</td>
<td>P P P P P</td>
</tr>
<tr>
<td>Week 4: Strategic Planning</td>
<td>L L L L L</td>
</tr>
<tr>
<td>Developing Plan</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Assessment</td>
<td>T T T T T</td>
</tr>
<tr>
<td>Intervention</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Week 5: Workplace Action</td>
<td>D D D D D</td>
</tr>
<tr>
<td>Identifying Action</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Plan, preparation and calendar</td>
<td>D D D D D</td>
</tr>
<tr>
<td>Pressure tactics/Work to rule</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Strikes</td>
<td>D D D D D</td>
</tr>
</tbody>
</table>

**Track 6: Labor Law and Special Topics**

<table>
<thead>
<tr>
<th>Week 1: Family and Medical Leave Act</th>
<th>Region 1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts Small Necessities Leave Act</td>
<td>C C C C C</td>
</tr>
<tr>
<td>Week 2: Fair Labor Standards Act</td>
<td>O O O O O</td>
</tr>
<tr>
<td>Overtime rules</td>
<td>M M M M M</td>
</tr>
<tr>
<td>Labor-Management Reporting and Disclosure</td>
<td>P P P P P</td>
</tr>
<tr>
<td>Act union officer elections</td>
<td>L L L L L</td>
</tr>
<tr>
<td>Week 3: Workers Compensation</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Occupational Safety and Health Act</td>
<td>T T T T T</td>
</tr>
<tr>
<td>Week 4: Americans with Disability Act</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Age Discrimination Act</td>
<td>D D D D D</td>
</tr>
<tr>
<td>Worker Adjustment &amp; Retraining Notification</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Act</td>
<td>D D D D D</td>
</tr>
<tr>
<td>Employment Discrimination HIPAA</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Uniformed Services Employment and Reemploy-</td>
<td>D D D D D</td>
</tr>
<tr>
<td>ment Rights Act of 1994</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Week 5: NLRB &amp; the Kentucky River/</td>
<td>D D D D D</td>
</tr>
<tr>
<td>Oakwood cases</td>
<td>E E E E E</td>
</tr>
<tr>
<td>Nurse supervisor issues</td>
<td>D D D D D</td>
</tr>
</tbody>
</table>

**Labor School Locations**

**Region 1, Western Mass.**
241 King Street
Northampton
413.584.4607

**Region 2, Central Mass.**
365 Shrewsbury St.
Worcester
508.756.5800

**Region 3, South Shore/ Cape & Islands**
60 Route 6A
Sandwich
508.888.5774

**Region 4, North Shore**
10 First Avenue, Suite 20
Peabody
978.977.9200

**Region 5, Greater Boston**
MNA Headquarters
340 Turnpike Street, Canton
781.821.8255

Massachusetts Nurse  May 2010  21
MEMBER APPRECIATION DAY
A Fun-Filled day for the MNA Members, Friends and their Families!

Saturday - July 24, 2010

SAVE OVER 50% PER PERSON
ONLY $37.00 PER PERSON • TAX INCLUDED
KIDS 2 YEARS AND UNDER ARE FREE

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✓ ALL DAY ADMISSION TO SIX FLAGS NEW ENGLAND AND HURRICANE HARBOR WATER PARK $41.99 VALUE!
✓ ALL-YOU-CARE-TO-EAT MENU $20.00 VALUE!
   Hamburgers, Hot Dogs, Baked Ziti, Tossed Salad, Baked Beans, Potato Chips, Ice Cream Novelties, Condiments, and Coca-Cola Products.
   Meal Time 12:30-1:30 (Served in the Rivers Edge Picnic Grove)
✓ FREE PARKING $15.00 VALUE!

TO PURCHASE TICKETS OR FOR MORE INFORMATION VISIT:
SFNEPICNIC.COM/MNA

BONUS
UPGRADE YOUR PICNIC TICKET ON THE DAY OF YOUR VISIT TO A 2010 SEASON PASS FOR ONLY $19.99!
Save $5 off the standard upgrade price.

TO PURCHASE TICKETS:
Visit WWW.SFNEPICNIC.COM/MNA
or
Call Jennifer Marshall at the MNA office @ 781-830-5726

*Must Purchase by July 17, 2010

• For Directions and Park Operating Hours, please visit sixflags.com/newengland • Wristbands will be required for entry into the Rivers Edge Picnic Grove
• PLEASE NOTE: Additional Tickets are not available on the day of the event. SUPERMAN and all related characters and elements are trademarks of and © DC Comics.
Log onto “myMNA,” the new members-only section of the Web site

**Personal & Financial Services**

**Professional Liability Insurance**
Nurses Service Organization ........................................ 800-247-1500

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Lead Brokerage Group .................................................. 800-842-0804
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**Long Term Care Insurance**
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Flexible and comprehensive long-term care insurance at discount rates.

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Six-month disability protection program for non-occupational illnesses & accidents.

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Provides income when you are unable to work due to an illness or injury.

**Retirement Program**
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Specializing in providing retirement programs including 403(b), 401(k), IRA, NQDA, Mutual Funds, etc.

**Home Mortgage Discounts**
Reliant Mortgage Company ............................................. 877-662-6623
Save on your next home loan/mortgage with discounts available to MNA members and families. Receive free mortgage pre-approvals.

**LIFE & ESTATE PLANNING**
Law Office of Dagmar M. Pollex ....................................... 781-535-6490
10-20% discount on personalized life & estate planning.

**BLUE CROSS BLUE SHIELD**
For details on health insurance plans, call 800-422-3545, ext. 65414

**Products & Services**

**Auto/Homeowners Insurance**
Colonial Insurance Services, Inc................................. 800-571-7773
MNA discount available for all household members. No service changes with convenient EFT payment.

**Cellular Telephone Service**
AT&T Wireless ............................................................... 800-882-2056, ext. 726
MNA members can now go to any AT&T Wireless company store for all transactions. 24% discounts on rate plans.

T-Mobile.......................................................... 866-464-8662
Get a free phone, free nationwide long distance and roaming and free nights and weekends (on specific plans). No activation fee for members.

**Discount Dental & Eyewear Program**
Creative Solutions Group .............................................. 800-308-0374
Best benefits—a health care savings plan that cuts the cost of health care expenses. Discounts on dental, eyecare and chiropractic expenses.

**ASSOCIATED EDGE (FORMERLY MEMBER ADVANTAGE)**
Associated Edge........................................................... 781-828-4555 or 800-232-0872
Discount prices on a broad range of products. Log into myMNA.

**Oil Network Discount**
Comfort Crafted Oil Buying Network ......................... 800-660-4328
Lower home oil heating costs by 10–25 cents/gallon or $150 per year.

**Wrentham Village Premium Outlets**
Present your MNA membership card at the information desk to receive a VIP coupon book offering hundreds of dollars in savings.

**CAMBRIDGE EYE DOCTORS**
Obtain your Sight Care ID card to receive discounts on eye exams, eyeglasses & contact lenses at Cambridge Eye Doctors or Vision World.

**HEALTH CARE APPAREL**
Work’n Gear Discount ............................................... 800-WORKNGEAR
Receive 15% discount off all regularly priced merchandise. Visit www.massnurses.org for a printable coupon to present at time of purchase.

**BROOKS BROTHERS DISCOUNT**

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**Car Rental**
Avis Car Rental ................................................ 1-800-331-1212
Discounts can be used for both personal and business travel.

Hertz Car Rental ......................................................... 800-654-2200
MNA members discounts range from 5 – 20%. (For MNA discount CDP, call 781-830-5726.)

**Exclusive Travel Deals**
MNA Vacation Center ............................................ www.mnavacations.com
Powered by TNT and GoHead tours. Get exclusive access to travel specials at prices not available to the public.

**Discount Movie Passes** ............................................. 781-830-5726
Showcase Cinemas/National Amusements, $7.75. AMC Theatres, $6. Regal Cinemas (not valid first 12 days of new release), $6.

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Discounted tickets to Walt Disney World and Disneyland along with other Florida attractions.

**Anheuser-Busch Adventure Parks Discount**
Obtain Adventure Card to receive discounts to Busch Gardens, Sea World, Sesame Place, Water Country USA & Adventure Island in Tampa, Fla.

**Universal Studios Fan Club** ........................................ 888-777-2131
Log onto the MNA Web site at www.massnurses.org and click on the Universal Studios Link to obtain special discount prices.

**Working Advantage**

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Seasonal. Contact MNA’s Division of Membership at 800-882-2056, x726.

For more information call member discounts at the MNA, 800-882-2056, x726. All discounts are subject to change.
Save the Date
October 13-15

MNA
Massachusetts Nurses Association
2010 CONVENTION

Shaping Our Future Together

Go to www.massnurses.org for more information to come.