The State of Our Hospital

A Report by Registered Nurses at Wilkes-Barre General Hospital

Wyoming Valley Nurses Association, a union local of the Pennsylvania Association of Staff Nurses and Allied Professionals (PASNAP)

December 2018
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THE STATE OF OUR HOSPITAL: A REPORT BY REGISTERED NURSES AT WILKES-BARRE GENERAL HOSPITAL

Authored by the Wyoming Valley Nurses Association (WVNA), a union local of the Pennsylvania Association of Staff Nurses and Allied Professionals (PASNAP). PASNAP is a union of dedicated nurses and health professionals across Pennsylvania formed in 2000 dedicated to the belief that patients receive the best care when clinical care staff has a strong voice to advocate for both patients and themselves.

December 2018

PURPOSE:
To highlight ongoing staffing issues and the impact they can have on patient care at Wilkes-Barre General Hospital. This report will discuss economic data and a background on why an investment in adequate staffing is in the interest of area patients, nurses, and the Commonwealth Health hospital system as a whole.

SUMMARY:
The Commonwealth Health System: Wilkes-Barre General Hospital is one of six hospitals in the Commonwealth Health System in northeast Pennsylvania owned by Tennessee-based Community Health Systems (CHS). CHS is the largest for-profit hospital corporation in the United States and owned 119 hospitals in July 2018.1

At the time of purchase by CHS in 2008, Wyoming Valley Health Systems was the largest employer in Luzerne County and Wilkes-Barre General Hospital was the largest facility within that system. Since that time, staffing at the hospital has been under scrutiny by regulatory agencies, accrediting organizations, and the local union for registered nurses (RNs).

Hospital Staffing Concerns:
In early 2018, as part of ongoing efforts to improve staffing, RNs at the hospital documented several serious, persistent staffing issues including illegal forced overtime, high patient to nurse ratios, and the utilization of expensive agency nurses to fill holes in schedules across the facility. Insufficient staffing is not a new problem. Over the last several years, nurses have documented hundreds of unsafe staffing situations, that the hospital has refused to respond to or even investigate.

In March, the Pennsylvania Department of Labor cited the hospital for 10 violations of Pennsylvania Act 102, which bans mandatory overtime for nurses and other health care workers.2

Following strikes in April over staffing issues at two CHS facilities, First Hospital in Kingston and Moses Taylor Hospital in Scranton, on May 31, Wilkes-Barre General RNs went on strike for one day citing the need to properly staff the facility with enough full-time RNs to maintain an appropriate level of patient care.

At that time, union nurses estimated that the hospital was short-staffed by about 107 full-time nurses. In the emergency room alone, the union counted more than 900 unfilled shift vacancies during a six-week period.3

In July of 2018, WVNA alerted the Pennsylvania Trauma Systems Foundation that WBGH was not meeting the staffing requirements of its recently acquired certification as a Level II Trauma Center. The Trauma Foundation identified several areas of non-compliance, which they investigated during a site visit in July. Despite being alerted to those issues, the Hospital

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1 “CHS to sell two Arkansas hospitals to Little Rock's Baptist Health”, Modern Healthcare, July 18, 2018
2 “WB General Hospital cited by state for allegedly forcing overtime”, Times Leader, March 8, 2018
3 “W-B General nurses say staffing levels at hospital are unsafe”, Times Leader, June 1, 2018

https://www.citizensvoice.com/news/w-b-general-nurses-say-staffing-levels-at-hospital-are-unsafe-1.2344325
continues to fall short of the requirements of its Trauma certification.

In response to a large packet of documented patient care and staffing concerns at Wilkes-Barre General Hospital submitted by WVNA in July, Pennsylvania Department of Health (PA DOH) initiated an unannounced onsite investigation on September 10 that concluded September 14.

The PA DOH found a “systemic nature of non-compliance with regards to nursing services” citing, among other evidence, that management “failed to schedule a sufficient number of RNs and/or ancillary staff on the nursing units for 81 of 148 shifts reviewed.” The report found 91 open RN positions and reliance on an excessive use of overtime.

Investigators cited the hospital for violations of nineteen state and federal health codes related to patient rights, staffing, and emergency services. The findings were based on interviews with at least 61 hospital employees and multiple patients, as well as review of staffing grids, schedules, and selected medical records.

Inadequate staffing can spread nurses thin, causing a negative impact on patient care. Also in November, The Leapfrog Group, an independent hospital watchdog, gave a “C” grade to Wilkes-Barre General Hospital in their Fall 2018 hospital safety report. The report found performance to be below average on various metrics including the rate of some infections, patient falls, and dangerous bed sores.

Even after citations by state agencies and the May strike, nurses report that the hospital continues to force RNs to work beyond their schedule shifts, even when a hole in the schedule could have been predicted and filled with a full or part-time RN.

Nurses continue to propose adding stronger staffing language to their union contract that would enable RNs to give meaningful input into overall patient care. Unfortunately, hospital management has not agreed to the RNs’ staffing proposals and contract negotiations remain ongoing.

Meanwhile, staffing legislation modeled after California that would set minimum staffing levels remains stalled in the state legislature in Harrisburg.

**Issues in Direct Care Units:**

While nurse to patient ratios are governed by internal staffing grids which specify how many nurses there should be on each unit for a given number of patients, there are not enough nurses to meet those guidelines, and nurses therefore end up with more patients than are specified by the hospital’s own policy. In addition to registered nurses, the staffing grids also call for ancillary staff such as nurses’ aides, technicians, and unit secretaries that are in many cases understaffed or absent altogether. This results in bedside RNs being responsible for all aspects of their patients’ care, decreasing clinical care time for each patient.

For example, a nurse may be pulled away from her assignments into a room to monitor a psychiatric patient or a patient with a fall risk that could otherwise be monitored by a mental health technician or aide. Without nursing aides, tasks like bathing, restroom trips, and meals keep RNs from other clinical duties that can only be performed by an RN, such as ongoing assessment and provision of medications. Without unit secretaries, an RN can be overwhelmed with the volume of calls to their unit, clerical duties, paperwork, and trying to reach doctors during their on-call hours.

The Pennsylvania Health Care Cost Containment Council (PHC4) found in 2016 that the hospital exceeded expected mortality rates while treating heart attack patients with angioplasty and arterial stents, patients with kidney and urinary tract infections, pneumonia patients, and sepsis patients.

In 2017, PHC4 found that the hospital exceeded expected mortality rates while treating patients with abnormal heartbeats, acute kidney failure, and sepsis.

Safe staffing is part of the solution to saving lives. Studies show that every additional patient-per-nurse in a Pennsylvania hospital increases that patient’s risk of death by 7%. Surgical patients in hospitals with 8:1 ratio have a 31% higher risk of death. Research from other states suggests that short-staffing increases patients’ risk of death by between 4% and 6%. This risk is higher within the first 5 days of admission.

Higher patient-to-nurse staffing ratios have been significantly associated with higher rates of hospital mortality and with administration of the wrong care.

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4 PA Department of Health findings, November, 2018. https://sais.health.pa.gov/commonpoc/content/publiccommonpoc/PDF/PBUB118705031100L.PDF


9 Aiken, Cimiotti, Sloane et al, ‘The Effects of Nurse Staffing and Nurse Education on Patient Deaths in Hospitals with Different Work
medication or dose, pressure ulcers, and patient falls with injury.¹⁰

Nurses also report equipment shortages and broken equipment at the hospital as well as the substitution of cheaper and less effective medication.

**Issues in Non-Direct Care Units:**

Ancillary staff is also needed in non-direct care departments. In the case management department, for example, RN case managers coordinate holistic aspects of patient care such as discharge into skilled nursing facilities, home health aids, insurance payments, and teaching patients and families how to use equipment at home.

In addition to managing their caseload, RNs are often making arrangements that are better suited for a social services worker such as coordinating rent payments, pet sitters, child care, or assistance from family and friends for patients admitted for long stays at the hospital.

**No shortage of registered nurses in PA:**

Some hospital companies falsely claim that short staffing is due to a shortage of nurses. However, there is presently a surplus of RNs able to work and it is dangerous short-staffing that is primarily driving nurses to leave bedside care.

Pennsylvania has (and will have) more than enough licensed RNs. The Pennsylvania Department of Health regularly surveys all RNs and LPNs renewing their license. The most recent survey showed only 76% of RNs were employed in nursing, with 6% unemployed.¹¹ Pennsylvania is projected to have a surplus of 5% (8,200) RNs by 2030.¹²

Pennsylvania is also training and graduating more than enough RNs. Enrollment in Pennsylvania RN programs has increased by 49% since 2003 (from 15,651 to 23,278), and by 138% since 2002 (from 2,939 to 7,003).¹³

**Staffing Legislation and Implementing Nurse Input:**

The Pennsylvania Hospital Patient Protection Act, introduced in the Pennsylvania House of Representatives and State Senate, would help to insure adequate RN staffing across the Commonwealth.

The introduction of laws which set safe patient limits for nurses has been proven to protect patients and increase the ‘supply’ of working nurses. After passing a law setting safe patient limits for nurses in 2004, the California Board of Nursing reported a 60% increase in applications for nursing licenses from other states,¹⁴ a 4% increase in RNs overall, and an 18% increase in the number of applicants for the certifying exam.¹⁵

Nurses know what nurses need: sufficient nurse staffing to provide adequate patient care and ongoing input regarding how patient care is delivered. RNs at Wilkes-Barre General Hospital are attempting through the bargaining process to make sure these conditions are met so that it is possible to both recruit and retain nurses. Their proposal for a stronger Patient Care Council to address their concerns is key to that goal.

**Pennsylvania Hospitals Pay CHS Bills:**

Corporate filings by CHS with the Securities and Exchange Commission reveal that in 2017 their six northeast Pennsylvania hospitals yielded $1.2 million per licensed bed, two thirds more in revenue than all CHS facilities nationally, which averaged $736,000 per licensed bed. Pennsylvania hospitals generated 9.2% of CHS operating revenues in 2017, or approximately $1.413 billion in revenue.¹⁶

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According to the PHC4, since 2015, Wilkes-Barre General has made $11 million in profit and averaged $276 million per year in revenue.\(^{17}\)

<table>
<thead>
<tr>
<th>Wilkes-Barre General Hospital Financials:</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
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<tr>
<td>Revenue</td>
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<td>$281</td>
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<tr>
<td>Operating Expenses</td>
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<td>$271</td>
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<tr>
<td>Profit</td>
<td>$3</td>
<td>$11</td>
<td>-3</td>
<td>$11</td>
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*Figure 2 - Wilkes-Barre General Hospital revenue, operating expenses, and profit for FY 2015-2017*

Where is the money going? CHS has accrued $13.67 billion in debt as of June 30, 2018, in large part due to their flawed acquisition of Florida-based Health Management Associates in 2014. The acquisition brought their total number of hospitals across the country to 206. Since then, in an effort to reduce its debt, CHS has sold off nearly half of its hospitals, retaining 118 currently.\(^{18}\)

CHS reported to their shareholders earlier this year that $4.7 billion of that debt is coming due by 2020.\(^ {19}\)

To leverage loans or restructure debt from lenders, corporations back their deals with revenue from existing operations. In the case of CHS, the officers are extracting the revenue from Wilkes-Barre General to pay back Wall Street lenders for unprofitable operations elsewhere in the country.

**Share Prices Have Crashed:**

Wall Street has lost faith in CHS. Since 2015, the CHS share price has crashed 95% from a high of $52.93 to below $5 per share. In 2017, CHS suffered $2.46 billion in net losses.\(^ {20}\)

**Executive Salaries Have Nearly Doubled:**

From 2015 to 2017, as executive decisions led to heavy losses, executive compensation was restructured from relying less on stock options, an incentive-based system, to relying more on non-incentive-based pay like salaries and bonuses.

Salaries for top executives have nearly doubled over three years from $2,115,000 to $4,134,396, not including other forms of direct compensation. This kind of "golden parachute" insulates executives from the consequences of reckless business decisions.\(^ {21}\)

**Our Past Gives Us Hope:**

We know this story. Northeast Pennsylvania has hosted industries such as timber, coal, textiles, waste, and natural gas and each time it has taken the collective strength of communities, public citizens, and labor unions to reform them. CHS in Tennessee and their investors appear to view northeast Pennsylvania as those industries always have: as an opportunity to extract resources and wealth with a workforce to take advantage of.

At their for-profit hospitals, it appears they are cutting corners when northeast Pennsylvanians are at our most vulnerable: in hospital beds. In the CHS business model, patients are treated as a raw material and their insurance plans are their source of value.

Hospitals are not mines or factories. Our patients are not pieces of coal in a breaker or bolts of fabric in a mill. Nurses are trained clinical professionals, like doctors, who provide complex medical care that saves lives every day. Taking a cue from our past movements for change, northeast Pennsylvanians must advocate for respect, excellent patient care, and good healthcare careers in our region.

Our union is leading the way.

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20 Form 10-K for fiscal year 2017, Community Health Systems, [https://www.sec.gov/Archives/edgar/data/1108109/000119312518064091/d506201d10k.htm](https://www.sec.gov/Archives/edgar/data/1108109/000119312518064091/d506201d10k.htm)

ISSUES IN DIRECT CARE

Overall Staffing

According to the PA Department of Health’s findings based on an unannounced visit in September, there is a “systemic nature of non-compliance” with regards to nursing services at Wilkes-Barre General Hospital. Inspectors found that hospital management failed to oversee and provide adequate clinical staff, according to their review of patient assignments, schedules, and employee interviews. The Department also found an excessive use of overtime.

EXCERPT (pages 46 - 68): These following standards were cited and show a systemic nature of non-compliance with regards to nursing services as follows:

...the facility failed to ensure Nursing Administration provided oversight of clinical services related to nurse staffing.
...the facility failed to schedule sufficient number of Registered Nurses and/or ancillary staff on the nursing units for 81 of 148 shifts reviewed.
...the facility failed to provide registered nurse supervision for licensed practical nurses scheduled on the Six center/south/north nursing unit for seven out of seven assignment sheets reviewed.
...the facility failed to administer medications on time for two of three medical records reviewed (MR12 and MR13).

Review of the overtime by position for June, July, August 2018 revealed RN 15434.88 hours; Agency RN 3025.75 hours; RN Weekender/Alternate RN Rate 286.3 hours; Nursing Assistant 4781.97 hours; Unit Secretary 2171.9 hours.

The Department found the hospital in violation of federal health codes including:

(b) Standard: Staffing and delivery of care. The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

(1) The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted under § 488.54(c) of this chapter.

In addition, the Department found the hospital in violation of the following related state health codes:

PA CODE 109.4 Professional nursing staff
A sufficient number of registered professional nurses shall be on duty at all times to plan, assign, supervise, and evaluate nursing care as well as to give patients such nursing care as requires the judgement and specialized skills of a registered nurse. A graduate nurse, or graduate practical nurse, providing care shall be under the supervision of a registered nurse.

PA CODE 109.6 (b)(1) Staffing Schedules
109.6 (b) Staffing schedules shall accomplish the following: (1) Staffing patterns which reflect the quality and quantity of various categories of nursing personnel necessary to carry out the nursing care program.

Mortality Rates, Negative Outcomes, Lack of Sufficient Staff

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency charged with collecting, analyzing, and reporting information that can be used to improve the quality and restrain the cost of healthcare in the state.

PHC4 found in 2016 that the hospital exceeded expected mortality rates while treating heart attack patients with angioplasty and arterial stents, patients with kidney and urinary tract infections, pneumonia patients, and sepsis patients.

In 2017, PHC4 found that the hospital exceeded expected mortality rates while treating patients with abnormal heartbeats, acute kidney failure, and sepsis.

Safe staffing is part of the solution to saving lives. Studies show that every additional patient-per-nurse in a Pennsylvania hospital increases that patient’s risk of death by 7%.22 Surgical patients in hospitals with

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22 Aiken, Clarke, Sloane et al, ‘Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction’, Journal of the

American Medical Association, 2002,
8:1 ratio have a 31% higher risk of death.\textsuperscript{23} Research from other states suggests that short-staffing increases patients’ risk of death by between 4 and 6%. This risk is higher within the first 5 days of admission.\textsuperscript{24}

Lower patient-to-nurse staffing ratios have been significantly associated with lower rates of hospital mortality, failure to rescue, cardiac arrest, hospital-acquired pneumonia, respiratory failure, patient falls (with and without injury), and pressure ulcers.\textsuperscript{25}

Higher numbers of patients per nurse is strongly associated with administration of the wrong medication or dose, pressure ulcers, and patient falls with injury.\textsuperscript{26}

The Pennsylvania Department of Health report after an unannounced visit in September includes two instances of late administration of medication out of three medical records reviewed.

This aligns with the report’s finding that staffing is inadequate, which causes delays in patient care as nurses become overwhelmed with their patient assignments.

\textbf{EXCERPT (page 78):} Review on September 14, 2018, of MR12 revealed MR12 was admitted to the facility on April 6, 2018, for treatment of left lower quadrant pain, an abdominal abscess, and a fall at home. There was documentation of an order for Zosyn (an antibiotic) 3.375 gm (grams) IV (intravenous) Piggyback every 8 hours (0800 1600 2400). There was nursing documentation the medication was administered late at 1712 instead of 1600 on April 10, 2018. There was no documentation of an explanation.

The Department found the hospital in violation of federal and state health codes related to medicine administration:

\textbf{U.S. CODE § 482.23 (c) Standard: Preparation and administration of drugs.} Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient’s care as specified under § 482.12 (c), and accepted standards of practice.

\textbf{PA CODE 109.61 Drug Administration Procedures.} Medication or treatment shall be administered only upon written and signed orders of a practitioner and in accordance with the provisions of 107.61-107.65 of this title.

In their interviews with employees, Pennsylvania Department of Health inspectors noted:

\textbf{Interview on September 10, 2018, with EMP9 revealed they feel the patients are sicker now when admitted to the hospital than they were years ago therefore, the acuity of these patients is higher...Facility doesn't follow staffing grids. They stated there aren't enough aides or secretaries to go around. The aide may start the shift on telemetry, but get pulled to the ED to help out.}

\textbf{Interview on September 10, 2018, at approximately 5:30 PM, with EMP43 revealed EMP43 stated the staff does not have enough help. EMP43 stated an Medical Surgical Intensive Care Unity (MSICU) RN is pulled from their patient assignment for any trauma level one's called in the emergency department.}


EMP43 explained a nurse could be gone for up to two hours for a trauma and it is possible for multiple traumas to occur at once, which leaves the remaining MSICU nurses to cover 3-4 total patients.

EMP43 explained the nurses never get breaks, there is a delay in care/treatments/medications for patients due to the staffing. EMP43 explained there is not enough staff to turn patients or care for patients properly. EMP43 stated the staffing was unsafe for patients and staff. EMP43 explained the MSICU does not have an aide on second shift and they do not always have a secretary.

EMP43 explained when a patient needs to be transferred to a tertiary facility and is highly unstable nurses are often pulled away from the patient to complete the administrative paperwork to prepare for the transfer. EMP43 stated the lack of ancillary staff leaves patients at risk. EMP43 further explained nurses are also taken away from their patient assignment when aides or sitters are necessary for suicidal patients. EMP43 explained the nurses have been told by nursing supervisors to relieve the sitters for breaks and lunches. EMP43 stated the patients on our unit are very sick and this is not fair to them.

Interview on September 10, 2018, at approximately 7:25 PM with EMP51 revealed EMP51 had also been asked to take three patients but refused. EMP51 explained they felt three CVICU patients was not a safe assignment and would not accept that assignment. EMP51 stated there are no aides or secretaries in the evenings and that makes it difficult to take care of the patients especially during an emergency. EMP51 explained often when they need emergent blood for a patient there is no staff to retrieve the blood. EMP51 explained on multiple occasions they had to call the nursing supervisor to retrieve the blood. EMP51 explained it is frustrating and they do their best to take care of the patients.

Interview on September 10, 2018, with EMP21 stated weekends are worse. Everyone calls off. They stated it’s difficult to get your work done on time when there isn’t enough ancillary help. This is the worst they have ever seen it. Morale is down. EMP21 stated they might discharge two patients in a shift and then admit two more and admissions are a lot of work.

Critical Care Units

Critical care units include the Surgical Intensive Care Unit, Critical Care Unit, and Cardio-Vascular Intensive Care Unit. In their November report, the Pennsylvania Department of Health findings concurred with RNs stated concerns about staffing in those units. In addition to not having enough RNs, critical care nurses cite that the lack of ancillary staff has forced them to become primary care nurses, where an RN is responsible for complete care of a patient as opposed to team nursing utilizing nursing assistants, unit secretaries, technicians, and licensed practical nurses.

Surgical Intensive Care Unit RNs also report malfunctioning beds that get stuck in an upright position, forcing them to move patients to properly functioning beds. The shortage of lifts for heavier patients complicates that process. Even more seriously, a shortage of feeding tubes available for patients on ventilators has been reported in critical care units, especially during flu and pneumonia season.

Telemetry

The telemetry unit at the hospital is a progressive telemetry unit, which means they also treat heart patients who would typically be sent to progressive care or intensive care units at other hospitals. The nurse to patient ratio is typically five patients for every nurse with one monitor technician.
On a shift with a high census of patients, an aide is recommended by the hospital’s staffing grid, but is often unavailable, especially on night shift. Telemetry RNs also cite a shortage of intravenous (IV) pumps that often forces them to call around the hospital to borrow them from other units. Blood pressure cuffs used to take vital signs and sequential compression devices (SCDs) used to help blood circulation are also reported to be in short supply.

Medical/Surgical
The medical/surgical units, or “med surg” for short, are where adult patients are admitted who are acutely ill with a wide variety of medical issues or are recovering from surgery. Med surg is especially busy in the afternoon and evenings due to the high number of admissions from the Emergency Department and outside facilities.

To relieve unit nurses from some duties, the hospital has employed admissions nurses in the past, but currently only has one nurse designated for admissions. Staffing problems during high census could also be resolved with an expanded float team of cross-trained nurses who are available to go to units where extra help is needed. Currently, there is only one full-time nurse on the float team.

Emergency Department
The Emergency Department is accredited as a Level II Trauma Center by the Pennsylvania Trauma Systems Foundation, a non-profit corporation recognized by the Emergency Medical Services Act. The Foundation board consists of appointed legislators and healthcare professionals.

In their findings after an unannounced visit in September, the Pennsylvania Department of Health documented that nursing administration regularly fails to schedule a dedicated Flow/Trauma Nurse for all dates they reviewed.

Wyoming Valley Nurses Association again notified the Foundation of these deficiencies and filed a Right to Know Request with the Foundation to further investigate how the hospital received and maintains their Level II accreditation.

The Foundation has refused to respond with information detailing the accreditation process for Wilkes-Barre General Hospital, claiming that they are a private organization not subject to Pennsylvania’s Right to Know Law. It is unclear if the Foundation has ordered any corrective action to be taken at the hospital to address cited deficiencies.

The PA DOH inspectors wrote in their report about the conditions they found in the Emergency Department during their visit:

EXCERPT (pages 99 - 104): Interview with EMP29, EMP30 and EMP31 on September 10, 2018, revealed there is not always a Flow/Trauma Nurse always assigned to cover this position. These employees revealed when a trauma patient presents to the ED, and there is no Flow/Trauma Nurse coverage, a RN is pulled from their patient assignment to cover the trauma.

Review on September 11, 2018, of the ED staffing sheets for August 1, 4, 8, 12, 13, 14, 17, 19, 20, 21, 22, 25, 26, 27 and 28, 2018, revealed no designated Flow/Trauma Nurse coverage.

Review on September 11, 2018, of the ED trauma list for August 2018, revealed the following trauma patients presented to the ED:

| August 8, 2018 | 2 - Level II trauma patients |
| August 13, 2018 | 1 - Level II trauma patients |
| August 20, 2018 | 1 - Level I trauma patient |
| August 21, 2018 | 1 - Level I trauma patients |
| August 25, 2018 | 1 - Level I trauma patient; 3 - Level II trauma patients and 1 - Level III trauma patient |
| August 26, 2018 | 1 - Level I trauma patient and 1 - Level III trauma patient |
| August 29, 2018 | 1 - Level I trauma patients |

Interview with EMP3 and EMP7 on September 11, 2018, at approximately 10:45 AM confirmed there was no designated Flow/Trauma Nurse coverage on August 1, 4, 8, 12, 13, 14, 17, 19, 20, 21, 22, 25, 26, 27 and 28, 2018. EMP7 confirmed when trauma patients present to the ED and there is no designated Flow/Trauma Nurse coverage, a RN is pulled from their assignment to cover the trauma.

Review on September 11, 2018, of the ED staffing sheets for September 4, 5, 6, 7 and 9, 2018, revealed no designated Flow/Trauma Nurse coverage. Review on September 11, 2018, of the ED trauma list for September 2018, revealed the following trauma patients presented to the ED:

| September 4, 2018 | 3 - Level I trauma patients and 1 - Level II trauma patient |
| September 5, 2018 | 1 - Level 2 trauma patients |
September 6, 2018: 1 - Level I trauma patients; 2 - Level II trauma patients; and 1 - Level III trauma patient.

September 7, 2018: 2 - Level II trauma patients.

Interview with EMP3 and EMP7 on September 11, 2018, at approximately 12:00 PM confirmed there was no designated Flow/Trauma Nurse coverage on September 4, 5, 6, 7 and 9, 2018. EMP7 confirmed when trauma patients present to the ED and there is no designated Flow/Trauma Nurse coverage, a RN is pulled from their assignment to cover the trauma.

Interview with EMP29, EMP30, EMP31, EMP32, EMP33, EMP34, EMP35, EMP36, EMP37 and EMP38 on September 10, 2018, revealed there is inadequate staffing of Registered Nurses (RN), Techs, Nursing Assistants (NA's) and Unit Secretary's (US) in the ED.

On September 10, 2018, a random sample of the ED staffing sheets for August 2018 and September 2018 were selected for review.

Review on September 11, 2018, of the staffing sheets for August 1, 3, 4, 5, 6, 10, 11, 12, 20, 21, 25, 27, and 31, 2018, revealed the facility did not meet the required staffing per the staffing grid for the ED.

Interview with EMP3 on September 11, 2018, at approximately 10:15 AM confirmed the facility did not meet the required staffing for RN’s, Techs, NA’s and Unit Secretary’s per the established staffing grid in the ED for August 1, 3, 4, 5, 6, 10, 11, 12, 20, 21, 25, 27, and 31, 2018.

Review on September 11, 2018, of the staffing sheets for September 2, 4, 5, 6, and 9, 2018, revealed the facility did not meet the required staffing per the staffing grid for the ED.

Interview with EMP3 on September 11, 2018, at approximately 12:00 PM confirmed the facility did not meet the required staffing for RN’s, Techs, NA’s and Unit Secretary’s per the established staffing grid in the ED for September 2, 4, 5, 6, and 9, 2018.

The Department cited the hospital for violating the federal health code standards for emergency services:

U.S. CODE § 482.55 Condition of participation: Emergency services. The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

(a) Standard: Organization and direction. If emergency services are provided at the hospital—

(2) The services must be integrated with other departments of the hospital;

(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff;

(b) Standard: Personnel.

(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

Commonwealth Health also advertises a “thirty minutes or less ER pledge”, committing that a physician or physician’s assistant will see a patient within thirty minutes of arrival.

However, when the doctors in the ED are admitting a high volume of patients, they must be moved to medical/surgical, critical care, telemetry, or other units throughout the hospital. Often patients are told there “are not enough beds” at the hospital, but that typically means there are not enough nurses to take on additional patients in their assignments.

Also, in their November report following their unannounced inspection in September, the Pennsylvania Department of Health found that the Emergency Department was not staffed adequately enough to observe mental health crisis patients who present a risk of harm to themselves or others.

In their discussion of mental health patient issues, the Department cited the emergency department for a violation of health codes including:

PA CODE 117.21 Staffing and organization

Where there is an emergency service, regardless of its scope, it shall be well organized, properly directed, and integrated with other departments of the hospital. Staffing shall be related to the scope and nature of the needs anticipated and the services offered.

PA CODE 117.31 Emergency Service Facilities

Facilities for the emergency service shall be such as to ensure effective patient care.
Obstetrics & Pediatrics

In obstetrics and pediatrics, staffing benchmarks set by the hospital fall short of meeting widely accepted safer ratios proposed in legislation, supported by nurse unions nationwide including the Pennsylvania Hospital Patient Protection Act.

For a mother-baby couplet, the proposed legislation would require that immediately after delivery, there be no less than one nurse assigned per couplet. Core staffing guidelines for Wilkes-Barre General allow for one nurse to be assigned up to three couplets, regardless of how recently the babies were born.

In the newborn nursery, proposed legislation would require no less than one nurse per two newborns needing intermediate care. Wilkes-Barre General core staffing guidelines call for one nurse for up to three newborns needing intermediate care. For well newborns, proposed legislation calls for no less than one nurse per five newborns, but Wilkes-Barre General allows up to six newborns to be assigned per nurse.

In the pediatrics unit, proposed legislation would require no less than one nurse per three children, but Wilkes-Barre General core staffing guidelines allow for up to five children per nurse.

Additionally, pediatric RNs report that their unit has become an overflow floor for medical/surgical patients. The admission of med surg patients limits nurses’ ability to provide acute care and supervise their most vulnerable patients.

Labor & Delivery RNs report that lidocaine, a fast-acting local anesthetic, is not being administered to mothers for episiotomy procedures during difficult births. They report that the hospital is utilizing cheaper and slower-acting ropivacaine. Studies show that lidocaine has a quicker onset of anesthesia, with a mean time of 1.3 minutes (range, 1 to 2.7 minutes). Ropivacaine has a mean onset time of 4.5 minutes (range, 3.5 to 5.5 minutes), leaving mothers in pain for minutes unnecessarily.27

During periods of low census in the pediatrics unit, medical/surgical adult patients are sometimes brought to the unit where, as of October 2017, hospital policy forbids adults with communicable diseases or history of substance abuse.

Nurses warn that caring for sick or injured adults, usually without a nurse aide, puts children on the unit at risk of exposure to contagions and lack of supervision.

Additional nurses on medical/surgical units would relieve the need for those patients to be brought to pediatrics and help to attract and retain nurses overall.

<table>
<thead>
<tr>
<th>UNIT</th>
<th>Proposed Legislation</th>
<th>Wilkes-Barre General Core Staffing Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics/Post-Partum</td>
<td>1:2 Immediate Post-Partum</td>
<td>1:5-6</td>
</tr>
<tr>
<td></td>
<td>1:6 Three couplets</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1:3</td>
<td>1:4-5</td>
</tr>
<tr>
<td></td>
<td>Well newborns 1:4-5</td>
<td>Well newborns 1:5-6</td>
</tr>
</tbody>
</table>

Figure 3 - Staffing ratios for obstetrics and pediatrics in proposed legislation versus Wilkes-Barre General Core Staffing Guidelines

ISSUES IN CASE MANAGEMENT

Nurses Working Unpaid Overtime  
CASE

Case management nurses are RNs who coordinate all aspects of care for individual patients. They ensure proper utilization of services and resources as well and assistance within, between, and outside of facilities.

Case managers often work late, far beyond their scheduled shifts to ensure that their patients are taken care of and paperwork is processed for their swelling caseload. As salaried employees, they are the only nurses at Wilkes-Barre General Hospital whose overtime is unpaid.

In the case management department, 13 RNs are typically assigned 18 or more patients at a time. The case managers are often working ten or more hours to complete their work and feel that their workload would be manageable inside of a regular workweek with 15 patients each. If the hospital added three additional case managers to the department, case managers would be able to spend more time on each patient’s case with an average caseload of 15 and work little to no unpaid overtime.

Case managers make provisions for post-discharge needs of patients and it is critical that additional staff be assigned to case management to ensure the best possible assistance.

If a patient is elderly and to be admitted to a skilled nursing facility, the nurse will discuss options with the patient and find a facility that meets their preference.

If a patient is addicted to drugs or alcohol, the nurse will help locate a rehabilitation facility for them to be admitted.

If a patient is being discharged to their home, other aspects of care must be considered. For example, proper medical equipment like oxygen tanks and CPAP must be ordered and their use explained to the patient. If the patient requires assistance in the home, a nurse may ensure that a family, friend, or home care aide is available.

Two discharge planners have been hired to assist, but the RNs are responsible for tasking those discharge planners with duties, which adds to their workload. Discharge planners are also not qualified to work with insurance companies to arrange pre-certifications and reimbursements for medical procedures and prescriptions. In addition to working with insurers, if a patient must self-pay, case managers coordinate that as well.

Case managers work holistically, ensuring that care meets the physical, social, and emotional needs of patients. Sometimes, miscellaneous needs fall in the wheelhouse of case managers such as making sure someone has fed a pet during an extended stay, rent is paid, and air conditioning is available.

The hospital employs only one licensed clinical social worker, dedicated to the trauma team in the Emergency Department. The workload for case managers could be eased if aspects of care related to social services could be handled by a social worker or social services coordinator.

“Avoidable days”  
CASE

Case management is a collaborative process. RNs meet once a week with doctors and hospital management at an interdisciplinary team meeting to coordinate care and discuss the recommended length of stay. Hospital management asks nurses why patients have not been discharged out of concern for unnecessary lengths of stay, called “avoidable days”.

Community Health Systems requires RN case managers to review every two days to determine if a patient can be discharged, more frequent than every four days which is the Medicare requirement. The cost of avoidable days may not be billable to insurance companies depending on the diagnoses, which is bad for business.

Doctors must assess patients for either safe discharge or continued care, but the process of completing and submitting discharge paperwork can cause avoidable days.

For example, a doctor who submits discharge orders to a case manager in the late afternoon may cause an avoidable day or an extra overnight stay because insurance offices, medical equipment companies, and home health agencies may close before the nurse can process the discharge.

Patients able to be safely discharged should not lay in wait and those patients who require inpatient care longer should not be discharged simply to open up a hospital bed or save money.

Most of all, an “avoidable day” is contrary to a nurse’s commitment to her patients. RN case managers often work selflessly beyond their shifts, unpaid for their overtime, and away from their families to ensure their patients can return home to their families or take the next steps in their care beyond the hospital.

If hospital management is highly concerned about the cost of avoidable days, the issue can be resolved primarily by hiring additional RN case managers to provide relief to the current staff.
STAFFING SOLUTIONS

No shortage of registered nurses in PA

Some hospital companies falsely claim that short staffing is due to a shortage of nurses. However, there is presently a surplus of RNs able to work and it is dangerous short-staffing that is primarily driving nurses to leave bedside care.

Pennsylvania has (and will have) more than enough licensed RNs. The PA Department of Health regularly surveys all RNs and LPNs renewing their license. The most recent survey showed only 76% of RNs were employed in nursing, with 6% unemployed. Pennsylvania is projected to have a surplus of 5% (8,200) RNs by 2030.

Pennsylvania is also training and graduating more than enough RNs. Enrollment in Pennsylvania RN programs has increased by 49% since 2003 (from 15,651 to 23,278), and by 138% since 2002 (from 2,939 to 7,003).

There is, however, a serious problem with nurse retention. Nurse burnout and turnover in Pennsylvania has reached record-high levels in the last 2-3 years. A Nurses of Pennsylvania survey of 1,000 bedside nurses last year found 79% reported increased turnover since they started.

Research published in November by the University of Pennsylvania School of Nursing surveyed 53,644 RNs and 805,881 patients in 535 hospitals in four states, including PA, between 2005 and 2016. They concluded that one in three RNs (29.6%) find patient safety to be “unfavorable” at their hospitals. Roughly 4 in 5 RNs rate their clinical work environment less than excellent.

According to the study, from 2005 to 2016, Only 21% of hospitals substantially improved their clinical work environments and 7% had worse work environments, which included staffing benchmarks. In hospitals that improved their work environments, patient and nurse appraisals of patient safety increased by 11% to 15%. When work environments deteriorated, favorable grades on patient safety fell by 19%.

Roughly 1 in 5 nurses surveyed said that the actions of management showed that patient safety is not a top priority. More than one-third of the RNs reported that "staff do not feel free to question authority."

Staff shortages for positions such as aides and unit secretaries were also reported by 31% who said they spent a large part of their last shift on non-nursing tasks that could have been completed by ancillary staff.

The stress of nursing has left nearly 7 in 10 hospital nurses less than very satisfied with their job and 31% reported they were on their way to burning out.

Short-staffing is the single biggest driver of nurse burnout and turnover. In the PA Department of Health’s most recent licensure survey, the highest factor of ‘job dissatisfaction’ was staffing (37% unsatisfied), and for respondents under fifty who were planning to leave nursing the most common reported reason was stress/burnout.

Improving staffing to safe levels would reduce nurse burnout/turnover, encourage more licensed nurses to return to the bedside, and make the single biggest difference in improving nurse retention, patient safety and saving hospitals the cost of high turnover.

The Need for Staffing Legislation

Two pieces of legislation have been introduced in the Pennsylvania House of Representatives and State Senate titled the Pennsylvania Hospital Patient Protection Act that would address RN staffing across the Commonwealth.

The Wyoming Valley Nurses Association, a local of the Pennsylvania Association of Staff Nurses and Allied Professionals continues to urge legislators to co-sponsor the bills, HB1500 and SB214.

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The introduction of safe patient limit laws has been proven to protect patients and increase the ‘supply’ of working nurses. After passing a safe patient limit law in 2004, the California Board of Nursing reported a 60% increase in applications for nursing licenses from other states, a 4% increase in RNs overall, and an 18% increase in the number of applicants for the certifying exam.

Patient Care Council

Patient care committees are a widely established venue for convening clinical care nurses along with management level hospital staff to consider current hospital staffing plans and outcomes. Committees provide feedback for the selection, implementation, and evaluation of minimum staffing levels for inpatient units based on the level of care required for patients. Every other PASNAP-represented hospital has an effective patient care committee.

Nurses in Illinois, where patient care committees are required by law, have cited specific benefits including “we are always working on solutions for staffing issues,” “our team regularly provides feedback to administration,” “we share best practices across units,” “we now use acuity to drive assignments,” “I have learned about the budgeting process,” “our committee has developed strategies to improve retention,” and “we developed floating guidelines.”

Currently, union contract language at Wilkes-Barre General only provides for a Patient Care Council that meets once each quarter for one hour. Union nurses at Wilkes-Barre General Hospital are attempting through the bargaining process to establish legally binding language for a more robust Patient Care Council process that would include longer, more regular meetings and broader representation of nurses from the main areas of the hospital.

A strong Patient Care Council will enable nursing administration to implement changes quickly and ensure conditions are improving. In turn, addressing the patient care concerns of nurses will help recruit and retain nurses.

Adequate staffing is key to improving the hospital and nurses who are the frontline caregivers and advocates for patient care should not need to resort to calling the Pennsylvania Department of Health tip line to resolve issues in their units. Nurses must be an integral part of the decision making on how care is provided.


35 Kemski, Ann, Market Forces, Cost Assumptions, and Nurse Supply: Considerations in Determining Appropriate Nurse to Patient Ratios in


FINANCIAL REVIEW

Share Prices Have Crashed

Since June 2015, the share price of Community Health Systems, holding company of Commonwealth Health, has crashed from a closing price high of $52.93 to below $5. In 2017, CHS suffered $2.46 billion in net losses nationwide as their business model of buying and flipping hospitals for sale has proven unmanageable.37

Pennsylvania Hospitals Make Money

However, CHS’ financial woes lie primarily with their hospital holdings outside of Pennsylvania. Corporate filings by CHS with the Securities and Exchange Commission reveal that in 2017 their six northeast Pennsylvania hospitals yielded $1.2 million per licensed bed on average, two thirds more in revenue than all CHS facilities combined nationally, which averaged $736,000 per licensed bed. Pennsylvania hospitals generated 9.2% of CHS operating revenues in 2017, or approximately $1.413 billion.38

According to the PHC4, since 2015, Wilkes-Barre General has made $11 million in profit and averaged $276 million per year in revenue.39

<table>
<thead>
<tr>
<th>Wilkes-Barre General Hospital Financials</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
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<td>$282</td>
<td>$281</td>
<td>$827</td>
</tr>
<tr>
<td>Operating Expenses</td>
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<td>$271</td>
<td>$264</td>
<td>$816</td>
</tr>
<tr>
<td>Profit</td>
<td>$3</td>
<td>$11</td>
<td>-$3</td>
<td>$11</td>
</tr>
</tbody>
</table>

Figure 2 - Wilkes-Barre General Hospital revenue, operating expenses, and profit for FY 2015-2017

Over-Billing Medicare:

The hospital has also been found to bill public insurance much higher than the national average for surgical procedures. A New York Times report updated in 2015 found that the hospital was billing Medicare between 110% and 130% the national average for arterial stent procedures and 170% the national average for permanent cardiac pacemaker implants and other major cardiac procedures.

Overall, the report showed the hospital was billing Medicare at 120% higher than the national average for all surgical procedures.40

CHS Debt is Immense

Where is the money going? Through their business model of purchasing and reselling hospital systems, CHS has accrued $13.67 billion in debt as of June 30, 2018, in large part due to their flawed acquisition of Florida-based Health Management Associates in 2014. The acquisition brought their total number of hospitals across the country to 206. Since then, in an effort to reduce its debt, it has sold off nearly half of its hospitals, retaining 118 currently.41

In September, bond rating agency Moody’s downgraded CHS’ Corporate Family Rating (CFR) to Caa3, which signals that their debt is in poor standing and subject to very high credit risk. Moody’s also lowered the liquidity ranking to SGL-4, which signals that CHS relies on external sources of financing and the availability of that financing is, in Moody’s opinion, highly uncertain. The ratings reflect Moody’s view that Community’s liquidity will be weak over the next 12-18 months, elevating the probability of a default on their debt.42

CHS reported to their shareholders earlier this year that $4.7 billion of that debt is coming due by 2020.43

In order to leverage loans or restructure debt from lenders, corporations back their deals with revenue from existing operations. In the case of CHS, the officers are extracting the revenue from Wilkes-Barre General Hospital to pay back Wall Street lenders for unprofitable operations elsewhere in the country.

Executive Salaries Have Nearly Doubled

Meanwhile, executive salaries have doubled. As the company floundered from 2015 to 2017, compensation for CHS executives was restructured from relying on stock options, an incentive-based system, to

42 Moody’s downgrades CHS/Community Health’s CFR to Caa3; liquidity rating to SGL-4 https://www.moodys.com/research/Moodys-downgrades-CHSCommunity-Healths-CFR-to-Caa3-liquidity-rating-to--PR_389528
relying on non-incentive-based pay like salaries and bonuses. This kind of “golden parachute” does not deter executives from making reckless business decisions. In the case of CHS, corporate leadership was hardly dealt any consequences from their board of directors for bad hospital acquisitions and mismanagement.

The Biggest Shareholder
Chen Tianqiao, a video game billionaire, is the largest shareholder by far in CHS. Through his holding company Shanda Asset Management, Tianqiao owns 23% of CHS’ stock. While initially purchased as a passive stake, in March 2017 Tianqiao made clear that he planned to get actively involved in the company’s operations. Tianqiao at this point has declined to take a seat on CHS’ board, but it is worth wondering what the experienced businessman’s game plan is, considering the precipitous fall of CHS’ stock.

In March, Tianqiao spent $39 million purchasing the historic Vanderbilt mansion in New York City.

Community Health Systems Executive Compensation 2015-2017
Since 2015, the share price of CHS stock has crashed and profit margins have dipped $2.46 billion into the red, but executive salaries have nearly doubled. Compensation for CHS executives was restructured from relying on stock options, an incentive-based system, to relying on non-incentive based pay like salaries and bonuses. This kind of “golden parachute” does not deter executives from making reckless business decisions. In the case of CHS, corporate leadership was hardly dealt any consequences from their board of directors for bad hospital acquisitions and mismanagement. (Source: Morningstar.com)

FORMATION OF THE COMMONWEALTH HEALTH HOSPITAL SYSTEM

- **March 1999** - CHS purchased Berwick Hospital Center

- **August 2008** - CHS purchased Wyoming Valley Health Systems, the largest employer in Luzerne County at the time, which included Wilkes-Barre General Hospital, First Hospital Wyoming Valley (formerly Nesbitt Hospital), CHOICES, Community Counseling Services, Heritage House, Wyoming Valley Manor, the Visiting Nurse Association, United Health and Hospital Services among others. The sale totaled $750 million.

- **May 2011** - CHS purchased the Mercy Health Hospitals system, which included Mercy Hospital of Scranton (renamed Regional Hospital of Scranton), Mercy Tyler Hospital in Tunkhannock (renamed Tyler Memorial Hospital), and Mercy Special Care Hospital in Nanticoke which they sold to Camp Hill-based Post Acute Medical, who closed the facility in 2014. The sale totaled $150 million.

- **January 2012** - CHS purchased Moses Taylor Hospital in Scranton. The sale totaled $150 million.

*Figure 1 - Commonwealth Health System Hospitals*
To Make Change, We Follow in the Tradition of Labor.

We know this story. Historically, northeast Pennsylvania has hosted industries such as timber, coal, textiles, waste, and natural gas and each time it has taken the collective strength of communities, public citizens, and labor unions to reform them.

Our valleys are surrounded by visual reminders of our relationship with industry in the past and present. By the mid-19th century, more than 90 percent of Pennsylvania’s forests were cleared for timber to build and heat the East Coast’s cities. Much of the timber holdings were held by Wall Street investors, not by those who lived here. It took a national conservation movement into the 20th century led by native Pennsylvanians Gifford Pinchot and Mira Lloyd Dock to reforest and manage our landscape.

Abandoned coal breakers, strip mines, coal waste dumps, and mine drainage outflows surround our valley towns. By the time of the historic Anthracite Coal Strike of 1902, most mining operations in northeast Pennsylvania were financed by Wall Street banker James Pierpont Morgan.

That year, United Mine Workers of America President John Mitchell and labor organizer “Mother” Mary Harris Jones led 145,000 miners on strike for a living wage, mine safety, and recognition of their union and won. Child labor laws, minimum wage laws, and mine regulations were passed in the years following.

Meanwhile, barons of the garment industry were seeking a new low-wage labor force, away from the unionized mills in major East Coast cities. They employed the miners’ wives and daughters in the “runaway” mills of northeast Pennsylvania. Some mills owned locally were run by organized crime boss Russell Bufalino.

In 1959, the Knox Mine Disaster killed 12 men and caused the Susquehanna River to flood much of the remaining interconnected mines in the Wyoming Valley, making garment work the primary source of income for many families.

At that time, Min Matheson, labor organizer with the International Ladies Garment Workers Union, arrived in the Wyoming Valley to find six organized garment shops with 650 union members. When she left in 1963, there were 168 organized factories and 11,000 ILGWU members.

Over the next three decades, free trade policies allowed garment and other manufacturing companies to abandon Pennsylvania and move operations overseas. Many of the mills stand vacant, a stark reminder of how quickly employers can exit, leaving us with our pockets turned out.
The healthcare industry, however, cannot be outsourced and continues to thrive in the region, employing predominately women in middle class careers like nursing.

In the 21st century, over ten thousand new gas wells to our north and west deliver Marcellus Shale gas to neighboring states and foreign countries for heat, with gas power plant stacks casting shadows, pipelines winding through our towns, and drilling waste crowding our landfills.

In return, those neighboring states send Pennsylvania more imported garbage than any other state. Slowly, Harrisburg politicians respond to the gas and waste industries with regulations, often stalled by major contributions to their campaigns.

To us, it appears that CHS in Tennessee and their investors view northeast Pennsylvania as those industries always have: as an opportunity to extract with a workforce to take advantage of.

At their for-profit hospitals, it appears they are cutting corners when northeast Pennsylvanians are at our most vulnerable: in hospital beds. In the CHS business model, patients are treated as a raw material and their insurance plans are their source of value.

Hospitals are not mines or factories. Our patients are not pieces of coal in a breaker or bolts of fabric in a mill. Nurses are trained clinical professionals, like doctors, who provide complex medical care that saves lives every day. Taking a cue from our past movements for change, northeast Pennsylvanians must advocate for respect, excellent patient care, and outstanding healthcare careers in our region.

Our union is leading the way.
Appendix

Pennsylvania Hospital Patient Protection Act, Legislative Summary (SB1500 & HB214)

Summary of University of Pennsylvania School of Nursing, “Nurses’ and Patients’ Appraisals Show Patient Safety in Hospitals Remains a Concern”

Leapfrog Hospital Safety Grade Report – Fall 2018

Summary of PA Department of Health Findings – November 2018

Full PA Department of Health Findings – November 2018

CHS 2017 Annual 10-K Report to the U.S. Securities and Exchange Commission

Wilkes-Barre General Hospital “Plan for Patient Care Manual” (available for review upon request)

Pediatrics Unit Policy on Patient Admissions (available for review upon request)

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