

A Supplement to
*Breaking Faith: How Catholic Health
Executives Abandon Social Teachings*

Understaffed and Overworked

A looming crisis for patients,
employees and Catholic Health

By the Western New York Workers' Rights Board

Sponsored by
The Coalition for Economic Justice

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Understaffed and Overworked



*WRB Hearing Officers, From Left to Right:
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Rev. Kirk Laubenstein*

Introduction

“Sometimes being a nurse is awful and awfully tough, some days it truly tests your ability to multi-task, keep a level head, and keep a warm and comforting face. It seems easy to keep your composure from room to room ... fighting back the tears, swallowing your emotions ... when you walk out of a dying patient’s room and into another with a smile on your face. It sucks when you fight so hard to save a life and death comes knocking despite your efforts.”

“No one except another nurse can TRULY understand how hard it is to keep your composure after losing a patient. It’s even harder when you lose two in the same shift, especially seeing the heartache and pain on their spouse’s face. After a day like that, you just need a hot meal, a cold beer, a good cry, and a bed in order to wake up tomorrow and do it all over again. Why? Because despite it all ... I still love my job. I love what I do.”

The meditation to the left was written by Sarah Donovan, RN, following the death of two patients in her care during her twelve-hour shift.

In her Workers’ Rights Board testimony, Ms. Donovan reported that she is responsible for the “sickest of the sick,” caring for patients with balloon pumps in the Coronary Care Unit (CCU) at Mercy Hospital. She noted that when she began at the hospital, each nurse was assigned one such patient; today, each is assigned three patients.

“It is not right to let someone’s needs not be met due to poor staffing.”

Ms. Donovan’s words are precisely what drew the Workers’ Rights Board (WRB), established by the Coalition for Economic Justice, to once again examine Catholic Health’s policies and practices, specifically regarding the issue of short-staffing as it affects both patients and employees.

Since the initial WRB Report, *Breaking Faith*, was published in October, 2015, many Catholic Health (CH) employees have expressed additional serious concerns, most centering on the negative results of chronic short-staffing. Accordingly, this report focuses on how CH is responding (or not responding) to its own staffing crisis. The testimony of CH employees falls within three major categories, specifically illustrating the continuing impact of short-staffing on:

- **Patient Care**
- **Employee Physical and Mental Health**
- **Health and Safety**

It is important to note that throughout their testimony, employees unfailingly testified to their continued allegiance and commitment to their patients, often to the detriment of their own health:

- The CNA who suffered a miscarriage mid-shift was asked “if she could carry on,” sought medical care after work, and returned the next day for her 12 hours, to minimize hardship for her beleaguered co-workers.

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- The many RNs and other employees who rarely take time for lunch or bathroom and water breaks, while being told by their supervisors that they are “not allowed to have any drink on the desks.”
- The nurse who broke down physically from the crush of work and the responsibilities of caring for more ill patients than any nurse should be required to handle. She was rushed to her own ER.

Everyone who testified for this report expressed their absolute commitment to their patients, their sadness that they are no longer able to do for their patients what they know should and must be done, and their disappointment in CH’s failure to, as one put it, “practice what they preach.”

Representative of all of the above is **Carrie Dilbert, RN**, who testified that she had chosen “my vocation of nursing after originally wanting to be a nun. Being a nurse, especially at a Catholic facility, allows me to live my faith and serve God.” Her obvious pain in being unable to fulfill that vocation and unable to deliver the care she should was evidenced when she spoke of patients lying in their own waste because of short staffing; of patients not getting turned frequently enough to prevent bedsores; and of requesting permission to organize teams of volunteers to clean and re-paint filthy areas within the hospital—a request that was refused. She concluded:

“This breaks my heart. I just feel like curling up in a ball. It is unsettling. This is a Catholic facility and I am very prideful about the care we deliver and our Catholic values. I want to carry out Catholic values. It is very important to me.”

“I want to carry out Catholic values.”

That 8,000 employees continue to try to offer the most beneficial and professional care to all their patients, while suffering from inadequate staffing, can only be

viewed as a testament to the character and moral fiber of these employees. It remains the hope and prayer of the WRB that the attached testimony will lead to real changes at Catholic Health, undertaken in the spirit of CH’s core values of Reverence, Compassion, Justice and Excellence. (All testimony presented to the WRB is available at www.cejbuffalo.org).

NOTE: The Workers’ Rights Board, created and first utilized in 1995, includes community, academic and religious leaders. Most recently convened on July 6, 2016, the board was composed of the following hearing officers:

- **Sister Judith Justinger**, SSJ, Leadership Team, Sisters of St. Joseph
- **Rev. Kirk Laubenstein**, Executive Director, Coalition for Economic Justice
- **Joan Malone**, Ex. Director, CEJ (retired); Secretary, Living Wage Commission of Buffalo
- **Rev. Merle Showers**, United Methodist Minister (retired); Chair, Living Wage Commission of Buffalo
- **Howard R. Stanger**, Ph.D., Professor of Management, Wehle School of Business, Canisius College, Buffalo, NY

The Workers Rights’ Board repeatedly invited executives of Catholic Health to hear directly from employees at the July 6 hearing. The invited CH participants declined our invitation.

NOTE: Catholic Health was formed in 1998 when several hospitals, nursing homes and clinics, operated by a number of religious orders, came together under one organization, the Catholic Health System, known today as Catholic Health (CH). The entities that jointly own CH are the Diocese of Buffalo and the Catholic non-profit corporations, Ascension Health and Trinity Health.

CH comprises five hospitals: Kenmore Mercy Hospital; Mercy Hospital of Buffalo; Sisters of Charity Hospital; Sisters of Charity Hospital, St. Joseph Campus; and Mount St. Mary’s Hospital, Lewiston.

In addition to the hospitals, CH includes a number of free-standing clinics and several nursing homes: Father Baker Manor; St. Catherine Laboure; McCauley Residence; Mercy Nursing Facility at Our Lady of Victory; St. Francis, Williamsville; St. Elizabeth’s, Lancaster; and St. Vincent’s, Dunkirk.

The Crisis of Short-Staffing

“Studies have shown that lower staffing levels lead to many pitfalls for the hospital patient population, including increase of hospital acquired infection rates, missed care, medication errors, complications leading to longer lengths of stay, added costs and increased post-surgical and post-procedural mortality rates. Hospitals with safe staffing have been shown to have better scores, less turnover (less burnout, greater career satisfaction, decreased worker injuries), improved patient outcomes and reduced 30 days readmission rates, resulting in higher reimbursement and lower overall costs.”

– Lina H. Aiken, “Hospital Nurse Staffing and Patient Mortality,” JAMA, October 23/30, 2002

The crisis testified to in this WRB report proves the veracity of the studies noted above. More importantly, CH employees offer direct testimony, not about hypothetical situations, but about real patients in real hospital beds who are impacted by a continuing policy of short-staffing.

Kathy Kelly, RN, a 32-year CH employee, testified to the way “short-staffing stresses our staff and short-changes our patients.” She added, “Catholic Health has squandered millions of dollars bringing in nurses from private, for-profit staffing agencies.” Costs for agency nurses are considerable, as they comprise salaries, fees to agencies, travel and housing expenses. In data provided by CH itself, 2015 payments for agency nurses are listed at \$1,979,826.23.

Ms. Kelly further pointed out that, contrary to CH claims that everyone in the hospital is happy with the current situation, CH’s own 2015 figures document extraordinarily high staff turnover. “Catholic Health reports an 11.14 percent turnover rate for Registered Nurses in their documents provided on June 1, 2016. Kaleida Health, on the other hand, reports a 2015 turnover rate of only 2.32 percent,” Ms. Kelly testified.



The consequences of short-staffing include:

- **negative impact on patients;**
- **burnout, stress, physical and emotional harm to employees;**
- **need to rely on agency nurses, with corresponding increased costs;**
- **high turnover rates among staff, with resulting challenges.**

At the same time, members of management are doing very well, as evidenced by their increases in pay and bonuses for the last three years. Specifically, CEO Joe McDonald saw an increase of \$1,238,458; COO Mark Sullivan realized an increase of \$620,206; and VP for Human Resources Mike Moley received an increase of \$460,250.

Perhaps even more compelling than testimony offered by CH employees is the following letter sent to CEO Joe McDonald, in which a parent airs her concerns about what she witnessed while her critically ill daughter was cared for at South Buffalo Mercy Hospital. This parent’s direct observations tragically support the testimony offered by CH employees. Understandably, her letter was introduced anonymously at the WRB Hearing.

2015 RN TURNOVER RATES
Catholic Health: 11.14 percent
Kaleida Health: 2.32 percent

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Dear Mr. McDonald
President & CEO of Catholic Health Systems

June 23rd 2016

My husband and I would like to express our strong opinion concerning the care at South Buffalo Mercy Hospital.

Our daughter [REDACTED] was admitted on 6/6/16 with pneumonia and has been in ICU since. The nurses and entire staff we have encountered during this time have been wonderful. They never stop with life saving care. They are constantly on the move to meet the ever changing needs of these patients. Our concern is that staffing levels in these units seems so thin that it has to be difficult, at best, to keep up a safe quality of patient care. The in the past two and a half weeks [REDACTED] has been intubated three separate times, had a very high fever, needs to be constantly turned and suctioned as well as constant new med orders given and tests to be done. Alarms are constantly going off for [REDACTED] and the other patients.

The physical and mental stresses they deal with on a daily basis has to take its toll when they appear to be spread so thin. If you or your staff have not spent time there, just observing what they do on a daily basis, it would probably be beneficial to do so.

We have been on many different floors with [REDACTED] over the years and found that all staff members from the janitors, security, office workers, nurses etc. have been very professional and always had the patients and there visitors best interests in mind.

As you go through the contract negotiating process we would only hope that you and your negotiators would completely understand the importance of each and every one of your employees to the community they serve and many times the thankless job they do to preserve life in a caring and compassionate manner.

If you would like to contact us, feel free to call us at the numbers listed below.

[REDACTED]

Sincerely

[REDACTED]

The parents of a critically ill patient

Testimony on the Effects of Short-Staffing on Patient Care



The testimony offered by CH employees alleged a corporate policy of maximizing profits via deliberate short-staffing. Alarmingly, the effects often fall on patients in CH facilities.

Carrie Dilbert, RN, a Mercy Hospital employee of nine years, explained a typical night shift, staffed with two night nurse's aides, each of whom has respon-

sibility for 23 patients. When one aide is on break, the other must cover all 46 patients. She noted that for years she and her co-workers have raised concerns over caregivers being spread too thin and the problems this causes to her bosses. She added:

"Many patients are incontinent and when we are short-staffed, they are lying in their own urine and feces. This is wrong. Many of them come from nursing homes; many of them are congestive heart failure patients."

"Many patients are incontinent and when we are short-staffed, they are lying in their own urine and feces. This is wrong. Many of them come from nursing homes; many of them are congestive heart failure patients."

Ms. Dilbert added that often she receives backlash from her patients' families because:

"their family members are not getting turned

frequently enough to prevent bed sores. They are not getting lotion for their feet, or back rubs. We are not able to keep them dry and clean."

Katie Hummel, RN, a five year employee in Mercy Hospital's Emergency Room (ER), testified to the results of what she called "dangerously low staffing," especially as the hospital is now receiving more critically ill



patients, including those suffering opioid-induced crises. With five nurses responsible for 44 rooms, each is responsible for some eight patients, who are:

- suffering from heart attacks, strokes, miscarriages;
- needing IV lines, blood and urine work, medications, special tubes;
- needing their vital signs assessed every two hours;
- if opioid patients, requiring intense monitoring as they are found overdosed in bathrooms, stealing hospital needles, even shooting their pain medication directly into their IV lines.

Ms. Hummel testified to her typical night:

"I have critical patients dying; a septic patient on medication to increase blood pressure; a patient with a ruptured abdominal aortic aneurysm who was hemorrhaging into the abdomen and I needed to start a blood transfusion."

*"I received a patient with no pulse, and while I was performing compression on this patient, blood was infusing on my abdominal aortic aneurysm. I could not stop compressions on this patient to check to see if my abdominal aortic aneurysm was having a reaction to the blood or if that patient was stable. **There were no other nurses who could check my patient.**"*

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“When I regained a pulse on my patient, it meant he/she was now a hypothermia candidate. Hypothermia treatment is when we cool a patient to hopefully protect brain function. This patient, per protocol, is supposed to be one-on-one, meaning the nurse is supposed to take care of this one patient only. How could I?”

“I am convinced that if the nurse had had more time to care for her, the patient might have survived.”

After sharing these medical challenges and the stress they cause nurses, Ms. Hummell concluded her testimony by stating that the ER is not considered a critical care unit, meaning there is no maximum limit on how many patients a nurse can be assigned. She added:

“It also means the ER nurses have no training in critical care. On a daily basis, there are no beds in the critical care units and the patients must stay in the ER. How can I hold a patient that is supposed to go to a critical care unit when I don’t have training? When I have more patients than a critical care nurse is allowed to have? I feel bad for the patients in the ER.”

The testimony of two Registered Nurses was offered anonymously as in both cases, the nurses feared reprisals.

An RN in the Operating Room (OR) of St. Joseph’s Hospital testified that nurses have been submitting short-staffing forms because they are frequently assigned add-on cases on top of their scheduled ten cases.

“The result is that we are constantly moving, running from case to case, with no relief. Someone has to be in an OR at all times; we can’t just stop, we can’t leave.”

Significantly, this RN testified that in her specialty unit, the Operating Room, eight months are required to orient new staff to the unit’s unique and complex demands. She concluded:

“Rather than fix the problem, the hospital is filling positions with agency nurses who are given only two days of on-the-job training.”

The second anonymous testimony was submitted by a Registered Nurse who came to CH immediately upon graduation from Nursing School. She stated that because of high staff turnover, she was assigned to be the charge nurse on her floor after only four months of experience.

She notified several managers that she was uncomfortable in this role, and requested more experienced staff. Her request was denied. She sadly concluded:

“We worked very hard to care for our patients but we were all new on the job, and we regularly were three nurses short. Everyone took two patients more than the grid calls for, which forced us to cut corners.

“That night a patient coded and died. The assigned nurse did an outstanding job and was in the patient’s room for several hours but also needed to care for her six or seven additional patients.

Sarah Donovan, RN, a Registered Nurse in the CCU at Mercy Hospital, testified that her patients are the “sickest of the sick.” She stated that while prescribed staffing calls for six RN’s to be assigned two patients each, the reality on most days is they are staffed with only four RN’s assigned up to three patients each. Sarah described the heavy mental toll on nurses of not being able to give patients the excellent care they deserve.



Sarah offered the example of a patient on a balloon pump. Formerly, these patients were cared for at a nurse-to-patient ratio of one-to-one. That was later changed to one RN for every two patients; now each nurse is caring for three patients, who:

- have recently had heart attacks and have been brought to Mercy to make sure they survive and recover;
- are in cardiogenic shock and need constant monitoring, at least every 15 minutes;
- are on complete bed rest, needing help with literally everything. Sometimes they are confused and if they try to get out of bed, they could die. I must have my eyes on them constantly;
- have numerous life-saving IVs and ventilators for breathing.

Ms. Donovan concluded her testimony by indicating that the patient she had described is only one of her three. The other two require just as much care. As did

all others who testified, Sarah expressed her profound sadness at being unable to provide the level of care to her patients that she was trained to provide.

“It is not right to let someone’s needs not be met due to poor staffing. Staffing levels are at a critically dangerous point and need to be addressed. Patients’ lives depend on it every day and every shift.”

Linda Bain, RN, works as an acute care nurse on a unit with 40 cardio-thoracic beds at Mercy Hospital. She explained that four patients would be a heavy assignment, but on one particular day, she was assigned five patients, all with a high level of acuity and who require constant monitoring and care. Ms. Bain briefly testified to the nature of her cases as follows:

Patient 1, a large patient unable to move without assistance, had Congestive Heart Failure and was hooked to several medication drips.

Patient 2, a post Open Heart patient, with pacer wires and a chest tube, had many mandatory protocols.

Patient 3, a post thoracotomy patient, with a chest tube and in severe pain. The patient was connected to a PCA pump, which is used to alleviate pain and must be closely monitored.

Patient 4, with a thrombosis of the left ventricle. The patient is at a very high risk for having a stroke and must be monitored very closely. The patient needed frequent neurological checks and had several lines. This patient did have a stroke the next day.

Patient 5, awaiting Open Heart Surgery, had to be taken for several tests off the floor; the nurse is responsible to get the patient there and back.



Ms. Bain testified that she explained her concerns about caring for five such acutely ill patients. She was told:

“There are no other staff.”

Her essentially impossible assignment took its toll that day:

“I began to feel ill. The stress of the situation and the care that I needed and wanted to provide to

my patients was insurmountable. I physically got sick. I vomited and was taken to the ER. My blood pressure was 186/106.”

Testimony was next offered by **Julie Ortel, RN**, who, as both employee and patient, recently experienced what can happen when the ER is short-staffed. In painful detail, she outlined her travails, beginning at:

7:30 p.m. first experienced neck pain.

8:06 p.m. called 911.

8:16 p.m. arrived at Mercy Hospital and had both a CT Scan and an MRI.

3:00 a.m. received test results, indicating need for a neurovascular consult

3:18 a.m. called ICU and spoke directly with the Neuro Nurse Practitioner.

4:30 a.m. was told I had had a stroke.

7:00 a.m. had a cardio catheterization.

“I was told at 4:30 a.m., I had had a stroke, eight hours after first arriving at the Mercy ER. Dr. Omar informed me that I should have received the stroke protocol, tissue plasminogen activator (TPA) that night in the ER, and I should have been code stroked immediately when I arrived. I remember hearing from the staff that they were short nurses that night. I remember multiple codes happening that night. I believe I was forgotten or pushed aside because there wasn’t adequate staff to care for everyone. I believe my own co-workers missed symptoms that they would otherwise have picked up if they had not been so short-staffed.

*“As a patient, I experienced first-hand the medical consequences of poor care, i.e. more severe symptoms of pain and suffering. I had to learn to walk again, to eat, and above all I couldn’t see properly for months. I was out of work for five months. I am lucky I did not die that night or suffer irreparable damage as a result of my stroke. **I often wonder how many patients die or are maimed due to lack of staffing.**”*



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Testimony on the Effects of Short-Staffing on Employees

WRB hearing officers received numerous testaments to the negative and often permanent effects on the health of CH employees as a result of chronic short-staffing. Equally compelling was the employees' absolute commitment to their patients' well-being, even when they jeopardized their own physical and/or mental health.

Kevona Neely, CNA, has worked for some seven years at Our Lady of Victory Skilled Nursing Facility. Kevona began her testimony by sharing a typical work day. After her 12 hour shift, her shift was extended by four hours. She added that on another day, her floor had been staffed with only one LPN and one CNA for a period of two hours. The two staff members cared for 21 residents, nine of whom were bedridden. She testified that, "my co-workers and I are tired and burned out," and added, "it is not possible to give good quality care with such staffing."

Ms. Neely concluded her testimony by sharing her personal tragedy, literally of life and death:

"When I went to work, I was bleeding very heavily. I went to my supervisor's office and described my symptoms (i.e. unusually heavy bleeding, severe cramping, my pants soaked

through with blood). My first shift supervisor asked me:

"See if you can make it through your shift."

"I worked for as long as I could, but halfway into my shift I returned to the bathroom and passed a big clot. I was crying, called the supervisor and she told me I may have miscarried. She told me to leave and go to the hospital, where it was confirmed I had had a miscarriage.

"I called my job, told them what had happened. I was scheduled to work the next day; no one told me not to come in, so I came for my usual 12-hour shift.

"I did not want to receive a call-off, nor did I want to leave my co-workers short and our residents not properly cared for."

Wendy Byer, RN, an employee for 34 years at Mercy Hospital, testified to her disappointment in witnessing significant and continuing failings in their stroke program:

"I am in fear that we will lose our accreditation that we worked so hard to get. We have lost great doctors and nurses because our complaints are not taken seriously. We are short-staffed almost every day. We should have two nurse's aides every day; many times we have one or none. There are days when we don't even have a secretary, so we have to answer the phone, call out consults, answer the doorbell, etc. Many of the patients in the NEURO ICU have hourly readings (EVD, ICP, URINE, Blood sugars), they need to be suctioned and receive tracheostomy care.

"They need to be turned and positioned every two hours to prevent skin breakdown. This does not always happen, because we are short-staffed. We are told by management that we have the worst skin, the only VAP (ventilator acquired pneumonia) and catheter associated UTI in the hospital. They tell us not to take it personal, but this infuriates me.

"I am in fear that we will lose our accreditation"





"It is all because we are short-staffed; we are not able to care for the patients as they deserve to be cared for."

Ms. Byers concluded her testimony by sharing the personal toll this policy of short-staffing is taking on her own health:

*"We are hurting ourselves because we are positioning our patients ourselves due to short-staffing. I am personally affected by this. I was just told by the neurosurgeon **I need major back surgery that will require about one year recovery time.** I am sick about this. I am 53 years old and still have many years to work."*

Debra Hayes, RN, Area Director, CWA, AFL-CIO, testified to the origins of CH policy regarding short-staffing. She explained that in earlier contract negotiations, CH had admitted to critical underfunding of their employees' pension plan, a policy they could legally pursue because as a "Church Plan," they were exempt from the regulatory oversight governing most U.S. employee pension funds. CH's only response was what Ms. Hayes called a "Hobson's Choice":

"Either agree to drastic cuts in employee wages and benefits or they would continue to underfund the pension plan."

Specifically, Ms. Hayes testified that CH demanded the elimination of longevity step raises, and an end to daily overtime and supplemental pay. The union argued that such drastic cuts would (1) negatively impact staff retention; (2) discourage employees from working an

additional four overtime hours to cover absences and (3) discourage employees from responding to a need to return to hospital on days off.

"We insisted the elimination of the wage scale, daily overtime and supplemental pay would likely result in younger employees leaving to work for the more generous 'competition' and would discourage the remaining overworked employees from working over and beyond their shifts."

Ms. Hayes testified that CH Management dismissed the union's concerns, pledging they "would do whatever it would take to bring staffing up to safe levels, if our members voted to accept these cuts in order to bring pension funding up."

"Sadly, we were right and management was wrong. We do know these cuts in benefits have led to an exodus in younger staff to other area medical facilities as well as injuries and burnout among the senior staff that remain. CH facilities are getting dirtier, many patients are receiving inadequate care, and CH is jeopardizing its once-fine reputation."



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Testimony on the Effects of Short-Staffing on Health and Safety

The WRB hearing concluded with testimony outlining the negative effects that CH's short-staffing policy has on the health and safety of patients, employees and hospital visitors.



Ray Brun, Environmental Services Lead at Mercy Hospital for some 30 years, testified to the degradation in service he has witnessed during that time. He explained that at the beginning of his employment, Mercy Hospital employed 125 service workers and five supervisors. At present, the number is 65 - 70 service workers with two supervisors on day shift, only one supervisor on second shift and no supervisor at all on the overnight shift. In short, Mercy Hospital has cut the number of service workers in half while actually enlarging the footprint of the hospital itself. Ray summed this situation up plainly: "Service workers can't keep up with our workload either. And the bosses don't seem to care."

Regarding the ER, Mr. Brun testified that service staff has gone from three or four workers to just two at the most, who are wholly responsible for cleanliness, sanitation,

and waste disposal. Ray invited Katie Hummel, who had previously testified about ER staffing issues, to share her own experiences in this regard. Katie described in detail how the RNs are forced to use small wipes to clean ER toilets and of her regretfully having to place a patient in a room while the previous patient's blood remained on the floor of that room. No service staff were available to clean and the patient desperately needed the bed.

Mr. Brun concluded his testimony by relating how he continues to try to responsibly clean beds on surgical floors. He recounted the response he had received from his supervisor when he complained that new hires were shown shortcuts rather than the thorough cleaning protocols he had learned. "I told the supervisor that you are not teaching them to lift up the mattress to inspect and clean under them. **There may be blood on the side rails and under the mattress.**" The supervisor told him:

"That's old school. New school is hurry up, get it done, and get out."

Donata Aldrich, Pharmacy Technician at Mercy Hospital, testified to the **approximately 20-year timeframe during which raw sewage has been leaking up through a floor drain into the pharmacy**; the unbearable smell permeated not only the pharmacy itself, but also other departments.

Hospital administrators have indicated that they have developed plans to correct the problem and efforts have been initiated, including correcting the sewer backup itself. Ms. Aldrich testified that, "damaged floor tiles remain, lifted off the floor, allowing for the possibility that sewage material remains under the tiles."





Karen Zicarrelli, Respiratory Therapist at Mercy Hospital, testified that she “administers breathing treatments to patients and is required to remain with the patient throughout the treatment and note his/her response to it. This is critical: If the ventilator is not checked and malfunctions, these patients in all likelihood will not survive. I am

responsible for the ICU with 24 beds.”

Ms. Zicarrelli further explained that she “is being asked to do more with less. Respiratory Therapy used to have an equipment person in the department, but the hospital administration eliminated that position. That person used to check all the respiratory equipment to ensure it was available when we needed it. They cleaned it, ordered replacement parts, stocked equipment and checked and changed the oxygen tank. Now, everything that person did full time, has been placed on the respiratory therapists. And we cannot keep up.”

“We all really like our work and the patients we care for, but the conditions that we currently work under and the lack of staff make this job unappealing but, more importantly, unsafe.”

Kimberly Orzchowski, a Patient Access Specialist of seven years in the Business Office at the Mercy Ambulatory Care Center (MACC), testified how, on at least five occasions, staff were told renovations were forthcoming; each time they had to be postponed due to expenses. She added that, “doctors, patients and staff constantly complain about the disgusting filthy car-



pet, the ceiling tiles damaged and falling down on us, the main registration area not even handicapped accessible for wheelchairs.”

Deborah Drews, Surgical Technologist for some 15 years at Kenmore Mercy Hospital, testified that she had sustained two job injuries resulting from lifting both patients and surgical instruments, necessitating two surgeries as the result of the injuries.

Ms. Drews explained that her injuries resulted from “pushing, pulling and lifting patient trays and equipment. Several other employees have gotten hurt for the same exact reasons and continue to do so to this day.” She concluded that **their request for weight limits for surgical trays to 25 pounds has been refused** as has their request for yearly ergonomic training, even though such training is available with no charge from the WNY Council on Occupational Safety and Health.

“... the conditions that we currently work under and the lack of staff make this job unappealing but, more importantly, unsafe.”

NOTE: WRB hearing officers asked testifying employees whether the the Erie County Health Department inspects CH facilities as mandated. Several employees replied that:

1. CH Management is made aware of inspections in advance and prepares for them.
2. Supervisors select the employee(s) who will speak with the inspectors.
3. Employees always know when inspectors are coming because additional staff (e.g. Social Workers) are assigned to the area to be inspected, and management ensures that sufficient supplies are on hand.

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There Is a Better, and Proven, Way Forward

Throughout the hearing, employees testified to the impact that CH's short-staffing policy continues to have on both patients and employees. Importantly, testimony was also presented which outlined a completely different approach, in which a hospital system consciously chose to address short-staffing issues, thereby improving patient outcomes and employee morale.

LOCAL EXAMPLE

Cori Gambini, RN and President of CWA Local 1168, represents nurses and other healthcare workers at Catholic Health and Kaleida Health, both in Western New York.

Ms. Gambini recounted her December 2015, discussion with Kaleida Health CEO Jody Lomeo wherein she shared the frustrations of Kaleida employees regard-

ing staffing issues. "Within days, an action plan was initiated including meetings between union leadership and site presidents. Bonuses and overtime were offered and when those efforts were exhausted, Kaleida hired agency personnel until more staff could be hired."

Throughout the spring and summer of 2016, substantive discussions continued, in which both sides expressed commitment to putting more staff at the bedside. These discussions resulted in a precedent-setting collective bargaining agreement which included the following improvements:

"Kaleida Health agreed to put 134 full-time equivalents (FTE's) on the payroll, specifically 95 RN's and 39 ancillary support staff, all of whom are direct caregivers.

"These positions are above and beyond any new positions



needed to address increased volume, expanded or new services that Kaleida creates, or what will be needed to replace those who leave through voluntary resignation, involuntary terminations and retirement.

“Equally important, the new agreement calls for the union leadership and staff to be part of the decision making process determining in which departments and units the new staff will be placed. Under this procedure, the union and Kaleida management will be working hand-in-hand to address staffing and patient care.”

NATIONAL EXAMPLES

There is a long history of formal and informal labor-management cooperation programs in the United States and in Western New York, in industries such as automobiles, steel, coal-mining, railroads, printing, airlines, healthcare, and more. While some have failed for various reasons, others were successful and long-lasting. (For those in WNY, see <http://digitalcommons.ilr.cornell.edu/reports/11/>).

The recent Kaleida contract offers a good example of how management and labor can come together to ad-

dress important workplace concerns that affect patients, employees and the community. An older, much larger and highly successful model can be found in the Labor-Management Partnership (LMP) that exists between Kaiser Permanente (KP) and a coalition of 28 unions in some 40 facilities across the country.

Founded in 1997 as a partial solution to addressing KP's financial and labor relations problems, the LMP has received overwhelming support from KP's executives and the vast majority of its unions and employees. In doing so, it has contributed to improved outcomes in patient care, labor relations, employee satisfaction and financial strength.

At the core of the LMP are local unit teams and union leaders who work together to ensure that the LMP meets its goals and supports KP's mission and objectives. It is an impressive arrangement that can serve as a model for Catholic Health and its unions.

(For more detail on the LMP, see <http://www.Impartnership.org/what-partnership>).

Conclusion and Recommendations

“A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person’s race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the right of employees to organize and bargain collectively without prejudice to the common good.”

– Directive #7, The Social Responsibility of Catholic Health Care Services, US Catholic Conference of Bishops, Nov. 17, 2009

At both the WRB hearing of June 2, 2015, and the second hearing on July 6, 2016, WRB hearing officers noted the lack of meaningful collaboration between CH Management and staff. While the first hearing had focused on testimony relating to the effects of cost-cutting, management abuse and negative labor policies, this second hearing report focuses on the extensive and negative impact of short-staffing on both patients and employees.

WRB hearing officers were deeply moved by nurses’ testimony, in which they shared heartbreaking stories of their inability to offer the care they knew was needed and that they wanted to deliver, for example:

“We are put in that situation, where we are denied the ability to do what is needed and then expected to return the next day and do it all over again.”

“CH management has no idea what it is like to have to drive home after that, wracked with guilt and grief.”

The WRB also was dismayed at the disturbing testimony about the effects of staff cutbacks on Environmental Services, and the serious unsanitary conditions that threaten both patients and staff.

We have learned that, fortunately, health care does not need to be this way, as evidenced by the Kaleida Health system practice and the Labor-Management Partnership of the larger Kaiser Permanente System. As Ms. Gambini testified, “We have proven that safe staffing can be achieved if management has the will and shares our concern for the healthcare workers and the patients we serve.”

In closing, we wish to reiterate our belief, expressed in our report dated October 1, 2015: It is inappropriate for a religious non-profit healthcare system that espouses core values of Reverence, Compassion, Justice and Excellence to base its executive bonus system on meeting net income targets. That choice may have been the folly leading to a multitude of sins. *(See graph on the back cover of this report.)*

Recommendations

The Workers' Rights Board recommends:

- that Catholic Health replace its old Executive Bonus criteria, based on meeting net income targets, with a public and transparent system centered on:
 - good patient outcomes;
 - clean and sanitary facilities;
 - staff retention;
- that Catholic Health commit the resources necessary to solve the crisis of short staffing in its facilities;
- that, once an acceptable level of safe staffing is achieved, CH management should work with its unions toward the reinvention of collaborative labor relations.

As people of faith we believe it is not too late to get started on this mission.



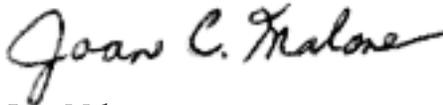
Sister Judith Justinger, SSJ

Leadership Team, Sisters of St. Joseph, Buffalo, NY



Rev. Kirk Laubenstein

Executive Director, Coalition for Economic Justice



Joan Malone

Ex. Director, Coalition for Economic Justice (retired)
Secretary, Living Wage Commission, City of Buffalo



Rev. Merle Showers

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Chair, Living Wage Commission, City of Buffalo



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Income Inequality Thrives At Catholic Health

We know the national trend. The rich are getting richer. The rest of us struggle.

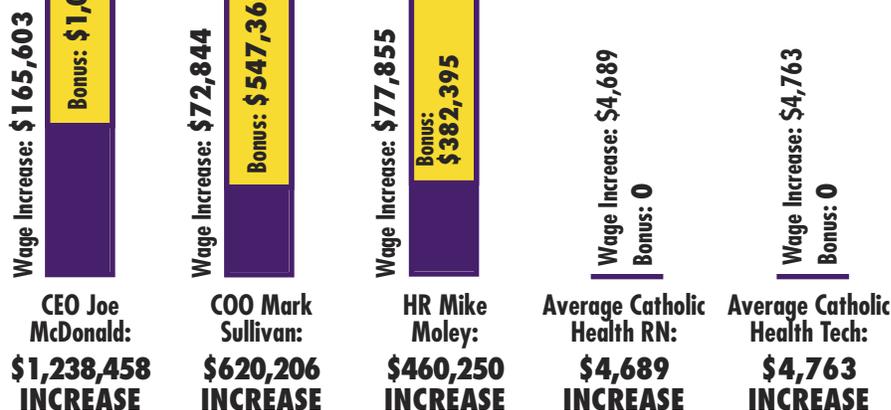
Now we see the same thing happening in Buffalo, within our beloved Catholic Health, an institution founded on the values of Reverence, Compassion, Justice and Excellence.

While the front-line employees were forced to take cuts in pay and benefits, the top brass at Catholic Health reaped huge raises and bonuses.

Data from CH IRS 990 Tax Forms

Three Years of Exploding Inequality

How Three Years of Increases in Catholic Health Executive Compensation Compare With Increases for CH Hourly Workers*



*Management also took away step increases, daily overtime and shift bonuses from hourly workers, which has depressed take home pay and led to preventable staff shortages. Wage and bonus figures from Catholic Health 990 tax filings.

CWA, SEIU, UFCW, IUOE: Making Good Healthcare Better

For more information please go to www.ReformCatholicHealth.org

This flyer was produced and distributed by the unions at Catholic Health using publicly available data.



The Western New York Workers' Rights Board

Sponsored by

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