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HOUSE OF REPRESENTATIVES
COMMONWEALTH *of* PENNSYLVANIA

House Democratic Policy Committee Hearing

ACCESS TO CARE
Wednesday, Feb. 11 | 10 a.m.

Reps. Kosierowski, Mullins, Donahue

10 a.m. Welcome and member introductions.

PANEL ONE
10:10 a.m. Dr. Patrick Conaboy, MD, Chief Medical Officer
Commonwealth Health Regional Hospital & Moses Taylor Hospital
Q & A with Legislators

PANEL TWO
10:35 a.m. Maria Montoro-Edwards, Phd, President & CEO
Maternal and Family Health Services

Jill Avery-Stoss, MBA, President & CEO
The Institute
Q & A with Legislators

PANEL THREE
11 a.m. Jennifer Huber, RN
Geisinger Community Medical Center, PASNAP

Sue Wiggins, Medical Laboratory Technologist
Service Employees International Union
Q & A with Legislators

MFHS

Northeastern Pennsylvania Legislative Delegation

Dr. Maria Montoro Edwards, President and CEO, Maternal and Family Health Services

Good morning and thank you for the opportunity to speak with you today. I want to begin by expressing my sincere appreciation for your continued commitment to improving maternal and child health outcomes across Pennsylvania. Your leadership directly impacts the health of families and the strength of communities throughout Northeastern Pennsylvania. Maternal and child health indicators are among the most reliable measures of community wellbeing, and your support helps ensure those indicators continue to move in the right direction.

I am Dr. Maria Montoro Edwards, President and CEO of Maternal and Family Health Services. MFHS has been a trusted provider of care since 1971. Today, we serve more than 100,000 individuals annually across 17 counties through 28 locations and two mobile units, delivering maternal and child health services, nutrition and breastfeeding support, reproductive health care, and the Nurse-Family Partnership home visiting program.

MFHS is proud to be the largest WIC provider in Pennsylvania, serving approximately 27 percent of all WIC participants statewide—about 50,000 mothers and young children each month. WIC remains one of our nation's most effective and cost-efficient public health programs, offering nutrition education, breastfeeding support, access to healthy foods, and referrals to health and social services. Every day, we see how WIC strengthens families and gives children a healthy start.

A major innovation in our region is MFHS's Circle of Care maternity medical home in Lackawanna County—the first of its kind in Pennsylvania. Since opening, Circle of Care has provided tens of thousands of visits and supported more than 1,000 maternity clients through integrated prenatal care, ultrasounds, oral health services, breastfeeding support, postpartum anxiety and depression care, maternity clothing, care navigation, nurse home visiting, and WIC—all in one location. In 2025 alone, MFHS served 322 new maternity patients and supported 257 deliveries. While 97 percent of these patients had at least one high-risk factor, preterm birth and low-birth-weight rates were lower than county and state averages.

MFHS is also advancing maternal mental health through a Pennsylvania Department of Health-funded initiative that integrates mental and behavioral health screenings, referrals, and treatment into rural WIC locations. This initiative was launched directly in response to client feedback. Surveys of WIC mothers showed that 81 percent wanted in-person counseling, 62 percent experienced times when counseling was unavailable, and 78 percent said they would use telehealth for prenatal or postpartum counseling. These findings underscore the importance of accessible, flexible care models that meet families where they are.

Beyond direct services, MFHS provides regional leadership as the convener of the Northeast Regional Maternal Health Coalition. In partnership with The Institute, the coalition includes more

than 100 active participants across 14 counties, including health care providers, community-based organizations, payors, academic partners, and individuals with lived experience. Together, we are developing a comprehensive regional maternal health plan grounded in local data, community priorities, and the recommendations of the Pennsylvania Maternal Mortality Review Committee. This work ensures that maternal health strategies are evidence-informed, community-driven, and responsive to the unique needs of Northeastern Pennsylvania.

MFHS programs consistently demonstrate positive outcomes for families facing economic hardship, food insecurity, housing instability, transportation barriers, and other drivers of health disparities. Our Nurse-Family Partnership home visiting program, which pairs registered nurses with first-time mothers from pregnancy through a child's second birthday, shows particularly strong results: 95 percent of babies are born full term and over 5.5 pounds, breastfeeding initiation rates reach 84 percent, and 92 percent of children are fully immunized by age two.

At the same time, the families we serve are facing increasing challenges. Affordable housing remains out of reach for many, food and utility costs continue to rise, and some families report reductions or loss of SNAP benefits. Transportation barriers persist, and many families rely on food banks and assistance with basic necessities such as diapers and car seats. These pressures make strong, accessible maternal and child health infrastructure more important than ever.

I want to thank you for Pennsylvania's continued investments in maternal and child health, including Medicaid eligibility for 12 months postpartum, support for home visiting and behavioral health, WIC modernization, and community-based prevention efforts. These policies make a measurable difference for families across our region.

I also respectfully ask for your support in preserving and strengthening Pennsylvania's reproductive health care safety net. MFHS is one of four Pennsylvania recipients of the federal Title X Family Planning Program, which has provided essential reproductive health services since 1970. Title X supports cancer screenings, contraceptive care, STI testing and treatment, pregnancy support, health education, and referrals for low-income, uninsured, and underinsured individuals. More than 130,000 Pennsylvanians receive care at Title X-funded centers each year. Federal funding for this program is uncertain, and we are working with the Shapiro administration and legislative partners to identify policy solutions and pursue sustainable state funding to protect access to care.

Thank you again for the opportunity to speak with you today and for your partnership. The work of strengthening maternal and child health is urgent and profoundly impactful. MFHS is proud to be your partner in this effort, and I look forward to continuing our collaboration. I am happy to answer any questions.

Healthcare Access in Pennsylvania and Northeastern Pennsylvania – Jill Avery-Stoss

We know that our region benefits from strong provider networks and medical education programs, yet gaps persist — particularly in rural areas and in primary care, behavioral health, maternal health, and affordable services for uninsured and underinsured residents. These gaps influence how easily people can get the care they need and how effectively the system operates.

Closure of hospitals and other facilities is among the more significant challenges facing communities. Community and rural hospitals in particular operate with very limited financial margins. They provide care to everyone who comes through their doors, regardless of insurance status. When fewer people have health coverage, hospitals deliver more care that is never reimbursed. Over time, that creates financial strain that is difficult for any institution to absorb.

When a facility closes, the effects are immediate. Residents need to travel farther for routine services such as prenatal care, cancer treatment, dialysis, and primary care visits. Emergency care is also farther away, which adds logistical challenges for patients and providers.

This is why maintaining access to health insurance is important. Insurance coverage is not only about individual affordability; it is also a key part of how hospitals and clinics remain financially stable. When more people are insured, providers are reimbursed for a larger share of the care they deliver. When coverage declines, the financial pressure on hospitals increases.

Healthcare access also has broader economic implications. When people can obtain primary care, preventive services, and mental health support, they tend to remain healthier, miss fewer days of work, and stay employed more consistently. When access is limited, chronic conditions go unmanaged, mental health needs escalate, and preventable issues become more serious. Employers then face higher absenteeism, lower productivity, and rising healthcare costs.

Delayed care also leads to higher costs. Without timely access to a doctor, many individuals end up in emergency departments, where treatment is significantly more expensive. Preventive care is more cost-effective, and the financial benefits accumulate over time.

Beyond all that, healthcare is also a major economic sector in Northeastern Pennsylvania. In 2025, the region's healthcare sector generated a Gross Regional Product of $5.4 billion, including $4.6 billion in earnings and more than $120 million in tax revenue (the remainder being real estate income). Hospitals, clinics, and long-term care facilities are among the largest employers in many Pennsylvania communities, particularly in rural areas. For regions the size of Lackawanna and surrounding counties, the national average would be about 52,000 healthcare employees. Here, we have more than 62,000. The demand for care already exceeds the supply of people to provide it; the loss of facilities means the loss of jobs, providers, and economic impact.

The bottom line is that healthy populations support stronger economies. People who can access reliable healthcare are better able to learn, work, and contribute to their communities. When access breaks down, the economic effects show up in lost productivity, higher public spending, and reduced competitiveness. Ensuring stable healthcare access – including insurance coverage, strong hospital systems, and a sustainable workforce – is essential for community resilience.[1]

[1] All economic and workforce data sourced from Lightcast

Sue Wiggins Testimony for State Policy Hearing on Regional

February 11th, 2026

Testimony

Good morning and thank you to our state representatives for providing me with the opportunity to speak today. My name's Sue Wiggins. I've been a Medical Laboratory Technologist for over 40 years and work at Regional Hospital. I'm also a proud member leader of our union, SEIU Healthcare PA. Our union represents 800 members, almost all the healthcare workers at Regional, which includes the Moses Taylor Campus. We have helped lead the tireless advocacy efforts over the past year, alongside our elected officials and community members, to save our hospital.

We are hopeful and relieved to finally have a new chapter for our hospital and a resolution to keep our hospital open. Tenor has respected our union by agreeing to our request to maintain our contract and they have positively expressed a willingness to work together. Having a strong union voice empowers us to advocate for safe, quality patient care and good jobs that recruit and retain staff.

We are committed to partnering as a union with Tenor to ensure the success of our hospital. Regional and Moses Taylor Hospital are absolutely critical for the health and economy of our entire area. The population of NEPA is older, sicker, and needs more complex care than ever before. Regional has over 381,000 patient visits a year, including 36,000 ER visits. We also deliver over 1,700 babies a year, 70% of the births in Lackawanna county, and have the only Level III intensive care unit for newborns in the area.

Our hospital needs a lot of improvements that can be achieved in part through new management leadership who is willing to work with and listen to those of us on the front lines. Based on recent town halls and conversations our union leadership has had with Tenor's CEO, it seems like we have the opportunity to build that collaborative approach. We are setting up a meeting between our union and Tenor leadership soon to start talking about how we work together to address immediate challenges.

And we have a lot of work to do after years of under-investment by CHS. We need to invest in the physical plant. Our hospitals are old and crumbling. We need new equipment and supplies. It is imperative that we have an immediate infusion of investment in these areas.

We also will need to rebuild a stable workforce. We've held on this far out of dedication to our patients and community. We are starting from a strong foundation with our current union contract and we're proud of what we have achieved despite the challenging environment with CHS. But we need to build on this foundation and sustain our new optimism by providing competitive compensation and benefits that will recruit and retain staff.

As you know, there is a healthcare workforce shortage crisis throughout nursing, techs and almost every job title, which was aggravated by the pandemic and is only getting worse. Healthcare work is very tough physically, mentally and emotionally. In order to attract qualified staff, it takes incentives like good benefits, longevity pay and keeping up with whatever hospital is offering the latest sign-on bonus.

The cost of living has increased by 25% over the past five years. Groceries, housing, childcare and utilities have all gone through the roof and our wages have not kept up, so Regional workers are falling further behind. As we all struggle with affordability, one of our big focuses in our union contract negotiations will be keeping our out of pocket healthcare costs frozen for the coming year.

We believe that if we improve the experience for our patients and the environment they receive care in, we can attract more patients and physicians. That will help us not only maintain services but regrow ones that we've lost, such as Hematology/Oncology, Pulmonology, Neurology, and Maternal Fetal Specialists. We know the demand for healthcare is there, we just need to inform and reassure everyone in our area that they should come to Regional to receive those high quality services.

The bottom line is that all of these necessary improvements will take real, hard dollar investments.

It will be imperative for our community that Tenor follow through on their commitments and use their resources to invest in patient care and frontline staff. And for the sake of our hospital and our community, we need the help of the elected leaders here to provide oversight and ensure this investment happens in a timely manner.

State dollars that could be allocated now or earmarked through the new rural health funding would be especially helpful to start immediate investment. So we urge our elected leaders to support Tenor's ability to invest in our hospital and our workforce.

Finally, there are challenging times ahead given the cuts to Medicaid and Affordable Care Act subsidies under the President and Rob Bresnahan's devastating one big bill. Our hospital relies on Medicaid for 21% of revenue, and we will face lower reimbursement rates from the federal government. More uninsured people will need uncompensated care, and sicker patients who have not received primary care will be flooding our emergency room. It is our mission and our duty to care for everyone, even as that federal funding is slashed.

So state level policy and funding will be even more critical to support safety net hospitals like ours and rural hospitals in NEPA like Wayne Memorial, where workers are also represented by SEIU Healthcare Pennsylvania.

At the state level, we will have a choice of either raising revenue or making painful cuts to services and jobs which will severely damage the health of our communities. **We have fought too hard to keep our hospitals open to go backward.**

Our healthcare system is facing a crisis in large part because Pennsylvania has one of the most unfair tax systems in the country, which is rigged to favor the wealthy elite over working people.

As a union, we are part of a broad coalition to make sure the largest corporations and the richest billionaires pay their fair share to support our hospitals and healthcare system.

In closing, we look forward to working with Tenor, and have high expectations that they will invest in our hospital. There is a lot to do and as we move forward, we need both support from state leaders, as well as oversight to ensure funding is invested in bedside care and frontline staff. We need both immediate and longer term policies, especially given the federal healthcare cuts, so our communities receive the quality healthcare services they deserve.

Thank you.

Pennsylvania Association of
Staff Nurses & Allied Professionals

Jennifer Huber, RN

House Majority Policy Committee

February 11, 2026

Good morning, and thank you to the House Majority Policy Committee for the opportunity to be here today.

My name is Jen Huber. I'm a registered nurse at Geisinger Community Medical Center and the president of the Northeast PA Nurses Association, the PASNAP nurses' local at GCMC. I'm here to share what the nursing workforce crisis looks like on the ground in Northeastern Pennsylvania.

In our region, the biggest challenge isn't just recruiting new nurses — it's keeping experienced nurses at the bedside. We're losing nurses to burnout, unsafe staffing, and working conditions that make it hard to provide the level of care our patients deserve. When nurses leave, the workload on those who remain increases, which only accelerates the problem.

At GCMC and hospitals across this area and throughout Pennsylvania, short staffing has become normalized. Nurses are often responsible for more patients than is safe for either the patient or the nurse, often leading to poor patient outcomes and driving moral distress among staff. **Nurses don't leave because they don't care — they leave because they care deeply and feel that they're being set up to fail.**

This isn't just a workforce issue; it's a patient care issue and a regional access issue. When hospitals can't retain nurses, units close beds, services are reduced, and patients face longer waits or have to travel farther for care.

We've tried internal fixes — committees, incentive programs, temporary staffing — but without real accountability and enforceable staffing standards, little changes. Nurses want to stay at the bedside, but we need working conditions – specifically staffing – that makes staying sustainable.

I appreciate the chance to share this perspective and look forward to answering questions and discussing solutions that will help stabilize and retain the nursing workforce in our region.

Thank you.

Attached:
February 9, 2026; Research Study - “Organizational Factors to Reattract Nurses to Hospital Employment”

JAMA Network Open

Research Letter | Health Policy

Organizational Factors to Reattract Nurses to Hospital Employment

Karen B. Lasater, PhD, RN; Matthew D. McHugh, PhD, JD, MPH, RN, CRNP; K. Jane Muir, PhD, MSHP, FNP-BC

Introduction

US hospitals have a retention and recruitment crisis of registered nurses (RNs).[1] Consensus among major nursing organizations is that the retention crisis is a problem that cannot be resolved by training more RNs.[2] Continuing to expand the nursing workforce without addressing the underlying reasons why nurses leave hospital employment (and what would reattract them) is akin to fueling a leaking gas tank.[3] In this study, we examine what factors, if addressed by employers, would be likely to reattract RNs to hospital employment.

Methods

This cross-sectional study used data from Nurses4All survey of RNs in 10 states. RNs were included if they reported (1) their employment status as employed but not in health care, not currently employed, or retired; (2) their most recent job was as a hospital staff RN; and (3) they had left their job in the past 5 years (2023 to 2019). Data on RNs' age, employment, and career experiences (eg, satisfaction with career, years worked as RN, and likelihood of returning to work as RN) were collected. RNs responded to the question, "What would increase your likelihood of return to work as a nurse?" by selecting all that apply from a list. The study was approved by the UPenn institutional review board and conforms to the STROBE reporting guidelines. Informed consent was acknowledged through respondents' participation in the study. Additional methods are available in the eAppendix in Supplement 1.

Results

Of 4043 RNs who left a hospital job in the past 5 years and were not currently working in health care, 340 (8%) reported being employed outside health care, 1438 (36%) were not currently employed, and 2265 (56%) were retired (**Table 1**). A total of 3197 RNs (79%) reported being very or moderately satisfied with nursing as a career, with high satisfaction among 2032 retired RNs (90%).

Most RNs not currently employed recently searched for work in health care (719 [51%]) and were likely to return to work (939 [67%]). RNs employed outside health care were less likely to return to RN work, although 66 (20%) said they are very likely to return. Among retired RNs, 855 (37%) reported retiring earlier than planned. Most retired RNs were unlikely to return to work and had not recently searched for work; thus, they were excluded from the remainder of analyses.

Most nonretired RNs said adequate staffing (1113 [65%]), flexible scheduling (1006 [59%]), and better wages and benefits (1013 [59%]) would increase their likelihood of returning (**Table 2**). RNs of all ages identified these top factors as important to them, but they were particularly salient to younger RNs. Only 141 RNs (8%) reported that nothing would bring them back.

+ Invited Commentary

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Discussion

In this cross-sectional study of 4043 RNs who recently left a hospital staff nurse job, we found opportunities for reattracting an existing RN workforce if hospitals are willing to address organizational issues driving RNs away. Many nonretired RNs, particularly those not currently employed, reported being very likely to return to work. The top factors to increase their likelihood of returning were adequate staffing, flexible scheduling, and better wages or benefits.

Inadequate staffing is a top reason RNs leave,[4] and as this study suggests, improving staffing adequacy could bring them back. Opening more RN positions at the bedside and providing flexible scheduling arrangements are promising strategies to reattract RNs.[5] A limitation of this study is that we were only able to survey RNs who maintained a license; thus, the sample may be biased toward RNs who are more likely to return to work.

Table 1. Demographics and Employment Experiences of Registered Nurses Not Employed in Health Care[a]

Measure	No. (%) of nurses[b]			
	Total (N = 4043)	Employed but not in health care (n = 340)	Not currently employed (n = 1438)	Retired (n = 2265)
Demographics				
Age, mean (SD), y	57.2 (14)	44.9 (13)	45.0 (14)	66.3 (5)
Time worked as a nurse, mean (SD), y	27.5 (15)	16.6 (12)	15.6 (13)	36.7 (9)
Experience				
Are very or moderately satisfied with nursing as a career choice	3197 (79)	239 (71)	926 (65)	2032 (90)
Retired earlier than planned	NA	NA	NA	855 (37)
Searched for work in the last year				
In health care	1035 (26)	83 (25)	719 (51)	233 (10)
Not in health care	397 (10)	126 (37)	143 (10)	128 (6)
Have not searched for work	2545 (64)	127 (38)	540 (39)	1878 (84)
Likelihood of returning to work as a nurse				
Very likely	687 (17)	66 (20)	534 (38)	87 (4)
Somewhat likely	738 (19)	53 (16)	405 (29)	280 (13)
Somewhat unlikely	805 (20)	78 (23)	244 (18)	483 (21)
Very unlikely	1741 (44)	136 (41)	215 (15)	1390 (62)

Abbreviation: NA, not applicable.

[a] Missing responses were minimal (<5%). Age was missing in 201 respondents (5%). In conducting a missingness analysis, respondents with missing age had slightly fewer years of experience, were not currently employed, and were likely to return to work.

[b] Unless otherwise indicated.

Table 2. Organizational Factors That Would Increase Nonretired Nurses' Likelihood of Returning to Work as a Nurse Overall and by Age Category[a]

Organizational factor	No. (%) of nonretired nurses					
		By age categories, y				
	Total (n = 1778)	≤30 (n = 238)	31-40 (n = 509)	41-50 (n = 274)	51-60 (n = 287)	≥61 (n = 282)
Adequate staffing or a manageable workload	1113 (65)	175 (74)	356 (70)	193 (71)	167 (58)	137 (49)
Flexible scheduling	1006 (59)	154 (65)	328 (64)	168 (62)	143 (50)	125 (45)
Better wages and benefits	1013 (59)	168 (71)	355 (70)	164 (60)	143 (50)	92 (33)
Better opportunities for career advancement	536 (31)	85 (36)	241 (47)	88 (32)	47 (16)	26 (9)
Other	382 (22)	34 (14)	93 (18)	56 (21)	88 (31)	86 (31)
I want to work in nursing but cannot find employment	138 (8)	22 (9)	30 (6)	22 (8)	27 (9)	26 (9)
Nothing would bring me back to work in nursing	141 (8)	19 (8)	29 (6)	17 (6)	32 (11)	36 (13)

[a] This analysis is based on a sample size of 1778 nurses who are either not currently employed or employed in work outside the health care sector. Column percentages do not sum to 100% because nurse respondents were instructed to select all that apply. Missingness for organizational factors data was minimal (<5% missing for variables). Among the 1778 nonretired nurses, 142 (8%) had missing data on age and thus are not reported in the age categories. In conducting a missingness analysis, respondents with missing age had slightly fewer years of experience, were not currently employed, and were likely to return to work.

Most RNs are satisfied with nursing as a career but dissatisfied with their employers. High RN turnover is a solvable crisis that can be remedied by employers because the reasons RNs leave are the same reasons they would return, if addressed.[2,4]

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Data Sharing Statement: See Supplement 2.

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SUPPLEMENT 1.
eAppendix. Study Methods

SUPPLEMENT 2.
Data Sharing Statement