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March 4, 2011

Kathleen Hale, MS, RN, CE-BC
President
Association of Women's Health Obstetric and Neonatal Nurses
2000 L Street, NW, Suite 740
Washington, DC 20036

Dear Ms. Hale:

The Council of Women and Infants Specialty Hospitals (CWISH) is a membership organization of not-for-profit hospitals which are identifiable women's hospitals, with most of their activity focused on women's and infant's services. Present membership is comprised of twelve, Level 3 perinatal care hospitals with large obstetrical and neonatal volumes. On average, more than 8800 women are delivered at each hospital every year. Between July of 2009 and June of 2010 over 108,000 babies were born at the CWISH hospitals collectively. CWISH members make up ten of the top 25 hospitals in birth volume as listed in the 2009 American Hospital Association Data Base.

CWISH is dedicated to facilitating excellence in providing healthcare services to women and infants nationally through collaboration and through support of programs, practices and national policy. Through sharing of quality, operational and financial data, CWISH members are driven by and represent the highest standards of perinatal care and hospital operation in the nation. Therefore, the recent release of the AWHONN Guidelines for Professional Registered Nurse Staffing for Perinatal Units was of much interest to all members of the organization.

CWISH members individually and collectively have analyzed the "Guidelines" from the point of view of value added for quality, cost, and the patient experience. The result of this analysis is a formal objection of the "Guidelines" by the CWISH members.

Quality of care, prevention of adverse and sentinel events, and patient safety should be the first goal of any initiative affecting healthcare proposed by an organization. One could conclude this was AWHONN's goal as is evident in sections of Principle-Based Staffing and Nurse Staffing and Patient Outcomes sections of the document. Of interest was the sentence in the Principle-Based Staffing section, "Models of staffing that may be appropriate for medical-surgical units are not applicable to perinatal care." (pg. 10) Unfortunately, it was models of staffing for medical surgical units that were used to justify the proposed ratios throughout the document. Cited studies are only of medical surgical type units including ICUs. CWISH agrees that models of staffing that may be appropriate for medical-surgical units are not applicable to perinatal care and, also, cannot be used to justify staffing ratios in perinatal units. There are few, if any, studies that support the proposed guidelines.

It is concerning to note that only one study of the impact of the California nurse staffing ratios on patient outcomes was cited in the document (Aiken, 2010). And although this study may be cited as evidence that staffing ratios "are associated with lower mortality and nurse outcomes predictive of better nurse retention", it is important to recognize that the study does not take into account that patient safety/quality initiatives may have been occurring in the hospitals at the same time the survey of nurses for this study was conducted. In addition, this study once again only addresses surgical patient outcomes, and is not specific to perinatal nursing. On the other hand, there are several studies that have shown that although the California nurse staffing ratios have increased RN staffing in hospitals, the ratios have not made a difference in patient outcomes (Bolton, 2007; Donaldson, 2005; Spetz, 2009). It's important to note that although the California nurse staffing ratios are being held out as the role model for others to emulate, the AWHONN

Guidelines go far beyond the mandated ratios for perinatal care with no evidence to support the increase in intensity of staffing.

Because quality care and patient outcomes are of acute interest to the CWISH members, each member facility reviewed adverse and sentinel events that have occurred at their respective hospitals over the last three years. These were events that occurred while the present staffing ratios were in place. Root cause analyses of these events, done at the time of the event, showed zero events could be attributed to staffing of the units on which they occurred. With this analysis, as well as the lack of evidence to support increased ratios in perinatal care, it is difficult to justify, from a quality of care point of view, the increase in staffing ratios as proposed in the "Guidelines".

CWISH members then applied the "Guidelines" at each hospital in each applicable specialty. Implementation of the "Guidelines" would result in an increase of greater than 785 FTE's at a cost of over $66,000,000. In this time of health care reform, decreasing reimbursements, and the pressure to reduce debt through cost cutting initiatives by the states and federal governments, hospitals and other health care organizations, the impact of the "Guidelines" appears to be not well analyzed. Without solid evidence to justify the increased ratios, the added cost of over $600 per delivery will not be supported by insurance carriers. The end result will most likely be the costs being absorbed by the hospital which will result in overall increased costs for all services provided, or being charged to the obstetric patient of which few, in this stage of their lives, can afford. All in all, implementing these guidelines would be an unjustified increase to the cost of health care for the citizens of this country.

Finally, CWISH members are focused on providing individualized, relationship based care that results in the ideal patient experience; one that generates loyalty resulting in our patients highly recommending our organizations to others for care. There is no evidence that supports increased staffing ratios in the perinatal setting results in an improved patient experience.

As previously stated, the Council of Women and Infants Specialty Hospitals strongly objects to the AWHONN Guidelines for Professional Registered Nurse Staffing for Perinatal Units. This objection is based on lack of evidence to support improvement in quality of perinatal care, increased costs, and no evidence to support a more positive patient experience. We respectfully request AWHONN remove this publication from circulation and strongly recommend that to develop a reliable and valid staffing model AWHONN launch studies that examine the use of ratios in perinatal nurse staffing.

Sincerely,

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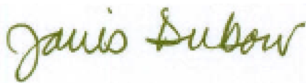

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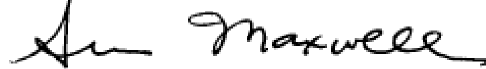

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Aiken, Linda et. al. (2010) Implications of the California Nurse Staffing Mandate for Other States, *Health Services Research*, accessed January 19, 2011. Available at http://www.nursing.upenn.edu/chopr/Documents/Aiken.2010.CaliforniaStaffingRatios.pdf

Bolton, L. B., C. E. Aydin, N. Donaldson, D. S. Brown, M. Sandhu, M. Fridman, and H. U. Aronow. 2007. ''Mandated Nurse Staffing Ratios in California: A Comparison of Staffing and Nursing-Sensitive Outcomes Pre- and Post regulation.'' Policy, Politics, and Nursing Practice 8 (4): 238–50.

Donaldson, N., L. B. Bolton, C. Aydin, D. Brown, J. D. Elashoff, and M. Sandhu. 2005. ''Impact of California's Licensed Nurse–Patient Ratios on Unit-Level Nurse Staffing and Patient Outcomes.'' Policy, Politics, and Nursing Practice 6 (3): 198–210.

Spetz, J., et. al. 2009. ''Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care''. An Issue Brief for the California HealthCare Foundation [accessed January 19, 2011]. Available at http://www.chcf.org/topics/view.cfm?itemID=133857