

Policy Brief

Connecticut's Health Care Crisis

A Policy Framework for Reform



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Executive Summary

Connecticut is facing a health care crisis. Our health care system is one of the costliest in the world. Yet, the high rate of spending has not translated into better health outcomes. While most Americans believe that our health care system is the best in the world, a number of studies indicate that Americans receive less than optimal care. Expanding access to cost effective, high quality health care is important to improving the health and productivity of Connecticut residents.

In early 2006, the Business Council of Fairfield County issued the *Connecticut Health Scorecard*. The Scorecard measures 26 indicators of Connecticut's health. The Scorecard clearly shows areas where Connecticut excels as a state, but more importantly, it reveals many more areas where Connecticut lags behind the rest of the nation and in some cases, ranks in the bottom 50 percent of states. The Scorecard points to a number of troubling factors, such as personal behaviors, risk factors, and health policies, that threaten to undermine the health of Connecticut's residents and workforce.

Too many Connecticut residents lack access to care because they lack health insurance. Deficits in health care quality pose a serious threat to the health of Connecticut's residents and come with a huge price tag adding billions in unnecessary health care expenditures.

The Business Council of Fairfield County believes that the State of Connecticut must act now to address this looming health care crisis. We offer the following policy framework for health care reform in Connecticut:

First, commit to a Healthy Connecticut.

- The state and each municipality should commit to the following goal:
"Connecticut will be the healthiest state in the nation that has high quality health care delivered by the most effective, efficient, safe, timely, patient centered and equitable health care system."
- To achieve this goal, each state and municipal agency and department should identify how it can contribute to improved health status and quality of life for all of Connecticut residents and align their policies and programs accordingly. Connecticut must focus efforts not only on preventing disease. (e.g. support of immunization programs): but also preventing the

- Progress toward a healthier Connecticut should be measured annually with results posted on the Governor's website.

Second, empower consumers and purchasers of health care to make informed decisions.

- To empower the consumer and purchasers of health care, the State will need to increase transparency of health care information - The health care system should make available to patients and their families and health care purchasers reliable information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. Price and quality information about hospitals, physicians, health plans and treatment options must become widely available.

Third, Connecticut must make a commitment to fact-based policy analysis. Public policy makers need credible information and better tools to inform decision-making. Effective governments and high performance organizations use data to inform decision-making and to drive performance.

- Connecticut should establish and fund a Connecticut Center for Health Information and Policy Analysis.
- The Connecticut Center for Health Information and Policy Analysis would establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health related data and statistics.

Fourth, recognize that expanded access to health care must be coupled with improvements in the quality and safety of the health care system. Poor quality care has undermined patient outcomes and added billions of unnecessary costs to the health care system.

- Connecticut should strive for health coverage that is universal, continuous, affordable to individuals and families, affordable and sustainable for society, and that enhances health and well-being.
- Connecticut should review existing programs to identify barriers to enrollment and access to health care.
- Connecticut should undertake a dispassionate, careful, and transparent examination of current mandated health insurance benefits.
- Connecticut should promote quality and safety. Health providers should be given incentives to implement practices that evidence shows can work to reduce or prevent adverse events and medical errors.
- Connecticut must actively promote evidence based care with an emphasis prevention of disease and illness and management of chronic disease.
- Connecticut should promote increased use of health information technology and make sure that these systems are able to communicate

reform and an on-going process to sustain reform efforts such as creation of a Connecticut Health Care Reform Study Group.

There is much work to be done. It is time for Connecticut to get started.

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Fact

The purpose of the health care system is to reduce continually the burden of illness, injury, and disability, and to improve the health status and functioning of the people of the United States.¹

The Issue

Our health care system is broken; it has serious issues of quality, access and affordability.

Introduction

In early 2006, the Business Council of Fairfield County issued the *Connecticut Health Scorecard*. The Scorecard measures 26 indicators of Connecticut's health. The Scorecard clearly shows areas where Connecticut excels as a state, but more importantly, it reveals many more areas where Connecticut lags behind the rest of the nation and in some cases, ranks in the bottom 50 percent of states. The Scorecard points to a number of troubling factors, such as personal behaviors, risk factors, and health policies, that threaten to undermine the health of Connecticut's residents and workforce.

While individual biology and behavior, physical and social environments, as well as policies and interventions have a profound effect upon the health of individuals, the health of individuals also depends greatly on access to a quality health care system. Expanding access to cost effective, high quality health care is important to eliminate health disparities as well as and to increase the quality and years of healthy life for all people living in the United States.² At this time, our healthcare system is one of the costliest in the world and it has serious gaps in quality. Further, too many Americans do not have access to health care due to the lack of health insurance. In short, our nation's healthcare system is broken.

The failure of the federal government to enact comprehensive health care reform is forcing many states to experiment with a variety of health care reform strategies. It is time for Connecticut to act; the status quo is no longer acceptable or sustainable. We believe that quality, cost, and access of the health care system are interrelated and that all three factors must be addressed in Connecticut's health care reform

QUALITY

Every day someone is harmed by the health care system intended to help him or her. Medical errors are one of the Nation's leading causes of death and injury and Connecticut lacks an effective system for measuring and addressing these errors.

While most Americans believe that our health care system is the best in the world, a number of studies indicate that Americans receive less than optimal care.³ According to recent studies, U.S. adults receive about half of the recommended health care services.⁴

In a 2001 report, the Institute of Medicine (IOM) stated that between the health care we now have and the health care we could have lies not just a gap, but a chasm.⁵ The IOM identified six dimensions of quality as priorities for healthcare system improvement:

- **Safe:** avoiding injuries to patients from the care that is intended to help them.
- **Effective:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
- **Patient centered:** providing care that is respectful of and responsive to individual patient preferences, need, and values, and ensuring that patient values guide all clinical decisions.
- **Timely:** reducing wait time and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** avoiding waste, including waste in equipment, supplies and ideas and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.⁶

Deficits in health care quality pose a serious threat to the health of Connecticut's residents and come with a huge price tag adding billions in unnecessary health care expenditures. A 2002 study commissioned by the Midwest Business Group on Health estimated that the "cost of poor quality" in the health care system accounts for 30 percent of all health care spending as a result of overuse, misuse and waste.⁷ The 30 percent figure does not include the financial impact of under use of health care services in health care spending cost. The cost of poor quality care is passed on to

³ Midwest Business Group on Health, Reducing the Cost of Poor Quality Healthcare Through Responsible Purchasing Leadership, 2003, www.mbg.org.

⁴ Rand Health, The First National Report Card on Health Care in America, 2006, Santa Monica, CA,

private and public purchasers of health care, consumers, and others in the form of higher fees.

There are a number of health care quality measures that can be reported; the following measures were selected to illustrate that Connecticut residents are not immune to poor quality of care and its associated costs.

Patient Safety

Our healthcare system should be safe. It should avoid harm to patients from the care that is intended to help them.⁸ However, medical errors are one of the Nation's leading causes of death and injury.⁹

The Institute of Medicine (IOM) estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors.¹⁰ Medical error is defined as "the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim." Medical errors cost the nation about \$37.6 billion each year, with about \$17 billion associated with preventable medical errors.¹¹

About one-third of Americans (34 percent) report that they have been personally involved in a situation where a preventable medical error was made in their own care or that of a family member.¹² On a comparison survey of physicians in 2002, a similar share (35 percent) report that they have been personally involved in a situation where a preventable medical error was made in their own care or that of a family member.¹³

Connecticut has a mandatory medical error reporting law that requires hospitals and outpatient medical facilities to report "adverse events" to the Connecticut Department of Public Health within specified time periods. According to the Connecticut Department of Public Health, there were just 239 events reported between July 1, 2004 and September 14, 2005.¹⁴ These events were primarily falls, perforations from endoscopic procedures and pressure ulcers.

However, the data on adverse events collected by the Connecticut Department of Public Health appears to be incomplete. The Connecticut Office of Health Care Access using hospital discharge data and extrapolating from national figures in the IOM report estimated that the number of adverse events statewide is 11,081 to

⁸ Institute of Medicine, *To Err is Human: Building a Safer Health Care System*, November 1999, <http://www.iom.edu/file.asp?id=4117>

⁹ Institute of Medicine, *To Err is Human: Building a Safer Health Care System*, November 1999, <http://www.iom.edu/file.asp?id=4117>

14,138, the number of preventable adverse events is 5,873 to 8,200 per year, and the number of preventable adverse events that result in death is 517 to 1,115 per year.¹⁵ Thus, the number of adverse events reported to the Connecticut Department of Public Health falls far short of expected levels. Data is only reported at the state level; no facility specific information is available. Why isn't there an effective system for adverse event reporting in Connecticut?

In October 2006 the National Quality Forum (NQF) updated and endorsed a list of 28 serious reportable events in healthcare. Connecticut's reporting system included the earlier list of NQF serious reportable events. In November 2006, the Leap Frog Group, a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded, issued a call to hospitals to commit to its new "Never Events Policy".¹⁶ Hospitals would be given the opportunity for public recognition for agreeing to do the following if a "never event" occurs within their facility:

- Apologize to the patient and/or family affected by the never event.
- Report the event to at least one reporting program: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO); a state reporting program; or a Patient Safety Organization.
- Perform a root cause analysis, consistent with the chosen reporting program.
- Waive all costs directly related to the never event and refrain from seeking reimbursement from the patient or a third party payer.¹⁷

Hospital infections

Another measure of patient safety is the rate of healthcare associated infections. According to the Centers for Disease Control (CDC), healthcare-associated infections are infections that patients acquire during the course of receiving treatment for other conditions or that healthcare workers acquire while performing their duties within a healthcare setting.

Health-care associated infections occur worldwide and affect both developed and resource poor countries.¹⁸ In the United States, one in 136 hospital patients become seriously ill as a result of acquiring an infection in a hospital.¹⁹ Nationally, health-care associated infections account for an estimated 2 million infections, claims 90,000 lives, and result in \$4.5 billion in excess health care costs annually.²⁰

In early November 2006, The Pennsylvania Cost Containment Council released its first hospital specific report on hospital-acquired infections. The report includes

information on approximately 1.6 million patients treated in 168 acute care hospitals during 2005. Among the findings were:

- Hospitals reported 19,154 cases in which patients contracted a hospital-acquired infection, a rate of 12.2 per 1,000 cases. The hospitalizations in which these infections occurred amounted to 394,129 hospital days and \$3.5 billion in hospital charges.
- The mortality rate for patients with hospital-acquired infection was 12.9 percent; the mortality rate for patients without a hospital-acquired infection was 2.3 percent.
- The average length of stay for patients with a hospital-acquired infection was 20.6 days; the average length of stay for patients with out a hospital-acquired infection was 4.5 days.
- The average hospital charge for patients with a hospital-acquired infection was \$185,260; the average charge for patients with a hospital-acquired infection was \$31,389.
- When looking at private sector insurance reimbursements (which do not include Medicare and Medicaid), the average payment for a case with a hospital-acquired infection was \$53,915, while the average payment for a case without a hospital-acquired infection was \$8,311.²¹

According to the World Health Organization, hand hygiene remains the primary measure to reduce healthcare acquired infections, but compliance is very low throughout the world.²² According to a recent report, average compliance with hand hygiene recommendations varies between hospital wards, among professional categories of health care workers, and according to working conditions, as well as according with definitions used in the studies.²³ **Compliance with hand hygiene recommendations is usually estimated at less than 50 percent.**²⁴ The low rate of hand washing represents a serious patient safety challenge.²⁵ In addition to low hand washing compliance, other factors contributing to an increase in health care acquired infections include:

- Sicker and more immunocompromised patients in hospitals,
- Infrastructure repairs and renovations to aging hospitals and new construction on existing campuses creating risk of airborne fungal diseases caused by dust and spores released during demolition and construction, and
- Increasing antimicrobial use in hospital and long-term care facilities creating a large reservoir of resistant microbial strains.²⁶

Currently, data on healthcare associated infections is not tracked by the State of Connecticut. However, during the 2006 legislative session, Public Act 06-142, An Act Concerning Hospital Acquired Infections, was passed. This new law requires Connecticut hospitals to report hospital-acquired infections to the Connecticut Department of Health; the first report indicating the results of the reporting system

legislation is that the Connecticut Department of Public Health is required to implement the recommendations of Committee on Healthcare Associated Infections, within available appropriations. Considering the burden of health care acquired infections (HAI) and its associated costs, public policy makers need to commit to an effective reporting and prevention system for HAI.

Medication errors

Medication errors are another important health care quality measure. In any given week, four out of every five U.S. adults will use prescription medicines, over-the-counter drugs, or dietary supplements of some sort, and nearly one-third of adults will take five or more different medications.²⁷

More than 1.5 million preventable medication errors occur every year in the United States.²⁸ Comparable data at the state level is not available. However, as part of Connecticut's mandatory reporting law, ten (10) cases of patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration) were reported to the Connecticut Department of Public Health during the period is July 1, 2004-September 14, 2006.

Medication errors can result in significant financial costs. It is estimated that one Adverse Drug Event adds more than \$8,750 to the cost of a hospital stay.²⁹ Multiple factors can result in medication errors including: packaging and labeling, similar drug names, medication orders (illegible handwriting), abbreviations.

Rand researchers indicated that if all hospitals had a Health Information Technology system including Computerized Physician Order Entry systems for medications, around 200,000 adverse drug events could be eliminated each year, at an annual savings of \$1 billion.³⁰ Hospitals with over 100 beds generated most of the savings.³¹ Additionally, patients aged 65 years and over accounted for the majority of avoided adverse drug events.

Medication errors also occur in community settings. In a recent report by the Agency for Healthcare Quality and Research (AHQR), 3.1 percent of the noninstitutionalized population aged 65 years of age and over used at least one of the eleven drugs that should always be avoided by the elderly and 18.4 percent of elderly persons used at least 1 out of 33 drugs that are inappropriate for the elderly.³² State level data was not reported.

Effectiveness

Poor quality care is not just the result of errors; other factors such as under use of

second dimension of quality identified by the IOM as a priority of for health care improvement was “effectiveness”.³³

That is, the health care system should be providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit. However, the Institute for Medicine noted that it takes an average of 17 years to incorporate the discovery of new more effective forms of treatment into routine patient care.³⁴

Prevention

Prevention is categorized as Primary, Secondary and Tertiary:

- **Primary prevention:** These interventions seek to halt or delay the development of disease. Examples are immunizations to prevent infectious diseases such as influenza and tetanus, or support of physical activity and healthy diet in children to prevent obesity and all of it’s associated problems.
- **Secondary prevention:** These interventions seek to prevent serious complications of a disease once it occurs. Examples are the adequate treatment of high blood pressure to prevent strokes, or tight control of diabetes to prevent or delay eye and kidney disease.
- **Tertiary prevention:** These interventions seek to control the devastating complications once they do occur. An example of this would be assuring the proper use of dialysis for someone with kidney disease.

All types of prevention play a role in improving the quality and cost of health care. Clearly, primary prevention is the most cost effective method of decreasing the burden of disease, but secondary and tertiary prevention play major roles.

Immunizations

“Under use” of health care services occurs when there is evidence that a patient did not receive a service or procedure whose benefits exceeded its risks.³⁵ A classic case of “under use” of services is immunizations.³⁶ Immunizations are important for reducing mortality and morbidity, yet many individuals do not receive recommended immunizations!

Among adults, the two key immunizations are influenza vaccines, recommended annually for those over age 65 and for those with selected chronic health problems, and pneumococcal vaccines, recommended once for persons over age 65 and for those at increased risk of serious complications from pneumonia.³⁷ Nationally, 65.5 percent of adults aged 65 years and over had a flu shot in the past year compared to 71.1 percent of the elderly in Connecticut who had a flu shot in the past year.³⁸ The

percentage of adults aged 65 years and over who ever received pneumococcal vaccination was 65.7 percent in 2005 nationwide. In Connecticut, the figure was 69.3 percent of the elderly.³⁹ Thus, **more than one-fourth of the elderly persons are not receiving the recommended immunizations!** One study estimated that under use of influenza and pneumococcal vaccinations kill between 10,000 and 20,000 individuals each year.⁴⁰ The cost of delivering the influenza vaccine is about \$16.70 per vaccination.⁴¹

Immunized children are those who receive **4:3:1:3:3**, which is four or more doses of diphtheria, tetanus, and pertussis, three or more doses of poliovirus vaccine, one or more doses of any measles containing vaccine (MCV), three or more doses of Haemophilus Influenza type B (Hib), and three or more doses of hepatitis B vaccine (HepB).⁴² Nationally, 81 percent of children aged 19 to 35 months have received recommended immunizations in 2004. In Connecticut 88 percent of children received the recommended immunizations in 2004 compared to 91 percent of the children in 2003.⁴³ **Thus, slightly more than 1 out of 10 children in Connecticut are not receiving all recommended immunizations!** The drop in immunization levels cost Connecticut its leadership position in the nation; Connecticut dropped from first in the nation in 2003 to third in the nation in 2004.

Smoking

Another type of preventive care is characterized by counseling or other interventions to prevent behaviors that are known risk factors for the development of serious chronic conditions.⁴⁴ Smoking is a leading cause of preventable illness and death. One out of five American adults smoke; 16.5 percent of Connecticut adults smoke.⁴⁵

Approximately, 440,000 premature deaths occur annually in the United States as a result of smoking.⁴⁶ The economic toll (direct and indirect costs) for smoking exceeds \$157 billion or \$3,443 per smoker per year.⁴⁷ Advice from a practitioner to quit smoking has been demonstrated to be an effective intervention.⁴⁸ Yet about a third of nation's smokers who visited a doctor during the past year were not advised to quit smoking. Nationally, in 2002, only 63.5 percent of current smokers age 18 and over with routine office visits during the preceding year reported that their providers had advised them to quit. **Almost one out of four Connecticut's smokers who**

³⁹ CDC, Behavioral Risk Factor Surveillance Study, <http://www.cdc.gov/brfss/>

⁴⁰ Midwest Business Council on Health, Reducing the Costs of Poor Quality Healthcare through Responsible Purchasing Leadership, www.mbg.org, 2003, p.15.

⁴¹ NCQA, The State of Health Quality-2004 Industry Trends and Analysis, 2004, Washington, D.C., 2004, p.36.

⁴² State Health Facts, Percent of Children Age 19-35 Months Who Are Immunized, 2004, www.statehealthfacts.org, downloaded July 26, 2006

visited a doctor during the past year were not advised to quit smoking. This gap represents a major quality of care problem. In Connecticut, 77.1 percent of current smokers age 18 years of age and over who had a routine office visit during the preceding were advised to quit smoking.⁴⁹

Prenatal care

A leading indicator of the quality of acute care is the proportion of pregnant women initiating prenatal care in the first trimester.⁵⁰ Prenatal care includes: risk assessment, treatment for medical conditions or risk reduction, and education.⁵¹ Each component can contribute to reductions in perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors, such as smoking and alcohol use that contribute to poor outcomes.⁵²

Prenatal care is more likely to be effective if women begin receiving care early in pregnancy.⁵³ Women who see a health care provider regularly during pregnancy have better birth outcomes. Nationally, 84.1 percent of mothers in 2003 began prenatal care in the first trimester; in Connecticut the figure was 88.7 percent. That means that more than 1 out of 10 mothers did not begin prenatal care in the first trimester.

Breast cancer screening

A woman living in the United States has a 1 in 7 lifetime risk of developing breast cancer.⁵⁴ Early detection through screening is critical to reducing the number of deaths due to cancer.⁵⁵ Regular mammography screening has been shown to be effective in reducing breast cancer deaths. It is recommended that women aged 40+ have regular mammograms every 1-2 years. The estimated direct and indirect cost associated with breast cancer in the United States total between \$2.4 and \$3.1 billion. Almost \$2 billion is for late state cancer treatment.⁵⁶ A mammography costs about \$100.

Many women are not receiving the recommended screening for breast cancer. Only 74.6 percent of American women aged 40 years and over had a mammogram within the past 2 years while 81.1 percent of Connecticut women aged 40 years and over had a mammogram in the past two years.⁵⁷

⁴⁹ Agency for Healthcare Research and Quality, 2005 National Healthcare Quality Report, AHRQ Publication No. 06-0018, December 2005, USDHHS, Rockville, MD.

⁵⁰ President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry: Improving Quality in a Changing Health Care Industry, Chapter One-The State of Health Care Quality:

Diabetes

Nationally, 7.3 percent of the adult population has been diagnosed with diabetes. In Connecticut, 6.5 percent of the adult population have been diagnosed with diabetes.⁵⁸ The estimated direct and indirect costs of diabetes are \$132 billion annually.⁵⁹ Under diagnosis and inadequate treatment of diabetes results in unnecessary expenditures as well as premature death, limb amputations, kidney disease, and blindness.⁶⁰

Only about one half of adults (52.7%) diagnosed with diabetes age 18 and over reported receiving all three recommended tests for diabetes care (HbA1c test, retinal exam, foot exam).⁶¹

High blood pressure

More than one out of four adults nationally (25.5 percent) have high blood pressure. Connecticut's rate is on par with national figures with 23.8 percent of adults having high blood pressure.⁶² Untreated high blood pressure causes stroke, coronary heart disease, kidney failure, and blindness.⁶³ In 2004, the estimated cost of high blood pressure in the United States is \$55.5 billion; \$41.5 billion in direct medical expenditures and \$14 billion in indirect expenditures such as absenteeism and lost work productivity.⁶⁴ Among those treated for high blood pressure, **only 29 percent have it under control.**⁶⁵ The Healthy People target is 50 percent and at the current rate of improvement will not be met for 20 years.⁶⁶ State level data was not available.⁶⁷

Substance Abuse

Alcohol use can result in long- and short-term health consequences, including liver disease, cancer, high blood pressure, heart disease, psychological disorders, and injury from alcohol-related accidents.⁶⁸ In 2003-2004, there were 1.5 million youths aged 12 to 17 (6.1 percent of youths) who were classified as needing treatment for alcohol use.⁶⁹ Of the youths who were classified as needing treatment for alcohol use, only 7.2 percent received specialty treatment for alcohol use. In Connecticut,

⁵⁸ CDC, Behavioral Risk Factor Surveillance Study, <http://www.cdc.gov/brfss/>

⁵⁹ Midwest Business Council on Health, Reducing the Costs of Poor Quality Healthcare through Responsible Purchasing Leadership, www.mbg.org, 2003

⁶⁰ Ibid.

⁶¹ Agency for Healthcare Research and Quality, 2005 National Healthcare Quality Report, AHRQ Publication No. 06-0018, December 2005, USDHHS, Rockville, MD.

⁶² CDC, Behavioral Risk Factor Surveillance Study, <http://www.cdc.gov/brfss/>

⁶³ NCQA, The State of Health Quality-2004 Industry Trends and Analysis, 2004, Washington, D.C., 2004,

there is an estimated 19,000 youth aged 12 to 17 years of age who are abusing alcohol or who are alcohol dependent. Also in Connecticut, there were 18,000 youth aged 12 to 17 classified as needing treatment for alcohol use but not receiving it.⁷⁰

Also in 2003-2004, there were 1.4 million youths aged 12 to 17 (5.4 percent of youths) who were classified as needing treatment for illicit drug use; 9.1 percent of the youths who were classified as needing treatment for illicit drug use received illicit drug use treatment. 16,000 Connecticut youth aged 12 to 17 are abusing or dependent on illicit drugs; 15,000 Connecticut youth aged 12 to 17 need treatment but are not receiving it.⁷¹

Studies confirm that significantly higher costs and use of medical services are associated with substance abuse disorders and that costs decline with treatment.⁷² One study reported that every dollar invested in substance abuse treatment yields \$7 in benefits.⁷³ In a report to the Connecticut Legislation to determine the appropriate number of inpatient acute care behavioral health bed capacity for Connecticut youth, the Office of Health Care Access indicated that the process was hindered by the fact that patients in the state do not seem to have adequate access to all levels of care.⁷⁴

Overuse of antibiotics

Overuse of services occurs when a health service is provided that poses substantially greater risks than potential benefits to the patient.⁷⁵ A significant area of overuse of health services lies in the use of medications. Treatment of respiratory infections is one of the most common reasons for Americans visiting a physician. The cause of many upper respiratory infections is a virus; antibiotics are not an effective treatment for viral illnesses.⁷⁶

Overuse of antibiotics results in as much as \$5 billion in unnecessary expenditures each year.⁷⁷ Overuse and inappropriate use of antibiotics is a major cause of antibiotic resistance. The rate of outpatient visits for the common cold in which antibiotics were prescribed is 35 percent higher than the Healthy People target of 126.8 antibiotics prescribed at visits of a diagnosis of a common cold per 10,000 population.⁷⁸

⁷⁰ Office of Applied Statistics, Substance Abuse and Mental Health Services Administration (SAMHSA), 2004 Estimates of Substance Abuse-Connecticut, <http://www.oas.samhsa.gov/2k4State/Connecticut.htm>

⁷¹ Ibid.

⁷² Necochea, L. Treatment of Chemical Dependency May Reduce Medical Utilization and Costs, Research Highlight Number 6, August 2006, Robert Wood Johnson Foundation.

⁷³ Necochea, L. Economic Benefits of Treating Substance Abuse Outweigh Costs, Research Highlight

End stage renal disease

The percentage of dialysis patients on the waiting list for transplantation is 15.9 percent in 2002. In Connecticut, 11.7 percent of dialysis patients are on the waiting list for transplantation.⁷⁹ The rate is well below the Healthy People target of 66 percent and at the current pace of improvement the goal will not be met for 70 years.

Timeliness

Timeliness is another dimension of quality identified by the Institute of Medicine as a priority for improvement in the health care system.⁸⁰ That is, the health care system should reduce waits and sometimes harmful delays for both those who receive and give care. However, about 15 percent of adults aged 18 and over report that they sometimes or never get care for illness or injury as soon as wanted.⁸¹

Patient centeredness

The healthcare system should be patient centered.⁸² That is, the systems should be providing care that is respectful of and responsive to individual patient preferences, need, and values, and ensuring that patient values guide all clinical decisions. Approximately, one out of ten adults reported that their health providers sometimes or never listened carefully, respected what they had to say, and spent enough time with them.⁸³

Equitable

The final dimension of health care quality improvement identified by the IOM is equity. The health care system should provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic characteristics.⁸⁴ As shown in the following tables, health outcomes vary substantially based upon racial/ethnic characteristics.

Infant mortality

Infant mortality is an important measure of a nation's health and a worldwide indicator of health status and social being.⁸⁵ Compared with other countries, the United States has one of the highest infant mortality rates in the world with a rank of

⁷⁹ Agency for Healthcare Research and Quality, 2005 National Healthcare Quality Report, AHRQ Publication No. 06-0018, December 2005, USDHHS, Rockville, MD.

⁸⁰ Institute of Medicine. *Crossing the Quality Chasm: A New Health Care System for the 21st Century*.

28. In fact, the infant mortality rate of 7.0 in United States is more than three times the infant mortality rate of Hong Kong (2.3 infant deaths per 1,000 live births), the country with the lowest reported infant mortality rate.⁸⁶ This ranking is due in part to the large disparities that exist between various racial and ethnic groups in the United States particularly African Americans. In Connecticut, the black to white ratio in infant death is 2.4.

**Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity,
2000-2002 Linked Files**

	Race/Ethnicity			
	White	Black	Hispanic	Total
Connecticut	5.4	14.2	7.1	6.4
United States	5.7	13.5	5.5	6.9

Notes: Infant mortality rates varied considerably by State and within States by race and Hispanic origin of mother for 2000–2002. To obtain statistically reliable rates by race and Hispanic origin, three years of data were combined. Infant death rates are calculated by dividing the number of infant deaths in a calendar year by the number of live births registered in the same period. Infants are defined as children under one year of age. They are presented as rates per 1,000. Race/ethnicity for infant deaths is determined by the race of the decedent, and the race/ethnicity for live births is determined by the race of the mother as reported on the infant's birth certificate.

Sources: Matthews, TJ, M.S., et. al. Infant Mortality Statistics from the 2002 Period Linked Birth/Infant Death Data Set. Division of Vital Statistics. National Vital Statistics Report, Vol 53, No. 10, November 24, 2004. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_10.pdf.

Data were downloaded from www.statehealthfacts.org on November 2, 2006.

Heart Disease Deaths

Heart disease is the leading cause of death in the United States.⁸⁷ In 2002, rates of death from diseases of the heart were higher among black population than among white population.

**Number of Heart Disease Deaths per 100,000 Population
by Race/Ethnicity, 2002**

	Race/Ethnicity Rate per 100,000		
	White	Black	Other
Connecticut	215.2	240.3	125.2
United States	236.7	308.4	138.3

Cancer deaths

Cancer is the second leading cause of death in the Connecticut⁸⁸. In 2002, rates of cancer death were higher among black population than among white population.

Number of Cancer Deaths per 100,000 Population by Race/Ethnicity, 2002

	Race/Ethnicity Rate per 100,000		
	White	Black	Other
Connecticut	185.8	205.9	79.5
United States	191.7	238.8	115.4

Sources: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 1999-2002, Series 20, No. 2H 2004 on CDC WONDER On-line Database.

Data were downloaded from www.statehealthfacts.org on November 2, 2006.

COST

The United States spends more per capita on health than does any other country. Per capita health expenditures were \$5,317 in the United States, more than double the spending of most other countries.⁸⁹ In spite of this high rate of spending the United States consistently lags behind other countries on major health outcomes such as life expectancy and infant mortality.⁹⁰

Health care costs also represent a significant component of state budgets. The largest shares of state health expenditures were Medicaid, state employees' benefits, population health services, and community based services.⁹¹ In Connecticut, state health spending comprised nearly 26 percent of the total state budget in FY2003.

Not yet factored into Connecticut's state budget is the cost of future retiree health benefits currently estimated at \$21 billion. A new accounting rule issued by the Government Accounting Standards Board, GASB 45, to take place in 2007 will require governments and school boards to disclose these costs in their financial reports. Connecticut may well face a "fiscal tsunami" in the very new future as the cost of future retiree health benefits coupled with the cost of the State of Connecticut's 20-year agreement for health care benefits with the state employees union not scheduled to expire until 2017 are factored into the budget.

health care premiums in Connecticut for single coverage are the 13th costliest in the nation.

Average Annual Cost of Employment-Based Health Insurance

	2002	2004	Change 2002-2004	
			\$	%
United States				
Single coverage	\$3,189	\$3,705	\$516	16.2%
Family coverage	\$8,469	\$10,006	\$1,537	18.1%
Connecticut				
Single coverage	\$3,373	\$3,864	\$491	14.6%
Family coverage	\$9,047	\$11,035	\$1,988	22.0%

Source: Kaiser Family Foundation, www.statehealthfacts.org. The data was downloaded from the Kaiser Family Foundation, State Health Facts site.

The cost of health insurance is a major factor influencing who is and who is not insured. Premium cost is the main reason why employers do not offer employer sponsored health insurance.⁹² Insurance cost is also a major reason uninsured adults give for being without coverage and why employed persons turn down workplace health insurance.⁹³

Not only do rising health care costs affect Connecticut employers, but they also affect Connecticut employees. Many employees find that their wages are not keeping pace with their increasing medical plan payroll deductions and out-of-pocket costs.⁹⁴

When asked to name the most important health problem for government to address, health care costs historically top the list.⁹⁵ In August 2005, such costs were mentioned by nearly four in ten adults (39 percent).⁹⁶ Two-thirds (66 percent) of those with health insurance say their premiums have increased over the past five years.⁹⁷ In Connecticut health insurance premiums rose 14 for single coverage and 22 percent for family coverage between 2002 and 2004.

Health care costs create significant barriers to obtaining health care for many people. Nearly three in ten adults (28 percent) report a time in the past year when they did not have enough money to pay for medical care.⁹⁸ About 30 percent of adults say that they or a family member have avoided filling a prescription, skipped recommended medical tests or treatment, or cut pills or skipped doses of medicine because of cost.⁹⁹

A Pricewaterhouse Coopers report examined the underlying drivers of rising healthcare costs. The results indicated that:

- General inflation accounted for 27 percent of the 2005 increase in health insurance premiums.
- Increased utilization of services accounted for an estimated 43 percent of the increase.
- Price increases in excess of inflation for health care services accounted for the remaining 30 percent of the increase in health insurance premiums.¹⁰⁰

Contributing to increased utilization of services were increased consumer demand, new medical treatments, more intensive diagnostic testing due partially to the practice of defensive medicine, an aging population and increasingly unhealthy lifestyles.¹⁰¹ The extent to which physicians practice defensive medicine in Connecticut is not known. While the AMA has cited research that indicates that many physicians practice defensive medicine to avoid lawsuits,¹⁰² the GAO reported that the prevalence of defensive medicine and costs of such practices has not been reliably measured.¹⁰³ A study by the National Academy for State Health Policy indicated that while defensive medicine does exist, it might be the result of causes other than the fear of medical malpractice.¹⁰⁴

However, the cost and availability of medical malpractice insurance is causing a major problem in many states nationwide including Connecticut. Connecticut is one of 20 states designated by the American Medical Association as a Medical Liability Crisis state.¹⁰⁵ The number and amount of medical malpractice awards has been cited as a factor contributing to the high cost of medical malpractice insurance. According to Kaiser Family Foundation, Connecticut has the highest average medical malpractice claims paid in the nation at \$731,695 compared to \$290,984 nationwide.¹⁰⁶

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Pricewaterhouse Coopers, *The Factors Fueling Rising Healthcare Costs 2006*, <http://www.pwcglobal.com/extweb/pwcpublishations.nsf/docid/E4C0FC004429297A852571090065A70B>

¹⁰¹ Pricewaterhouse Coopers, Op. Cit.

²³ American Medical Association, *Medical liability crisis map, 2005*, [www. http://www.ama-assn.org/ama/noindex/category/11871.html](http://www.ama-assn.org/ama/noindex/category/11871.html).

The movement among purchasers toward broader access health plans, provider consolidation, increased costs of labor, and higher priced technologies were reasons for price increases in excess of inflation.¹⁰⁷ Connecticut has very high labor costs.¹⁰⁸ Labor shortages in the healthcare delivery system have been well documented in numerous studies and reports. With the pending retirement of the Baby Boomers, many who are health care workers, into peak health care consumption years, the issue of high labor cost is unlikely to disappear. Connecticut needs to urgently address this issue and must build capacity of the regional higher education system to graduate more qualified allied health professionals.

While federal and state mandates contribute to the cost of health insurance, nationally, they were not a major contributor to the increases in 2005 health insurance premiums.¹⁰⁹ Laws that require insurers to provide coverage for a variety of health care services, medical treatments, and specific diseases are typically called mandated benefits.¹¹⁰ In 2003, Connecticut had the fifth highest number of insurance mandates nationally.¹¹¹ Connecticut had 53 health insurance mandates: 33 for benefits, 13 for providers, and 5 for persons covered.¹¹² In 2005, a new Connecticut law took effect that requires health insurers to cover infertility treatments for women until age 40. State mandated benefits typically do not apply to employers who self-insure their employee benefits and thus have a financial impact on the small employer health insurance market.

ACCESS

Too many Connecticut residents do not have access to healthcare due to the lack of health insurance. And simply put, not having health insurance is bad for your health. Health insurance is a major factor affecting access to the nation's health care system. Those without health insurance are less likely to have a regular source of health care than their insured counterparts. The uninsured are less likely to receive preventative care, more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in late stages of disease.

When uninsured persons are unable to pay their medical expenses, those costs are passed onto the insured and businesses through higher fees. The Connecticut Hospital Association reported that in 2003, \$62 million of \$149 million of Connecticut hospitals' uncompensated care was associated with inpatient and outpatient care provided to the uninsured.¹¹³

²⁸ Pricewaterhouse Coopers, *The Factors Fueling Rising Healthcare Costs 2006*, <http://www.pwcglobal.com/extweb/pwcpublishings.nsf/docid/E4C0FC004429297A852571090065A70B>

²⁹ Connecticut Program Reimbursement Investigation Committee, *Funding of Hospital Care, September 2004*

It is unacceptable that anyone should lack health insurance. Nationwide, 46 million persons do not have health insurance. In Connecticut, 407,000 persons do not have insurance or about 12 percent of the population.¹¹⁴ This figure represents about the size of the population of Bridgeport, New Haven, Hartford, and New London combined. Between 2003 and 2004, an additional 50,000 persons became uninsured.¹¹⁵ That figure is about the size of the population of Stratford, CT,

Employer provided health plans are the foundation of the Nation's health care system. Approximately 61 percent of the Connecticut's population are covered by employer provided insurance, 25 percent of the state's population are covered by public insurance and 3 percent by individual health insurance.¹¹⁶

Connecticut has one of the highest percentages of private sector firms nationally that offer employer sponsored health insurance. In 2003, 65.3 percent of private sector establishments offered health insurance compared to 56.2 percent nationally, earning Connecticut a rank of 6 nationally. Hawaii has the highest percentage of private sector establishments that offer health insurance to their employees; Arkansas ranked 51st with only 42 percent of the firms offering health insurance to their employees.

If you work for a large employer, the chances of your employer providing health insurance are much better than if you work for a small employer. In 2003, 96.2 percent of private sector establishments with 50 or more employees in Connecticut offered health insurance to employees compared to 54.6 percent of private sector establishments with fewer than 50 or more employees in Connecticut offered health insurance to employees.¹¹⁷ Businesses that employ fewer than 50 employees comprise about 95 percent of the private sector establishments in Connecticut and represent about 44 percent of the state's employment.¹¹⁸ Clearly, addressing the affordability of the small business health insurance market needs to be a priority in any health care reform strategy.

The Institute of Medicine offers a set of principles for guiding the debate and evaluating various strategies that would reduce the number of uninsured persons:

- Health care coverage should be universal.
- Health care coverage should be continuous.
- Health care coverage should be affordable to individuals and families.
- The health insurance strategy should be affordable and sustainable for society.

- Health insurance should enhance health and well being by promoting access to high-quality care that is effective, efficient, safe, timely, patient centered, and equitable.¹¹⁹

A POLICY FRAMEWORK FOR REFORM IN CONNECTICUT

Rising health care costs limit the ability of Connecticut companies to compete in the global marketplace. The United States spends significantly more than other countries to provide health care and Connecticut's health care costs are among the highest in the nation. Yet this high level of health care spending has not translated into better patient outcomes or a higher quality of care. And there are too many individuals who lack access to health care because they lack health insurance.

There are currently at least 20 groups working on solutions to the health care crisis in Connecticut. Each has defined the issue from its own perspective, resulting in a wide range of potential policy recommendations. No comprehensive strategic framework has yet to be developed which incorporates all of the concerns of all of the groups.

During the next legislative session, leaders in both houses certainly take up the issue of health care. Whose voices will be heard? Will the state attempt comprehensive health care reform or incremental improvement? Will we give priority to access, quality or cost? Prevention or safety? Children or adults?

The Business Council of Fairfield County believes that the State of Connecticut must act now to address this looming health care crisis. We offer the following policy framework for health care reform in Connecticut:

FIRST, COMMIT TO A HEALTHY CONNECTICUT.

The reason is simple... Good health is essential for individuals to flourish as citizens, family members, workers and consumers.¹²⁰

And good health is less costly than poor health. Unhealthy lifestyles often contribute to the development or worsening of chronic disease. Chronic disease, such as diabetes, heart disease, and cancer, are a leading cause of death and disability. Seven out of ten deaths are the result of chronic disease and the medical costs of people with chronic disease account for 75% of the nation's medical costs.¹²¹ We cannot stem rising health care costs without addressing the problem of chronic

Connecticut will be the healthiest state in the nation that has high quality health care delivered by the most effective, efficient, safe, timely, patient centered and equitable health care system.

To achieve this goal, each state and municipal agency and department should identify how it can contribute to improved health status and quality of life for all of Connecticut residents and align their policies and programs accordingly. Connecticut must focus efforts on all three levels of disease prevention. The nation's disease prevention and health promotion agenda, Healthy People 2010, provides a framework for each state and municipal agency and department to follow.

The State should undertake a comprehensive review of health care reimbursement policies. Connecticut should develop and test financing models that are effective for reimbursing health care providers for prevention and chronic disease management services.

To launch the campaign to make Connecticut the Healthiest State in the Nation, the Governor and Legislature should convene a Healthy Connecticut Summit involving all stakeholders to develop a roadmap for comprehensive health care reform and an on-going process to sustain implementation efforts, such as a Connecticut Health Care Reform Study Group.

Progress should be measured annually with results posted on the Governor's website.

SECOND, EMPOWER CONSUMERS AND PURCHASERS OF HEALTH CARE WITH INFORMATION TO MAKE INFORMED DECISIONS.

Individuals, also, must take personal responsibility for their own health and become actively involved in their own health care. To empower the consumer and purchasers of health care, the State will need to increase transparency of health care information. The health care system should make available to patients and their families and health care purchasers reliable information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments.¹²² Price and quality information about hospitals, physicians, health plans and treatment options must become widely available.

Increased efforts will need to be taken to educate and inform enrollees about the safety, quality and affordability of health care and the importance of comparing the care health care providers give. To assist individuals to become actively involved in their health care, Connecticut must improve the health literacy of Connecticut's population.

national standards with significant gaps between racial/ethnic groups and poor/non-poor students.¹²⁴ This is a major problem as reading failure follows a child throughout his school career unless it is corrected. Because of the devastating psychological, social and economic consequences of reading failure, the National Institute of Child Health and Human Development (NICHD) has declared reading failure not only a critical educational issue but also a significant public health issue.¹²⁵

THIRD, CONNECTICUT MUST MAKE A COMMITMENT TO FACT-BASED POLICY ANALYSIS.

Effective governments and high performance organizations use data to inform decision-making and to drive performance. Both the Governor and the Legislative leadership must make a commitment to high quality government performance. GOVERNING, a respected public policy journal, rated Connecticut a C- for the overall quality of its service to its citizens. This was not a one-time occurrence. Connecticut has consistently fallen behind its peers.

Connecticut should establish and fund a Connecticut Center for Health Information and Policy Analysis. Development of a center is a critical building block of the 21st century health care system in Connecticut. A wealth of data and information is collected concerning population health and the health care system; however, data gathering is fragmented and is located within numerous state departments and maintained in inconsistent formats. Connecticut does not have a centralized health data system that provides reliable information about all components of health, including current health status, the determinants of health, resources and outcomes and that can drive quality improvement.

The need for improved data was acknowledged in a 1994 Health Cost Containment study prepared by the Connecticut Legislative Program Review and Investigations Committee:

"Inadequate data have perpetuated a system in which health care choices are not made on the basis of quality or cost...Given that information needed to monitor and support a competitive health care delivery system in the state is totally inadequate, Connecticut must support serious efforts to establish a statewide data repository".¹²⁶

The Connecticut Center for Health Information and Policy Analysis would establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health related data and statistics. The centerpiece of this effort would be a system to measure the quality performance of health plans and health care providers. The center should be

A Consumer Health Information and Policy Council should also be created to work with the center. The Council should be comprised of a broad base of stakeholders such as state policy makers, advocates, researchers, health care providers, employers, consumers, and insurers.

FOURTH, RECOGNIZE THAT EXPANDED ACCESS TO HEALTH CARE MUST BE COUPLED WITH IMPROVEMENTS IN THE QUALITY AND SAFETY OF THE HEALTH CARE SYSTEM. POOR QUALITY CARE HAS UNDERMINED PATIENT OUTCOMES AND ADDED BILLIONS OF UNNECESSARY COSTS TO THE HEALTH CARE SYSTEM.

Connecticut should strive for health coverage that is universal, continuous, affordable to individuals and families, is affordable and sustainable for society and enhances health and well being.

First, Connecticut should review existing programs to identify barriers to enrollment and access to health care.

Many individuals who are eligible for free or low cost public coverage through Medicaid or Children's Health Insurance Program (CHIP), but do not take up that coverage.¹²⁷ Connecticut should examine current state policies and procedures which make it difficult for eligible persons to enroll and/or stay enrolled in public programs such as HUSKY and SAGA in order to increase enrollment of those who are eligible for these programs.

Second, Connecticut must address the issue of Medicaid reimbursement rates.

Connecticut has one of the lowest Medicaid reimbursement rates in the nation.¹²⁸ Thus, low Medicaid reimbursement rates make it unlikely that physicians would be willing to accept new enrollees into their practices making expanded access to public health insurance an exercise in futility.

The low reimbursement rates coupled with free care to the uninsured, result in cost shifting to private payers as providers try to recoup their losses from Medicaid. This in turn increases the cost of employer sponsored and private health insurance.

An open and transparent analysis of Medicaid reimbursement rates coupled with a comprehensive review of plan design should be undertaken. The goal would be to raise reimbursement rates and to ensure that any reduction in cost shift is returned

A third step is for Connecticut to undertake a comprehensive review state health insurance mandates.

The issue of mandated benefits is clearly a contentious one and centers on consumer protections versus cost.¹²⁹ Those who support mandated benefits feel that mandates are necessary to ensure comprehensive health care coverage for consumers. Opponents of mandated benefits indicate that mandates drive up the cost of health insurance and contribute to the growing number of uninsured.¹³⁰ Mandates clearly have a financial impact on the affordability of health insurance products in the small business market.

Therefore, we believe that a dispassionate, careful, and transparent examination of current mandated health insurance benefits must be undertaken and publicly debated. The goal of such an analysis would be to develop a benefit plan design using principles established by the Institute of Medicine. That is, health benefits, programs, and reimbursement policies should improve health status and functioning of individuals and reduce the burden of illness, injury and disability by providing access to care that evidence-based, medically appropriate, cost effective, safe, timely, respects patient values, and does not vary in quality due to patient characteristics. A qualified consultant should be retained to undertake this review. A broad-based stakeholder steering committee, including employers and consumers, should be created to guide the work with the consultant. The study should also include recommendation for establishment of a credible on-going mechanism to evaluate future mandates that may be proposed.

Fourth, Connecticut must actively promote quality and safety.

The National Quality Forum, with support from the Agency for Healthcare Research and Quality (AHRQ), has endorsed 30 safe practices that evidence shows can work to reduce or prevent adverse events and medical errors.¹³¹ The National Quality Forum is a private, non-profit public benefit corporation created in 1999 in response to the need to develop and implement a national strategy for health care quality measurement and reporting. It includes representatives of 215 of the Nation's leading health care provider, purchaser, and consumer organizations.

Connecticut should encourage adoption of these safe practices by all applicable health care settings to reduce the risk of harm to patients. Health providers should be given incentives to implement practices that evidence shows can work to reduce or prevent adverse events and medical errors.

Connecticut needs to develop an effective reporting system for medical errors and health care acquired infections. The Veteran's Administration has implemented a

Fifth, Connecticut must actively promote evidence based care with an emphasis prevention of disease and illness and management of chronic disease.

Patients should receive care based upon the best scientific knowledge available and that care should not vary from clinician to clinician.¹³² Payment systems should be devised that reward clinicians who provide evidence based-care. The current fee for service payment system pays for service regardless of quality.

Consumers and health care providers should understand the value of prevention strategies. They decrease not only the incidence of serious disease, but once those diseases do occur, they decrease the burden of the complications of disease.

Consumers and health care purchasers should choose hospitals with extensive experience and the best results with certain high-risk surgeries and conditions. By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria — such as the number of times a hospital performs these procedures each year or other process or outcomes data — research indicates that a patient's risk of dying could be reduced by 40 percent.¹³³

Sixth, Connecticut should promote increased use of health information technology and make sure that these systems are able to communicate using an open architecture and embracing the principle of interoperability.

Encourage adoption of health information technology systems in hospital and physician offices such as electronic medical health records and computer physician ordered entry systems for prescribing medications to improve patient safety and quality. With CPOE systems, hospital staff enters medication orders via computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50 percent.¹³⁴

Seventh, Connecticut must build capacity of the regional higher education system to graduate more qualified allied health professionals.

Research by others confirms that Connecticut is facing a severe workforce shortage in several health care occupations.¹³⁵ The situation will only get worse as the Baby Boomers begin to retire in 2011.

Connecticut must urgently address this issue by:

- Addressing the nursing faculty shortage- The State of Connecticut should allow Community College Presidents the ability to offer competitive salaries to faculty in current and project workforce shortage areas as identified by the

Connecticut should develop a plan that identifies specific numerical targets for each occupation and monitor the number of individuals that graduate annually from the higher education system. The results should be reported annually to the Legislature.

Conclusion

The health care crisis creates the opportunity for the State of Connecticut and its business community to work together to make sure our state has the best access to the safest, most affordable, high quality health care. The solutions to the health care crisis will require leadership and sustained efforts on the part of all stakeholders. We ask the Governor and Legislature to convene a Healthy Connecticut Summit that will develop a blueprint for comprehensive healthcare reform and a mechanism for on-going process to sustain reform efforts, such as creation of a Connecticut Health Care Reform Study Group.

There is much work to be done. It is time for Connecticut to get started.