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LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. Box 541
HONOLULU, HAWAII 96809
Phone Number: (808) 586-2850
Fax Number: (808) 586-2856
www.hawaii.gov/dcca

LAWRENCE M. REIFURTH
DIRECTOR

RONALD BOYER
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON FINANCE

TWENTY-FOURTH LEGISLATURE
Regular Session of 2008

Friday, March 28, 2008
Agenda #2
3:15 p.m.

WRITTEN TESTIMONY ONLY

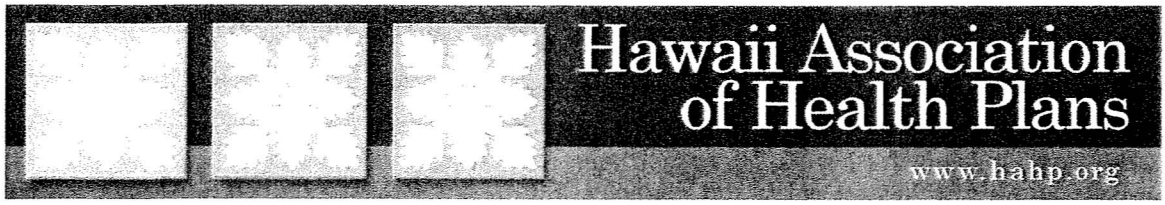
TESTIMONY ON SENATE BILL NO. 409, SD 2 – RELATING TO HEALTH.

TO THE HONORABLE MARCUS R. OSHIRO, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J. P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no position on this bill, which creates a mandated benefit for medical vigilance services.

The Department does not have the medical expertise necessary to express an informed opinion on the merits of this bill. However, while mandated benefits help some patients, they also increase premiums for consumers.

We thank this Committee for the opportunity to present testimony on this matter.



March 28, 2008

The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

House Committee on Finance

Re: SB 409 SD2 – Relating to Health

Dear Chair Oshiro, Vice Chair Lee and Members of the Committee:

My name is Rick Jackson and I am President of the Hawaii Association of Health Plans ("HAHP"). HAHP is a non-profit organization consisting of seven (7) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.
MDX Hawai'i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify <u>in opposition</u> to SB 409 SD2 which mandates health plans to cover a specific remote monitoring technology for members who are receiving in-patient health care services at an acute care hospital.

We believe that SB 409 SD2 is particularly problematic as it seems to be mandating that health plans provide coverage for a specific trademarked product and not a health service. This is the conclusion reached by the State Auditor in a report issued recently on mandating this technology. Passage of SB 409 SD2 would set a dangerous precedent by mandating the use of a specific product. This could in turn open the door for numerous other companies with health related technology and devices approaching the legislature with requests to mandate the use of their wares.

In addition, HAHP recognizes that legislative health mandates are often driven by the desire for improved health care services to the community; as health plans, our member organizations are committed to the same ideal. In general, however, HAHP member organizations oppose legislative health mandates as inefficient mechanisms for health care improvement for three reasons:

1. Mandates, by their basic nature, increase health care costs for employers and employees.

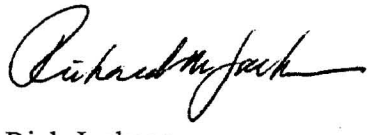
2. We believe employers should have the right to, working with their insurer, define the benefit package they offer to their employees. Mandates misallocate scarce resources by requiring consumers (and their employers) to spend available funds on benefits that they would otherwise not choose to purchase.

3. Mandates impose static clinical procedures which can fail to promote evidence-based medicine, defined as the daily practice of medicine based on the highest level of available evidence determined through scientific study. Evidence-based medicine promotes high quality care. Unfortunately, even when a mandate promotes evidence-based medicine when adopted, the mandate does not timely change to reflect medical advances, new medical technology, or other new developments. Mandates can become obsolete or even harmful to patients.

For the reasons listed above, we would respectfully request the Committee hold this measure today.

Thank you for the opportunity to testify.

Sincerely,



Rick Jackson
President

The Chamber of Commerce of Hawaii

Since 1850

Testimony to the House Committee on Finance
Friday, March 28, 2008 at 3:15 p.m.
Conference Room 308, State Capitol
(Agenda #2)

RE: SENATE BILL NO. 409 SD2 relating to Health

Chair Oshiro, Vice Chair Lee, and Members of the Committee:

My name is Jim Tollefson and I am the President and CEO of The Chamber of Commerce of Hawaii ("The Chamber"). The Chamber does not support SB 409, SD2 relating to Health.

The Chamber is the largest business organization in Hawaii, representing over 1100 businesses. Approximately 80% of our members are small businesses with less than 20 employees. As the "Voice of Business" in Hawaii, the organization works on behalf of members and the entire business community to improve the state's economic climate and to foster positive action on issues of common concern.

This measure requires health insurance policies to cover medical vigilance services for subscribers who are receiving in-patient health care services at an acute care hospital.

While the Chamber understands the need to find ways to enhance patient safety, mandating coverage for a method of providing a benefit is not the right approach. The implications of this measure are far-reaching for the entire business community. Furthermore, The Chamber's concern is that any new health care mandate will undoubtedly increase the overall cost of health care premiums for employers. These types of benefit decisions should be left to the purview of the employer purchasing the coverage.

In light of the above, The Chamber of Commerce of Hawaii respectfully requests that the committee holds SB 409 SD2. Thank you for the opportunity to testify.

1132 Bishop Street, Suite 402 • Honolulu, Hawaii 96813 • Phone: (808) 545-4300 • Facsimile: (808) 545-4369

HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

Conference Room 308
March 28, 2008 at 3:15 p.m. (Agenda #2)

Testimony in opposition to SB 409 SD 2.

I am Rich Meiers, President and CEO of the Healthcare Association of Hawaii, which represents the entire spectrum of health care, including acute care hospitals, two-thirds of the long term care beds in Hawaii, as well as home care and hospice providers. Thank you for this opportunity to testify in opposition to SB 409 SD 2, which mandates that all health care insurance plans cover medical vigilance services.

At the outset, let me say that the intent of this bill is noteworthy since it attempts to improve the treatment of illnesses, injuries, and diseases. At the same time, however, Hawaii's Prepaid Health Care Act (PHCA) was never meant to provide total coverage for all treatments of all illnesses, injuries, and diseases because of the high costs that would be incurred. These high costs would then be reflected in health care insurance rates paid by employers and employees. Rather, the PHCA was meant to provide basic coverage to a broad population.

It is true that this bill would raise health care insurance premiums by only a small amount. However, there are many different types of mandates that have been proposed in the past, that are currently being proposed, and no doubt will be proposed in the future. In the eyes of their advocates, all of these mandates are equally worthy. However, the adoption of all of these mandates would increase health care insurance costs significantly.

For the foregoing reasons, the Healthcare Association of Hawaii opposes SB 409 SD 2.

932 Ward Avenue Suite 430 Honolulu, Hawaii 96814-2126 Phone: 808/521-8961 FAX: 808/599-2579

THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 538-9011 • Fax: (808) 547-4646

HOUSE COMMITTEE ON FINANCE
Representative Marcus R. Oshiro, Chair
Representative Marilyn B. Lee, Vice Chair

Friday, March 28, 2008 – 3:15 p.m.
State Capitol, Conference Room 308
Deliver to: Room 306, 2 copies

In Support of SB 409 SD2, Relating to Health

Chair Oshiro, Vice Chair Lee, and Members of the Committee:

My name is Cindy Kamikawa, Vice President of Nursing and Chief Nursing Officer at The Queen's Medical Center. The Queen's Medical Center supports Senate Bill 409 SD2, which requires health insurance policies to cover medical vigilance services for subscribers who are receiving in-patient health care services at an acute care hospital.

The Queen's Medical Center is the largest private tertiary care hospital in the State of Hawaii. We have over 20,000 inpatient admissions per year and offer specialized care in the areas of cardiology, neuroscience, orthopedics, behavioral health, oncology, women's health, emergency services and trauma.

The issues challenging healthcare can be overwhelming. As a community, we expect the best healthcare delivery; nevertheless, complicating issues such as an the aging population, greater patient acuity, increasing costs, a shortage of qualified nurses, etc., make continued delivery of quality healthcare a challenge for hospitals. Inpatient care is further complicated because of ongoing changes in Medicare reimbursements and insurance coverage. Hoana's LifeBed is helping us face these challenges, as we can now monitor patients from admission to discharge, to provide high quality care.

Our experience with LifeBed at Queen's has been very positive. LifeBed serves as a safety-net for our patients. We can find patients in trouble early and quickly bring nursing to the bedside, resulting in early interventions that improve the quality care and patient outcomes. For all these reasons, I urge you to support the reimbursement of the LifeBed patient vigilance system through the passage of Senate Bill 409 SD2.

Thank you for this opportunity to testify.

Cindy Kamikawa, RN, MS, CNAA
Vice President, Nursing, and Chief Nursing Officer
The Queen's Medical Center

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Government Affairs

Testimony of
Phyllis Dendle
Director of Government Affairs

Before:
House Committee on Finance
The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair

March 28, 2008
3:15 PM
Conference Room 308

SB 409 SD2 RELATING TO HEALTH

Chair Oshiro and committee members, thank you for this opportunity to provide testimony on SB 409 SD2 requiring health plan coverage for medical vigilance services.

Kaiser Permanente Hawaii has concerns about this bill.

Kaiser Permanente's position on proposed legislative mandates of health coverage is that they are usually not a good idea, for several reasons:

1. First, because they generally tend to raise the cost of delivering health care, thereby resulting in higher premiums and increased cost to the purchasers and payors of health plan coverage, whether they be employer groups or individuals;
2. Second, because they often tend to dictate how medicine should be practiced, which sometimes results in medicine that is not evidence based and usurps the role and expertise of the practicing physician and other health care professionals who provide medical treatment and services; and
3. Finally, because they often lock in statutory requirements that become outdated and do not keep pace with the ever evolving and advancing fields of medicine and medical technology.

All three of these reasons apply to this proposed mandate. In addition, in the impact assessment report, which was requested in SCR209 HD1CD1 of 2007, the Legislative Auditor made no recommendation. The report did however, explain that what is being proposed here is to mandate, not a service, but a specific, trademarked product available from only one source.

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5210
Facsimile: 808-432-5906
Mobile: 808-754-7007
E-mail: phyllis.dendle@kp.org

As the auditor explains: "the use of the term, intelligent medical vigilance system, more aptly identifies a specific product rather than services or intangible activities performed by a person to benefit another." Also from the auditor's report: "We found that the only early alert system with intelligent medical vigilance technology that meets this definitions of the bill refer to a specific, trademarked, commercial product, rather than a specific health care service…"

This sets a bad precedent. It could give an unfair competitive advantage to a single company. The mandate would not require coverage for a new service. The services this product might provide are services already provided through other means in acute care facilities. Nothing prevents an acute care facility from using this product if they believe it is a more effective means of patient monitoring.

We also note that the auditor found that this bill does not identify:

"• the extent of the coverage, such as length of use, level of service, provider, conditions to initiate or terminate service;
• limits on utilization, if any, that is, limited to certain types of patients, conditions, frequency; and
• standards of care to be followed for accident prevention, and how this relates to a specific health service, disease, or provider.

The bill needs to accurately identify the target groups that would be covered."

In light of these concerns we urge you to hold this bill.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 28, 2008

The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

House Committee on Finance

Re: SB 409 SD2 – Relating to Health

Dear Chair Oshiro, Vice Chair Lee and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 409 SD2 which would require health plans cover the use of a certain trademarked patient monitoring technology. HMSA opposes this measure.

On the surface this measure may resemble other unfunded mandated health care benefits which have been proposed throughout this legislative session. Upon closer examination however, what SB 409 SD2 really proposes is to legislate the reimbursement of a specific trademarked technology which hospitals in the state would be forced to purchase and health plans required to include in their benefit packages. We believe that the cost of this unprecedented legislation could be quite considerable and cause a significant impact on health care premiums. As the only state with a true employer mandate in the U.S., the majority of these costs would be borne by Hawaii's employers.

Prior to the inclusion of any new mandated benefits, the State Auditor is requested to perform a study on the financial and social impact of the additional health care services. At the beginning of this month, the State Auditor published a study on this issue. We appreciate the work done by the Auditor whose report specifically stated that a recommendation could not be made due to the fact that it was inappropriate for her office to recommend "a specific, trademarked, commercial product" for coverage as a mandated benefit. We believe that a dangerous precedent would be set with the passage of this measure where companies turn to legislative relief in order to mandate the usage of their specific product or technology.

Not only would health plans be required to provide reimbursement for a trademarked product, this measure would essentially force facilities to remain wedded to a specific technology in a rapidly changing field. Hawaii's hospitals would not be able to make decisions based on the best technology available since SB 409 SD favors one company's technology above all others. Tying the hands of Hawaii's hospitals in this manner may not be in the best interest of consumers who are utilizing their services.

Additionally, we believe that this type of mandate would be difficult and onerous to implement due to the current payment structure used by most health plans in the State. Currently hospitals are paid using Diagnosis Related Groups (DRGs) which provide a finance and patient classification system using diagnosis, type of treatment, age and other related factors as screening criteria. Under the DRG system, hospitals are already compensated for patient safety and monitoring processes through this system of reimbursement. Passage of this measure would set a precedent and could open the door for separate payments being requested for additional technologies, equipment and supplies.

Due to the shortcomings of SB 409 SD2 and the flawed policy it represents as supported by the State Auditor's report, we would respectfully request the Committee hold this measure.

Thank you for the opportunity to testify in opposition to SB 409 SD2.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations

Hawaii Pacific Health

55 Merchant Street • Honolulu, Hawaii 96813 • hawaiipacifichealth.org

[2 Copies]

Friday, March 28, 2008 – 3:15pm
Conference Room 308
Agenda #2

The House Committee on Finance

To: The Honorable Marcus Oshiro, Chair
The Honorable Marilyn B. Lee, Vice-Chair

From: Virginia Pressler, MD, MBA
Executive Vice President

Re: Testimony in Opposition to SB 409 SD2 - Relating to Health

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Dear Honorable Committee Chairs and Members:

My name is Virginia Pressler, Executive Vice President for Hawaii Pacific Health (HPH). For more than a century, families in Hawaii and the Pacific Region have relied on the hospitals, clinics, physicians and staff of Hawaii Pacific Health as trusted healthcare providers. Our non-profit integrated healthcare system is the state's largest healthcare provider and is committed to improving the health and well-being of the people of Hawaii and the Pacific Region through its four hospitals -- Kapi`olani Medical Center for Women & Children, Kapiolani Medical Center at Pali Momi, Straub Clinic & Hospital and Wilcox Memorial Hospital -- 18 outpatient centers and a team of 1,100 physicians on the islands of Oahu, Kauai and Lanai.

We are writing in **strong opposition to SB 409 SD2** which requires insurance policies to cover medical vigilance services for subscribers who are already receiving in-patient health care services at an acute care hospital. There is currently only one product that would meet the criteria providing "medical vigilance services" as defined in this legislation. Therefore the passage of this bill would be at the expense of all other patient monitoring technology devices that are currently in place.

Ensuring patient safety and quality is the highest priority of Hawaii Pacific Health. However we believe that mandating specific medical equipment is bad public policy and will set a dangerous precedent whereby individual companies can seek out support via legislation for purchase of their products/services.

Therefore we ask that you **hold SB 409 SD2 from this committee**.

HOUSE OF REPRESENTATIVES
24th LEGISLATURE
REGULAR SESSION OF 2008

COMMITTEE ON FINANCE
Representative Oshiro, Chair

3/27/08

SB 409, SD 2
Relating to Health
Agenda #2

Chair Oshiro and members of this Committee, my name is Max Sword, here on behalf of Outrigger Hotels & Resorts to speak against this bill.

SB 409 basically proposes to mandate coverage for a service that is already provided in hospitals and covered by the current health plans. The bill mandates a very specific type of product, which requires a separate payment schedule that is beyond the current payments by a health plan.

I am sorry Mr. Chairman, but this bill is rather self-serving to a few who would benefit financially from this bill and will only drive up the cost of medical care, unnecessarily.

We ask that you pass this bill out.

HOANA™
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Legislative Testimony Presented Before the House Committee on Finance
Representative Marcus R. Oshiro, Chair
Representative Marilyn B. Lee, Vice Chair

Friday, March 28, 2008
3:15 p.m.
Conference Room 308
State Capitol
415 South Beretania Street
Honolulu, HI 96813

Testimony in support of Senate Bill 408, S.D.2 Relating To Health

Chair Oshiro, Vice Chair Lee and members of the committee:

Thank you for the opportunity to testify in support of Senate Bill 409, S.D.2 Relating To Health.
My name is Larry Burgess. I am a practicing surgeon and the Vice President of Medical Affairs at Hoana Medical, Inc.

In the 1999 landmark report entitled "To Err is Human," the Institute of Medicine, part of the National Academies, estimated that at least 44,000 and as many as 98,000 Americans die each year unnecessarily because of medical errors. In its 2006 report The HealthGrades, Inc. 2006 estimated that nearly 200,000 Americans die each year unnecessarily because of medical errors.

In April 2007, HealthGrades released its Fourth Annual Patient Safety in American Hospitals Study. This report is based on the examination of 40.5 million Medicare discharges from non-federal hospitals nationwide from 2003-2005. During this three year period, their report estimated the following for Medicare patients:

- 1.16 million patient safety incidents
- $8.6 billion of excess cost to taxpayers due to patient safety incidents
- 285,000 deaths in low-mortality, low-risk diagnosis related groups (DRGs)
- 248,000 of 285,000 (87%) were preventable deaths
- Failure to rescue was the most common patient safety incident (57%)
- Failure to rescue was the most common cause of death (69%)
- Distinguished hospitals for patient safety (the top 15%) had a 40% lower incidence in patient safety incidents.

Where does Hawai'i stand in patient safety? The State of Hawai'i scores very poorly in this analysis, and alarmingly, ranks dead last in the two key mortality indicators (no pun intended). Hospitals in Hawai'i ranked as bottom performers for all hospitals in the rate of patient safety incidents nationwide for Medicare patients, ranking 43rd of 51. For the

key mortality rates, failure to rescue and death in low-mortality DRGs, Hawai'i ranked dead last or 51st out of 51 for each indicator, respectively. In other words, ***patients admitted to hospitals in Hawai'i are more likely to die from a patient safety event than anywhere else in the United States. The situation for Hawai'i will become more dire in the immediate future, as we continue to face a nursing shortage, increase in the number of the State's aging population who require hospitalization and struggle with significant budget deficits.***

Failure to rescue is the most commonly occurring patient safety indicator and leading cause of death. What is Failure to Rescue? It is the hospital's inability to save a patient's life when the patient has acquired a complication, such as when a patient gets over medicated or is given the wrong medication or experiences an unexpected cardiac arrest and dies. This indicator identifies patients who die following the development of specified complications. Failure to Rescue is associated with lack of early detection or recognition. Failure to identify complications early can result in more difficulty in "rescuing" such patients, with an increase in the death rate and an increase in hospital cost. Death from a low mortality-DRG is the other mortality indicator in the HealthGrades nationwide study. A low-mortality DRG can be defined as a diagnosis or group of diagnoses that are unlikely to result in death, because they are considered to be low-risk. As such, the indicator is intended to identify in-hospital deaths in patients who are not expected to die during hospitalization. The underlying assumption is that when patients are admitted for an extremely low-mortality condition or procedure and they die, a health care error is quite likely to be responsible. Patients experiencing trauma or having an immunocompromised state or cancer are excluded, as these patients have higher non-preventable mortality (AHRQ, 2006).

With most safety incidents either being identified or managed on the medical surgical unit (MSU), enhancing care and reducing errors on the MSU will improve patient safety and reduce mortality. **The current standard of care for patient monitoring on the medical surgical unit consists of interval vital sign checks every 4 to 8 hours by the nursing staff, which leaves large gaps in patient monitoring for evolving or sudden deterioration** (Evans et al, 2001). Eighty percent of MSU patients are not monitored by any electronic device, and those 20% that are being monitored for heart or respiratory rate conditions are not monitored continuously (Akridge, 2005), and the monitor is in the patient's room away from the nursing staff. Hillman (2001) and Buist (1999, 2004) have shown that MSU patients have abnormalities in heart and/or respiratory rates several hours (mean 6.5 hrs) prior to a critical cardiopulmonary event. Galhotra and Devita at al (2007) confirmed that event survival rates from a cardiopulmonary arrest on the MSU were significantly lower than those for arrests occurring in monitored beds (intensive care 83%, monitored 69%, and unmonitored med surg floor 36%, p=0.002). **They point to the lack of monitoring on the MSU, and late recognition of patient deterioration as the causes of these differences.**

More recently, the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission) (2007) summarized these and other findings, reporting that 4% to 17% of inpatient admissions have critical events such as cardiopulmonary and respiratory arrests and vital sign changes, with warning signs preceding events by an average of 6 to 8 hours. Moreover, epidemiologic analysis of the timing of crisis calls in hospitals has demonstrated clustering of emergency calls at times of nursing handovers

and routine observations, suggesting that episodes of patient deterioration have gone unrecognized and have been accumulating throughout the shift (Jones 2005, Devita 2006). Similarly unrecognized cardiac arrest occurs during the late night shift (graveyard shift) (Peberdy 2007). With this known problem of interval vital signs monitoring, intensive care (ICU) and telemetry units are frequently overburdened with patients that instead require more vigilant monitoring for general cardio-respiratory issues, as opposed to intensive care or telemetry (arrhythmia) monitoring (Bonvissuto, 1994; Pelczarski and Barbell, 1993). This drives the cost of care higher, but from the provider's perspective is somewhat understandable, since there is no other alternative than the current standard of care of interval vital sign checks on the med surg floor. One might propose increasing the frequency of vital sign checks on the med surg floor, but workload will increase, monitoring gaps will still be present between readings, and trends will still be difficult to detect without computerized algorithms to track the data.

Nursing shortages are contributing to unacceptable nurse:patient ratios, adding to the lack of vigilance in patient monitoring on the MSU. Currently, a shortage of approximately 126,000 nurses exists in the U.S. This shortage is expected to increase to 808,000 by the year 2020 (both figures from US Dept. of Health and Human Services, 2002). In the State of Hawai'i we currently have a shortage of approximately 1,211 FTE RNs or a 14% demand shortfall. By the year 2020, our shortage is expected to be 2,669 or a 24% demand shortfall according to the Hawai'i State Center for Nursing, 2007. A recent study of nurse:patient ratios concluded that "...each additional patient per nurse (after 4) is associated with a 7% increase in both patient mortality and deaths following complications ..."(Aiken *et al*, 2002, pp. 1987). In patients who underwent general surgical procedures, lower failure-to-rescue rates were found at hospitals with high ratios of registered nurses to beds (Silber et al, 1995). Needleman and Buerhaus confirmed that higher registered nurse staffing (RN hours/adjusted patient day) and better nursing skill mix (RN hours/licensed nurse hours) were consistently associated with better failure-to-rescue rates. The nursing shortage is a critical element in delivering quality care at the bedside, but even with adequate nurse: patient ratios, the standard practice of interval vital sign checks will still miss sudden or evolving changes in a patient's condition.

Given the deficiency in patient vigilance due to interval vital signs monitoring, rising acuity of hospitalized patients, the aging U.S. population, overuse of ICU/telemetry beds, and the nursing shortage, cost-effective solutions need to be developed to provide patient safety on the MSU. In response to these concerns, The Joint Commission's 2008 National Patient Safety Goal #16 is mandating hospitals to "improve recognition and response to changes in a patient's condition." As the primary certifying body of hospitals in the United States, The Joint Commission has recognized the importance of more vigilant monitoring of patients. In responding to a deteriorating patient, the likely solution for most hospitals will be a Rapid Response Team (RRT) program, which allows for rapid evaluation and management of the patient. However, this resource cannot be successful without the early recognition of changes related to deterioration in a patient's condition. Late activation of the RRT will still lead to poor patient outcomes, while premature activation will lead to a costly resource drain for the institution.

"...The inescapable conclusion will be that hospitals do not reliably find patients in crisis, which is an obviously dangerous situation. To respond to this finding, a redesign is in order. Hospitals need some form of improved detection system, involving increased staffing, more frequent visits, or more frequent use of monitoring, perhaps in every hospitalized patient," Galhorta and Devita et al (2007). These researchers conclude that increased staffing is not likely, and that continuous monitoring of all hospitalized patients may be less expensive and life saving.

The purpose of S.B. 409, S.D.2 is to ensure that patients in Hawai'i hospitals receive quality health care by requiring health insurance providers to include patient safety measures such as medical vigilance services in their policies for covered patients who are receiving in-patient health care services on Medical Surgical Units at an acute care hospital.

Timely recognition of emerging patient conditions is the most critical component to cost-conscious patient safety, allowing the delivery of the appropriate level of care to the patient's bedside at the appropriate time. Young et al (2003) found that a delay of greater than four hours in transferring a critically ill patient to the intensive care unit (ICU) was associated with significant increase in morbidity, mortality, and costs. With early recognition, the response can range from activation of a Rapid Response Team (RRT), but more commonly, nursing or physician assessment to evaluate issues that can be resolved without RRT activation. In fact a vigilance system that can alert the nurse of any change is even more rapid that an RRT because it provides constant surveillance of the patient. Early recognition of patient deterioration is the key element in providing patient safety under this needed change in the standard of care.

S.B. 409 S.D. 2 provides for a medical vigilance system or a patient safety monitor which provides continuous vigilance round the clock and that alerts the nurse early of changes in a patient's condition which is important in providing patient safety and care and avoiding deaths. A vigilance system that has the ability to see changes in vital signs before anyone notices the change is essential. Vigilant surveillance can improve patient safety while being economically feasible. A patient vigilance system has been shown to provide an important safety net on the MSU, reducing risk to the patient while maximizing the efficient use of resources The State Auditor mistakenly characterized the medical vigilance system as a product and a trademark of Hoana Medical, Inc. Hoana's trademark is "Intelligent Medical Vigilance System" and "LifeBed". What Hoana – and other companies offering similar systems - offer is a service. We are not asking the Legislature to limit the bill to the use of Hoana's services. Certainly there are other solutions that can meet this need.

Improving patient safety is one of the most highly publicized issues facing health care organization in the nation and within Hawai'i. Regulatory, accreditation and performance improvements groups, the Institute of Healthcare Improvement (IHI), the Institute of Safe Medical Practice (ISMP) and others have published a wide range of mandates and recommendations to improve patient safety in hospitals. With ever increasing demands and scarcer resources, coupled with Hawai'i ranking last in the nation for death surrounding failure to rescue and patient safety, some of the state's collective bargaining organization's health and welfare trust funds are being responsive to these concerns. In fact the Trustees (comprised of employer and employee

representatives) of 7 of the Union's Health and Welfare Trust Funds representing approximately 230,000 people want patient safety services for their members and their families. (Several more are interested and are looking into providing patient safety services to members). Accordingly, these Trust Funds have provided a medical vigilance service or patient safety monitor service while hospitalized on the MSU as a benefit through the health plans. The Trust Funds are: the Employer Union Health Trust Fund (EUTF) which represents all state and county government employees; Hotel and Restaurant Employees, Local 5; Teamsters; ILWU Hotel Workers; Carpenters; Laborers and the United Food and Commercial Workers Union. Additionally, the Hawai'i Medical Assurance Association has decided to provide medical vigilance service as a covered benefit to its members/participants. These providers and payors recognize the importance of stepping up to ensure that their members receive continuous vigilance and are safe from failure to rescue on the MSU of an acute care hospital. They also recognize that continuous vigilance will provide an important cost-effective safety net for its members, saving lives and protecting against complications, while protecting the health and welfare trust fund economically against some of the catastrophic costs surrounding certain patient safety complications.

We believe that we all want to do the right thing in a precarious environment like a Hawai'i hospital where failure to rescue is of great concern. We believe that it is reasonable and appropriate to request the Legislature to stand up for the people of Hawai'i in providing medical vigilance service. We believe that the Legislature of the State of Hawai'i can play an important role in improving the State's ranking of being 51 out of 51 for failure to rescue by supporting SB 409 SD2.

We would like to offer the following amendments to SB409 SD2:
Section 3, 432:1, (a)

(3)The extent of the coverage is the entire hospital stay on the medical surgical unit of an acute care hospital

(4) The target group includes adult patients on the medical surgical unit of acute care hospitals

(5) Use of the service is limited to standard hospital beds in use on inpatient medical surgical units. It would not apply to bariatric beds, wound care beds, patients that exceed the 99-499 pound parameters, or to pediatric patients.

(6) The standard of care for all patients on the medical surgical unit shall include an early warning system or early recognition of a patient's condition, including but not limited to the following:

a. continuous monitoring of heart rate and respiratory rate that provides an alert to nurses to enable them to identify patients who are decompensating prior to a critical event.

b. continuous monitoring of patient movement within the hospital bed to prevent falls and their sequelae (such as broken hips, which have been found to be a leading cause of deaths particularly among older men)

c. nurse staffing levels to provide safe and effective care.

Thank you for this opportunity to offer our comments. The State of Hawai'i can no longer tolerate being last in the nation in patient safety and related mortality. An economically viable alternative, vigilant surveillance, can immediately improve the patient safety climate in our hospitals and save lives. A patient vigilance system has proven itself in this arena. The people of Hawai'i, our family, our friends, we, only deserve the safest health care. Nearly all of us know about friends or relatives, who went to the hospital, and for some reason, expired on the MSU when they were apparently doing fine. Unfortunately, this will happen, as the system of periodic vital sign checks allows patient deterioration to go unnoticed. In its place, vigilant surveillance will provide continuous observation of patients on the MSU, serving as the final safety net for the patient, whether deterioration is due to complications of disease or due to hospital errors.