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HEALTH DIVIDES

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Ambulance Diversion — a Shortsighted Strategy to Alleviate Emergency Department Congestion

By David Tuller, Health Affairs Journal
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Efforts to mitigate ambulance diversion have been effective, but questions remain for future progress.

What's the issue?

Ambulance diversion is a controversial strategy for temporarily relieving overcrowding in emergency departments (EDs). When a hospital invokes diversion status, incoming ambulances are directed to other facilities. As a response to ED congestion — first cited in a 1990 article in the journal Hospital Topics — less severely injured patients were transported to other nearby facilities.

At that time, ambulance diversion was viewed as a relatively rare option for coping with unexpected events or crises, but the phenomenon became a frequent occurrence over the next decade. In 2003, according to a 2006 study in the Annals of Emergency Medicine, 45 percent of EDs in the United States reported having gone on diversion status during the previous year, and in urban hospitals the rate

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Deadly Hep C Going Untreated in Native Communities

By Tanya H. Lee, Indian Country Today
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Hepatitis C is raging through American Indian and Alaska Native communities, and the Indian Health Service does not have nearly enough funding to fight the disease, according to a May 26 article in the Journal of the American Medical Association.

"Access to [HCV, or hepatitis C virus] treatment for IHS patients should be a federal priority to fulfill its obligations to tribal nations and American Indian/ Alaska Native people," wrote Joe Finkbonner, Lummi, executive director of the Northwest Portland Area Indian Health Board, and Jessica Leston, Tsimshian, HIV/STI/HCV Clinical Programs Manager for the non-profit tribal advisory organization.

Roughly 120,000 people living on reservations are positive for the HCV

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was almost 70 percent.

The study also reported that there were about half a million incidents of ambulance diversion in 2003 — an average of about one per minute. In the short term, ambulance diversion provides breathing room to the ED that invokes diversion status, allowing it to return to optimal functioning as it processes the overflow of patients. If the situation continues for an extended period, however, it can create a domino effect, triggering nearby facilities — now clogged with the diverted patients — to themselves go on diversion status. It can also lead to delays in medical care for patients elsewhere in the health care system. If an ambulance cannot bring people to the nearest facility, they have to be transported longer distances to receive necessary treatment. This increased travel time can reduce the availability of ambulances for new calls for other patients awaiting emergency medical service. Despite these drawbacks, persistently high ED traffic has led to the continued use of ambulance diversion as a strategy for managing patient volume. "With the belief that ambulance diversion is a quick way to reduce hospital and ED overcrowding, many hospitals regularly use ambulance diversion," noted a 2015 editorial in the American Journal of Emergency Medicine. "However, experts believe the practice does little if anything to reduce crowding; and research also suggests that diversion has negative patient care consequences."

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While research has linked ambulance diversion to delays in treatment and related indicators, such studies have often used diversion as a proxy for ED overcrowding. Given the many factors implicated in generating such conditions, experts generally consider restricting ambulance diversion, on its own, to be an ineffective and shortsighted strategy for addressing the problem. In recent years, studies from California, Massachusetts and elsewhere have focused on efforts to reduce or ban ambulance diversion as part of comprehensive and coordinated approaches to alleviating ED congestion and improving patient flow, both within hospitals and among multiple facilities across a city or region.

What's next?

Ambulance diversion remains a critical issue at EDs across the country. Yet addressing it is complex because it is a symptom of the larger problem of ED and hospital overcrowding. Focusing solely on altering diversion strategies, therefore, might lead to temporary relief but is unlikely to resolve the overall problems that diversion is supposed to address.

As recent research has shown, approaches to overcrowding that incorporate additional strategies alongside limitations on diversions are more likely to be effective in generating long-term changes. Moreover, greater regional communication and cooperation can minimize the likelihood of a domino effect that flips one hospital after another into diversion status. In

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addition to seeking to improve patient care, hospitals recognize that they have a significant financial incentive to grapple with ambulance diversion, since sending patients away results in revenue loses. One study at an urban teaching hospital calculated that each hour of diversion was associated with a loss of more than $1,000 in revenue from patients brought by ambulance, while implementation of changes that limited diversion led to increased revenue of almost $200,000 a month.

Yet widespread progress in mitigating diversion has not occurred. The Affordable Care Act (ACA) did not include specific provisions about ambulance diversion. But the primary care system is not prepared to address the needs of the many millions of newly insured people, so EDs could see a continued increase in demand. Although the rise in urgent care centers could mitigate the impact, a recent post-ACA survey conducted by the American College of Emergency Physicians revealed a concerning statistic: 70 percent of respondents stated that their ED would not be adequately prepared for substantial increases in patient volume. Further research on the ACA's impact on ED usage should help health care officials and administrators develop comprehensive policies to improve patient flow and reduce ambulance diversion that are appropriate for the new environment.

Source: "Health Policy Brief: Ambulance Diversion," Health Affairs, June 2, 2016. Health Policy Briefs are produced under a partnership of Health Affairs and the Robert Wood Johnson Foundation.http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=158

Affordable Housing Offers Promising Health Care Outcomes

By Samantha Curran
CFI Communications Associate

It has long been understood within the health care sector that health outcomes and housing are correlated.

But no empirical research has ever been done to prove the link between the two until the release of a new study from the Center for Outcomes Research & Education, "Health and Housing: Exploring the Intersection Between Housing & Health Care."

This groundbreaking report, which could be thought-provoking for Colorado policy makers, analyzes how investment in affordable housing can be a key factor in lowering health care costs, increasing access to primary care and improving

quality of care for low-income individuals and families.

The study was conducted with two primary objectives in mind: assessing the impact of affordable housing on health care for low-income individuals who have experienced housing instability and analyzing the role that integrated health services has on health care costs and quality.

Conducted in Portland, Ore., this analysis included 1,625 individuals across 145 low-income housing properties including three specific types: family housing, permanent supportive housing and housing for seniors and people with disabilities. Medicaid claims for these individuals were analyzed one year before and one year after they moved into one of these types of housing. The results show that residents of all three housing types saw improvements in health.

On average, health care expenditures were 12 percent lower — or about $48 less — per member per month in the

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year after moving into affordable housing compared to the prior year. The decrease in health expenditures were evident in all three types of housing, with the biggest difference for permanent supportive housing and housing for seniors and people with disabilities, decreasing their expenditures by 14 percent and 16 percent respectively. Overall, moving into affordable housing for these 1,625 Medicaid covered individuals, resulted in a decrease of $936,000 in health care expenditures. This large decrease in expenditures was connected to a better optimization of health care utilization, through a 20 percent increase of primary care use, coupled with an 18

"OVERALL, MOVING INTO AFFORDABLE HOUSING FOR THESE 1,625 MEDICAID COVERED INDIVIDUALS, RESULTED IN A DECREASE OF $936,000 IN HEALTH CARE EXPENDITURES."

As shown, affordable housing positively affects health outcomes. However, the integration of health care services with affordable housing offers the most significant impact.

Residents of housing units with onsite care, saw a greater decrease in expenditures and more significant reductions in emergency department visits compared to properties without such services. On average, properties with integrated health staff and services saw a decrease in health expenditures of $115 per member per month, despite having low levels of awareness for these services. In turn, this study suggests that there are even greater positive impacts for health care still accessible.

This study offers promising evidence that affordable housing, especially housing with integrated health staff and services, helps to optimize health

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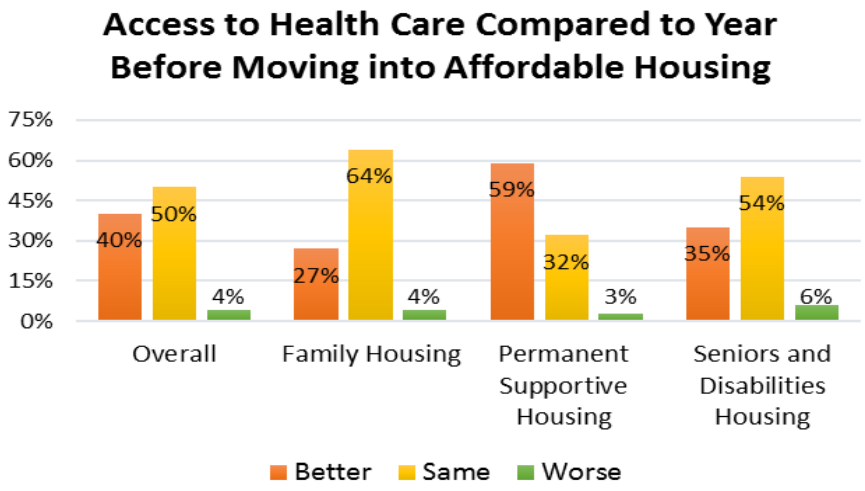

Source: "Health and Housing: Exploring the Intersection Between Housing and Health Care"

"Hep C Going Untreated"

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antibody. Ten percent of AIAN veterans born between 1945 and 1965 show an HCV antibody-positive seroprevalence, meaning they have been exposed to the virus at some point in their lives, say the authors. Eighty percent of those exposed will not be able to clear the virus out of their bodies on their own and may spread the disease even if they do not have any symptoms.

Hepatitis C is a viral infection that damages the liver and can be fatal if left untreated. From 2009 to 2013, AIAN HCV-related mortality rates increased by 23.2 percent to 12.2 deaths per 100,000 population, more than double the national rate of 5.0 per 100,000.

AIAN people have "both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any U.S. racial/ethnic group," according to the article, "The Need to Expand Access to Hepatitis C Virus Drugs in the Indian Health Service."

According to IHS, "Hepatitis C is treated with medications that your doctor can prescribe. Many people can be cured from hepatitis C."

New direct-acting antiviral treatment regimens "have high rates of achieving sustained virologic response with few contraindications or adverse effects.

These advances represent a major shift in treatment options for HCV and may likely reduce HCV-related deaths," wrote Finkbonner and Leston.

So what's the problem?

Actually, there are three related problems.

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The first is that these antiviral treatments are expensive, well beyond the means of most families to pay even a small part of the costs.

The second is that many state Medicaid programs and insurance companies have sought to control costs by requiring that people already have significant liver damage before they can get the drugs that would prevent such damage. "These criteria present a quandary: earlier treatment can prevent advanced liver disease, but late-stage liver disease is needed to qualify for treatment," the authors said.

And the third is that IHS, which spends an average of $2,849 per year per patient, compared with the $7,713 per year of treatment of individuals in the U.S. general population receive, simply cannot pay for treatment for all HCV-infected AIAN people. If Medicaid or private insurance (which may have the restrictions mentioned above) will not pay for treatment, the only recourse for patients or their doctors is to ask the drug manufacturer for help, Leston told ICTMN.

The authors compare this situation with that of the U.S. Department of Veterans Affairs. After Congress allocated more than copy billion for HCV treatment for veterans and drug manufacturers were convinced to lower the price of the drugs, the VA

"issued guidance that all patients with HCV should be treated, regardless of stage of liver disease," they note.

IHS, which has a budget of $4.6 billion to serve 2.2 million people, compared with

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care utilization and reduces costs. By investing in affordable housing, health care systems across the nation may get a bigger bang for the buck as the investment reallocates dollars to upstream services and helps avoid expensive downstream costs. The implementation of affordable housing and onsite services is an effective solution that positively impacts health outcomes without compromising for the quality of or access to health care for these low-income individuals. As a result, affordable housing should take a more prominent role in our health care reform, as it can bring us closer to our health care goals.

"IN THE YEAR AFTER MOVING INTO AFFORDABLE HOUSING, RESIDENTS USED 20 PERCENT MORE PRIMARY CARE AND HAD 18 PERCENT FEWER EMERGENCY DEPARTMENT VISITS."

Although this study only sampled residents within Portland, Ore., it provides important national implications for health care reform. According to Housing Colorado, 40 percent of renters in Colorado in 2010 lived in rent-burdened households, paying more than 30 percent of their income for rent, and 24 percent lived in severely cost-burdened households, paying more than 50 percent of their income in rent.

Let's put that in context.

The National Low Income Housing Coalition found that a Colorado worker would have to earn about $21 per hour in order to afford a modest two-bedroom apartment in the state. However, within a state that has a minimum wage set at $8.31, this is out of reach to say the least. A minimum wage worker would have to work 80 hours a week to afford a modest one-bedroom apartment in Colorado.

With booming population growth, skyrocketing housing prices and a dearth of affordable housing, Colorado should take a close look at how housing and health are related.

Medicaid covered individuals, resulted in a decrease of $936,000 in health care expenditures. This large decrease in expenditures was connected to a better optimization of health care utilization, through a 20 percent increase

of primary care use, coupled with an 18 percent decrease in emergency department use.

In order to determine that the decrease in expenditures did not come at

the expense of withdrawing access to the care these individuals needed, a subsample of 275 individuals were surveyed about quality and access to care. Within that sample, 40 percent reported experiencing improved access to care and only 4 percent saw a decline; the remainder experienced no change. In addition, 38 percent of all individuals reported an increase in quality of service and very few, 7 percent, saw a decrease.

As shown, affordable housing

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the VA's $59 billion budget to serve 9 million veterans, has not received supplementary funding for HCV treatment and must rely on limited Medicaid and manufacturer-based Patient Assistance Programs for access to HCV drug therapies, said the authors.

The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America recommends providing HCV drug therapies for all patients with HCV except for those with other, immediately life-threatening illnesses.

Congress may need to step in with a special allocation to pay for HCV treatment for IHS patients, as it has done

for veterans. "Human rights and health equity are not simply vague ideals — they are guiding operational principles for health care institutions, health care business, and governments — embodied to create a system of equity, especially for marginalized populations," wrote Finkbonner and Leston.

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Residents of housing units with onsite care saw a greater decrease in expenditures and more significant reductions in emergency department visits compared to residents without such services. On average, residents of properties with integrated health staff and services saw a decrease in health expenditures of $115 per member per month, despite having low levels of awareness for these services. In turn, this study suggests that there are even great positive impacts for health care still accessible.

This study offers promising evidence that affordable housing, especially housing with integrated health staff and services, helps to optimize health care utilization and reduces costs. By investing in affordable housing, health care systems across the nation may get a bigger bang for the buck as the investment reallocates dollars to upstream services and helps avoid expensive downstream costs. The implementation of affordable housing and onsite services is an effective solution that positively impacts health outcomes without compromising for the quality of or access to health care for these low-income individuals.

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Find the full report here: https://s3.amazonaws.com/KSPProd/ERC_Upload/0100981.pdf

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