# Future Policy Trends: Disruptive Forces impacting Emergency Medicine Practice

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# A Few Points

- These are my predictions and like a weather forecast may change or not happen.
- The future is relative in health policy. That which is implemented this year may have its greatest affect years later.
- Tort reform is not part of this presentation.

# Learning Objectives

- To imagine potential policy trends related to the pandemic
- To grasp the connection between trends in federal policy and ED workforce needs
- To understand the consequences of the continues shift to public payers and outsourcing to private plans

# Health Policy is like a Christmas tree

Changing the position of any ornament changes everything and removing an ornament creates instability.

# Policy in the Time of Covid-19

- Disaster preparedness
- Workforce
- EMS system
- Models of care
- Shifts in the population
- Pharmaceutical innovations
- ????

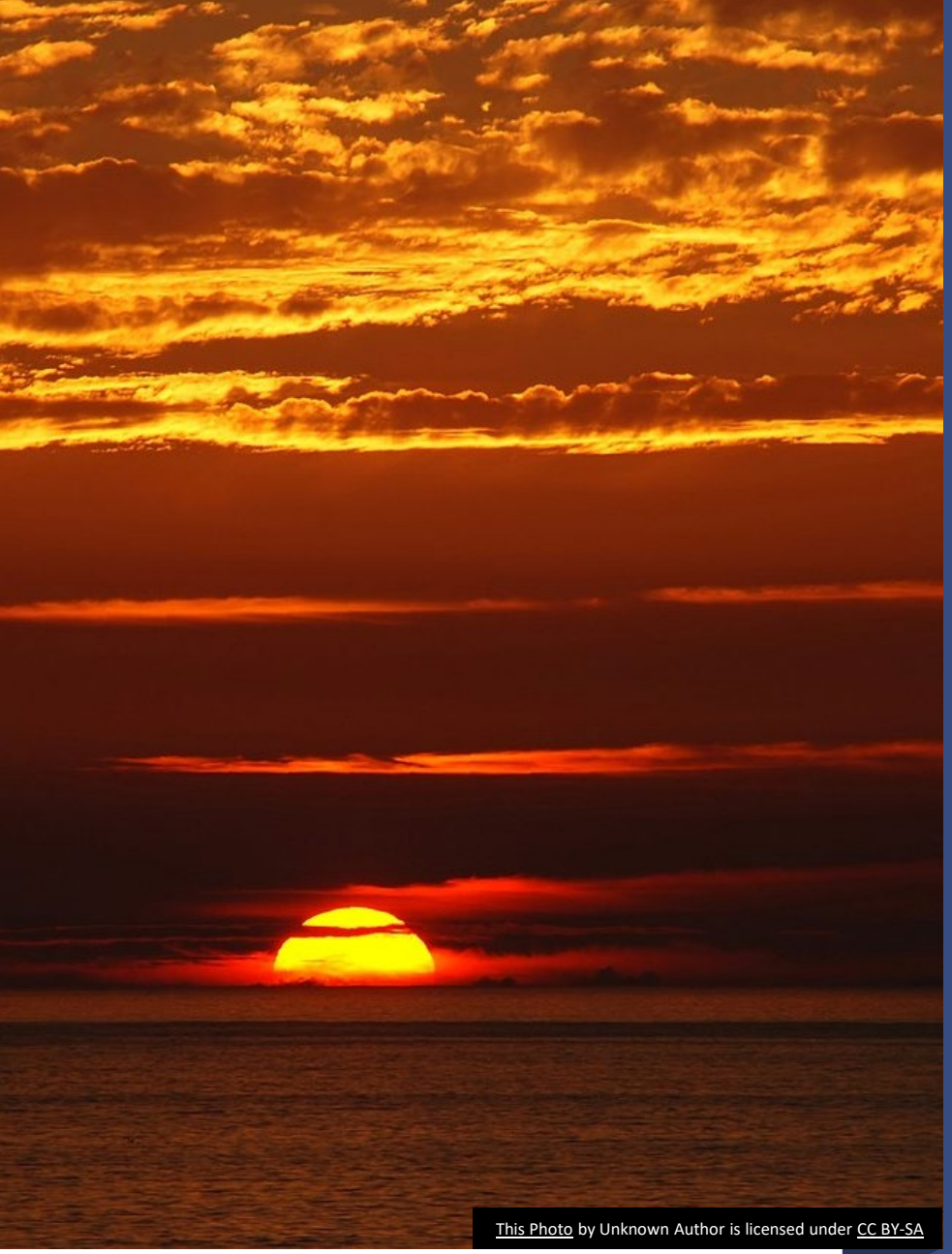
# Hierarchy of macro-forces we don't control

**Climate Crisis**
- Thawing permafrost
- Migration

**Innovation**
- Pharmaceutical advances
- Devices and technology
- Gene therapy
- Telehealth

**Demographics**
- Increase in chronic care
- Fewer children
- Futile care

Forbes, August 8, 2021





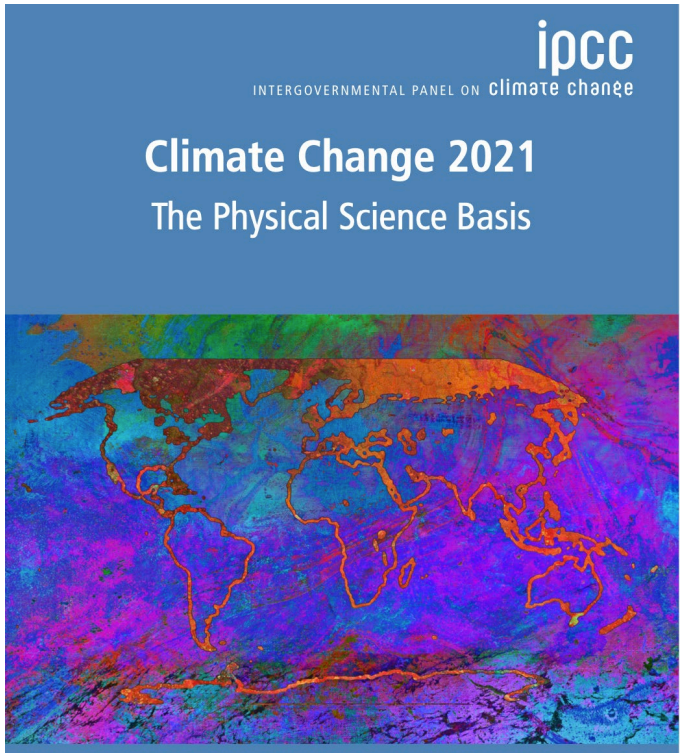
# The Impact

## Patient Mix

## Policy and Payment

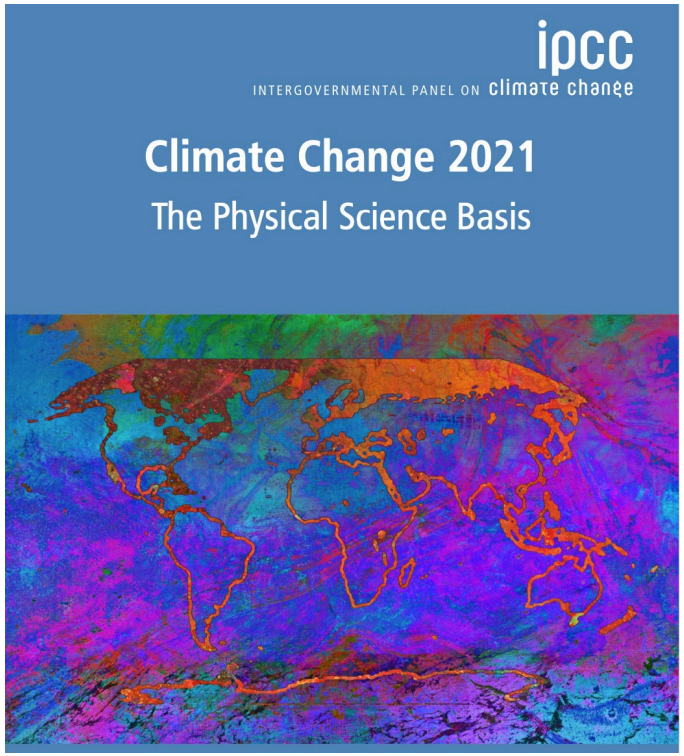
## Work Force

# Macro-force #1- Climate Change




- Thawing permafrost and new viral threats (what is old is new)
- Migration
- Increase in natural disasters
- Supply chain disruptions

# Macro-force #1- Climate Change




**Patient Mix-** Potential increase in respiratory conditions. More tropical diseases in U.S. as vectors migrate North. Increase in climate change associated disasters.

**Policy and Payment-** Investment in disaster readiness and infrastructure.

**Work Force-** Impact on location of opportunities. Increase in global opportunities for practice.

# Macro-force #2- Disruptive Innovation


- Pharmaceutical advances
- Growth in outpatient procedures and shrinkage of catheters
- Gene therapy will make some disease go away- Sickle Cell
- Telehealth will continue to grow and rapidly become a commodity
- Self-driving cars will change the rate of MVC

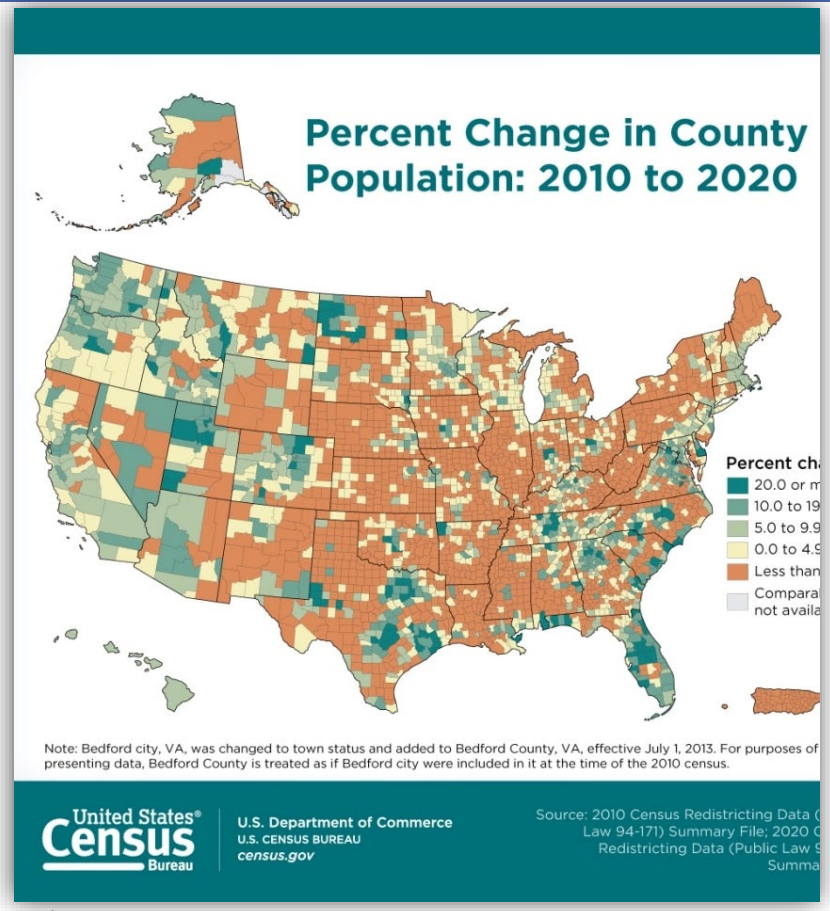
# Macro-force #2- Disruptive Innovation

- **Patient Mix-** Fewer immediate care type visits and acute care conditions will continue to decrease or disappear. MVC related visits will likely decrease with the advent of self-driving cars.

- **Policy and Payment-** Telehealth will become a commodity as public and private insurers, and employers will continue to move patients away from the acute care system. Increasing move away from condition-specific quality measures and programs as cases drop.

- **Work Force-** Fewer positions in pediatric ED and changes in acuity level may impact double and triple coverage. More opportunities in remote work in telehealth. Fewer specialists with staff privileges and more virtual consults.

# Trend #3- Demographic and Geographic Shifts




- Decrease in birth rate
- Increasingly older population in some regions
- Internal migration away from rural areas toward urban centers and South
- ?? Limits on immigration

# Trend #3- Demographic and Geographic Shifts

**The Top-20 Emerging Housing Markets:**

We reviewed data for the largest 300 metropolitan areas in the United States.

The second ranking surfaced the following areas:

| RANK | Metro Area | 2020 Population |
|---|---|---|
| 1 | Billings, Mont. | 181,723 |
| 2 | Coeur d'Alene, Idaho | 165,656 |
| 3 | Fort Wayne, Ind. | 412,874 |
| 4 | Rapid City, S.D. | 142,876 |
| 5 | Raleigh, N.C. | 1,392,356 |
| 6 | Portland-South Portland, Maine | 540,087 |
| 7 | Waco, Texas | 274,362 |
| 8 | Johnson City, Tenn. | 203,980 |
| 9 | Bangor, Maine | 151,823 |
| 10 | Huntsville, Ala. | 471,683 |
| 11 | Topeka, Kan. | 231,862 |
| 12 | Jefferson City, Mo. | 150,973 |
| 13 | Elkhart-Goshen, Ind. | 206,268 |
| 14 | Colorado Springs, Colo. | 747,337 |

**Patient Mix-** Significant shift in social determinants of health, age, disease burden.

**Policy and Payment-** Medicaid expansion, Medicare lowers eligibility age, States seeing highest jump may not have safety net in place. Shift to Medicare Advantage. Pay for quality programs will likely decrease.

**Work Force-** Need to consider moving into new areas. Fewer positions in cities where residents train. Advanced practice models will still come into play.

# The Interconnected Nature of Health Policy

## The Web

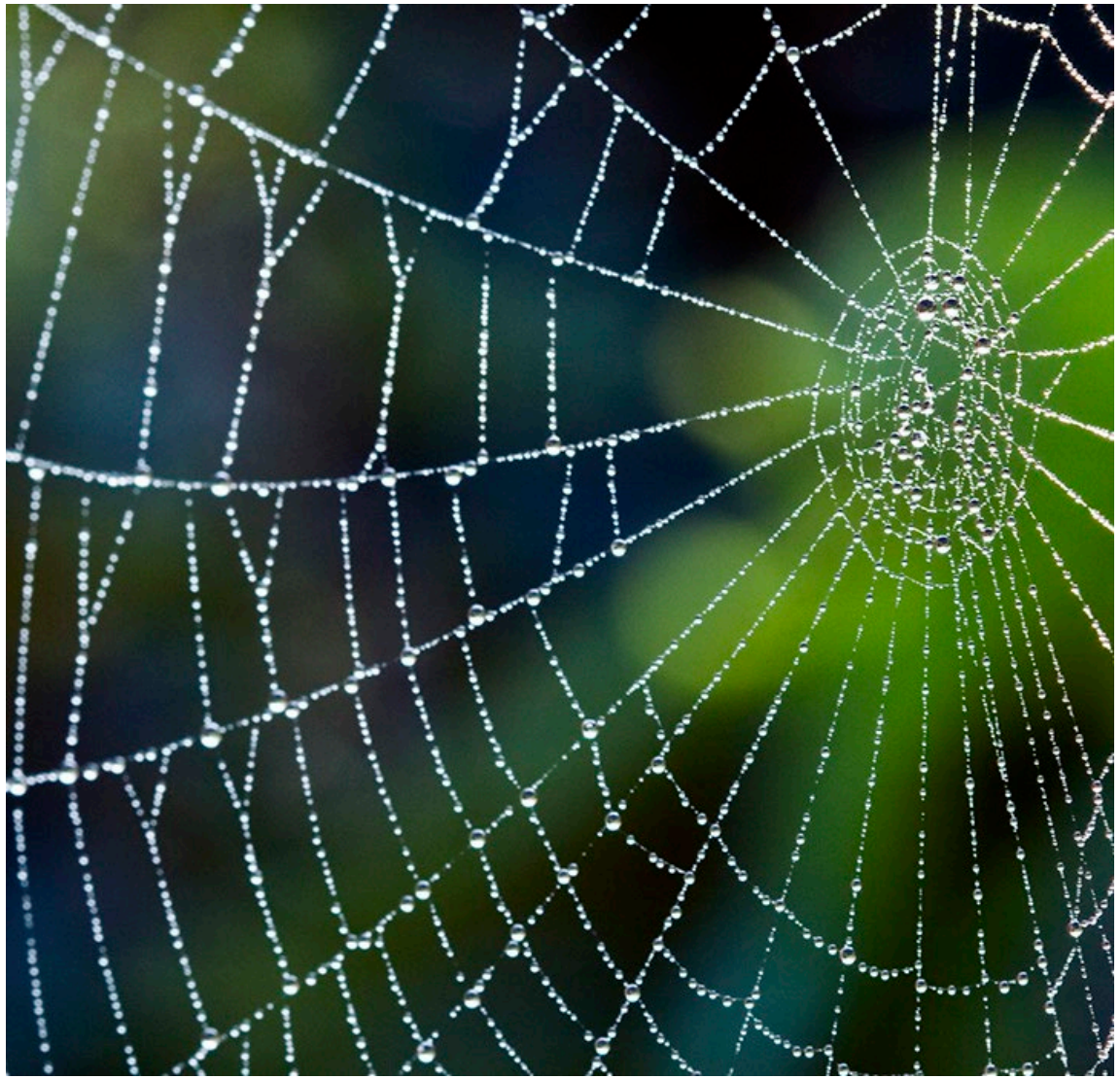
by Denise Levertov

Intricate and untraceable
weaving and interweaving,
dark strand with light:

Designed, beyond
all spiderly contrivance,
to link, not to entrap:

Elation, grief, joy, contrition,
entwined;
shaking, changing forever
forming, transforming;

All praise, all praise to the great web.



# The webs we weave…the stories we will tell

**Patient mix** is not static and will likely become more volatile. Lower acuity visits will shift to telehealth models. Innovations in pharmaceuticals, gene-editing, and devices will impact both prevalence and severity of disease. The age of those being treated in the ED will continue to climb. ED visit volumes are likely to be less predictable as volume associated with seasonal disasters or infectious disease. Pediatric visits will continue to decline.

# Schrodinger's cat vs. The hockey puck

The prediction of **work force needs** will be complicated by uncertainty and the complex changes in the delivery of care will make it difficult to even know where the net is. The only certainty is the need to build a flexible education model that monitors the macro-forces impacting the availability of positions. It is unlikely that traditional ED-specific fellowships will translate into additional compensation. Fellowships will need to be offered that match the need aging population, rural practice, disaster medicine and health policy.

# Legislating and regulating on the edge of chaos

**Policy and payment** will be driven by demographic changes, population migration, environmental threats and the relentless advancement in technology. More people will be covered by government sponsored insurance plans as the cost of innovation rises. States will likely adopt new models of licensure for advanced practice providers. EMS systems will be redesigned due to migration from rural areas and dependence on volunteers or private companies.

Legislators will be under intense pressure to **fund a delivery model that will serve their rural constituents.**

**In the post-pandemic era**, federal legislation and regulation will blur the lines between the healthcare, telecom, data, and environmental sectors. This portends a greater need to recognize that forces impact emergency care go well beyond our doors.


There are no conclusions in health policy- only continuous change and forces that lay outside the doors of the hospital.