CHANGE DEFINES HEALTH CARE

From coping with the opioid epidemic and the urban-rural divide to controlling costs, North Carolina's health care industry faces multiple challenges.

The round table was hosted by Poyner Spruill LLP and sponsored by the city of Greenville, Poyner Spruill and Scott Insurance. The transcript was edited for brevity and clarity.

From left:
Gregory Chadwick, dean, *East Carolina University's School of Dental Medicine*
Nick Kammeyer, vice president, benefits consultant, *Scott Insurance*
Robert Seligson, executive vice president, CEO, *North Carolina Medical Society*
David Tolentino, associate dean for clinical affairs, *Jerry M. Wallace School of Osteopathic Medicine, Campbell University*
Tina Gordon, executive director, *North Carolina Foundation for Nursing*
Kenneth Burgess, partner, *Poyner Spruill*
Stephen Lawler, president, *North Carolina Healthcare Association*

PHOTOGRAPHY BY BRYAN REGAN

WHAT IS THE STATE OF HEALTH CARE IN NORTH CAROLINA?

GORDON Well, I think "change" is the one-word answer, that health care is changing now probably on a daily basis. Every time I talk to nurses in the field, they're telling me a new story. Some of the stories are better. Some of the stories are about innovation. Some of the stories are about growth and opportunity. Some of the stories are about stress on the workforce, stress on the patients to make choices about how they pay for their care. Some of it's about stress on the employers where nurses work and the employers where their patients work.

SELIGSON I think as we talk about health care transformation, the reality is, both at the state and federal level as well as in the private sector, the cost of health care is at the forefront of the discussions. And, clearly, one thing that started at the federal level that's impacting us on the state level is the move toward the value-based health care: Improving outcomes, improving efficiencies and promoting collaboration across the health care sector. The challenge is to make sure that we are providing the tools and data to make better health care decisions, to improve outcomes, improve efficiencies and make our citizens healthier.

BURGESS We want better care, meaning we want better outcomes. That's a given. We want better value, meaning we want to either reduce or certainly not increase the cost of care. How do you do that? You can control the amount of care given. You can affect the length of care for some of our institutional settings, the number of procedures or how long somebody is getting that care. Thirdly, you can control how much the care costs, each unit, whether it's therapy or an MRI or a surgery. The last thing you can control is the number of people getting the care, aka rationing. The question becomes which variables we tweak, monitor, deflate or increase to get to our goal of better outcomes at a controlled price.

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>
> **DAVID L. TOLENTINO**
> Campbell University

KAMMEYER What I hear most is a general feeling of a lack of transparency. I think health care is the one thing that we consume as Americans without any regard for the costs or quality until after we've consumed it. Anything else that we buy, we know what we're paying for, what we expect the outcome to be, and what we want the benefits to be. What do we pay? What do we get? How do I know that Dr. A is better than Dr. B at shoulder surgery and has better outcomes and better value? There's no great way yet to get to that. That's becoming more and more of a frustration point.

WHAT IMPACT IS THE OPIOID EPIDEMIC HAVING?

SELIGSON If you look at just the overall impact and the cost due to unintentional deaths, you're talking about probably $1.5 billion in this state, anywhere between 3% to 5% of our GDP. It's had an incredibly negative impact. We have a responsibility to work with drug courts and everyone

else to get people in the care they need when they need it and to no longer ignore the problem.

KAMMEYER We've seen a big uptick in workers' comp injuries of people that ultimately wind up testing positive for opioid usage. We've seen more and more of our clients institute 11-panel drug screens to [test for the] presence of opioids. Not all of them are doing that, but we're seeing folks lead the charge to get to that spot, especially in the post-accident environment from a workers' compensation standpoint. As it relates to the health plan side, they're trying to do as much as they can to reasonably limit what people start with from a dosing standpoint. We're seeing the administrators and the carriers start to try to manage some of those things.

LAWLER There are a fair number of hospitals and health systems running experiments. We've got several hospitals in the state that have hired folks that are recovering from opioid addiction who are acting as navigators in the emergency department, which is the destination for people with no other destination. The navigators are connecting with these folks, and then they're helping them move from their experience in the [ER] to getting help. People that are participating in those programs have a much higher rate of success [when they have] somebody that's caring and compassionate linking them with the right social service and also following them through that program.

BURGESS When we're looking at solutions, one is more treatment for opioids, but also, behavioral health. We have to have both inpatient and outpatient settings for people. We used to have them housed, and didn't just turn them out onto the streets [where] they end up in nursing homes, assisted living and emergency departments. We have some regulatory approval processes which can make getting entrance into the care market a challenge. It's great to talk about how we want to fix it, and we know how to fix it, but providers have to be able to get into a program. We need access, balanced with assurances of their ability to perform at a quality level.

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>
> **GREGORY CHADWICK**
> East Carolina University

TOLENTINO Education for this is so important too. It's not just for the health care providers, but even first responders, getting them Narcan and Naloxone — the antidote, or treatment, if you will — in their hand. Being able to recognize somebody who's in acute opioid withdrawal or even in an overdose is so important. I know that we've recognized this, the importance of being able to treat opioid addiction, in our curriculum. We've already implemented it in our second-year curriculum so that when I'm sending students out into their clinical campuses in [their] third and fourth year, they already have that knowledge.

CHADWICK I think education plays a huge role. On the dental side, obviously, we prescribe a number of pain medications. Many of them have been opioids. We are educating our dental students on the alternatives. Every dentist in the state is required to take one hour every year training on opioids. When you look at a map of North Carolina, we're measuring the severity of it in deaths. You're seeing a lot more in the west and the east. It's the rural areas that are hit by it even more. I hope we're getting to the end of it. My fear is that we may not be. I think we need to be doubling down on education and

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looking at alternatives. It's the social determinant of health. The situation that people find themselves in just lends itself to this opioid crisis that we have.

HOW DO RURAL AND URBAN HEALTH CARE COMPARE TO EACH OTHER?

LAWLER There is a pretty big divide between what goes on in an urban setting and what goes on in a rural setting. Sometimes it really is about scale, and it's about access to experts. One of the challenges for small community hospitals is they just don't have the resources to reinvent themselves for what their community needs. In many cases, they're picking a partner. Many small hospitals in North Carolina have a relationship or a partnership with a system in order to have access to a level of support and sophistication that otherwise they'd have to go out and buy. Partnerships also provide access to high-quality subspecialists through network-like relationships. There is real value in picking partners based on competency to deliver care for the people you're serving. Smaller hospitals are starting to realize there's a real value in a role as a navigator and an access point for health care. It doesn't necessarily have to be balance sheet integration.

TOLENTINO We are in a position now where we cannot have rural hospitals closing, whether it's North Carolina, South Carolina or Georgia. Across the Southeast, across the U.S., rural hospitals serve a reason. They have the pulse of that community. People can't be traveling hours to get access to a primary care physician. Community hospitals are where the bread-and-butter diagnoses are. That's where you see your diabetic crises, your congestive heart failures, your [chronic obstructive pulmonary disease] exacerbations. That's why medical students get great education in community hospitals. It's the reason why we work so hard to put our students in community hospitals.

Health care is changing now probably on a daily basis. Every time I talk to nurses in the field, they're telling me a new story.

TINA GORDON
North Carolina Foundation for Nursing

GORDON The rural areas of North Carolina are in significant need of increased access to care, particularly primary care and insurance coverage. Advanced practice registered nurses are already providing safe, quality care in many areas of our state and are positioned to do much more. We've seen study after study after study showing that APRNs both provide quality care and are more likely to choose to practice in a rural area than their physician colleagues. Our state already has significant provider shortages, and if coverage is expanded to even more patients, as legislators plan to do, we will need more in every corner of the state. We should be looking for every opportunity to let APRNs provide this much-needed care.

BURGESS We're starting to see medicine not just in the places we used to see it, but all over the place. And there's the question: 'How do you regulate it? Where can you have it?' If I live a few more years, it won't be too long before I can walk into a retail center and do 60%, maybe 70% of what I used to do in five different places. Now, whether that's a good thing or a bad thing I leave to my nephews to figure out. It's coming.

CHADWICK About 40% of the population is living in a rural environment. What we need out there is primary care. We don't need bypass surgeons. We don't need orthodontists and everything else. We need good primary care, and we need partnerships. That's a theme that's coming through in our partnerships.

SELIGSON Our community practitioner program started in the early '90s as a means to try to get primary care doctors, [physician assistants] and nurse practitioners in underserved areas of the state. We placed a lot of physicians and folks and paid up to half their tuition loans. In some cases, we worked with hospital systems to get the whole tuition paid off as a way of them to stay in the community for at least five or six years.It's been a great program. It continues to grow. Obviously, I'd like to have more money to pay off more tuition loans, but it's been successful.

WHAT ROLE DOES THE WELLNESS MOVEMENT AND PERSONAL RESPONSIBILITY PLAY IN HEALTH CARE?

KAMMEYER We see that a lot on the employer's side as a tool. People say, philosophically, 'If we can help people be healthier, then they're going to cost us less, from a health care perspective.' To a certain extent, that's true, right? We reduce risk factors. Where employers sputter and lose momentum is where you make somebody healthier. They make lifestyle changes. How do you quantify that they didn't have the quadruple bypass six years later that they were destined for if they hadn't made those lifestyle changes? You have a CFO looking at the bottom line saying, 'You know, our costs are continuing to go up, and we're investing time, energy and resources in these programs, but we're not seeing a reduction in costs.' It becomes difficult, then, for them to sustain it.

CHADWICK That all goes back to the social determinants of health, and we're going to hear more and more about that. We're seeing it more in education, and it's not a rural or an urban thing. The same social determinants of health occur in the poorest section of Raleigh as they do in the wealthiest section of Raleigh.

LAWLER We've got people that are working together with lab companies to look at lab test results and profile individuals and even zip codes to say a community is more susceptible to this disease, be it hypertension or diabetes. They're customizing plans that are trying to get at that issue. One of the opportunities for North Carolina is redefining what personal accountability means. Making investments and helping people understand how to become personally responsible and identifying tools that are available to do that: putting dollars in people's pockets. Because when they're healthier, they go to the doctor less or go to the hospital less. ■

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