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Roundtable: Healthcare check up

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Health systems and hospitals create more than 275,000 jobs in North Carolina, making them one of the 10 largest employers in 92 out of the state's 100 counties, and one of the top three employers in 45 counties.

They also directly created $40 billion of the state's gross domestic product, or about 6% of North Carolina's economy. And they provided another $5.8 billion in community contributions, whether that's through charity care, Medicaid and Medicare losses and donations.

Business North Carolina recently gathered a group of industry leaders to discuss the issues facing healthcare and what can be done to improve the situation. The conversation was moderated by Executive Editor Chris Roush. What follows is an edited transcript.

The discussion was sponsored by:

- CarolinaEast Health System
- North Carolina Healthcare Association
- Smith Anderson Law Firm

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WHAT DO YOU SEE AS THE BIGGEST ISSUE FACING HEALTHCARE IN NORTH CAROLINA TODAY?

SHAW: I think the biggest issue in healthcare is the tremendous challenge of aligning incentives of the stakeholders – patients, the payers, the providers – and those that work in the interests of those stakeholders. And it turns out that it's a very challenging thing to do, and it's essential for the long-term success of the system.

TERHUNE: The biggest issue today is staffing and how to deal with the newer generations and the technology that they deal with and combining all of the different kinds of benefits. In North Carolina, for example, we lack a number of child psychiatrists. We don't have enough psychiatrists to cover the whole state.

ZASS: I think the biggest challenge is really the workforce. And it's not just staffing. I think it's designing the staffing model and workflow force of the future and trying to think differently of how we create a career in a profession that attracts, retains and develops top talent to stay in the healthcare industry.

LAWLER: It sounds like a broken record, but it is workforce. How do we design a plan and orchestrate a new delivery model that allows individuals to participate and to care for others at the top of their ability? And how do we extend that care to individual homes? How do we stay connected to people throughout their lifetime so they're able to enjoy their optimal health?

LUDLAM: Yes, workforce. And for the providers and organizations that work with the department. I think it's change fatigue. We've been radically changing our systems, bringing in Medicaid managed care, expansion, COVID. And I think people are tired. We'd like to just get to the business of delivering health.

BAGGETT: I think that the essential piece around the workforce is building resilience. And that resilience has to be in the structural systems of where our folks work and how they work, as well as in the personal mind and body pieces. And those are more complicated issues than we've typically paid attention to as employers and as medical teams that are training the next workforce.

FARMER: I'm going to take a little different approach although I agree with all of you so far. I'm going to go with patient access. While there's been incredible work on walk-in clinics, same-day appointments, telehealth and digital tools, I'm concerned with the offsetting burden of the commercial health plans, with authorizations and excessive delays of care.

SMITH: I'm in eastern North Carolina, which is rural health. And access certainly is an issue for us with a spread-out population that we try to serve, so it's a challenge in recruiting qualified providers and physicians to eastern North Carolina. It's not like recruiting to Raleigh or Charlotte or Winston-Salem. That's one of our biggest challenges.

HOW DO WE CHANGE IT TO GET MORE PEOPLE INTERESTED IN WORKING IN HEALTHCARE?

LAWLER: I don't think it's a silver bullet. I think it's taken us a while to get where we are. And the pandemic certainly magnified the problem. And it's going to take 10 to 15 years of intentional work and investment to get us to the other side, but I'm pretty optimistic. Healthcare makes up 8% of the state's workforce. I think just using that as an accelerator to attract new people into that field is going to be key.

BAGGETT: Short term, there's administrative burdens, those can be done very quickly if only the will of certain people were there to do it. We've been pushing prior authorization reform or partnership with our good (health insurance) friends. My members tell me all the time that they are being damaged by 1,000 paper cuts a day. How do we get everybody else out of the exam room between the physician provider and the patient and let them decide what's best?

ZASS: I think we're starting to see the tides turn in terms of the partnerships with our technical schools and community colleges with the number of nursing applicants and our dependence on contract labor decreasing. But we can't let this go to waste and realize that if we just try to hire back into the way that we've delivered care before, we're not going to achieve our long-term goals. So I would challenge all of our hospitals and health systems and practices to say, 'Let's not just recruit to fill the old model; let's redesign the model. We really aren't efficient.'

FARMER: I would challenge leaders in the healthcare industry to look at how other industries have reacted to labor shortages – banking, software, hospitality. I think we need to challenge ourselves. Let's really get creative and meet patients where they are. If you can use remote monitoring tools, there's a wealth of opportunity to relieve the burden of the face-to-face experience. Working from home, we have found the turnover of work-from-home employees is nominal. People just are starting to prioritize their own schedules and what they're willing to commit to a job. If we can compromise on that, I think it could be a long-standing workforce.

MICHAEL, HOW DIFFICULT IS IT TO GET PEOPLE TO WORK FOR YOU IN THE EASTERN PART OF THE STATE?

SMITH: It's those other positions that don't pay enough to move a family from Charlotte to rural North Carolina. ECU Health has been a wonderful partner for us. They only accept North Carolina residents into their medical school, which is phenomenal because 70-plus percent stay in North Carolina. Physicians aren't a challenge.

LAWLER: There are some communities that are more urban than rural where housing is a real issue. It's an issue for trying to recruit nurses or even competing for hourly wage employees. We never used to compete with hourly wage employees. Now we're competing with Starbucks and the local hotel. We need to really take a holistic approach in regard to what makes somebody choose healthcare. What makes somebody choose that community?

ZASS: We have other barriers. We're not as flexible in our hours as other industries. We need to learn to be equally as flexible or more flexible with remote work with variable hours. We need to get better at telling our stories. We have so many amazing stories that lead to meaningful impact and joy. If we create that flexibility, if we create that sort of career ladder trajectory growth, we're going to retain people. If we focus on the idea that we're just going to have to match the salaries of Five Guys, we're really going to struggle because we're missing some of the unique things that we have. But sometimes we're our own worst enemy.

HOW IS TECHNOLOGY HELPING THE SITUATION?

FARMER: I'm excited about the future of technology with healthcare. I think it's wonderful the tools that are coming online to complement our physicians and the level providers. It's unlimited the value of care that can be given, and I'd love for the United States to be leading in this. You've heard too many times, 'Don't waste a good crisis.' We did more with technology in the first 60 days of COVID and have reaped the benefits of a much more efficient way of communicating. I hate that that happened to our country. I don't want to minimize it. But it sparked a fire of the need for technology.

TERHUNE: I would agree, but I have some concerns. My first concern is the feds have not yet approved the money that would give many rural people access to high-speed internet. For a lot of people, you could only use that technology if you have access to the internet. And in North Carolina, there's a lot of places that people do not have access.

Artificial intelligence is going to have an impact. It's going to take away the burden of physician notetaking once we get it so that we're sure it's accurate and appropriate. I don't think AI is going to replace healthcare. I just don't see it happening. I think people will try it. But you're still going to need that nurse by the bedside. You're still going to need that level of clinical knowledge and expertise. I don't see a bot doing that.

LUDLAM: For us as regulators, technology has been a fantastic tool. And it's also freed us up to be able to recruit from local communities all across North Carolina. As a regulator, I am completely excited by AI. First, it brings joy back to the work; instead of spending five days organizing financial reports that work can be done in an hour. We're using technology and experimenting with AI to be able to combine tremendously large data sets, so that our analysts can actually now get to follow those leads and really pick apart and focus on those

high-value activities. I think that without some of these tools, it would be difficult for us to manage the number of health plans that we now have.

TERHUNE: We need to use AI a lot bigger than we're thinking. So Monarch is using remote staffing. We've discovered that I can replace those direct support staff that I need all over the state with remote staffing in some situations. It's incredible technology. It's out of this world, and it's going to help that direct support workforce down the road. If that patient has a screen in their bedroom, you can just pop in and talk to him and look at him and see him and now we have a whole different picture. And so I think there are ways to use technology far beyond what any of us have thought of.

ZASS: I worry a little bit that the technology can do so much more than we allow, whether it's due to regulatory barriers, reimbursement barriers or cultural barriers within our teams. We could markedly accelerate the use of remote patient monitoring. We could sustain much higher levels of telehealth use. Technology really isn't the barrier. And I think our patients and families as consumers really want that and we can use it to address health disparities in rural areas. Can we get to the point that 25% to 30% of all patients get all of their care at home? The national average is still around 10%.

LAWLER: One of the exciting parts of AI is it ties to what's going on at the academic institutions. We're going to be able to do predictive analysis of patients, and we're going to be able to intervene with people in communities before it becomes a crisis. AI really is going to give us some insight and understanding on how to connect with individuals and communities outside the four walls of a hospital or even a practice and be much more involved in their lifestyle choices, their support network and how to access care at the right time. It'll be so interesting to see what our teaching institutions do to help accelerate that process and that learning.

BAGGETT: This is a human touch business. And it always will be. How do we use it in smart ways to augment and enhance? How do we use it to predict and avoid certain things? Ten years ago, I sat in an exam room and saw an example where the electronic health record was projected onto a wall. And the voice activation of the doctor talking was filling in the notes in front of the patient in real time. Where's the widespread adoption of that so we maintain that human touch?

SMITH: There's a lot of benefits that I see for the technology. My concern is that if we use that to drive payers and providers further apart, that's going to make things really untenable. We've got to bring those two groups together. Because if someone's just using the technology to search through for a reason not to pay some money, that's a problem. And so we've got to figure out how to bridge that gap.

JAY, COULD YOU TALK ABOUT WHAT MEDICAID EXPANSION MEANS FOR HEALTHCARE IN NORTH CAROLINA?

LUDLAM: About 421,000 (451,194 as of May 9) individuals have been moved over to the Medicaid expansion benefits since Dec. 1, which is almost a little more than two-thirds of our two-year goal in four months. There's a couple of benefits or opportunities that we're going to see. So one is we're gonna have a lot of pressure on access. I think consumers are going to start putting more pressure on us as an agency, you all as deliverers of care, for access.

I think expansion will be very good for North Carolina. It is cost shifting much of our current costs. A lot of these 420,000 people were already on Medicaid, but the state was paying for them. And now 90% of that cost is covered by the federal government. That's an opportunity now for us to take those state dollars and apply them in places that we haven't traditionally applied them in the past.

And the last piece is we have the whole-person perspective on care – traditional medicine, physical and behavioral health and also the social determinants. We are seeing that because of efforts addressing food insecurity, housing insecurity, transportation issues, especially in rural communities, and wrapping services around victims of interpersonal violence at very tangible cost savings. We're seeing a reduction and faster recovery times, and a lot of promise. And we're resolving those social needs.

ARE HEALTH CARE PROVIDERS STARTING TO SEE THE IMPACT?

TERHUNE: I see that all the time. I love that North Carolina is focused on the whole person because that has made a huge difference in our psychiatric world. People are healthier because they're paying attention to their diet, and they're going to see their primary care physician for their high blood pressure, not just the schizophrenic person going to see their psychiatrist. I think that has been critical.

SHAW: It's no longer sort of taboo to say that it's everything from health, to mental health, to substance use disorders. Access and other social determinants is an inherent part of achieving a healthy outcome. The system is really starting to understand and react to that reality.

LUDLAM: So many of these healthy opportunity programs are community driven. So the community itself is identifying what it needs in order to help its neighbors. It's the people that live within that community. And it comes up with solutions for that community, which

for North Carolina is a fantastic model. It's what makes North Carolina different from many other states.

FARMER: I do want to bring us all back that this does need to be a business-minded conversation. The vast differences in the way that we pay for our services cannot be more important and needs to be top of mind. We've got to continue to work together on that. I don't think the consumers are completely educated on the mechanics behind that. I think that is disappointing. This is our responsibility to put light on that as more and more of our patients are on high-deductible health plans. There does need to be a level set before any of the value-based care initiatives can have any success or that is going to continuously be a barrier behind the mechanics of the numbers.

LAWLER: Value-based care shouldn't be some sleight of hand trick by a payer that includes a withhold that you can earn back if your quality and patient safety scores are commensurate with what was negotiated in the contract. The best value-based care is actually driven by the people that are taking care of folks. I think the compact with all individuals or organizations that are involved in the ecosystem is just making sure people are showing up at the table trying to do the right thing. And the right thing should be investing in people in programs to care for folks versus investing in processes to deny claims or create barriers to care.

WHAT ARE YOU EXCITED ABOUT FOR THE FUTURE OF HEALTHCARE IN NORTH CAROLINA?

SMITH: We're positioned in North Carolina to take advantage of just the nature of North Carolina – the medical schools that we have here, the training programs that we have, the technology that we have. For a 50-something-year-old CPA, it's hard to imagine what that looks like in the future, but I'm excited about it.

FARMER: When it gets right down to it, North Carolina is just a wonderful place to live. That means a focus on healthcare and medicine. I think there's a focus on active living and wellness that you don't see in other geographies in the United States. I think that we are positioned for greatness. With good continued leadership and governance, that it'll be positioned for success.

BAGGETT: I'm excited about our past because our past is an example of where we have been a thought leader and innovator. And we've been the model that has been copied all over the nation before. So people are looking to us to do that again. And because of that

innovation, we're not afraid to go try those new things. We're not afraid to step out of the box and do something different.

LUDLAM: We've caught up to the other 38 states that have done Medicaid expansion, and I think now it's the time to capitalize on that. We need to compensate providers for better data for higher cost workforce, and to continue to make investments in themselves to continue the innovations that are made that make North Carolina great. Now we need to continue to make those investments going forward.

LAWLER: What I'm really enthusiastic about is just this feeling of hope that we're at this tipping point. It's really about springing forward. The work that's been done over the past several years in regards to expansion, creating new training programs and using technology. I think that for small communities, it's raising hope and raising the possibilities for the future, which I think is vitally important. I think the other piece that I really am excited about is we continue to be a destination for new companies and new people. If we're gonna continue to track those people, there's a bright future for healthcare.

ZASS: We have all those key elements, from the universities to the technology, the innovation, the growing communities. Most importantly, we have amazing people from our frontline care team members to our leaders. We can learn to work together, across silos, break down barriers between government and health systems and between health systems and different industries. So I think the burning platform for all of us right now is how do we seize that opportunity and really ensure that because we owe that to the residents of the state.

TERHUNE: It's a combination of whole person care and innovation. The state is incredible. We pay attention not just to those wealthy corporate people, but we pay attention to everyone in North Carolina, and our health system actually cares. And because it cares it's continually innovating, and it continually is coming up with new and different ways to do things that make it better for the end user and makes the end user healthier. And if we can help our population be healthier in every aspect, that just continues to make North Carolina an incredible place to be.

SHAW: There's never been more enthusiasm and investment in innovation and healthy outcomes. With technology and AI, we can look forward to 20 years from now how much incredible innovation and new investments and new technologies will improve healthcare in the long run. ■