NAM Vital Directions for Health and Health Care: The North Carolina Experience
November 21, 2019

Unperfected transcript

>>DZAU: Well, good morning, everyone. Good morning.

>> Good morning!

>>DZAU: All right. That's good. Thank you. I'm Victor Dzau. I'm the president of the National Academy of Medicine. I'm a Dukie. I'm sorry to say to some of you. But I'm a North Carolinian. That's the most important one. My wife and I still live in North Carolina. I'm actually a Duke faculty on leave of absence in Washington.

So for those of you who may not be familiar with National Academy of Medicine, let me just give you one slide to tell you who we are. Most of you know us as Institute of Medicine, but then I want to tell you about why we're so excited about being here in North Carolina. There you go. So there are three national academies in the United States, certainly in the science area, National Academy of Sciences, National Academy of Engineering, and, of course, Nationr,na Th

as the most esteemed authoritative advisor on issues of health and medicine, and its reports can transform medical thinking around the world. Certainly we believe so, and we hope so, and that's why we're here.

I want to welcome you to the symposium, Vital Direction for Health and Healthcare, the North Carolina Experience. Before I begin, I'd like to thank NC Biotech Center, and CEO Dr. Ashton, is he here? Doctor, thank you very much for hosting us. Greatly appreciated. And of course to the planning committee, to Mandy Cohen, my co-chair, and, of course, to staff, particularly Jessica Marx, for organizing this event.

Okay. So first, you know this so well. This nation has faced major challenges in healthcare. Errors of increasing demand, unsustainable costs. And we also face issues about access and quality in addition to affordability. Efforts are bein(e)3 u No(t)1 (s)2I905 0 T1 (e)-2 (a)-1 (' (ng)1 (e)-2 (s)

[Applause]

One talent that I think I have is attracting good people in to where I work. You ve got to do that to make up for your own deficiencies. But this is really outdid myself with her. And I'm grateful that she is here. There is no question that North Carolinians are healthier because of her good work, and although we have both had to deal with unnecessary partisan fights, we know how partisan healthcare can become, and that really is hurtful at the end of the day, but we've continued to strive to move forward, and I know she will talk with you a little bit today about how we're dealing with transformation and expansion, but still succeeding in many areas, even though we're having some debates and disputes in those areas.

With health, you're going to continue to get old. There's just no question about it. And you ve got to keep yourself as healthy as you possibly can. But it reminds me of what has been happening a little bit at my house, having moved into the North Carolina Governor's Mansion which, for a guy who grew up in eastern North Carolina, this is way above my raisings, but Kristin and I are enjoying it, and for those of you who have been there, you see portraits of former governors that are lined up downstairs, and the law requires the governor, I think at least by two years into your term, to begin the process of making sure that you have a portrait done so that the state can put it up in the executive mansion. I'm not that interested in it. It makes me a little uncomfortable, but it's something that by law is required. Well, now you all know that I'm nearing my third year in completing my third year of my first term. We'll have a second one.

[Applause]

But my wonderful wife Kristin, who is a great lawyer and who is spending time going to all 100 counties. She's been to 80 so far and done events in 80 of them, and she's been spectacular, particularly in the area of children's health and hunger. We're doing a No Child Hungry event tonight, and so grateful for her, but she's been on me about, Honey, you need to get time to start taking your pictures and pick somebody to do your portrait. I don't have time. Let me do the budget thing. You take care of it for me. She says, Honey, you've got to do this said, And I I've got a budget meeting. She grabbed me by the arm. She looked at me and said, it's not getting any better.

[Laughter]

Those of you who know Kristin know that to be absolutely true. I think she sort of enjoyed saying it, but it got my attention, so the appointment is set and all that kind of stuff. I hadn't thought about it that way.

I have a mission for North Carolina. I say this every day, multiple times a day, to my staff, to my cabinet. I want a North Carolina where people are better educated, where they're healthier, where they have more money in their pock I -2 (tg .n)-1 (nd a)hd(nd -1 (l)-1 2 (')6 (r)-1 ()1 (4 (m)-1 (o)

Our opioid 2.0 action plan updated the 2017 plan with feedback from partners and stakeholders, and now includes local strategies that are going on right now in counties. Coalitions, stakeholders who are working together.

I'm also proud of our Early Childhood Action Plan. We know more than ever now how much zero to three matters, when brain formation is going on with that child. Early childhood education and healthcare is critical to success of that child, and the more science we see, the more overwhelming that is. North Carolina has seen that, and we go for it, one of my predecessors started Smart Start. We have worked very hard to have four-star and five-star child care agencies. We know that it's not just babysitting that we've got to have interactive education with our children, and we've got to make sure that they are as healthy as possible.

We put this opioid action plan in place because we know too many babies are born in our state with the odds stacked against them. More vulnerable than others because of social, racial and economic factors, and we are on target to dramatically reduce disparities in infant mortality by 2025. We have to do that. We must ensure that babies and children and young families have access to high-quality, affordable healthcare services. We've got to increase the number of our children enrolled in Medicaid and health choice to access wellness and visits, and home wellness visits and immunizations, and, of course, we've got to expand Medicaid to hard-working people who need access to critical preventive care.

In our schools, we know that we have to address health issues there. Spend a lot of time talking to our teachers and other educators across our state. When I go into a public school, I come out smiling, because I know the good things that are happening there. We need to lift up our educators. We need to give them the respect instead of sweeping corporate tax breaks, we need to be investing more in our teachers and principals. It's interesting that I had a discussion with a bipartisan set of legislators, and boy, we had some differences about public education and whether we should be slapping letter grades on schools or putting money in to unaccountable private school vouchers. I guess you see how I feel about that. But, we agreed on two things that would improve public education. A good teacher in every classroom and a good principal in every school. You've got to get the pipeline of people to do that. So you've got to pay them more, you've got to show them respect. When they get their master's degree, you've got to reward them. You can't charge them for when they have to take a leave day, and you can't charge them to pay for their substitute like they're doing now. You've got to greatly expand teaching fellows' scholarships across this state. They have to be robust. They have to recruit our best and brightest and recruit diversity. When we tell young students coming out of high school we think education is so important that we will pay four years of your school if you'll give us at least four years back in teaching in our public schools, you are not only going to

plan that sends teams in to these communities who are often short-staffed to help them address their challenges, and we know that matters for health, and once again, Medicaid expansion is going to play a big role in helping to improve rural health.

So let's talk about Medicaid expansion. We are sending billions of dollars of our taxpayer

happened to have a master's. She could be doing a shte -could be a public school teacher and make more money. We have to do more to improve our pipeline of early childhood educators, and not just our teachers. And Dr. Cohen will talk to you about that, and that's part of our early childhood action plan. But that is not right! It is not right. Every person should have the availability of affordable, quality healthcare in the richest country in the world. Come on!

Now, we can have a debate about how much the government should be involved in this, clearly, but right now, we're all of the partisan politics, we have a path that is narrow. We can close gaps under the present system. We have to continue to make the system better. The system needs to transform. We need a value-based system. Fee-for-service we know can keep healthcare costs up in a way that we don't need to be doing, but we need to do it in a way where we maintain our providers who are continuing to provide for our lowest-wealth people, and we can do this thing. We have to do this thing. And it takes strong leadership and it takes people talking about it. It takes people there's Wendy over here, a county commissioner, and, you know, you guys telling this story and chambers of commerce stepping up and saying this is something that we should do. We don't need It takes peuyWe 0 Tstsnd-1 (e)-2 (c)1 (t ne)-2 (l)

Mandy is an internal medicine physician like me, and has experience leading complex health organization. Before coming to North Carolina's DHHS, she was the chief operating officer and chief of staff at the Centers for Medicaid and Medicare Services, CMS. She brings a deep understanding of healthcare to state, and has been responsible in implementing policies for Medicare, Medicaid and children's health insurance program in the federal health insurance marketplace.

Secretary Cohen has been recognized as a national leader for her work at DHHS. In February 2019, Modern Healthcare named Secretary Cohen as one of the top 25 women leaders in healthcare. As a graduate of Cornell University, she received her MD from Yale, master's in public health from Harvard School of Public Health and trained at my old stomping ground, the Mass General. And I must add that, as I said, it's wonderful to work with her, and her office, especially Betsy Tilson, and North Carolina is really lucky to have leader that Mandy is as our leader. So please help me welcome Mandy.

[Applause]

>>COHEN: Good morning! So, it's been a week. So thank you for the kind words, because I kind of needed it this week. But this is such I think a-- well-timed conversation that we're going to have over the next two days here. I'm so grateful to Dr. Frau and the National Academy for choosing North Carolina as the first site to think about taking the Vital Directions blueprint on the road. I think it's the right choice not just because you're a North Carolinian, because I think there's incredible work going on here. And while we did have a setback, and for those of you who haven't read the news, because of some gridlock, we aren't going to be able to move forward quite yet with our managed care implementation, which has a lot of the pieces that we'll hear about built into it, but despite that setback, it's given me this opportunity to sort of reflect on the last three years that I've been here in North Carolina and what we've been working on and accomplishing, and it was an opportunity to remember that it was always bigger than just this transition to managed care. And so I'm going to talk through a lot of that, and someone asked me, oh, did you have to spend a lot of time rewriting your speech? No. Because I wanted to talk about our blueprint here in North Carolina, because I hope it is helpful for us as North Carolinians to remind ourselves where we're headed, but hopeful for those of you not from North Carolina are here to learn with us that maybe that is also a blueprint that you can use as you move forward. And I've been talking specifically about how we focus on health and not just healthcare for a number of years.

The term Social Determinants was a buzz word for a long time, and

infrastructure we're building there, and I think that is what is going to move us from just focusing on two parts of the triangle to actually focusing on all of them.

And so here is my little blueprint for what I think we're trying to achieve in North Carolina. And as I reflect over the three years that I have been here, this is where I think that we have come. And so it started with a commitment to a clear vision of health. And I'll come back and talk about that. Then it's this great alignment around incentives and initiatives that lead to important action, right? I will say some of the incentives built into healthcare right now actually prevent you from focusing on health. It's actually keeping you from doing the thing that would help you focus on health.

And then there's been this incredible alignment of cross-sector investments. And that has been just gamechanger here, and there are many of you in the room that have been part of that crosssector investment, and it's just been something that has accelerated the work. So we committed to a vision, we aligned incentives and then aligned that infrastructure investment. So let me go through that a bit and just take you on a trip down memory lane.

When I joined here in North Carolina, the very first meeting that I went to, the big annual meeting of the Hospital Association, before they've changed their name as well, their session was focused on the social determinants, or on the medical drivers of health. They had a bunch of different speakers. And there was all this energy and thought of, like, oh, this is interesting. How do we do that? The Medical Society, under Bob Salina's leadership, had already invested in a lot of different ways through the Physicians Foundation and others, in thinking about how can we move towards health?

We were faced with a huge opioid crisis, as mentioned by the governor, and how do we put those pieces together. I was new to North Carolina. I did a lot of listening and talking to folks, both sides of the aisle, asking folks, well, what are you worried about in the healthcare space. And they rightly pointed me towards, I'm worried about some things in health, whether it was rural health and access to care, or I'm worried about that folks are dying young when they shouldn't be, or infant mortality rate and the disparity. And I saw this opportunity here in North Carolina that was already happening, and I don't think that it was anything I particularly did, but I saw the folks all running in a direction, and what we needed to do was take that energy and direction and turn it into an agenda that allowed us to actually do the things that I think it would take to transform the state and drive us towards health. And I also knew we were in a challenging political environment, and I was right, that this couldn't be about something new, meaning, like, that I was going to create -- we were going to create this big plan

and we were going to go to the legislature and go to my office, the governor, and say hey, we should invest X number of new dollars in something.

I knew this was going to have to be about using the resources we had wisely and efficiently, and so as part of that, we came up with this vision for overall how we were going to think about

And then, of course, our Medicaid transformation, right? This was where we, as a payor, and a

next two days, about the work going on nationally. And what I see is really exciting in North

So again, that was sort of the play book embedded into our tool of moving in managed care, but now with where we are in timing of implementation, you will see us think about how can we continue to move forward along these lines to continue that change in incentives so that we

human services, it’s got to start with relationships. And if anything, this week has taught me is that change only happens at the pace of trust. And I’m learning that lesson more deeply every day, and that’s whether that

room visits when what I want to buy is health. So this is the opportunity to learn. And we are going to continue to move forward with this work. The cadence of this pilot was actually not meant to launch until 2021 in terms of service delivery. We're doing a procurement now for the lead pilot entities, and then there was a fair amount of time of capacity building and building things up. So we're going to continue marching forward with this work and so I'm going to encourage all folks who are interested in this to stay engaged in this because it was running at a delayed cadence from the start of managed care, so I think we have a bunch of run room to still get ready for this pilot. Again, I think managed care is a when, not an if, and so we're continuing to run forward with this work.

But thisis going to be huge, and not just for Medicaid, but so I can tell my fellow other payors to say this is what you should invest in because we realized when we were writing the rules around managed care, I wanted to tell the insurance companies to say, you must spend your money on this food intervention. Then we looked around at the literature and realized we didn't know exactly what to tell them to buy, or to do, or to invest in, and particularly, we didn't know what set of patients and what phenotype of p

all tools at our disposal to make us a healthier state of North Carolina. I was asked yesterday by a reporter, you know, about all of the things that we're doing in managed care, and aren't you so sad, and you're getting national attention, but honestly, the thing that we could do that would move North Carolina forward the most in terms of fighting the opioid crisis and reducing infant mortality and helping our rural hospitals, it's not managed care, it's Medicaid expansion and so I just want to make sure we get our priorities right on that. Now, I am fully committed to moving to managed care. I think it's important because we built in all of these pieces, but we ve got to

this vision of buying health to this partnership in alignment, and really, it’s all about the children, the families, the communities that we serve. Right? That is hopefully what you will

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And so you see here the first four of these are Incentives For Action, Pay For Value, Empower People, Activate Communities and Connect Care, think NCCARE360. And the second four are focused on infrastructure issues, Measure What Matters Most, Modernize Your Workforce Skills, Accelerate Real-

[Applause]

>>McGINNIS: So with that, let me now turn to the first panel of the symposium and turn it over to Dr. Pam Silberman, who's going to lead our discussion on health and healthcare priorities and challenges to North Carolina, and offer perspectives on those pressing challenges. Thanks to each of you.

>>SILBERMAN: Okay. I'm going to see if I can figure out how to work this. Oh, there we go. Okay. Is this working? It is. Okay. Great. Hello, everyone! And welcome to the symposium and the first panel discussion. We're working to really set the ground for the rest of the work that you're going to be hearing over the next two days. So in this panel discussion, we're going to be talking about health and healthcare challenges facing our state. I'm going to give a little bit of an overview and then I'm going to introduce our panelists and they're going to give their perspectives.

So what I want to do, though, is start with a little bit of the history of health in North Carolina because I think it's really important for us to know where we started from, see how far we've come, and then to put the challenges that we're facing today in perspective. So I'm going to go back to the 1940s. Many of you know about this in the 1940s, but North Carolina had the notoriety in the 1940s after World War II of having more men rejected for health reasons in World War II of any state in the country. And that led our governor at the time, Governor Broughton, to create a commission to try to figure out what was going on in North Carolina that we had so many people rejected for health reasons. And that was a hospital and medical care commission, and it led to something that was known as the Poe Commission, because Poe was the doctor who was -- actually, I don't think it was a doctor -- who was in charge of that commission.

And the Commission, the Poe Commission, created the Good Health Plan. So I'm going to do the same thing that we did before, which is how many of you have heard of the Good Health Plan in North Carolina? Only about less than a quarter of you. You have a treat. Hopefully we'll hear it later today, I don't know if we will or not, but if you haven't heard it before, you should go and Google "Frank Sinatra and Dinah Shore, It's All About You" because there was a song done about the healthcare in North Carolina and it's really fun.

But, the Poe Commission came up with a series of recommendations, and the reason I put it up here is because when you look at that list, you're going to see how many of them are still plaguing our state today. They said we needed more physicians. We needed more hospital beds. We needed greater affordability of care, and more health insurance coverage. We

needed to address health disparities. We needed more community resources to address the needs of people with mental illness. We needed greater funding for public health and we needed a school health program.

And if you think about what Governor Cooper said earlier today and what the secretary said, so many of those issues we are continuing to work on right now.

So I'm going to fast forward us to the 1960s or '70s because I want to highlight something that came up earlier in the discussions, which is that we are a state of innovation. In order to address the primary care shortage, North Carolina was the first – Duke had the first program in the country for training physician assistants. It grew out of Duke. Around the same time, we had one of the first nurse practitioner programs in the country. So we were at the forefront of training non-physician clinicians who could address the healthcare needs of our state.

We were the first state to pass innovative health legislation at the time, in 1975, to allow nurse practitioners to practice. We are now a little bit behind the curve in terms of nurse practitioners and scope of licensure, but at the time, we were at the forefront.

We created the first state office of rural health in the country to try to address rural health challenges. We were one of the first states to create an Area Health Education Centers Program to help continue education for practitioners. Again, that grew out of the Poe Commission and what the Poe Commission recommended.

And then, of course, we created CCNC, Community Care of North Carolina, which is an award-winning Medicaid care management program that really helped launch us towards improving the quality of care we provided to Medicaid recipients and to link them with a medical home. So we have made – we have been innovators and we did that clue collaboration between the professions, between communities in order to address these problems.

But we still have challenges that we're facing. As a result of our past efforts, we did put more emphasis on expanding the health professional workforce, but we still lack primary care providers to meet the needs across the state, and dentists, for example. If you take a look at overall health professional shortages, we don't fare as poorly as we do when you look at geographic distribution. We have a significant problem with misdistribution of health professionals. North Carolina is not unique in that regard, but you can see from the slide that we have 82 counties that are considered either in whole or part a primary care shortage. We

have too few primary care providers. We have 84 counties that have too few mental health providers, and 74 counties that have too few dental health professionals.

And then, of course, we've already heard about the fact that North Carolina has not expanded Medicaid, so North Carolina has one of the highest uninsured rates in the country because of that -- of the fact that we have not expanded Medicaid.

Our clinical care system is good overall. If you look at the Agency For Healthcare Research and Quality, they produce a report card that looks at how we were doing on clinical care and you can see that there are many areas where we are well above the national average in terms of person-centered care, care coordination, acute care, chronic care management. I think a lot of that came out of the work from CCNC and some of the other initiatives we've had in the state. But we have other areas where we have still challenges, and where more work is left to be done.

Now, this chart is a little bit harder to read. It comes out of health affairs. It's a recent article that came out of health affairs that shows how North Carolina's doing compared to other states in new model innovation, adoption of new models. And this slide in particular, it's how many ACOs, Accountable Care Organizations, we have in the state, and how many people are covered by that. And it shows when you can sort of try to discern the difference in the color of the blue that North Carolina's slightly above average in both regards there.

So clinical care is not our problem. Stepping up to innovation is not our problem. Where we have our problem is in those non-medical drivers of health. We know from the work of Mike McGinnis and from the work that's followed from the community -- the county health rankings and Robert Wood Johnson, that only about 20 percent of people's health outcomes are really attributable to the medical care we receive. So much more is due to the social and environmental factors, the physical environmental health factors and health behaviors that we engage in.

And when you look at our data, this is where we really have to focus our efforts. And that's what's so exciting about what the state is moving in to with the Triple Aim opportunities. We are 40th in the percentage of children living in poverty. We are 35th in health disparities. We are 45th in median household income. And that leads, of course, to poorer health outcomes, where we also are at the bottom of infant mortality, of low birth weight, and of premature deaths.

So this the takeaway is that North Carolina has both great strengths and many challenges we have to face. We have a history of innovation. We have a history of collaboration. We have

quality clinical care. We are willing to and have historically been innovators in new care delivery, and all the work that you've heard about with Medicaid transformation I think is going to really move us forward, but we have significant challenges that we have to face that we've already discussed.

So now, let me introduce our panelists and the rest of the time we're going to hear from them talking about both the strengths and challenges that our state faces.

First I'd like to introduce Karen Smith, who is to my left. She is a family physician and she is a medical director of Aledade's North Carolina ACO.

Then to her left is Steve Neorr, who is the senior vice president of Population Health, Cone Health, and the senior vice president and chief administrative officer for Triad Healthcare Network.

And then to his left is John Lumpkin, who is the president of Blue Cross and Blue Shield of North Carolina foundation, and a vice president of Drivers For Health Strategy at Blue Cross Blue Shield of North Carolina.

So I'm going to turn it over to them. I've asked them each to give about five to seven minutes in introductory comments, and really to say from their perspectives what do they think are the strengths of the state and what are the most pressing health and healthcare challenges facing our state. So Karen, I'm going to first turn it over to you.

>>SMITH: Perfect. I do appreciate the opportunity to be here. The best time to practice medicine is when we have the opportunity to make a difference in someone's life forever.

32 years ago I took the Hippocratic oath of medicine, and those words were inspiring then, just as much as they are inspiring today. The physician navigation journey through North Carolina's healthcare transformation needs us to think about what are the best physician characteristics? What do we have now? And then to take those physician characteristics and realign them with trend-setting strategies such as TOPPSS, Technology, Opportunity, Options, People, Preparing, Scalable and Strategic, and then what is our best solution, the affordable care organizations? How are we utilizing those entities? And then finally to realize our prize at the end of the road, which is that comprehensive care in North Carolina.

But then we need to make sure that we're utilizing sustainable efforts. So we need to enhance our leadership and our own home, in our own patient-centered medical homes, as well as make sure that our staff have proper education in terms of health information technology, that they are Google savvy, and then we want to make sure that we continue to have those businesses that are sustainable.

By the way, those new practice trends are actually bringing those doctors, who left the traditional fee-for-service, are coming back into the joy of independent practice.

We move forward and we still recognize that the value-based payment model system is a little bit of discomfort for doctors. So we're still continuing to look for solutions. And we come up with the affordable care organizations, and some of us were entertained with the clinically integrated 2 (nte)n-1 (nte)-ope

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>> NEORR: John, I don’t want to follow that. Thank you, Dr.

And onething local I would like to call out is at least in our market we're seeing a lot of much greater connection with our public and private partnerships, and this I like to call out the one, the Get Ready Gilford initiative. We've already raised over $30 million and people in our community are really interested in early childhood education.
The challenges, again, I think we could go on and on about those. We've heard about a lot of

[Laughter]

So I'm going to talk about the work, and as you've heard, I've got two hats, so I'm going to shift from one hat to another when I talk about some of the work in the company, as well as the work of the Foundation. And the mission of Blue Cross Blue Shield of North Carolina is to improve the health and well-being of our customers and communities. And you're going to hear a lot about some of the initiatives that we're doing on value-based purchasing with other speakers. I'm going to focus on the issue of communities because the health of our nation, the health of this state, and the health of people is determined by the health of the communities where they live.

Now, when you look at the data for North Carolina, and Sig, it's good to see you here from Wake County, because Wake County is the healthiest state in this nation on the county health rankings, and if every county were as wealthy as Wake County, North Carolina would be the healthiest state in the nation. But that's not the case.

Just five miles from here, five miles from here, where Wake County is, but in this particular zip code, a distance of just five miles is reflected in a 11-year difference in life expectancy. So as we begin to look for solutions, we have to look into our communities, because when you look at

airport, and I walked all the way over there, and it was a florist shop. Now, the good thing about that was I did get some exercise.

A few years back, I was back at the airport, and this is what I saw. The opportunity to make the healthy choice when that's presented versus what we typically see in an airport are the kinds of choices that we have as a nation.

Now, Rocko Pearla from the health initiative has looked at some of the data related to North Carolina looking at the health in our counties, and we begin to focus on how we see health

The red dots are where the term "Red lining" came from. And yellow are the areas that were next. The green are the best areas. And when you overlay that same area, imagine the same area and look at this particular one, there's a lot of colors on here, but just say that darker colors means that high-income, high-housing value, and the lighter colors, low-income, low-housing value, exactly in the same locations as the red-lined communities 70 years ago. And then when you add in concentration of racial poverty, the same areas that we saw earlier on in the red lining.

Red lining is a system that is imbued a system of racial inequality that has to be overcome if we're, in fact, going to improve health outcomes in the state. So when we look at the drivers of health related to food insecurity, and you say well, let's look at it compared to health insurance, there's not a strong coalition correlation. And these, are, again, from Rocco Pearla at the Health Initiative. When you look at income, because we know income is directly related to health outcomes, there's a much stronger correlation. But in North Carolina, the strongest correlation is based upon race. And that when you look at the percentage of African-Americans in a particular county, the larger the percentage, the more likely they are to be food insecure.

So to make a difference, we need to address the issue of health equity. Health equity is that everyone has a fair opportunity to be as healthy as possible. And you may have seen this infographic from the Robert Wood Johnson Foundation, that the difference between equality, that is everyone gets the same thing, and equity, is that people get what they need to be healthy. And this shouldn't be a new concept for those of us who are clinicians, because we know we don't give every patient the same doses of insulin. We, in fact, titer their dose based upon where they live, their activities and how they live their lives.

And that the key issue and vital directions race for this is we think about making these solutions in addressing health equity is that we have to listen to the voices of communities.

This is Paula Avery. Paula Avery is part of the Community Centered Health Initiative of the Blue Cross Foundation, and her changing moment , the thing that really transformed for her was when someone asked her, what's the vision for her community. And her answer was, gee, I had never even knew I could have a vision for my community.

And when communities begin to develop visions, then change can happen. Paula Avery's vision was setting up a community garden. And we have been working at the Foundation with communities across the state, each one developing partnerships of healthcare and community organizations, but with people who are involved in the communities taking the lead. It is that

kind

So what we realized is there a socialization here that we had to start making, and I have to give a lot of credit because really it was NCCARE360 that really we started introducing this, and they're like, oh, my gosh, this is available? Yes, it is. And that's been a really great way to do that.
So from that perspective, a lot of this is doing education with our practices about what's available, and helping them along. We were just, like I said, somewhat surprised by the folks that don't --just aren't aware of those particular services.

>> SILBERMAN: So let me turn now to John. John, you talked a lot about sort of place base and the differences in health outcomes between in-Wake County, the 11 years difference and five miles, if I remember that correctly. And you talked also about disparities. The last slide you showed was the strong correlation between sort of health outcomes and race. What do we do as a state? I mean, it's great to invest in a particular community, but how can we move the needle from a state perspective and really start addressing health disparities and health inequities in our state?

>>LUMPKIN: The critical task as a state is to identify and support our communities. I believe, and our state health officer in Illinois before I went to the Robert Wood Johnson foundation, that the role of state agencies were to create the conditions in which communities could be successful. And I think that when we look at, as a state basis, where are the barriers, and where can we facilitate change at the state level?

Let me give an example. I talked about food insecurity. One of the barriers that exist around food is that because regulations are in place, local growers can't sell to schools unless they have certain certifications which becomes cost prohibitive for those growers to be able to sell to those local communities and local schools. So removing those kind of legislative barriers, and providing support to communities.

>> SILBERMAN: So let me come back at you on more, and then I'm going to turn to Karen. Which is I think that makes sense in certain contexts, but how we have a problem with disparities in wealth in our communities. Some of our communities, like Wake County, is pretty wealthy. Some of our communities, like Burtee County, isn't. I happen to be on the board of Alliance Health Plan, and they during the last hurricane, they were talking about how they were lucky because Fayetteville had housing stock where they could house people after they lost their homes, but that some of the other communities that were affected by the hurricane didn't have housing stock, and they don't have the wealth in those communities to build housing. And we talked about I think -- I can't remember whether it was -- I can't remember the analogy that we talked about earlier, but there's a movement of housing first in order to get

people in to housing is one of the critical factors to address social determinants. So how do you, in a state that has this inequal wealth and inequal ability, how do you rely purely on communities to do it? What else do we need in order to address some of those challenges?

>>LUMPKIN: So I'm going to start off saying number one, we need to expand Medicaid. Number two is that as we think about ways that we improve our systems, we give concern to our local communities. So you take Asheville. We, as a foundation, supported the Mothering Asheville as an initiative, as part of our community-centered health. And what they did was they were addressing infant mortality disparities in Asheville. And when they address it, they developed a doula program, and they hired women from the community and they trained them to be doulas. So the care that was being provided in the community didn't come from outside, it came within the community. That led to economic development.

And as we think about Medicaid transformation, as we think about shifting to value-based purchasing and partnering with health systems, the emphasis on using local resources and building up and supporting the capacity of local non-profits to provide these services rather than having a company from Philadelphia coming in to deliver meals, I think that's a critical aspect of the kinds of transformation we need that builds local economic development and stability into the system.

>>SILBERMAN: Right. Karen, you've been one of the most articulate spokespeople I know for many years about the role of electronic health records and using data systems to really understand your patient population and to really connect them with care and provide high-quality care. But what we heard earlier today is the challenges physicians still experience

that information to now go back in to the community for the patient. But I wanted to highlight a project that is part of the American Academy of Family Physicians, and it comes through our Center for Diversity and Health Equity. It has been recognized on a national level. Therefore, the education has already gone out to those physicians who are part of the organization. But they recently released a gravity project, and a gravity project is utilizing the longest acronym I will use this year. HL7FHIR Accelerator Program. Okay. What in the world is that? And basically it is an advanced data exchange system that now allows us to utilize the language, the metric that can be captured in a interoperable system, which is also recognized in our electronic health records, which will also be identified in our ACO platform.

Finally, we are speaking the same language, so we'r

because it is an agreement, it is a collaborative, and it works well, and that one patient will be coming back to our office for induction next week. So we are utilizing that information without barriers of the firewall.

>> SILBERMAN: Okay. I think we're coming to the close of our session. We have about ten more minutes. I'm going to ask the panel to really briefly, if you had one policy solution that you could raise with the state, we've already got the Medicaid expansion. I think all of us up here would agree with that. But if you had one policy solution that you think could make a huge difference in terms of '-2 (o)2 (fpri)-1 (o)2 voing theh(e)-2 (a)-1 lith of our statepfriomwhtatevelrer

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from high school, is nine years. So I think it's a policy difference that can improve health across the state.

>> SILBERMAN: Great. Thank you. I want to just take a minute or so to summarize some of the key points that I heard today, and then I want to thank our panelists. This was a great opening session. We really had a wealth, sort of a wealth of perspectives on what some of the key challenges are in the state. I think fragmentation is clearly an issue, but it sounds to me like we are making huge strides from when I heard Karen probably ten years ago talk about some of the fragmentation issues we had there to what we're doing now, both in terms of moving towards better interoperability, and also towards coordinating care that we're getting with this new models of care, and that there's been some great improvements in helping provide the supports needed for local practitioners to really be able to engage in this new model of care.

From Steve I heard a lot about the importance of really looking deeper at what is driving people into the health system so that we can address the underlying problems that people are facing that's causing them to come into the system. And really stepping back and saying, the goal isn't to put people in to hospital beds. The goal is to figure out what is driving their health needs and addressing that. And that may mean some discomfort in our period of transition between the sort of different financing models that we have, fee for service, keeping a bed occupied, and value-based care, keeping people back in the community. But that it sounds like we are making great strides, and I am glad to be corrected about how much ahead of the curve North Carolina is in moving in those innovations. And from John, we really emphasized the real point about addressing disparities, not just racial and ethnic disparities, although those are key to the whole population health in the state, but looking at geographic disparities, looking at access to food. Looking at ACEs, adverse childhood experience, and that we need to focus in both at the local level and let communities sort of from the ground up figure out what is most important to them and get them involved in addressing their health problem. But also creating the policies for our state to enable us to be a healthier state, such as Medicaid expansion, although I'm sure it was not limited to Medicaid expansion. Early childhood education as well.

So I think you've heard a lot today that you will be hearing over the next day and a half about how North Carolina is at the front in many areas. We have still a long way to go, and how we have the wherewithal and the knowledge to really move our state forward in terms of improving health.

>> MCGINNIS: Thank you, Pam, and to Karen and Steve and John as well for a really wonderful overview of the key issues and a beautiful setup to the next panel on place matters from health and healthcare disparities to equity. And if our next panel could come up.

North Carolina, and a very active community member there leading a number of important initiatives.

And then lastly, we'll hear from Weyling White, who is the practice administrator at the Roanoke Chowan Community Health Center in Ahoskie, North Carolina, and is, I'm so pleased to announce, the first African-American mayor of Ahoskie, North Carolina.

[Applause]

And I just want to give a shout-out. We're so proud to have a health CEO, and so interested in underserved populations, and in eastern North Carolina covering 29 counties, but we're so proud of Weyling and the work that he's done at the Community Health Center, which is a partnership with us there, and his community in driving many of these issues forward. So we look forward to the discussion.

And so I actually want to position the conversation looking at place mattering at three different levels. I want us to think about this from a national and regional perspective and then kind of from a statewide and then looking at some of the local communities here in North Carolina. So

Carolina. And again, widespread geographic differences when it comes to health, and these are based on health outcomes, including self-reported health, infant mortality and other outcomes. What you'll notice here is -- whoops, what you'll notice, if I can get this to move, we have in North Carolina our own black belt, right? And we know that in the black belt, that's where we have our worse health outcomes, right?

So again, place, mattering and race mattering intersecting to create kind of these conditions in the State of North Carolina. But if you look at the drivers of health, right? So this is things like economics. These are things like health behaviors, those same drivers of health are also overlay geographically in the State of North Carolina and, again, go along racial lines as well geographically in our state.

And so these, again, are -- this, you know, shows the kind of primacy of place in the State of North Carolina specifically.

And we see this in terms of life expectancy. So how many of you all travel up 64? Highway 64? Right? So there's about -- on highway 64, going from Raleigh to RocS up 3 (rt)1 (h)1 (C)-ak,

institutional and structural racism has created separate and unequal living conditions for folks in our state and around the country.

And so red lining map, this is a red lining map, actually of Philadelphia. And again, the same places that were red lined back in the 1930s are the same places that are disinvested. But it's not just these red lining maps, right? The way structural racism works is that it finds a way to re-create itself. So we got rid of discrimination in housing in 1968 with the Fair Housing Act. But we still see high levels of residential segregation across the country. And so red lining started the kind of cascade of events, but we still have discriminatory lending practices, and other practices that create these separate and unequal environments.

And so this is actually a map of Durham, right? And in that kind of southeast corner where Lincoln Health System is, we see that same place being an area that has been is disinvested to this day. Right? So why do I kind of go through this history lesson in my kind of talk about restrictive residential covenants, also talk about racialized violence? We cannot talk about segregation without talking about racialized violence, but it's so critical, because again, it shows that our communities have been segregated not by accident, but by design. And if we can figure out ways to create these inequitable environments, we can figure out ways to create these equitable environments through policy and through interventions that actually make communities more equitable, and make it so that folks can actually not only survive, but thrive.

And so -- and we know that segregation is fundamental, because of things like because of things like schools and jobs and access to healthy foods and, you know, all of the all of the resources that are conducive to healthy living. Right? And so I often -- you know, we often, you know, kind of harp on the food part, but that's only one of the symptoms of the disinvestment. And so I think in local communities, one of the things that we have to move towards as we're thinking about how do we create more healthy and more equitable communities, you know, think about yes, access to healthy foods. Think about optimizing healthcare systems, but how about investment in jobs? How about investment in education? Those -- sectoral policies that will actually build up communities on multiple domains, and really improve the health of those communities.

So I've done work, actually, for the last six or seven years in Jacnacnacraains,raaio3(y)-2 (1 (e)- i)-1 (r

So change the environment, change the outcomes. And this can happen even among an African-American population. Right? So again, getting at that idea that these are structural and fundamental causes of health and health inequalities in our cities and our state.

And so finally, I'll just -- want to just highlight one of the kind of exciting innovations that I see happening in this area of building healthy communities. So the California Endowment was started in 2010, a Building Healthy Communities Initiative, and really thinking about places, you know, your zip code is more important than your genetic code in determining health, but

Americans, and when you disempowerment and disenfranchisement. Two-weeks ago we just have had our first black mayor, 126 years. That says something in itself.

In comparison to North Carolina, some of our rates are lower, some are higher. Some of the -- we're looking at today's, of course, our birth rate, median household income is lower, our education attainment rate is lower than in comparison to North Carolina. However, when it comes to poverty, we have a higher rate. And I see Lin Hollowell is here. I'm shouting out people today, so if you get

[Laughter]

>> I wanted to say in regards to insurance coverage, we did have a decrease in our uninsured population through some of the other things that we've done in the community. We are having higher medical coverage in comparison to North Carolina around that.

So structural racism, I'm not going to tackle this, Sharrelle did. She did an amazing job; but one thing I will say about health equity, you cannot achieve health equity, you cannot address health equity without first acknowledging and being intentional about racial equity in this regard as well.

We do know that there's race versus racism, and I don't know if you all are aware, but race is a direct product of racism. Racism came first, and that's why we all attribute to a particular race, and we knowT* [(a)-1 (a)-1 (a)-1 T* [(a)-1h(a)-1 (02 Tw 7.54 0 Td [(e)-2 (, (n)h ( )-4 e44 0 Td4an)1.1 (c

In Ward A, I know you are pretty familiar with our Roanoke Chowan Community Health Center [phonetic] and of course, Vidant Hospital, all located in Ward A. All of our public schools, our health department, we have a nice amphitheater, Ahoskie Recreation Center, our Vital Wellness Center, our police station. All of our resources are located in Ward A. In Ward B, we have three tobacco shops. We don't need one; we need three.

[Laughter]

>> Two are within 20 feet walking distance, so if you come over here and they don't have your particular pack of cigarettes, you could just walk 20 steps and get your option.

We also have increased crime; our infrastructure is diminishing, a large number of funeral homes and, of course, all of our African churches are located in Ward B.

Ward A, just to give you all a better picture of Ward A, we have an amphitheater, we have a new display with the Hertford County bear. So we just had that built. We have a dog park in Ahoskie, so if you all are coming to visit, please bring your pets with you.

[Laughter]

>> I'm very proud about that; I don't own a dog, but I am very proud of that. So we have our hospital and a health center, of course.

And Ward B, this is part of the reason why I wanted to take action and take a part in my community. This news article right here, we just got this in our newspaper two days ago. This shooting took place on Sunday.

These are buildings this is right off of our main street, at the top, I used to get my haircut there. And I got that cut in high school. I'm not that old, so you can tell the type of structure this building was in.

And this is one of our tobacco shops that I was talking about earlier. Also in this ward, with all of this, we also with all of this, we also have a lack of small businesses and healthy food options as well which we couldn't fit on this slide. But this is just to show you what's going on in that ward.

So I see some Community Health Center folks in here, Community Health Center Association, I know you all are aware of what this video is. This is out in the rural. So to give you all a little bit of background of where we are moving towards in our organization at Roanoke Chowan Health Center, another funny story -- not a funny story --

We also implemented interpreter services. Another story that really, really drives home as to why it’s important for us to actually think about health equity in the healthcare delivery role. We actually had a situation where there was a patient that came, and this patient’s last name, I think, was Martinez; and a front desk staff person where the person walked up, they said, "Oh, I need somebody that speaks Spanish." And the person said, "Hey, I’m just here for my appointment." They spoke English, but it’s that bias that is embedded in our community.

strategic partnerships and strategic plans in our community. One of those has been transportation and addressing social determinants of health. And with transportation, we know that that has been a direct link to people not accessing healthcare, not being able to live healthier lives, and so we have been able to strategically put together a program that can help patients that can't afford transportation or don't have it to help to be able to get to the resources that they need.

We've also been able to build our community partnership. So it's not just a lot of medical facilities and medical organizations in the community. We have DSS at the table, office [phonetic] of aging, Chowan University, [indiscernible] Community College, anyone that has an impact on the residents of our community, we bring them to the table through this partnership.

Lastly, just some of the things that we are doing for the community, we are just are just identifying action steps for each member, focusing on staff diversity. So we are being intentional about our recruiting practices and things around that nature and policies.

We're also focusing on pay equity, opportunity equity, and are very, very excited about our leadership skill development. Not only are we just being more equitable for our patients and our staff members as well, but we do realize that all of our staff members are not able to access the same skill development as others as well. So if you work front desk or you're in medical records or a janitor, and you want a class in public speaking; you want to learn how to do resume building or developing an agenda, we're going to be developing skills in-house at our organization so that we are having equitable opportunities for all of our staff members as well.

And we're also partnering with our leadership team to identify topics, teaching, and schedules as well. That's my time. Thank you very much.

[Applause]

>> LEGERTON: It's almost afternoon, I guess. So I'll say Good Afternoon. It's good to be here today. I particularly want to honor Jessica Marx for her work. Our panel actually had two introductory calls together in planning for this particular panel. And I'm going to turn my timer on here.

Besides being a community practitioner, I'm a minister and educator, and education and preaching conflict often.

[Laughter]

>> They're different forms of communication. So I'm going to certainly make sure I stick to the allocated time.

Okay, let's see here. Sharrelle, Wey, and I and Dr. Johnson took our call very seriously. And I'm going to break this down in terms of the community practice angles. And so, my subject is Building Health Equity Through the Convergence of Grassroots and Professional Communities and Cultures.

I live in Robeson County. I want to ask you -- you all probably know about Robeson County, particularly the negatives and the reputation of our county. But we also have many assets. Besides our racial diversity that most folks know about, we are also very eco-diverse county. We're the largest county in North Carolina. We have 50 swamps and a river running through it. Actually wear many hats and actually have the only outfitter on the Lumbee River. It is home for the Lumbee, the largest Native American nation east of the Mississippi. It's also one of the poorest counties in North Carolina and the sixth poorest in the nation.

Sharrelle commented on Eastern North Carolina, and you saw how much of the poverty is in the east. It's not only the historical home of our African-Americans, but also four of the six Native American Indian nations that are recognized by our state are also in the east. And so the convergence of indigenous and African-American populations are a major reason for the poverty as well as distance from our urban areas, which means that many of our European-American families are also poor.

I won't go through all the data, but you can look at this list over here for Robeson County and our health factor rating and our health outcome rating. We've always been near the top or the bottom, whichever way you want to look at it in terms of the state.

This particular study really gets it, the issue of this panel and this conference, if you haven't seen this report it's a very good report on racial

Okay, so how are grassroots professional barriers manifest in the medical field? Well, it's mostly one-on-one case management, focus on productivity and efficiency – I don't need to go through this list. It's already been discussed this morning. But I just want to point out this last note. The word "patient" indicates a level of irony because it really means suffering and passive.

So how do we converge our grassroots and professional cultures to advance health equity? I have a number of steps; I'm not going to go through them all. All these PowerPoints will be available. I want to just point out to this one: Meet on a regular basis. I'm working on a book on social action, because practitioners that practice don't write and academics the write don't practice.

[Laughter]

>> So there's a major gap in our literature when it comes to all forms of social action, no matter how you do it or what your ideology is. There's a major lack of understanding. And when I've researched social action, every group that is serious about changing lives meets on a regular basis, once a week. And if you're not that serious about changing lives, you can't do it once a month, whether it's Boy Scouts, Sunday school, Kiwanis, Jaycees, support groups. AA meets every night, that's the most clear example for me.

And this is real important, to work together to identify the cultural barriers, dysfunctions, and challenges in both of our cultures. I was involved very deeply in the Robert Wood Johnson opening doors efforts in the 1990s; and really began to understand through our local project with a healthcare agency how difficult it is to talk about this dysfunctions in our own community culture, whether it's organizations or grassroots communities. And this is so important if we're really serious about assessing the barriers and solutions for health equity.

Also we really need to assess the relationship between our health care agency or system and our community partners and how it hinders and deters meaningful relationships. It's o healthcare providers, if you will, that have the power to invite and include our grassroots organizations and leaders into the room as equal partners.

And then we need to work together to identify solutions to reduce and remove these barriers and create, as we've said today, meaningful relationships. And engage our two cultures in healthcare institutional and systems context working together to actually transform both.

Also we need to consider the use of groups of community care, communities of healing participants in your medical practice. And what I mean is, unbiased toward groups, not the individual care approach. Groups, for grassroots people, they want to know loneliness is a medical illness, and for grassroots people, when they hear the stories of other people who are going through the same challenges they're going through, they'll come back. But our show rate in our county is 50% with our healthcare providers, even though we have the largest Medicaid percentage, and Medicare, over 40% of the entire population is on Medicare, and with Medicaid it's close to 50%. In spite of that, and with private insurance, we still have a 50% no show rate.

Now this book, "The Community Cure: Transforming Health Outcomes" is really a radical book. "Radical" means getting to the roots of how to work with grassroots people in a health context. The book promotes group meetings and I'll show you a really wonderful quote, "the medicine

that we use in the health and healthcare profession fit neatly under one of these four types of change.

So what are my major learnings? My major learnings in addressing health equity are, that to advance it, we really need this convergence and engagement of the clinic and the community as equal partners in identifying, removing, and overcoming barriers and challenges together. My proposal is -- How often should they meet?

>> AUDIENCE: Weekly.

>>LEGERTON: Weekly, if you're really serious about it, just to build relationships and build community so when the challenges come you have that those relationships and community to fall back on.

I don't like the word "patients." I don't like the word "client." I don't like the word "consumer." I am a consumer in the mental health system because my son has chronic schizophrenia. I don't like being called a consumer; it sounds like you're there just to take. I don't think it's a better term than the legal term "client." I particularly prefer "program participants" as a term rather than patient, client, or consumer.

And in the group setting with functional medicine, I love this quote, "You get your community support and medical care before you get sick in a group setting." So we have support groups just like AA, just like we need diabetes support groups in a ten mile radius of everyone living in Eastern North Carolina. You do this before you get sick. You bring in your family members as well.

A couple of the learnings, to create significant health equity involve relationships of accompaniment and empowerment. This is very staff intensive. I don't think our funders realize how staff intensive it is. In spite of -- I work extensively with Blue Cross Blue Shield projects with our regional food system and others. I think they understand it, but this type of accompaniment cannot be fulfilled in a conventional case management or crisis management role.

Also, lastly, research indicates that health equity programs that engage and empower program participants in sustained groups optimize changes in behavior and health outcomes, advance participant leadership, equalize relationships of power between providers, reduce cost, and increase revenue for healthcare service providers. Thank you.

[Applause]

>> WALDRUM: You get an idea about how much fun I had working with this group to plan this, and I'm going to pull an audible. We're going to be done at 12:30 for lunch.

>> Let's say 25 minutes.

>> WALDRUM: Okay, 25 minutes, I see frowning.

[Laughter]

>> No. And I'm going to pull a little bit of an audible, instead of me moderating and asking questions. I just really would like to get the audience engaged. It's just such rich work. I can tell you from an organization that's highly embedded in our community as we eluded to a little bit in Ahoskie, we have a hospital in Bertie County. And if you've never watched the movie "Raising Bertie," you need to watch tonight. It is an incredibly impactful movie. But as we work as an organization to advance economic development, education, and health and well-being, you really have to -[t's a]d[u 5]3 0 Td ( )Tj E72'sgement and embedding tal pm0ft:30 for ng (d)-4 (m)-1 (o)7

[Laughter]

>> WHITE: Well, Decemb

>> BARBER: And I want to just comment, one of the definitions of social racism that are often used by physician and epidemiologist [indiscernible] Jones, and she says that, one, it's a systematic, kind of the ways in which we systematically create systems that benefit some individuals, disadvantage some individuals, but also sat the strength of the whole society. And I think in this conversation about structural racism and how it infuses itself or finds itself in different systems, whether it's the residential segregation or a healthcare system, we have to get to the conversations like, this is bad for all of us. Right? This is not just impacting black folks or indigenous folks or cells or Hispanic folks; it's actually making it so that our state as a whole won't flourish and won't thrive.

And so I think, this conversation is really inspiring to see that folks, I think, are really willing to, like, "Let's wake up to this. Let's think about how do we take up structural racism and think about the systemic and historical things that have happened and create the policies that actually move us all forward." And I do think that that's really necessary as we have these conversations. So we can say the word "racism." It's okay; it's not going to kill us, but it is going to move us forward.

I was actually at Greenleaf Christian Church with Ibram Kendi who has written a book "How to Be an Antiracist," and he talks about racism in our country, in our state as being a cancer. And when you find out the diagnosis of cancer, you're scared, you don't want to deal with it, you really don't want to confront it. But if you don't actually deal with the cancer, it'll kill you. And that's what we're seeing. We're seeing it in our health outcomes, we're seeing it in ways that we are not thriving as a state and as a nation. And if we don't, in this country, deal with the issue of racism, we're not going to move the needle on equity in our state or in our nation.

>> WALDRUM: I really appreciate those comments because I think, two to follow comments is, one, that the issue is yet, it will kill us, but it's killing the people that are, you know, at the margin, right. And so, the voic-2 (pe)u.4 Td fT (v)2 t-1 c7 (M:)- I, deoue(o)3 (u)1 t-1 c7 1 (ty)-2 (arg)2

community activism and engagement, I think that we have to really find it interesting, I'll just tell you, and that's why I said watch "Raising Bertie," you've lived that reality you described. I was in Ahoskie last and go to Bertie, and all of our community meet with community leaders. Extending care to those environments and/or services is extremely difficult and, you know, we can talk about Medicaid expansion, but it's not just Medicaid expansion. A hospital so your map, I loved your map, so you stopped in Rocky Mount, and Martin County, which is 30 miles down the road -- 25 -- they just closed OB services in that hospital in a part of the country that has one of the highest, if not the highest infant mortality and maternal mortality, which primarily is ten times higher in African American women than Caucasian women. And it's low volume services, and so that institution couldn't carry that burden with less than one birth a day, but when you close that service, more women die and more babies die. We have one baby a day in Ahoskie, but if we're not there, a mother and a child has to drive over an hour to get prenatal care or baby dies.

>> LEGERTON: I’ll make just a quick c

the community piece, especially as we think about disparities and inequity in that important of engaging our communities. And then, finally, Chris Koller, there he is. He's very tall; he's often hard to hide, but he was hiding over there. Chris Koller who will really help bring some of that national perspective for us. He's the President of the Milbank Memorial Fund and helped think through some of the financing mechanisms of this. Because you can have the best intentions in the world and the best design in the world, but if you can't figure out that sustainable financing piece, then you'll need that for the sustainability piece. So really excited about that and the conversation that we'll have with each other, but then we'll also open it up for the room for conversation and questions from you all and have this be interactive.

So really briefly, teeing up and, again, you heard this morning, at least from the perspective of North Carolina, North Carolina DHHS, but we are surely committed to ensuring that all North Carolinians have that opportunity for health and well-being. And so we really, through that lens, how do we buy health, not just healthcare. And think about how we design, how we catalyze, and how we execute a comprehensive multilayer, multicomponent, multiyear, multiplayer plan, a[crosstalk] a unified agenda for North Carolina healthcare and health system.

And I think about North Carolina, it's an incredible opportunity to try to innovate in North Carolina or to innovate in North Carolina, because if we can do it in North Carolina, it can be translated to anywhere in the country. So I 1 (aro)31 (])3 (a u)1 (n)bw(in)1 (t)1 (h)1 (e)1 (e)ul(t)0.9u2

segregating? So how do we think about embracing that and drawing strength from our diversity and making sure that we're very culturally humble? I've learned not to say "culturally competent" because whenever I'll be culturally competent, but culturally humble to recognize what we don't know and have this work across all of our populations and do it our populations, not for.

And we're politically purple. And so, healthcare is divisive, but what we're finding is that health is not. And so how do we think about that health perspective and not have it be caught in the political world, but really understanding in general, we all actually are pretty unified concept of what drives health. And we've done a fair amount of work with some partners, just saying, "If you have $100, how would you invest?" It is incredibly consistent across gender, race, political affiliation, physicians, laypeople, pretty much everybody will invest in health very, very similarly. So that's, I think, the advantages, is that health doesn't have to be partisan. And how do we do that, drive health, despite political partisanship?

And we have incredible alignment across our payers, across our partners, incredible alignment in drawing from the history of North Carolina of Collaboration and Partnership. And then using our Medicaid program, not as the sole driver, but as that catalyst and that market mover of our

not build silos that we have to spend all this money trying to connect. Let's think about where do we have those shared tools, those shared resources. So where do we want to collaborate? And then where do we compete and innovate on top of that? Competition innovation is awesome, but we don't think we necessarily need to compete and innovate on every piece of that. So where do we agree that we're going to share tools, and then where do we compete on that?

And so thinking about, again, some of the shared tools that we have really been trying to make sure is available for all North Carolina. The standardized set of screening questions, people really like their own question, and we compare it all, we convene with our technical advisory group, like there's so many screening tools out there, all the questions are pretty much the same, like, come on. I actually thought it was going to be a lot harder to get those set of questions, but it took us three or four meetings, and people understood the benefit of having a shared set of questions. A, systematically ask that question, but B, when we think about pulling in data that data and the data integration and thinking about using that population level data to guide investment. People understood that the value of having shared questions.

And then NCCARE360, of course, thinking about what's the shared technology platform, coupled with the people that are connecting people and people, we'll be the first state to have one shared platform. And when we go to other states where their ACOs each built their own, and now their relying on interoperability, that's a bear. So the fact that we'll have one shared infrastructure, I think will be huge, and then we can innovate on top of that.

And then aligning our push to value based payment and using a lot of those levers, that when we do go into Medicaid managed care, those levers will really be market drivers. So we're really excited about that, and I think because in North Carolina we have such a history of collaborating, I'm really excited about those shared infrastructure pieces to accelerate. And I think this will be an area where standardization will actually fuel innovation because we're not all having to create our own wheels; we can share the wheel and then innovate on top of that.

With that as a tee up, I am going to then turn it over to my esteemed colleagues to do some brief opening remarks, and then we'll have moderated Q&A.

>> TILSON: So I'm going to go to Kathy first, right? Okay.

>>COLVILLE: All right. Thank you, appreciate that. I just want to acknowledge that this is the after lunch crowd, which is a special crowd.

[Laughter]

>> Thank you. This is the dug in, this is like I'm taking the whole day off. I'm going to let the emails pile up, I'm going to be here after lunch too. I appreciate that. We are together here for a reason; we are very alike, people in this room, So I appreciate how aligned I felt with so much of what I heard this morning. I was telling Weyling it's so neat to know that you're over there in Ahoskie and thinking and doing, and we're here thinking and doing, and we're bringing a lot of dispatches to you today from what this work looks like at a local level.

I've worked in safety net access and social determinants of health in Guilford, Alamance, Rockingham Counties, almost exclusively, that's been my focus for the last five years of my career at Cone Health. And I wanted to just pull one particular moment of alignment from the morning from Governor Cooper's discussion of his mission for the people of North Carolina "to have lives of purpose and abundance." That spoke so much to me, and I'm bringing you in these opening remarks also the words of one of the women that we've been able to work with in Greensboro, and her definition of what health is to really underscore why we're working so hard to swim upstream in so many of these ways and how good it is to see the system shifting so that you're getting a little bit of the current helping along the way as well. We really appreciate that.

I wanted to mention that I, because I work at a health system, but I'm not in clinical care, I get to be a part of the downstream, midstream, and upstream work, and I'll just tell you how I conceive of that with the example from a child with asthma. So I want us to remember and

put up with kids having to live in unhealthy homes in the first place? Why aren't we thinking about affordable housing. Why aren't we thinking about tenant leadership and eviction prevention and understanding that is the work of health systems as well?" So how cool is that to get to have a job where you get to work with partners internally and externally, to work at all of those levels? It is amazing.

I want to go back to the midstream because I think that's where I've been asked to focus my remarks today and, again, I'm just going to tell you one particular story and hope that this particular specific story will speak in some ways for the whole. I want to just mention my colleagues, Jay Smith in rehab, Beth Murray in occupational therapy, and Rhonda Rumple in care management, not here, but these three just jump up and down about this program called Aging Gracefully. And Greensboro is one of four sites to have done a pilot with Aging Gracefully. The purpose is to prevent injuries in the homes of older adults by providing minor housing repairs. The pilot participants in Aging Gracefully, which was a randomized trial, had fewer falls annually, improved measures scores on their and ADLs, improved quality of life, and one of the biggest jumps was in their PHQ scores for depression. Significant improvement as compared to controls.

All right, so this is all important work, and I'm going to bring to you that the words of Madeline Reed; [phonetic] she's a resident of Greensboro. She was a participant in the first phase of Aging Gracefully. She got new back steps installed, and she also got some grab bars in the shower and things like that. But here's what I'm going to ask you to do about this. I'm going to ask you to do very crass and cynical work, and I'm going to ask you to assign a monetary value to what she's talking as I read you her words. So how much would you pay for what I'm about to read to you? And how much would you pay for yourself? But then I also want you to think how much would you pay for your mom to get this? I ask you what this is worth to you.

So, in her words, "I am now free to safely come and go from my home." So just, how much is that worth to you? You're just doing this inside your head. "I have a secure handrail and steps that are the right size. I have a secure floor on that little porch. Now I can get back to doing my own grocery shopping and taking out my own garbage." All right, are you adding up inside your head? "But the greatest gift that it has given me is my freedom, and that means my independence. At the end of the bathroom repairs, which were a shower chair and grab bars, I went to take a shower for the first time. When I got out, I noticed that I'd been in there for over 30 minutes. The reason I was in there for so long is that I was sitting on the shower chair crying. I know that sounds mushy, but what was causing me to cry was the realization that this was the first time in ten years that I was able to shampoo and shower using both hands and not just one hand because I was no longer grabbing for the wall. I felt safe and secure, and that has made all

North Carolina, and we are cover a very diverse geographic framework in North Carolina, South Carolina, and now in Georgia, as I think many of you are aware.

So those communities of need, we actually overlaid or looked at rates of diabetes, rates of heart disease, rates of obesity, unnecessary EDU utilization, and readmissions. And guess what? It was a high correlation, right, higher rates of all of those things that we looked at in those neighborhoods that had those high social challenges. And so, again, I know I'm speaking to the choir here, and in most of your nodding your heads, you're not you not shocked by that. But, you know, this is often the question I pose when I'm presenting that data, and I've shown that heat map in probably a thousand different settings across every single community that we work in. And I always pose the question, well, how many are shocked? So on the map, the high social needs area are dark red and dark orange, so I say, "How many are shocked by where those neighborhoods are where those communities are?" And I've only had one person ever raise their hand in over, like I've said, I've probably given this talk a thousand times. That was shocking to me, that one person was shocked, but then I had to have a conversation afterwards and found they just moved to that community.

[Laughter]

>> Thank you. But I started my day with a message in my EMR from my triage nurse to say, "Please give me a call, one of your patients passed away last night at home." So connected with my nurse, explained my patient had passed away in his sleep. I immediately called his wife to check and see how she was doing. Very peaceful passing, definitely a death with dignity, and was something that we had discussed and he had advance care planning on file, so this was

our Meals on Wheels program in Mecklenburg County, for my patient to now have access to meals that were already prepared.

So I say all that to say, we know what can work, especially when we really start to look at the causes of inequity. The question I pose is: Do we really have -- Are we really at a point where we are tired of the disparity and we're really ready to act?

[Applause]

>> TILSON: So now we're going to shift to Amelia, thinking about that Center of Excellence Integrated Care. And then, Chris, you'll be the one who can tell us how to pay for all this.

[Laughter]

>> MUSE: Can't wait for that part.

[Laughter]

>> As part of our attentiveness to you all as the after lunch crowd and as the therapist on the panel, I'll ask everyone take a deep breath in through your nose, our through your mouth, let go of any of that tension, those emails racking up in your brain, bring it back, and we can focus on the work that we are setting out to do today and share today.

Some of the things that have come up today that have really spoken to me are about the potential for change, but the difficulty of change, and the readiness for change, and that is at the heart of the work that I do at the Foundation for Health Leadership and Innovation, Center of Excellence for Integrated Care. And I'll tell you about the foundation first, and then I'll tell you about the center.

So the foundation is a nonprofit here in North Carolina that's focused on whole person healthcare, whole community health and wellness. We support innovative partnerships and leadership, and our vision is for "all communities to be healthy and all people in our communities to flourish." So we are one of the partners for NCCARE350; we're also the home of Rural Forward North Carolina, the North Carolina Oral Health Collaborative, and Health EMC, which is the program that helped organize the community health needs assessments in Eastern North Carolina.

And through all of our programs and partnerships and work that our programs do, we really work on health issues in North Carolina and try to help catalyze change, put support and technical assistance and expertise in place where people need help with change.

And my work is as the Director the Center of Excellence for Integrated Care, and our change area specialty is behavioral and physical health integration. And when I say that, there might be hundred different definitions of that for you all in the room, and I'll speak more a little bit later into our panel about what that means, the different models associated with that. But what we do at the center is help health systems -- and that can be one clinic, one team of providers, a hospital system, a community collaborative, primary care, and behavioral health practices -- transform their clinical, operational, and financial worlds of their clinic to better support whole person care and to support integration of physical and behavioral healthcare.

And we believe that is on a continuum of behavioral health integration. Sometimes it means that a system is going to do the best coordination they possibly can between physical and behavioral healthcare. They're going to set up better protocols to communicate with external providers and make sure that very important information comes back to the primary care provider and the care team and that important information from the primary care side is shared with the behavioral health provider.

And we work at integrating behavioral health into primary care; we worked in the past on integrating primary care into behavioral health, which is a little more difficult. Take me out for a cup of coffee, I'll tell you all about that. 9 (te) moo b (i)-1 1.1 (h)1 (e)-1(y)]TJ 0 Tw 13.925 (t o)nvthetoa

with our foundation and the work of NCCARE360 and the initiatives in our state, as well as

is, you may not feel like a Rolls-Royce, but you got the it factor. There's a lot of folks paying attention to you, and you should take that as being good, not a standard that you have to live

came up with the five A's of what health systems have to do as they approach this work, what Alisahah was describing at Atrium. I think she gave an example of it in terms of their work. And they are sequential.

First, you just have to raise awareness, and there's been a lot of awareness raising going on even today. The second is that, you have to adjust your own systems to accommodate what you are becoming aware of. Think about how you do your--not you --how appointments are scheduled. Do you even have face-to-face appointments? What are transportation benefits and things like that? Then you engage in the actual assistance around how do you help folks address the needs that you've become aware of.

Then you get into more heavy-duty work around alignment. It's not enough just to assist, but we actually have to align our work with our partners who are providing social services or providing community services. And then the big one that, again, we are challenged here today is advocacy. Are we so moved that we are willing to work on these things?

So thanks to the Academy of Medicine for giving this framework for what the health systems ought to do. And then what Betsy and I worked on were--we--weren't smart enough to do, ma Ie23.85 (e)-2 (nt.)2 7 -1.40-5 (o)2 (t em)-1 (-2 (nt.)2 7 f)-2 n we.unityusk on1653 snx *a to wo3(A)

Why are we talking about a return on investment in primary care or in social services expenses when we're not talking about a return on investment in diagnostic services or in pharmaceutical services? So we should not—those of us who are working to integrate social services into a healthcare setting to finance social services, to finance primary care, should not let ourselves get trapped into a return on investment argument that says, "Give us the money now, and I'll reduce your ED visits tomorrow" when we're not holding the rest of the system to that same standard. But if we're going to make the case that there's got to be some redistribution here, it's got to be in the context of budget constraints. And I think that's the importance of value-based purchasing and alternate payment mechanisms, is that they actually encourage providers to think about under fixed budget. Where do I put my money?

I'm close to a primary care driven ACO in Rhode Island, and it's been fascinating to watch the decision—this is one of the most successful ones in the country—it's been fascinating to watch the decisions that they get, that they've been going through in terms of when they work with a fixed budget, where do they put their money, and at what point do they get to social care needs? It wasn't the first thing that they got, but they got to it, because pretty soon after they had brought

So one of the lessons that you might think about from other places is, how do I get my arms around the whole thing? Because when you do that, you actually strengthen the case for making the sorts of investments that you guys are doing. Look forward to more conversation. Thank you.

[Applause]

>> TILSON: Okay, I am going to on the fly change just a little bit. So I'm going to -- I think us talking about the accomplishments and what we've done and what the vision is awesome. But I think a lot of the learnings is the mess. Right?

[Laughter]

>>What didn't work, which is great, because I think when you're on the bleeding edge, well -- actually my husband says sometimes we're not on the cutting edge, we're on the bleeding edge, like you're so far out that like anyway -- so a lot of us are on the bleeding edge, which is great.

And I'll say that, Kathy, when we were thinking about where do we deploy NCCARE360 first, Kathy came to us and said, "If you want a community that you can, not necessarily fail, but you can figure out the mistakes, that you can choose us because let's figure it out, let's get in that mess together. Let's make the mistakes together. If you want a community that you can fail in," -- well, that's not -- "use us."

[Laughter]

>> So like, that's where the learning is, in the mess. If we all knew how to do this, it would have been done long ago. So I think there's great lessons in the mess. and what we learn from that. So let's talk a little bit about that mess, and then we will then open it up to questions from the audience.

So, Amelia, as you think about -- so there's the on the-shelf best practice models of integrating care, what looks good in a policy paper, but you actually try to implement that in practice. Can you talk about that a little bit? What are the best practices, but then what have you learned in your work of implementing and where's the mess we need to think about?

>>MUSE: Sure. I have a visual to help us a little bit, give you something to look at. Like I said before, behavioral health integration can have lots of different definitions to all of us. And it can

benefits are there. But putting it into a system that's already stressed is difficul

>> TILSON: Kathy, Cone Health, so much of your system now is in a value-based contract, right, and so you've really thought about reengineering those clinical flows and having that be up front. So can you talk a little bit about when you try to change clinical workflows and IT pieces and some of the lessons learned in that piece?

>> COLVILLE: Yeah, I appreciate that, and I was actually thinking about this yesterday because the mess and failure was not just a topic about NCCARE360, but when we met to talk about this panel, I was like, how messy are we supposed to get?

[Laughter]

>> TILSON: As messy as you can get.

>> COLVILLE: Who's going to be here?

[Laughter]

>> I was thinking yesterday, it's like the rolling in the mud messy version or the messy bun version. We're somewhere on that spectrum, in talking with you all.

So I do think it's helpful to know that for Cone Heath, Steve Neorr talked to this morning about Triad Healthcare Network, and obviously that entire 263 million that they get is at risk in the ACO. But Cone Health's over 50% of Cone Health's revenue is in either shared savings or completely at risk contracts at this point. And we have those agreements with all of the commercial payers except for one, and as Steve mentioned, on the ACO side, they're in the NexGen model, which is the full risk model for that.

So I think that even amidst all of the mess, that is really the huge enabling factor for people at the highest levels of the organization to be thinking about innovation and flexibility in how we provide care. And because THN was successful early on in 2014, we've had a number of years to move forward with that mindset. So even amongst the mess, there really is an opportunity to do this.

Now, the mess sort of looks like this, Steve Neorr and Terry Akin, our CEO, and all those folks that are the top level saying, "Yes, let's move this forward." But the work that has to be done, happening at a mid-level manager level and even below, and trying to get those folks to change

their systems, especially when they've got pressures of making their budgets whole is a big place where the mess comes in, right. And that's just the administrative side of this. These people need to lose money so that we're not doing it over here, but it's hard for them to be able to give that up, So that's one huge piece of it, is just thinking about the budgets altogether and that just being sort of an organizational c

>> COLE: Well, I think that’s the first thing, we have to stop doing that. And that was definitely a

So we actually launched mental health first day in one of our, now amazing partners, No Grease Barber School, which is an African American training school that trains both barbers and beauticians. And so now every student that comes through that program is trained on mental health first aid. And you know you had that conversation? It was one of my faith community nurses, African American female, who had connected with one of the owners of the barbershop at the church. So, again, thinking about the what and the who is critically important.

And then I think of the third thing that we're really focusing on right now is, how do we train our current workforce to have these conversations around equity, but also our future workforce? And so we're really excited to partner with Wake Forest to bring a new medical

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thinking about that and not pay lip service to the idea, but make it to cheap. Alignment is tough, and I'm talking alignment of the payers so that they're sending consistent signals, so that Amelia can do her behavioral health and primary care integration. Because if you've got four payers paying you 12 different ways --

>> Don't get me started.

[Laughter]

>> Yeah, so lessons from other states around alignment? Smaller is better, it always helps if you don't have a whole lot of payers, so it's easy to talk about me in alignment in Rhode Island because we got like three or four payers. [crosstalk]

Locally accountable commercial providers are really important because you got to be able to call the boss person and say, "Come out, we need some speaks." The role of convening and leadership are both really important. The payers are not going to want to get together. They are trained to compete. Even the local [phonetic] one. This is what I learned as a regulator. They just play by the rules that are set out for them, and if you want them to do something different, you got to change the rules.

And that is the job of community leaders and government. So lessons from other places. Government can be a very powerful convener, and there needs to be leaders. In Rhode Island, I would call in the payers and the providers, our versions of the HMs and I make them listen to employers. I make them put up small business people and say how long am I going to get rate increases? When you get the other 80% in the conversation, it changes the conversation quite a bit.

What are some other lessons? Start with quality measures. It's easier to get aligned on quality measures than it is to get on dollars. Dollars, it's really hard. If you're going to get into dollars, start talking about payment methods, because at least we can have a conversation in general about, "Do we want to put up some money to primary care on a per capita basis as upfront money to do this stuff?" as opposed to just making them all perform and then paying them all on the back end.

The level of transparency is really important. You have cultures within the organizations that says, "Provider contracting is a source of competitive advantage." Yet, it's a source of mental illness for the providers.

[Laughter]

>> And you have a whole workforce that's trained to say it. Now, keep in mind, we are completely closed about the details of our contract because those are competitive proprietary, except when it comes to Medicaid or Medicare, in which case, it's all transparent. We can all figure out what people get paid.

So the lessons are around, it's important to that you convene the payers because that's who the money travels through. Medicaid, if they're going to use managed care, needs to retain the authority of the contracts because it's all in the contracts and you do whatever you want them to do. I ran a Medicaid managed entity, my Medicaid director was my boss, and if they said, "Jump," I said, "How high?" Use that authority, and have someone who can convene the payers and include the self-insureds. Self-insureds are really important because often they benefit from this stuff and don't always step up.

And figure out what the rules are engagement. [phonetic]

I go back to actually what Reverend Legerton said this morning. He talks about community locally in Lumbee County and you got to get together and meet every week. In Arkansas, the Medicaid Medical Director in the Arkansas Blue Cross and Blue Shield Medical Director meet every week to say, "How are we going to transform primary care?" It's the same dynamic that he's describing. It's happening in a larger bit because that's how you build common cause. And then every once in a while, if someone's disagreeing, you got to figure your way through it. You can't let them just kind of throw up their hands and say, "Well, we couldn't get to agree." Or they window dress or white wash it or something like that. But you need alignment, and that means pushing to get alignment on the key stuff.

>> TILSON: That's awesome. Okay, so we have a couple minutes for questions. If you all take advantage of this incredible wealth expertise and insight.

>> HUTCHINSON: I'm Sig Hutchinson, I'm a Wake County Commissioner, and, Chris, I appreciated your comments about North Carolina having a "it factor." At the elected level when things seem to be falling apart, and this whole conversation is about Medicaid expansion, to hear that we're doing a lot of things right—and I'm particularly glad that Dr. Cohen is in the audience to be able to hear that message. Dr. Cohen's had a tough row to hoe. So that's great appreciate. I appreciate that.

My question, Betsy, to you, recognizing that we've got budget issues that we have to deal with, in your opening comments you mentioned that people collectively agree on how healthcare dollars should be spent. I wonder if you can share a little bit more information about how the public sees their healthcare dollars should be spent.

>> AUDIENCE SPEAKER: Hi. Thanks for a wonderful, wonderful enlightening panel. I can't help but be struck. First, I have a comment, then a question. By the irony that North Carolina, which is at the very forefront and innovative in all these 18 bullet points, seemingly, it still has this buggabear [phonetic] of transition Medicare. And this is, I believe, it was half a million people that are kind of falling in the cracks there. Where would charity care come in that arena, is one point?

And the second point, and this goes on to the National Academy of Medicine victor also is, are we looking at what's succeeding or not internationally? Just to give you an example, botanical natural products, Japan, they have something called functional foods; in Europe, it's called nutraceuticals, and in America, we call them dietary supplements. So these are just other areas we might look at.

>> TILSON: Yeah, I don't know if were here at an earlier session or earlier part of the morning, but when we think about Medicaid expansion, right, huge, huge lever to dramatically really improve the health and well-being economically as well as physically and behaviorally is just a huge lever we need to pull in North Carolina. But it's caught in the political divisiven/MCID 2 >>B (o1 (s

>> COLE: I would say just two things. One in regards to our community members who, unfortunately, uninsured. As a healthcare provider in a community clinic, I take care of those patients every day. And they are being taken care of by a lot of our healthcare systems across our state, and this is charity care. And I often say, this is actually a segment of the population that we are already 100% at risk for. So we really should be thinking about, from a clinical care standpoint, how do we better serve that segment of the population. At the same time, pushing for the policy, the big P policy at the state level and the federal level to bring access to those community members.

So I just want to say, as a provider who takes care of those patients every single day and those community members every single day, I think we are doing the best that we can with the resources that we have, but there are still things that we can be doing better. And I think, again, we have to be uncomfortable enough to say that.

And then, I think the whole notion of, quite frankly, the evidence around food as medicine is very, very clear. I think this is the one that we've done a lot of work around. Food insecurity was the first social determinate that we put a strategy around back in 2017 across our entire enterprise. But one of the key learnings that we found, and I know we're not supposed to be pigeonholed, but I do feel like I am the health equity person up here, one of the things we found, particularly here in the South, there are certain cultures where food is a part of that culture. So you're not going to just necessarily like -- I can't just tell my patient to stop eating fried chicken on Sunday's if that's a part of the Sunday dinner. At least not initially, right. I have to be able to establish that trust.

And so a lot of what we've done have actually been to work with our different segments of the population to learn more about what is their traditional food that they eat as part of their family, as part of their culture, and then actually create healthier recipes with substitutions for certain things. Instead of using margarine or lard -- quite frankly, a lot of people are still using that -- using some of the butter substances or switching to olive oil, just little minor recipe changes that you can at least start to have that conversation and not just expect that you're going to change an entire family or a community's culture to eat healthy, especially when they have -- this is the way they have their whole entire life.

And so I think, again, that goes back to us being humble and saying, "Okay, we have to listen. If this is your culture, then we need to be able to adjust and try to just figure out ways that we can maybe make some of those recipes a little bit healthier."

>> TILSON: I'm going to let Chris have the last note because Jessica has already held out. So one last--

>> KOLLER: I'm going to speak to the international piece. Five lessons. Countries that spend a higher ratio, not total, a higher racial of social to medical have better outcomes. And we've seen that in a bunch of different places including NAM reports, Betsy Bradley's work. So the ratio of social to medical have better outcomes, not lower costs overall, just better outcomes, which is a pretty darned good thing.

And thereare folks here from the Commonwealth Fund, they do a lot of international

[Applause]

>> MCGINNIS: Fourth panel of this symposium, Connecting Care: Moving towards seamless information flow and data sharing, is moderated by Dr. Aaron McKethan. and Aaron is a Senior Policy Fellow at the Duke Margolis Center for Health Policy, and he's also the CEO of NoviSci, Incorporated.

stage cancer, stage IV, lung cancer, very common form of lung cancer. And so there we sat all figuring out what are we going to do now. And at the time, we lived in Washington DC. I grew up in North Carolina, moved to DC for nine years. As soon as we got that diagnosis, my wife and I looked at each other and said, "Time to go ----

So I think part of the challenge of building a healthcare information architecture is that we're doing it in the abstract. We need to do it to solve very specific problems like that, answer very specific questions, and solve really specific problems. This is a long way of saying, Dad get to go to the beach, he did get the chemo, but he did go to the beach, and that was an important quality of life to mention that we cherished to this day. I was just looking over there of a picture of Dad and Uncle Gene on the beach enjoying their last month's together.

Data matters, and every numerator and every denominator is a person. And so this panel is going to try to bring that to life, and ask the question: How are we doing in North Carolina to fulfill the vision of a payment system that rewards quality and outcomes in health, that has an organization capable of taking downside risk? How can they do any of that unless they have information about who their patients are, where they are in the system, and how to help them?

So let me now introduce the folks on the panel. I'm going to start just to my left with Patrick Getzen. And by the way, I was also reflecting on this list I'm going to read for you. These titles only reflect their current roles, but many of you know, these folks to my left have been very impressively involved in all sorts of things, in different organizations in North Carolina and around the country.

Patrick Getzen is the Senior Vice President and Chief Data and Analytics Officer at Blue Cross and Blue Shield of North Carolina. We'll start out with him in just a moment.

Dr. Annette DuBard is currently a Vice President of Clinical Strategy at Aledade based in Bethesda, Maryland. She's bas

UNC Physicians. He's also a neurosurgeon. My first question for you, in a minute, will be: How many years have you been in school to be a neurosurgeon? But I'll come to that in a second. Count it up while you're waiting.

[Laughter]

>> MCKETHAN: So, Patrick, you are responsible for data and analytics at the largest insurance company in the state. When we talk about interoperability, maybe we can start with just, what problems are we trying to solve when we talk about that? And what tools do we need in North Carolina to do so?

>> GETZEN: Thank you, Aaron. Let me start by saying, the really sad story about your father is that the data probably did exist. It's what I kind of like to say is that, we are very data rich in healthcare. It's not integrated very effectively, so we're pretty insight poor. And then we're absolutely execution poor even with the insights that we have. So it exists; it's just not housed correctly and used correctly. So there's a lot there.

So Aaron said we all had different roles in the past. I'm the Chief Data Analytics Officer at Blue Cross North Carolina, but for a period of time, I used to be in actuary, and I spent a lot of time thinking about the business problems we needed to solve in healthcare. The three outcomes that we all like to talk about are affordability, quality of care, consumer experience.

As an actuary, I spent most my time on the affordability side, and there were a couple of data points that used to really bother me. The first is that healthcare premiums go up 6 to 8% per year on average; salaries go up 2 to 2.5% per year. And you don't need a designation as an actuary to understand that over time, that's an unsustainable cost model.

The other thing is, we recently have done some affordability analysis to look at what percentage of household incomes in North Carolina are going towards premium and out of pocket costs. And I would say that it's startling to find how much people are paying for healthcare, but what's even more startling is how to it degrades overtime because of the first data point that I gave you.

So we really are at a point where we need to do something and do something fast around that. So to the point that Aaron's talking about, we have these tools that are available to us, we need to put them to use. One big step Blue Cross North Carolina is trying to tackle on now, which you heard about, both in sessions today, but also in media relations for Blue Cross, is moving toward alternative payment models towards value based reimbursement. And that's a program

>> MCKETHAN: Let's begin the tradition of clapping for our fantastic panelists, because that was great.

[Applause]

>> MCKETHAN: So Dr. Dubard, you have spent a lot of your career working in the primary care world and understanding the needs and information and otherwise the primary care practices. Reflecting on what you've just heard, you know, how do you reflect on now the state of primary care in North Carolina with respect to information? What do they need? How well equipped are they to get it?

>> DUBARD: Great. And thank you for letting me to be a part of this panel. To give some background of the perspective I'm hoping to bring, Aledade, the company I'm working with right now, is very particularly focused on helping independent primary care practices succeed and thrive in value-based care models. And so we work in 25 states with 6500 independent primary care physicians helping them organize, and two are accountable care organizations, and get into value-based contracting with Medicare and commercial and Medicaid payers. And importantly, bringing not only that opportunity and the size that it takes to do that well, while maintaining your independence and serving your community, but giving them the practical help. And very often that means the data and the technology it takes to kind of step up and recognize the needs of your population and tend to those needs.

And it's going well. Our partner practices across I think we had 18 ACOs operating in 2018, generated $69 million in savings to Medicare in 2018, and are having substantial success in commercial value-based contracts in other states. But I would tell you, we've been to North Carolina a little less than a year now, and this has been our fastest growing state. We already have 1,600 primary care practices across 180 practice sites that are working with us, that are grabbing opportunity to work with Blue Cross on Blue Premier and to do Medicare and hopefully coming soon some additional commercial value-based contracts, because primary care practices are very ready to be valued differently and to be recognized for the actual value that they bring to the healthcare ecosystem.

So the business model of Aledade is completely predicated on the notion that doing primary care the way it was meant to be, meaning you have access to a primary care provider who knows you and will see you when you need to be seen and will have a longitudinal relationship with you and cares about your total healthcare needs and will coordinate those needs, that that as is actually the key to success after all. And that is the model that keeps people out of a

hospital. It keeps people out of the emergency room, reduces unnecessary duplicative testing, unnecessary specialist visits.

And so I think the- back to your question-

And we do fancy stuff too. We do some machine learning and we, you know, predict who's most likely to come to go to the emergency room within the next three months. And we predict risk and mortality so we can flag patients who haven't had advanced care planning and are laying in those kinds of really actionable need-to-know information to make sure right patients are getting right care. But the information needs really at the core are much more basic than that.

[Applause]

>> MCKETHAN: So we've heard this morning or in this afternoon the Deming quote, about systems design, and they get what they're supposed to and alike. So Genie, I was reflecting on that. Universities are designed the production function of universities is to produce papers and grants. And so when you say to them, do something for the world. That's really hard. They want to, but they have this overriding desire to produce more papers and grants.

[Laughter]

>> MCKETHAN: Big health systems, historical design is to do more tests and procedures. And health plans is to play claims and try to not pay as many as possible, you know, come up with a way to not pay them.

[Laughter]

>> MCKETHAN: So those are some pretty embedded -- those are pretty embedded systems to overcome. And you've sat on both sides of a health system and now health plan and previously with a health plan. What does it take against that north star of health? How do we reengineer these big bureaucracies so they produce something different?

>> KOMIVES: Whoa.

[Laughter]

>> KOMIVES: How about an easy question to start? Yeah, so Aaron eluded to, I trained here at

agreements back then, but we didn't have nearly the sophistication that I think the team there now has really brought to that.

And I got enticed back a way to return to clinical practice at Duke and about a year and a half later joined the Accountable Care Organization at Duke as Senior Medical Director there. And four months ago -- I can blame Greg [phonetic] -- Greg is in the audience -- for that. But I joined Wellcare North Carolina, which is one of our new Medicaid prepaid health plans still waiting to launch.

[Laughter]

>> KOMIVES: You know, so we'll move past that, yeah. But so, you know, Aaron I think really wanted me to try to speak from the health care system, the [indiscernible] system perspective. And it's complicated. I mean, and so you're right, there's conflicting priorities when you deal with large health systems. In a way I'm jealous of Annette because when you're working with primary care practices, in a sense, they 1 (m)1 (a)1 utid me1 Tc 0.001 Tw 0.22h1 (s)0tuk-1 (O)3 d

predictive-- deep machine learning predictive analytic model to figure out who was going to end up in the hospital in the next six months.

And that was really just kind of a guess -- and talking about unplanned hospitalizations, which we were able to identify. And we used a combination of our clinical electronic health record data, as well as a claim data that we got curtesy of Medicare for being an MSSP program. And we had pretty good predictive capabilities in that model, which is great. And so we deployed our care managers and said, dig in deeply, really work closely with these high-risk patients and let's see if we can't avert some hospital stays. I wish I could tell that that was widely successful. It wasn't the predictive model that was that problem. I think it is really hard to change the trajectory of health for this sic

And so now I've been able to like say I'm vindicated; right? You know, I am a big advocate of using clinical data for risk prediction, but I am not sure whether we need cost because of that. And Interestingly, we looked at our model at Duke where we were only using clinical data. If anything, it over predicted risk in underserved, so just interesting. And that kind of makes sense too, because if you're -- have same disease state, but you have fewer resources at your fingertips, are you more or less likely to end up in the hospital? I think we all know the answer to that.

So anyway, and the other, I would be remiss if I didn't just mention quality data. And we've come a long way from, you know, running around the state, collecting 15,000 charts for HEDIS. We are still collecting a whole bunch of charts for HEDIS, but the ability to exchange flat file quality data -- and having been on the provider side of that, you know, we wanted the claim data to fill in the gaps of what we didn't already know from our clinical record; right? So when we said in the Medicaid standup, that the plan should share quality data with the providers. I am like more than happy to share it, but the truth is that the providers probably know more about their quality than I do. And they know it sooner because they're the ones, for the most

[Laughter]

>>MCKETHAN: That information is the father for, like, what else do you have on out there in cyber space? But I do think we ought to be creative. Claims is important, but how do we put all the data sources that we have to use for the health outcomes that we're working on? And Jessie, you are now chief data officer of an enterprise. There's lots of data, lots of different types of the data, probably so many that you haven't even gotten to them all yet; data on everything you can think about in Medicaid, but also all the social services, SNAP, WIC, TANF, etcetera. How do you prioritize what data to work on and how to us it for good?

>> TENEBAUM: I was not anticipating that question.

[Laughter]

>> MCKETHAN: Answer whatever question you'd like.

>> TENEBAUM: All right. So there is a lot of data at DHHS. So I've been at DHHS -- is this on?

>> AUDIENCE: No.

>> TENEBAUM: Thank you. So I've been at DHHS for six months now. And I describe my first few months as kind of getting the layout of the forest. And I felt like, okay, I am finally starting to see the forest from the trees, but each time I think I get the rough shape of it, I realize there's a whole grove over there that I didn't know about. And then it turns out that grove is on fire. And we have to fig3 (,)1(o)2 (ut tha)-1 (-1.405 (ta)-1 (r)-KE)-2 (T)2.o-1 (.)2-1.9 (t) irr ˝ r

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within DHHS. And earlier today I talked to someone, and I mentioned who I was or what I did. And they said, "oh, you're the IT person." And I bristled a little and said, "not the IT person." And I realize it's subtle to other people, but let me clarify that you can think of it as plumbing. And the IT people are the ones who build the pipes and build the systems that are going to carry the content. And we informatics, data science types are the ones that deal with the things that flow through the pipes and how we're going to make use of it. So that is our focus.

[Laughter]

>> TENEBAUM: The clean water. Well, funny you mention

[Laughter]

>> TENEBAUM-- the clean incoming stu

draw, and then the usage. How are we using this? To point about the machine learning and the sexiness of that, I love going back to Duke and giving a talk in which I show the deep learning network, and say this is what people in academia are concerned about. And it's the sexy buzz words. And then I show the slide that has a sequel statement that's "select with summarize," and saying this is really what the world needs, basically, counting. I love especially doing it right after the guy who is really into deep learning.

[Laughter]

>> TENENBAUM: No, but close. So I think I semi answered your question and then some.

>> MCKETHAN: Excellent. Thank you. So Matt

[Applause]

>> MCKETHAN: Okay. Matt, so how many years does is it take to become a neurosurgeon?

>> EWEND: That's my whole question?

>> MCKETHAN: No, that's part one.

>> EWEND: Part one. Yeah, I tell my kids it's 27th grade by the time you're done.

>> MCKETHAN: Excellent. So 27th grade. Okay. You're not selling it short but we do appreciate all those 27 years. Thank you. So I'm impressed for many reasons having you on the panel. You're leading a lot of value initiatives, alw( )Tj EM3 0.001 Ta,(iv)3 (10 >>BDC 0.001 Tct5)3 (M4 (iat)1 (iv)3

Many states are struggling to bring alive the notion of health information exchange. And many states we have to work with multiple data partners to try to get hospital notifications to our practices. North Carolina is not at the head of the pack here. And it’s been a struggle. And the HIE is making a ton of progress and working really closely with u

hospital. We got a notification to them, and they were able to really follow up quickly with folks as they came home. And that's the most vulnerable time for patients. So it's a real challenge. The other thing is there are other solutions out there. They happen to be very expensive. We've poked around at all of them, and none of them are perfect. And so I think some of those are more multi-payer, but there's a big price tag attached. And it just seems like we should be able to solve this problem.

>> GETZEN: So I'll add something really quickly. The answer I think has been to yes. We have to share data, unless we're happy with the outcomes that we're getting, unless we're happy with the health care premiums we're paying, the quality that we're getting, and the experience. This is our shot here. We have information. It can be used. I think that there's a couple of things that are tough about it. One is that everybody like the w25 0 Td (--1w9a (f the)-2 (m)-1 (-0.))-1 (m)-1 (-1 (y

too much, but let me just mention APIs and that you can think of an analogy of the world we're living in today, we exchange the data as if we're sending snail mail. You kind of take something, you package it up, you put it in a box, and it disappears and you're not really sure what happened to that. APIs will enable us to do it more like e-mail. You send it. It gets there in real time. If there's something weird or corrupted, it gives you an error, hopefully an error you can understand. And you find out what happened to it. You've got some providence there. So we're moving in that direction to try to exchange the data by APIs. Another thing, there's sort of a common joke in data standards of the wonderful thing about data standards is there's so many to choose from.

[Laughter]

>> TENENBAUM: This seems to be the case with the ADT as well. We've got the HIE with the state. We've also got venders, a few venders that do a lot of this. And each of them get some partially, overlapping subset. And that's part of the problem. We need to be clever and creative about how to align those. And I'm not sure how, but know that this is a priority on the state side to try to work this out, so stay tuned.

>> EWEND: I was just going to say, first, it's so exciting to be a neurosurgeon and maybe have a chance for once month not to nerd out the panel.

[Laughter]

>> EWEND: But we've said and a number of people have said, and Mr. Kibbe today said a little bit about changing the rules. The system that we operated under created the behaviors that we have about sharing data. So it would be a continued transition of the health care system that would suddenly make it in everybody's interest to share data because that data would become more valuable if I shared some of mine or a lot of mine, and you shared a lot of yours. We can legislate it; right? That's the other way to do it, but I don't think we'll shame folks into it. So we've really got to continue to encourage the movement of the system in a way that looks at patient health and that will drive us to share data, because that will make us more successful as participants in patient's health.

>> MCKETHAN: Great. I'm going ask one more question and let anyone to my left answer it or not, and then we'll take your questions. I'm not sure how much time we have because I think

But I'll ask it to this panel because this is the one we are in now. And that is about the time horizon problem in health care. You know, think about if you're insured by Blue Cross. And you're an actuary, Patrick, so you'll know the precise answer to this probably. But you're in that plan for some period of time, and the

acknowledged

five years for each place to figure it out because there’s too much of the role you described. There needs to be an onramp for folks who are willing with rapid education and a chance to be successful so that you can build some institutional momentum so that when these bumps in the road come with changes and systems, you can weather those.

>> MCKETHA2 (r6he)-2 (r)-1 (e)-2 (ne)-r those.uc

And I just wonder-

>> AUDIENCE MEMBER: Thank you. First, I want to thank you for informing me that I'm probably one of the wealthiest people in this room, because I've had practice for 27 years. And I have a lot of data that I'm still trying to tackle.

[Laughter]

>> AUDIENCE MEMBER: But my question it is that. And it is in the private or in the independent practicesetting. We do have a lot of data. We know what frustrates us, in regard to practice, kind of like, you know, the prior [indiscernible]. So we know that frustrates us. And we also know what causes burn out, a lot of those features. But we also know what makes us feel good. And we have the opportunity of actually thinking about office-based research and having this data that we can utilize for the care of the patients in our community, what's the potential for that?

>> TENEBAUM: So that's a huge opportunity. How many people here heard of the concept of the learning health care system or the learning health system? So the individual is Victor Dzau is raising his hand. I'm glad.

[Laughter]

>> TENEBAUM: The idea being that we've always done research to inform clinical care, but now with the adoption of electronic health records every single time you go to the doctor that's a piece of data could be collected. We could be leveraging that and learning from that as opposed to just leaving it on the table. There's a key part, and academic medical centers are already doing this, mining that data. There's a lot of ethics involved in this; ethics, legal, social things to say, you know, consent. What does informed consent look like? Important things -- from a smaller -- and I don't know if you're in a large practice or a small practice, here's where interoperability is key because any given practice, if you've got a roster of 1,000 patients, that's interesting. And that's good, but they're probably pretty heterogtha lo50.0io (o)4 (2 (s)2

when we talk about the value of the data, where are more thinking about aggregated data and what we can do with aggregated data. But the advent of my chart and the ability to put the health record in the hands of patients and let them read their chart notes -- by the way, we all get better at writing our notes, when we know our patients are reading them; right? And that's a good thing. That's a good thing.

>> DUBARD: I just want to rag on my fellow panelists a little bit. I think when you come from a health system background, you tend to think the world is your health system. And we have to realize that -- someone had kind of a great pyramid slide up earlier. You know, the amount of a person's life spent in the hospital system is teeny tiny. And the health determinants for that person are much bigger. More than half of primary care in this state is delivered outside of health care systems be independent and primary care providers. And it is dangerous the mentality that everything is in Epic is doing harm. We've got to share. We need to share an infrastructure around this.

>> TENENBAUM: I want to just quickly put out that FHIR and Apple has done some very interesting things using FHIR to enable patients to control their data and pull it from wherever they're getting their care and then share it with other providers. I'll leave that at that.

>> AUDIENCE MEMBER: I wanted to follow up on Greg's comment. I am Robin Huffman, and I'm the Executive Director of the North Carolina Psychiatric Association. So I'm working with over 900 physicians in North Carolina who are struggling with the ones who understand how important it is to communicate with their colleagues about a patient's mental illness and the ones who just are working with patients who would dry rather than have anybody know that information. And so as we look data breaches, I was going to finish your sentence, Greg, with it's my information. I want all my health care providers to share it. But that's the only people you want to have sharing it. And you don't want -- so I think we're still working in a world -- and I really appreciate Dr. Ewen's "the second mouse gets the cheese" comment. I think I was the one laughing the loudest. I think psychiatry, one, they were the one specialty that was not given the funding to be trained in how to do the work flow for electronic health records in their practices. So they're a little bit disadvantaged from that perspective, but we're also looking for a world where there isn't stigma about mental illness, where folks can talk about the medications that they take just the same way they talk about their broken arm or things like that. And so we are working back and forth in trying to increase awareness with the patient population and with our physicians, but it's still real hard. And there still are patients who would not get mental health care if they knew thei

>> MCKETHAN: Any quick comments on that or amens? Amens or thumbs up? Okay, I'm giving the high sign. I see the next panel coming in. So let me let me make an attempt to summarize very briefly and you can shout me down, if I get it wrong. But we started out by talking about health as the true north and how helpful it is to mobilize all stakeholders in that goal, particularly motivated by real patients. To earn the hype that North Carolina is getting, we're going need to get continue to build on our posture of humility to meet real information needs of all people, including patients recognizing there are very important safeguards to protect, but a lot of different actors at the community level and in the provider community that need to take care of individual patients and populations, focus on solving real problems in the short run that can continue to build progress toward those longer sort of infrastructure things, and doing so in an agile way collaboratively and recognizing that sometimes that means this failed, let's try a better way and not giving up.

And speaking of which, to go ahead and quote an [indiscernible] guy Jim Valvano of not give up in the face of legislative changes and timelines, in the face of difficulties getting information, in the face of all kinds of others changes happening, we got to keep at it to earn this hype. So thank you all very much. Please join me in thanking these panelists for great comments.

[Applause]

>> MCGINNIS: The panel that we just heard, again, was very nicely summarized by Aaron and clearly is at the heart of where we're all heavy with respect to the potential for a continuous learning health system. We're now going to move to a discussion of what's necessary in the workforce that's necessary in order to achieve that vision. And I think is Jessica in our chair here? Jessica [phonetic]? [Off mic]

>>MCGINNIS: Oh, yeah, he was. Okay. He'll be back. I'll just introduce Gene Washington, although this is obviously a community that knows each other very well. It's part of the wonderful spirit of things in North Carolina is that you are a family. And Gene Washington is a strong member of your family. He followed Victor Dzau as the Chancellor for Health Affairs at Duke University and President and CEO of the Duke University Health System. And Gene also is someone who I've been a longtime friend and associate with in both in his positions here at Duke University and previously when he was at UCLA and before that even at UCSF. He's been an important player on the health policy scene for a number of years. And he also has been a real leader in academic medicine. Jessica, is it [Off mic]

[Laughter]

>>MCGINNIS: Is he out there taking a break? Well, let me, while we're finding him, read our list of panel members. We have on this panel, again focusing on the workforce, Erin Fraher, who is

just listening to parts of the previous session, I mean, they get connected real quickly: Value-based care, community-based care, and education and social determinants.

keeps rising. We’re now at just about 7,200. Two-thirds of the primary care and the mental health, behavioral he

And you can see this. This is the country. The grey areas are the most restricted states, including North Carolina. The lime green are the reduced-practice states. And the dark green is where there's no practice restrictions. Look at that. I think you can kind of get the picture, but this is some other data that we discovered that in the restricted states, the top line here, 34% of the population living in these restricted counties in these restricted states had access to a good capacity primary care system. The states with full practice without these restrictions, it was more than double. 63% of the people in those counties in those states had access. So these state-level restrictions do matter when it comes to access.

So in sum, I hope I've convinced you that looking at the physician workforce patterns, it's hard to see how if we just rely on physicians alone, we'll get all this care that's needed, particularly in rural areas and in this southeast. So we've got to use our workforces much more wisely, not just nurse practitioners or PAs, but others. And I think our panel will talk about that. But lift lifting the restrictions, this is a something you've dealt with. And I ask you to reconsider that this is a way to, I think, increase access. It's not the answer, the total answer. It will help. Other things will be necessary. But if you do this in North Carolina, I think the (o)2 th1 (t)]73nS (n N)-4 (o)2

And so I worry that our current workforce is perhaps designed around professions, and the needs of professions and not patients. And I'm struck when I hear our own health system leaders, who I admire so much for the work that they're doing in these times and other health system leaders, I can hear it. There is concern about the fact that we have venture capitalists out there and private people and insurers who get that it's about the patient. And so we're going to bring Amazon in -- basically the whole model of Amazon is bringing it to the patient, bringing care close to home. And so you've got city block here that has four locations in North Carolina, they get it. It's about not retrofitting care delivery models and the workforce to meet the current workforce, but it's about thinking where and what our patient's unmet needs for care.

And we've talked a lot about that today, whether that's the elderly in their home who don't have a ramp or can't use the bathroom appropriately because they don't have a handrail. And I love that model that I used to talk about, that I heard about today, aging gracefully. It actually is similar to the capable model. And I used to joke that it was sort of like a joke that went like this: An OT, a nurse, and a handyman go into a bar, but in this case, they actually go into a patient's home. And it's a remarkable model because they're recognizing that there are multiple health care needs. And whoever thought that a handyman would be considered part of the health workforce, but critical; right? And how can we better get the workforce to meet those unmet needs? So this is a chart that's from 2000 to 2017. It's national data. And it looks at where job growth has been. And you look at the fact that jobs grew 11% in hospitals. But where did jobs really grow? Home health and ambulatory care; right?

And so all these new payment models that we've spent the morning talking about are shifting -- and frankly, you know, penalties that are fining hospitals for readmissions are

see that we had a gap of 6.1 more physicians in metro than in non-metro back in 1980. That gap has doubled. I want you to stop and absorb this chart. We have arguably the best AHEC in the country. We have five amazing medical schools, maybe a sixth coming online. We've got incredible universities. We've got a great state loan repayment program.

Why is this still a problem? It's a problem I would argue and pause it because most of our training is not just in acute care, it's in urban settings. And we've got to decentralize funding and decentralizing a bunch of much more sort of graduate medical education opportunities, training for nurses, and get them out into rural communities. We know that makes a difference. We also need to think about if we're going to think about buying health, we have to think about designing a workforce for health. And a workforce for health looks different than a traditional workforce. A workforce for health includes a much broader range of health workers. We're talking about patient navigators, home health workers.

I'm so glad that people brought up utilities today because medical lawyers are part of the health workforce. The clergy are part of the health workforce. Dietitians are part of the health workforce, but we fit we typically focus on nurse

They may not want to delegate to them. And they're not going to function as a health care team unless they understand that. They're going to have to do maybe oral health as part of screening in primary care. They're going to be doing more behavioral health. We've got to think about continuing education and care delivery models that allow this workforce to gain new skills. Thank you very much.

[Applause]

>> GEORGE: Well, good afternoon. I know that I'm the only thing standing between you and adjournment. So what could be better to have a regulator late in the afternoon after your break? Okay. How exciting. But I'm Julie George. I'm very happy to be here with you today. And as George [phonetic] said, I am the CEO of the North Carolina Board of Nursing. And so I'm really happy to have an opportunity to talk a little bit about nurses and their contributions to the health care and to our movement toward health in North Carolina. We regulate 160,000 nurses in North Carolina and that includes a little over 13,000 APRNs. There is a little over 9,000 nurse practitioners and then CRNAs, nurse midwives, and clinical nurse specialists, so the smaller groups.

And I believe nurses are really essential to having these conversations about health. Even across the country and in North Carolina, nurses comprise the largest single segment of the health care workforce. So I cannot say that enough. It is the nurse that is there when the patient often is at home or alone or at night. And nurses are quite accustomed to working in teams. And I think one thing that lends them to be quite an asset with the changing models is the nursing education, by virtue, is a holistic approach. So Nursing has always had more of a holistic approach to looking at the individual, the entire individual, the family, the community, etcetera, and not just a diagnosis. Having said that, as a regulator in our daily work, you know, we actually look for opportunities to collaborate with others.

Regulation, in and of itself, can be pretty dry and at times it can be quite the barrier. We heard this earlier this morning about the issue of food and how local food couldn't be delivered to the schools because there were all these regulations on food that it had to come from elsewhere. So that's a good example of bad regulation, quite frankly. So I think it's been our challenge in North Carolina to do what we normally do in regulation, as far as licensure and setting standards and approving education programs. But other than that it's been the collaborating and seeking opportunities to really work outside of our comfort zone, if you will, of regulation. And one of those great collaborations we have had, and I have to give a shout out to Erin and the Sheps Center, is using health care data that we share with the Sheps Center.

And I can tell you that at a national level and even international level, we are known. North Carolina is known for having the best health care data anywhere. And the boards have been-- our board has been contributing data to Sheps since 1979. So as part of that, one of the things that we try to do is track things, and they track patterns based on our data, our licensure data and renewal data, where we ask nurses if they're working, where are you working, what populations are you working with; and also just sheer numbers. So this slide, I think, is the state slide that Peter showed in a bit of a bar graph of a national slide, but this shows you over a period of time from 2000 to the current time the growth of nurse practitioners in metro areas.

The next line is in non-metro areas, below that physician assistant growth in metro areas, below that physician assistant in non-metro, and then physicians, both in metro and non-metro area. So as Peter said, I think this just reinforces. This is the trend of the workforce. So this is the current, but it is a sharp curve of growth. Some examples that I would like to brag on North Carolina a little bit about is you heard from one of our earlier speakers how we take pride in North Carolina being a cutting-edge state. We didn't want to say a bleeding edge, but a cutting edge, and kind of the star out there. We were first in flight. We were actually first in nursing regulation, 1903. That we were early on in nurse practitioners and PAs in this state. So back in the '70s that was just cutting edge. I mean, North Carolina was out there. We still are in so, so many ways. I can tell you that it's been fairly easy for me to even recruit people from other states and boards of nursing because they see North Carolina as such a progressive, a wonderful place to live, and to work.

So some of the things that we have done, some we've been approached by others and some we have done outreach ourselves, but we have what we call the ribbon project in North Carolina. Now, the board supports the data for that. Many of you are familiar. But this is where nurses are educated at the community college level with an articulation, a clear articulation plan, to the University. They get their eRN degree first and one year later their BSN. So we track specifically those graduates. So that then Erin and her team years down the road we can see: Did they stay where they were educated? Did they go on for other education?

We do know from data that our community college nurses and our LPNs tend to stay more rural and local. So always to me it raises the question: So what if we want to step beyond ribbon? If you could still get that local nurse after a BS and with experience to be a nurse practitioner, to be a nurse midwife, to stay in these rural settings and provide care, how wonderful would that be? Our prep program is something we started back in 2000. And that really was a program designed to try to remediate rather than discipline nurses working with employers, hoping to keep-- particularly young nurses, in the workplace and encourage the reporting of eras and not

Pharmacy Board, OEMs [phonetic], Department of Health and Human Services, and have a lot of joint position statements that we develop.

One of the most helpful, I think, has been related to the community paramedic. And so we've worked with OEMs to really give clarity when we talk about teams. Again, it's not just going to be physicians and nurses, we've got to look at everybody who can provide care. And the community paramedics, it's a relatively new concept. It actually started I believe in Minnesota, but we've had them for several years. And they've got some great outcomes. Situations, we heard this morning about the lady that didn't have -- you know, she didn't have anybody, any support so she calls 9-1-1. And they told me that very thing. Well, we only get paid if we take them to the emergency room. But the community paramedic can check their blood pressure, can see if they're taking their medicine, can see if they ate something. And so it -- it really had a great impact in those areas that have used that.

And lastly, I guess I would like to talk about our partnership with Sheps. Because one of the most exciting things we're doing right now is a workforce study. So Erin's team is doing a supply and demand of the nursing workforce in North Carolina. This is the first time North Carolina has had the demand data, in what? Over ten years? So we're very excited about that. She'll be able to sort it by AHEC area, by metropolitan, non-metropolitan. She and her team can do quite the bag of tricks, as most of you know. So they just had our committee just enraptured a couple of weeks ago just showing what all they could do with this, but I'm very, very excited about that. Because I think that will give us in North Carolina some really valuable data about the projected demands and some models that we can look at. And so in closing, I would say to you, one of the challenges we face every day when we try to be innovative and try to look at the workforce is that tension of regulation between, you're the upholder of the standards, but you don't want to stifle innovation. And so that's always a balancing act. And I -- this great slide was given to me by David Cal Becker [phonetic] my chief information officer. And it shows that we're first in flight. If you'll notice, yes, we may have not had the lie detector, but we got it off the ground here in North Carolina.

But I think in closing for me, I would just encourage everyone to continue these kinds of discussions because sometimes they are messy discussions, but we'll get through them because I have every confidence that for North Carolinians we have the resources. We're a rich state. We have the resources, the human resources. We just need to align them and empower them. Thank you.

[Applause]

>> MURILLO: So Julie gave you a bit of the false hope saying that she was last between you and your next endeavor. It's actually me. So I realized that, when looking at the agenda so I thought, oh, I have to be really strategic in how I deliver this information. So I have the unique opportunity to present you an initiative that in- - I'm actually a South Carolinian. I'm a native South Carolinian. I'm at the University at South Carolina. And so I will be presenting for you an initiative that we've taken at the university to really -- when looking at the trends in particularly the nursing workforce, so to really take an action oriented, explicit, formal, systematic approach to link our academic and practice connections to ultimately improve the lives of the patients in our state.

I will say, being here today has been invigorating for me. In the state of South Carolina we haven't progressed as much as you have here in North Carolina. And unfortunately, we've also seen some decreases in our patient outcomes and actually in the overall health of our state. And so it's clear that -- when I looked at this morning, I was like, oh, gosh, that might not be the best message that I intended to send. I see this is an opportunity to restructure what we're doing with the workforce in order to better meet the needs of the rapidly changing health care system. I thought, well, you probably see the bridge collapsing. And I'm not implying that our health care system has collapsed. I am saying that the connections between academia and practice from an academic perspective, often we have little idea of what is really needed to improve the lives of the patients. We're largely focused on our competency or sort of end-of-programmatic examinations. It's not that we're not concerned.

In the state of South Carolina, we haven't done a good job of having those conversations about how can we best prepare our students for the workforce? And so I started out with just looking at some data of the nursing workforce. I wanted to know sort of where were in the workforce as far as - you all may that know that nursing shortage is a rising concern. The shortage is expected to increase. There are many factors that contribute to that, but in the state of South Carolina what I found is that in these green areas we were ideally oversaturated with nurses. When I look at the health of our state, this also was where the health outcomes were most optimal. The yellow, the adequate, the nurse-patient ratios were rather adequate. And then in the red areas of the state these were where there were critical shortages of nurses. Also, in these areas the health outcomes were the poorest. These were also the most rural counties in our state.

And so at this point I was just in really exploration of what can I do in academics to be better informed about practice and to also be action oriented? So my background is in experiential

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region of the state. And so we collaborated with academics, with practice, with the Office of Rural Health. And this collaborative group is probably one of the first to really move forward in the state of South Carolina. We're actually quite siloed between academics and practice.

And so what we're doing in phase one is identifying what these competencies are, and then this group will serve the information or informing of a curriculum that we'll actually use. It's an experiential learning curriculum using simulation as the conduit. So what we're doing to do is have the nurses in practice participate in this curriculum that largely focuses on the racial health care disparities specific to their region, and we're going to measure them. So it's a very early attempt to identify critical competencies in regions of the state that the patient outcomes are really the worst. Ideally, what we'd like to see happen is that in academics we focus on sort of the end goal for us is licensure. In practice, it's recertification. So what we'd

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And so if you want to prioritize, what jumps out? You probably walk around. Crystal, you have ideas here. Some that you're saying, okay, if I could do one thing right now without something new, but taking advantage of something existing, what would it be? Anyone can start. [Inaudible] Yes. Testing.

>> BUERHAUS: Can I do two?

>> WASHINGTON: Oh, sure.

[Laughter]

>> BUERHAUS: Well, the first one I think is the nurse practitioner workforce. I've seen estimates that if the country did that, we could quickly get to 40 million people with access. As I said earlier, it's not going to get the whole job done. It would be something relatively quick. And there's a good body of evidence that suggests that is something that could be done. The other thing that I would like to see us do is sort of rethink, what is the goal of what we're all doing? And you have this chance and we have this system that we've built, which is to produce good medical care. And I think we do that. We could go to a system that says, well, let's produce good health care and that would look a little different than just medical care. Or we could have a system that says we want to reduce or eliminate health inequities. And that would be something yet different.

So I think part of it is to say, what do we want going forward? And then sort of as Erin said, then align our workforce and all our capacities to achieve that. And, Julie, I loved your talk about it's messy, an alignment. And I think it's there. It's going to be hard. And I hope this is one of those steps that is challenging us.

>> FRAHER: All right. It's the end of the day. And I'm going to touch the third rail just to make sure everyone's awake. So I'm keen on really highlighting the fact that I believe we spend a lot of money in this state on training. And we don't get a very high return on investment. We know, for example, we track our medical students five years out. 2% end up in rural primary care in North Carolina, 2%. We invest a lot of money in this state in medical education and graduate medical education as well. And we know what works. We know, for example, UNC Chapel Hill has a program called the First Program where we accept medical students from rural

that retention is much higher. We know that there are models of training and education that develop pipelines that work.

And so I really think we've got to be honest and transparent about the money that we're spending, both nationally and in this state on training. We have to ask, where is the return on investment? I am not asking this just about physicians. I'm asking this about nursing as well. Let's be honest. Let's be transparent. Many of you know, I've spent my life producing data that really irritate people. I vow to continue to do that. But it's really important. I do that for a reason. I'm really trying to shift policy and get people to recognize that there are models out. If I were queen for the day, it really is increasing transparency on the amount of money that we invest in training and asking ourselves, where does that money need to go to support a North Carolina for health, rather than a specific profession?

>> GEORGE: Well I would have to say, tagging on to Peter's comments, if I were to pick one thing and be queen for the day, I would like to see North Carolina be the leader in the southeast and look at removing restrictions from nurse practitioners, from nurse midwives, and whether that's pilot programs, whether that's widespread. I think we've already begun to have some meaningful conversations, but as I said earlier, it is messy. It takes work, but I think it would be worth it. It's something that would not cost one penny to the state of North Carolina. And it would save money according to at least a lot of economic studies that have been done; the Chris Conover study from Duke. So it doesn't cost anything. It would save money. The data shows the outcomes are very good. The data shows there is an increase in access if we do this. So I'm not at an APRN. So I'm not speaking from a personal point of view, but I think we are remiss if we don't take this opportunity to really ask the hard questions and do the work.

goals? I don't know that we have completely shared goals, at least when I think about the academic and practice connections. We're very siloed.

>> WASHINGTON: So [off mic] that's now today. Let s look toward the future. And the future was kind of defined for us – [off mic] [inaudible]

>> WASHINGTON: I am a preacher's kid. I like using my hands.

[Laughter]

>> WASHINGTON: Okay. But the panel is 21st century health workforce, not health care. Just hearing how difficult it is for us to really focus on that – almost of what we've been talking about has still been health care. And I am looking at Michael Miginus [phonetic], and I just drew out your pie chart that published a couple of times. [Inaudible] – really talking about health, health care contributes and best probably 25%. So if we go back to one of the emerging themes that we listed, it was social determinants of health. So my question here is in the context of the future, let's redo those graphs you had up there about what the trends look like now. Let's take off the doctors. Let's take off the nurses. Let's take off the physician assistants. Let's take off the nurse practitioners even because we know them. We have the numbers on them. What does that graph look like? What are the categories? What are the new workforces? Then we can talk about how we begin to train. Actually, I said I only had two questions. So this is my last question. And then we turn it over to – please go on.

>> MURILLO: So I think one of the things when I read about – and I realized that social determinants of health is an uncomfortable term for some. One of the things that I think about with social determinants of health is that we largely teach individuals the knowledge of, but where do we – or when or how do we teach individual systems how to act upon? I think without this, we further perpetuate. And I don't know if that really answers your question, but for me, when I think about social determinants of health, can we give people more than just the knowledge of them? Let's tell and train people what to do about it.

>> WASHINGTON: I am just probing a little. Who are we training to what to do about it? In other words, who are we training to provide that beyond the doctors and the nurses and the physician assistants?

>> MURILLO: Well, the patients as well. I mean, I think it's communities. It's obviously in – not only in practice, but it's communities. It's those in our educational systems. I think in general when we think about social determinants of health, it involves humans. So that's who we train how to

expanded its Medicaid. But not they're going a step further. And your response to that last question intrigued me. Because they are taking a good amount of their expanded Medicaid dollars and they're putting it in nutrition and housing.

And I wonder if you know of that state is Massachusetts. I can't utter that down at Jones street. But my question is: Are you aware of other states that what other states or models should we look to? Because that addressed what you, Eugene, you were talking about. We may be talking about; do we need more farmers or we need housing? And they realize this is a big issue in their state. And is this something that we're overlooking? And do you know of other states that are looking at things that are this interesting?

>> BUERHAUS: I wish I did, but I don't.

>> WASHINGTON: Well, I do. You're in one. I saw Mandy [phonetic] early. Is that someone here from the health department who can expound on this? [Indiscernible] Tell them about what's happening right now in terms of the Medicaid Waiver.

>> AUDIENCE MEMBER: Sure. So I forget what year, but sometime recently North Carolina got what's called an 11 to 15 Waiver from CMS, which essentially says you can do creative things and innovative things with Medicaid dollars. And so in North Carolina the Healthy Options program and the NCCARE360 is part of that that was mentioned, that's the platform to enable it, that in addition to paying for medical visits and days and doctor visits, they're also going to be able to use Medicaid dollars to reimburse for food security, transportation issues, housing issues, and interpersonal violence counselingl (s)2 (e)-1 1 (e)-16-2 ((,)1 (h)1 h-1 (M h)1 -1.4n (o)2 (

>> AUDIENCE MEMBER: Yeah, so Pam Silberman [phonetic] again. I'm just curious, and this can be for any of you all, as we especially in North Carolina give in the whole move to healthy opportunities and we are now moving upstream and we're trying to address the social drivers of health, we are - there's all this other workforce. And, Peter, you've mentioned that you could be bringing in, in terms of addressing these housing and transportation. The one foray we've gone into it is with community health workers. And we are medicalizing them.

And this is a big issue that has been raised within North Carolina whether we should require credentialing for the community health workers. Number one, does it excluded certain workforce who might not get into it? But are we now taking a workforce that existed before and now creating little medical workers that have to be credentialed and turning our social system into a medical system? And I just like people understand for reimbursement purposes that may be needed, but I'd like to hear some comments on that.

>> FRAHER: So I will jump in here. I think it's a really important question. So I would see that question as fundamentally a question of you have a workforce that sort of come up through the community, specifically to address community needs to actually act as almost a nexus between the community and the health care system; right? That was their real benefit of using community health workers. And so we're sort of at a point where we're thinking, do we standardize their education and training? Do we get better outcomes if we do that?

It's the same argument with medical assistants, actually I would argue i

equities. So I wouldn't be blanket. I would challenge us though to be very aware of that kind of tendency and history to do that because we could be not baking in a new set of trouble. So I think it's a good question to bring up. So I appreciate Sean [phonetic], I think you want to

And so what are the competencies of the leaders of the health care system or the health system of the future, and what are their competencies?

>> MURILLO: Well, I don't know—I don't know if I can effectively answer that question, but I think it's a great question. And I think honestly, I know from the South Carolina perspective, those are answers that we don't have. I think it's important that we begin to collaborate to answer those questions, because as it relates to nursing, I will say, in practice we know that they are minimally competent when they graduate from their programs, but beyond that, we don't really know what competencies are needed for the patient outcomes. And so as it relates to the new roles, those are new competencies that will need to be developed.

>> GEORGE: Two things that come to mind for me is cultural competence more than clinical competencies, but cultural competence for the future and also, technologically, technology competencies. Because you still have some of the workforce that are very resistant to the use of technology.

>> WASHINGTON: Well, I get to answer a question; right?

>> AUDIENCE MEMBERS: Yes.

>> WASHINGTON: I'm not violating rules am I, Jessica [phonetic]? Jessica's giving me the look. But at any rate, on the leadership part, again, I go back to what we talk about, but seem to then move away from it. If we really want to improve health, we got to be addressing housing. We got to be addressing jobs. We got to be addressing transportation, food. We need a multi-sector, multi-stakeholder coalition to do that. And so at the top of the list of competencies for a leader is an individual who appreciates that and has some facility with building them and/or participating actively in helping to drive them forward.

>> FRAHER: So I think this is a great question. I just want to add a couple things that totally dovetail with what we've talked about today. Number one, we don't have enough behavioral health workers in this state. So we're going to have to diffuse more behavioral health knowledge out into the generalist in general workforce, number one. Number two, we don't have enough geriatrics or geriatricians.

Sowe are going to have to do the very same thing is really bolster curriculum around dealing with our long-term care population. The other thing we don't do enough of, and I recognize this is really hard to do—we are or trying to work towards this, the American Medical Association is leading us in this—is we have many health care workers who have no idea about health care

system change. They have no idea what value-based care is. They have no idea what's happening. And so trying to help our learners and help our existing workforce understand and educate them about the colossal change that is underway, will go a long way towards engaging

But the main thing is, how do you get the kids in? And then make those medical students do you get yours to make up their mind, Gene? And I see Wesley [phonetic] was back there too. They have to make up their mind. And then they see a heart surgeon, and it's over; right?

[Off mic] [indiscernible]

>> BUERHAUS: A few years ago we published a study in "JAMA." And we looked at who are physicians marrying? And women were marrying highly educated spouses far more than the

we're challenged with shifting the focus or expanding the focus to the caregiver. So I can say from our perspective, we haven't figured out how to do that.

>> GEORGE: And one thing I failed to mention in my presentation, from a regulatory point of view, we have partnered with North Carolina Home Health and Hospice so that nursing students can get clinical rotations in the home and hospice setting and working with them also to develop more of orientation and support programs so that, number, one, you can recruit the workforce and future workforce into that setting. They'll understand palliative care, and they'll be more likely to stay, if they're supported in that.

>> AUDIENCE MEMBER: By the way this, this is my first question today. And to the last one, I think most of the issues I want bring up is somewhat covered. But perhaps I can make a couple of comments to emphasize some points.

First of all, by the way, this is a great panel and great audience participation and everything you said I think resonates with us and [indiscernible] myself. The two points I want to make is one, informal workforce; actually if you think about most of the care is given by family members and others. And that's entirely [indiscernible] workforce that's been not discussed. I think the last person kind of addressed it, but I'm not talking about hospice. I'm talking daily chronic disease; what do you do about that? I think that's a really big part of your workforce in the future. I would love to hear how you're going to be to be able to educate them. And, as you know, in some countries they even get reimbursed for that kind of work. How do you see ourselves in the future? I think that's a big question.

The second is kind of what Julie started talked about, which is the technologies of future. And by that I don't mean to get anything away from professional relationship, compassionate care. But think about every day the digitalization of everything that we do. And Julie started talking about telemedicine, but, in fact, I would think that even your workforce in remote areas have to have some competency with regards to understand how to use data technology, etcetera. And then taking all the way to AI and how that's can be employed or deployed is in context of workforce development. I'd love to hear what you guys think.

>> MURILLO: Well, so we are looking at digital literacy. And that's sort of the horizon report for those in education, lists digital literacy as a priority. But I think can I also move into our takeaways, or am I jumping ahead here? [Off mic] [indiscernible] So I think thinking about the informal workforce is a major takeaway for me. I know in the state of South Carolina we have many caregivers who are essentially providing care. And so I think moving forward, I will take that piece back to the state and see how we move forward with that.

>> GEORGE: And I think it’s an untapped, certainly, workforce as well, but I think that regulation

about, health or getting rid of inequities, I think we could end up with a happier and a more confident workforce. Because we're starting to see what we're doing connecting to things that matter. People are more educated. There is less gun violence. There's less behavioral health issues. There are less suicides. We're connecting to something that really matters. We can have our medical care as well in all that, and it has a role. But I would like us to have a workforce that is confident, secure, happier. And I don't think that is what we're seeing in today's world. So I think the framework needs to shift so that we can bring that resource with us and really turn it loose.

>> WASHINGTON: Just a couple points by way of wrapping up. One, each of you has underscored and that is, we already have so many opportunities that we could better leverage, just multiple-- [off mic] [inaudible]. And then the last point I would like to bring back to us was somewhat provocative, but the truth is I think it does point the way for the future. And that is in response to my question about the graph. The graph is not about types of people, that if we really do start with what the people need. I'm saying people, rather than patients. Because in a value-based care world, we're going to have lives attributed to us, and we don't want them to be patients. And so if we start with what people need and work back from that (inaudible) of

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necessary. And yet we, as a society, are some distance from the training and education and financial capacity to make those changes that are necessary to help them adjust to the circumstances. I think that those lessons came home very well throughout the conversation and laid the groundwork for not only what can be done here in North Carolina, in SouthCarolina, what probably is already being done at some level in Montana, and by for what we can do at the National Academy of Medicine. So thanks to each of you.

We go now to a reception. Tomorrow morning, we begin at 9. with the keynote from Karen DeSalvo, who also will be very integrative and inspiring in her comments. Again, thanks to all of you.

[Applause]

DAY 2

>> DZAU: It's great to see so much energy still left in this group. I was saying that yesterday was a long day, but, I felt not tired, but actually exhilarated because of the great conversation we had, and how all of us are really committed towards improving the health -- I guess I have to speak loud

[Laughter]

-- of North Carolina and of the nation. I thought I would begin just to recall one slide, which Mike McGinnis actually talked about that a little bit. That is: What is vital directions? And how I thought everything about this meeting is looking at these important priorities. So, as you can see, this was an initiative we did in 2016. Mark McClellan and I launched this with an outstanding student group and 150 experts that put together 19 papers on different topics of health, which are really written in a way for po2[caytes.n.3tyrod cod cestearday, conversatiot to

a lot of credit.

Of these areas, as you can see, there are four priorities. Actually, if you think about the topics we touched on yesterday and today, we are looking at each one of those. Pay for value, a big topic for today's discussion. Empowering people. And how much did we talk about that yesterday? Activate communities. And importantly, connected care. And certainly we touched on all those things. We also look at the infrastructure needs, as many talked about the needs in this state. But if you look at them, it is measure what matters most. Certainly we had a whole session about the skills of the workforce for the 21st century. Accelerate real-world evidence. And, of course, advancing science. So I would say congratulations to North Carolina. You really are right on track, if not ahead of the pack, in many of these issues. I want to -- I look forward to the rest of the day in seeing where we

right initiative and emphasized the kind of strategies here that were going to make those health gains possible through alignment around common priorities, as well as through building the infrastructure necessary to engage them.

We heard from an extraordinary group of participants on five panels that were focused on North Carolina's health and health care priorities. Secondly, the importance of place in health, health care disparities and health equity. Thirdly, the need for integrating physical, behavioral, social endeavors to approach the issues in a wholeperson manner. Fourthly, the panel on connecting care through seamless information flow and data sharing. NC360, a great example in that respect. And fifth, the importance of fundamental shifts in perspectives, incentives, and training to create the workforce necessary to carry forward the priorities.

The discussion throughout the day was so rich, it's virtually impossible to capture that richness in a summary fashion and certainly not in sound bites. But there were several sound bites that I noted, found, as I was looking through my notes. I'll just read a few off. The Governor mentioned lives of purpose and abundance as an inspiration. We heard about the importance to keep it simple, keep it real, keep it practical. We heard that there is a different way, let's base our margins on keeping people healthy. We heard that choices depend on opportunity. And we heard the voice of Pamela Avery, shared with us by John Lumpkin. I never knew I could have a vision for the community. We heard about systemic exclusion. We heard the term "segregated by design." We heard about Ward A and Ward B. We heard participants and not patients. We were reminded to be culturally humble. And we were reminded that payers play by rules, but they need to change the rules. And we also heard that we need to know what the data know. And finally, and in many ways best capturing the reason for our conversation, we heard North Carolina has the It Factor. Which we all resonated with. Especially those from out of town who are treated to this magnificent weather and scenery, and these creative ideas.

Today we'll be discussing in the following series of panels. First of all, health care transformation and moving to payment for value. We're going to hear about community engagement and its importance, its centrality for better health and well-being. Then we're going to end the day with a call for action, a panel that's going to review what we've heard throughout this session, and identify priorities, practical, actionable steps that can be taken by all of us in the course of our movement forward.

>> McGINNIS: To start us off today, we have a very, very special treat. We have the privilege of being joined by Karen DeSalvo, who is an individual who brings really

unparalleled experience, insight, passion, and leadership to the full range of the issues that we discussed yesterday. Karen has provided leadership in medicine, in public health, information technology, health equity, all of these repeated themes. And not only has she provided leadership, but she's really been at the forefront, at the tip of the spear, on these issues at the national level. So to complement what we heard yesterday from Secretary Cohen, we're going to hear a national perspective from Dr. DeSalvo.

Let me just tell you a little bit about her. She's currently a Professor of Medicine in Population Health at the University of Texas, Dell Medical School at Austin. She's also a Senior Fellow at the Bipartisan Policy Center. And she's on her way in just a week or so to Google, where she is going to be the Chief Health Officer for Google. We're all very, very fortune that they have made that decision. But let me tell you a little more about Karen. In the Obama Administration, Karen served as Assistant Secretary for Health, which is head of the Public Health Service, the health side of the programs. So she obviously worked closely on the health financing side with Secretary Cohen. It's really a privilege for us all to have that dynamic duo with us here today to identify our opportunities. Prior to her position as Assistant Secretary for Health, she was the IT czar for the nation, the Director of the Office of Health Information Technology. The reason that she was tapped -- one of the reasons, she may tell you what the real reason was -- for that position is that before she came to the Federal government, she was the Commissioner of Health for the City of New Orleans. And she was instrumental to efforts to restore health after the devastation of Katrina. And relied not only on her activation of community forces and leadership, but on the use of IT to help jump start the progress in rebuilding the health sector throughout New Orleans. Before that, she -- actually, I should say that she also has a deep reservoir of experience in

[Applause]

We're going to have an informal conversation.

>> DeSALVO: Who needs a mother when you have a guy like that?

[Laughter]

>> McGINNIS: I actually could have gone on for a lot longer. And maybe after this session, I will.

>> DeSALVO: How are you all doing? Good morning.

>> Good morning.

>> Howdy.

>> DeSALVO: Howdy.

[Laughter]

>> McGINNIS: Welcome, Karen. We obviously are delighted and very grateful for your being here with us. This is a conversation. It could be very-wide-ranging, given Karen's wide-ranging experience and expertise. But we're going to start with a focus on a theme that has coursed throughout much of our conversation, and that is social circumstances and the way social circumstances shape our health prospects. And more importantly, in many ways, at least by example of stark contrast, the way -- how we have come to be in the international community such outliers in the health arena. You all know the figures. You saw them yesterday. Despite spending 50% more than our closest second spender, we are ranking somewhere in the 30s with respect to overall health importance. And when you look at that importance in terms of returns on investment, it's not just poor importance, it's disastrous, given the amount of money that we spend.

So it would be, I think, very helpful -- that doesn't matter, Karen.

[Laughter]

>> DeSALVO: Shave ten minutes off.

[Laughter]

>> McGINNIS: Thank you very much. Thank you.

>> DeSALVO: Chief resident.

>> McGINNIS: With this right here. Which is an Academy's report, consensus study report, on integrating social care and delivery of healthcare, moving upstream to improve the nation's health. Karen, you were on this panel. This—it's issued a vitally important set of determinations and recommendations for us as a nation. Could you talk a little bit about the high-level recommendations of the report?

>> DeSALVO: I will. Let me start by saying thanks for inviting me and having me here. I'm a fan (a)-1 (ne)-1 (s a)-1l ofso s adc th.n n i s a3(m a (h)1 f a)-1l o ( )]T ndatie. ank y on thi

have this opportunity and base it on primary care, and digitize it, and focus on quality. A

let's go upstream, we need to do more to change context. But really where we were charged is to focus on what the health care system and clinicians could do. So the recommendations in the report are in that vein of moving medicine upstream.

We tried to get a frame on what is there was so much activity happening on the front lines. Some of it in the peer-reviewed literature, some of it published, so that it could be assessed and evaluated and said, yes, this actually is a good approach, or to anything we want to do. A lot of the work happening in social determinants, especially related to the health care system, is in the gray literature or on someone's website about how wonderful they are. So, hard to know if we can believe it. Right? And so the committee tried to cast a broad net to look for promising practices. You all will not be surprised that North Carolina is in there. It's particularly in the data and tech chapter, talking about NCCARES360. But we have (pte)-2 (r)-1(r)-1 (m8eki)-1 (ng)1 (a)-1 (boe)-2 (tr)(o)2 (r)-1 (th)]TJ (8eki)
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community. Some organizations like Kaiser Permanente are further along in that journey. Bernard Tyson and other leaders in the organization I think have really moved very swiftly from we know there's a challenge, we're trying to help individuals, but really there's more we could do with our organizational heft as health care to advocate for better public transportation, better housing, living wage, these really structural, conceptual changes that are going to make the difference over time.

So the five A's really are just designed to give organizations and communities a way to anchor what the health care system might do. We have a set of recommendations in big areas around workforce, digital, and technology and financing that are pointed largely at the public space; but there are a quite a lot that the private sector can do. Some of those efforts are either under way or we have good hope that they might be helpful. And we might talk about some of those later. I do hope that you all will take a look at the report, not only because of the opportunity to help frame as you're talking to health care systems and to health plans, this is the sort of five A's ways to think about it, or to individual clinicians; but also to think about what are the changes that need to happen with respect to the way we do business as health care. Again, the report is designed to talk to health care. We don't believe that's the whole-all and end-all, but it's -- the Academy was charged with beginning to have that conversation to help medicine, move medicine upstream.

>> McGINNIS: Thank you, Karen. It was a really wonderful overview from a very practical ground-level perspective of the issues and opportunities. Two or three things prompted in listening to you. One observation and two questions. The observation was that we really lost a very important ally when Bernard Tyson passed away a couple of weeks ago because what Kaiser has been doing has been extraordinary. One of the questions picks up on the notion of what's required in the way of linkages with other sectors in engaging it. I'd like to come back to the question of how do we play out, identify, and cultivate those partnerships; but first I want to pick up on a self-centered perspective and that is ask you what you think the National Academy of Medicine, the National Academy, might be doing to help advance the evidence base in order to mobilize and provide resources to and prompt the kind of activity that you see as necessary and that you, in the course of your committee work and elsewhere, beyond the notion of just health care and the linkage between health care and community, what is it that the national academies ought to be doing or has the opportunity to do in order to help move the frontier?

>> DeSALVO: I'll answer that if you promise me you'll get back to other sectors.

>> McGINNIS: Yes.

>> DeSALVO: Okay. Sort of changing the name of the Academy to the National Academy of Health, but--

[Laughter]

[Applause]

We--

We will take those suggestions on what we should do to heart. And I'm confident that I can speak for Victor and myself that we will give a stronger measure of attention, certainly as strong as we can, to advancing that science base.

>> DeSALVO: Thanks. Can I say one thing about that? Just in case Francis Collins is watching.

[Laughter]

Back to the house of medicine. When the NIH says go left, every academic medical center in the country goes left. And what that means is that not only the scientific pillar of the training -- I'm going to be very doctor-focused, but this is true for nursing -- is it also begins to influence what the students are exposed to. So the teaching enterprise and the clinical enterprise are effected. It's really powerful. That's a very powerful tool in the toolbox of elevating the respect and appreciation and the credibility of the social determinants of health. So part of it is the funding and the building of a new enterprise. But it's also just to have the scientific community like the Academy say this is real, this is not fuzzy stuff. There's actual data that shows that the social determinants of health effect your biology. Right? And your physiology. So there's a grounding. And this is not fluffy, qualitative research. So hopefully Francis will continue to lean in. I'm being a little facetious, but he is a very credible leader, and we need folks like that, like the Academy, to do just what you're doing and step up and say this is really important for the health of the country. We need to do all the other work we're doing to build better drugs, or better pathways, better payment models; but we also need to understand that there's more to health than health care.

>> McGINNIS: Well said. Signals matter in a very big way. And we need to take full advantage of that. So, as I promised, back to partnerships. Health improvement is a collaborative enterprise. How do we in the health s (o)2 (r)-1 (ta)-1b(iv)3 (e)--1 ( )]TJ (thth)5 (s11(e)-1 ( )]T2 (do)2(

the other side. And public health is a partner we had pretty tightly bound to medicine for a lot of years until the-- through good intention, but I think over the course of generations, those two fields have split off and have different language and professional tracts and accreditation and different rooms in which they work.

>> McGINNIS: And resources.

>> DeSALVO: Very different resources. And it's just, I think it's really hurting the country. We've disarticulated that in governmental processes. And I, by the way, think that is part of the secret sauce of North Carolina is the vision to have somebody like Betsy, who is deeply experienced in public health, also be part of leading the Medicaid program and bridging those worlds to think about Medicaid as a tool to improve health broadly, not just as a way to reimburse providers for services that they deliver. I hope that this kind of example, we stop disarticulating public health from various other really important health drivers. We have even done that with environmental health. All across the country. Preparedness now is sort of separate and apart. It really worries me that we're not in the same rooms working together for the same shared goals. So, a part of this change that I think we're going to have to do, not only in the research strata, but also in the work strata, is to bring-- to do a forcing function, to bring the fields together at the policy and the practice, the practice level. When I-- when I became Health Commissioner. And I didn't want to do it. It was like nine months of talking to Mitch Landrieu. I was like, I'm not going to do that. I'm going to find you somebody to do that. I don't want to be Health Commissioner. I was

I had this very visceral experience. And it has forever changed the way I see that part of the world. But

organizations, health care systems in particular, that are further on the value-based care journey, that are on those downside risk models that cause them to want to have these more structured, aligned relationships with social care partners, they're running into social care partners are overwhelmed. There's long queues. There are social care providers are learning how to pick and choose the less needy folks that are coming to them since they're getting kind of paid a flat rate and they as a mom and pop, soft money, housing, support agency, don't want all the super sick people with behavioral health disorders. They're trying to balance their books. And they don't have good digital infrastructure, et cetera. So there's a lot

3.0, which was a call to arms for the public health community to address the social determinants of health, which is a report that my office put out. And even in the technology space, we rewrote the strategic plan and included in it a pathway to a digital world that could address the social determinants of health. So the groundwork was there. I think this is an important take-away is that states can innovate because you have a rapid cycle of change, proximate, and you have local health plans and local public health and local philanthropy that allows you to do fast work. But the federal government has a longer arc. But I think that I guess I'm going to say a couple things. And I'm not trying to be political. But I think the first thing that I'm going to say is more in the health care space. I would just like to just stop talking about coverage expansion. I want it to happen so that everybody has access to affordable health insurance. Can we just clap for that? Yes. Including in North Carolina.

[Applause]

Because it sucks the policy oxygen out of the room and there's no space to talk about the other important things that we need to do to actually get to health. I also think that we need to marshal the Office of Management and Budget, which I believe could be a much more powerful resource at understanding the assets that we already have that can drive health -- being selfish here -- but health is a pathway to well-being and economic prosperity. And begin to really, truly evaluate the benefit out of those programs and be as clear as possible within -- and figure out how far we can go within statutory authority and then what Congress needs to do to help allow us to pool resources on the front lines. I think the siloing of, not just data, but of money and of personnel. When you are working on the front lines, it's a ridiculous morass to get through. And what people need is as much flexibility as possible within current -- and they need clarity through clear guidelines. And it needs to come from the White House, not just from HHS, because there are important opportunities in labor and housing and commerce and USDA and other departments. So this isn't just about what the House Secretary can do. It is actually something that the White House can do. And the reason I go to OMB is because they know where everything is, and they know what all the rules are, and they can bend them or decide where we need to go to Congress to get changes. But I actually -- so, to maybe say it more simply. I think we've got a significant structural problem in the country. And I've said that in different ways. The structural problem is we keep separating things into different rooms. And I wouldn't want social determinants to be separated into a different agency or department. I would just want all of the potential opportunities that we have to drive health. Maybe I'll just say one more thing because I know you care a lot about this. This is kind of a -- well, I mean, a health thing. Is, we actually -- this may surprise some of you all if you haven't been in federal government. But, the President or the Secretary doesn't have a dashboard of health for the country that's near term. So the