Duke
NORTH CAROLINA
LEADERSHIP FORUM

2023 Report

Conversations on Health Policy in NC

Contents

Conversations on Health Policy in NC

Introduction

The North Carolina Leadership Forum (NCLF) seeks to create constructive engagement between North Carolina government, business, and non-profit policy leaders across party lines, ideologies, professional experiences, and regional perspectives. A program of Duke University, NCLF has been bringing together cohorts of NC leaders since 2015.

The Challenge

Although North Carolinians have always had significant political differences, they have historically exhibited a practical, problem-solving mindset to politics. Today, however, the tenor of the times is highly partisan, and North Carolina, like many other states, finds itself sharply divided. Progressive and conservative leaders often depend on different media and social media outlets, operate with different facts and beliefs, seldom engage substantively with people with whom they disagree, and all too often assume the worst about the motives of others. For these reasons, our leaders are less willing and able to work together to create widely-embraced solutions and opportunities for our state and its people. Our aim is to help bridge this divide.

Our Approach

NCLF focuses on those who engage in state-level policymaking as leaders in government, business, nonprofits, and local communities. For each cohort, we provide an opportunity for these diverse leaders to:

- Build authentic relationships based on trust and understanding through frank, civil, and constructive discourse, and
- Significantly deepen understanding of a specific issue and the underlying values and concerns of others without diminishing one's own or another person's point of view.

> The overarching goal of NCLF is to develop a critical mass of civic and political leaders who have the will, the skills, and the relationships to address challenging issues and to model constructive engagement across the ideological divide.

NCLF IN-PERSON MEETING PHOTOS BY KEN A. HUTH

Our Method

Over the course of several months, in a series of face-to-face multi-day meetings, we work to:

1. Increase participant understanding of their own and others' concerns and values that underly their varying views about the issue;
2. Establish a shared understanding of the nature of important problems and the relevant facts;
3. More clearly articulate the benefits and inherent downsides of proposed ways to address concerns;
4. Identify points of agreement about proposed actions to address concerns;
5. Examine and seek to understand the values, perceptions and experiences that underlie the most polarized disagreements about the proposals;
6. Build authentic relationships among leaders of different political parties and ideological views, as well as across sectors, geography, and other demographics; and
7. Create a foundation for future constructive engagement among their fellow participants.

The Question Addressed

Each year, NCLF selects an important public policy topic for discussion based on several criteria. The topic must be important to a wide variety of people in North Carolina, it should be currently controversial and under discussion, and people of different perspectives or ideologies should have different views about the nature of the problem and its best solutions. The topic is typically intentionally broad, leaving it to the group to narrow the issue and set priorities for discussion, but it should not be so broad that it is impossible to consider the context of the issue or arrive at practical actions to address facets of the issue. An ideal topic presents tension between closely held values, involves many actors, and related solutions involve tradeoffs.

Given the COVID-19 pandemic and the issues it presented around health care needs and outcomes, as well as ongoing debates about health care in North Carolina, the 2021 North Carolina Leadership Forum addressed the topic of health care, asking:

How can we improve health outcomes for North Carolinians?

The Leadership

NCLF is primarily led by a diverse Steering Committee made up experienced leaders from around the state. This group spent significant time designing the format, focus, and pacing of the 2021 program. Members of the Steering Committee also facilitated program sessions during each participant gathering. Duke University provides expertise on the topic and student interns, as well as operational support, and helps to evaluate the impact of NCLF and communicate the impact of the program more broadly to the public.

The Participants

The 2021 NCLF Cohort consisted of 32 participants, in addition to the NCLF steering committee. Participants included members of the General Assembly, state and local officials, leaders of nonprofit and philanthropic organizations, medical practitioners, and business leaders from across the political spectrum and from across North Carolina. Some of the participants are deeply engaged in health care policy or the health care system in NC, and some are more generally engaged in the development of public policy in North Carolina. All of them play a significant leadership role in their local community and most at the state level. The group was fairly evenly divided between Democrats and Republicans, with a handful of participants identifying as unaffiliated.

For a complete list of the 2021 NCLF participants on Health Care, see Appendix A.

The Process

Overview

The group gathered for four day-and-a-half meetings between October 2021 and April 2022, plus a short added online session in February. The first and last meetings were held at Duke University, and the second and third meetings were held, respectively, in Hickory and Greenville, North Carolina. All meetings operated under the Chatham House Rule:

When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.

The program progressed as follows:

- Establish ground rules for constructive engagement.
- Learn who is in the room, and begin to build relationships and trust among members of the cohort.

The 2021 NCLF Steering Committee members were:

John Hood, Co-chair
President, John William Pope Foundation

Leslie Winner, Co-chair
Former Executive Director, Z. Smith Reynolds Foundation; Former Member, NC Senate

Abdullah Antepli, Associate Professor of Public Policy and Interfaith Relations, Duke University

Tamara Barringer, Associate Justice, NC Supreme Court; Clinical Professor of Law and Ethics, UNC Kenan-Flagler Business School; Former Member, NC Senate

Anita Brown-Graham, Professor and Director of NC Impact, UNC School of Government

Maurice "Mo" Green, Executive Director, Z. Smith Reynolds Foundation

Charles B. Neely, Retired Partner, Williams Mullen; Former Member, NC House of Representatives

Ray Starling, General Counsel, NC Chamber of Commerce, P resident, NC Chamber Legal Institute

Debbie Goldstein, Executive Director, NC Leadership Forum

- Identify the broad array of concerns related to health care in North Carolina, and the core things that participants value related to a system of health care.
- Develop a shared knowledge base by establishing basic facts and a greater understanding of where the complexities lie.
- Establish the overarching concerns related to the topic. Identify and discuss potential options to address each of these concerns, including benefits and downsides of each option.
- Determine the extent of agreement and disagreement about the proposed options and the levels of tolerance for their downsides.
- Identify the actions about which there is a consensus. For those actions that have substantial but not complete support, determine how they could be modified to broaden support. Dig deeper into the options that generated the greatest amount of disagreement to allow participants to articulate deeply held views, further understand others' view points, and to practice skills in constructive engagement.

Relationship and Trust-Building as a Primary and Ongoing Goal

Opportunities for participants to build relationships with people of different perspectives were woven throughout the program. The first afternoon was devoted to a relationship-building exercise in which members of the cohort were asked to talk about a transformative person or event in their lives. Participants approached the exercise with vulnerability and open-mindedness and remained engaged with each other for the whole afternoon. It was a remarkable experience that created a foundation for conversations to come. Other examples included pairing "buddies" of differing ideologies to meet outside of sessions, creating diverse "home room" groups which were used at some point in each meeting, and assigning intentionally diverse groupings for small-group discussions, jigsaw sessions, and dyads. Each of these tools encouraged and enabled connections among individuals who may not otherwise have interacted in a meaningful way.

Session 1: Identifying Areas of Concern, Things Held Valuable, and Basic Facts

The discussion of health care began with identifying the range of concerns related to the topic, followed by a conversation about things held valuable in health care. This session was an opportunity for participants to present as many perspectives as possible.

We finished Session I with an overview of basic facts concerning the relationship of demographics to health outcomes around the state, barriers to health care, the health care workforce, how people pay for health care and the distribution of health insurance around the state and its relationship to the cost of health care.

During dinner between the two days, the group heard remarks from Duke University President Vincent Price, and NCLF Alumni NC House Majority Whip John Hardister and NC House Democratic Leader Robert Reives.

Panel Discussions: From Theory to Practice in Hickory and Greenville

During our meetings in Hickory and Greenville, participants saw examples of efforts to train NC's health care workforce and provide health care in underserved parts of the state. These sessions were valuable in providing real-world, on-the-ground context to the general and theoretical conversations unfolding during NCLF sessions.

Session 2: Prioritizing Values, Defining Chief Concerns, and Beginning to Identify Solutions

At the second meeting, held at Catawba Valley Community College in Hickory, NC, the group revisited the core values identified in Session 1, using live-polling software to determine relative priority of values for the group. The results of this polling are set out in in the Values discussion below.

The agenda then turned to narrow down the list of concerns from the group and select three to focus discussion for the remainder of the program. The group then broke into small groups to brainstorm actions to address the selected concerns and voted on which actions would benefit from further discussion.

The group also toured ValleySim Hospital, a 27,000-square-foot hospital setting for education and research. The hospital features a variety of realistic patient simulators for training students and health care professionals in a variety of medical scenarios. Participants also had an opportunity to see other workforce development programs at the Catawba Valley Community College's Workforce Solutions Complex, including its engineering, robotics, and automotive systems facilities.

Session 3: Benefits and Tradeoffs

The third meeting, held in Greenville, NC, focused on specific policy options to address the identified concerns. Participants discussed the benefits and inherent downsides of each policy option and then voted on their degree of support and extent of their ability to tolerate the downsides for each one. The resulting "polarity charts" show the degree of agreement and disagreement among the group and are included in the discussion section of this report. Of note, the Greenville meeting was delayed due to concerns about a high prevalence of COVID-19 in January 2022, resulting in a brief online discussion of two topics in February, followed by a meeting in March of the same year.

At the start of the Greenville program, participants also heard presentations on ECU's extensive efforts around telehealth and community engagement in the Eastern part of North Carolina in a range of medical fields. We were also fortunate to enjoy evening social time at the Greenville Museum of Natural Sciences, a satellite facility of the state museum.

Session 4: Understanding our Agreements and Disagreements

For the final meeting, hosted at Duke, the goals were to determine the policy areas with the highest levels of agreement and to dig deeper into the issues and ideas that produced the most polarized responses. To facilitate this process, the cohort used the polarity-chart results from the previous meeting, which provided a visual representation of the group's attitudes towards each policy option. In addition, before launching the discussion of areas with the greatest disagreement, NCLF moderators modeled how to respectfully convey the deeply emotional and personal perspective on the content of a topic while also clearly articulating a particular view. The resulting conversation was candid and respectful, and participants engaged with each other on sensitive topics with conviction and understanding. At the end of this meeting, time was reserved for participants to reflect on what they were taking away from the experience.

Background: Health Care and Health Outcomes in NC

Across a variety of measures, North Carolina residents' health outcomes compare poorly to the country overall. North Carolina has a higher infant mortality rate, higher death rate, and lower life expectancy than the national average. North Carolina also has a higher incidence of invasive cancer and higher rates of diabetes in adults compared to the national average. According to a 2021 report by Mental Health America, North Carolina ranked 44th among states for access to mental health care and 45th for youth mental health. Reports since COVID-19 have only suggested that the rate of youth seeking behavioral health care in North Carolina has increased significantly.

Health Outcomes: NC vs. US

	North Carolina	US
Infant mortality rate	6.8 per 1,000 births	5.7 per 1,000 births
Death rate	767.3 per 100,000	715.2 per 100,000
Life expectancy	77.6	78.7
Adult self-reported health status	5.4% poor 14.0% fair 32.9% good 29.9% very good 17.8% excellent	4.7% poor 14.1% fair 32.3% good 31.5% very good 17.4% excellent
Invasive Cancer Incidence (Age-Adj)	473.6 per 100,000	452.8 per 100,000
Diabetes (Adults, ever)	11.8%	11.1%
Heart Disease Death rate	154.7 per 100,000	161.5 per 100,000

Source: Kaiser Family Foundation State Health Facts (https://www.kff.org/statedata/?rgn=35)

Of particular concern, health outcomes for some parts of the North Carolina population are worse. Indicators of health with regard to death rates overall and in the area of maternal and child health measures are worse for African Americans and Native Americans, for example, compared to the white population.

Mortality Rates

Mortality Rates, 2012-2016 [20]		Total	White	African American		American Indian		Hispanic/Latinx		Other	
		Rate	Rate	Rate	Disparity Ratio	Rate	Disparity Ratio	Rate	Disparity Ratio	Rate	Disparity Ratio
Heart Disease		161.3	159.0	187.1	1.2	182.0	1.1	56.6	0.4	76.0	0.5
Stroke		43.1	40.6	56.0	1.4	39.5	1.0	21.7	0.5	36.4	0.9
Diabetes		23.0	18.8	44.0	2.3	45.0	2.4	11.3	0.6	14.3	0.8
Chronic Lower Respiratory Disease		45.6	50.7	27.6	0.5	43.8	0.9	8.6	0.2	12.5	0.2
Kidney Disease		16.4	13.4	31.0	2.3	19.6	1.5	8.2	0.6	10.5	0.8
HIV Disease		2.2	0.8	7.5	9.4	1.6*	♦	1.1	1.4	♦	♦
Cancer	Total	166.5	165.0	190.7	1.2	158.7	1.0	72.9	0.4	104.4	0.6
	Colorectal	14.0	13.3	18.9	1.4	13.1	1.0	5.0	0.4	8.0	0.6
	Lung	47.5	49.1	46.3	0.9	51.2	1.0	13.1	0.3	23.5	0.5
	Breast	20.9	19.4	28.3	1.5	20.2	1.0	9.9	0.5	13.2	0.7
	Prostate	20.1	17.2	39.1	2.3	28.5	1.7	6.8	0.4	6.5	0.4

■ Green indicates a group is faring better than the referent group
□ White indicates there is no significant difference between the referent and comparison group
■ Red indicates a group is faring worse than the referent group
♦ Symbol indicates reliable rates could not be calculated
* Rates based on fewer than 20 cases may be statistically unstable and should be interpreted with caution. Rates based on fewer than five cases are suppressed in this report.

Source: NC Department of Health and Human Services, NC Health Equity Report 2018: Racial and Ethnic Health Disparities in North Carolina, available at https://schs.dph.ncdhhs.gov/SCHS/pdf/MinorityHealthReport_Web_2018.pdf

Maternal and Child Health

Maternal/Child Health Indicators	Total	White	African American		American Indian		Hispanic/Latinx		Other	
	%/Rate	%/Rate	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio
Infant Death Rate (per 1,000 live births), 2012-16[10]	7.2	5.4	13.0	2.4	9.0	1.7	5.1	0.9	5.3	1.0
Low Birth Weight (<=2500 grams) Births (%), 2014-16[11]	9.1	7.5	14.1	1.9	12.0	1.6	7.0	0.9	8.6	1.1
Late or No Prenatal Care (%), 2014-16[11]	30.6%	23.9%	39.1%	1.6	35.9%	1.5	41.1%	1.7	32.6%	1.4
Maternal Smoking During Pregnancy (%), 2014-16[11]	9.4%	11.9%	9.0%	0.8	23.1%	1.9	1.7%	0.1	1.6%	0.1

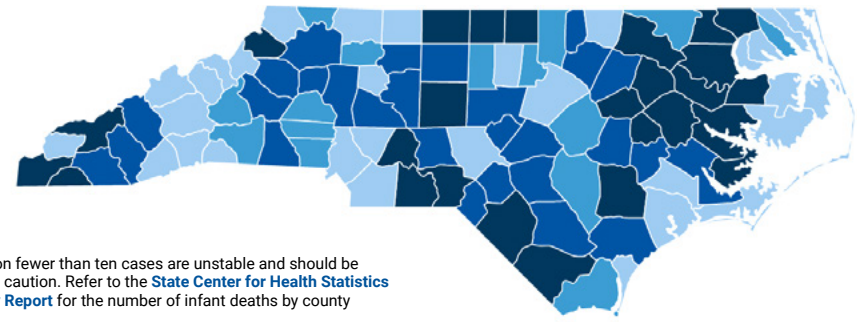
Green indicates a group is faring better than the referent group
Red indicates a group is faring worse than the referent group
White indicates there is no significant difference between the referent and comparison group

Source: NC Department of Health and Human Services, NC Health Equity Report 2018: Racial and Ethnic Health Disparities in North Carolina, available at https://schs.dph.ncdhhs.gov/SCHS/pdf/MinorityHealthReport_Web_2018.pdf

Filter by
Infant Mortality

Resident infant death rates (per 1,000 live births)†

- 0-6.1
- 6.1-7.2
- 7.2-9.1
- More than 9.1

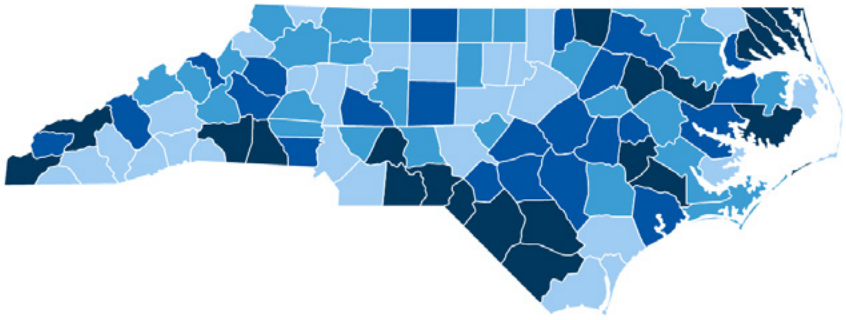


† Rates based on fewer than ten cases are unstable and should be interpreted with caution. Refer to the **State Center for Health Statistics Infant Mortality Report** for the number of infant deaths by county

Filter by
Heart Disease

Age-adjusted rate of heart disease per 100,000 population

- 0-157.3
- 157.3-175
- 175-193.4
- More than 193.4



Source: NC Institute of Medicine, NC County Health Data, available at https://nciom.org/nc-health-data/map/.

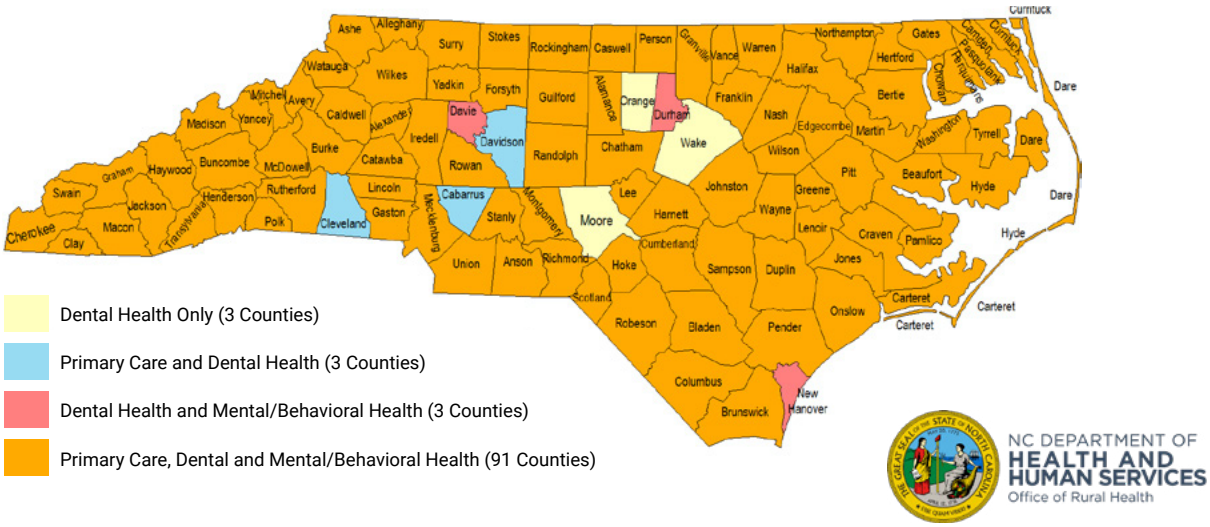
Similarly, rural counties and lower-wealth counties, also experience worse health outcomes—as depicted here in the case of infant mortality rates and heart disease death rates by county.

One contributor to health outcomes in the state is a lack of access to health care services, which can come in several forms. For rural North Carolinians, the closure of rural hospitals has limited the availability of care. At least 11 rural hospitals have closed in North Carolina since 2006, including 7 since 2010. The Sheps Center for Health Services Research at UNC finds that when a rural hospital closes, patients typically travel 5 to 30 miles to access inpatient care. Since rural residents are less likely to have reliable transportation, this can be an even more significant burden than the data implies.[i]

Another challenge has been a lack of health care professionals, a challenge across the state, but particularly in rural areas. North Carolina faces a primary care workforce shortage across the entire state.

As of January 2021, 87 of the state's 100 counties face a shortage of primary, dental, and mental/behavior health providers. In another analysis, the Sheps Health Workforce Center found that only 60% of NC's counties meet the target ratio of 1 primary care provider for every 1500 people. While the number of physicians has been growing over time in the state, it is growing at a faster pace in metropolitan areas compared to non-metropolitan areas. However, when taking nurse practitioners and physician assistants into account, the growth in the workforce looks slightly better.

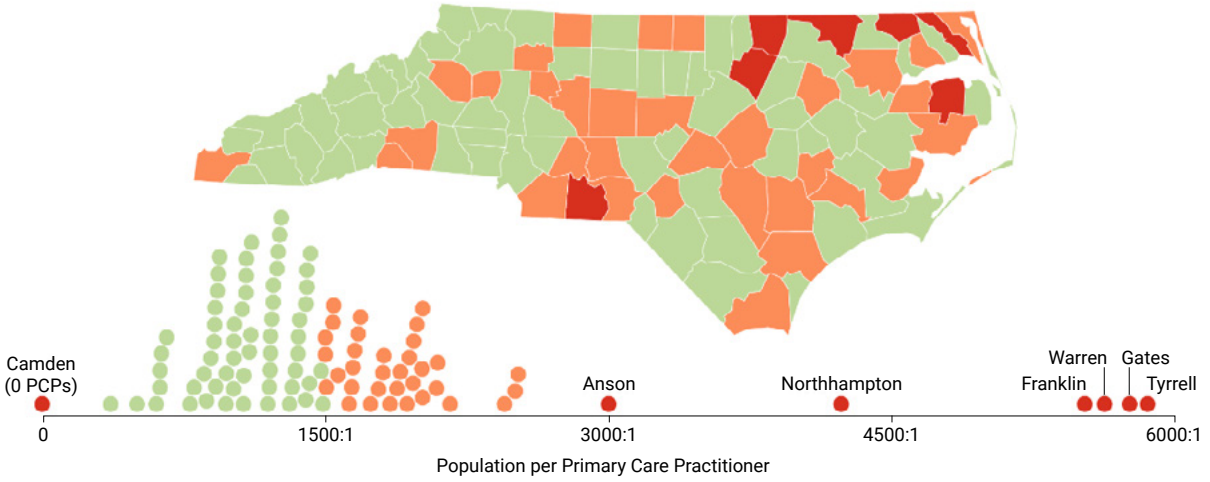
North Carolina Office of Rural Health
Counties Designated Health Professional Shortage Areas



Source: https://www.ncdhhs.gov/media/9374/open (Accessed 1/3/2022)

Data as of March 18, 2022

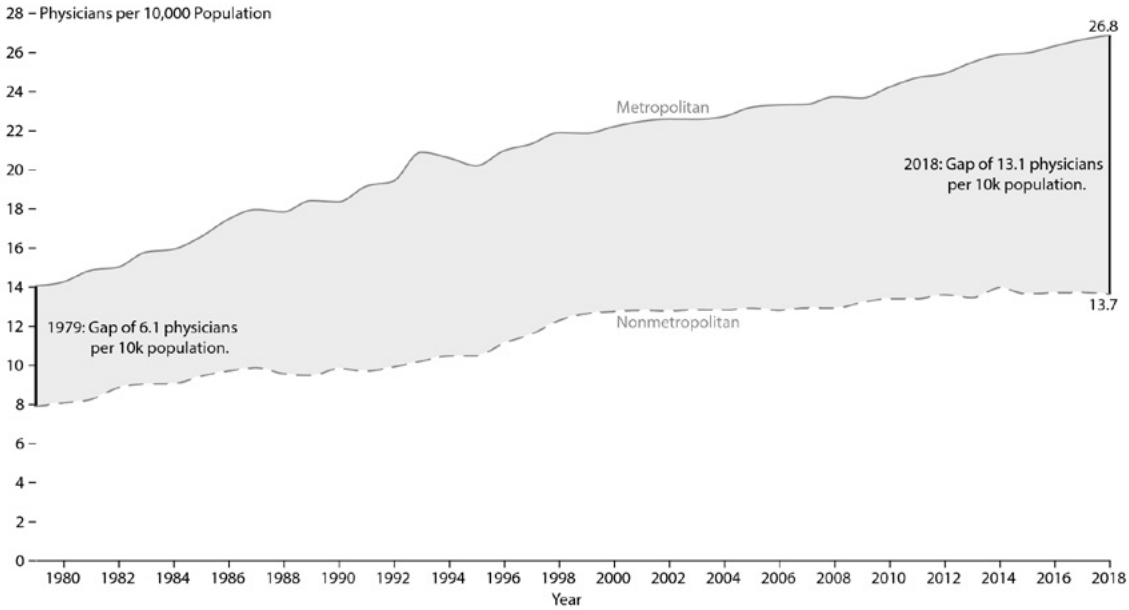
Population per Primary Care Practitioner, North Carolina, 2017



Notes: Updated March 10, 2020 to reflect adjustments to 2017 nurse practitioner data. Primary care physicians, physician assistants, and nurse practitioners are defined as in Spero, J. C., & Galloway, E. M. (2019). Running the Numbers, North Carolina Medical Journal, 80(3), 186-190. Physicians with a primary area of practice of obstetrics/gynecology were weighted as 0.25 of a full-time equivalent (FTE) primary care practitioner. All other primary care physicians were weighted as 1 FTE. Primary care physician assistants, nurse practitioners, and certified nurse midwives were weighted as 0.75 FTE. Physician and physician assistant data are derived from licensure data provided by the North Carolina Medical Board. This analysis only includes physicians who are not residents-in-training and are not employed by the Federal government. Nurse practitioner and certified nurse midwife data is derived from licensure data provided by the North Carolina Board of Nursing. Data include active, licensed practitioners in practice in North Carolina as of October 31, 2017. Practitioners are assigned to counties based on primary practice location. County populations were adjusted for age and gender according to primary care use rates described in data from the Medical Expenditure Panel Survey. The raw (unadjusted) population data was from the NC Office of State Budget and Management.

SHEPS HEALTH WORKFORCE NC

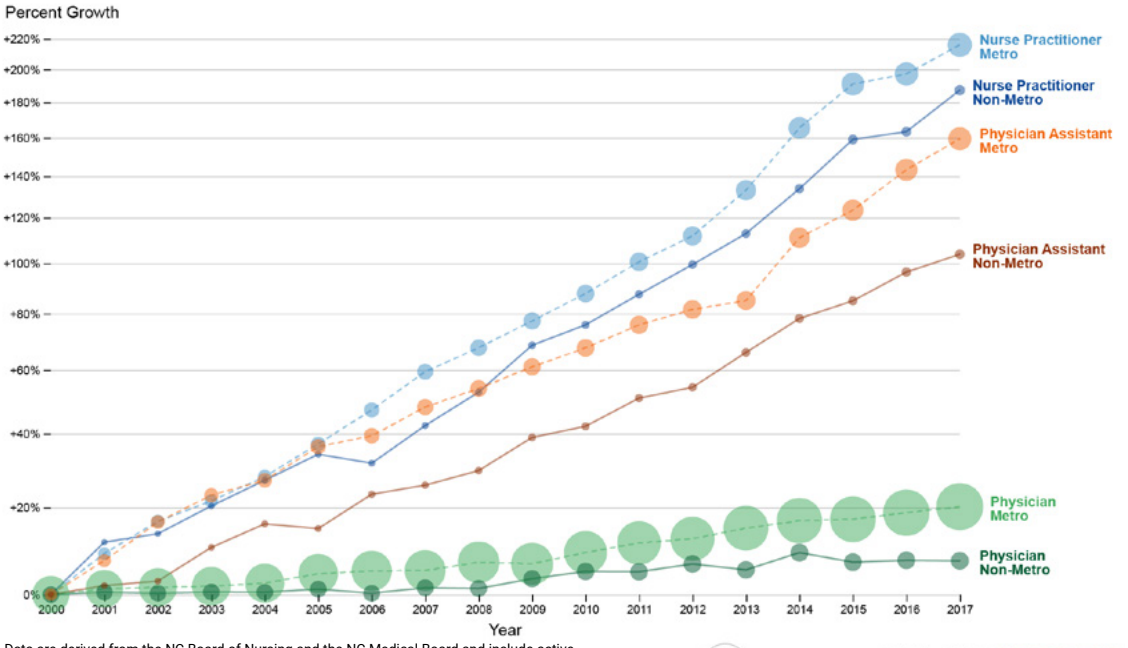
Physicians per 10,000 Population for Metroplitan and Nonmetropolitan Counties, NC, 1979-2018



NOTES: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents in training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board. County estimates are based on primary practice location. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data.

SHEPS HEALTH WORKFORCE NC

Cumulative Rate of Growth per 10,000 Population in Metropolitan and Nonmetropolitan Counties in NC since 2000: Nurse Practitioners, Physician Assistants, and Physicians



Data are derived from the NC Board of Nursing and the NC Medical Board and include active, licensed NPs, PAs, and physicians in North Carolina as of October 31, 2017. Residents-in-training and federally employed physicians were excluded. NC population census data and estimates were downloaded via Log into North Carolina (https://osbm.nc.gov/facts-figures/linc), a data retrieval tool maintained by the NC Office of State Budget and Management. Metro or non-metro county status was defined using 2017 Office of Management and Budget Core Based Statistical Areas (CBSAs). Non-metropolitan counties include micropolitan and non-CBSAs. Using this definition, NC has 54 non-metro counties.

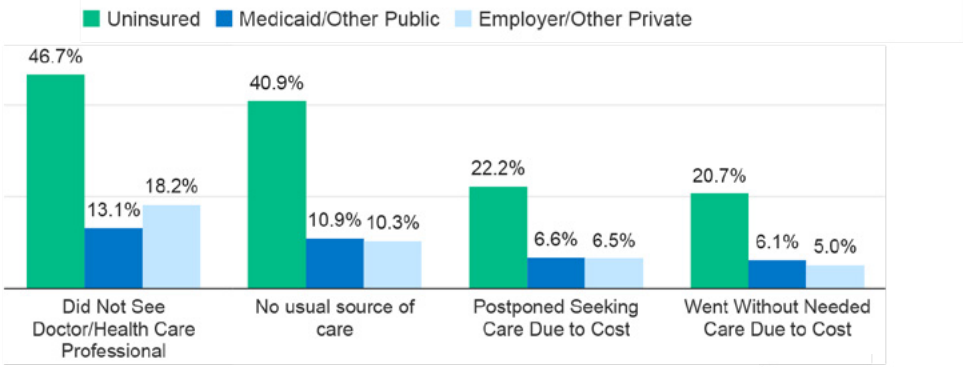
SHEPS HEALTH WORKFORCE NC

Another clear barrier to improved health outcomes is access to health care due to cost. As seen in the Kaiser Family Foundation national data below, cost can be a deterrent for adults to seek care when needed. This deterrent is even more extreme when the adult is uninsured.

According to the Health Care Cost Institute, per person health care spending in North Carolina is about $8,230 per year (including payments from source of coverage plus any out-of-pocket costs, excluding premium payments). However, that cost varies across the state, depending on county, population and age group. Medicare pays a much higher average per person enrolled (about $15,670 per person), while employers and Medicaid pay much less ($6,361 and $5,480 respectively). Urban areas generally also experience lower per person spending than rural counties.

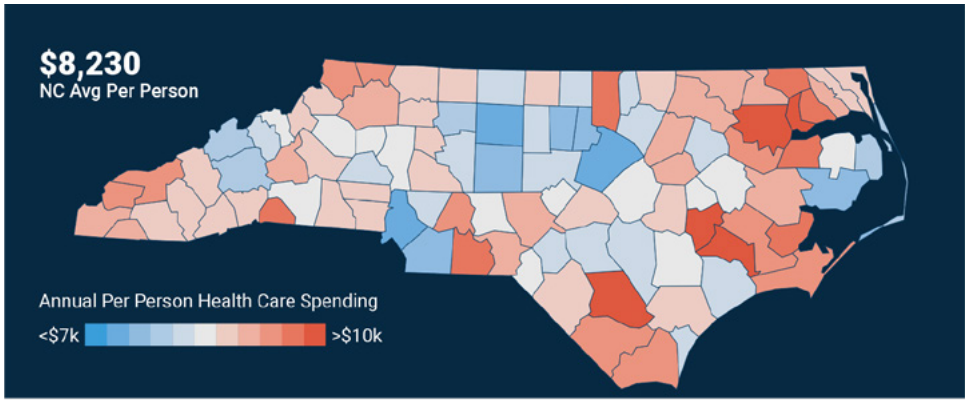
Approximately 1.1 million North Carolina residents, or 11.3% of the population is uninsured. North Carolina's uninsured population makes it 41st in the country—nationally, only 9.2% of the population is uninsured. Historically, African Americans, Native Americans and Latinos in North Carolina have been uninsured at an even higher rate.

Barriers to Health Care among Nonelderly Adults by Insurance Status, 2021



Source: Kaiser Family Foundation, *Key Facts about the Uninsured Population*, available at https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=Nearly%20seven%20in%20ten%20(69.5,in%20outreach%20and%20enrollment%20efforts.

Per-Person Health Care Spending in North Carolina



Source: https://healthcostinstitute.org/hcci-originals/north-carolina-health-care-spending-analysis (more county-level and population-level data available at the site).

Values, Concerns, Actions, Benefits and Downsides

Over the course of their four meetings, members of the NCLF cohort engaged in substantive conversations informed primarily by their own considerable experience, supplemented by background material from NCLF. The goals were to prioritize the critical concerns about health outcomes and policy in North Carolina, to consider a range of possible actions that addressed those concerns, to identify the level of agreement on those actions, and where there was disagreement, to better understand the values and experiences that informed the opposing views.

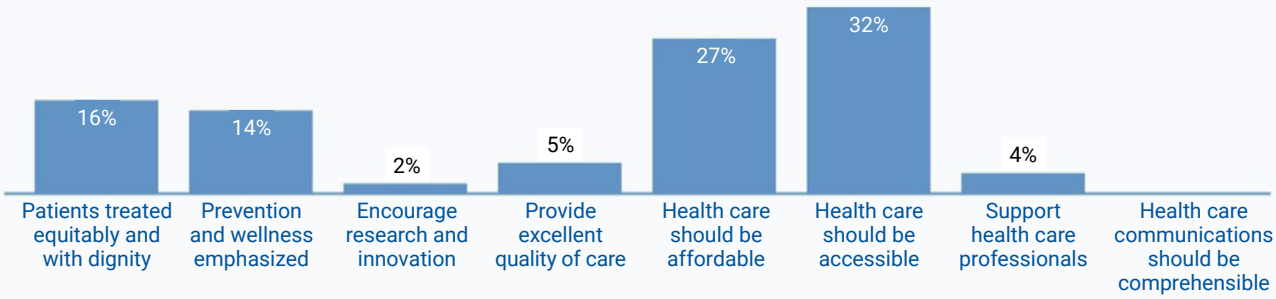
What the Group Values

The forum explored the values participants held as foundational when considering health care and health outcomes. Although not all members held all of these values, members of the group put forth the following list of things they value when it comes to health care in North Carolina:

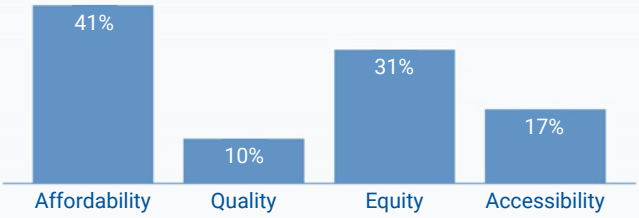
- Patients should be treated with dignity
- Prevention and wellness should be emphasized
- Research and innovation should be supported and used
- There should be a high quality of care
- Health care should be affordable
- Health care should be accessible
- Health professionals should be trained, supported, and utilized well
- Health care communications should be comprehensible and personal

In our second session, NCLF asked the participants to express top priorities from the full list of values developed by the group. We used instant polling to ask forced-choice questions, requiring participants to choose between potentially competing values. This prioritization showed that the group overall prioritized affordability, accessibility, equity, and prevention over other important values, with some tension when forced to choose among those values. Overall, affordability and access dominated values priorities, with equity as an additional strongly held value.

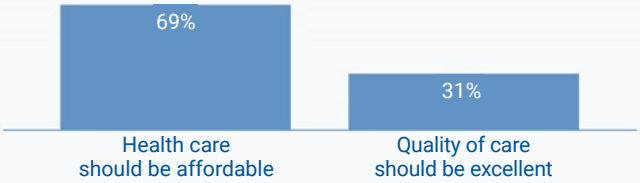
Please select the 2 values clusters you consider the MOST important



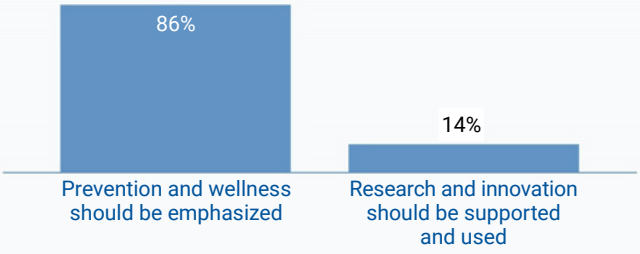
Please choose the MOST important value from the list below (choose one of four)



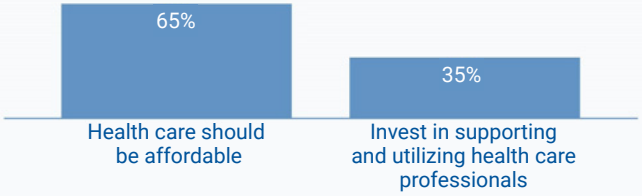
When considering the following two values, which value do you consider most important?



When considering the following two values, which value do you consider most important?



When considering the following two values, which value do you consider most important?



Concerns Overview

The members of the cohort generated an extensive list of concerns related to health care and health outcomes. See Appendix B for a complete list of concerns. Participants ultimately chose to focus on three related and critical concerns. The remainder of this report describes the deliberation of the forum with respect to the possible ways to address these three areas of concern:

1. Affordability: The cost of health care is too high and prevents people from receiving the care they need.
2. Access: North Carolinians need better access to treatment and insurance, particularly specific sub-populations such as rural residents, small business owners and employees, seniors, and low-income people.
3. Social determinants of health: In order to improve health outcomes, policy needs to address social determinants of health such as poverty, quality housing, access to healthy food, access to transportation, and early childhood education.

It is important to note that not all Forum members agreed that each of these concerns should be addressed with policy actions. Rather, among all of the concerns shared, these concerns merited substantial enough attention from a majority of the group to be prioritized for further discussion. In addition, even those who raised particular concerns did not necessarily support pursuing specific actions to address them when faced with the tradeoffs in doing so.

Discussion of Actions to Address Concerns

Participants developed policy options that addressed the three main topics (cost of health care, access to treatment and insurance, and social determinants of health). Participants then selected which policy options they would most like to discuss further and explored the benefits and drawbacks of about five options per concern.

After their discussion, participants were asked to vote on “polarity” charts to determine the level of agreement in the cohort for particular proposals (see discussion below for examples of polarity charts for some options). Participants placed two “votes” on a polarity chart for that option. For the first vote, a participant indicated his or her level of support for the option by placing a sticker above the x axis, on the spectrum of “agree” to “don’t agree,” while also taking into account the intensity of that viewpoint. The second vote shows the extent to which someone can tolerate the downsides of an option and also the intensity of that opinion. Taken in aggregate, these votes provided a visual representation for the level of agreement on particular options.

1. Cost of Health Care is Too High

As NCLF's health care cohort put forward proposals to address the cost of health care, ideas tackled a variety of approaches, looking for ways to reduce the cost of providing health care, reduce what patients pay, or to create incentives for providers to keep patients healthy at a reduced cost. Of note, in health care, "cost," "price," and "charge" are not synonymous, and each has different meanings. For example, a hospital will view the cost of a procedure as the sum of direct and indirect expenses to provide the operation, the patient sees costs as what they owe out-of-pocket to have the process completed, and the health insurer will define costs as what the amount payable to the provider. Therefore, when attempting to reduce care costs, it is helpful to consider what kinds of costs an action aims to address and from what perspective.

In this context, the group considered five key proposals:

1) **Cap prescription drug costs**;
2) **Increase price transparency** for patients;
3) Allow health insurers to **capitate payments**;
4) Align incentives for **value-based care**; and
5) **Loosen scope of practice limits** for providers in North Carolina to address workforce shortages and lower the cost of patient care.

Overall, the cohort expressed strong support for making the capitation model more widely available and for requiring price transparency from providers and insurers. The group showed some support for value-based care, and held strong differences of opinion regarding caps on prescription prices and scope-of-practice reform for health care professionals.

Health Care Costs Too High

Areas of Broad Agreement:

- The NC Department of Insurance should require all health insurers to allow providers to opt for a capitation model (per patient per month payment), rather than traditional billing for primary care.
- Providers and insurers should be required to offer price transparency, so that consumers can shop for the lowest-cost care.

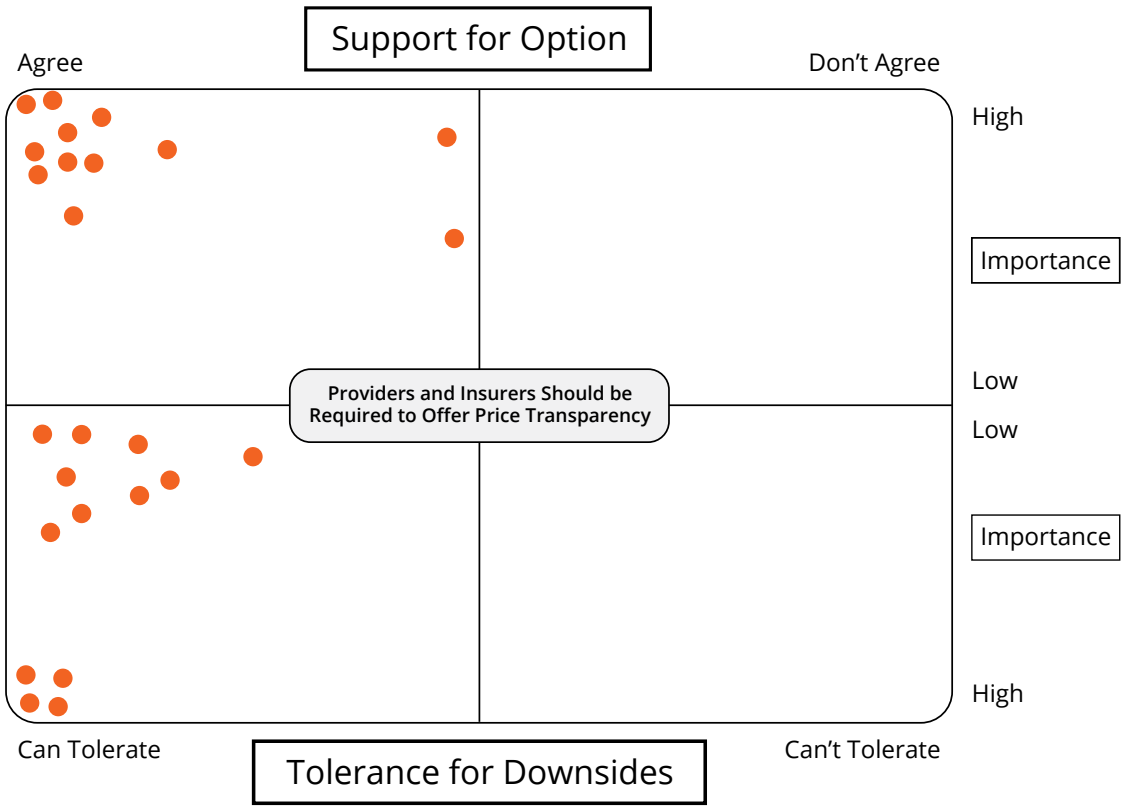
Areas of Moderate Agreement:

- The legislature should cap the monthly price of medications that treat chronic conditions.
- We should align incentives to reimburse for health outcomes instead of paying per treatment/test ("Value-Based Care")

Varying Degrees of Support:

- The NC Legislature should enact scope-of-practice reform to allow healthcare professionals, particularly nurse practitioners, nurses, and physicians' assistants to practice at the top of their licenses.

Price Transparency



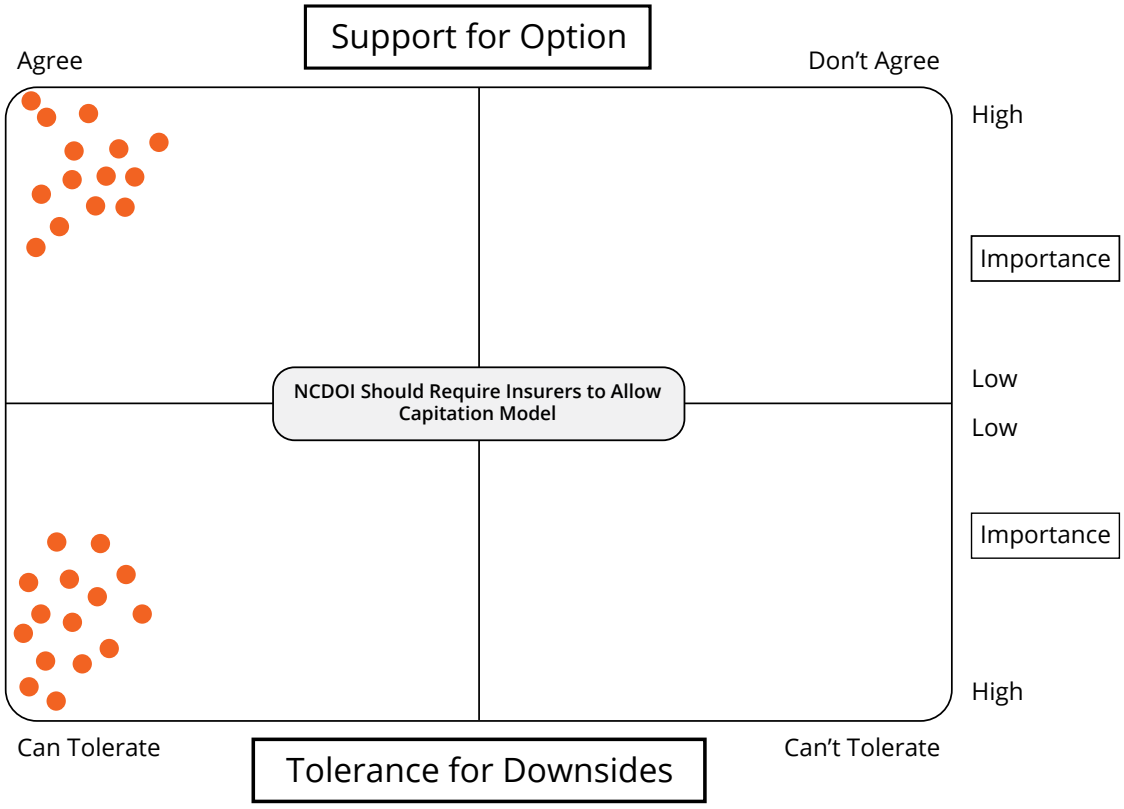
Providers and insurers should be required to offer price transparency, so that consumers can shop for the lowest-cost care.

Nearly all participants supported requiring providers to offer price transparency so that consumers could shop for the lowest-cost care. They noted that such transparency is generally helpful and leads to more informed decisions, would curb surprise billing, and would allow patients to make informed choices. Participants also believed payers would have better leverage if pricing were clear and that disclosure of pricing would increase competition and lead to reduced prices. One key concern that did emerge is that it is complex for providers to capture prices clearly given the layering of services and overhead, requiring extra personnel (and therefore administrative overhead) to manage pricing data. There was also some concern that transparency would affect quality or force providers to set floors and ceilings around pricing rather than offer variation that is appropriate for different patients. Regardless of these concerns, the group largely favored increased requirements around price transparency in health care.

The polarity chart above regarding requiring providers and insurers to offer price transparency is illustrative of different views in the group on the proposed action. The chart shows that most participants strongly supported the idea, with two participants staying neutral or in the middle, and others clustering in the top left corner (strongly agree and see it as very important). On the lower half of the chart, participants largely could tolerate the downsides of the proposal, but spread towards the middle/neutral, and did not see downsides as very important. In both cases, voting towards the middle could indicate

indifference or that the participant is unsure or neutral. It should also be noted that not all participants voted on the proposal. This again could be because the participant was unsure of their position, or it could represent that some participants were unable to be present during that portion of a meeting. Throughout the discussion below, different actions resulted in different distributions, with some examples of broad agreement, some polarization showing strong disagreement, and some mixed reactions.

Capitation



The NC Department of insurance should require all health insurers to allow providers to opt for a capitation model (per patient per month payment) rather than traditional billing for primary care.

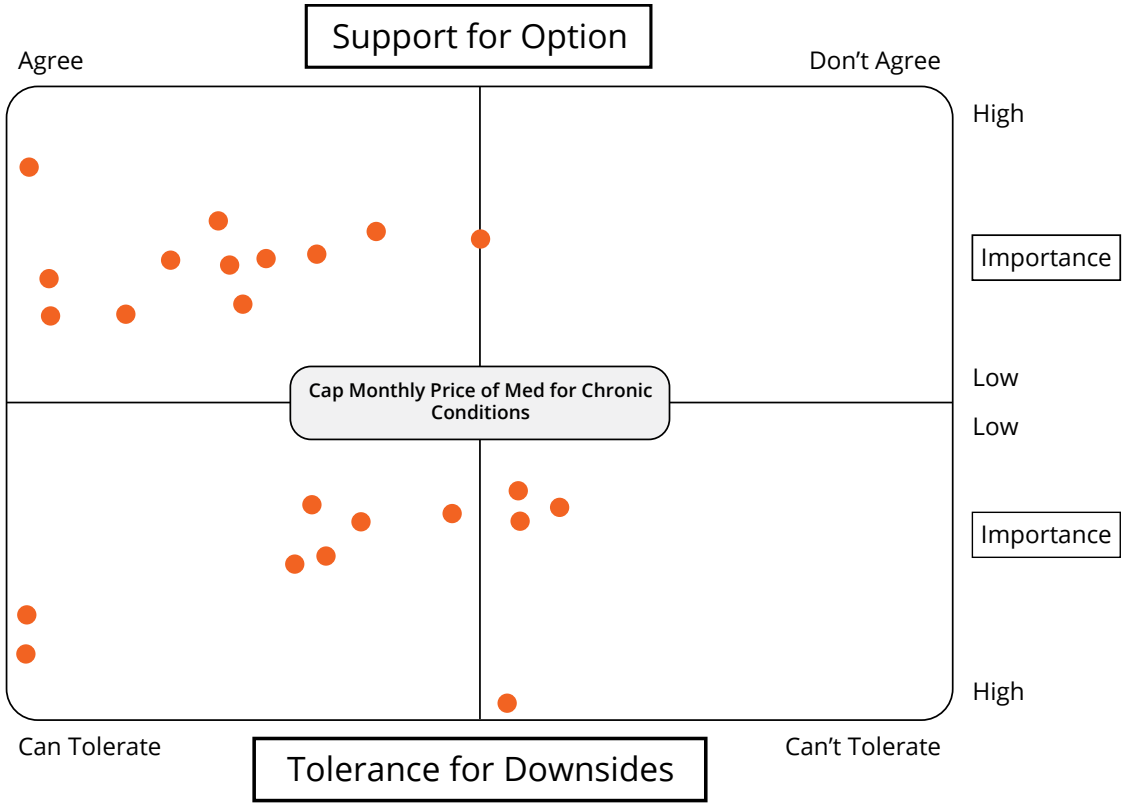
Capitated payments, are where providers receive a fixed amount per patient over a set period and are then responsible for providing defined medical services for those patients, as opposed to the traditional fee-for-service model of payment. Specifically, the NCLF cohort discussed capitation payments for Direct Primary Care. Under the proposal, insurers would be required to offer an option where patients have the option to pay a primary care provider a flat monthly rate, instead of fee for service. Providers can keep any money that does not go towards patient care. In such a model, payments are capitated to a monthly rate for primary care, with no effect on other health care services.

Overall, the cohort favored requiring health insurers to allow patients and providers to opt for a capitation model. Numerous participants shared real-life examples of how the capitation model worked in their own health care service area. Amongst the benefits shared, participants noted that the capitation model reduces overhead and administrative costs for health care providers and subsequently allows providers to spend more time with each patient.

They saw these saved costs and increased time as enabling more predictability and stability for both provider and patient, as well as a higher quality of service. They also thought this model enabled provider and patient to spend more time on preventative care rather than addressing more costly needs if someone misses preventative care and becomes sicker.

However, even while favoring the idea, participants still identified some downsides of the capitation model. First and foremost, they noted that the approach could create an incentive for physicians to avoid treating the sickest patients or to offer fewer services. They were also concerned about whether smaller providers could afford to operate in a capitation model, thinking that the model could favor larger providers that can spread risk amongst a larger pool of patients. Finally, they noted that while the model had appeal, it was hard to scale given our current health care system.

Capping Medication Prices

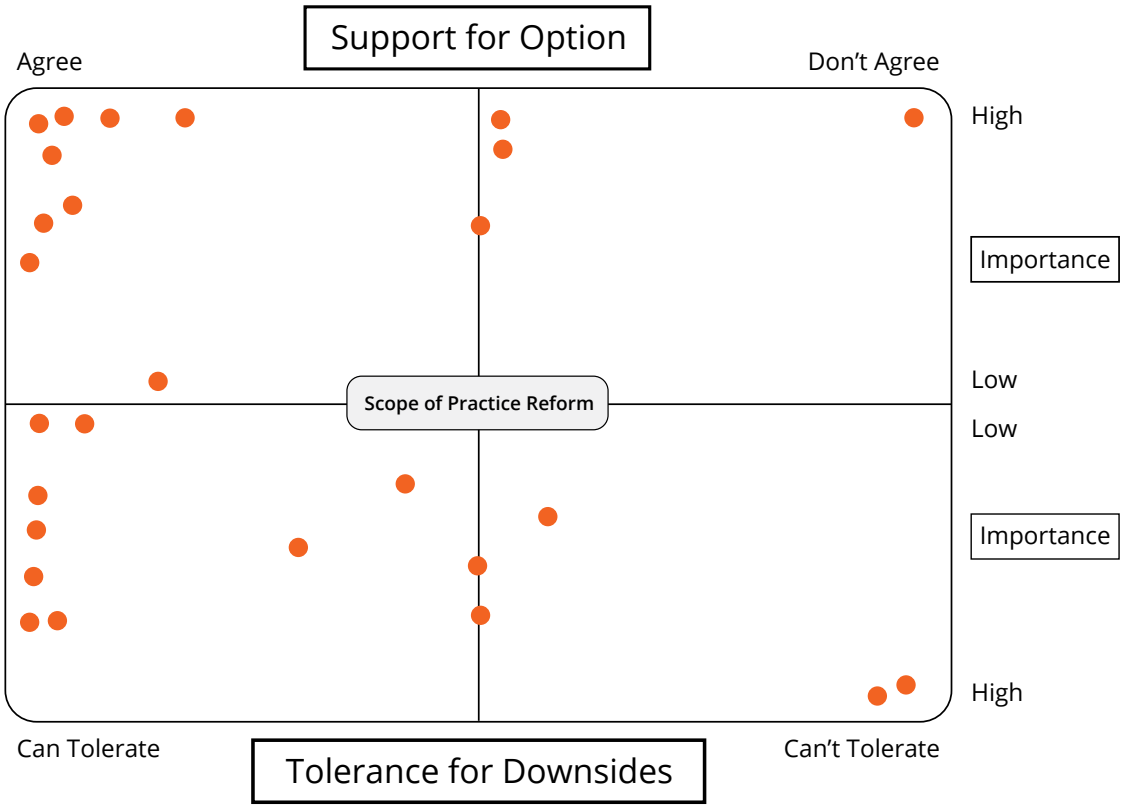


The legislature should cap the monthly price of medications that treat chronic conditions.

Participants noted that prescription drugs are one of the fastest growing expenses in health care and that more was needed to address this important area of concern. While there was some support for capping the monthly price of medications for patients with chronic conditions, many participants ranked the proposal in the middle in terms of importance and support, similarly falling in the middle in terms of concern about the downsides of the proposal. People who favored the idea raised the benefits of capping medication prices would reduce patients' out of pocket costs, take families out of the position of choosing between medicine and other life essentials, and improve health outcomes, especially of those over 65. On the other hand, many participants

were unclear whether a state has authority to act in this area, and thought that any action by North Carolina would have limited impact. Some also raised downsides that capping prices could lead to cost-shifting and potentially reduce the incentives for drug companies to do research and bring medicines to market, especially life-saving medicines that are also costly.

Scope of Practice Reform



Scope of Practice Reform: Legislature should enact scope-of-practice reform to allow health care professionals, particularly nurse practitioners, nurses, and physicians' assistants, to practice at the top of their licenses.

One of the cohort's most divided conversations was on the topic of Scope of Practice reform. A health care provider's scope of practice (SOP) is the services their license allows them to provide. While providers take generally national exams for licensure and also become certified for specialized practice areas, states individually determine SOPs. For example, Nurse Practitioners (NPs) must have a graduate degree in nursing and hold national certification, but North Carolina state law determines what services they can provide. In North Carolina, Nurse Practitioners and Physician Assistants (PAs) are required to have physician supervision, a signed agreement with a primary supervising physician that is reviewed and signed annually, and documented meetings with that physician every 6 months. NPs and PAs have prescription authority, including controlled substance refills, but their prescription authority is more limited than that of Physicians. This limitation is often phrased as "not allowing NPs and PAs to practice at the top of their license," meaning state law does not permit them to offer medical care in accordance with their full training or certification. Limiting a provider's SOP is intended to protect a patient's health

and safety, but the limitation can impact access to care and limit treatment options. For example, the requirement for physician supervision can restrict NPs' and PAs' ability to practice in medically underserved areas.

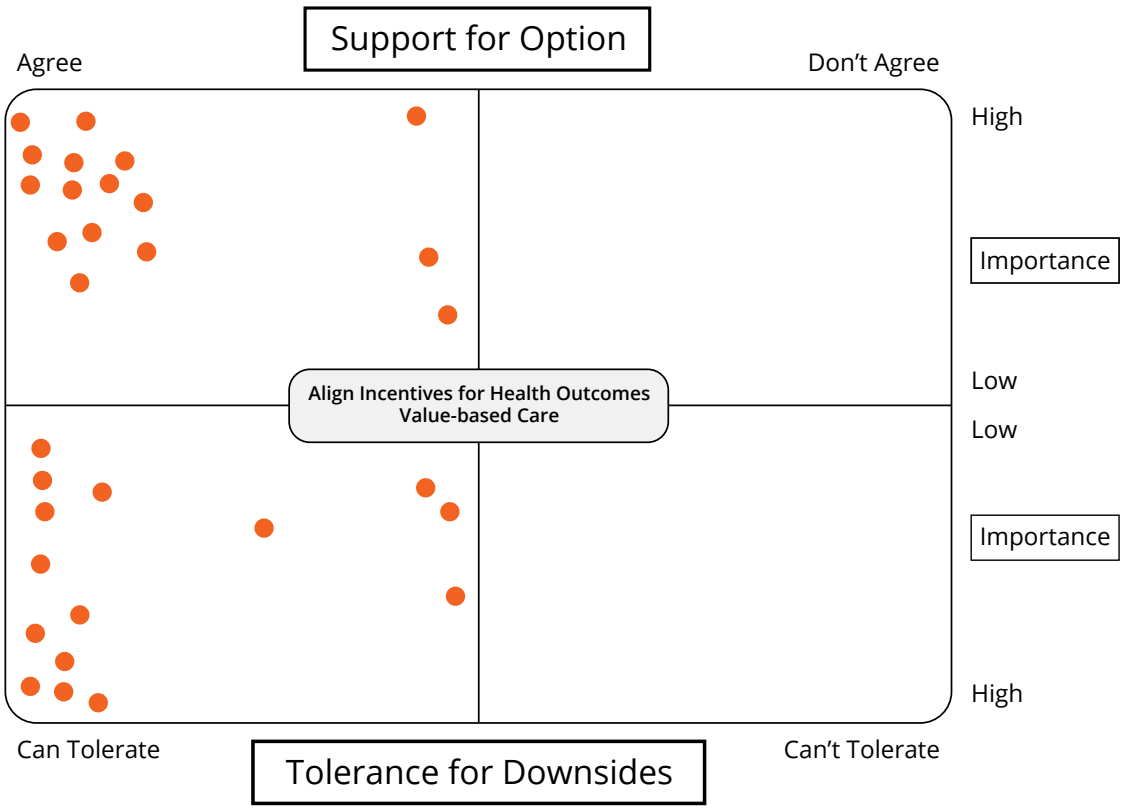
In general, those in favor of scope of practice reform were strongly in favor of expanding the scope, while many others in the group were neutral or in the middle on the topic. However, a handful of participants were strongly opposed. It is noteworthy that the scope of practice discussion was highly personal nature—in many cases, the participants' position was rooted in personal experience serving patients or working in the health care field. It took patience and care to have a constructive discussion of the tradeoffs of this policy proposal and to listen to opposing views given the personal connection to the subject matter.

Those who favored scope of practice reform argued that current requirements are onerous and poorly administered—a physician might contract with nurse practitioners to provide oversight remotely, but the nurse practitioners in fact were successfully providing care without participation from doctors. At its extreme, participants cited examples of "sham supervision" and how the current oversight requirements increase the cost of care. Proponents also argued that in some cases, such as maternal care, these practitioners had better outcomes. Participants thought that lifting the requirements and allowing NPs and PAs to practice at the top of their license would boost morale and expand the available health care workforce. They also pointed out that allowing NPs and PAs to practice at the top of their license would free up doctors to focus on cases that require their skills. Taken together, they argued that scope of practice reform would result in lower-cost, high quality health care service to patients in need of care.

When participants talked through the downsides of the proposal, they identified the potential for abuse as a significant concern, for example if a nurse practitioner or physicians' assistant exceeded their scope of practice beyond their capacity. They saw the current system as prioritizing collaboration between doctors and practitioners, and some risk of endangering patients without such collaboration if reform were enacted. Participants with this view noted that expansion could also raise the costs for NPs and PAs to practice in the form of increased liability and insurance needs, costs which would in turn be passed onto the patient. They also expressed concern that allowing NPs and PAs to practice at a broader scope would result in a two-tiered system in which only the wealthy had access to doctors and the poor had access to practitioners and in some cases, a lower quality of care. Finally, there was some concern that a downside would be reducing incentives to become a doctor, further tilting a workforce away from trained doctors that are needed in the community.

Value Based Care

Participants also had a brief discussion of value-based care, but focused more heavily on other proposals. Some participants saw some of the benefits of moving to value-based care as forcing the health care system to be more aware of outcomes and increasing the quality of care. They also thought the approach would encourage centers of excellence and improve results while reducing the cost of care. At the same time, some participants were concerned



Value-based care: We should align incentives to reimburse for health outcomes instead of paying per treatment/test.

about the downsides, such as risks that a value-based system would cherry pick healthy patients and avoid complex cases. There was also a concern that value-based care disadvantages smaller providers who don't have the scale and smaller hospitals. Finally, some participants were unsure whether it was possible to implement value-based care and thought it was difficult to accurately measure quality in this context.

2. Access to Treatment and Insurance

Participants in the cohort highlighted numerous concerns about how North Carolinians access health insurance and how a lack of insurance or limited insurance options makes it harder for residents to get either preventative care or care when they are sick. Proposed solutions responded to different aspects of the problem of access. Some focused on how expensive it can be for small businesses to offer health insurance to employees. A prominent concern was the challenges of rural health care—the limited work force available to provide care in rural areas, the lack of transportation to care providers, and in some cases, how insurers' coverage requires customers to drive further for affordable care. Finally, the group also discussed the barriers to healthcare access faced by low-income North Carolinians, including lack of insurance coverage. Of note, during the discussion of access to health insurance, participants watched videos of several small business owners and how they handled health insurance for their employees as well as the stories of two individuals who did not have health insurance and could not afford treatment as a result.

Access to Treatment and Insurance

Areas of Broad Agreement:

- Expand telehealth through Partnerships with rural libraries, schools, town halls, and provide necessary staff.
- Incentivize doctors and primary care workforce infrastructure to locate in underserved areas by paying off education loans, tuition-free solutions, and recruitment of people who are from the targeted areas.

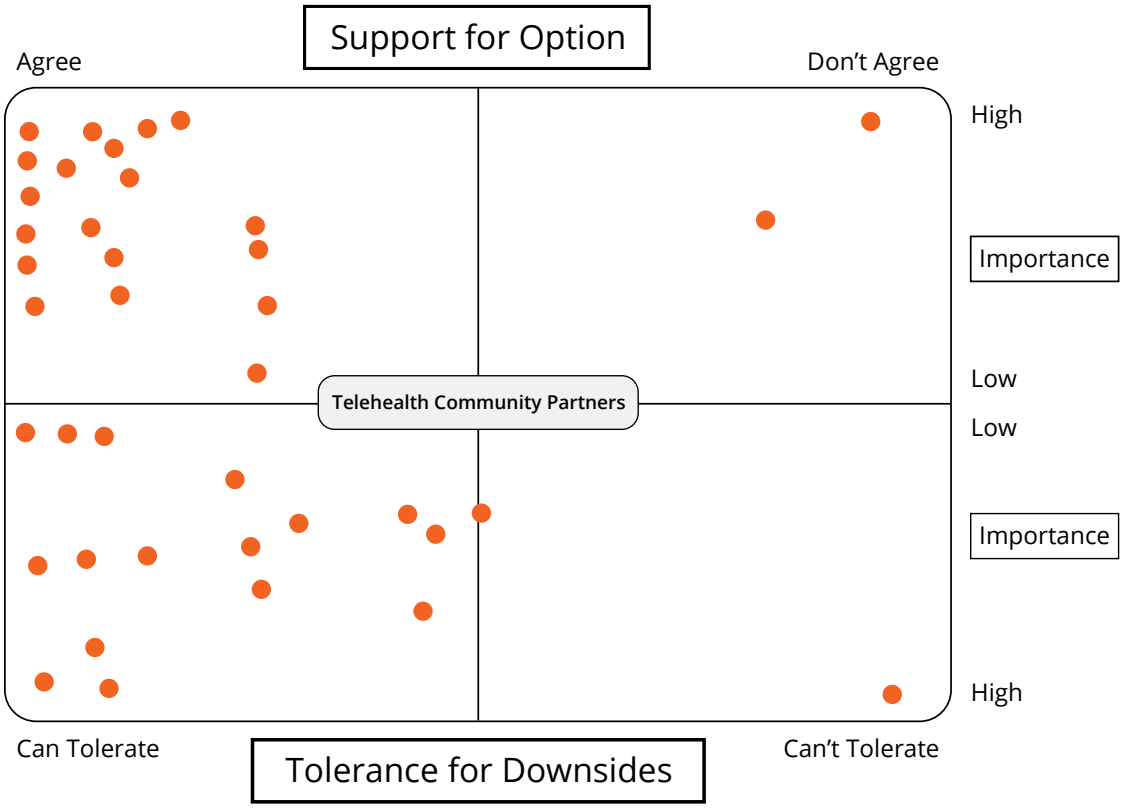
Varying Degrees of Support:

- Expand telehealth through parity in telehealth reimbursement
- Reform Certificate of Need Rules
- Expand Medicaid to cover all people with household incomes below 133% of federal poverty level

Area of Least Agreement:

- Increase number of FQHC sites to utilize them to provide primary care to small businesses and their employees.

Telehealth

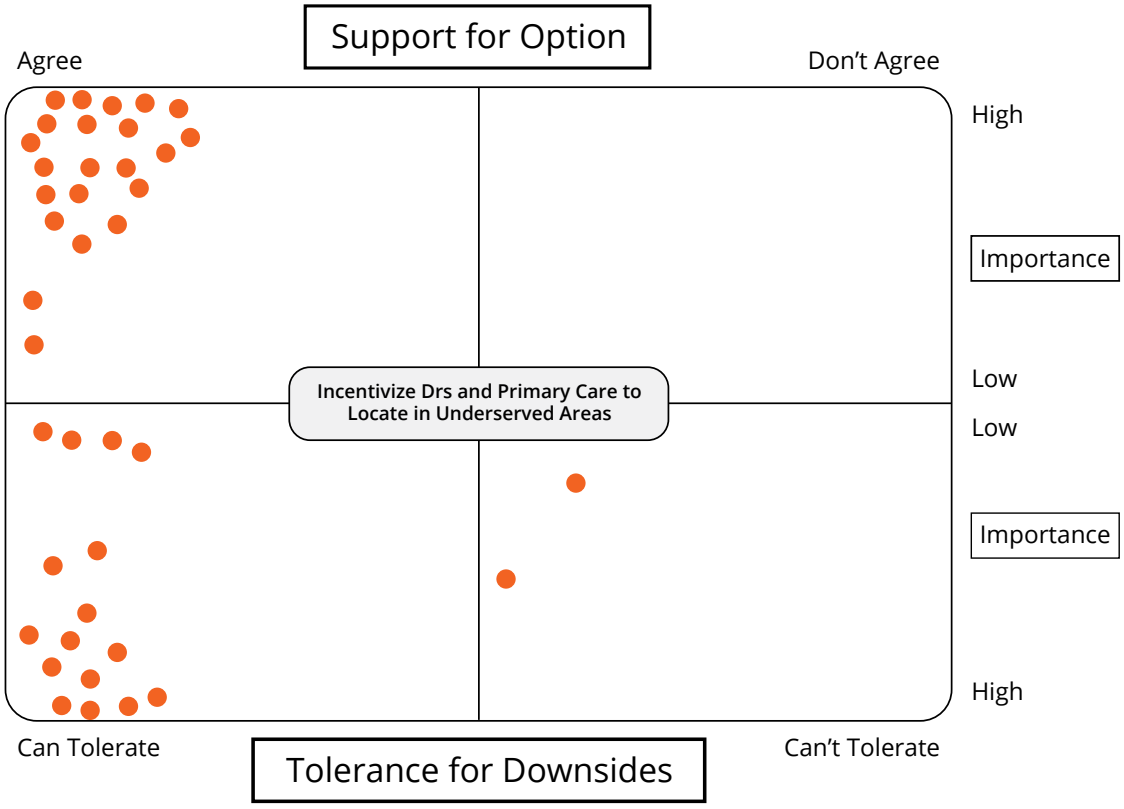


Expand telehealth through partnerships with rural libraries, schools, town halls, and provide necessary staff.

With regard to telehealth, the group noted that such services could drive down the costs of care, help with addressing transportation issues, save costs for patients, and were particularly useful for checking in on chronic illnesses and increasing preventative care for underserved populations. There was particular interest in partnerships with schools and other community hubs where issues of privacy, security, and space could be addressed. People saw some advantage to these partnerships where a telehealth option could be hosted by other related or specialized services (i.e., a school nurse or a social worker), if concerns about resources could be addressed. The group also spent some time talking about reimbursement rates for telehealth. During COVID-19, insurers had offered parity in telehealth reimbursement compared to in-person care. The group generally favored parity, but was not universally in support for a variety of reasons, including the perceived downsides of increased use of telehealth and a perception that the cost of telehealth services may be lower, requiring lower reimbursement, compared to in-person care. Downsides included the limitations of telehealth services, pressure on providers to go beyond the appropriate scope of an online visit, and a risk that providers would push people to telehealth who would be better served in person.

Workforce

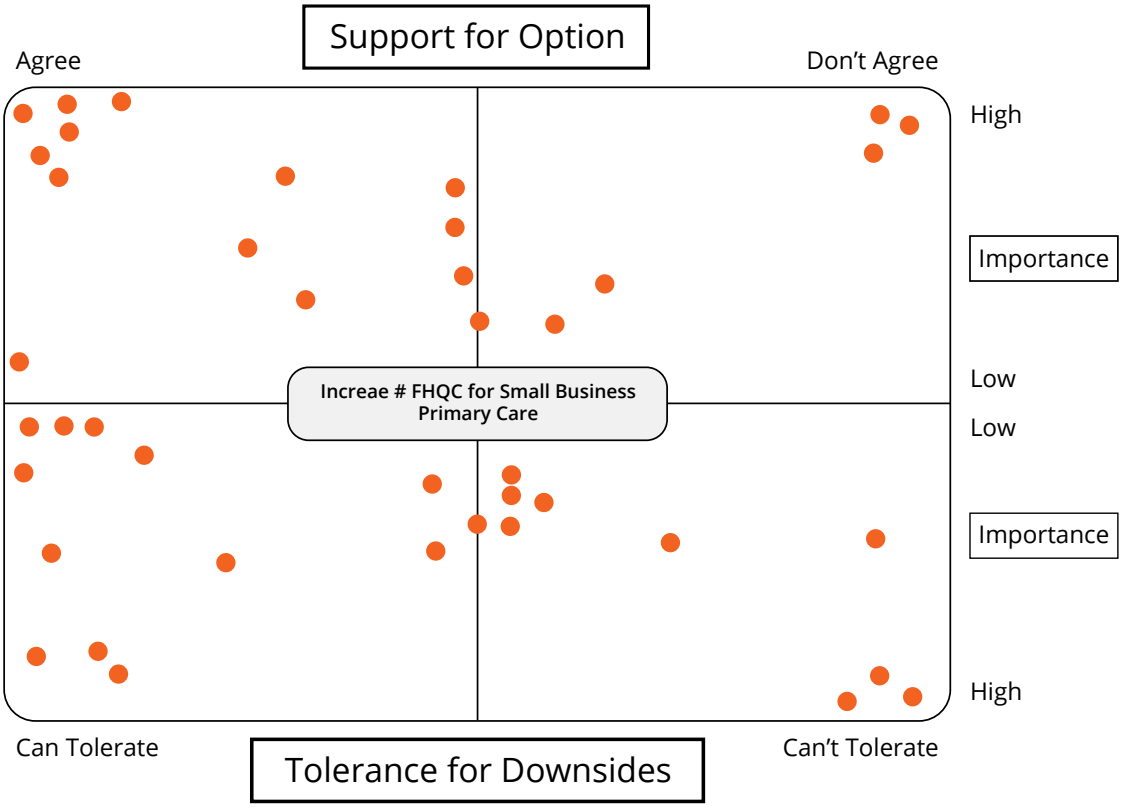
Most participants were also strongly in favor of incentives that would encourage health care professionals to locate in underserved areas. They emphasized that increasing the availability of providers led to better health outcomes, increases the quality of care, and reduces the cost of health care for patients. Participants also noted that local practices enhance economic development in rural areas



Incentivize doctors and primary care workforce infrastructure to locate in underserved areas by paying off education loans, tuition-free solutions, and recruitment of people who are from the targeted areas.

by creating higher income jobs. While most participants agreed that financial incentives such as loan repayment can attract providers to undeserved areas, they also expressed a downside that loan repayment has a high cost and could result in providers coming for a short-term and then leaving the area once their loan is repaid. Some participants with experience in this area noted that if you can increase access to training programs and make them affordable for local residents, they are more likely to stay in the area and serve their own community for the long haul. Finally, some participants also spoke to broader issues, including the need to improve infrastructure, local schools, and opportunities for spouses, to enable underserved areas to attract health care professionals and/or faculty for training staff who are considering bringing their families. This challenge is especially acute in attracting professionals of color, who may be wary of moving to an unwelcoming environment.

Small Businesses



Increase number of FQHC sites to utilize them to provide primary care to small businesses and their employees.

With regard to small businesses, the group explored whether Federally Qualified Health Centers (FQHCs) could be expanded to provide primary care to small businesses and their employees. FQHCs are community-based health care providers that receive federal funds to provide primary care services in underserved areas. To be classified as an FQHC, providers must meet a stringent set of requirements, including using a sliding scale fee schedule to ensure anyone can receive care regardless of ability to pay.[ii] As of 2017, there were 41 FQHCs with 2116 service sites in North Carolina that serve over 500,000 patients.[iii]

FQHCs can have multiple locations and typically serve at-risk and underserved populations, including the uninsured and those with low incomes. FQHCs do not only serve uninsured and underinsured patients or those on Medicaid and Medicare; they also accept patients with employer-sponsored private insurance.[iv] Nationally, privately insured patients made up 19% of FQHC patients, with rural FQHCs seeing 28% of patients with private insurance. For example, in North Carolina in 2020, Community Health Centers, including FQHCs, served 173,184 privately insured patients.[v]

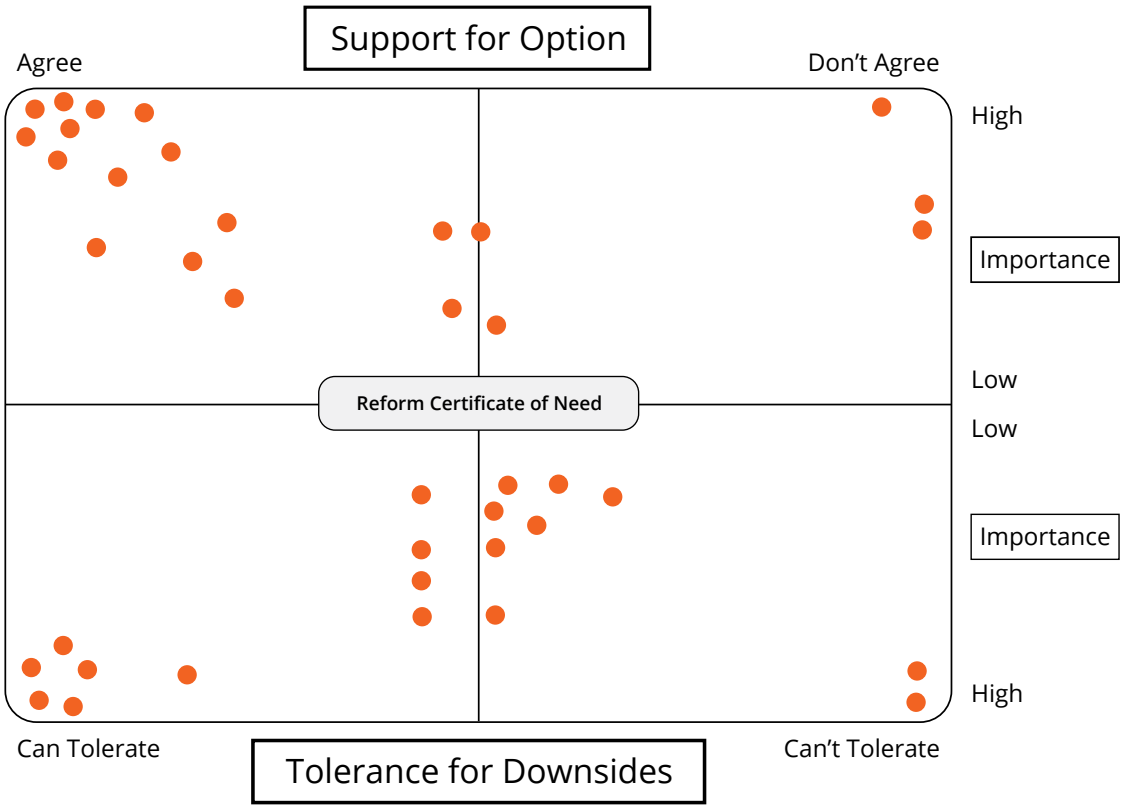
Participants supporting this proposal asserted that FQHCs play a critical role in North Carolina's health care system, and small businesses play a crucial role in the state's economy. Offering health insurance as a small business is expensive, and searching for ways to reduce the costs of care for employees makes sense. While FQHCs offer discounted care to some patients and are potentially closer to small businesses in rural and underserved areas than are traditional health care providers, FQHCs are designed to serve those without insurance or financial means to pay for their care. Small business employees with health insurance would be unlikely to receive discounted care at an FQHC.

Those participants who favored this proposal thought this idea would increase access to health care at a low cost to businesses, would offer health care where there are limited facilities, and could also increase access to affordable medication. They also thought the mix of patients and providers would lead to a better clinic environment compared to the current FQHC. On the other hand, some participants saw numerous practical problems that prevented their support. They thought that current federal regulation and practices around FQHCs made them ill-suited to serve businesses and a different population than originally intended. They also saw the additional regulation or oversight that would be needed to protect against abuse and measure performance as a downside. Finally, they noted that there are a limited number of FQHCs to fill the proposed role.

Certificate of Need

In order to provide government oversight of health care costs by limiting the "unnecessary duplication of medical facilities,"[vi] North Carolina requires that "no person shall offer or develop a new institutional health service without first obtaining a certificate of need."[vii] Examples of "new institutional health services include" hospitals, nursing homes and adult care facilities, rehab facilities, diagnostic centers, etc. NC has one of the strictest CON programs in the United States.[viii]

Participants in our cohort were fairly evenly divided over further changes to Certificate of Need rules. Those in favor of eliminating Certificate of Need rules believed that like other businesses, medical providers should be free to invest where they wanted to, that competition would create incentives for providers to better serve patients, and that lower barriers to entry would entice entities to put facilities in areas where access to medical services are needed. They also thought increasing the number of providers would reduce patients costs and decrease the reliance of patients on hospitals, which are often more expensive. Finally, those in support of changing Certificate of Need rules highlighted the drawn out and expensive litigation that delays the approval of new medical providers' applications, even if they were likely to be approved. They saw this delay and government process as needless and costly, with underserved patients typically bearing the long-term cost.

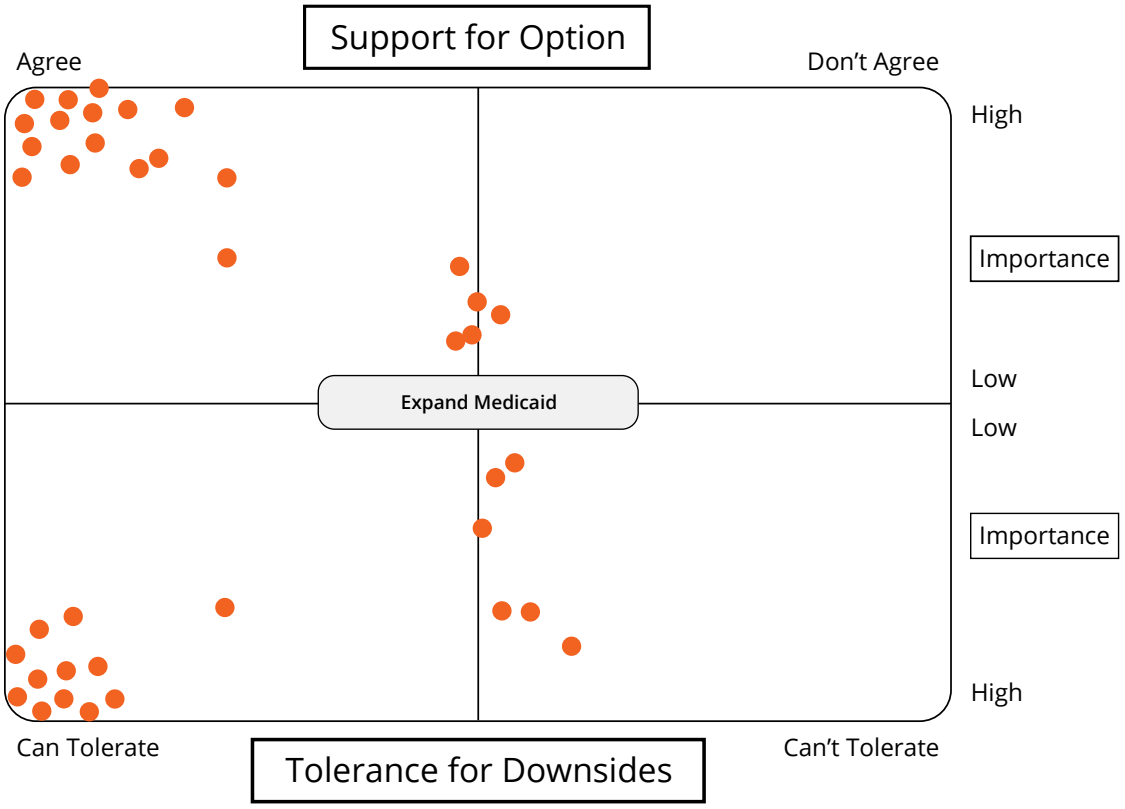


Reform Certificate of Need rules.

On the other hand, those opposed to reform believed that the Certificate of Need process protects a higher quality of care and argued that "health care is not a free market," but is instead government-controlled to ensure competitors do not undermine the quality of care offered by existing providers. Further, they pointed out that allowing new providers to enter the market without a government-controlled process could undermine already fragile hospitals, particularly in rural areas, by attracting healthier and/or wealthier patients with the ability to pay for services. Finally, those opposed were concerned that removing Certificate of Need requirements would not actually result in new facilities where they are most needed, but instead would lead to increased concentration of medical providers in urban areas.

Medicaid Expansion

During discussions of Medicaid Expansion, participants did not split evenly into strongly in favor and strongly opposed. Instead, one subgroup of participants clustered strongly in favor of expansion and the other hovered around the middle, largely neutral or ambivalent about expansion. Those who strongly favored expansion argued that the policy would boost preventative care and early diagnosis of disease, increase care generally for low-income people, improve health outcomes, and stabilize rural hospitals. They also saw collateral economic benefits, from reducing medical debt to boosting small businesses that could not currently insure their workers. Another benefit is that increased coverage would reduce disparities in health care services for rural residents, people of color, and low-wage workers.



Expand Medicaid (to cover all people with household incomes below 133% of federal poverty level).

On the other hand, one key downside raised by the group was a concern that current medical providers who serve Medicaid patients do not have the capacity to handle the new patients that would be covered by Medicaid expansion. Some also expressed a downside of the Medicaid system generally, stating that it is costly to operate Medicaid and that people stay on Medicaid for too long, arguing that there should be more incentives for people to move off of the program. Another perceived downside was that people may not take advantage of the insurance even if it were available. Finally, those not supporting Medicaid expansion expressed a downside that existing federal funds may not always be available to support expanded Medicaid, putting extra pressure on the state's General Fund in the future.

Social Determinants of Health

Areas of Broad Agreement:

- Encourage eating healthy food (via extra money for fresh produce; allowing SNAP to be used for prepared foods; or by redefining SNAP rules to disallow junk food);

Varying Degrees of Support:

- Universal access to quality early childhood education;
- Increase transportation in rural areas to health providers, such as through a public schedule, ride-shares, or vouchers for private services;
- Putting FQHC's in schools and offering health-related education and coaching;

Areas of Least Agreement:

- Inclusionary zoning in housing.

3. Social Determinants of Health

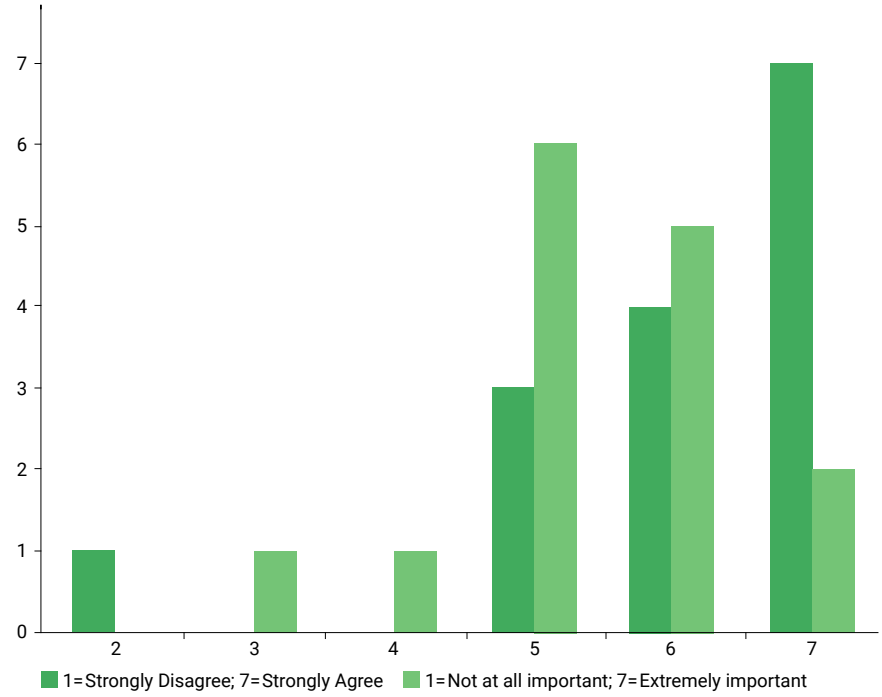
Participants in the health care cohort raised several social determinants of health as areas where policy could improve aspects of daily living in order to prevent illness in the first place, reducing demands on our health care system. While the group couldn't tackle the full scope of these social issues, the group spent time on five proposals.

Healthy Foods

The cohort was very interested in promoting wellness through increased access to healthy foods and explored several ideas on this topic, including providing extra money for fresh produce (i.e., via Super SNAP), allowing SNAP to be used for prepared foods that meet nutritional standards, and by redefining SNAP rules to disallow junk food. While there was significant enthusiasm in the group for the principle of encouraging healthy food, some participants expressed the challenges of implementation and tensions arose over telling people what to eat. In general, participants thought that extra funds would increase the availability of healthy options and encourage healthier eating habits. Supporting ways for people to access healthy prepared foods was seen by many participants as a benefit and as an effective approach. Downsides included that the government should not tell people what to eat or drink and that if a program tried to do so, it could backfire as people rebelled against being told what to do. Other downsides expressed was the potential burden on asking retailers to implement programs that have complex definitional issues—what is a healthy food, what counts and what does not, and that funding might not be sustainable enough to produce long-term outcomes. Most participants opposed disallowing junk food noting that this approach is too paternalistic and that in some cases, junk food is more readily available and cheaper than healthy options. As an alternative, some participants were able to highlight community-based efforts that are promoting healthy food locally and emphasized engaging communities in improving access to healthy foods as an effective approach.

While participants strongly favored proposals to increase access to healthy foods, there were differences in implementation that also can be seen in the following votes on the proposals.

North Carolina should encourage eating healthy food by providing extra money forfresh prɒduce (via permanent SuperSNAP program)



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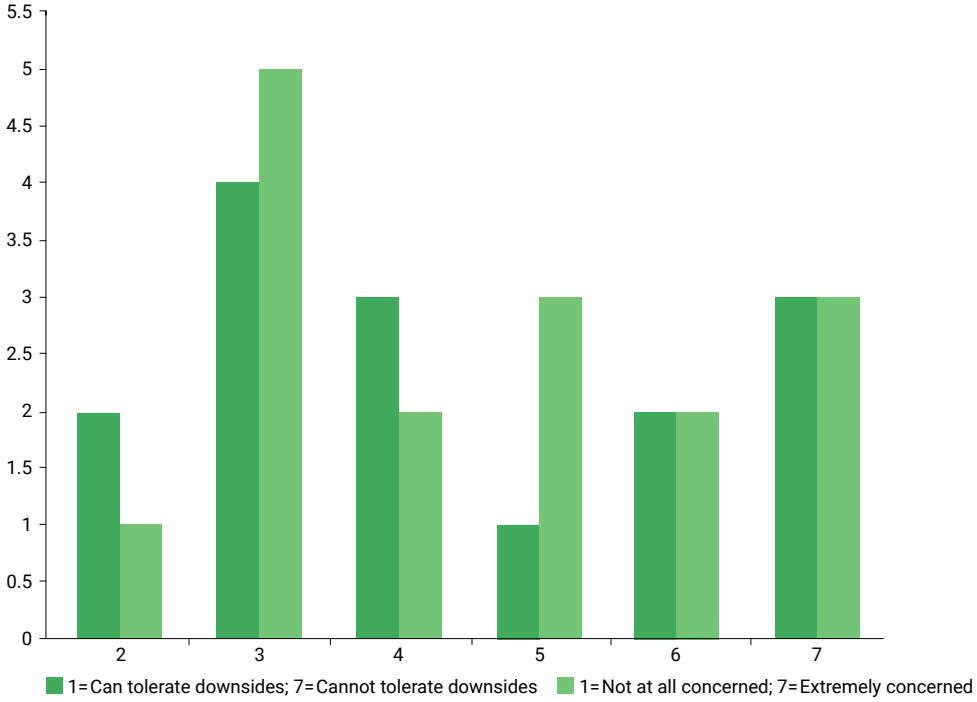
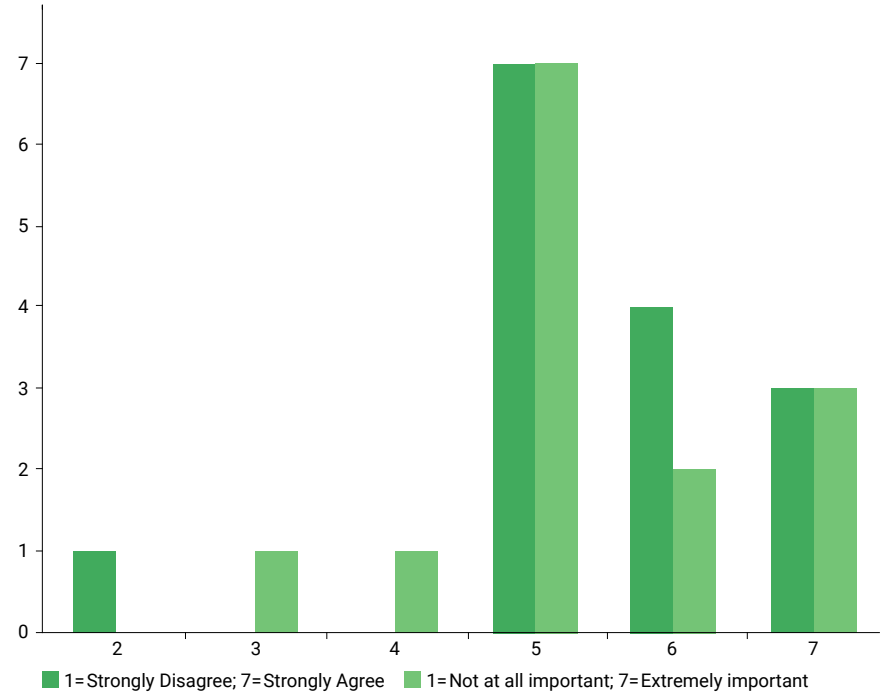


North Carolina should encourage eating healthy food by providing extra money for prepared foods that meet nutritional standards



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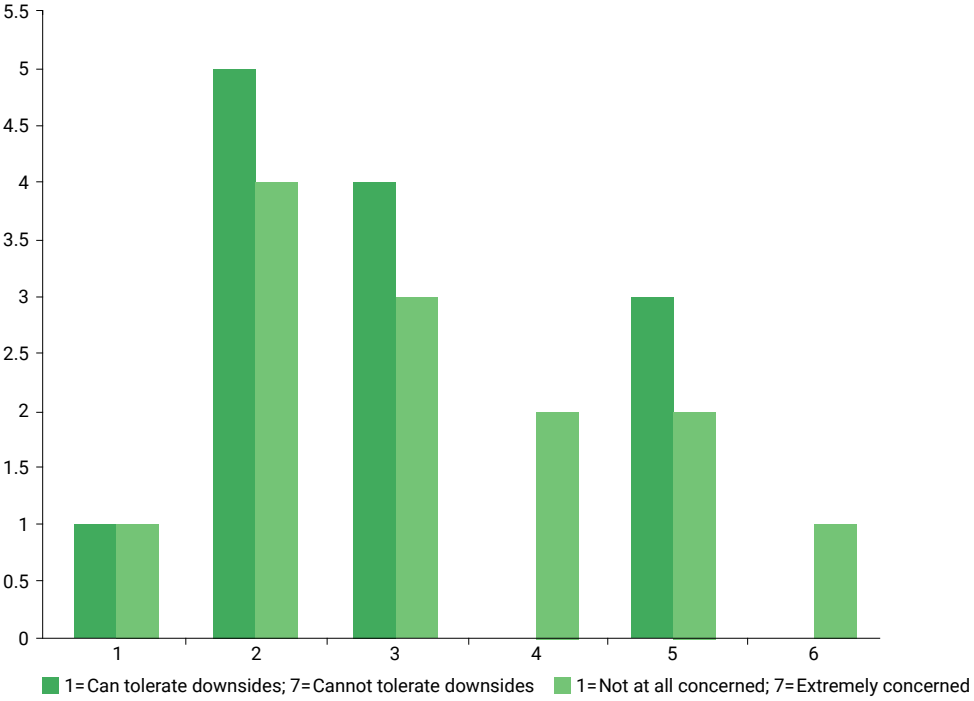
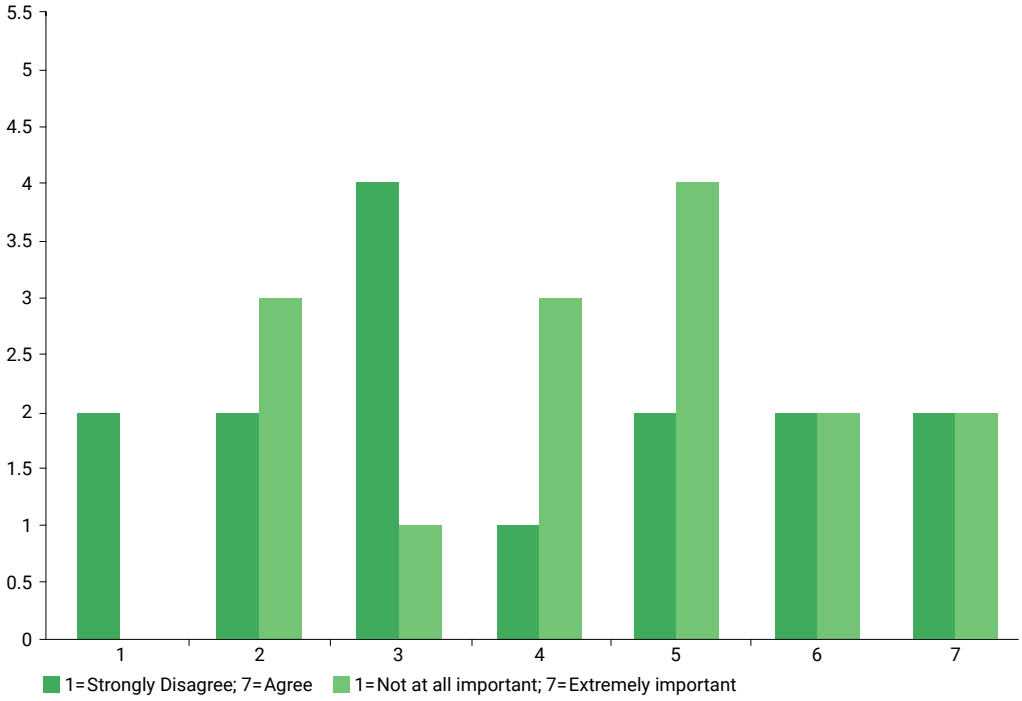


North Carolina should encourage eating healthy food by prohibiting the use of SNAP benefits to purchase junk food



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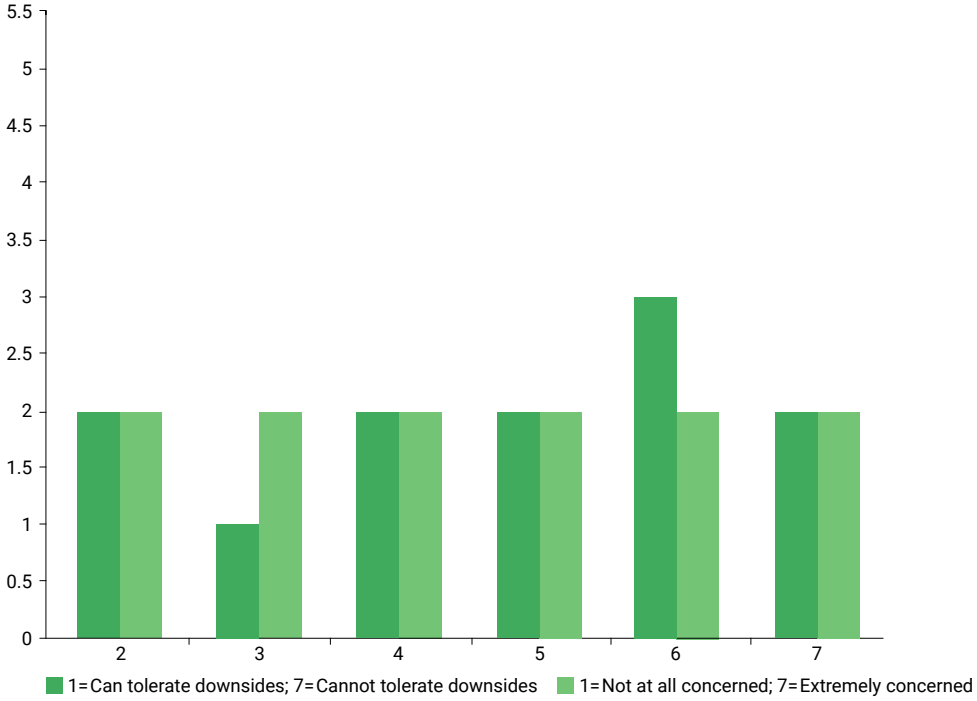
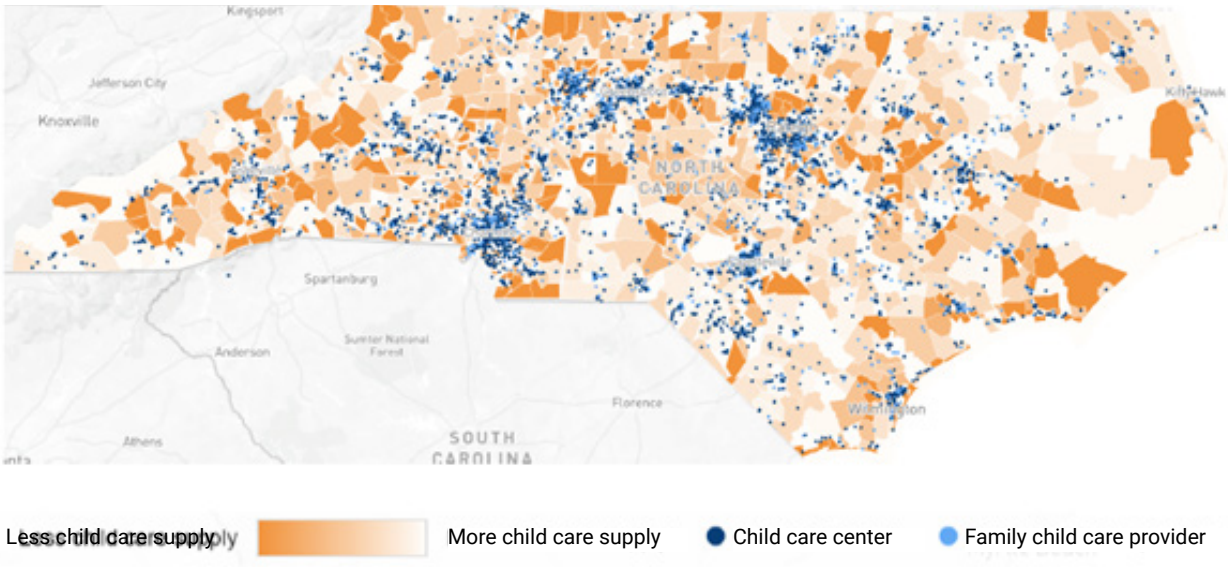


Early Childhood Education

Karen McKnight, Deputy Director for Early Learning Programs at the Hunt Institute, presented to the group about the availability of child care in North Carolina and the cost of care. She noted that there are about a half million children ages 3-6 in the state, and that the average cost of care for a four-year old in the state is about $8,000. Ms. McKnight showed that during the COVID-19 pandemic, the sector lost a significant number of child care centers and care givers, making the availability of child care scarcer. She also explained some of the subsidies available and needed in the state, and a map of where child care was most needed in the state.

North Carolina Landscape

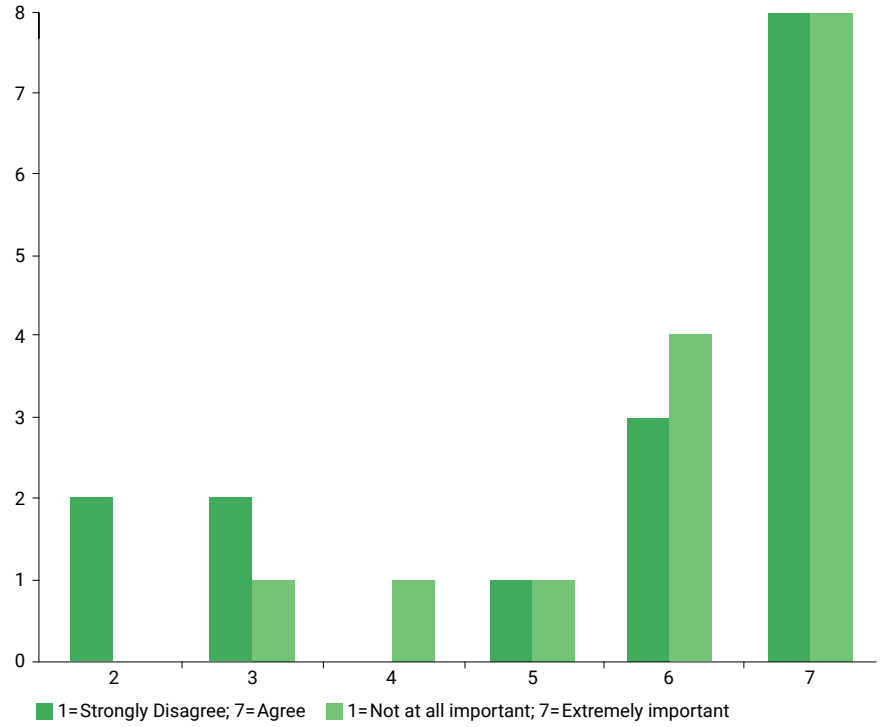


Source: Karen McKnight, Early Learning Programs, NC Hunt Institute

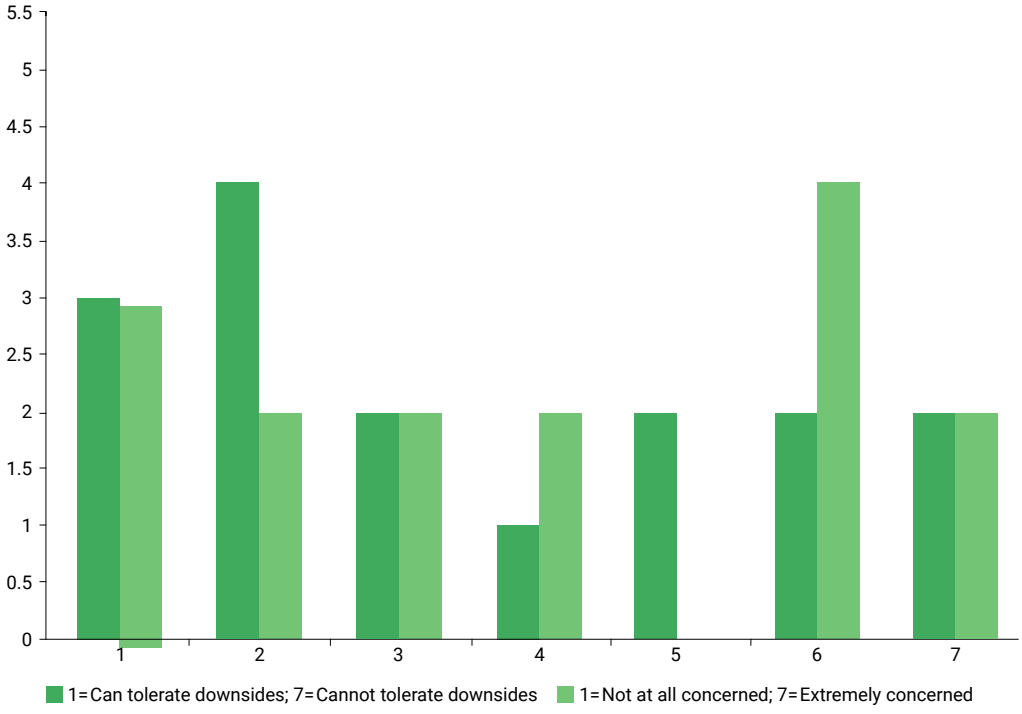
In talking through the benefits of increasing the availability of early childhood education, some participants thought that it would enable children to enter school ready to learn and make it easier for parents to participate in the workforce. Another possible benefit would be improving wages for child care providers. Proponents thought access to early education is necessary to enable upward economic mobility for people in the state. Other participants expressed downsides related to the cost of expanding childcare subsidies and who would bear the burden of paying higher taxes or losing other services. Some participants thought it would be hard to pay enough to provide quality care, and there was a concern that there are not enough childcare workers to address the need. Finally, some participants posited that the benefit of childcare fades over time. One idea that emerged was support for employer-owned childcare centers, but some participants were unsure employers have the expertise or enough incentive to pursue this option.

Because this part of the forum was held online, participants voted on the proposal via survey rather than using polarity charts. The following graphs depict the distribution of positions in favor or opposed to the proposal and the tolerance for the downsides.

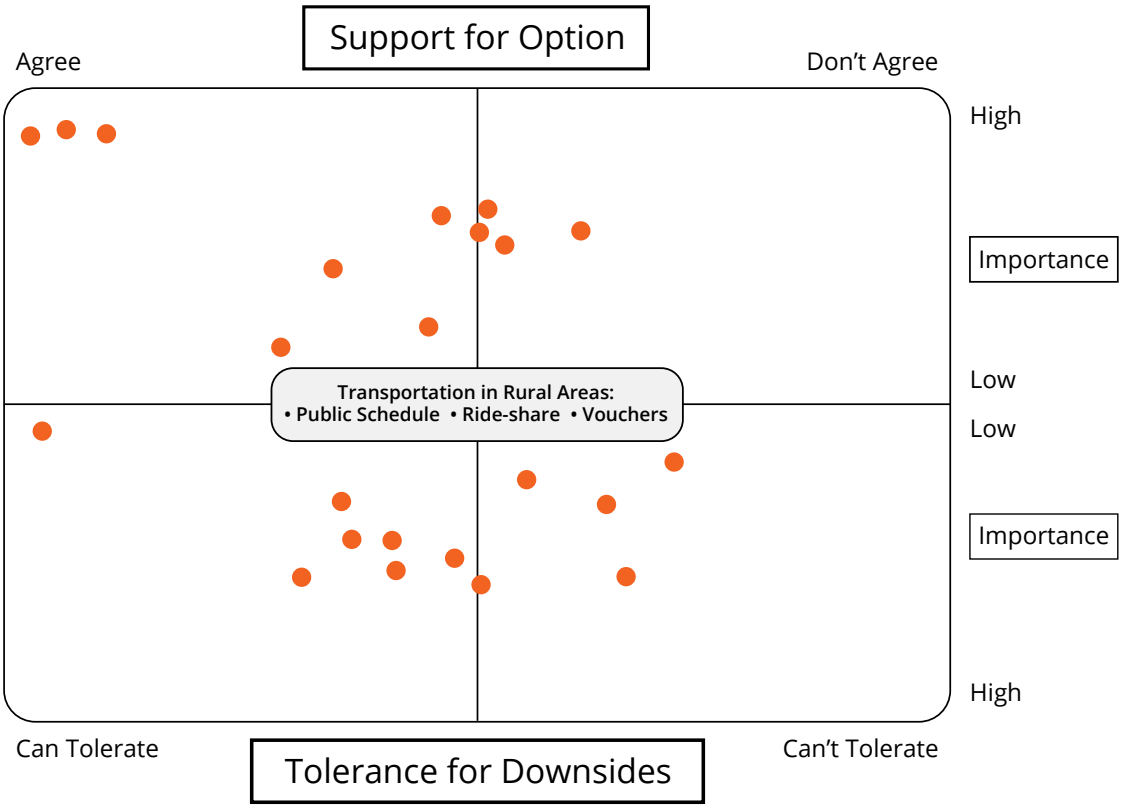
North Carolina should provide universal access to high quality early childhood education (childcare and preschool)



North Carolina should provide universal access to high quality early childhood education (childcare and preschool)



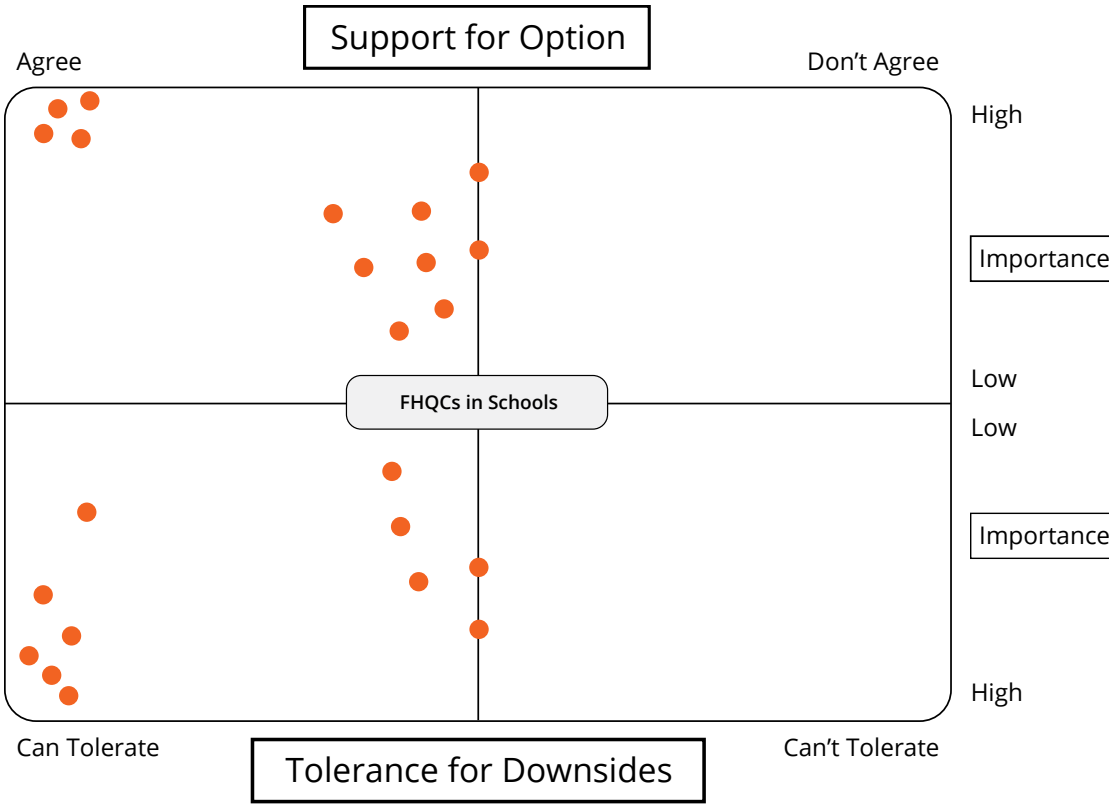
Transportation in Rural Areas



Increase transportation in rural areas to health providers, such as through a public schedule, ride-shares or vouchers for private service

Many cohort participants had a strong interest in improving the options in rural areas for transporting patients to health care providers, but acknowledged serious challenges in solving the problem. A lack of transportation is a top barrier to patients getting the care they need, and many health care providers pointed to missed appointments and the ways in which getting patients to the health provider for appointments would improve health outcomes. In their discussion, the members of the group focused on the high cost and complexity of addressing rural transportation needs, noting that it is tough for the system to address last minute or emergency needs and the long routes that often come with rural patients. Further, it can be difficult to train transportation workers to work with disabled patients. One participant shared that while they are often able to get people to the doctor for care, getting people a ride home is an especially difficult problem because of the unpredictability of when treatments will end. Ultimately, the group considered two ideas for improving transportation access that had potential to be effective: the use of ride vouchers, such as those available through Medicaid and Medicare, and non-profit/on-demand public transit partnerships.

Health Centers in Schools

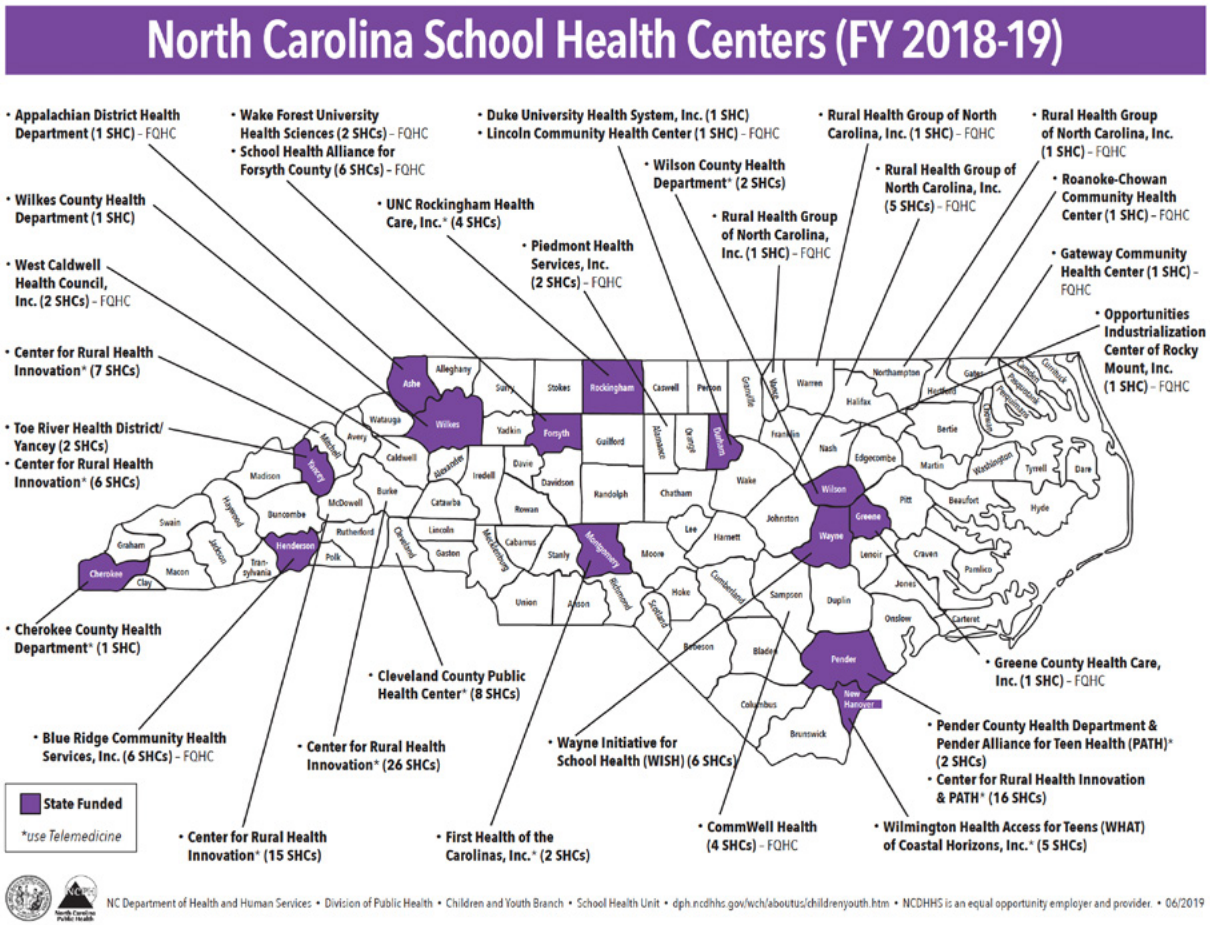


FQHCs in schools: FQHC's (Federally qualified health centers) should be in schools and provide health-related education and coaching.

According to the Health Resources and Services Administration, there are about 2,000 School-Based Health Centers nationwide.[ix] These SBHCs provide primary care to students and their families, and often also offer mental/behavioral care, dental care, substance abuse counseling, health education, nutrition counseling, and other services. Such SBHCs are often operated in partnership with a local community health organization or hospital.

A survey by EdNC in 2020 found that there are at least 140 School Health Centers across 28 counties in NC serving more than 130,000 children.[x] The State funds 31 such centers that provide health care services for children ages 10 to 19 in collaboration with local community-based agencies. About half have extended their impact by introducing telehealth services as well.[xi]

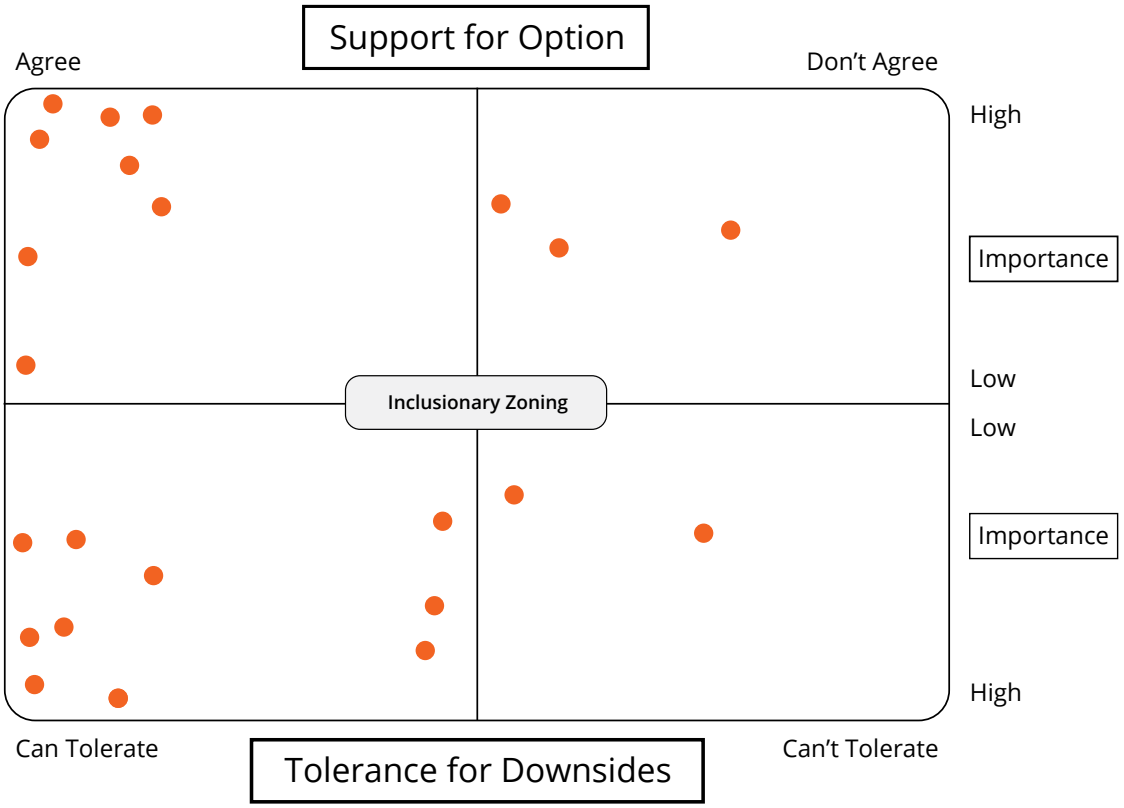
Generally, most participants saw the benefits of health centers in schools. Participants noted that schools are at the front line of identifying children in crisis and often able to provide critical services. They observed that children generally feel safe at school, and that schools provide an opportunity to better manage care, and could potentially best diminish stigma around issues like behavioral care. On the other hand, participants expressed downsides about funding and whether schools have the resources to handle expanded health care services, including the risk of over-burdening educational institutions. Another downside focused on how schools could handle parental consent and whether parents are receptive to health-related services in school, especially if such services were to expand beyond prevention and into behavioral care or other arenas.



Inclusionary Zoning

One of the areas with the least agreement focused on whether inclusionary zoning could lead to better health outcomes for North Carolinians. Poor quality housing is often cited as a social determinant of health for a range of reasons. First, the physical housing could lead to poor health outcomes (i.e., lead paint, mold, overcrowding). Researchers have also pointed to the stability of housing, as well as other factors such as safety, control over living arrangements, and a broader sense of community as factors in why housing could affect health outcomes. In North Carolina, it is widely acknowledged that there is currently a shortage of adequate housing available in many parts of the state.

Inclusionary Zoning requires that all new development in a jurisdiction include a certain number of units that meet affordable housing requirements based on area median income. Programs can be voluntary, conditional, or mandatory. In a voluntary program, the local government typically offers a "conditional use permit" as an overlay on the original zoning requirements in exchange for inclusion of housing that meets certain income requirements. Examples of what may be permitted as an incentive includes greater density allowances, smaller setbacks, lot sizes, and buffers. In a "conditional inclusionary zoning program," the local government negotiates with the developer in exchange for including affordable units. Finally, a "mandatory" program would require an explicit percentage of affordable units in all residential developments. As of 2016, one survey found that there are 886 inclusionary zoning laws in jurisdictions in 25 states and DC.[xii]



The state should authorize local governments to have inclusionary zoning.

Davidson, Manteo, and Chapel Hill, have all experimented with mandatory inclusionary zoning ordinances for for-sale units, however these programs occupy a legal grey zone. In North Carolina, local governments only have powers granted to them by the state constitution and statutes, and the state has not granted the power to enact inclusionary zoning. However, towns do have the authority to regulate the "location and use of buildings," so some have argued that affordable housing can be understood as a protected "use."[xiii] Others have argued that local governments can offer incentives, but cannot require affordable units as part of a development. The state could resolve this question either statewide, or for a specific local area. The state could also overturn a local government's inclusionary zoning ordinance. To date, the local governments in NC that have used inclusionary zoning have focused on units in new developments. Davidson was sued in 2014 by two local developers who claimed they did not have the right to require homebuilders to include affordable housing or collect fees for public services, but the town settled the case by easing their requirements, offering a fee-in-lieu of required affordable units and lowering the fee.

In the case of Chapel Hill, the city requires that any new development with five or more units must include 15% of the units at prices (or 10% in the town center) that are affordable to low- to moderate-income households. Housing is considered affordable if a household pays no more than 30% of its income for housing costs. Davidson requires 12.5% of homes in new developments be affordable if there are more than eight units.

The initial reaction of some participants was that inclusionary zoning requirements would be unpopular with local communities and would lead developers to revolt, for example by relocating proposed developments to communities that did not have such requirements. Those in favor of inclusionary zoning argued that mixed income neighborhoods created more opportunities for low-income people and improved schools. They also raised the need for more workforce housing (i.e., for law enforcement, teachers, firefighters, etc.) and suggested that much of the opposition to mixed-income neighborhoods can be a misperception of who would occupy new housing in the area. The group acknowledged that North Carolina needs much more housing generally, and talked about how the housing mix might need to include multifamily units, duplexes, and housing near popular transportation routes. Opponents highlighted common resistance to density and a strong preference for single-family homes and large yards. Further, opponents cited two other broader principles, first that property owners should have the right to do what they want with their property and second that if the state gave authority to cities or counties without limits, the local governments would abuse their authority. These deeply held concerns against inclusionary zoning prompted a passionate discussion, where participants on both sides of the issue listened carefully to other perspectives.

While the group was very divided over the inclusionary zoning proposal, and spent much more of their time on policy options more closely connected to health care, the discussion provided an important opportunity for the participants to have an honest and direct conversation about discrimination in housing and the economic and racial dynamics involved in local housing issues.

What We Learned

What Participants Gained from and Valued about the Process

The primary goal of NCLF is to shape how our participants view themselves as leaders and how they view other leaders with whom they disagree. While much of this report is about the substance of the health care discussion, it is important to focus on the impact the program had on its participants. To help assess this, NCLF begins each cohort with a pre-program survey and concludes with a post-program survey. We also ask participants for feedback on the program at our final meeting and in some cases, follow up with participants to ask about how they have changed their behavior months after the program.

About two-thirds of NCLF health care cohort participants took our post-program survey, at the final program or via email. All respondents agreed with the statement that they "formed new or deepened relationships that they otherwise would not have formed," with 63% strongly agreeing. Of note, participants showed stronger agreement with variations of the statement that emphasized building relationships with people in other sectors and in different regions from where they live, and all but one respondent agreed that they had formed relationships with people with different ideologies or party affiliations. One participant noted that they had formed relationships with legislative leaders that they had never spoken to and met leaders in the medical community. Several highlighted new professional and personal relationships with their buddy, and a third emphasized getting to know a hospital executive in their region and legislators from the opposite party.

Participants in the NCLF cohort also noted that the experience helped them better understand the complexity of health care issues, both in terms of understanding the issue better and better understanding the views of others:

- 94.7% said they "better understand the perspective of others from a different political party or ideology regarding health care."
- **89.5% that they "view some issues about the response to health care differently than they did before participating."**
- 89.5% agreed that they learned more about the topic of health care.

Of note, the experience changed the approach of many participants to the problem of improving health outcomes.

Participants noted the ways in which the forum helped them appreciate viewpoints and collaboration more positively than they had prior to the program. One participant stated,

"I realized that it is important to look at a problem or issue from more than one perspective and that even those with opposing political views may share many of the same core values and motivations."

"I realized that it is important to look at a problem or issue from more than one perspective and that even those with opposing political views may share many of the same core values and motivations."

Another said

"I learned that most people want what is best for North Carolina. The values are similar, the path to execution is different."

A third participant said

"I was already very willing to engage with the other side, but this showed me the values that others have in access to health care that give me more confidence we can compromise."

In addition, the health care field is broad and complex, and in many cases, a participant that had expertise on one topic was less familiar with another. At the end of the program, several health care practitioners noted that the discussions had given them new appreciation of the connection between policy and their own health care practice, and a renewed commitment to engage their team or details of their work to policy more frequently. One participant said,

"It helped me see the three-dimensional sides of my work: Direct services, policy change and structural change and how these three have to be connected intentionally to make change possible and to move forward to a more equitable health care system."

Another advantage of the program is that it gives participants the confidence and motivation to attempt to have conversations with people they know disagree with them. When asked how NCLF affected "confidence in their ability to engage constructively with people from different political parties or ideologies," all respondents reported an increase in confidence (73.7% with somewhat more confidence, and 26.3% with significant increase in confidence.) 89.5 of respondents said they felt more hopeful about working across parties or ideologies as a result of the program (63.2% felt somewhat more hopeful and 26.3% reported a significant increase in feeling hopeful.)

This change in interest in engaging with others with different political views was borne out by early changes in behavior by participants. When asked about whether and how often they talked to someone with other views, read or listened to or watched information or opinions from people/sources of a different political party or ideology, or made an effort to encourage conversations between people of different views, we saw significant changes in behavior six months prior to the program and post-program. For example, while 42% of the group said their efforts to encourage conversations were rare prior to the program, this percentage dropped to 5.3% post-program. The percentage of people talking with someone else with a different point of view at least twice per month rose about 15% and the percentage of people reading, listening or watching a different point of view at least once a week also rose about 15%. Examples shared with the group included having coffee with cohort members outside of forum meetings, being more open to being in spaces with people with different opinions or political positions, and reading a broader spectrum of news sources or more intentionally reading news and opinion pieces with different perspectives.

What the NCLF learned

NCLF learned several critical lessons during its health care cohort. First and foremost, the program confirmed the importance of attending in-person meetings and relationship building for the purpose of constructive engagement on critical issues in our state. During the time period of this program (October 2021 through April 2022), we still encountered challenges with regular participation, as a result of COVID-19, its work transitions, and challenges for highly active health care professionals still confronting periods of crisis in the health care system. During a period of peak COVID cases, we made the difficult choice to reschedule a January 2022 meeting and move the remainder of our meetings to later in the Spring. This combination of factors meant that many participants attended some, but not all, of the cohort meetings, and did not have the full opportunity to build relationships with a regular group of participants. This diminished our group's capacity for conversation on some important issues and made the experience different than prior cohorts.

Second, we learned that the topic of "improving health outcomes in North Carolina" presented some challenges both in its breadth and in its highly technical aspects, with leaders having significant expertise in narrower areas of the topic. This led to discussions about the practicalities of various proposed actions, rather than about concerns, values, and ideologies. It was necessary to reinforce the importance of personal narratives in exploring how our highly technical experts in the room relate to their position on policy issues. By having facilitator-leaders share their own personal stories of what causes then to care deeply about the issues they work on and then asking participants to do the same in pairs and small groups, we were able to push the participants to have deeper conversations about how their values and experiences bear on their positions on policy proposals. As one participant said,

[NCLF] has inspired me to be more curious, look for the shared humanity in each person I'm encountering, staying open and trying to understand things from others' points of views.

At other times, we had challenges when one expert in the room dominated on a specific topic, leading the group to focus more on what works than on their conflicting values. While it was valuable to introduce personal stories to facilitate the conversation, it would likely to be beneficial to have fewer subject matter professionals in the group, and more general public policy leaders. A narrower topic might also decrease the amount of time needed to understand the implications of various proposed actions. We might help facilitate a focus on differences in values and concerns by pre-selecting some of the policy options which are designed to draw these out in the discussion.

Third, because this is a program for leaders, it can be difficult to get the voices of grassroots people directly impacted by the health care system in the room. This makes it important to have not only elected and business leaders in the room, but also leaders of community groups that are impacted by the problem under discussion, and to be sure there is an opportunity for leaders to share the concerns and experiences of their constituents. While we did incorporate some voices using video and interviews, the anecdotes were not always helpful, and we intend to continue to explore other methods to bring a variety of grassroots perspectives into the discussion.

As with prior programs, we also concluded that NCLF could have more impact by repeatedly engaging alumni of our cohorts in additional programming, and 74% of respondents indicated interest in participating in alumni programming. This would enable NCLF to build a network of NC leaders committed to constructive respectful, cross-partisan policymaking environment.

Finally, participants expressed strong praise for the program. In some cases, they have been interested in working with NCLF to replicate the program in their own region or on another topic area. This enthusiasm has reinforced for NCLF that there is a lack of forums in which leaders can engage deeply on issues, particularly with people who hold different ideological viewpoints or come from different sectors or areas of expertise, that these arenas are very needed, and that NCLF should continue to fulfill this need.

Conclusion

For our democracy to succeed, policy leaders must be able to work together to create broadly acceptable solutions to our state's greatest challenges. This year's group of NC leaders addressed important concerns related to health care in NC. They found some solutions they agreed on, some that were negotiable, and some about which they had very significant disagreements. In the process, participants came to understand what values, experiences and perceptions lay under their disagreements, and they came to trust, respect, and perhaps even like each other.

Even in these politically fractious times, it is possible to bring together a widely diverse group of policy leaders and provide them the opportunity to gain the will, skills, and relationships that will enable them to constructively engage with each other in the future. NCLF has provided, and should continue to provide, this opportunity to North Carolina's leaders.

Acknowledgments

NCLF was founded at Duke's Sanford School of Public Policy and is now housed within the Office of the Provost at Duke University and is made possible by the generous support of the Duke Endowment, the John William Pope Foundation, the Z. Smith Reynolds Foundation, Bank of America, and the Hewlett Foundation. Special thanks to Karen McKnight, Deputy Director for Early Learning Programs at the Hunt Institute, who presented to the group on Early Childhood Education needs in North Carolina. Thank you also to the Duke-Margolis Scholars program, whose undergraduate and master's students provided timely research support, as well as NCLF's Research Assistant Joey Rauch, and the Duke Digital Initiative for assisting to make videos for the program. Finally, thank you to Amber Rogers for her work on this program and to the NCLF steering committee for their continued leadership and facilitation of the Forum.

Appendix A | Participants

Gale Adcock, NC House of Representatives

Nida Allam, Durham County Commissioner

Donyel Barber, Gastonia City Council Member and Community-Centered Health Coordinator, Gaston County Family Health Services

Sydney Batch, NC Senate

Ronny Bell, Professor, Wake Forest School of Medicine, and Director, Office of Cancer Health Equity at Wake Forest Baptist Cancer Center

Rick Brajer, former NC Secretary of Health and Human Services and co-chair, Governors' Task Force on Mental Health and Substance Use

Phil Brown, former Chief Community Impact Officer, Novant Health, and President, NC Medical Society

Jim Burgin, NC Senate

William Buster, Senior VP of Impact, Dogwood Health Trust

Robert Clark, President of Leesona Corp. and Winston-Salem City Councilman

Mandy Cohen, former Secretary, NC Department Health and Human Services

David Craven, NC Senate

Sarah Crawford, NC Senate

Josh Dobson, NC Commissioner of Labor

Nicole Dozier, NC Justice Center, Director of Health Advocacy Project

Brian Forrest, President, Access Healthcare, DPCMH, Professor at UNC CH and ECU

Michelle Hughes, Executive Director, NC Child

Ricky Hurtado, NC House of Representatives

Lindsay Keisler, President, Catawba Chamber of Commerce

Sarah Riser Newton, SAS, Senior Manager, US Public Sector Health Policy team

Nathan Ramsey, Executive Director**,** Land of Sky Regional Council, former member, NC House

Devdutta Sangvai, VP Population Health Management at Duke Univ. Health Services

John Simpkins, President, MDC

Karen Smith, M.D., Former President of NC Academy of Family Physicians

Tunde Sotunde, President and CEO, BCBS North Carolina

Sarah Stevens, NC House of Representatives

Edwin Thomas, Financial Adviser, Northwestern Mutual

Michael Waldrum, CEO of Vidant Health System

Frank Williams, Brunswick County Commissioner, chair, NC Assoc of County Commissioners

Patrick Woodie, President, NC Rural Center

Magaly Urdiales, Co-Director, WNC Worker Center; NC Collaboration for Strong Latinx Communities

Appendix B | Full List of Health-Related Concerns, as Identified by Participants and Grouped by NCLF

Social Determinants of Health and Economic Effects

- We don't pay enough attention to social determinants of health
- Poor people are often blamed for their medical conditions or challenges
- Patients need to take more personal responsibility: want a quick fix vs lifestyle change
- People don't believe/listen to their physicians and providers about health care issues and treatments
- Food-related
    - SNAP covers unhealthful foods, but often does not cover the healthful ones
    - Low literacy about how food drives health
    - Food insecurity
    - Need incentives for healthy food; example of Dollar Stores in communities that sell unhealthy food, some healthy food.
    - Need for food preparation equipment, education
    - Quality of food
- Workers have been displaced by COVID and lack the means to afford care during the COVID months a nd future economic downturns
- Social determinants may be more important than access to clinicians
    - Social supports that address urban/rural divide

Health Care Quality and Safety

- Important for patients to have continuity, same doctor over time
- Centralization of care makes it hard to get answers to questions. Patient may talk to a different person each time.
- Patients concerned about safety in hospitals, nursing homes
    - Going to the hospital poses a risk of getting sick
- Too slow to adopt virtual options, telehealth
- Incentives don't encourage move towards value-based care
- Short visits to doctors may save money but they reduce quality and trust in providers; Inhumane
- Care for children is not comprehensive: physical, developmental, dental, social, behavioral all in one place.
- Need more investment in cures or prevention instead of services
    - Don't realize part of cost/insurance pays for research
    - Need to invest in preventative diagnostics
- Tend to provide care too late, when it is also too costly
- Need to make mental health an essential part of health care
- Lack of healthcare coordination
- Not prepared to deliver long term care to aging population

- Funding systems lead to health care decisions
- It's time to put patients over profits
- Health care businesses make more money when people are sick—this creates bad incentives
- Consolidation can produce savings from economy of scale, but can also create monopolies

Health Care Communications/ Complexity

- State health plan is too complicated, poorly explained to patients
- Patients don't know what questions to ask, what choices they have
- Need to be mindful of health literacy, culturally competent communications needed
- Patients forced to repeat info over and over, need more interoperability of systems
- Veterans have a hard time navigating services
- Need deeper Q&A and understanding
- People don't understand information they're given
- People/businesses not aware of options or utilizing options provided by insurance
- Too much information is thrown at patients
- Use more motivational interviews to coach patient, learn important info for health
- Lack of advocates within the system to help people navigate

Workforce and Incentives in Medical Care

- Young people are being discouraged from making medicine a career, don't see it as a calling
- Physician training is so onerous that it deters some from becoming doctors
    - Training of doctors, nurses, and other providers has become "inhumane." Financial, physical, emotional toll is too great.
    - End of life care difficult, lack support
- There are pay inequities in medicine based on social and other indicators
- Healthcare professionals aren't asked to perform services they have been trained to do (not performing at peak ability).
- There aren't high enough reimbursements to encourage primary care
- Funding system for training physicians is unsustainable and inadequate, with regards to medical school, pre-med, nursing, and allied health. Difficult to fund diversity of trainees
- Critical shortage of clinicians and other workers in hospitals and other providers
- Lack of child care to accommodate the needs of health care workers, especially women
- Shortage of direct support professionals for people with disabilities: $11-13 wages lead to shortages. Low pay for very hard jobs.

Access to treatment and to insurance

- Varying income, risk of injury poses real dangers to workers at small businesses
- Affordable health care should be a basic human right

- Many people have incomes just high enough to lose subsidies but not enough to afford care
- Some people have insurance on paper, but it fails to cover needed services
- Small businesses need more choices to offer plans, premiums too costly
- Uninsured rate is higher than in other industrial countries
- Employer-sponsored insurance can trap people in unfavorable conditions (i.e., need health care so stay in job, job is unhealthy so need health care)
- Too difficult for small practices to take insurance
- Mental health services are not broadly available
    - Insurance doesn't cover mental health
- Universal health insurance would boost cost, reduce innovation and quality
- Quality concern around insurance coverage: is my insurance working for me?
- Worried a lot about access to care for immigrants, especially undocumented ones. Often can only access at hospital if things are dire, late and costly approach.
- It isn't clear what public health departments do or should do. Variation by county, administration.
- Health care is hard to access in rural communities
    - Many places lack pediatricians, psychologists, are contraceptive deserts, lack primary care
- Financial sustainability of local hospitals in rural areas is in question
- Infrastructure of rural community hospitals is inadequate: no A/C, boiler doesn't work, etc.
- Access to care shouldn't be based on income
- Uninsured only have access in life-threatening situations
- Many doctors aren't taking new patients or there is a large delay
- Can take 6 months+ for appointment for regular care
- Lack of transportation to care--- social access
- Care ought to be paid for according to one's ability to pay
- Technology is a barrier where patients don't have broadband, internet access, or computers (or computer literacy) People need access to affordable medications. Still pricey even with insurance
- Lack of access drives up costs
- Health care services are never really free: someone has to pay the cost, directly or indirectly
- Everyone pays for health care through required insurance premium
- Consumers need more choices in health coverage

The Cost of Healthcare is Too High

- Lack of access drives up costs
- Health care services are never really free: someone has to pay the cost, directly or indirectly
- Everyone pays for health care through required insurance premium
- Consumers need more choices in health coverage
- Affordable health care should be a basic human right
- Small businesses need more choices to offer plans, premiums too costly

- Access to care shouldn't be based on income
- Care ought to be paid for according to one's ability to pay
- Incentives don't encourage move towards value-based care

Health Care delivery is not equitable

- We don't address risk factors that produce higher mortality rates for black mothers and their children—significantly higher mortality
- When we identify patients by race, not using a biological factor. Including race in assessment or diagnosis initiates disparities, assumptions about medical care.
- Workers/low-income populations feel they are treated badly when go to a clinic, face discrimination
- Indigenous people find resiliency when connected to social networks, family, land, tradition. Have issues when lack access to healthy food, face disease, lack access to high-quality healthcare
- Gender and age/generational differences in care
- Lack healthcare workers who originate from rural or minority populations, where the population faces barriers to access
- Lack of equitable evaluation and assessment: look at wrong factors, not culturally competent. May focus on financial breakeven, not patient satisfaction.

Data Transparency

- Provider/patient experience—too much is focused on collecting data to be paid vs what patient needs
- Privacy of health info
- Data analytics need to be robust
- How do we measure health care outcomes and how do the measurements drive financial outcomes (e.g., use of mortality as outcome measure)
- We don't adjust health care measurements/outcomes for societal issues
- Need more cost transparency: sick patients make money for provider

Broader Concerns

- Breakdown of politics will likely impede solutions
    - Ideological polarization turns health care into political turf war. E.g., Abortion, COVID.
- American health care system doesn't learn enough from experience of other countries
    - For example, Swiss insurance system seems to be more efficient, producing competitive market for health care services
- Healthcare system is too fractured, but something we could centralize more while others favor decentralization. Standardization vs local control.
- NC performs poorly on health indicators when compared to other states
- Cost of lawyers/litigation
- Where should we put limited resources (e.g., education, upstream to social determinants)
- Absence of collective strategy to drive health outcomes in NC

Endnotes

[i] George H Pink, NC Rural Health Research Program, Sheps Center for Health Services Research at UNC Chapel Hill, Testimony before US Senate Finance Committee (2018).

[ii] https://bphc.hrsa.gov/about/what-is-a-health-center/index.html

[iii] https://nciom.org/wp-content/uploads/2017/09/Silberman2_Safety-Net-4-18.pdf

[iv] https://caplink.org/images/Rural_Financial_and_Operational_Trends_Report_2021.pdf

[v] https://www.kff.org/other/state-indicator/chc-patients-by-payer-source

[vi] https://info.ncdhhs.gov/dhsr/coneed/index.html

[vii] Ibid.

[viii] Ibid.

[ix] https://www.ncdhhs.gov/divisions/child-and-family-well-being/whole-child-health-section/school-adolescent-and-child-health/school-health-centers

[x] https://www.ednc.org/health-service-delivery-in-north-carolina-schools-landscape-analysis-and-bright-spots/

[xi] https://www.dph.ncdhhs.gov/wch/doc/aboutus/SHC-AnnualReport-COLOR-web-021120-Revised.pdf

[xii] Bloomberg CityLab at https://www.bloomberg.com/news/articles/2018-07-17/inclusionary-zoning-everything-you-need-to-know#:~:text=Inclusionary%20zoning%20is%20a%20policy,market%20to%20subsidize%20affordable%20housing.

[xiii] See e.g. Tyler Mulligan, A Primer on Inclusionary Zoning (November 2010) at https://canons.sog.unc.edu/2010/11/a-primer-on-inclusionary-zoning/. *See also* Matt Hartman, Eight Years Ago, Chapel Hill Enacted the Most Progressive Affordable Housing Policy in the Triangle. Here's How It Failed, IndyWeek (August 2018) at https://indyweek.com/news/eight-years-ago-chapel-hill-enacted-progressive-affordable-housing-policy-triangle-failed/.

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