

National Rural Health Association Speech  
May 9th, 2018  
8:30am-9:15 (30 minutes – 15min Questions)

Thank you, to your CEO, Mr. Morgan and to your President, Mr. Barnhart, and the staff of the National Rural Health Association for inviting me here to speak at your conference. Welcome to New Orleans, Louisiana!

It is an honor to be here this morning with all of you to give the opening remarks for the nation's largest convening of leaders gathered together because of the shared interest in and passion for improving rural health.

Whether you are clinical practitioners, executive directors, administrators, lay health workers, state/federal employees, social workers, academics or community members.

Thank you for the work that you do in the communities you serve. We need leaders like you in all sectors working together to improve rural health outcomes.

I commend the National Rural Health Association for also holding the Rural Medical Education Conference and Health Equity Conference the day before this conference.

As well as the Rural Hospital Innovation Summit taking place during this time. And for sharing important information, just now, about the international efforts of this organization.

We need these forums to elevate best practices and challenge ourselves to develop new strategies and innovative models that tackle some of our most pervasive health issues in Rural America.

We can't shy away from the reality that people living in rural communities experience greater health challenges - health issues such as higher incidence of disease and disability, especially chronic diseases, increased mortality rates, and lower life expectancies.

As you know, these are a result of a variety of risk factors that people living in rural communities face -- like geographic isolation that can contribute to loneliness and addiction, lower socioeconomic status, higher rates of risky behaviors to their health, access to employment/livable wages, lower education, limited transportation, among other factors.

Rural communities have older populations and are experiencing greater poverty with worse health outcomes -- and fewer physicians than ever to care for people.

Access to the care that IS available is also not made easy for people to use when employer-provided health care coverage is not widely available to rural residents.

This is why Medicaid expansion is a key part of improving access to care for rural households.

I serve as Secretary of Health for the state of Louisiana and lead the largest state agency for Governor John Bel Edwards.

My job is to oversee a 14 billion dollar budget that supports the “health and health care” for a state of 4.6 million people. Over 750,000 of our residents live in rural parts of the state, where a quarter of the people live in severe poverty in a state where 40% of us live under 200% of poverty, in rural areas 1 in 5 people do not complete even a high school degree.

Under Governor Edwards’s leadership we have expanded access to healthcare through Medicaid for nearly 500,000 people; thousands in our rural communities.

Over the past two years, we have taken what were previously patches of care throughout the state and woven them into a patchwork quilt of nearly complete coverage.

This coverage allowed low-income people access to healthcare that they didn’t think was possible. And we expanded coverage to these rural areas through partnerships with organizations and navigators, who were already working on the ground with people, to sign them up.

As a result of the Medicaid expansion more than 41,000 women, many for the first time in their adult lives, have received mammograms.

We have saved over three hundred women’s lives by picking up their cancers early.

I believe in this good work we do every day for the people of Louisiana and I strongly believe that health care is a human right.

As the richest nation on earth, we should not be putting families in a position to choose between mammograms and meals.

We are making progress. However, challenges remain. Our biggest problem is the overall cost of care.

Take my state.

Louisiana invests \$14 billion dollars—nearly half the state budget—in health care services. But all this spending on healthcare is not making us healthy. We remain 50th or 49th in many of the most important indicators of health.

This is because of a number of factors.

First and foremost, our poor outcomes are because of challenges related to the poverty of our people; the poverty of our state.

But compounding the challenges of a poor state are the fact that payments for “health” almost all go toward “health care services.”

This is how we as a country and in our individual states invest in the health and well-being of the public, even though one of my mentors, Mike McGinnis, would remind us that health care services represent only about 10% of health.

Despite having the most expensive health care system by far in the world —the US gets a poor return on our investment because we underspend and under prioritize these key determinants of health that make up the 90% outside of healthcare.

- We don’t provide meaningful resources for connection and support for individuals who age.
- Childcare supports are almost nonexistent.
- We build towns without thinking about the public infrastructure that is needed to sustain a healthy environment and promote physical activity.
- We don’t invest in good roads and public transportation so people can easily get to their jobs and families.

Instead, we build jails and prisons, nursing homes and hospitals and invest in proton beams and fancy 3D x-rays.

These investments don’t deal with the underlying problems.

One of the primary reasons I became an obstetrician/gynecologist is because of the opportunity to connect on a deeper level to women - appreciating the many layers to their lives - focusing on what matters to them.

The opioid crisis has a lot to do with loneliness, social isolation and depression -- and not everything to do with the tall tales told by pharma.

Our lives are shorter because we eat more and more, and exercise less and less, not because of lack of medical technology.

This is why we are not improving and in many cases declining in our health outcomes. I often think about how we can shift and blend our public spending to align better with improving the quality of our lives – what really matters.

In Louisiana, we are shifting focus—trying to move dollars into permanent supportive housing and community health workers who can visit a home to see if a baby is sleeping safely and provide social support to women and families as needed.

We are looking for innovative approaches and partnerships, including with our managed care organizations – we want to incentivize innovation so we can more easily fund these social determinants of health – the other 90% of what influences our health status

I am not arguing that it is the job of the health department to pay for all the things that make rural communities strong—what I believe is that when we spend our public dollars all on sick care to the exclusion of these social supports—we are being penny wise, pound foolish.

This is one of the biggest challenges for our future - shifting our investments in “sick care” to “health care.”

But shifting from “sick care” will require all of us in the positions we hold to look at how we spend our “health dollars,” so that they better align with what truly impacts our health.

Rural hospitals in our country are closing at an increased rate. More than 80 rural hospitals have closed since 2010 and over 670 additional facilities are vulnerable to closure. This is more than one-third of rural hospitals nationally.

We have been fortunate in Louisiana not to have experienced the closures other states have experienced and are threatened with today. Rural hospitals in our state have the protection of the rural hospital preservation act, but they are still vulnerable because hospital revenue depends on patient volume and patient volume is declining.

Fee-for-service models put pressure on hospitals to do what they can to grow their patient volume to survive financially when we know we need to reduce hospital stays and work to keep people out of hospitals by focusing on prevention – more upstream approaches.

The health of the communities we serve is negatively impacted by these financial pressures.

This is why Louisiana is looking at a promising model called global budgeting, after seeing the success of Maryland and recent progress in Pennsylvania. We aim to shift payment structures more with a focus on health care than sick care.

Who better than a rural hospital and its staff to understand the needs of a community in the context of health? And with a global budget, they can plan for a set amount of revenue and invest outside the hospital walls in their communities.

Instead of paying hospitals to fill beds—why not pay them to keep folks out of beds?

Buy an air conditioner for an elderly woman who is getting overheated? Provide home visits for new mothers to prevent infant death? Help install assistive supports for individuals who have frequent falls at home?

Louisiana is grateful for the opportunity to send a team to the State Policy Academy on Global Budgeting for Rural Hospitals hosted by Johns Hopkins University in collaboration with Millbank, RWJF, and the National Rural Health Association later this month in Baltimore with 4 other states.

We at the Department of Health could not continue making improvements to the work that we do without these national opportunities and partnerships as well as our state partners the Louisiana Rural Health Association, Louisiana Primary Care Association, FQHCs, Rural Health Clinics, and Community Health Centers, Area Health Education Centers, Critical Access Hospitals, and many other health and social service agencies.

Whether it is global budgeting or other innovative approaches to care delivery – the sky is the limit when you have the right people and organizations on your team.

Some of our team members from Louisiana are here at this conference to highlight the quality improvement work that we began a few years ago to increase the number of individuals with controlled diabetes and managed hypertension.

Working on the ground with our partners we started Clinic-led quality improvement projects with 10 clinics and we are now looking at increasing the number of clinics participating in an upcoming grant.

This work will align with the current plans and technical assistance we are receiving from the NGA to focus on collaborative efforts that address hypertension and reduce the burden from heart disease in our Delta Region, the northeastern part of the state.

And we hope to integrate and build off these promising practices working in rural parts of our state as we develop and implement a statewide cancer strategy in Louisiana – with a public kickoff this Friday that will be announced by the Governor in Baton Rouge.

Part of that strategy will be ensuring that individuals are screened for cancer in rural areas and when they are diagnosed- they will have access to the most state of the art clinical trials and cancer care.

We are aligning the public and private sectors in our state toward a common goal of improving outcomes.

This type of quality improvement and alignment work is important and many of you are involved in similar projects.

Many of you are probably also becoming more engaged in discussions around the Patient-Centered Medical Home models, with more focused training that is needed for rural health care sites. We hope to begin those efforts in Louisiana.

Patient-Centered – means putting the patients’ needs at the core of our interactions and services we provide.

These patient-centered medical home models will allow people to be cared for in settings other than a hospital or a doctor's office.

As with global budgeting, we must take our services outside our walls. To follow up with people after they go home or are discharge -- especially for older and sicker patients who live far away from a care center.

And we need to make it easier for providers to use telemedicine for their patients.

We are promoting the use of telehealth in our state and working through the barriers in order to increase utilization – one clinic in our state is managing telehealth services across 6 schools that we see as a promising example.

They are seeing positive health outcomes and presented their program and initial findings at the Health Equity Conference yesterday – and most importantly they are getting paid.

This is just some of the innovative work that people across our state are doing, even in the midst of the budget crisis we currently face, and they give me hope.

I want to encourage all of you to look for ways not to work harder, but work smarter with existing resources. Opportunities to promote and incentivize high-quality healthcare in spite of the economic challenges we face.

I know this is easier said than done when we face many financial and health challenges – most importantly an opioid epidemic that has hit our rural communities the hardest.

We recognize in our state planning here in Louisiana that we have to take action to curb this epidemic on multiple fronts - both short and long-term with partners we aren't always used to working with.

We are looking at actions and policies that focus both on reducing the supply of opioids and expanding access to treatment and mental health services through Medicaid.

People should not be feeling alone in their addiction. Treatment needs to be easier to access than opioids.

I am a partner with you in the great work of the National Rural Health Association.

I look forward to joining you in advocating for our rural communities and to sharing our promising practices during this conference and throughout the coming year.

Rural hospitals and providers are in a unique position not just to heal people—but to heal communities.

I hope it is going to be an exciting yet relaxing few days for all of you.

Again, I welcome you to New Orleans and hope you can experience the richness of our culture and the warmth of our people --- thank you again for this opportunity to be with you all today.