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Invited Testimony

**United States Senate
Committee on Health, Education, Labor and Pensions**

**The Honorable Edward M. Kennedy, Chairman
The Honorable Barbara A. Mikulski, Chairwoman**

February 23, 2009

Mr. Chairman, Madam Chairwoman and Members of the Committee:

It is an honor to be asked to testify before this distinguished body on an issue of such vital importance as healthcare reform. As a nurse, I have worked as a nurse practitioner, health care administrator, NIH funded researcher and am currently a professor of nursing at the University of Minnesota where I also serve as the director of an interdisciplinary integrative health program – the Center for Spirituality and Healing.

Our health care system is on a trajectory that mirrors what has happened in the financial system. There has been greed, excess, and the failure to do what is right due to vested interests. Putting more money into the same system will only produce more of what we currently have, which is untenable. Everyone in this room is well aware of the statistics. We spend more money in our nation on health care than any other country in the world yet 46 million or more have no insurance and thus limited access and we are ranked near the bottom of the industrial world in health outcomes.

I want to highlight strategies related to integrated healthcare that have the potential to be transformative to our healthcare system.

- We need a fundamental shift in orientation from disease to health and well-being. In my first public health course in nursing school over 35 years ago, I learned the core principle that it is cheaper to prevent disease than to cure it. We need to get into the hands of consumers information, tools and resources that will enable them to better manage their health and health care. We have a health coaching program at the University of Minnesota where we are preparing health and wellness professionals who are prepared to help people focus on comprehensive lifestyle change which includes the use of integrative health care approaches. We have also created a website for consumers titled “Taking Charge of Your Health” that focuses on helping people learn how to navigate the health system, serve as a health advocate, and develop a personal plan for their health and well-being.
- We need to re-think the workforce – particularly around primary care. Numerous studies have confirmed that nurse practitioners and physician assistants can effectively manage 80% of primary care. Nurse practitioners in particular are educated to focus on wellness, health promotion and chronic disease management

including the use of integrative therapies. In 2008, Minnesota passed health care home legislation – we do not call it a medical home. While a primary care provider has traditionally been viewed as a physician trained in typical specialties such as family medicine, pediatrics, and geriatrics, the health care home legislation recognizes the importance of expanding the definition to include nurse practitioners, pharmacists, physician assistants and others who provide primary care. In this definition, primary care provider includes the first provider-patient contact for a new health problem and ongoing coordination of patient-focused care. There are licensed complementary and alternative medicine (CAM) providers (naturopathic medicine, chiropractic and acupuncture/Chinese medicine) who can meet this definition as well. While not included by name in the MN legislation, licensed CAM providers need to be part of the workforce solution.

- We need new models of care that use primary care providers to the highest and best use of their respective education and capacity, that focus on health promotion as well as disease prevention and chronic disease management, that make use of all therapeutic approaches and providers including CAM, and that facilitate collaboration and team delivery of care. We also need reimbursement mechanisms and incentives that will help us get intended results. We remain locked in a fee for service mentality. It is very simple formula – the more services you provide or tests and procedures you do, and the higher the price – the more money the provider makes. As Clay Christensen noted in his book the Innovator's Prescription – it encourages providers not to offer as much care as needed, but to offer as many services as possible for which there is coverage. In order to make ends meet for clinics, providers are constantly trying to patch together procedures that will help cover costs rather than focusing on what would help patients lead healthier lives. The system is flawed in that it will reimburse for procedures, but will not reimburse for a nutritional or lifestyle counseling session. Reimbursement from both private and government sponsored programs reflect not the level of service performed, but rather the educational level of the provider. Reimbursement for services provided by advance practice registered nurses (APRNs) can range from 65-85% of the physician fee. This differential has the effect of discouraging clinics from having APRNs provide services for which they are trained and capable and encouraging the same services to be performed by physicians in order to maximize reimbursement. Discrimination in reimbursement occurs with CAM professionals as well as PA's and APRNs.
- We need strategic investment in infrastructure, particularly in the areas of research and education.
 - Research – the stimulus package is providing a desperately needed influx of funds for the research enterprise which is badly underfunded. Instead of using these funds for business as usual, it would be most helpful to have the investment focus on research that is very applied – that will create jobs – the research equivalent of “shovel ready projects”. NIH has focused heavily on basic science research over the past 8 years, we need translational and applied research. Integrated health care is ripe for this

and could produce the innovation that is so badly needed within healthcare reform.

- Education – As daunting as the task is to fundamentally change our health care system including care models and reimbursement, we face an equally daunting task in transforming how we educate health professionals. There is tremendous resistance to change, lots of incentive to maintain the status quo, discrimination in how CAM institutions fare compared to conventional institutions and very few, if any, educational programs that are truly transformative. Faculty cultures in both CAM and conventional institutions are deeply engrained and are a major barrier to change. We need disruptive innovation in education that is based on a future view of health care that includes a focus on health (diet, nutrition and exercise) as well as disease, a different mix of health professionals, a broader array of therapeutic approaches, and consumers who are activated to take charge of their health. If we invest in educational infrastructure, it is essential that the focus be on innovation, rather than maintenance of the status quo.

To provide the leadership necessary to launch and manage this initiative, it is recommended that a Federal office be established, with a director and staff, who would be responsible for developing policies and programs for lifestyle-based chronic disease prevention and management, integrative health care practices and health promotion.

Integrative health care holds the potential of shifting the current US health care system from one that is sporadic, reactive, disease-oriented and physician-centric to one that fosters an emphasis on health, wellness, early intervention for disease, patient empowerment, and a focus on the full range of physical, mental, spiritual and social support needed to improve health and minimize the burden of disease.