202 - 456-2957

202 - 456 2439 - (FAX)??

Sandy Thurman:
Can not attend - send info
Maybe someone else can
make it.

Sandy Thurman
202-456-1414 PH
1 (2437)
202-456-2438 FAX

HIV / AIDS

Sidney Wolfe
202-588-1000
x 7735
See Note

Agenda
Ex order
Questions

Mary Ann Richardson
2-1272
CA. Cost effectiveness
from experience
M.D. Anderson
& other persons

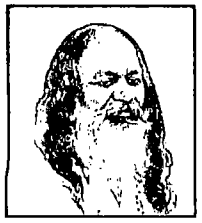
10 Jan 01

Joan,

Can you please:

① Make a copy for me

② File the original with the material from the 4-5 Dec 00 mtg? Thanks, Joe



MAHARISHI INTERNATIONAL UNIVERSITY 1971–1995

MAHARISHI UNIVERSITY OF MANAGEMENT

Fairfield, Iowa 52557-1134 U.S.A.

COLLEGE OF
MAHARISHI VEDIC MEDICINE
Telephone: (515) 472-1150 . Fax: 472-1167
E-mail: cmvm@mum.edu • www.mum.edu/CMVM

CENTER FOR
NATURAL MEDICINE AND PREVENTION
Telephone: (515) 472-1129 . Fax: 472-1167
E-mail: cnmp@mum.edu • www.mum.edu/CNMP

MAHARISHI
MAHESH YOGI
The Founder

DEGREE PROGRAMS

Ph.D. Programs
- Management
- Neuroscience of Human Consciousness
- Physiology
  *Maharishi Vedic Medicine**
- Physics
- Psychology
- Science of Creative Intelligence

Master's Programs
- Business Administration
- Computer Science
- Distance Education M.B.A
- Education
- English
  Creative Writing
- Fine Arts
  Digital Media
  3-D Animation
  Visual Arts
- Mathematics
- Professional Writing
- Psychology
- Science of Creative Intelligence

Bachelor's Programs
- Biochemistry
- Biology
  Environmental Studies
  Pre-Medicine
  Sustainable Agriculture
- Chemistry
- Computer Science
- Education
- Electronic Engineering
- Electronics
- Fine Arts
  Digital Media
  Film/Video Arts
  Intermedia Arts
  Music
  Theater Arts
  3-D Animation
  Visual Arts
  Website Design
- Literature
  Writing
- Maharishi Vedic Medicine
- Management
- Mathematics
- Physics
- Psychology
- Science of Creative Intelligence

Certificate Programs
- ESL
- Furniture and Woodworking
- Sanskrit and Reading Vedic Literature

Rotating University
Courses available overseas

**Italics indicate a specialization, emphasis, or minor. Additional programs are authorized and may be offered in some academic years*

December 18, 2000

Dr. Joseph Kaczmarczyk
White House Commission on Complementary and Alternative Medicine Policy
6701 Rockledge Drive
Suite 1010, MSC 7707
Bethesda MD 20817

Dear Dr. Kaczmarczyk;

Enclosed are materials from Dr. Robert Schneider that are in response to Dr. Gordon's request for information on reimbursement for Maharishi Vedic Medicine, including the Transcendental Meditation program.

If you have any further questions, please let us know.

Sincerely,

Jean Symington Craig
Executive Assistant to the Dean
College of Maharishi Vedic Medicine
Maharishi University of Management
504 N. 4th St., Suite 207
Fairfield IA 52556

Engaging the Managing Intelligence of Nature

Benefits to Employees and Organizations that Result from Stress Reduction through the Transcendental Meditation Program

Improvements in

Health, Personal Effectiveness, Quality of Life, Teamwork, Organizational Effectiveness, Economic Vitality

The following list of individual and organizational performance measures have been identified as being stress-caused, stress-related, or exacerbated by physiological stress. These metrics are derived from 1) organizational research on the cost of stress; 2) interviews with hourly and salaried human resources personnel employed by General Motors, Ford Motor Company, and DaimlerChrysler Corporation; 3) economic research; and 4) scientific research on the Transcendental Meditation (TM) technique.

This list of stress-related metrics is by no means comprehensive; it merely indicates some of the many ways that individual employees and organizations benefit from implementation of the TM technique as a means to reduce stress.

BENEFITS OF ORGANIZATIONAL STRESS REDUCTION

1 IMPROVED EMPLOYEE HEALTH; REDUCED HEALTH-RELATED COSTS

1.1 Improved Physical Health

1.1.1 Reduced need for healthcare (in-patient, outpatient, medications)

1.1.2 Improved energy and vitality

1.1.3 Reduced premature death

1.1.4 Few incidences of disability (short- and long-term)

1.1.5 Fewer sick days

1.2 Improved Mental Health

1.2.1 Reduced anxiety

1.2.2 Reduced depression

1.2.3 Reduced anger and hostility

1.2.4 Increased self-efficacy and self-confidence

1.2.5 Improved adaptability; flexibility; willingness to change

1.2.6 Increased frequency and duration of psychological "flow"

1.3 Reduced "Other" Health-related Costs

1.3.1 Reduced workers compensation costs

1.3.2 Reduced sick leave abuse

1.3.3 Less need for replacement workers

1.3.4 Fewer accidents / injuries *(Blue Cross data: 63% reduction in injuries due to accidents for individuals practicing the TM technique)*

1.3.4.1 Reduced wage-costs from time lost by injured worker(s)

1.3.4.2 Lower salary costs for time lost by workers who were associated with an accident but not injured

1.3.4.3 Less damage to material or equipment due to accidents

1.3.4.4 Reduced cost of overtime work due to accidents and injuries

1.3.4.5 Reduced wages paid supervisor for time required for activities necessitated by an accident (including investigations or processing compensation application forms)

1.3.4.6 Reduced wage costs caused by decreased output of injured worker after return from work

1.3.4.7 Reduced cost of learning period for new worker

1.3.4.8 Lower uninsured medical costs

1.3.4.9 Reduced miscellaneous usual costs (e.g., liability claims, etc.)

1.3.5 Less absenteeism

1.3.6 Less overtime to cover for absent workers

1.3.7 Reduced drowsiness from medications

1.3.8 Lower salary replacement costs

1.3.9 Lower turnover rates; reduced loss of job knowledge

1.3.10 Fewer work-related stress incidents

1.3.11 Improved sleep patterns

1.3.12 Less age-related illness

2 IMPROVED INDIVIDUAL EFFECTIVENESS

2.1 Improved prioritizing, planning, organizing, and time management

2.2 Increased effectiveness, efficiency, performance, and accomplishment

2.3 Increased flexibility; more rapid adaptation to business / technology changes

2.4 Improved primary- and secondary-process creativity

2.5 Faster / improved learning ability; improved comprehension

2.6 Improved analytical ability, problem-solving ability, and decision-making

2.7 Broader comprehension; improved systems thinking; increased field independence; improved alertness and ability to focus

2.8 Improved personal initiative

2.9 More effective leadership practices

2.10 Optimized climb orientation

2.11 Higher job satisfaction / morale

2.12 Reduced diversion of supervisor / manager time

2.13 Easier accommodation to off-shift work

2.14 Improved ability and tendency to follow processes

2.15 Reduced waste

2.16 Reduced equipment damage; reduced jobsite pilferage / theft

2.17 Less "presenteeism"

2.18 Fewer incidences of tardiness

3 PERSONAL BENEFITS FOR INDIVIDUAL EMPLOYEES

- 3.1 Greater self-actualization
- 3.2 Increased personal income
  - 3.2.1 Higher real spendable hourly earnings
  - 3.2.2 Growth of real median annual family income
  - 3.2.3 Increased sharing of income from productivity improvements
- 3.3 Shorter work hours (multiple jobs, overtime)
- 3.4 Decreased involuntary part-time work
- 3.5 More paid time off: vacation time, holidays, sick pay
- 3.6 Greater job security

4 IMPROVED TEAMWORK

- 4.1 Increased harmony, reduced friction among workers
- 4.2 Enhanced communication
- 4.3 Increased trust
- 4.4 Improved cooperation and collaboration
- 4.5 Reduced need for redundant administration
- 4.6 Improved interpersonal relationships
- 4.7 Reduced training costs (faster training, less training required)
- 4.8 More effective managerial style
- 4.9 Improved employee satisfaction
- 4.10 Better recognition and rewards for good performance
- 4.11 Greater access to sufficient information to do job well
- 4.12 More effective active encouragement to be creative and use initiative
- 4.13 Accelerated design-to-market speed
- 4.14 Higher level of staff support
- 4.15 More/better suggestions made and implemented

5 GREATER ORGANIZATIONAL EFFECTIVENESS

5.1 Improved "flow of value" through the organization

5.2 Greater degree of employment / team / organization alignment

5.3 Improved ability to meet targets for financial, customer, and internal-process objectives sources: employees, systems, and organizational alignment

5.4 Greater organizational cohesion; improved diversity-based synergies

5.5 Improved customer satisfaction

5.6 Improved profitability

5.7 Increased revenue per employee

5.8 Increased stock prices, improved price-to-earnings ratio, increased shareholder support

5.9 Accelerated rates of modernization

5.10 Improved competitiveness

5.11 Healthier organizational climate

5.12 Improved strategic job coverage ratio

5.13 Improved information system capabilities

5.14 Higher percentage of processes with real-time quality

5.15 Reduced cycle time

5.16 Better public image

6 IMPROVED LABOR RELATIONS

6.1 Improved health and safety for hourly employees

6.2 Improved quality of work life

6.3 Lower grievance rates

6.4 Improved participative decision-making

6.5 Higher overall satisfaction with company

6.6 Lower turnover rates

6.7 Reduced loss of job knowledge

7 ECONOMIC BENEFITS

7.1 Higher macroeconomic productivity growth rates

7.2 Improved productivity dividend (the difference between productivity growth and real wage growth)

7.3 Lower labor unit costs

7.4 Lower inflationary pressures

7.5 Lower interest rates

7.6 Reduced unemployment

7.7 Improved foreign trade performance

7.8 Increased share of gross domestic product devoted to gross fixed nonresidential investment

7.9 Improved investment performance

7.10 Increased investment share (the share of gross domestic product devoted to gross fixed non-residential investment)

7.11 Faster rate of growth of capital intensity (the ratio of productive capital to worker hours or employment)

7.12 Improved capital productivity

7.13 Faster adjustment to skills needs of economy; reduced earning gaps due to skills-mismatch

7.14 Reduced macroeconomic tension between full employment and productivity growth

7.15 Accelerated technological development

8 SOCIAL BENEFITS

8.1 Higher standards of living, reduced incidence of poverty

8.2 Improved family harmony and marital stability, reduced domestic violence

8.3 Stronger sense of community

8.4 Decreased incidence of teen pregnancy, illegitimacy

8.5 Lower school drop-out rates

8.6 Lower crime rates, lower incarceration rates; lower government costs due to lower incarceration rates

The Stress Management / TM Program

References

from General Motors employees and educational, governmental, medical, legal, military, and religious institutions

Corporate Development Institute

5600 West Maple Road, Suite C-312 • West Bloomfield, Michigan 48322 • Tel: 248-737-5889

The Stress Management / TM® Program

Introduction. The Transcendental Meditation® (TM) program is the most thoroughly researched relaxation method in the scientific literature. Over 600 TM studies have been conducted at more than 200 independent research institutions. Research on the TM program has been published in over 150 peer-reviewed scientific journals.

Among research findings, a five-year Blue Cross study of 2,000 TM practitioners has reported a 56% reduction in 17 major illness categories—including 87% less cardiovascular disease, 55% less cancer and tumors, and 63% fewer injuries due to accidents. Over 40 measures of aging are reduced or reversed through practice of the technique. A study by the Swedish National Health Board reported that psychiatric hospital admissions for the 35,000 TM participants in Sweden were 150 to 200 times lower than the national norms. More than twenty TM studies have shown significant reductions in substance misuse for cigarettes, alcohol, and illegal drugs among both normal and heavy users. Over 45 published TM studies have identified improvements in brain functioning that are correlated with improvements in mental performance, behavior, and interpersonal relationships.

Reducing risk factors. Peer-reviewed published research on TM program has demonstrated its effectiveness in

- reducing physiological stress;
- reducing hypertension (16 studies, including 7 NIH-funded studies);
- reducing hypercholesterolemia;
- improving factors related to atherosclerosis (lowering lipid peroxide levels and elevating serum dehydroepiandro-sterone sulfate levels);
- reducing exercise-induced myocardial ischemia in patients with coronary artery disease;
- reducing cigarette, alcohol, and illicit drug use;
- improving psychological health (reducing trait anxiety, depression, neuroticism, aggression, and improving self-actualization and other psychological measures);
- improving physiological stress measures associated with Type A behavior;
- nomalization of weight (unpublished study).

Comparison with other stress management approaches. Comparative research—pooling over 790 studies—consistently indicates that the TM technique is the most effective stress management method available. A Stanford University meta-analysis of 146 separate studies on a wide range of stress management programs, found the TM technique to be four times more effective than the next best method for reducing trait anxiety. Other comparison studies report the TM technique to be the best stress management modality for reducing hypertension; reducing substance abuse; and increasing self-actualization.

In addition, while the TM program's effectiveness is independent of self-selection influences, the program is beneficial for promoting compliance with physical fitness and lifestyle modification approaches.

Practice of the TM technique. The TM technique is practiced twice daily while sitting comfortably with the eyes closed. Practice of the technique does not require change in lifestyle. The technique is neither philosophical nor religious in nature. People from all walks of life practice the TM technique. Over two million Americans have been instructed in the technique, including 40,000 Michiganians. The TM program has been endorsed by hundreds of city, state, and federal agencies including, the U.S. Congress and the U.S. Army. The U.S. National Institutes of Health have provided over $18,000,000 in funding for on-going TM cardiovascular and cancer research.

Instruction in the TM technique. The TM course begins with six **Foundation** classes attended within the first month of instruction and one **Acceleration** class attended monthly in each of the next four months following Foundation classes. In addition, employees may attend optional, on-site Acceleration classes held weekly (on employees' time) during 48 weeks of the year.

Tuition. Tuition for the Stress Management/TM program is $1,000. In addition to the Foundation classes and Acceleration classes, this one-time tuition fee also covers unlimited optional consultative support for the employee's lifetime at any TM training center in the United States.

TM Instructor qualification. The procedure of instruction in the TM technique is precise and closely attuned to the unique experience of the individual learning the technique. The TM technique can be learned only from qualified instructors. TM instructor training involves approximately 1,500 classroom hours and 1,100 laboratory hours. Corporate TM instructors average over fifteen years' experience teaching the TM technique.

Contents

In this volume, letters of endorsement on the TM technique appear in eight sections:

Section 1

History of the Stress Management / TM® Program at General Motors

During the past four years there has been growing interest in the use of the Stress Management/TM program to promote employee health and development on the part of some GM healthcare and organizational development staffs. Over the past twenty years, thousands of GM employees have attended the TM course of instruction, and two formal GM studies of the TM program have been conducted.

In 1993 a three-month study of 125 GM employees in Dayton who learned the TM technique was published in the journal *Anxiety, Stress, and Coping.* The study reported significant improvements in health and health behaviors, employee development, work relationships, and job satisfaction. Two years later, a follow-up survey found that 80% of the study participants were still practicing the TM technique on a daily basis; most of the remaining 20% of participants stated that they continued to use the technique on a 'frequent' basis.

Tuition Assistance Eligibility. In March 1997, on the recommendation of GM Organizational and Employee Development management, the TM course of instruction became eligible for coverage under the Tuition Assistance Program for salaried personnel. In August 1997, the TM program became eligible for coverage by UAW-GM Tuition Assistance for hourly employees.

GM employees attending TM courses have come from a diverse range of GM organizations: Truck Group, Car Group, Powertrain Division, Metal Fabricating Division, UAW-GM Center for Human Resources, Quality Network, Health Care Initiatives, and Milford Proving Grounds.

Letters of endorsement from GM personnel employed at the following GM organizations follow.

- Powertrain
- Car Group
- Delphi - Delco Products

Section 2

Educational Institutions

Since the first TM/SCI course was attended by 400 students at Stanford University in 1970, hundreds of thousands of students at hundreds of American colleges and universities have learned the TM technique and enjoyed improvements in their academic performance. Letters of endorsement from faculty members of a few of the universities where the TM course has been taught follow.

- Harvard University
- Stanford University
- University of Michigan
- Yale University

Section 3

Medical Institutions

Over half of individuals learning the TM technique are physician referrals. Following are letters of endorsement for the TM program from nationally renowned experts representing a variety of health disciplines.

- David F. O'Connell, M.D., Corporate Clinical Director, Caron Foundation (one of America's top three addiction treatment centers)
- Peter Salk, M.D., Vice President and Scientific Director, Jonas Salk Foundation
- Brian F. Hoffland, Ph.D., Senior Vice President, The Retirement Research Foundation (America's largest private foundation dedicated to research on aging)
- Stephen M. Teague, M.D., F.A.C.C., Editorial Board of the *American Journal of Noninvasive Cardiology*
- Frank Staggers, M.D., Stress Management Department, West Oakland Health Center
- Gary Kaplan, M.D., Ph.D., Department of Clinical Neurology, North Shore University Hospital
- Jerome Markovitz, M.D., M.P.H., Division of Preventive Medicine, School of Medicine, University of Alabama at Birmingham
- Arthur Cohen, M.D., Department of Pathology, Presbyterian Hospital
- Cesar Molina, M.D., Cardiologist

Section 4

Governmental Agencies

Over the past thirty years thousands of federal, state, and local governmental agencies have endorsed or issued proclamations recognizing the unique value of the TM program. A sample of these documents from the following institutions are included in this volume:

- United States Senate
- Office of the Governor - State of Michigan
- House of Representatives - State of Michigan
- House of Representatives - State of Illinois
- House of Representatives - State of Missouri
- Senate - State of Montana
- Office of the Mayor - Ann Arbor
- Office of the Mayor - Detroit (available on request)
- Office of the Mayor - Fraser
- Office of the Mayor - Kalamazoo
- Office of the Mayor - Sterling Heights
- Office of the Mayor - Utica
- Office of the Mayor - Warren

Section 5

Legal and Corrections Agencies

Over thirty-one U.S. correctional facilities have implemented TM courses of instructions for staff and inmates. The following letters discuss the efficacy of the TM program for rehabilitation from some of these institutions and legal experts.

- Supreme Court of Missouri
- Twenty-second Judicial Circuit of Missouri
- District Court of Hampshire, State of Massachusetts
- American Correctional Association
- United States Department of Justice, Department of Prisons
- Alternative Discipline Center, Fern Ridge High School
- Gallop, Johnson & Neumann, L.C.
- Corn Associates

Section 6

Military Services and Veterans Administration

Since the 1970s the Transcendental Meditation program has been taught to United States military personnel from all of the armed forces. The TM technique has been taught at the Pentagon, at the military academies, and at bases throughout America. The TM course has been taught at USAEURA (U.S. Army Headquarters, European Area) and at twenty-two military facilities in Germany. Generals have learned the TM technique in the field in Korea. In 1974 the U.S. Army gave its highest peacetime award—the Army Commendation Medal, approved by the Secretary of the Army—to the serviceman who implemented the TM program as a drug treatment modality.

Today, the Veterans Administration covers the cost of TM instruction for veterans whose VA physicians recommend the TM technique for their treatment. This section includes documents from the following military departments:

- Department of the Army - The Army Commendation Medal
- Department of the Air Force
- Department of Veterans Affairs

Section 7

Religious Institutions

The Transcendental Meditation technique is a simple, natural technique that provides profound benefits for mental and physical health. Practice of the technique involves no change in lifestyle. The TM technique requires no particular belief—even regarding the effectiveness of the technique—in order to produce the profound benefits that it generates for the individual. The TM technique is neither philosophical nor religious in nature. Over two million Americans from every walk of life have learned the TM technique—among them, several thousand clergy from every religious tradition. Included below are samples of letters from religious authorities who have recommended the TM program to their communities.

Christian

Protestant

- *Baptist:* Beth Eden Baptist Church (available on request)
- *Episcopal:* Narragansett School, St. Paul's Church
- *Lutheran:* Hope Lutheran Church
- *Methodist:* Wesley United Methodist Church
- *Presbyterian:* Christ United Presbyterian Church
- *Religious Science:* First Church of Religious Science
- *United Church of Christ* (Congregational) of Windham

Roman Catholic

- Holy Family Rectory
- Maryknoll Seminary
- Notre Dame High School
- Order of Saint Francis
- Saint John's University Sisters of the Divine Savior
- Saint Mary Church
- The Christian Holiday House
- University of St. Thomas

Jewish

- Temple De Hirsch of Sinai
- Temple B'Nai Emet
- Jewish Community Center of Houston
- Congregation Beth Shalom
- Neve Shalom

Section 8

Scientific Research on the TM Program

The scientific research on the Stress Management / TM program is the largest and strongest body of research in the world on any program to develop human potential. Over 600 studies on the TM program have been conducted at 200 independent universities and institutions. The findings of this research, published in over 150 leading scientific journals, document the program's benefits in every sphere of life. The benefits in each area have been replicated many times. Meta-analyses—the most quantitatively rigorous means to review a body of research—find a high degree of consistency of the results.

Research on the TM technique is also unique in the extent of its cross-validation by many different types of measures. For example, the finding that the TM technique decreases stress is validated by physiological changes such as decreased cortisol (the major stress hormone), decreased muscle tension, normalization of blood pressure, increased autonomic stability, and increased EEG coherence. Psychological research on the TM technique also indicates decreased stress, including decreased anxiety and depression, decreased post-traumatic stress syndrome, and increased self-actualization. Likewise, stress reduction is demonstrated by sociological changes produced by the TM technique, such as improved relationships with supervisors and co-workers, improved teamwork and organizational effectiveness, and increased family harmony.

Increased Intelligence

The TM-Sidhi Program, Pure Consciousness, Creativity, and Intelligence. *The Journal of Creative Behavior,* 1985, 19(4): 270-275.

The TM-Sidhi Program, Age, and Brief Tests of Perceptual-Motor Speed and Nonverbal Intelligence. *Journal of Clinical Psychology,* 1986, 42: 161-164.

Longitudinal Effects of the Transcendental Meditation and TM-Sidhi Program on Cognitive Ability and Cognitive Style. *Perceptual and Motor Skills,* 1986, 62: 731-738.

Increased General Intelligence through the Transcendental Meditation and TM-Sidhi programs. Paper presented at the *Annual Meeting of the American Psychological Association,* New Orleans, August 1989.

Increased Intelligence and Reduced Neuroticism through the Transcendental Meditation Program. *Journal of Psychology,* 1975, 3: 167-182.

The Effect of the Transcendental Meditation Program on the Organization of Thinking and Recall (Secondary Organization). *Scientific Research on the Transcendental Meditation Program:* Collected Papers, Vol. 1: 385-392, MERU Press.

Enhanced Creativity

The Transcendental Meditation Program and Creativity. *Scientific Research on the Transcendental Meditation Program:* Collected Papers, Vol. I, 1977, MERU Press.

Creative Thinking and the Transcendental Meditation Technique. *The Journal of Creative Behavior,* 1979, 13(3).

The Psychophysiology of Advanced Participants in the Transcendental Meditation Program: Correlations of EEG Coherence, Creativity, H-Reflex Recovery, and Experience of Transcendental Consciousness. *Scientific Research on the Transcendental Meditation Program:* Collected Papers, Vol. 1: 208-215, MERU Press.

The Transcendental Meditation Technique and Creativity: A Longitudinal Study of Cornell University Undergraduates. *The Journal of Creative Behavior,* 1979, 13, 169-180.

EEG Phase Coherence, Pure Consciousness, Creativity, and TM-Sidhi Experiences. *International Journal of Neuroscience,* 13: 211-217.

The TM-Sidhi Program, Pure Consciousness, Creativity, and Intelligence. *The Journal of Creative Behavior,* 1985, 19(4): 270-275.

Improved Problem Solving

Meditation and Flexibility of Visual Perception and Verbal Problem Solving. *Memory & Cognition,* 1982, 10: 207-215

Neurophysiological Entry Characteristics: Correlation between EEG Coherence and Math Achievement with Subjects Practicing the TM Program. *Scientific Research on the Transcendental Meditation and TM-Sidhi Program:* Collected Papers, Vol. 3: 1720-1723.

A Unified Approach to Developing Intuition in Mathematics. Proceedings of the *Eugene Strens Memorial Conference on Intuitive an Recreational Mathematics and Its History,* Calgary, July/August, 1986. Mathematical Association of America Notes.

More Effective Learning

The Transcendental Meditation Technique and Postgraduate Academic Performance. *British Journal of Educational Psychology,* 1985, 55: 164-165.

Participation in the Transcendental Meditation Program and Frontal EEG Coherence during Concept Learning. *International Journal of Neuroscience,* 1986, 29: 45-55.

Frontal EEG Coherence, H-reflex Recovery, Concept Learning, and the TM-Sidhi Program. *International Journal of Neuroscience,* 1981, 15: 151-157.

Academic Achievement and the Paired Hoffman Reflex in Students Practicing Meditation. *International Journal of Neuroscience,* 1984, 24: 261-266.

Paired-Associate Learning and Recall: A Pilot Study of the Transcendental Meditation Program. *Scientific Research on the Transcendental Meditation Program:* Collected Papers, Vol. 1, 377-381, MERU Press.

Performance on a Learning Task by Subjects Who Practice the Transcendental Meditation Technique. *Scientific Research on the Transcendental Meditation Program:* Collected Papers, Vol. 1: 382-384, MERU Press.

More Rewarding Personal Relationships

Transcendental Meditation and Social Psychological Attitudes. *The Journal of Psychology,* 1978, 99: 121–127.

Effects of Sensitivity Training and Transcendental Meditation on Perception of Others. *Perceptual and Motor Skills,* 1979, 49: 270.

Effects of Transcendental Meditation on Self-identity Indices and Personality. *British Journal of Psychology,* 1982 73: 57–68.

Transcendental Meditation Program and Marital Adjustment. *Psychological Reports,* 1982, 51: 887–890.

Other Improvements in Work-related Measures

Effects of the Transcendental Meditation Program on Stress Reduction, Health, and Employee Development: A Prospective Study in Two Occupational Settings. *Anxiety, Stress, and Coping,* 1993, 6: 245-262.

Transcendental Meditation and Productivity. *Academy of Management Journal,* 1974, 17: 362-368.

Effects of the Transcendental Meditation Program on Work Attitudes and Behavior. *Study conducted at the Graduate School of Business, University of Chicago.*

The Effects of a Stress Management Program in a High-security Government Agency. *Anxiety, Stress, and Coping,* 1997, 10: 341-350.

Improved Mental Health

Differential Effects of Relaxation Techniques on Trait Anxiety: A Meta-analysis. *American Psychological Association Convention,* August, 1984.

Transcendental Meditation, Self Actualization and Psychological Health: A Conceptual Overview and Statistical Meta-Analysis. *Journal of Social Behavior and Personality,* 1991, 6(5): 189-247.

Psychological Findings on Transcendental Meditation. *Journal of Humanistic Psychology* (in press).

The Effects of the Transcendental Meditation Program on Levels of Hostility, Anxiety, and Depression. *California Education Research Association, Fifty-third Annual Meeting,* November, 1974.

Effects of Transcendental Meditation on the Mental Health of Industrial Workers. *Japanese Journal of Industrial Health,* 1990, 32(7): 346.

Cognitive Orientation toward Positive Values in Advanced Participants of the TM and TM-Sidhi Program. *Perceptual and Motor Skills,* 1987, 64: 1003-1012.

Better Physical Health

The Effects of Transcendental Meditation Compared to Other Methods of Relaxation and Meditation in Reducing Risk Factors, Morbidity, and Mortality. *Homeostasis,* 35, 1994, No. 4-5.

In Search of an Optimal Behavior treatment for Hypertension. From *Personality, Elevated Blood Pressure, and Essential Hypertension.* 1992, pp. 291-312, Hemisphere Publishing Corporation. Washington, D.C.

Lower Lipid Peroxide Levels in Practitioners of the Transcendental Meditation Program *Psychosomatic Medicine,* 1998, 60: pp. 38-41

Effects of Transcendental Meditation on the Health Behavior of Industrial Workers. Japanese *Journal of Public Health* 37(10): 729 (1990).

Reduced Healthcare Utilization and Costs

Medical Care Utilization and the Transcendental Meditation Program. *Psychosomatic Medicine,* 1987 49: 493-507.

An Innovative Approach to Reducing Medical Care Utilization and Expenses. *American Journal of Managed Care,* 1997, 3:135-144.

The Impact of the Transcendental Meditation Program on Government Payments to Physicians in Quebec. *American Journal of Health Promotion.* January-February 1996, 10(3): 208-216.

Responses to the following questions would assist the Commission to arrive at recommendations for the report to the White Conveners. Please provide the information available to you and supplement with additional

Questions for 4-5 Dec 00 WHCCAMP Meeting on Access and Delivery

Session II Systems of CAM Access and Delivery
General Questions:

1. What are the clinical effectiveness and cost-effectiveness data for access to and delivery of the complementary and alternative medicine (CAM) modality about which you have been asked to testify? When providing clinical effectiveness data, please indicate for which conditions and populations the CAM modality has been demonstrated to be effective as well as where (type of practice setting), how (as a stand-alone CAM therapy or in conjunction with conventional medicine), and by whom (type of practitioner) it was delivered. When providing cost-effectiveness data, please specify if the modality were delivered as a stand-alone CAM therapy or in conjunction with conventional medicine as an integrative approach and how the costs compare with those of conventional medicine. Also, if there are any [patient] satisfaction data available, please include these as well. In general, these data should address why access to and delivery of the CAM modality is worthwhile.
2. What are the barriers to access and delivery of the CAM modality about which you have been asked to testify and what policy recommendations can you suggest to overcome those barriers?
3. Should the CAM modality about which you been asked to testify be delivered as a stand-alone CAM therapy or along with conventional medicine as part of an integrative model and why?
4. What other policy recommendation would you like to make about the CAM modality about which you have been asked to testify?

Additional Specific Question for Dr. Dennis Awang:
What should be done to prevent adverse interactions such as botanicals with prescription or OTC drugs, dietary supplements, or foods?

Session III Use of CAM for Selected Health Conditions
General Questions:

1. After describing your program in one paragraph, please compare it with conventional care. Specifically, is your approach better than conventional care? If so, how and why? Please include outcomes, cost-effectiveness, and patient satisfaction data (if available) to support access to and delivery of your program? In addition, you should submit any other relevant program descriptions, documentation, or other materials to the Commission.
2. What are the barriers to access to and delivery of your program and what policy recommendations can you suggest to eliminate those barriers?
3. To whom should your type of program be accessible and where, how, and by whom should it be delivered? Should your type of program be a stand-alone program or should it be integrated with conventional care and why?
4. What other policy recommendations would you like to make to translate your lessons learned into policy?

Session IV. Issues in Integrating CAM into Service Delivery

General Questions

1. Should CAM be integrated with conventional medicine and why or why not?
2. What are the keys to successful integration of CAM with conventional medicine and into what policy recommendations should they be translated?
3. What other policy recommendations would you like to make to the Commission?

Specific Questions for Michele Forzley:

1. After describing the purpose and methods of your pilot study of CAM integration in one paragraph (including how and why modalities and providers were selected), what were the results, particularly the common themes identified?
2. What are the international laws and treaties which have relevance to the integration of CAM by the US?
3. Based on the above two questions, what policy recommendations can you suggest to the Commission?

Specific Questions for Dek Kendall:

1. Given the significant (often conflicting) philosophical diversity among the multiplicity of schools or forms of acupuncture, how has OPEIU/the Guild contributed to improved access to and delivery of not only acupuncture in particular, but also oriental medicine in general?
2. What policy recommendations does OPEIU/the Guild have for the Commission to improve access to and delivery of acupuncture and the spectrum of oriental medicine for populations such as the under-insured, uninsured, poor, and medically underserved?

Specific Questions for Joseph Van Orsdel:

1. Why have you made CAM services available?
2. How do you decide which CAM services are available as well as who and where the CAM services are provided?
3. What barriers to access and delivery of CAM services have you encountered and how have you overcome them?
4. Based on your experience and Labor perspective, what policy recommendations do you have for the Commission?

Specific Questions for Candace Campbell-Meshin:

1. Why should there be access to and delivery of CAM products and practices?
2. What is the role of CAM products and practices in self-care?
3. From your perspective, what barriers are there to access to and delivery of CAM products and practices and how have (or how should) they be overcome?
4. What policy recommendations do you have for the Commission?

Specific Question for Consumer Protection Perspective Representative:

1. Should there be access to and delivery of CAM products and services? If so, why? If not, why not?

2. If current CAM utilization trends continue, what consumer protections should be implemented?
3. What policy recommendations do you have for the Commission?

Session V. Meeting Public Needs: Systems of Delivery

Specific Questions for Dr. Roberts Atkins:
As a solo practitioner in private practice,
1. What has worked for you in terms of delivering your type of CAM and why has it worked?
2. What barriers have you encountered in delivering your type of CAM and how have you overcome them?
3. Based on your lessons learned, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Specific Questions for Ms. Charlotte Eliopoulus, RN:
1. Recognizing the multiple types of nurses, what, in your opinion, is the role of the nursing profession in access to and delivery of CAM products and practices?
2. What can nurses do to improve the access to and delivery of CAM products and practices?
3. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Specific Questions for Mr. Mort Rosenthal:
As an example of a free-standing for-profit CAM center:
1. What has been the key to your success (both financial and clinical)? In other words, why has you CAM center succeeded and what have you done differently?
2. What unique insights have you gained about access to and delivery of CAM products and practices can share with the Commission?
3. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Questions for J. Donald Schumaker and Dannion Brinkley:
In terms of a hospice setting:
1. Why should there be access to and delivery of CAM products and practices?
2. Which CAM products and practices should be available, how should they be selected, and who should deliver them?
3. What barriers have you encountered and how have you overcome them
3. What policy recommendations do you have for the Commission?

Specific Questions for Tom Trompeter:
As an example of a community health center (and that that it entails relative to the medically underserved):

1. Why and how did you decide to provide CAM products and practices?
2. How did you determine which CAM products and practices to make available and for which conditions, where (on-site or off-site referral) and by whom should they be provided?
3. What barriers did you encounter and how did you overcome them?
4. What is the role of nursing in access to and delivery of CAM products and services in a community health center?
5. What policy recommendation do you have for the Commission to improve access to and delivery of CAM products and practices by community health centers?

Specific Questions for Dr. Sylver Quevedo:
As an example of a community hospital-based CAM center:

1. Why and how did you decide to open your center in a community-hospital?
2. How did you determine the staffing and CAM service mix?
3. What is the role of nursing in the access to and delivery of CAM products and practices in a community-hospital-based CAM center?
4. What are the keys to your success?
5. What have you done to improve access to and delivery of CAM products and services to the underinsured, uninsured, and medically underserved in your community?
6. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Specific Questions for Dr. Woodson Merrell:
As an example of a CAM center in an academic medical center:

1. Why and how did you decide to open your center in an academic medical center?
2. How did you determine the staffing and CAM services mix?
3. What is the role of nursing in access to and delivery of CAM products and practices in your center?
4. To what do you attribute your center's success?
5. What lessons can be learned from your financially-unique situation and applied to other less well-financed centers?
6. What have you done to improve access to and delivery of CAM products and services to the underinsured, uninsured, and medically underserved in your community?
7. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Specific Questions for Dr. James Dillard?
As an example of a managed care organization (MCO) offering CAM:

1. Why and how did your MCO decided to offer CAM products and services?
2. How did your MCO determine which CAM products and practices to cover/offer?

3. How did your MCO decide for which conditions, where, how, and by whom these CAM products and practices should be provided?
4. How much does it cost your members to access these CAM products and how were these rates established?
5. What is the role of CAM in self-care in your MCO?
6. Has your MCO collected and cost-effectiveness or patient satisfaction data? If so, what are the results?
7. Have any of your members had difficulty with access to or payment for Cam products or services? If so, please specify the difficulty and how it was resolved or should be resolved?
8. Based on your experience, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Specific Questions for Ms. Lori Beilinski:
From you perspective in Washington State Office of the Insurance Commissioner:
1. Should there be access to CAM products and practices? If so, to which products and practices and for which conditions should there be access and where, how, and by whom should these products and practices be delivered?
2. What should be done to make the CAM products and practices culturally and linguistically appropriate for CAM users?
3. Have you collected any data on clinical effectiveness, cost-effectiveness, patient satisfaction, or quality? If so, what did the data show?
4. What should be done to improve access to and delivery of CAM for the under-insured, uninsured, poor, and medically underserved?
5. Based on your experience, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

Specific Questions for Ms. Anna Silberman:
1. Why and how did you select the Ornish program?
2. Did you collect any data on its clinical effectiveness, cost-effectiveness, or patient satisfaction? If so, what did these data show?
3. How much does it cost your members to participate in this program?
4. Based on your experience with the Ornish program and other CAM products and practices, what policy recommendations do you have for the Commission?

Specific Question for Dr. Robert Schneider:
1. Do you have any data on the clinical effectiveness, cost-effectiveness, or patient satisfaction? If so, what did these data show? For which conditions and for whom was ayurveda effective?
2. Who should be providing ayurvedic products and practices?
3. Should ayruveda be accessed and delivered as a stand-alone system or should it be integrated with conventional medicine and why?

4. What policy recommendation do you have for the Commission?

Specific Questions for Dr. Tori Hudson:
1. Should naturopathic medicine in general be accessed and delivered as a stand-alone system or integrated with conventional care and why? Are there medical conditions or situations when this shouldn't be the case? Are there any data to support your position?
2. Should naturopathic health care for women be accessed and delivered as a stand-alone system or integrated with conventional care and why? Are there medical conditions or situations when this shouldn't be the case? Are there any data to support your position? Is there a documented patient preference for a stand-alone or integrated approach to naturopathic women's health care?
3. Based on your experience, what policy recommendation do you have for the Commission?

Specific Questions for Robert Duggan:
1. Should Traditional acupuncture be accessible and delivered as a stand-alone system or should it be integrated with conventional medical care and why?
2. Should Traditional acupuncture be accessible and delivered apart from or in conjunction with the other modalities of Oriental Medicine and why?
3. Based on your experience, what policy recommendation do you have for the Commission?

Specific Questions for Mr. Eddie Tso:
1. Should Traditional Navajo Medicine be accessible and delivered as a stand-alone system or should it be integrated with conventional medical care and why?
2. How can access to and delivery of Traditional Navajo Medicine be improved both on and off the reservation?
3. Based on your experience, what policy recommendation do you have for the Commission?

Specific Questions for Dr. Alan Trachtenberg:
1. What CAM products and practices does your Agency support? How, why, and by whom were they selected? Where, how, and by whom are they provided?
2. What has your Agency done to make the access to and delivery of CAM products and practices more culturally and linguisitically appropriate?
3. Is the delivery of CAM products and practices to your Agency's target populations accomplished as a stand-alone system or integrated with conventional care and why?
4. What does your Agency need to improve access and delivery of CAM products and practices to its target populations?

Focus of meeting is Access to and Delivery of CAM Services and Products. The Issue of Reimbursement will be presented in the Spring

Agenda - Using a Representative Sample of CAM, to Look at Clinical Effectiveness of CAM Intervention & Product, Inclusive of Pediatrics
Cost Effectiveness
Different Locations of CAM Delivery Systems & Utilization of CAM Services
Issues in Integrating CAM Interventions with Conventional Systems of CAM Delivery Systems Therapies

Summaries of October 5-6 meeting. Coordination of Services
Seattle Town Hall
will soon be posted on Website with the Transcript

Jim Sawyer will assist the Commission in the preparation of meeting summaries, interim report and final report

I would like to ask the Commissioners members to begin to think about possible recommendations for Interim report in July. We have had 2 Town Hall meetings with nearly 200 speakers and three Federal Hearings. The Commission will close to 100 speakers, both invited and public session meetings

I ~~and your Commissioners~~ Thank you to Presenters

* Wenn's testimony to
Send of Dr Wooly / Sal D'Onofrio

Phil Shinnick / Alice MacNeil — Dhan [illegible]

December 4-5,

WJ Social Dynamics of CAM Use — Involvement in all issues for [illegible]
* Send Out Chantilly Report to New Members
Lack of ~~Access to~~ Care / Insurance — Reason for using CAM
Yellow Book

From Chappell — Prevention & Wellness → How can it be brought down into reimbursement issues

- (Training & Education) — Interdisciplinary Training — Peer Commun[illegible] — to understand Benefits & components
Minnesota — $ /2 / Acupuncture Visit
MN
- Get Copies of Harley Goldberg — Advisory Panelson
- Education & Research — Multidisciplinary workgroup — what works, what doesn't work & why
- Reasonable Evidence of S & E
- QA Explore, who provides service & where do they work & where safety is OK, effectiveness not known? Who Pays is a & the most impt issue (?)

Fund organized systematic Review
↑ CL Review of Integration — compare to Standard Therapies
- Creating Public Info System
- Cost effectiveness of Mind Body Approaches
Guidelines
Policy - Promote the use of Whole Foods, by taxing junk food
WHO - Herbal Medicine / Herbal Remedies — TCM
American Herbalist Guild - Regulation Test & Nat'l Test — AYU — [illegible]

II J. ②

talk to Denise Drayton re NYC – People of Color

Wellness – What Pulls people into wellness Program & What keeps them in program
[illegible] – Psychological
Sociological

Frances Butler / February Credentialing + Licensing
different Groups to talk CO, WA, FL
Paul Kurtz | 21 PC | Studies
Evidence Based + Can not be done by Proponents Only
- Failure replications
- Experimental Bias
Pseudoscience
- Neutral Observer c̄ commitment to science

DEK
D.E. Kendall
→ Meeting c̄ AFL-CIO To discuss needs of Union Members
& movement to request CAM interventions

M.F. Harmonization – Licensing + Credentialing of professional / Healthcare Providers – (Maintain State Control but give examples of how things can be done)

Practitioner Freedom If they are willing to do this
If Substance, non toxic, Hx of non toxicity; No Economic Incentives for Product development
? Regulation of Practice (Modality)
Regulation of Practitioner

Anthropology of CAM practice in US.
Heterogeneity across USA

Reimbursement in current state is not optimal
- medical Savings Account -
- subsidy to those in need of treatment
-

Nursing Association
- AHNA - ANA -

12/5/00

Remove fear that licenses will be taken will be a major incentive.

Woody Merrell - Bill Israel - Integrated into
- all courses in Med School -
1 month rotation by all members of Family Practice residency
Fellowship / training Program - Doctors / Post MD
Role of CAM Providers - All CAM Practices should be integrated into ~~the~~ Family Practice

"Working on the Institution" - "not just the Patient"

Credentialing Guidelines for Chiro, Acu, Massage Therapy

"Belief Matters"

"Biology of Belief"

Personal
Wellness
Fitness
Fair ?
Health

Ⓢ

Highmark Overall Program — ✓ 17000/pt
Lifestyle Advantage   17 centers Healthplex   - 40,000 member/year
- Nutrition Counselor
- Osteoporosis

Set up meeting c̄ Len Nolan for a meeting c̄ [illegible]
February 13-15 (?) at the Bethesda Hyatt

Access - Something that is [illegible]
Service
(Visit) Chiropractic - Massage / Nutrition

Reimbursement cost / member / month   Dillard (Hard Data)
< 5% CAM   no Non CAM Practitioners

(Come back) — (Dillard Brubaker + Sullivan)

Natl Educational Program
Nutrition, Wellness,

5% c̄ [illegible] (HOTAS) Annual Budget
200,000

for travel June 30 - July 1 — Portland ME (6)

(1)(a) Check your ~~file~~ records for Reimbursement for the Honoraria you are entitled as a Commissioner (b) Expenses

Chantilly Report
Jim Sweeney

(2) Forms from Committee Management ~~Office~~ Office
Update ED OGC / Mandy Stoneberger / Mary

Chappell
DeVries
Fair
Loveday
~~Bay~~

(3) Working Subcommittees

Memo
Send letter to
Communicate
Major
Recommendations

(4) Recommendation - Draft - Outline

Congress /

Key Committee Contacts / Congress Briefing

= Osteopathic Manipulation in Hospitals
— Dentistry

CA Draft Letter to Congress

Blind Pointe
Blind Point ~~...~~
Prouts Neck, ME
Scarborough ME

7

Barnard Pub. Session
Nutrition onto agenda of AAMC / College
PHS - RFP for
Breast Ca

20 Year

9:00 R+
9:00 DP
10:30 CA
12:00 AY
1:30 Pavel

Alternative Link NCCAM COSAT ?

Boyd Landry

I Physician Acupuncture Reimbursement
II Hospital use of Acupuncture
III Diana Miller - (MD)
Courtney Banks - P. Hodgkins disease
Richard Pavek Biofield Research Institute -
All. Practitioners be funded
Conceptualizations ←

★ Dale's Information to Jim Gordon

Alan Trachtenberg → of Demonstration Programs / Integrative Demonstration

(Annie) Testimony to Alan Trachtenberg
Spirituality of addiction
Philosophy of
Financially Dependent - Model of Reimbursement
not trapped in old model of reimbursement

Top of the Menu

~~Well~~ Promoting Wellness (8)

Tom C - Equal Rights - Equal Accountability
Integration can occur where it's natural

David - Early Education - to get rid of those things ~~that~~ are detrimental to their health

V.G. - ~~Statement of Intent & Purpose of each~~ provider group
Adjustment is different than Manipulation

(BR) (Uninsured) - Minorities < Principles / Recommendations

CK - Multinational Corp
Dept of Agriculture

Spirituality

Subtle Energy
Public Health Aspect

J.F. Trustworthy - naturally get collaboration to keep everyone together

C.B. S+E of all treatments to get by-in by medical community
- "CAM" the name means so many different things
- Some groups in CAM don't want to integrate
"Universal Health care" - Interesting [illegible] issue

Need well thinker perspectives
a Wellness and
Health Care as a right not as privilege

"Liberation theology" — What women & minorities have done on the globe to show equality
Raise CAM up and affirm the equality

(GD)

onward wellness
Our Work is so important to the Health of the people of the United States

Recommendations can move in either track
Public Health Ed

W Fair — Universal Health Education — Family, Community
Recommendation on

Spirituality / Wellness

Values & Philosophy Issues
→ Health Support
Health Promotion methods for treatment
wellness

(Wants Needs Behavior
(Difference in the population)
"Access and Accountability" to get buy in
for delivery of care & services, quality of product,
AMA, HCFA, JCAHO,

Appraise process of something are always

Access (Pt right to Choose) if there is Accountability one

(Focus Group) ⇒ more Awareness

↑C Reimbursement is based on Affordability

(1) (A) System - definition — Medicine Whole System
Mercy Tran — Herbs, Acupuncture
Where We Are - W/ — How do we get there
(B) Liberal FDA Presence

CAM - Diagnosis of Symptom of the System and working

- Purpose & Meaning / What is Healing

Licensure — Individual States - Recommend States to License Statutes
Acupuncture / Chiro / Massage
↑ access + enhancement to delivery

Deepest Principle of Healing + Health Care

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

VII

Divider Title: _____

Kaczmarczyk, Joseph (NCCAM)

To: Groft, Stephen (NCCAM); Chang, Michele (NCCAM); Kingsbury, Doris (NCCAM); Pollen, Geraldine (NCCAM)
Subject: Update Briefing Books

2 Dec 00

I just finished assembling a briefing book for Ken Fisher and found a number of "items" which require updating. If I identify any additional "items" while reading the material tonight and Sunday, I'll point them out on Monday?

Please see below.

How do you want to handle the logistics of making these updates?

Thank you for the incredible team effort above and beyond the call of duty,
Joe

Briefing Book Updates:

[ ] Copy & insert Meeker's testimony behind II Tab B
[ ] Insert Brannon's testimony behind II tab I (she'll have 30 copies with her)
[ ] Correct placement Rosenthal's testimony behind V Tab C
[ ] Copy & replace page 8 Rosenthal's testimony
[ ] Copy & replace page 10 Rosenthal's testimony
[ ] Copy & insert Quevedo's testimony (2 parts... Initaial concept & Answers) behind V tab F
[ ] Invert 1st page reprint article in Scheinder's testimony V tab F (Recommend: hole punch & invert)
[ ] Move the press release (NIH Awards $8 Million...) from bios' (Schneider VI tab P) to V behind tab K
[ ] Copy and insert Quevedo Bio before Rosenthal's in VI tab P

***Note**: According to preprinted labels, 3 more briefing books need to be prepared... Doris Kingsbury, Fenton, and Dean Ornish. And what about one for Courtesy?*

CAM Cost Effectiveness/Clinical Effectiveness

I. Use of CAM Service by the Public

A. General Public - Eisenberg X2 , Astin, Druss/Rosenhack

B. MCO - Ken Pelletier

C. Why the Public Uses Cam Interventions -

D. Special Populations/Utilization Data

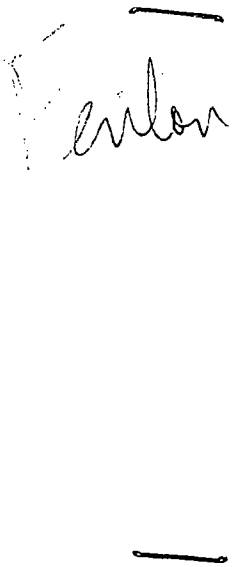
1.Geriatrics
2. Pediatrics — Michigan
3. HIV/AIDS - Sparber, Pawluck
4. Cancer - Solner, Morris, Rees, Richardson, Boss
5. Runaway Youth - Gardiner (Tufts), Breunner (UW)
6 .Cardiac Surgery - Lin (Columbiz)
7. Disabilities

II. Physician Knowledge /Attitude/Use/ Referral - Berman

III. CAM Practitioner Survey - Demographic Data - Cherkin

IV. Cost Effectiveness/Clinical Effectiveness

A. Mind /Body - Sobel
B. Reference to Other Presenters



On June 7, 1999, President Clinton signed Executive Order 13125, which seeks to improve the quality of life of Asian Americans and Pacific Islanders through increased participation in federal programs where they may be underserved.

The Executive Order establishes the first ever President's Advisory Commission on Asian Americans and Pacific Islanders, and a Federal Interagency Working Group on Asian Americans and Pacific Islanders.

The last Executive Order directly affecting AAPIs was Executive Order 9066, signed by President Roosevelt on February 19, 1942, which authorized the mass removal of over 120,000 Japanese and Americans of Japanese ancestry from western coastal regions to guarded, government-run concentration camps in the interior.

Asian Americans and Pacific Islanders have emerged from one of America's darkest periods in the history of personal freedom to a time of new hope for the future and for full participation in the democratic process.

Bay Area Community Reception Honoring the President's Advisory Commission on Asian Americans & Pacific Islanders

July 25, 2000
Golden Gate Club, San Francisco

Executive Order 13125

HOST COMMITTEE

Association of Asian Pacific Community Health Organizations, Asian Health Services, Asian and Pacific Islander American Health Forum, NICOS, Self Help for the Elderly, Southeast Asian Community Center, Vietnamese Community Center of San Francisco, Anni Chung, Lillian Galedo, Caryl Ito, Yvonne Lee, Steve Nakajo, Christie Noda, Dang Pham, Adrienne Pon, Alan Shinn, Winnie Yu

SPONSORS

Kaiser Health Foundation
Pacific Bell/SBC
Pacific Gas & Electric Company

Program

Mistress of Ceremonies *- Ms. Wendy Tokuda, News Anchor/KRON-4*

Lion Dance *- Tim Wong Martial Arts School*

Welcome
Brian O' Neil, Superintendent, National Parks Service
Honorable Kevin Shelley, California State Assembly
Honorable Michael Yaki, San Francisco Board of Supervisors
Honorable Wilma Chan, Alameda County Board of Supervisors

Executive Order 13125 and President's Advisory Commission
Shamina Singh, Executive Director of the White House Initiative on Asian Americans and Pacific Islanders

Message from the Honorable Norman Mineta *- David Mineta*

Commission Activities
Honorable Martha Choe
Honorable Tessie Guillermo

Closing *- Rev. Norman Fong*

The President's Advisory Commission on AAPIs

NORMAN Y. MINETA *-former U.S. House of Representatives member. He serves as Vice President of Special Business Initiatives at Lockheed Martin.*

HAUNANI APOLIONA - *Trustee of the Office of Hawaiian Affairs of the State of Hawaii.*

GLORIA CAOILE - *Special Assistant to the President of the American Federation of State, County and Municipal Employees labor union.*

MARTHA CHOE - *Director of the Department of Community, Trade and Economic Development of the State of Washington.*

SUSAN SOON-KEUM COX - *Vice President of Public Policy and External Affairs for Holt International Child Services.*

VINOD DHAM - *Chairman, President, and Chief Executive Officer of Silicon Spice, a communications technology development firm.*

TESSIE GUILLERMO - *Executive Director of the Asian and Pacific Islander American Health Forum, a national health policy and advocacy organization.*

DAVID HO - *Director and CEO of the Aaron Diamond AIDS Research Center.*

DENNIS HAYASHI - *Director of the State of California Department of Fair Employment and Housing.*

NGOAN LE - *Deputy Commissioner of Human Services for the City of Chicago.*

WILFRED P. LEON GUERRERO - *President and owner of W.P. Leon Guerrero & Associates, a consulting firm in Guam.*

JONATHAN LEONG - *President of JLA Companies.*

MIKE PATEL - *President of the Diplomat Hotel Company.*

JACINTA TITIALII ABBOTT - *Vice President and Assistant General Counsel for Tenet Healthcare Corporation.*

LEE PAO XIONG - *Director of Government and Community Relations for Concordia University in St. Paul.*

White House Commission on Complementary and Alternative Medicine Policy

Meeting on the Access and Delivery of Complementary and Alternative Medicine Services

December 4-5, 2000
Hubert H. Humphrey Building, Room 800, Washington, DC

PRELIMINARY AGENDA AS OF November 28, 2000 (10:42am)

DAY ONE: MONDAY, DECEMBER 4, 2000

8:00 a.m.	Registration
9:15 a.m.	Welcome and Introductions ♦ *Dr. Stephen C. Groft* *Executive Director, White House Commission on Complementary and Alternative Medicine Policy* ♦ *Dr. James S. Gordon* *Chair*
9:25 a.m.	Session I: Overview of CAM Utilization ♦ *Dr. James S. Gordon* ♦ *Commission Discussion*
10:00 a.m.	Session II: Clinical and Cost-Effectiveness of Selected CAM Services ♦ Mind-Body Approaches ♦ Chiropractic Practice *William Meeker, DC, MPH* ♦ Naturopathic Medicine *Konrad Kail, ND, PA* ♦ Acupuncture *Patricia Culliton, LAc* ♦ Homeopathy *Joyce Frye, DO, MBA, FACOG* ♦ Massage Therapy *Tiffany Field, PhD* ♦ Panel Discussion

11:00 – 11:15 a.m.	15-MINUTE BREAK & PANEL CHANGE

11:15 a.m.

- Herbs/Botanicals
  Dennis Awang, PhD, SCIC
  Christopher Hobbs, LAc, AHG

- Dietary Supplements
  Alan Gaby, MD

- Nutrition
  Patsy Brannon, PhD, RD

- Integrated Overview
  Harley Goldberg, DO

- **Panel Discussion**

12:15 – 1:35 p.m.	LUNCH BREAK

1:35 – 2:35 p.m.

Public Comment (Open Session, as pre-registered)

1. Francine Butler, Association for Applied Psychophysiology & Biofeedback
2. Nancy Dolores Kolenda, Center for Frontier Sciences
3. Diana Chambers, Friends of Health
4. Rustum Roy, University of Arizona-PIM

- **Panel Discussion**

5. David Murray Blalwas, Maryland Acupunture Society
6. Kathleen Golden, Acupuncture Society of New York
7. Natalia Egorov, California Oriental Medical Association
8. David Edgar Molony, American Association of Oriental Medicine

- **Panel Discussion**

9. Elaine Marie Wallzer, Henry M. Jackson Foundation
10. Bhavna P Bhut, OJAS Cancer Care Institute
11. Neeta Kunai Suryavanshi, Aspen Systems
12. Salvatore A. D'Onofrio, Natural Health Practitioners Board

- **Panel Discussion**

2:35 –2:50 p.m.	15-MINUTE BREAK & PANEL CHANGE

2:50 p.m. **Session III: Use of CAM for Selected Health Conditions**

- Addiction & HIV/AIDS
  Howard Josepher, CSW
  Denise Drayton, Patient

- Cancer
  Jeanne Andrews, Patient

- Heart Disease
  Richard Collins, MD
  Walter Czapliewicz, Patient

- Hospice Care
  J. Donald Schumacher, PsyD

- **Panel Discussion**

3:55 – 4:10 p.m. **15-MINUTE BREAK & PANEL CHANGE**

4:10 p.m. **Session IV: Issues in Integrating CAM in Service Delivery**

- Richard Miles
  Health Frontiers

- The Honorable Berkley Bedell
  The National Foundation for Alternative Medicine

- Paul Kurtz, MA, PhD
  Committee for the Scientific Investigation of Claims of the Paranormal

- **Panel Discussion**

5:00 – 5:10 p.m. **BREAK (Panel Change only)**

5:10 p.m.

- Donald Kendall, OMD, PhD, LAc
  Office of Professional and Employees International Union

- Candace Campbell
  American Preventive Medical Association

- Michele Forzley, JD
  American Bar Association

- **Panel Discussion**

6:00 p.m. ADJOURN

DAY TWO: TUESDAY, DECEMBER 5, 2000

8:00 a.m. Charge for the Day
Dr. James Gordon, Chair

8:05 a.m. Session V: Meeting Public Needs/Systems of Delivery

- Private Practice
  Robert Atkins, MD
- Nursing
  Charlotte Eliopoulos, RNC, MPH, PhD
- Stand-Alone CAM Center
  Mort Rosenthal, MBA
- Hospice Care
  Dannion Brinkley
- **Panel Discussion**

9:00 – 9:15 a.m. 15-MINUTE BREAK & PANEL CHANGE

- Community Health Clinics
  Tom Trompeter, MPA
- Hospital-based Centers
  Sylver Quevedo, MD
- Academic Centers
  Woodson Merrell, MD
- **Panel Discussion**

10:00 – 10: 15 a.m. 15-MINUTE BREAK & PANEL CHANGE

10: 15 a.m.

- Managed Care Organizations
  James Dillard, MD, DC, CAc
  Lori Biclinksi, LMP
  Anna Silberman, MPH
- **Panel Discussion**

11:00 – 11:05 a.m. BREAK (Panel Change Only)

11:05 a.m.

- Ayurveda
  Robert Schneider, MD
- Naturopathic Medicine
  Tori Hudson, ND
- Traditional Chinese Medicine
  Robert Duggan, MA, MAc
- Panel Discussion

12:00 – 1:30 p.m.	LUNCH BREAK

1:30 p.m. Public Comment (Open Session– as pre-registered)

1. Bruce Nordstrom, American Chiropractic Association
2. Neal D. Barnard, Physicians Committee for Responsible Medicine
3. Doreen Chen, Chinese Medicine Council, AAOM
4. Gary Sandman, Integrative Medicine, LLC

- Panel Discussion

5. Danny Freund, Pennsylvania State University
6. Melinna Giannini, Alternative Link
7. Jane Hersey, Feingold Association
8. Boyd Landry, The Coalition for Natural Health

- Panel Discussion

9. Lawrence Auburn Plumlee, National Coalition for the Chemically Injured
10. Michael John Rohrbacher, Certification Board for Music Therapists, Inc.
11. Andrew L. Rubman, American Association of Naturopathic Physicians
12. Marshall H. Sager, American Academy of Medical Acupuncture

- Panel Discussion

2:30 – 2:45 p.m.	15-MINUTE BREAK & PANEL CHANGE

2:45 p.m. Session VI: CAM Integration in Existing Delivery Systems

- Alan Trachtenberg, MD, MPH
  Substance Abuse and Mental Health Administration (SAMHSA)
- Bridget Duffy, MD
  Medtronic
- Milton Hammerly, MD
  Catholic Health Initiatives
- Panel Discussion

3:30 – 3: 45 p.m.	15- MINUTE BREAK

3:45 p.m. Session VII: Commissioners' Discussion

5:00 p.m.	WRAP-UP AND ADJOURNMENT

Jan articles
abstracts

CAM Cost Effectiveness/Clinical Effectiveness

I. Use of CAM Service by the Public

(16) A. General Public - Eisenberg X2 , Astin, Druss/Rosenhack

(23) B. MCO - Ken Pelletier ✓ – 97, 99

C. Why the Public Uses Cam Interventions -

D. Special Populations/Utilization Data

24 1. Geriatrics – Astin, Pelletier

(17) 2. Pediatrics — Michigan

(10) 3. HIV/AIDS - Sparber, Pawluck

(11) 4. Cancer - Solner, Morris, Rees, Richardson, Boss

(12) 5. Runaway Youth - Gardiner (Tufts), Breunner (UW) Adolescents

(13A) 6. ~~Cardiac~~ Surgery - Lin (Columbiz)

7. Disabilities – Zica

II. General Practitioner Physician Knowledge /Attitude/Use/ Referral - Berman, Astin, Pelletier Jarrell, AIM

III. (13) CAM Practitioner Survey - Demographic Data - Cherkin –

IV. 14 Cost Effectiveness/Clinical Effectiveness

A. Mind /Body - Sobel

B. Reference to Other Presenters

V Intro / Conclusion (18)

VI Selected References

* Copies
* Abstracts
* Value Statement (Front Page of Document)
* Posters
* 1° - USA
- Foreign articles (Gordon)

(1) ~~A~~ B

Rheumatoid Arthritis (6 → 3.5) van Haselen - UK

(1) Einst — (64 37) Jordan
53 (104) Roa
(66 Chandola
(~~244~~) Rheumatology
(~~203~~ 86 einst
~~115~~ Resch

(2) ~~A~~

Pregnancy (~~21~~ 44) allaire
midwifery

(3) ~~A~~ Inflammatory Bowel disease (~~113~~ 64) Hilsden
(110) 79 Hilsden
(89) Moody
96 Hilsden

4 Prayer (~~32~~ 69) Rasner - Judaism

midwifery (26) Dimond
(129) Tiran

(5) Health Economic Analyses (130 136) Lorimer

(6) Nurse Sydney (~~147~~ 78) Taylor
108 Rankin-Box

(7) Asthma (78) Ernst
(87) Davis
(117) Lewith

(8) End of Life (1) Pan

(9) Mental Disorder (3) Unutzer
(~~23~~ 13) Druss Rosenheck
(102) Davidson

(10) HIV/AIDS (~~9~~ 4) Beal
24 (~~38~~) Pawtuch
(~~68~~) 34 Greene
(~~100~~ 50) Wynia
(81) Fairfield
(153) Eisenberg
(~~100~~ 87) Calabrese
((18A) Anderson
(122) Nokes

(11) Cancer (~~12~~ 5) Sallnas
(~~15~~) 8 ~~Breast Cancer~~ Manne Breast Ca
(~~20~~ 10) Rees
(~~21~~ 11) Boon
(~~22~~ 12) Richardson
(~~37~~ 23) ~~Spacher~~
(~~70~~) 38 Yeh (China Pediatric Oncology Patient Taiwan)
(~~75~~) 40 Jacobson - Breast CA
(~~79~~) 41 (71) Casarotto
135 Cerny
141 Richardson
143 Kelly
3A
15A Henry
(~~27~~ 42) Schrand
(~~78~~ 43) Kao (Prostate
(54) Bennett
(~~125~~) Rural Cancer Pt
(~~104~~ 56) Gray
(~~113~~ 59) Adler (119)
60 Adler
(63) (~~21~~) Gatay Hawan
(~~104~~ 65) Wyatt (Older CA Pts
(~~127~~ 67) Nam Prostate
(~~44~~ 72) Richardson
(~~145~~ 74) Oneschuk
(~~104~~ 91) Ernst Cancer
(~~108~~ 94) Coss
(~~109~~ 95) Crocelli
101 Fernandez
(3A) ~~Abu-Realh~~
104 ~~Stevenson~~ (118)
(13A) Downer (114) Risberg

20 Chronic Pain (27) (43) Eggo
19A allay

21 dermatology (28) (44) Ernst
127 with

22 medical students (31) (42) Baugniet (111) (196) Carleton
(158) Dent
(88) (161) Uetzel
(100) (176) Hopper
(193) Saben

23 Interpretation MCO (32) (53) Pelletier
(112) (197) Pelletier

24 Genetics Population (33) (64) Astin
(45) Johnson
85 Orris
(93) (167) Bland
(4A) Hogan DB

(15) Multiple Sclerosis (~~31~~ 18) Huntley
(140) Schwartz

✓

(16) General Population (~~32~~ 19) Harris (UK) (~~202~~ 114) Aasland (Norway)

(~~112~~ 58)(70) ~~Sommer (Switzerland)~~ Yes OK (~~33~~ 20) Furnham ? Physician (204) Risberg (Norway)

(~~149~~ 77) Kitai (46) 29 Oldendick (~~1A~~ 119) Furnham → (Furnham Vincent Weave 110)

(~~157~~ 85) Krastins (Low Income Population) (61) 30 Ernst (~~20 A~~) 120 Vincent

39 Allen - Dominican Patients (~~19A~~) Furnham 17A 123 (132) Furnham

(~~163~~ 90) Berman 47 (~~244~~) Messerli-Rohrbach (Switzerland)

(~~172~~ 98) Krong (Ont. Mild v. Cottages - Switz) (~~184~~) Cushman (African American + Hispanic Women)

(~~188~~ 109 113) Bullock White (~~402~~ 52) Druss Rosenbeck

Pediatric ~~Pain~~ (~~36~~) 22 Rury (142) Ernst

(17) (~~96~~ 48) Adler 143 Kelly

(~~406~~ 55) Armishaw - New Zealand

(~~142~~ 73) Ernst

(~~155~~ 83) Sikand

(~~177~~ 101) Fernandez - Canada - Ped Oncology

(18) Introduction / Conclusion - RCT / (~~34~~ 25) Bloom (71) Eastwood

✓ (~~89~~ 46) Seahpush Australia

(~~99~~ 49) Mitzdorf

(57) Boiner ~~(58) Sommer~~

(184). Cohen 1C Eisenberg

(187) Elder ~~8~~ 8C Eisenberg

(19) • Premenstrual Syndrome (89) Singh

(12) Adolescents (13) Gardiner
(82/84) Brenner Homeless Guilty

(13)

(4) Beal

General Practitioners (14) Eastwood

(80/82) Astin (128) Barker
(84) Bauder (131) Himmel
103 Paterson
(6A) Ernst (110) Furnham
(8A) Berman → 58 Gnapa
(12/124) Goldszmidt ?
(10A/125) Tattenhof
128 Borkan

(15) Hall - (Australia)
(34) Perry
24 (41) Ernst (UK)
39 (42) Allen - Dominican Pte
(13/137) Crook
(148) Wrann (UK)

Surgery (9/18) Lin
(14) Nored NORRED
16 (28) Tsen - Perinatal Patients

(3A)

(14)

Economic Analyses (17/30) White

Contents of Background Information for Review of Access to and Delivery of CAM Services and Products

CAM Cost Effectiveness/Clinical Effectiveness - Results of Literature Survey (Numbers Refer to Numbered Abstracts from Pub Med Searches, i.e., Regular Numbers, A, B, C)

I. Use of CAM Services by the Public

A. General Public - Use of Cam Interventions 19, 20, 29, 30, 39, 47, 51, 52, 58, 70, 77, 85, 90, 98, 109, 113, 114, 119, 120, 123, 132, 14A, 17A

B. Special Populations/Utilization Data

1. Geriatrics - 33, 45, 93, 4A
2. Pediatrics - 22, 48, 55, 73, 83, 101, 142, 143,
3. HIV/AIDS - 4, 24, 36, 50, 81, 87, 122, 18A
4. Cancer - 5, 8, 10, 11, 12, 23, 38, 40, 41, 42, 43, 54, 56, 59, 60, 63, 65, 67, 71, 72, 74, 91, 94, 95, 101, 104, 116, 118 135, 141, 143, 3A, 13A, 15A
5. Adolescents/Homeless Youth - 6, 82
6. Surgery - 9, 14, 16
7. Disabilities - Susie Zick Article as an Attachment
8. Premenstrual Syndrome - 99
9. Multiple Sclerosis - 18, 140
10. Dermatology - 28, 127
11. Chronic Pain - 27, 19A
12. Arthritis - 1, 35, 37,.53, 66, 86, 115
13. Pregnancy, Midwifery - 44, 126, 129
14. Inflammatory Bowel Disorders - 64, 79, 89, 96
15. Mental Disorders - 3, 13, 102
16. Asthma - 75, 97, 117
17. Managed Care Organizations - 32, 112
18. Survey of Nurses - 78, 108
19. Medical Students - 31, 88, 100, 111

II. General Practitioners - Physician Knowledge /Attitude/Use/ Referral CAM Practitioner Surveys - Demographic Data - 15, 21, 26, 39, 76, 80, 84, 103, 110, 121, 124, 125,128, 131, 137, 6A, 8A, 5B

III. Cost Effectiveness/Clinical Effectiveness - 17, Reference to Other Presenters in Meeting

IV. Summary, Introduction or Conclusion Statements - 7, 25, 46, 49, 57, 186, 187, 1C, 5C

V. Selected References -Reprints Included

A. Surveys of Complementary and Alternative Medicine - Wooton and Sparber, 1999
B. Eisenberg, et al., 1993
C. Eisenberg, et al., 1998
D. Astin, 1998
E. Druss and Rosenheck, 1999
F. Vickers, 2000
G. Berman, Singh, et al. 1998
H. Astin, Marie, et al. 1998
I. Ernst, Resch, White 1998
J. Cherkin, Unpublished Article
K. Zick, Slide Presentation
L. Sobel, 2000
M. Astin, Pelletier, et al., 1999
N. Spigelblatt, 1997
O. Furnham, Bhagrath, 1993
P. Furnham, Smith, 1988
Q. Sparber, Bauer, et al., 2000
R. Sparber, 1995
S. Sparber, Jonas, et al.
T. Sparber, Wooton, Bauer, et al., 2000
U. Price Waterhouse Coopers Survey

Page 1 slightly edited version

Brief Summary of Major Themes from Seattle Meeting

Tie into the goals of Healthy People 2010, the Federal blueprint for public health.

Facilitate collaboration
(1) between conventional and CAM practitioners;
(2) among local, regional, state, and Federal government agencies (including regulators, licensing boards, public health officials, and community-based primary care facilities); and
(3) with 3rd party payers.

Identify obstacles slowing the incorporation of evidence-based CAM practices into mainstream practice. Address, through collaboration, lack of familiarity with CAM research and researchers, suspicion of CAM therapies, and mistrust of CAM practitioners and researchers. This is often difficult and a challenge for both communities.

Strengthen accountability and develop uniform, high quality standards; consistent licensing procedures; and practice guidelines as the basis for the inclusion of CAM practitioners in Federal, state, and regional/local health programs; to ensure uniformity of services for reimbursement; and to allow patients freedom of choice.

Develop public or private quality assurance programs to increase provider and public trust in CAM products.

Develop an herbal pharmacopoeia with standardization and regulation of manufacture, similar to the homeopathic pharmacopoeia.

Support with local, state, and Federal funds primary health care clinics that can serve as incubators for cross training and integrating multiple-practice approaches, and for stimulating other collaborative and relationship-building activities. Integrate CAM into community health center networks nationally.

Increase Federal agency support for local community demonstration projects to integrate CAM into conventional health services.

Eliminate arbitrary exclusions, avoid mandates, and focus benefits on scientific outcomes in state health programs.

Reduce the disparity in funding for research on conventional medical modalities and on CAM practices and products; increase funding to CAM professional schools for research and research training. Fund planning grants to CAM academic centers to develop research agendas, etc. Issue an RFA to support research infrastructure at CAM institutions. Establish collaborative relationships with universities and hospitals that have needed facilities and expertise.

Increase funding for education and training at CAM institutions and at traditional universities, including schools of medicine, nursing, dentistry, pharmacy, public health, and veterinary science. Train CAM professionals in public health.

Develop methodologies to study emerging unconventional healing practices. Find methodologies that accommodate the cultural context and patient-centered, unique questions posed by some CAM therapies. When placebo-controlled trials are not feasible or appropriate, employ practice-based outcomes research, best case series, clinical audits, cohort analysis, pattern recognition, statistical evaluation, multi-varied or cluster analysis, and other known or new methods. Start with practical health services trials as a basis for further study.

Include CAM professionals on research advisory councils, regulatory boards, review committees, and policy groups.

Educate IRBs to provide more informed oversight of CAM clinical research.

Examine regulations that lead to the removal of licenses of CAM practitioners and intimidate collaborating, allopathic physicians.

Study wellness, the effect of social context on health, quality of life measures, and cost effectiveness of CAM.

Increase research support to provide valid chiropractic clinical outcomes data. Support researchers and infrastructure at colleges of chiropractic. Integrate chiropractic research and education programs in conventional higher education environments.

Allow for continuum of care as part of collaboration between allopathic and CAM care.

Increase research on CAM as an alternative to conventional approaches that are not successful or create adverse reaction risk, especially for chronic conditions.

Be more proactive to ensure that CAM research findings reach a broader audience.

Support National Library of Medicine indexing of CAM journals.

Determine the distinctions between incorporation of CAM procedures into conventional medical practice and integration of CAM providers into patient care pathways.

Design services for reaching and covering the underserved; evaluate utilization by the underserved.

Expand Federal laws to include loan repayment and scholarships for some CAM professions to serve in underserved areas.

Include CAM in Medicare, Medicaid, and other Federal and state health-related program coverage.

Improve collaboration among payers, the research and regulatory communities, and the professions.

Fund research on insurance company CAM databases and how CAM affects health care costs.

Evaluate insurance data from the Washington state experience.

Examine the effect of insurance coding and "medical necessity" as limitations on CAM.

Investigate reimbursement for herbal practice in states with practice standards.

Work toward insurance coverage in private, Federal, and state plans to provide access to licensed CAM providers and to cover (approved) substances prescribed and certified as part of treatment.

Conduct regional conferences on CAM integration.

Strengthen Federal role as facilitator, partner, and referee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

White House Commission on Complementary and Alternative Medicine Policy

Notice of Meeting

Pursuant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is given of a meeting of the **White House Commission on Complementary and Alternative Medicine Policy.** The purpose of the meeting is to convene the Commission for a public hearing to receive public testimony from individuals and organizations interested in the subject of federal policy regarding complementary and alternative medicine. The major focus of the meeting is on the access to and delivery of complementary and alternative (CAM) services: use, effectiveness, and delivery systems. Comments received at the meeting may be used by the Commission to prepare the Report to the President as required by the Executive Order.

Comments should focus on the **Access and Delivery of Complementary and Alternative Medicine Services: Use, Effectiveness, and Delivery Systems**. Issues to be discussed include the following: Utilization of CAM Services; Access and Delivery of CAM Services; Issues in Integrating the Delivery of CAM Services; Patient Perspectives on the Use of CAM Services; Meeting Public Needs - Public and Private Sectors Delivery Systems; and Novel Systems of CAM Services Delivery. Discussion also may focus on the following questions:

(1) Do patients and health care providers have ready access to CAM practices and interventions?

(2) How can access to safe and effective CAM practices and interventions be improved?

Some Commission members may participate by telephone conference. The meeting is open to the public and opportunities for oral statements by the public will be provided on December 4, from about 1:30 p.m. – 2:30 p.m. (Time approximate)

Name of Committee:	The White House Commission on Complementary and Alternative Medicine Policy.
Date:	December 4-5, 2000
Time:	December 4 – 9:15 a.m.– 6:00 p.m. December 5 – 8:00 a.m.– 4:00 p.m.
Place:	Hubert H. Humphrey Building Room 800

200 Independence Avenue, S.W.
Washington, D.C. 20201

Contact Persons:

Michele M. Chang, CMT, MPH
Executive Secretary
OR
Stephen C. Groft, Pharm.D.
Executive Director
6701 Rockledge Drive
Room 1010, MSC 7707
Bethesda, MD 20817-7707
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E-mail: WHCCAMP@nih.gov

Because of the need to obtain the views of the public on these issues as soon as possible and because of the early deadline for the report required of the Commission, this notice is being provided at the earliest possible time.

Supplementary Information: The President established the White House Commission on Complementary and Alternative Medicine Policy on March 7, 2000 by Executive Order 13147. The mission of the White House Commission on Complementary and Alternative Medicine Policy is to provide a report, through the Secretary of the Department of Health and Human Services, on legislative and administrative recommendations for assuring that public policy maximizes the benefits of complementary and alternative medicine to Americans.

Public Participation

The meeting is open to the public with attendance limited by the availability of space on a first come, first serve basis. **Members of the public who wish to present oral comment may register by calling 1-800-953-3298 or by accessing https://safe2.sba.com/whccamp/index.cfm or the website of the Commission at http://whccamp.hhs.gov no later than November 28, 2000.**

Oral comments will be limited to five minutes. Individuals who register to speak will be assigned in the order in which they registered. Due to time constraints, only one representative from each organization will be allotted time for oral testimony. The number of speakers and the time allotted may also be limited by the number of registrants. All requests to register should include the name, address, telephone number, and business or professional affiliation of the interested party, and should indicate the area of interest or question (as described above) to be addressed.

Any person attending the meeting who has not registered to speak in advance of the meeting will be allowed to make a brief oral statement during the time set aside for public comment if time permits, and at the chairperson's discretion. Individuals unable to

attend the meeting, or any interested parties, may send written comments by mail, fax, or electronically to the staff office of the Commission for inclusion in the public record.

When mailing or faxing written comments provide, if possible, an electronic version on diskette. Persons needing special assistance, such as sign language interpretation or other special accommodations, should contact the Commission staff at the address or telephone number listed no later than November 28, 2000.

Dated:
LaVerne Y. Stringfield,
Director, Office of Federal Advisory Committee Policy.

(1) Entire Remarks

(2) Report

(1) Contents of Package
arrangement of room for Audience.
Convenience to the Speakers

(2) Thank you to everyone here

Thank you
(1) Michelle Chang
Gerri Pollen
Dr Joe Kaczynaryski
Doris Kerzenberg
~~Steven Ollenstein~~
(2) ~~Calhoun Dodd~~ Raymond TX #HHS Senator
(3) Commission Chair members who you will hear from later

(3) Thank you ~~to~~ attendees + Volunteers
who are willing to take a break from
their busy schedules to provide
us a brief glimpse of their
experience or concerns

(4) What we hear at these meetings
will be used to generate a report required
by the Executive Order OR to foster
to shape future agenda items for consideration
by the Commission - Keep in touch - search on White House
HTTP:// WHCCAMP.NIH.GOV Commission - on CAM.

(5) Ambitious Agenda Turn the meeting over to Dr Gordon our Chair

(4A) * Logistics for day
Seat Speakers in Order of Appearance for Each Session
Gerri Pollen, Dr Joe Kaczynaryski, Doris Kerzenberg
will assist speakers for order
* If you have not signed up to speak but would like to add comments, please sign up by 10:00 for comments to be presented this morning and by 3:00 this afternoon — 3 minutes — Open Session

* Time Crunch - We are here to listen - There may be a need to ask questions for clarification - Relax