Groft, Stephen (WHCCAMP)

From: Axelrod, Corinne (WHCCAMP)
Sent: Tuesday, September 25, 2001 10:38 AM
To: 'Dean Ornish (E-mail) ' (E-mail); 'Marjorie Dean Ornish office (E-mail) ' (E-mail)
Cc: Groft, Stephen (WHCCAMP)
Subject: Wellness Con't

Hi Dean,

Since you were driving during our call yesterday (very bad!), here's the things that Charlotte brought up, along with my ($0.02)comments:

1) Spirituality - Our goal is not to advocate for spirituality, but to acknowledge its role in healing. I think this is best addressed in the narrative portions of the report (both in the general introduction and the section introduction). Since spirituality is an intrinsic part of many CAM practices, spirituality is already implied in many of the current recommendations.

2) S.G. letter - The group already voted against this idea. Also, SG letters are done very infrequently and usually focus on a narrow health concern or public health issue. It would not be appropriate for the SG to tell the Nations docs to embrace CAM. However, we will have Ken Fisher check this out.

3) Physical Education/Preparedness - How is this CAM?

4) Center of Wellness at NIH - The group already voted against this idea.

5) Research - This is being addressed by the research group.

6) CDC focus - This is ironic, since issue 1 & 2 are very CDC focused.

.hink it will be very important to keep the group on track at the Oct. meeting. Our goal is to 1) get consensus from the rest of the Commission on the issues and recommendations and 2) identify any areas that have not been adequately addressed. If gaps are identified, they will go back to the workgroup to develop - we will not have time for any lengthy discussions. (Hopefully, everyone will have carefully read the document, especially people in the workgroup!) You will also need to leave time to present arguments for keeping this a separate section or incorporating it in the rest of the report. I would suggest doing this last, as people will have a better feel for the issues and recommendations after we've gone over them.

Also - we may want to change Issue 1, Recommendation 3, to read "...incentives be developed to promote the availability of foods that contribute to a healthy lifestyle" just to cast it in a more positive light. This can be done in the next draft.

Thanks again for helping to keep this group moving forward! Call me if you want to talk about any of this. Thanks,

CDR Corinne Axelrod, M.P.H., L.Ac.
Senior Program Analyst
White House Commission on Complementary
and Alternative Medicine Policy
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irs.

Groft, Stephen (WHCCAMP)

From: Kingsbury, Doris (WHCCAMP)
Sent: Thursday, August 30, 2001 1:40 PM
To: Bill Fair (E-mail); Dean Ornish (E-mail); Julia Scott (E-mail); Ming Tian (E-mail)
Cc: Marjorie Dean Ornish office (E-mail); Axelrod, Corinne (WHCCAMP); Fisher, Ken (WHCCAMP); Jim Swyers; Joan Albrecht; Kaczmarczyk, Joseph (WHCCAMP); Maureen Miller; Michele Chang; Pollen, Geraldine (WHCCAMP); Stephen Groft
Subject: Your conference calls

Please see below the change in TIME and CALL IN NUMBER of the (CAM WELLNESS) conference call scheduled for August 3. Thanks

(1) On AUGUST, 31-2001 (FRIDAY), Group G (CAM in Wellness) will convene 12:30PM–2:30PM EASTERN TIME

To be connected to this call please dial 888-456-0361 and reference the following:
PASSCODE: 37357 / LEADER: CORINNE AXELROD

If you are disconnected during this call, please repeat this procedure to be reconnected.

If you are unable to be connected, please call Ms. Juanita Tucker at 1-301-496-4516 or our office at 301-435-7592.

Thanks!

Schools + Health

IOM Report - Challenges in School Health Education

1997 IOM

Groft, Stephen (WHCCAMP)

From: Axelrod, Corinne (WHCCAMP)
Sent: Thursday, August 30, 2001 1:33 PM
To: 'deanornish@aol.com'; 'marjorie49@aol.com'; 'fairw@aol.com'; 'jrsct6@cs.com'; 'maingtian@aol.com'
Cc: Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Kaczmarczyk, Joseph (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP); 'jsgordon@mindspring.com'; 'jpswyers@starpower.net'
Subject: Wellness Document and Conference Call

Dear Wellness Workgroup,

Attached for your review is a draft of the first part of the Wellness section. As mentioned in my previous email, the group still needs to develop these issues and recommendations, even if they end up being woven into other sections later. The conference call for tomorrow, August 31, has been changed to **12:30 EST** so that Dean and Bill can participate in the Research call at 2:00 EST. For those of you not able to participate on this call, I will set up another time next week for us to talk. I will also send you the rest of the wellness section early next week.

Thank you all for your patience.


Wellness Workgroup.wpd


Wellness Workgroup.rtf

CDR Corinne Axelrod, M.P.H., L.Ac.
Senior Program Analyst
White House Commission on Complementary and Alternative Medicine Policy
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Topic: CAM in Wellness, Self-Care, and Prevention
Staff Lead: Corinne Axelrod
Members: Dean Ornish (Facilitator), Bill Fair, Julia Scott, Xiaoming Tian, Charlotte Kerr

Issue 1: Utilization of CAM in schools and the community to facilitate learning, improve behavior, and optimize well-being.

Background: Research shows that even moderate undernutrition can have lasting effects on children's cognitive development and school performance.[1] Yet, more than 84% of children and adolescents eat too much fat[2], and only 20% eat an adequate amount of fruits and vegetables. At the same time, almost 13 percent of children aged 6 - 7 are seriously overweight[3], and obese children and adolescents are more likely to become obese adults[4]. Physical activity is known to have many beneficial health effects, including reduction in anxiety and stress and increased self-esteem[5], yet daily participation in physical education classes by high school students dropped from 42% in 1991 to 29% in 1999. Of high school students, 70% have tried cigarettes and 36% are current smokers[6]. Among children ages 5-14, the leading causes of death are unintentional injuries, cancer, and homicide, respectively. In the 15-24 age group, the leading causes of death are unintentional injuries, homicide, and suicide, respectively[7]. Behavioral and mental health problems, especially depression, are widespread, and substance abuse continues to be a problem. Seventeen percent of high school students carried a weapon during the past month, and 19% have seriously considered suicide in the past year[8].

Most school districts require some form of health education to be taught as part of a student's total education. School health programs include activities and services to promote students' physical, emotional, and social development. Teaching students specific CAM practices, such as mind-body exercises, nutrition, etc., as well as a more integrated, holistic approach to life, can

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[1] - Center on Hunger, Poverty, and Nutrition Policy. Statement on the Link between Nutrition and Cognitive Development in Children. Medford, MA: Tufts University School of Nutrition, 1995

[2] - Lewis CJ et al. Healthy People 2000: Report on the 1994 nutrition progress review. Nutrition Today 1994; 29 (6): 6-14.

[3] - Centers for Disease Control and Prevention. Update: prevalence of overweight among children, adolescents, and adults - United States 1988-1994. Morbidity and Mortality Weekly Report 1997; 46:199-202.

[4] - Guo SS et al. The predictive value of childhood body mass indexvalues for overweight at age 35 years. American Journal of Clinical Nutrition 1994; 59:810-9

[5] - CDCP Guidelines for School and Community Programs: Promoting Lifelong Physical Activity

[6] - CDCP Guidelines to Prevent Tobacco Use and Addiction

[7] - CDCP, NCHS, National Vital Statistics System, 1999.

[8] - CDCP National Center for Chronic Disease Prevention and Health Promotion

complement the many efforts already underway to improve the health and well being of young people.

The Centers for Disease Control and Prevention (CDCP) has developed guidelines for schools on physical activity, healthy eating, tobacco use and addiction, and AIDS prevention. The Health Resources and Services Administration (HRSA) is developing guidelines on comprehensive school health programs, mental health, and safety.

Claim Wellness as part of CAM

Recommendations:
A) Agencies with the Department of Health and Human Services, especially the HRSA, CDCP, Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) should form a working group with other Federal organizations such as the Department of Education and the Administration for Children and Families (ACF) to develop guidelines on how to utilize CAM practices to improve students' physical, emotional, and social development, and to integrate these practices into school health programs in K - 12. The working group should include CAM professionals, and the guidelines should reflect the cultural diversity in the school systems.

B) DHHS should identify and provide information on successful models of utilizing CAM in schools and the community.

C) In partnership with the business community, develop incentives for schools to limit the sale and advertising of high fat snacks, soft drinks, and other products that do not contribute to a healthy lifesyle.

Discussion:
There are isolated programs such as low-fat school lunch programs[9], yoga[10], and others in some schools across the country, but very few schools are teaching holistic concepts of health or providing CAM type of programs.

Challenges: School programs are locally designed and implemented, and what works in one community may not be applicable to another.

Issue 2: Utilization of CAM to help achieve the Nation's health promotion and disease prevention goals.

Background: Since the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979, goals and objectives for the Nation's health have been defined and monitored. The most recent report, *Healthy People 2010*, includes the

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[9] - Demas A. Low-Fat School Lunch Programs: Achieving Acceptance, American Journal of Cardiology 1998; 82::80T-82T

[10] - Yoga Inside Foundation

involvement of all of the agencies within the Public Health Service, as well as State and local health departments and a wide range of private sector health organizations. HP 2010 is designed to achieve two overarching goals: 1) Increase quality and years of healthy life, and 2) Eliminate health disparities. These goals and objectives are the blueprint for the Nation's health promotion and disease prevention activities and influence data collection, national health policy, and program development and implementation. HP 2010 is a comprehensive document that addresses clinical, behavioral, environmental, and health systems issues that impact on health. It's focus is both on individuals and communities, and there is a strong emphasis on health education and changing health behaviors.

Recommendations:
A) The Department of Health and Human Services should form a working group within the Healthy People Consortium that includes CAM professionals to review the 10 leading health indicators[11] to determine the applicability of CAM to impact on these indicators and, where appropriate, develop strategies to encourage the use of CAM in these areas.

B) Include questions on specific CAM usage in the national surveys that are the sources of the HP 2010 data (e.g. NHIS, NHANES, MEPS, etc.)

Discussion: There are many areas where CAM could contribute to the achievement of the goals and objectives outlined in HP 2010. Some examples include: massage to reduce activity limitation due to chronic low back pain; acupuncture to reduce use and adverse effects of substance abuse; meditation to reduce high blood pressure and stroke, naturopathy to reduce the incidence of diabetes and improve quality of life, etc.

Challenges: HP 2010 is very data driven.

Issue 3: Utilization of CAM in the workplace to increase job satisfaction and productivity and reduce costs.

Background: Research has shown that high risk employees cost as much as 70% more than those at lower risk[12], and short term disability costs of participants in worksite health promotion programs is significantly less than non-participants[13]. Wellness programs can save companies a

[11] - The ten leading health indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.

[12] - Goetzel RZ et al. A systematic review of return-on-investment studies of corporate health and productivity management initiatives. AWHP's Worksite Health 1999; 12-21.

[13] - Serxner SA et al. The impact of a worksite health promotion program on short term disability usage. Journal of Occupational and Environmental Medicine 2001; 43 (1): 25-29.

median of $3 for every dollar spent[14], and some worksite health promotion programs have had a positive return on investment of up to 8.22:1 in combined reduced health care costs and absenteeism[15]. Many of these worksite health promotion programs include CAM practices such as yoga, stress reduction, and changes in nutrition and lifestyle.

Recommendations:
A) Include CAM wellness activities in all Federal worksite health promotion programs.

B) Require that federal health coverage plans offer a CAM wellness option.

C) Form partnerships with private organizations such as the Wellness Councils of America to encourage inclusion of CAM services in their worksite wellness programs

Discussion: The Division of Federal Occupational Health, in the Department of Health and Human Services, assists Federal organizations in improving the health, safety, and productivity of the Federal workforce. They provide comprehensive worksite services, including medical, nursing, and wellness/fitness services, to Federal agencies around the country. They currently serve over 300 Federal agencies with 1.6 million employees. Other Federal organizations may offer their employees wellness programs as well.

Challenges:

Issue 4: Research in the role CAM in promoting more optimal states of health and well-being and enhanced quality of life

Background:

Recommendations:

Discussion:

Challenges:

Issue 5: Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and decrease costs.

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[14] - Goetzel RZ, New York Times June 24, 2001, p11

[15] - Aldana SG. Financial impact of worksite health promotion and methodological quality of the evidence. Art of Health Promotion 1998; 2(1):1-8.

Background:

Recommendations:

Discussion:

Challenges:

Issue 6: Incorporation of CAM wellness activities in Federal health programs to improve health outcomes and decrease costs.

Background:

Recommendations:

Discussion:

Challenges:

Groft, Stephen (WHCCAMP)

From: Chang, Michele (WHCCAMP)
Sent: Tuesday, August 14, 2001 12:16 PM
To: Bill Fair (E-mail); Dean Ornish (E-mail); Julia Scott (E-mail); Xiaoming Tian (E-mail)
Cc: Corinne at home (E-mail); Jim Gordon (E-mail); Axelrod, Corinne (WHCCAMP); Fisher, Ken (WHCCAMP); Gerry Pollen (E-mail); Jim Swyers (E-mail); Joe Kaczmarczyk (E-mail); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Steve Groft (E-mail)
Subject: WHCCAMP G: Wellness

Until Corinne returns on August 20, I will serve as your staff lead for Wellness. Our first conference call is scheduled for Thursday, August 16 from 3-5 p.m. EST. Please call 877-918-2311 (passcode: 36763) to be connected. Our facilitator is Dean Ornish.

To launch the discussion, please review the attached document. This format will be used by each work group to identify the key issues, and to develop the contextual background for each issue, as well as draft recommendations. The attached document was developed by reviewing the briefing materials and is only a launching point. (As you may note, I have referenced testimony whenever possible so that you can refer back to your briefing materials.) This document is neither complete nor final and we welcome your comments and suggestions on the content.

For the purposes of the call on Thursday, please be prepared to focus on the Issues raised (did we miss anything?), Challenges and Draft Recommendations. All the other pieces can be refined primarily through e-mail, since much of it is likely to be word-smithing and staff research based on your input ("please find this, or that model or document," etc)

If you have difficulty downloading this document, please contact me immediately at 301-435-6232 or by e-mail so that I can get you the document to review before Thursday.

Thanks!

Michele M. Chang, MPH, CMT
Executive Secretary
White House Commission on
Complementary and Alternative Medicine Policy
tel: 301-435-6232
fax: 301-480-1691
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G strawdogrtf.rtf

TOPIC: CAM in Wellness, Self-Care, and Prevention
Staff Lead: Corinne Axelrod (Michele Chang substitute until 8/20)
Facilitator: Dean Ornish

OVERVIEW OF ISSUES:

Issue 1. Optimal well-being: Can CAM promote and support efforts of consumers to realize more optimal levels of functioning?

Issue 2. Whole person care: Can CAM be used to promote a more holistic view of health and health care?

Issue 3. Self-Care: Can CAM be used to empower and support consumers to care for themselves?

Issue 1. Optimal well-being: Can CAM promote and support efforts of consumers to realize more optimal levels of functioning?

Discussion: Most CAM practices are based on the recognition that human beings are capable of manifesting higher, more optimal levels of energy, creativity, and psychophysical well-being, and that health involves more than merely the absence of disease. Many mind-body therapies, such as meditation, Tai Chi, yoga, Qi Gong, were developed not so much to treat disease but to facilitate the development of various "positive" states of health such as equanimity, harmony with oneself and the world, compassion, mental clarity-concentration, heightened perceptual sensitivity (.e.g. to subtle energies), and spiritual insight or realization. [J. Astin, 3/27/01]. However, the current health care system remains primarily disease-focused, with most of research, education, training, reimbursement, and information development and dissemination directed toward identifying and treating disease.

Background:

- Murphy and Leonard, Integral Transformative Practice (ITP) study in Stanford. Examines the effects of a multi-modal lifestyle intervention program involving group emotional support, meditation and various self-awareness skills drawn from martial arts, and gentle exercise. Also studies the effects of ITP on healthy older adults. [J. Astin, 3/27/01]

- NIH is now including CAM pediatric research, and practitioners in homeopathy, nutrition and manual therapies are studying the effects of these practices on children. [M. Micozzi, 3/27/01]

- The Handbook of Religion and Health (Koenig et al, 2001) reviews more than 1200 published studies on the relationship between religion and/or spirituality and a variety of mental and physical health outcomes.[D.Larson, 3/27/01]

- Fetzer and John Templeton Foundation are funded limited studies on the role of spirituality on health. [D.Larson, 3/27/01]

- The Annals of Behavioral Medicine, 2001 article on the study that found that frequent worship attenders were in better health than non-attenders, and that those who were not in better health tended to develop healthier habits if they attended church regularly. [D.Larson, 3/27/01]

- Some medical schools already are employing teaching models that encourage collaborations between doctors and chaplains. [D.Larson, 3/27/01]

Challenges:

- Wellness activities, especially those directed at preventing illness, that are incorporated into the conventional health care system are, for the most part, disease screening (e.g. pap smears, mammograms, etc.), or are offered in response to an already identified illness or condition (e.g. physical therapy, nutrition counseling, etc.)

- Other wellness activities, particularly those considered "CAM," frequently take place outside of the conventional health care system, and are reliant upon a person's initiative and ability (education, finances, availability of resources, etc.) to access and incorporate them into their life.

- Research in CAM continues to be focused almost entirely upon the treatment rather than prevention of health related conditions. For example, despite considerable research showing both the significant clinical and cost benefits of worksite health promotion programs, insurers remain reluctant to invest in such services, in part because the gains may not be immediately apparent and can often only be realized over the long term. [J. Astin, 3/27/01]

- Negative attitudes continue to be propagated that create ideologic and practical barriers between CAM and conventional medicine, such as "CAM is holistic while conventional medicine is not." [J. Astin, 3/27/01]

- Although more than 90% of Americans describe themselves as either religious or spiritual [D.Larson, 3/27/01], most of conventional science either disregards the effect of these factors on health; a stigma continues to exist in the research, science and academic communities around such hypotheses. [D.Larson, 3/27/01]

Draft Recommendations:

1. CAM activities should begin in elementary school, as part of health education. Teachers and students should learn meditation and relaxation techniques, and information should be provided about the ancient civilizations and diverse cultures which gave rise to many of these health traditions.

2. Provide disincentives for corporate/school relationships where corporate contributions of computers and resources are tied to the presence of soft drink machines, or commercial advertising in schools.

3. Create programs in schools that help educate children about how to care for their bodies throughout their lives, and teach nutrition.

4. Increase research spending for CAM in the prevention of disease, particularly focusing on mind-body therapies that have shown transformational effects with depression, loss of sense of control, anger/hostility and other "mind" factors that interact with disease. [J. Astin, 3/27/01] For example, fund studies that assess the effect of mind/body techniques (Ayurvedic, meditation, Qi Gong) on reducing tension and stress in the school environment (targeted at preventing violence in the school place) , and aiding academic performance. [M. Micozzi, 3/27/01]

5. Conduct research on the effects of various CAM therapies in healthy populations, not solely in terms of preventing disease and illness, but in terms of promoting more optimal states of health (e.g., do people who receive regular acupuncture or bodywork manifest greater levels of energy, vitality and mental-emotional balance?)

6. Using the President's Faith-based Initiative, develop a centralized data base on spirituality and health that contains information on grants and funding on model care and educational programs and effective strategies for sensitively and ethically incorporating spirituality into health care, thereby helping to bridge the gap between research and clinical application. [D.Larson, 3/27/01]

7. Using the President's Faith-based Initiative, support continuing education conferences and other education materials to help make clinical and research communities better aware of research linking spiritual and religious factors to various aspects of health. This also should include forums where health providers can interact with clergy, chaplains, and pastoral care professionals so that clinicians can develop a better understanding of the roles that religious professional play in health and healing.[D.Larson, 3/27/01]

Issue 2. Whole person care: Can CAM be used to promote a more holistic view of health and health care?

Discussion: Many CAM therapies come from a holistic tradition of integrating body, mind, and spirit, and focus on optimal functioning to prevent, deter, or minimize illness and disease, and maximize one's potential to live life to the fullest. These qualities are the foundation of much of the interest in wellness, self-care, and prevention, which cover a wide range of activities such as support groups for people with cancer; meditation, yoga, or Tai Chi for relaxation and stress reduction; foods and dietary supplements to retain and enhance function and vitality; palliative care for the end of life; etc. All of these have a CAM component whose benefit is just beginning to be realized.

Background:

Challenges:

Draft Recommendations:

8. Measurements of health must be more than the absence of disease, and include qualities such as greater levels of energy, vitality, creativity, and overall well being.

9. CAM should be incorporated into well child care and pediatric practice.

10. Increased funding should be directed to research in self-care, wellness, and prevention, including the role of spirituality.

11. Encourage more communication between medical practitioners and spiritual leaders to address issues such as spiritual assessment, referrals, possible conflicts, etc.

12. Establish a Center of Wellness at the NIH

13. Encourage the U.S. Surgeon-General to send a letter to the nation's doctors reporting briefly on those CAM approaches that have been validated by clinical research within the last five years.

14. Support funding for research and education on the effectiveness of CAM for both prevention and recovery, with diet and lifestyle at the base and establish a pilot plan for clinical trials in some hospitals and health care centers.

15. Encourage hospitals, clinics, health care facilities, and medical schools to add dietary and wellness studies, counseling, cooking classes, and serving facilities with healthful menus.

16. Clinical nutrition and nutritional supplementation needs to be taught in medical school courses, and clinical competency courses are needed for practitioners.

17. Provide additional training for doctors and nurses to include: the role of spirituality in health and in end-of-life care; how to address patients' spiritual needs; how to recognize spiritual suffering; how an interdisciplinary approach to care can build communities of caring.

18. Train health care professionals, as well as faith and other social communities, to recognize the importance of spiritual care, particularly at the end of life, and how to work within the health care system.

19. Have the Surgeon General send a letter to the nation's doctors reporting briefly on the evidence of complementary approaches and encouraging a more holistic approach to healing.[M. Micozzi, 3/27/01]

20. Shift reimbursement codes from the ICD-9/CPT disease-based model to one that is based on health promotion and change our focus on acute and terminal care to focusing on early assessment and intervention to prevent and diagnose and treat and optimize health.

21. Offer employers incentives to start new workplace health and wellness programs that incorporate appropriate CAM modalities.

22. Support studies of CAM usage among different racial/ethnic populations.

23. Integrate CAM providers into traditional geriatric health provider teams in hospitals, the community, assisted living facilities, nursing homes, etc.

Issue 3. Self-Care: Can CAM be used to empower and support consumers to care for themselves?

Discussion: In the area of nutrition alone, it is estimated that great reductions in cardiovascular disease and some cancers may be achieved by diet and lifestyle. For example, it is estimated that over 80% of heart attacks, and over 70% of strokes and colon cancer could be avoided by not smoking, regular exercise and good diets. [W.Willet, 3/27/01]

Background:

- During the last decade, large prospective studies have provided strong evidence that diet is more important than previously thought for the prevention of disease, and that it acts in different ways than were believed.[W.Willet, 3/27/01] Examples include folic acid, recent studies on diabetes.

- The distinction between nutrition and CAM is generally unclear, and some topics within this general area are gradually moving into mainstream medicine and research, e.g., use of antioxidants and other supplements.[W.Willet, 3/27/01]

- The Food and Nutrition Board, Institute of Medicine, has recommended that nutrition therapy, upon referral by a physician, be a reimbursable benefit for Medicare beneficiaries and that registered dieticians be reimbursed as providers. In 2000, Congress approved legislation to reimburse nutrition therapy through Medicare for renal disease and diabetes. Expansion of this coverage for cardiovascular patients and other conditions is under consideration [C. Reeser, 3/27/01]

Challenges:

- There are varying degrees of evidence to support the safety and efficacy of dietary supplements. The nutritive value, efficacy and safety of herbs, botanicals, hormones and some other classes of dietary supplements are not fully known at this time. [C. Reeser, 3/27/01]

- The broad definition of "dietary supplements" and high consumer demand had increased the need for dietetics professionals who can help consumers make informed decisions based on sound scientific knowledge.[C. Reeser, 3/27/01]

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Draft Recommendations:

24. Promote self-care and wellness in older adults, and provide Medicare reimbursement for CAM.

25. Help facilitate the use of a proper diet and wellness plan in government programs, such as Meals On Wheels for seniors, and in prisons.

26. Extend the hospice benefit so that someone who is diagnosed with a potentially life-threatening illness could immediately be eligible for palliative care support.

27. Encourage the avoidance of daily consumption of food and water which are overly artificialized, chemicalized, irradiated. Encourage the proper evaluation of genetic modification, and encourage more respect for natural, organic, and traditional quality of food and drinks.

28. Promote improvements to secure a more clean, natural environment of our air, water, and soil, and encourage avoidance of technology that is environmentally harmful.

29. Review health education curricula to assess whether mind-body or other evidence-based CAM has been included and is being appropriately taught to teachers and students.[M. Micozzi, 3/27/01]

Groft, Stephen (WHCCAMP)

From: Axelrod, Corinne (WHCCAMP)
Sent: Friday, August 31, 2001 9:00 AM
To: 'Bill Fair (E-mail) ' (E-mail); 'Dean Ornish (E-mail) ' (E-mail); 'Julia Scott (E-mail) ' (E-mail); 'Marjorie Dean Ornish office (E-mail) ' (E-mail)
Cc: Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Kaczmarczyk, Joseph (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP); Kingsbury, Doris (WHCCAMP)
Subject: Reminder - Today's Conference Call

Reminder - Please call 1-888-456-0361, passcode 37357, today at 12:30 for our Wellness conference call. If you haven't received the material for the call, please let me know ASAP. Thanks,

CDR Corinne Axelrod, M.P.H., L.Ac.
Senior Program Analyst
White House Commission on Complementary and Alternative Medicine Policy
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Groft, Stephen (WHCCAMP)

From: Axelrod, Corinne (WHCCAMP)
Sent: Tuesday, August 28, 2001 9:25 AM
To: 'deanornish@aol.com'; 'marjorie49@aol.com'; 'fairw@aol.com'; 'jrsct6@cs.com'; 'mingtian@aol.com'
Cc: Chang, Michele (WHCCAMP); Groft, Stephen (WHCCAMP); Kaczmarczyk, Joseph (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP); 'jpswyers@starpower.net'; 'jsgordon@mindspring.com'; Fisher, Ken (WHCCAMP)
Subject: Wellness Workgroup - Conference Call 8/31

Dear Wellness Workgroup (Dean, Bill, Julia, Ming, and Charlotte),

Thanks to all of you for getting the workgroup discussion on this topic underway during my absence. Michelle did a wonderful job of putting together an initial working document, and she has provided a detailed summary to me of the discussion that you had on August 16.

Whether Wellness remains as a stand alone section or is woven into the rest of the document (an idea which I think has a lot of merit but needs to be decided by the full Commission at the Oct meeting), we still need to further develop the issues and recommendations to a level appropriate for Federal policy recommendations. Building on Michelle's "Strawman" document and your 8/16 discussion, as well as the material in the July briefing book and the Interim Report, I am developing a revised draft which you will recieve tomorrow with the issues, background, recommendations, and discussion. The important issues that have been brought forth by the Commission and the Workgroup are reworded to be more consistent with the rest of the report, and many of the recommendations will be grouped together. To give you a sense of where we're headed, the issues are listed below. Please think about any changes or additions that we should consider.

Since this may be woven into other sections, I suggest that we keep this as the "Wellness" section and not be concerned at this point about changing the name or writing an intoduction. For now, we need to concentrate on getting the issues and recommendations ready for presentation to the entire Commission at the October meeting.

Our next conference call is scheduled for Friday, August 31, from 2:00 to 4:00pm EST. I know this is not a great time for some of you, but Dean will be out of the country and its the only time available. Even if you can only participate on part of the call, please join in. To be connected to the call, please dial 888-810-3143, passcode 37357. If you are disconnected, repeat the procedure to be reconnected. If you are unable to be connected, please call Ms. Juanita Tucker at 301-496-4516 or our office at 301-435-7592.

Thank you all for taking time out of your busy schedules to work on this and your other workgroups. Your input has been and continues to be essential to the development and refinement of the ideas contained in this document, and I look forward to our continued discussions as we move forward. If you have any questions, comments, or concerns, please call me at 301-435-2212.

CDR Corinne Axelrod, M.P.H., L.Ac.
Senior Program Analyst
White House Commission on Complementary and Alternative Medicine Policy
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Issue 1: Utilization of CAM in schools and the community to facilitate learning, reduce violence, and

optimize well-being.

Issue 2: Utilization of CAM to help achieve the Nation's health promotion and disease prevention goals.

Issue 3: Utilization of CAM in the workplace to increase job satisfaction and productivity.

Issue 4: Research in the role CAM in promoting more optimal states of health and well-being and enhanced quality of life.

Issue 5: Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and decrease costs.

Issue 6: Incorporation of CAM wellness activities in Federal health programs to improve health outcomes and decrease costs.

"G"

TOPIC: CAM in Wellness, Self-Care, and Prevention
Staff Lead: Corinne Axelrod (Michele Chang substitute until 8/20)
Facilitator: Dean Ornish

OVERVIEW OF ISSUES:

Issue 1. Optimal well-being: Can CAM promote and support efforts of consumers to realize more optimal levels of functioning?

Issue 2. Whole person care: Can CAM be used to promote a more holistic view of health and health care?

Issue 3. Self-Care: Can CAM be used to empower and support consumers to care for themselves?

Issue 1. Optimal well-being: Can CAM promote and support efforts of consumers to realize more optimal levels of functioning?

Discussion: Most CAM practices are based on the recognition that human beings are capable of manifesting higher, more optimal levels of energy, creativity, and psychophysical well-being, and that health involves more than merely the absence of disease. Many mind-body therapies, such as meditation, Tai Chi, yoga, Qi Gong, were developed not so much to treat disease but to facilitate the development of various "positive" states of health such as equanimity, harmony with oneself and the world, compassion, mental clarity-concentration, heightened perceptual sensitivity (.e.g. to subtle energies), and spiritual insight or realization. [J. Astin, 3/27/01]. However, the current health care system remains primarily disease-focused, with most of research, education, training, reimbursement, and information development and dissemination directed toward identifying and treating disease.

Background:

- Murphy and Leonard, Integral Transformative Practice (ITP) study in Stanford. Examines the effects of a multi-modal lifestyle intervention program involving group emotional support, meditation and various self-awareness skills drawn from martial arts, and gentle exercise. Also studies the effects of ITP on healthy older adults. [J. Astin, 3/27/01]

- NIH is now including CAM pediatric research, and practitioners in homeopathy, nutrition and manual therapies are studying the effects of these practices on children. [M. Micozzi, 3/27/01]

- The Handbook of Religion and Health (Koenig et al, 2001) reviews more than 1200 published studies on the relationship between religion and/or spirituality and a variety of mental and physical health outcomes.[D.Larson, 3/27/01]

- Fetzer and John Templeton Foundation are funded limited studies on the role of spirituality on health. [D.Larson, 3/27/01]

- The Annals of Behavioral Medicine, 2001 article on the study that found that frequent worship attenders were in better health than non-attenders, and that those who were not in better health tended to develop healthier habits if they attended church regularly. [D.Larson, 3/27/01]

- Some medical schools already are employing teaching models that encourage collaborations between doctors and chaplains. [D.Larson, 3/27/01]

Challenges:

- Wellness activities, especially those directed at preventing illness, that are incorporated into the conventional health care system are, for the most part, disease screening (e.g. pap smears, mammograms, etc.), or are offered in response to an already identified illness or condition (e.g. physical therapy, nutrition counseling, etc.)

- Other wellness activities, particularly those considered "CAM," frequently take place outside of the conventional health care system, and are reliant upon a person's initiative and ability (education, finances, availability of resources, etc.) to access and incorporate them into their life.

- Research in CAM continues to be focused almost entirely upon the treatment rather than prevention of health related conditions. For example, despite considerable research showing both the significant clinical and cost benefits of worksite health promotion programs, insurers remain reluctant to invest in such services, in part because the gains may not be immediately apparent and can often only be realized over the long term. [J. Astin, 3/27/01]

- Negative attitudes continue to be propagated that create ideologic and practical barriers between CAM and conventional medicine, such as "CAM is holistic while conventional medicine is not." [J. Astin, 3/27/01]

- Although more than 90% of Americans describe themselves as either religious or spiritual [D.Larson, 3/27/01], most of conventional science either disregards the effect of these factors on health; a stigma continues to exist in the research, science and academic communities around such hypotheses. [D.Larson, 3/27/01]

Draft Recommendations:

1. CAM activities should begin in elementary school, as part of health education. Teachers and students should learn meditation and relaxation techniques, and information should be provided about the ancient civilizations and diverse cultures which gave rise to many of these health traditions.

2. Provide disincentives for corporate/school relationships where corporate contributions of computers and resources are tied to the presence of soft drink machines, or commercial advertising in schools.

3. Create programs in schools that help educate children about how to care for their bodies throughout their lives, and teach nutrition.

4. Increase research spending for CAM in the prevention of disease, particularly focusing on mind-body therapies that have shown transformational effects with depression, loss of sense of control, anger/hostility and other "mind" factors that interact with disease. [J. Astin, 3/27/01] For example, fund studies that assess the effect of mind/body techniques (Ayurvedic, meditation, Qi Gong) on reducing tension and stress in the school environment (targeted at preventing violence in the school place) , and aiding academic performance. [M. Micozzi, 3/27/01]

5. Conduct research on the effects of various CAM therapies in healthy populations, not solely in terms of preventing disease and illness, but in terms of promoting more optimal states of health (e.g., do people who receive regular acupuncture or bodywork manifest greater levels of energy, vitality and mental-emotional balance?)

6. Using the President's Faith-based Initiative, develop a centralized data base on spirituality and health that contains information on grants and funding on model care and educational programs and effective strategies for sensitively and ethically incorporating spirituality into health care, thereby helping to bridge the gap between research and clinical application. [D.Larson, 3/27/01]

7. Using the President's Faith-based Initiative, support continuing education conferences and other education materials to help make clinical and research communities better aware of research linking spiritual and religious factors to various aspects of health. This also should include forums where health providers can interact with clergy, chaplains, and pastoral care professionals so that clinicians can develop a better understanding of the roles that religious professional play in health and healing.[D.Larson, 3/27/01]

Issue 2. Whole person care: Can CAM be used to promote a more holistic view of health and health care?

Discussion: Many CAM therapies come from a holistic tradition of integrating body, mind, and spirit, and focus on optimal functioning to prevent, deter, or minimize illness and disease, and maximize one's potential to live life to the fullest. These qualities are the foundation of much of the interest in wellness, self-care, and prevention, which cover a wide range of activities such as support groups for people with cancer; meditation, yoga, or Tai Chi for relaxation and stress reduction; foods and dietary supplements to retain and enhance function and vitality; palliative care for the end of life; etc. All of these have a CAM component whose benefit is just beginning to be realized.

Background:

Challenges:

Draft Recommendations:

8. Measurements of health must be more than the absence of disease, and include qualities such as greater levels of energy, vitality, creativity, and overall well being.

9. CAM should be incorporated into well child care and pediatric practice.

10. Increased funding should be directed to research in self-care, wellness, and prevention, including the role of spirituality.

11. Encourage more communication between medical practitioners and spiritual leaders to address issues such as spiritual assessment, referrals, possible conflicts, etc.

12. Establish a Center of Wellness at the NIH

13. Encourage the U.S. Surgeon-General to send a letter to the nation's doctors reporting briefly on those CAM approaches that have been validated by clinical research within the last five years.

14. Support funding for research and education on the effectiveness of CAM for both prevention and recovery, with diet and lifestyle at the base and establish a pilot plan for clinical trials in some hospitals and health care centers.

15. Encourage hospitals, clinics, health care facilities, and medical schools to add dietary and wellness studies, counseling, cooking classes, and serving facilities with healthful menus.

16. Clinical nutrition and nutritional supplementation needs to be taught in medical school courses, and clinical competency courses are needed for practitioners.

17. Provide additional training for doctors and nurses to include: the role of spirituality in health and in end-of-life care; how to address patients' spiritual needs; how to recognize spiritual suffering; how an interdisciplinary approach to care can build communities of caring.

18. Train health care professionals, as well as faith and other social communities, to recognize the importance of spiritual care, particularly at the end of life, and how to work within the health care system.

19. Have the Surgeon General send a letter to the nation's doctors reporting briefly on the evidence of complementary approaches and encouraging a more holistic approach to healing.[M. Micozzi, 3/27/01]

20. Shift reimbursement codes from the ICD-9/CPT disease-based model to one that is based on health promotion and change our focus on acute and terminal care to focusing on early assessment and intervention to prevent and diagnose and treat and optimize health.

21. Offer employers incentives to start new workplace health and wellness programs that incorporate appropriate CAM modalities.

22. Support studies of CAM usage among different racial/ethnic populations.

23. Integrate CAM providers into traditional geriatric health provider teams in hospitals, the community, assisted living facilities, nursing homes, etc.

Issue 3. Self-Care: Can CAM be used to empower and support consumers to care for themselves?

Discussion: In the area of nutrition alone, it is estimated that great reductions in cardiovascular disease and some cancers may be achieved by diet and lifestyle. For example, it is estimated that over 80% of heart attacks, and over 70% of strokes and colon cancer could be avoided by not smoking, regular exercise and good diets. [W.Willet, 3/27/01]

Background:

- During the last decade, large prospective studies have provided strong evidence that diet is more important than previously thought for the prevention of disease, and that it acts in different ways than were believed.[W.Willet, 3/27/01] Examples include folic acid, recent studies on diabetes.

- The distinction between nutrition and CAM is generally unclear, and some topics within this general area are gradually moving into mainstream medicine and research, e.g., use of antioxidants and other supplements.[W.Willet, 3/27/01]

- The Food and Nutrition Board, Institute of Medicine, has recommended that nutrition therapy, upon referral by a physician, be a reimbursable benefit for Medicare beneficiaries and that registered dieticians be reimbursed as providers. In 2000, Congress approved legislation to reimburse nutrition therapy through Medicare for renal disease and diabetes. Expansion of this coverage for cardiovascular patients and other conditions is under consideration [C. Reeser, 3/27/01]

Challenges:

- There are varying degrees of evidence to support the safety and efficacy of dietary supplements. The nutritive value, efficacy and safety of herbs, botanicals, hormones and some other classes of dietary supplements are not fully known at this time. [C. Reeser, 3/27/01]

- The broad definition of "dietary supplements" and high consumer demand had increased the need for dietetics professionals who can help consumers make informed decisions based on sound scientific knowledge.[C. Reeser, 3/27/01]

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Draft Recommendations:

24. Promote self-care and wellness in older adults, and provide Medicare reimbursement for CAM.

25. Help facilitate the use of a proper diet and wellness plan in government programs, such as Meals On Wheels for seniors, and in prisons.

26. Extend the hospice benefit so that someone who is diagnosed with a potentially life-threatening illness could immediately be eligible for palliative care support.

27. Encourage the avoidance of daily consumption of food and water which are overly artificialized, chemicalized, irradiated. Encourage the proper evaluation of genetic modification, and encourage more respect for natural, organic, and traditional quality of food and drinks.

28. Promote improvements to secure a more clean, natural environment of our air, water, and soil, and encourage avoidance of technology that is environmentally harmful.

29. Review health education curricula to assess whether mind-body or other evidence-based CAM has been included and is being appropriately taught to teachers and students.[M. Micozzi, 3/27/01]

Chang, Michele (WHCCAMP)

From: Chang, Michele (WHCCAMP)
Sent: Tuesday, August 14, 2001 12:16 PM
To: 'Bill Fair (E-mail)'; 'Dean Ornish (E-mail)'; 'Julia Scott (E-mail)'; 'Xiaoming Tian (E-mail)'
Cc: 'Corinne at home (E-mail)'; 'Jim Gordon (E-mail)'; Axelrod, Corinne (WHCCAMP); Fisher, Ken (WHCCAMP); Pollen, Geraldine (WHCCAMP); Jim Swyers (E-mail); Kaczmarczyk, Joseph (WHCCAMP); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Groft, Stephen (WHCCAMP)
Subject: WHCCAMP G: Wellness

Until Corinne returns on August 20, I will serve as your staff lead for Wellness. Our first conference call is scheduled for Thursday, August 16 from 3-5 p.m. EST. Please call 877-918-2311 (passcode: 36763) to be connected. Our facilitator is Dean Ornish.

To launch the discussion, please review the attached document. This format will be used by each work group to identify the key issues, and to develop the contextual background for each issue, as well as draft recommendations. The attached document was developed by reviewing the briefing materials and is only a launching point. (As you may note, I have referenced testimony whenever possible so that you can refer back to your briefing materials.) This document is neither complete nor final and we welcome your comments and suggestions on the content.

For the purposes of the call on Thursday, please be prepared to focus on the Issues raised (did we miss anything?), Challenges and Draft Recommendations. All the other pieces can be refined primarily through e-mail, since much of it is likely to be word-smithing and staff research based on your input ("please find this, or that model or document," etc)

If you have difficulty downloading this document, please contact me immediately at 301-435-6232 or by e-mail so that I can get you the document to review before Thursday.

Thanks!

Michele M. Chang, MPH, CMT
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Tracking:

Recipient	Delivery	Read
'Bill Fair (E-mail)'		
'Dean Ornish (E-mail)'		
'Julia Scott (E-mail)'		
'Xiaoming Tian (E-mail)'		
'Corinne at home (E-mail)'		
'Jim Gordon (E-mail)'		
Axelrod, Corinne (WHCCAMP)	Delivered: 8/14/2001 12:16 PM	
Fisher, Ken (WHCCAMP)	Delivered: 8/14/2001 12:16 PM	Read: 8/14/2001 3:31 PM

Groft, Stephen (WHCCAMP)

From: Axelrod, Corinne (WHCCAMP)
Sent: Friday, August 31, 2001 3:20 PM
To: 'Bill Fair (E-mail) ' (E-mail); 'Dean Ornish (E-mail) ' (E-mail); 'Julia Scott (E-mail) ' (E-mail); 'Marjorie Dean Ornish office (E-mail) ' (E-mail); 'Ming Tian (E-mail) ' (E-mail)
Cc: Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Kaczmarczyk, Joseph (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP)
Subject: Followup to Wellness Conference Call

As discussed, here are the following:

1) The internet site for HP 2010 is: www.health.gov/healthypeople. Each volume is several hundred pages but you can scroll through it and download individual sections.

2) The Models That Work site is: http://bphc.hrsa.gov/mtw. This program identifies and promotes innovative community-based models for the delivery of primary health care to underserved and vulnerable populations. This could be a model for identifying CAM programs
in the schools and community.

3) The Institute of Medicine's report, Schools and Health: Our Nation's Investment, is almost 500 pages and sells for about $50. I will be faxing you a copy of the Executive Summary.

I will send you the rest of the Wellness section next week and we'll set up another conference call. Meanwhile, please let me know any thoughts or suggestions you may have.

Have a great weekend!

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06Sep01

Topic: CAM in Wellness, Self-Care, and Prevention
Staff Lead: Corinne Axelrod
Members: Dean Ornish (Facilitator), Bill Fair, Julia Scott, Xiaoming Tian, Charlotte Kerr

Issue 1: Utilization of CAM in schools and the community to facilitate learning, improve behavior, and optimize well-being.

Background: Research shows that even moderate under nutrition can have lasting effects on children's cognitive development and school performance.[1] Yet, more than 84% of children and adolescents eat too much fat[2], and only 20% eat an adequate amount of fruits and vegetables. At the same time, almost 13 percent of children aged 6 - 7 are seriously overweight[3], and obese children and adolescents are more likely to become obese adults[4]. Physical activity is known to have many beneficial health effects, including reduction in anxiety and stress and increased self-esteem[5], yet daily participation in physical education classes by high school students dropped from 42% in 1991 to 29% in 1999. Among high school students, 70% have tried cigarettes and 36% are current smokers[6]. Among children ages 5-14, the leading causes of death are unintentional injuries, cancer, and homicide, respectively. In the 15-24 age group, the leading causes of death are unintentional injuries, homicide, and suicide, respectively[7]. Behavioral and mental health problems, especially depression, are widespread, and substance abuse continues to be a problem. Seventeen percent of high school students carried a weapon during the past month,

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[1] - Center on Hunger, Poverty, and Nutrition Policy. Statement on the Link between Nutrition and Cognitive Development in Children. Medford, MA: Tufts University School of Nutrition, 1995

[2] - Lewis CJ et al. Healthy People 2000: Report on the 1994 nutrition progress review. Nutrition Today 1994; 29 (6): 6-14.

[3] - Centers for Disease Control and Prevention. Update: prevalence of overweight among children, adolescents, and adults - United States 1988-1994. Morbidity and Mortality Weekly Report 1997; 46:199-202.

[4] - Guo SS et al. The predictive value of childhood body mass indexvalues for overweight at age 35 years. American Journal of Clinical Nutrition 1994; 59:810-9

[5] - CDCP Guidelines for School and Community Programs: Promoting Lifelong Physical Activity

[6] - CDCP Guidelines to Prevent Tobacco Use and Addiction

[7] - CDCP, NCHS, National Vital Statistics System, 1999.

and 19% have seriously considered suicide in the past year[8].

Most school districts require some form of health education to be taught as part of a student's total education. School health programs include activities and services to promote students' physical, emotional, and social development. Teaching students safe and effective CAM practices, such as mind-body exercises, nutrition, etc., as well as a more integrated, holistic approach to life, can complement the many efforts already underway to improve the health and well being of young people.

The Centers for Disease Control and Prevention (CDCP) has developed guidelines for schools on physical activity, healthy eating, tobacco use and addiction, and AIDS prevention. The Health Resources and Services Administration (HRSA) is developing guidelines on comprehensive school health programs, mental health, and safety.

Recommendations:

A) Agencies with the Department of Health and Human Services, especially the HRSA, CDCP, Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) should form a working group with other Federal organizations such as the Department of Education and the Administration for Children and Families (ACF) to develop guidelines on how to utilize CAM principals and practices to improve students' physical, emotional, and social development, and to integrate these practices into school health programs in K - 12. The working group should include CAM professionals, parents and teacher groups, and the guidelines should reflect the cultural diversity in the school systems.

B) DHHS should identify and provide information on successful models of utilizing CAM in schools and the community.

C) In partnership with the business community and school boards, develop incentives for schools to limit the sale and advertising of high fat snacks, soft drinks, and other products that do not contribute to a healthy lifestyle.

Discussion/Challenges:

There are some schools across the country that have special school lunch programs[9], yoga[10], and other programs, but very few schools are teaching holistic concepts of health or providing CAM type of wellness programs. School programs are locally designed and implemented, and what works in one community may not be applicable to another, and it is essential that the local

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[8] - CDCP National Center for Chronic Disease Prevention and Health Promotion

[9] - Demas A. Low-Fat School Lunch Programs: Achieving Acceptance, American Journal of Cardiology 1998; 82::80T-82T

[10] - Yoga Inside Foundation

community (parents, teachers, school boards, etc.) are involved. Identifying and providing information on programs utilizing CAM concepts or practices in schools will assist other schools in developing their own programs.

Issue 2: Utilization of CAM to help achieve the Nation's health promotion and disease prevention goals

Background: Since the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979, goals and objectives for the Nation's health have been defined and monitored. The most recent report, *Healthy People 2010*, was developed by an alliance of over 600 Federal, State, and national organizations. HP 2010 is designed to achieve two overarching goals: 1) Increase quality and years of healthy life, and 2) Eliminate health disparities. These goals and objectives are the blueprint for the Nation's health promotion and disease prevention activities and influence data collection, national health policy, and program development and implementation. HP 2010 is a comprehensive document that addresses clinical, behavioral, environmental, and health systems issues that impact on health. It's focus is both on individuals and communities, and there is a strong emphasis on health education and changing health behaviors.

Recommendations:
A) The Department of Health and Human Services should form a working group within the Healthy People Consortium that includes CAM professionals to review the 10 leading health indicators[11] to determine the applicability of CAM to these indicators and, where appropriate, develop strategies to encourage the use of safe and effective CAM practices in these areas.

B) Questions on specific CAM usage should be included in the national surveys that are the sources of the HP 2010 data (e.g. NHIS, NHANES, MEPS, etc.) – they may be already planned for Chi

Discussion/Challenges: The two overaching goals of HP 2010 are consistent with the goals of CAM and there are many areas where CAM principles and practices could contribute to the achievement of the goals and objectives outlined in HP 2010. Some examples include: massage to reduce activity limitation due to chronic low back pain; acupuncture to reduce use and adverse effects of substance abuse; meditation or biofeedback to reduce high blood pressure, etc. Although HP 2010 is very data driven and CAM currently does not have an extensive database, adding a CAM perspective to these goals and objectives would build on a component of the public health infrastructure that is well established and could have far reaching impact on policies and programs.

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[11] - The ten leading health indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.

Issue 3: Utilization of CAM in the workplace to increase job satisfaction and productivity and reduce costs.

Background: According to a study on worker health and productivity, employers are annually spending more than $8,000 per employee for health care and related costs. Of this, 58 percent ($5,003) is for health care expenses, 22 percent ($1,897) for turnover, 8 percent ($698) for unscheduled absences, 7 percent ($630) for non-occupational disability, and 5 percent ($393) for workers compensation. For the 600,000 workers included in this survey, the cost was $4.9 billion.[12]

Wellness programs can save companies a median of $3 for every dollar spent[13], and some worksite health promotion programs have had a positive return on investment of up to 8.22:1 in combined reduced health care costs and absenteeism[14]. Many of these worksite health promotion programs include CAM practices such as yoga, stress reduction, and changes in nutrition and lifestyle.

Recommendations:
A) Include CAM in all Federal worksite wellness and health promotion programs.

B) Work with the Office of Personnel management to assure that federal health coverage plans offer a CAM wellness option.

C) In consultation with the business community, develop incentives for employers to include CAM in worksite wellness programs and health coverage.

D) Form partnerships with private organizations such as the Wellness Councils of America to encourage inclusion of CAM services in their worksite wellness programs

Discussion/Challenges: The Division of Federal Occupational Health, in the Department of Health and Human Services, assists Federal organizations in improving the health, safety, and productivity of the Federal workforce. They provide comprehensive worksite services, including medical, nursing, and wellness/fitness services, to Federal agencies around the country and currently serve over 300 Federal agencies with 1.6 million employees. Other Federal organizations may offer their employees wellness programs as well.

Incentives for businesses to include CAM in wellness programs and health coverage will vary

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[12] - The MEDSTAT Group and American Productivity Center. March 18, 1999, Press Release

[13] - Goetzel RZ, New York Times June 24, 2001, p11

[14] - Aldana SG. Financial impact of worksite health promotion and methodological quality of the evidence. Art of Health Promotion 1998; 2(1):1-8.

depending on the size of the business. For example, larger companies that negotiate health plans through a union will require a different set of incentives than a small company that may only offer limited coverage. Some incentives currently exist but have not been evaluated for their effectiveness. Any additional program or service will have start up costs that may deter some companies.

Issue 4: Research on the role CAM in promoting more optimal states of health and well-being and enhanced quality of life

(The Research workgroup is addressing this issue)

Issue 5: Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and decrease costs.

Background: The current health care system is disease-focused, with most of research, education, training, services, reimbursement, and information development and dissemination directed toward identifying and treating diseases and conditions. Wellness, self-care, or prevention activities that are incorporated into the conventional health care system are, for the most part, disease screening (e.g. pap smears), or offered in response to an already identified illness or condition (e.g. physical therapy after stroke, nutritional counseling for diabetics, etc.) Wellness, self-care, and prevention activities often occur outside of the conventional health care system, and rely upon a person's knowledge of these activities their potential beneficial, as well as their ability to pay for these activities, and the level of difficulty in accessing these activities (location, hours of availability, etc.). Incorporating them into the conventional health care system will make them available to more people, improve continuity of care and health outcomes, and could provide significant savings in reduced health care costs.

Recommendations:

A) In consultation with the American Academy of Pediatrics, American Academy of Family Physicians, National Association of Community Health Centers, and others, including CAM professionals and consumers, develop guidelines and provide training and information on CAM and wellness to clinicians in Federally-funded health programs (e.g. community and migrant health centers, maternal and child health programs, school health programs, etc.) that provide clinical services to children and their families.

B) In consultation with the American Hospital Association and others, including CAM professionals and consumers, identify strategies to incorporate CAM in wellness, prevention, and self-care in the nation's hospitals.

C) In consultation with national associations and organizations, and others, including CAM professionals, develop recommendations for the inclusion of CAM in wellness, prevention, and self-care activities in continuing education programs for physicians, pharmacists, nurse practitioners, physician assistants, dentists, etc.

D) In consultation with the Administration on Aging; Center for Medicare and Medicaid Services; Veterans Administration; nursing home, home health, long term care, and other national associations; and others, including CAM professionals and consumers, identify strategies to incorporate CAM in wellness, prevention, and self-care programs serving the Nation's aging population.
E) In consultation with the Hospice Foundation of America, National Hospice Foundation, Hospice and Palliative Nurses' Association, and others, including CAM professionals and consumers, develop guidelines and provide training and information to hospice providers on the use of CAM in the end of life.

F) In consultation with American Association of Health Plans, National Committee for Quality Assurance, representatives of major health plans, Center for Medicare and Medicaid Services, Department of Defense, and others, including CAM professionals and consumers, identify strategies to incorporate CAM wellness, prevention, and self-care in health plans.

G) Identify Federal programs (e.g. Head Start, Meals on Wheels, Women Infants and Children, State Children's Health Insurance Program, etc.) that could benefit from the addition of CAM in wellness, prevention, or self-care, and develop strategies to incorporate these into the programs as appropriate.

Discussion/Challenges: Incorporating CAM in wellness, prevention, and self-care activities within the conventional health care system requires expanding the way health care is viewed in this country. It is a consumer driven movement that many health professionals and organizations support, but faces numerous barriers in achieving. Federal leadership can help bring together key partners, identify barriers, and develop solutions that will facilitate integrating CAM in wellness, prevention, and self-care activities within the conventional health care system and highlight CAM's unique contribution to these activities.

NOTE TO WORKGROUP:

To address the proposal that Wellness be woven into the rest of the report instead of being a stand alone section, here are suggested sections for each of the identified issues:

Issue 1: Utilization of CAM in schools and the community to facilitate learning, improve behavior, and optimize well-being - **Information Development and Dissemination**

Issue 2: Utilization of CAM to help achieve the Nation's health promotion and disease prevention goals - **Access**

Issue 3: Utilization of CAM in the workplace to increase job satisfaction and productivity and reduce costs - **Access, Reimbursement**

Issue 4: Research on the role CAM in promoting more optimal states of health and well-being and enhanced quality of life - **Research**

Issue 5: Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and decrease costs - **Education and Training, Reimbursement**

07Sep01

Topic: Information Development and Dissemination
Staff Lead: Corinne Axelrod
Members: David Bresler (Facilitator), Tieraona Low Dog (Facilitator), Julia Scott, George DeVries, Tom Chappell

Issue 12: Adequacy of the Adverse Event Reporting (AER) System in identifying and addressing safety issues in a timely manner.

Background: The Dietary Supplement Health and Education Act (DSHEA) of 1994 gave the FDA authority to take enforcement action against dietary supplements that are misbranded, adulterated, or found to be a significant or unreasonable risk to consumers. To do this, the FDA relies in part on its adverse event reporting (AER) system to identify safety problems. The AER is an important mechanism to provide consumer protection while assuring access to these products, and is an educational tool to aid in ongoing research of safety and efficacy of products. Events can be reported by both consumers and health professionals. However, the system is entirely voluntary, and a recent study shows that the FDA receives reports on less than 1 percent of all adverse events associated with dietary supplements.[1] Serious or clinically significant adverse events[2] related to dietary supplements need to be identified and contained in a timely manner to prevent unnecessary morbidity and mortality.

Recommendations:
A) Strengthen the AER system by: a) encouraging voluntary registration of dietary manufactures so that the FDA can identify and contact them if an adverse event is reported, b) requiring dietary supplement manufacturers to report serious adverse events to the FDA (similar to the requirements for OTC drugs), c) mandating registration of manufacturers and developing a data base of manufacturers and product ingredients, and d) simplifying the system to facilitate increased usage and easier reporting.

B) Increase outreach activities to health professionals (including poison control centers and emergency room physicians) and consumers regarding the importance of reporting adverse events, and provide information on how to use the system.

Discussion/Challenges: In April, 2001, the Office of the Inspector General, DHHS, issued a report on adverse event reporting for dietary supplements, calling it "an inadequate safety valve". This report describes in detail the limitations of the current system in detecting serious adverse events related to dietary supplements and provides numerous recommendations to improve the system, some of which are included in the FDA's 10- year strategic plan. Most of the

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[1] - DHHS, OIG, Adverse Event Reporting for Dietary Supplements, April 2001

[2] - These terms are defined under Medwatch and in the FDA's Standard Operating Procedures of 1999

recommendations can be implemented administratively with additional funding, while some, such as mandatory manufacturer and product registration and reporting of adverse events may require legislative authority.

Issue 13: Adequacy of packaging and labeling information of dietary supplements in determining ingredients, strength, benefits, appropriate use, and potential risks.

Background: Laboratory testing of dietary supplements has shown that some do not contain the ingredients listed on the label, or do not contain the ingredients in the amount listed on the label, or contain ingredients other than those listed on the label. If the labels are not accurate, consumers may be getting more, less, or something other than what they think they are getting, and this could have negative health consequences.

Some labels state that an ingredient, or mixture of several ingredients, is standardized (e.g. "the product contains 3% of a standard extract of x", or "x is a standard extract"), but do not identify the standards against which it is compared. While some dietary supplements have industry-approved standards, many do not have any standards or their standards have not yet been scientifically confirmed. Labels claiming standardization of an ingredient or mixture product are misleading if the standard has not been fully established, and do not provide consumers with adequate information on the strength of the ingredients.

Product information on benefits, appropriate use, and potential risks is limited. Under DSHEA, dietary supplements are regulated as foods and do not have regulatory approval as drugs, and therefore can only make structure and function claims. As a result, even when there is research supporting a claim for preventing, treating, curing, or mitigating a disease, claims are still limited to structure and function, unless they already have an approved health claim under Nutrition Labeling and Education Act of 1990 (NLEA). Also, even when risk information is known, such as the interaction between St. John's Wort and certain drugs, this information is not required be included on the product label. Public understanding of this issue is also compromised by the complexity and implications of both existing regulatory guidelines and recent court decisions which have upheld the right of commercial free speech in advertising and labeling of dietary supplements.

Recommendation:
A) Implement the FDA's Good Manufacturing Practices (GMP) to help assure quality and consistency of dietary supplements.

B) Increase consumer information of dietary supplements through a) improved labeling, package inserts, and information at points-of-sale, b) inclusion of information on possible interactions with prescription or OTC drugs, foods, or other health products, c) inclusion of information on possible risks to vulnerable populations such as children, the elderly, pregnant or nursing women, and those with certain health conditions or compromised immune systems.

C) Require that claims of standardization be limited to products with industry-approved

standards.

Discussion/Challenges:
The regulation of dietary supplements and other products such as foods, prescription drugs, over-the counter drugs, and special dietary foods is determined by the intended use of the product. Product labels must conform to the laws and regulations that govern its intended use. Thus, a vitamin or a botanical that prevents or treats a disorder must be an approved drug for this information to be included on the label. If a product is marketed as a dietary supplement, only structure and function claims can be stated on the label.

The NLEA has authorized claims for calcium and reduced risk of osteoporosis, psyllium and reduced risk of heart disease, reduced sodium and reduced risk of high blood pressure, reduced fat and reduced risk of cancer, etc. However, glucosamine, which has had numerous controlled studies published in peer-reviewed journals showing it is effective for osteoarthritis, can only claim that it helps to maintain joint health because it is distributed as a dietary supplement instead of a drug. Statements of nutritional support can use terms such as stimulate, maintain, support, regulate, or promote, but cannot claim to "diagnose, treat, prevent, cure, or mitigate" a disease. The cost of preparing a drug application is prohibitive to many companies, the extensive time required for drug approval is a deterrent , and any realized benefits will apply to all manufactures, not just the one who prepared the application.

To increase the availability of standards, government and industry have formed a task force to validate analytical methods for botanicals and other dietary supplements. The task force includes the Association of Analytical Chemists (AOAC) International, United States Pharmacopeia (USP), American Herbal Products Association (AHPA), the FDA, NIH, and the National Institute of Standards and Technology (within the Commerce Department), and others. They are developing consensus standards on processing and manufacturing, and chemical and physical standards for composition and quality.

Issue 14: Quality control of dietary supplements to assure consumer safety.

Background: In addition inconsistencies in the amount and purity of the listed ingredients, some dietary supplements have been found to be adulterated with pesticides, microorganisms, heavy metals, or other potentially toxic substances.

Recommendation:
A) Implement the FDA's Good Manufacturing Practices (GMP) to help assure the purity of dietary supplements.

B) The Department of Health and Human Services, Department of Agriculture, Environmental Protection Agency, US Customs Services, and other appropriate Federal departments and agencies should work with manufacturers and importers to monitor the quality of imported and domestic dietary supplements and identify and prevent contaminated or adulterated products from entering the US marketplace.

C) The Department of Health and Human Services Department of Agriculture, Environmental Protection Agency, and others should work with the World Health Organization and other appropriate international organizations to establish guidelines to help assure the purity of herbal ingredients and, where possible, set international standards for consistency.

Discussion/Challenges: Testing of 25 echinacea products found that only 14 (56%) had the amount and type of echinacea and phenol levels that they claimed the product contained.[3] Testing of 13 SAMe products showed that 6 had less than half of the amount listed on the labels (one of which had no detectable level).[4] Aristolochic acid, which has been associated with serious health hazards such as cancer, renal failure, and neuropathy when improperly used, has been identified in various dietary supplements, prompting recalls of products by several companies[5]. There are numerous other examples of dietary supplements that have failed laboratory testing of the identity, quantity, quality, and amount of the ingredients listed on the labels. The GMPs developed by the FDA are widely supported by industry and seen as a minimum standard for the safety and integrity of dietary supplements.

In both imported and domestically produced products, contamination by pesticides and infectious organisms have been found. In April, 2001, Solgar Vitamin and Herb Company recalled some dietary supplements due to salmonella contamination of raw materials supplied by American Laboratories. In May 2001, Natural Organics recalled several dietary supplements, also due to salmonella contamination of raw materials supplied by American Laboratories. The University of California, Cooperative Extension, has found toxic levels of mercury in some pills from China[6]. While the extent of contamination of dietary supplements is not known, steps should be taken to assure that these products are free of contaminants.

Issue 15: Federal oversight to assure public access to and safety of dietary supplements.

Background: The use of all dietary supplements has grown significantly since DSHEA was enacted in 1994, and Federal and State regulatory agencies need well-trained, highly skilled professionals with expertise in dietary supplements, particularly in areas other than vitamins and minerals (e.g. plant, animal, synthetic, and microbial products) to assure appropriate oversight and public safety.

Recommendation:
A) Assure an adequate staff of professionals within the FDA and NIH (Office of Dietary Supplements, NCCAM) with expertise in dietary supplements, especially areas other than

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[3] - ConsumerLab.com, September 2000

[4] - ConsumerLab.com, January 2000

[5] - FDA

[6] - University of California, Cooperative Extension, Environmental Toxicology Newsletter, Vol. 19, No.1, 1999

vitamins and minerals (e.g. plant, animal, synthetic, and microbial products). This could include hiring people with these specific skills, and/or providing training to current staff, and may require increased staffing levels and/or funding.

Discussion/Challenges: In a regulatory agency such as FDA, it is critical that staff with oversight responsibility of specific products be sufficiently knowledgeable of both the regulatory system and the products to effectively balance consumer protection and access issues. Particularly in the rapidly evolving area of botanicals, having staff with adequate expertise is essential in developing good relationships with industry and engendering consumer confidence.

Groft, Stephen (WHCCAMP)

From: Axelrod, Corinne (WHCCAMP)
Sent: Thursday, September 06, 2001 10:59 AM
To: 'Bill Fair (E-mail) ' (E-mail); 'Dean Ornish (E-mail) ' (E-mail); 'Julia Scott (E-mail) ' (E-mail); 'Marjorie Dean Ornish office (E-mail) ' (E-mail); 'Ming Tian (E-mail) ' (E-mail)
Cc: Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Kaczmarczyk, Joseph (WHCCAMP); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP); 'jsgordon@mindspring.com'; 'jpsywers@starpower.net'
Subject: Wellness

Hi Everyone,

Attached is the completed draft of the Wellness section for your review. Please note the following:

1) I have merged Issue 6 into Issue 5, so we now have a total of 5 Issues, with a total of 16 Recommendations.

2) I have spoken with Gerry Pollin about Issue 4, and she told me that the Research group has agreed to address it.

3) Page 7 has a list of possible sections that each of the Wellness issues could go to, if its decided that they be integrated into the other sections.

4) We need to rank the issues, starting with the highest priority. Please think about this, and we will discuss it on our next **Conference Call**, which happens to be...

5) **Tuesday, September 11, from 4:30 - 6:00 pm EST.** Doris will send you the call in number and password. We will review issues 1, 2, and 3 to bring Charlotte up to date and get her input, and talk about issue 5. Charlotte has also asked at we include something about the environment, so please think about any possible recommendations and where they ay fit.

6) Thanks to Ken Fisher, we have an electronic version of the IOM report that Bill referred to on our last call. It is also attached, but keep in mind its 500 pages.

7) Dean is in Florence, Italy (poor thing - someone had to do it!) but he has promised to be a faithful email corespondent.

Thanks everyone, looking forward to talking with you next week,

CDR Corinne Axelrod, M.P.H., L.Ac.
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Wellness Workgroup.wpd


Wellness Workgroup.rtf


NRC.Edu.Rept.htm

- 15 Consecutive # of Rec's.
- Consolidate Recs
  Sep 10-15
- Delete discussion
- State as Challenges
- Keep to 4 areas
- Reduce length of Recs
  9, 10-15

06Sep01

Topic: CAM in Wellness, Self-Care, and Prevention
Staff Lead: Corinne Axelrod
Members: Dean Ornish (Facilitator), Bill Fair, Julia Scott, Xiaoming Tian, Charlotte Kerr

Issue 1: Utilization of CAM in schools and the community to facilitate learning, improve behavior, and optimize well-being.

Background: Research shows that even moderate under nutrition can have lasting effects on children's cognitive development and school performance.[1] Yet, more than 84% of children and adolescents eat too much fat[2], and only 20% eat an adequate amount of fruits and vegetables. At the same time, almost 13 percent of children aged 6 - 7 are seriously overweight[3], and obese children and adolescents are more likely to become obese adults[4]. Physical activity is known to have many beneficial health effects, including reduction in anxiety and stress and increased self-esteem[5], yet daily participation in physical education classes by high school students dropped from 42% in 1991 to 29% in 1999. Among high school students, 70% have tried cigarettes and 36% are current smokers[6]. Among children ages 5-14, the leading causes of death are unintentional injuries, cancer, and homicide, respectively. In the 15-24 age group, the leading causes of death are unintentional injuries, homicide, and suicide, respectively[7]. Behavioral and mental health problems, especially depression, are widespread, and substance abuse continues to be a problem. Seventeen percent of high school students carried a weapon during the past month,

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[1] - Center on Hunger, Poverty, and Nutrition Policy. Statement on the Link between Nutrition and Cognitive Development in Children. Medford, MA: Tufts University School of Nutrition, 1995

[2] - Lewis CJ et al. Healthy People 2000: Report on the 1994 nutrition progress review. Nutrition Today 1994; 29 (6): 6-14.

[3] - Centers for Disease Control and Prevention. Update: prevalence of overweight among children, adolescents, and adults - United States 1988-1994. Morbidity and Mortality Weekly Report 1997; 46:199-202.

[4] - Guo SS et al. The predictive value of childhood body mass indexvalues for overweight at age 35 years. American Journal of Clinical Nutrition 1994; 59:810-9

[5] - CDCP Guidelines for School and Community Programs: Promoting Lifelong Physical Activity

[6] - CDCP Guidelines to Prevent Tobacco Use and Addiction

[7] - CDCP, NCHS, National Vital Statistics System, 1999.

and 19% have seriously considered suicide in the past year[8].

Most school districts require some form of health education to be taught as part of a student's total education. School health programs include activities and services to promote students' physical, emotional, and social development. Teaching students safe and effective CAM practices, such as mind-body exercises, nutrition, etc., as well as a more integrated, holistic approach to life, can complement the many efforts already underway to improve the health and well being of young people.

The Centers for Disease Control and Prevention (CDCP) has developed guidelines for schools on physical activity, healthy eating, tobacco use and addiction, and AIDS prevention. The Health Resources and Services Administration (HRSA) is developing guidelines on comprehensive school health programs, mental health, and safety.

Recommendations:

A) Agencies with the Department of Health and Human Services, especially the HRSA, CDCP, Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) should form a working group with other Federal organizations such as the Department of Education and the Administration for Children and Families (ACF) to develop guidelines on how to utilize CAM principals and practices to improve students' physical, emotional, and social development, and to integrate these practices into school health programs in K - 12. The working group should include CAM professionals, parents and teacher groups, and the guidelines should reflect the cultural diversity in the school systems.

B) DHHS should identify and provide information on successful models of utilizing CAM in schools and the community.

C) In partnership with the business community and school boards, develop incentives for schools to limit the sale and advertising of high fat snacks, soft drinks, and other products that do not contribute to a healthy lifestyle.

Discussion/Challenges:

There are some schools across the country that have special school lunch programs[9], yoga[10], and other programs, but very few schools are teaching holistic concepts of health or providing CAM type of wellness programs. School programs are locally designed and implemented, and what works in one community may not be applicable to another, and it is essential that the local

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[8] - CDCP National Center for Chronic Disease Prevention and Health Promotion

[9] - Demas A. Low-Fat School Lunch Programs: Achieving Acceptance, American Journal of Cardiology 1998; 82::80T-82T

[10] - Yoga Inside Foundation

community (parents, teachers, school boards, etc.) are involved. Identifying and providing information on programs utilizing CAM concepts or practices in schools will assist other schools in developing their own programs.

Issue 2: Utilization of CAM to help achieve the Nation's health promotion and disease prevention goals

Background: Since the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979, goals and objectives for the Nation's health have been defined and monitored. The most recent report, *Healthy People 2010*, was developed by an alliance of over 600 Federal, State, and national organizations. HP 2010 is designed to achieve two overarching goals: 1) Increase quality and years of healthy life, and 2) Eliminate health disparities. These goals and objectives are the blueprint for the Nation's health promotion and disease prevention activities and influence data collection, national health policy, and program development and implementation. HP 2010 is a comprehensive document that addresses clinical, behavioral, environmental, and health systems issues that impact on health. It's focus is both on individuals and communities, and there is a strong emphasis on health education and changing health behaviors.

Recommendations:

A) The Department of Health and Human Services should form a working group within the Healthy People Consortium that includes CAM professionals to review the 10 leading health indicators[11] to determine the applicability of CAM to these indicators and, where appropriate, develop strategies to encourage the use of safe and effective CAM practices in these areas.

B) Questions on specific CAM usage should be included in the national surveys that are the sources of the HP 2010 data (e.g. NHIS, NHANES, MEPS, etc.)

Discussion/Challenges: The two overaching goals of HP 2010 are consistent with the goals of CAM and there are many areas where CAM principles and practices could contribute to the achievement of the goals and objectives outlined in HP 2010. Some examples include: massage to reduce activity limitation due to chronic low back pain; acupuncture to reduce use and adverse effects of substance abuse; meditation or biofeedback to reduce high blood pressure, etc. Although HP 2010 is very data driven and CAM currently does not have an extensive database, adding a CAM perspective to these goals and objectives would build on a component of the public health infrastructure that is well established and could have far reaching impact on policies and programs.

[11] - The ten leading health indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.

Issue 3: Utilization of CAM in the workplace to increase job satisfaction and productivity and reduce costs.

Background: According to a study on worker health and productivity, employers are annually spending more than $8,000 per employee for health care and related costs. Of this, 58 percent ($5,003) is for health care expenses, 22 percent ($1,897) for turnover, 8 percent ($698) for unscheduled absences, 7 percent ($630) for non-occupational disability, and 5 percent ($393) for workers compensation. For the 600,000 workers included in this survey, the cost was $4.9 billion.[12]

Wellness programs can save companies a median of $3 for every dollar spent[13], and some worksite health promotion programs have had a positive return on investment of up to 8.22:1 in combined reduced health care costs and absenteeism[14]. Many of these worksite health promotion programs include CAM practices such as yoga, stress reduction, and changes in nutrition and lifestyle.

Recommendations:

A) Include CAM in all Federal worksite wellness and health promotion programs.

B) Work with the Office of Personnel management to assure that federal health coverage plans offer a CAM wellness option.

C) In consultation with the business community, develop incentives for employers to include CAM in worksite wellness programs and health coverage.

D) Form partnerships with private organizations such as the Wellness Councils of America to encourage inclusion of CAM services in their worksite wellness programs

Discussion/Challenges: The Division of Federal Occupational Health, in the Department of Health and Human Services, assists Federal organizations in improving the health, safety, and productivity of the Federal workforce. They provide comprehensive worksite services, including medical, nursing, and wellness/fitness services, to Federal agencies around the country and currently serve over 300 Federal agencies with 1.6 million employees. Other Federal organizations may offer their employees wellness programs as well.

Incentives for businesses to include CAM in wellness programs and health coverage will vary

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[12] - The MEDSTAT Group and American Productivity Center. March 18, 1999, Press Release

[13] - Goetzel RZ, New York Times June 24, 2001, p11

[14] - Aldana SG. Financial impact of worksite health promotion and methodological quality of the evidence. Art of Health Promotion 1998; 2(1):1-8.

depending on the size of the business. For example, larger companies that negotiate health plans through a union will require a different set of incentives than a small company that may only offer limited coverage. Some incentives currently exist but have not been evaluated for their effectiveness. Any additional program or service will have start up costs that may deter some companies.

Issue 4: Research on the role CAM in promoting more optimal states of health and well-being and enhanced quality of life

delete

(The Research workgroup is addressing this issue)

Issue 5: Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and decrease costs.

Background: The current health care system is disease-focused, with most of research, education, training, services, reimbursement, and information development and dissemination directed toward identifying and treating diseases and conditions. Wellness, self-care, or prevention activities that are incorporated into the conventional health care system are, for the most part, disease screening (e.g. pap smears), or offered in response to an already identified illness or condition (e.g. physical therapy after stroke, nutritional counseling for diabetics, etc.) Wellness, self-care, and prevention activities often occur outside of the conventional health care system, and rely upon a person's knowledge of these activities their potential beneficial, as well as their ability to pay for these activities, and the level of difficulty in accessing these activities (location, hours of availability, etc.). Incorporating them into the conventional health care system will make them available to more people, improve continuity of care and health outcomes, and could provide significant savings in reduced health care costs.

Recommendations:

(10) A) ~~In consultation~~ with the American Academy of Pediatrics, American Academy of Family Physicians, National Association of Community Health Centers, and others, including CAM professionals and consumers, develop guidelines and provide training and information on CAM and wellness to clinicians in Federally-funded health programs (e.g. community and migrant health centers, maternal and child health programs, school health programs, etc.) that provide clinical services to children and their families.

(11) B) In consultation with the American Hospital Association and others, including CAM professionals and consumers, identify strategies to incorporate CAM in wellness, prevention, and self-care in the nation's hospitals.

(12) C) In consultation with national associations and organizations, and others, including CAM professionals, develop recommendations for the inclusion of CAM in wellness, prevention, and self-care activities in continuing education programs for physicians, pharmacists, nurse practitioners, physician assistants, dentists, etc. and other health care providers

delete ?

D) In consultation with the Administration on Aging; Center for Medicare and Medicaid Services; Veterans Administration; nursing home, home health, long term care, and other national associations; and others, including CAM professionals and consumers, identify strategies to incorporate CAM in wellness, prevention, and self-care programs serving the Nation's aging population.

E) In consultation with the Hospice Foundation of America, National Hospice Foundation, Hospice and Palliative Nurses' Association, and others, including CAM professionals and consumers, develop guidelines and provide training and information to hospice providers on the use of CAM in the end of life.

F) In consultation with American Association of Health Plans, National Committee for Quality Assurance, representatives of major health plans, Center for Medicare and Medicaid Services, Department of Defense, and others, including CAM professionals and consumers, identify strategies to incorporate CAM wellness, prevention, and self-care in health plans.

G) Identify Federal programs (e.g. Head Start, Meals on Wheels, Women Infants and Children, State Children's Health Insurance Program, etc.) that could benefit from the addition of CAM in wellness, prevention, or self-care, and develop strategies to incorporate these into the programs as appropriate.

Discussion/Challenges: Incorporating CAM in wellness, prevention, and self-care activities within the conventional health care system requires expanding the way health care is viewed in this country. It is a consumer driven movement that many health professionals and organizations support, but faces numerous barriers in achieving. Federal leadership can help bring together key partners, identify barriers, and develop solutions that will facilitate integrating CAM in wellness, prevention, and self-care activities within the conventional health care system and highlight CAM's unique contribution to these activities.

NOTE TO WORKGROUP:

To address the proposal that Wellness be woven into the rest of the report instead of being a stand alone section, here are suggested sections for each of the identified issues:

Issue 1: Utilization of CAM in schools and the community to facilitate learning, improve behavior, and optimize well-being - **Information Development and Dissemination**

Issue 2: Utilization of CAM to help achieve the Nation's health promotion and disease prevention goals - **Access**

Issue 3: Utilization of CAM in the workplace to increase job satisfaction and productivity and reduce costs - **Access, Reimbursement**

Issue 4: Research on the role CAM in promoting more optimal states of health and well-being and enhanced quality of life - **Research**

Issue 5: Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and decrease costs - **Education and Training, Reimbursement**