Integrative Healthcare: The Time is Now!

Lori Knutson RN, HNB-BC
Administrative Director
Integrative Health & Medicine
Meridian Health System
New Jersey

Integrative Healthcare Leadership
Faculty
Duke University
“The power of integrative healthcare is that it combines the best of what conventional medicine and whole system approaches have to offer...”

Daniel Friedland, MD, ABIHM
AIHM Chair
Integrative Health Defined

- Holistic Health: Philosophy (the whole is greater than the sum of the parts, presence, values/attitude/belief).
- Integrative Medicine/Functional Medicine
- Traditional Healing (Native American, Traditional Oriental Medicine, Ayurveda).
- Complementary Therapies (massage therapy, biofeedback, aromatherapy, guided imagery, healing arts).
- Nutraceuticals/Supplements/Herbals
- Allopathic Healthcare
Integrative Health Foundation

• Empowering individuals with the knowledge, skills, tools, and resources for optimal health (Self Care—True Primary Care)

• Nutrition (Food as Medicine)

• Physical Activity (Functional Capacity)/Sleep

• Mind Body Connection (Psychoneuroimmunology/stress response)

• Purpose and Meaning (What Makes Life Worth Living)

• Relationship
Why Now?

Setting the Stage
U.S. Hypertension 1990-2013

Hypertension Rate by State, 1990
Select years with the slider to see historical data. Hover over states for more information. Click a state to lock the selection. Click again to unlock.
Percent of adults with hypertension
- 0 - 9.9%
- 10 - 14.9%
- 15 - 19.9%
- 20 - 24.9%
- 25 - 29.9%
- 30 - 34.9%
- 35%

Hypertension among adults, 1990 to 2013

Hypertension Rate by State, 2000
Select years with the slider to see historical data. Hover over states for more information. Click a state to lock the selection. Click again to unlock.
Percent of adults with hypertension
- 0 - 9.9%
- 10 - 14.9%
- 15 - 19.9%
- 20 - 24.9%
- 25 - 29.9%
- 30 - 34.9%
- 35%

Hypertension among adults, 1990 to 2013

Hypertension Rate by State, 2011
Select years with the slider to see historical data. Hover over states for more information. Click a state to lock the selection. Click again to unlock.
Percent of adults with hypertension
- 0 - 9.9%
- 10 - 14.9%
- 15 - 19.9%
- 20 - 24.9%
- 25 - 29.9%
- 30 - 34.9%
- 35%

Hypertension among adults, 1990 to 2013

Hypertension Rate by State, 2013
Select years with the slider to see historical data. Hover over states for more information. Click a state to lock the selection. Click again to unlock.
Percent of adults with hypertension
- 0 - 9.9%
- 10 - 14.9%
- 15 - 19.9%
- 20 - 24.9%
- 25 - 29.9%
- 30 - 34.9%
- 35%

Hypertension among adults, 1990 to 2013

New Jersey, 1990
Adult Hypertension: N/A
99% Confidence Interval: N/A

New Jersey, 2000
Adult Hypertension: 23.5%
State Rank: 28
99% Confidence Interval: 22.1 - 25.0

New Jersey, 2011
Adult Hypertension: 30.6%
State Rank: 28
99% Confidence Interval: 29.0 - 32.2

New Jersey, 2013
Adult Hypertension: 31.1%
State Rank: 29
99% Confidence Interval: 30.4 - 31.9
U. S. Inactivity Rates 2006 - 2014
Depression results in more absenteeism than almost any other physical disorder and costs employers more than $51 billion per year in absenteeism and lost productivity, not including high medical and pharmaceutical bills. *

*According to a 2004 Rand Corporation report.

The World Health Organization predicts that by 2020 depression will be the second leading cause of health impairment worldwide. *

*WHO Study, 2002
Drug Poisoning Deaths Involving Opioid Analgesics, Cocaine and Heroin: United States, 1999–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Opioid Analgesic</th>
<th>Cocaine</th>
<th>Heroin*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>4,030</td>
<td>3,822</td>
<td>1,963</td>
</tr>
<tr>
<td>2000</td>
<td>4,400</td>
<td>3,544</td>
<td>1,843</td>
</tr>
<tr>
<td>2001</td>
<td>5,528</td>
<td>3,833</td>
<td>1,784</td>
</tr>
<tr>
<td>2002</td>
<td>7,456</td>
<td>4,599</td>
<td>2,092</td>
</tr>
<tr>
<td>2003</td>
<td>8,517</td>
<td>5,199</td>
<td>2,084</td>
</tr>
<tr>
<td>2004</td>
<td>9,857</td>
<td>5,443</td>
<td>1,879</td>
</tr>
<tr>
<td>2005</td>
<td>10,928</td>
<td>6,208</td>
<td>2,010</td>
</tr>
<tr>
<td>2006</td>
<td>13,723</td>
<td>7,448</td>
<td>2,089</td>
</tr>
<tr>
<td>2007</td>
<td>14,408</td>
<td>6,512</td>
<td>2,402</td>
</tr>
<tr>
<td>2008</td>
<td>14,800</td>
<td>5,129</td>
<td>3,041</td>
</tr>
<tr>
<td>2009</td>
<td>15,597</td>
<td>4,350</td>
<td>3,279</td>
</tr>
<tr>
<td>2010</td>
<td>16,651</td>
<td>4,183</td>
<td>3,038</td>
</tr>
<tr>
<td>2011</td>
<td>16,917</td>
<td>4,681</td>
<td>4,397</td>
</tr>
</tbody>
</table>

Note: Not all drug poisoning deaths specify the drug(s) involved, and a death may involve more than one specific substance. The rise in 2005-2006 in opioid deaths is related to non-pharmaceutical fentanyl (see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm). *Heroin includes opium.

Source: National Center for Health Statistics/CDC, National Vital Statistics Report, Final death data for each calendar year (June 2014).
New CDC Opioid Prescribing Guidelines
Improving the Way Opioids are Prescribed for Safer Chronic Pain Treatment

The problem:
Existing guidelines vary in recommendations, and primary care providers say they receive insufficient training in prescribing opioid pain relievers. It is important that patients receive appropriate pain treatment, and that the benefits and risks of treatment options are carefully considered.

259 million
In 2012, health care providers wrote 259 million prescriptions for opioid pain relievers — enough for every American adult to have a bottle of pills.

300% increase
Prescription opioid sales in the United States have increased by 300% since 1999, but there has not been an overall change in the amount of pain Americans report.

2 million
Almost 2 million Americans, age 12 or older, either abused or were dependent on opioid pain relievers in 2013.

RIP 16 thousand
In 2013, more than 16,000 people died in the United States from overdose related to opioid pain relievers, four times the number in 1999.
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN
NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)

| Use first-line medication options preferentially |
| Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies |
| Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors |
HCAHPS – Survey/Structure:

- Two “global” questions:
  - Overall rating of hospital
  - Likelihood of recommending hospital

- Seven focus areas “domains”:
  - Communication with nurses
  - Responsiveness of hospital staff
  - Communication with doctors
  - Physical environment (cleanliness and noise)
  - Pain control
  - Communication about medicines
  - Discharge information
Quality Measures, Reporting and Performance Standards

Quality data reporting and collection support quality measurement, an important part of the Shared Savings Program. Before an Accountable Care Organization (ACO) can share in any savings generated, it must demonstrate that it met the quality performance standard for that year. There are also interactions between ACO quality reporting and other CMS initiatives, particularly the Physician Quality Reporting System (PQRS) Physician Value-Based Payment Modifier, and the Electronic Health Record (EHR) Incentive Program.

2015 Reporting Year Documentation

The sections below provide resources related to the program’s 33 quality measures for Reporting Year 2015, which span four quality domains: Patient / Caregiver Experience, Care Coordination / Patient Safety, Preventive Health, and At-Risk Population. Of the 33 measures, 8 measures of patient / caregiver experience are collected via the CAHPS survey, 7 are calculated via claims, 1 is calculated from Medicare and Medicaid EHR Incentive Program data, and 17 are collected via the Group Practice Reporting Option (GPRO) Web Interface.

Narrative Specifications for all 33 Measures

2015 reporting period narrative measure specifications for the 33 quality measures are available and can be accessed in the following file:

- [2015 Reporting – ACO Measure Narratives](#)
Figure: Burnout by Specialty

- Emergency medicine
- General internal medicine
- Neurology
- Family medicine
- Otolaryngology
- Orthopedic surgery
- Anesthesiology
- Obstetrics and gynecology
- Radiology
- Physical medicine and rehabilitation
- Mean burnout among all physicians participating
- General surgery
- Internal medicine subspecialty
- Ophthalmology
- General surgery subspecialty
- Urology
- Psychiatry
- Neurosurgery
- Pediatric subspecialty
- Other
- Radiation oncology
- Pathology
- General pediatrics
- Dermatology
- Preventive medicine, occupational medicine, or environmental medicine

There are only two times I feel stress:

Day and night.
The Perfect Storm
“YOU NEVER CHANGE THINGS BY FIGHTING THE EXISTING REALITY. TO CHANGE SOMETHING, BUILD A NEW MODEL THAT MAKES THE EXISTING MODEL OBSOLETE.”

- BUCKMINSTER FULLER
Emergence of a New Model

“Upstream Solutions”

Managing and Surviving

Vitality, Hope, Thriving

*Model modified from original version by John W. Travis MD
Figure 1. IHI Population Health Composite Model

Integrative Health: The Gap Opportunity

Volume to Value

Volume-Based First Curve:
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

Value-Based Second Curve:
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

The Gap
Physical and mental health
“Body, Mind, and Spirit”

Individual/Family
Home/School/Worksite
Neighborhood/Community
Society
Integrative Health National Impact

• The U.S. government recently announced that it will spend $21.7 million over five years to investigate non-drug approaches to pain, PTSD, substance use, and sleep disorders.

• The U.S. Health Resources and Services Administration, Bureau of Health Professions, Division of Public Health and Interdisciplinary Education, recently awarded $1.7 million grant to establish a Center for Integrative Medicine in Primary Care.

• Effective January 2015, the Joint Commission standards for pain management in ambulatory settings now include non-pharmacologic strategies such as acupuncture, massage therapy, relaxation therapy, and cognitive behavioral therapy.
“expressly forbids health insurance providers to discriminate.....against any health care provider who is acting within the scope of that providers license or certification under applicable State law”
Personal Use of Complementary and Alternative Medicine (CAM) by U.S. Health Care Workers

Pamela Jo Johnson, Andrew Ward, Lori Knutson, and Sue Sendelbach
Objective. To examine personal use of complementary and alternative medicine (CAM) among U.S. health care workers.

Data. Data are from the 2007 Alternative Health Supplement of the National Health Interview Survey. We examined a nationally representative sample of employed adults \((n = 14,329)\), including a subsample employed in hospitals or ambulatory care settings \((n = 1,280)\).

Study Design. We used multivariate logistic regression to estimate the odds of past year CAM use.

Principal Findings. Health care workers are more likely than the general population to use CAM. Among health care workers, health care providers are more likely to use CAM than other occupations.

Conclusions. Personal CAM use by health care workers may influence the integration of CAM with conventional health care delivery. Future research on the effects of personal CAM use by health care workers is therefore warranted.

Key Words. Complementary and alternative medicine, health care workforce, National Health Interview Survey
Inpatient Self-Reported Anxiety Scores by Type of Patient Served, 2008-09

- Cardiovascular (n=1,405): 1.53 Before Intervention, 3.57 After Intervention, 57% Decrease
- Medical/Surgical (n=3,683): 1.44 Before Intervention, 3.54 After Intervention, 59% Decrease
- Neuroscience/Rehabilitation (n=2,988): 0.74 Before Intervention, 2.05 After Intervention, 64% Decrease
- Orthopaedic/Spine (n=1,453): 1.25 Before Intervention, 3.58 After Intervention, 65% Decrease
- WomenCare (n=2,409): 1.09 Before Intervention, 3.21 After Intervention, 66% Decrease

Anxiety Intensity Numeric Rating Scale 0-10 (10 = worst)

p = <.01
January 2008-December 2009
Impact of integrative medicine therapies on immediate pain and anxiety scores at Abbott Northwestern Hospital

Jeffery A. Dusek PhD, Lori Knutson RN, Gregory A. Plotnikoff MD

PENNIE GEORGE INSTITUTE FOR HEALTH AND HEALING, ABBOTT NORTHWESTERN HOSPITAL, ALLINA HOSPITALS & CLINICS, MINNEAPOLIS, MN 55407

SUPPORTED BY ABBOTT NORTHWESTERN HOSPITAL AND THE GEORGE FAMILY

Integrative Medicine (IM) emphasizes the patient–caregiver relationship by blending complementary and alternative medicine and conventional medicine to meet patients’ needs.

IM has routinely been shown to reduce pain and anxiety in the highly controlled environment of the randomized controlled trial. However, its impact has been less studied in observational studies.

Research Objectives

To evaluate the effectiveness of IM on:
- pain & anxiety scores after IM service.
- patient’s satisfaction with IM services at discharge.

Assessments

- Practitioners collected verbal pain & anxiety (0-10 scale) just before and immediately after IM therapy.
- Patient satisfaction with IM services was assessed by questionnaire at discharge.

Setting

The George Institute is the Integrative Medicine Department at Abbott Northwestern Hospital, a 629 bed flagship hospital of Allina Hospitals & Clinics.

Inpatient IM services are conducted individually in patients’ rooms, initiated by hospital staff providing direct patient care (physicians and nurses) and documented using the hospital’s EPIC–based electronic health record system.

Results

Pre/Post Pain scores collected from:
- 3,196 pts after initial IM therapy,
- 4,367 pts after second IM therapy,
- 2,355 after third IM therapy.

Pre/Post Anxiety scores assessed in:
- 2,590 pts after initial IM therapy,
- 3,162 pts after second IM therapy,
- 1,682 pts after third IM therapy.

From 7/05 to 12/08, 15,596 pts were assessed.

Conclusions

- Significant reductions in pain and anxiety indicate a positive patient response.
- The impact on use of pain medications is being evaluated.
- Cost effectiveness studies will use EHR data to determine if pain/anxiety reductions mediate shorter LOS and overall reduced costs.
NCIPH Goals

Under the leadership of a national **interprofessional team (InPLT)** the NCIPH will focus on achieving the following goals over the next 3 years:

1. Develop core **IH competencies** for interprofessional primary care teams.
2. Develop a 45 hour interprofessional IH online curriculum for primary care educational programs — *Foundations in Integrative Health*.
3. Create an accessible and interactive online infrastructure that will house:
   - IH curricula and other educational resources
   - Best IH practices for primary healthcare professions
   - Links to partner organizations and IH resources for healthcare professionals
   - Patient portal
4. Develop patient education IH materials and facilitate access to IH practitioners.
The Most Comprehensive Interprofessional Integrative Health & Medicine Education Available.

See our Catalog  Our Events  E-Learning Login
We’ve changed our name! The Academic Consortium for Complementary and Alternative Health Care (ACCAHC) is now the Academic Collaborative for Integrative Health (ACIH).

A new website is in development!

Some of the 80 professionals gathering at the ACIH Biennial Meeting, June 2013, at the
Healthcare Reform

The Integrative Healthcare Policy Consortium stands for access for all people to the full range of safe and regulated conventional, complementary and alternative healthcare professionals.
Integrative Health in the U.S.

Integrative Wellness in the Workplace
Research comparing the cost effectiveness of integrative therapies has significant potential for improving employee wellness but also for the care defined by company insurance plans.

THE CASE FOR INTEGRATIVE HEALTH CARE FOR EMPLOYERS

In case your regular physician, employer or anyone else (your insurance company) scoffs at the idea of using holistic/integrative therapies “because there’s no proof,” the attached sheet may help bring them up to speed on state-of-the-art research describing the benefits of integrative health, notably in workplace settings.
Create a culture of well-being.

Manage healthcare costs. Win the war for talent. Retain top employees. Maximize performance and productivity. It's time to move past wellness and engage your employees in what matters most to them — their well-being.
Healthways WholeHealth Living

Easy Access to Complementary and Alternative Medicine, Practitioners, Discounts and Education in Well-Being Improvement
It's a whole new patient experience.

Iora changes primary care as we know it. Our care team, which includes a dedicated advocate for each patient, works together to treat the whole person. We see people when they're sick, but also when they're well, so that we can keep them healthy. Here, the environment is caring and patients have a voice. It's our job to give them everything they need to live happier and healthier lives.
Iora Primary Care opened its doors to members of the New England Carpenters Benefits Funds in March 2013 and has been serving them ever since. Beyond a team-based primary care focus, the Iora Primary Care teams provide wellness classes and groups designed for the Carpenters and their families including Hammer Time.

Culinary Extra Clinic serves the hotel and restaurant workers who participate in the Culinary Health Fund in Las Vegas, NV. Sponsored by the Culinary Health Fund, the Clinic is open to those participants in the Fund who experience severe and chronic illness. The Culinary Extra Clinic is located at St. Louis Square on the north end of “the Strip” in Las Vegas, Nevada.

Grameen VidaSana is a membership-based primary care and health promotion program for Grameen America members beginning in the summer of 2014. This health promotion program combines Iora Health’s enhanced primary care model with Grameen PrimaCare’s peer educational group model to improve the health and well-being of hard-working, low-income women in immigrant communities.
What metrics capture the value of health and wellness programs?

Read the expert perspective on value of investment.

LEARN MORE

The Optum Resource Center for Health and Well-being helps employers improve workplace productivity, health care costs and employee quality of life through research-driven insights, innovative perspectives and ideas focused on driving a culture of health ownership among employees.
Beyond ROI: Building employee health & wellness value of investment

Optum™ & National Business Group on Health: Value of Investment Study results
Well-Being Index

The Gallup-Healthways Well-Being Index

Gallup and Healthways have developed a comprehensive, definitive source of well-being measurement, the Gallup-Healthways Well-Being Index. This scientific survey instrument measures, tracks and reports on the well-being of populations. The five essential elements of well-being are:

- **Purpose**: liking what you do each day and being motivated to achieve your goals
- **Social**: having supportive relationships and love in your life
- **Financial**: managing your economic life to reduce stress and increase security
- **Community**: liking where you live, feeling safe and having pride in your community
- **Physical**: having good health and enough energy to get things done daily
How to Realize Returns on Health

After demonstrating in *Maximizing Healthy Life Years* that health can have a positive return on investment, the 2016 report *How to Realize Returns on Health* shows how to tackle the silent NCD pandemic: why we should focus on Maximizing Healthy Life Years (MHLY) instead of just treating disease, why we need to act boldly now and how investments into health can have healthy returns in a multi-stakeholder environment by creating Ecosystems of Health.
While in financial management the term ROI refers to a single ratio, SROI analysis refers not to one single ratio but more to a way of reporting on **value creation**. It bases the assessment of value in part on the perception and experience of stakeholders, finds indicators of what has changed and tells the story of this change and, where possible, uses monetary values for these indicators.
“The only person you are destined to become is the person you decide to be.”

~ Ralph Waldo Emerson
Epigenetic adaptations

Environmental toxicants
Stochastic variations
Stress
Smoking
Poor Diet
Drinking
Aging

Grand parents: 1st generation
Transcriptional regulation

Parents: 2nd generation
Transcriptional dysregulation

Offspring: 3rd generation
Reproductive cells: 4th generation
Epigenetic disorder

Transcriptional regulation

Epigenetic-based therapy

Transcriptional dysregulation
Epigenetics and Gene Activation for Improved Health and Longevity

Excercise
- BDNF

Nutritional Factors
- Calorie Restriction
- Mediterranean Diet
- Polyphenols

Environment
- Clean air, water and soil
  - No smoking

Emotional Health
- Religion
- Meditation
- Spirituality

Transcription factors

Signaling molecules

Anti-Inflammatory
Anti-oxidant, Anti-mutation
DISEASES

Diabetes
Cancer
Heart disease
Arthritis
Auto-Immune diseases
Fibromyalgia
Obesity

UNDERLYING CAUSES

Inflammatory imbalances
Structural imbalances
Immune imbalances
Digestive, absorptive, and microbiological imbalances
Toxic emotions
(anger, fear, resentment, etc.)

Hormonal imbalances
Detoxification imbalances
Mitochondrial dysfunction
Toxic chemical exposure
THE FUNCTIONAL MEDICINE TREE

Organ System Diagnosis

Gastroenterology
Cardiology
Endocrinology
Pulmonary
Neurology
Immunology
Hepatology
Urology

Signs and Symptoms

The Fundamental Organizing Systems and Core Clinical Imbalances

Assimilation
Digestion, Absorption, Metabolism, Nutrition, Respiration
Excretion, Nervous System, Inflammatory Processes, Infection and Inflammatory Response
Energy
Energetics, Mitochondrial Function
Growth, Transformation, and Elimination
Toxicity, Detoxification
Communication
Endocrine, Neurotransmitters, Immune Response, Cognition
Transport
Cardiovascular, Lymphatic systems, Structural Integrity
From the subdivision to the macrostructure

Antecedents, Triggers, and Mediators

Mental, Emotional, Spiritual Influences
Genetic Predisposition
Experiences, Attitudes, Beliefs

Sleep & Relaxation
Exercised/Movement
Nutrition/Hydration
Stress/Resilience
Relationships/Network
Trauma
Environmental Pollutants
Microbiome

Personalizing Lifestyle and Environmental Factors
The convergence of systems biology, the digital revolution and consumer-driven healthcare is transforming medicine from its current reactive mode, which is focused on treating disease, to a P4 Medicine mode, which is medicine that is predictive, preventive, personalized and participatory.
HOW UBER WORKS

Users download a free app that asks for your basic information and a credit card number, to which it will bill all future rides.

Fares are calculated using a standard formula:
$2.50 base fare + $.35/minute + $1.60/mile. A 4-mile trip from Towne Center to Town Square downtown would cost around $13.

To request a ride, click on the app and a map appears, asking if you want to request a ride. If you click yes, the map indicates your location and the location of all nearby Uber cars. If you select one, it gives you the estimated time of arrival and information about the driver, including his name, the type of vehicle and how others have rated him.

Your credit card is automatically dinged for the fare, and the tip is factored in so you don't have to pull out your wallet and mess with cash.

Uber takes 20% off the top; your driver gets the other 80%.

After the trip, Uber asks you to rate your driver on a scale of 1-5 stars. It asks the driver to rate the fare too.
Uber Massage Therapy

We bring you same-day, in-home massages with the best licensed therapists.

New York City

GET A MASSAGE

OR JUST SIGN UP
Health and Wellbeing Technology
Meditation Devices

Enhance your energy. Uncover your calm.

Muse is your personal meditation assistant
GET SOME HEADSPACE

Headspace is meditation made simple. Learn online, when you want, wherever you are, in just 10 minutes a day.

SIGN UP FOR FREE

Watch our animation
Blue Ocean
The Time is Now!