State of Care: Complementary and Alternative Medicine in Veterans Health Administration–2011 Survey Results

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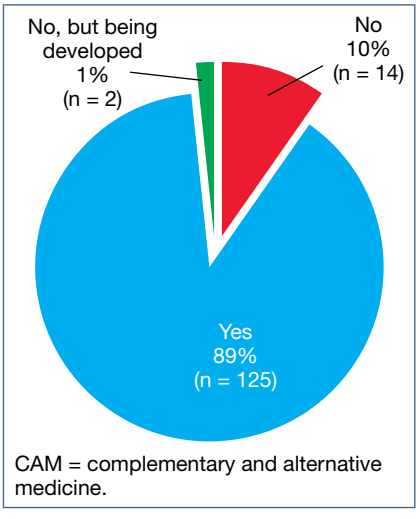
This article summarizes pertinent findings from a 36-question survey developed to better understand what complementary and alternative medicine services were being offered to U.S. veterans, the reasons for offering these services, the conditions being treated, the types of providers administering these services, the education and training of the providers, the process used to credential and privilege them, and the next steps needed to support effective complementary and alternative medicine services within Veterans Health Administration.

There is a growing interest and demand for complementary and alternative medicine (CAM) across the U.S. The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as "a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine" (conventional medicine also called Western or allopathic medicine).[1] The boundaries between CAM and conventional medicine are not absolute, and specific CAM practices may, over time, become widely accepted. *Complementary medicine* refers to the use of CAM together with conventional medicine, such as using meditation in addition to usual care in the treatment of posttraumatic stress disorder (PTSD). *Alternative medicine* refers to the use of CAM in place of conventional medicine. Integrative medicine combines treatment from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness.

National surveys since the early 1990s have shown health care consumers, including veterans, are going outside conventional medicine to assist with the management of a number of chronic conditions, wellness, and health promotion.[2-4] In 1993, *The New England Journal of Medicine* published a landmark study on unconventional medicine.[5] The study reported that one-third of respondents from a nationwide telephone survey reported using at least 1 CAM therapy in the year of the study. The primary reason for using CAM was for chronic medical conditions for which the majority of respondents also sought treatment from a medical doctor. Findings revealed that most chose not to inform their medical doctors that they had sought CAM interventions. In November 1998, a follow-up study was published that indicated a marked increase (42.7%) in the number of individuals using alternative therapies between 1990 and 1997.[6]

In March 2000, the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive



CAM = complementary and alternative medicine.

Figure 1. VA facilities offering CAM modalities (N = 141).[1]

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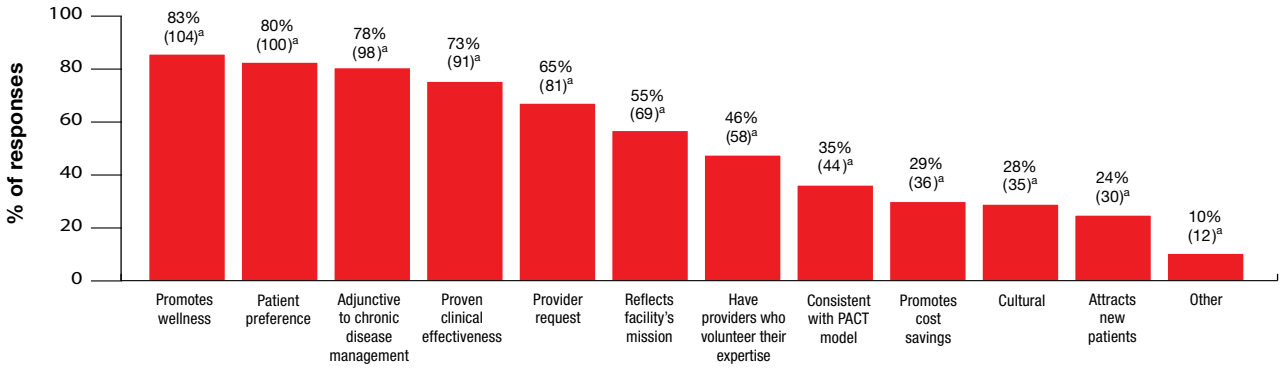


[a]Numbers in parenthesis represent absolute number responding "yes."
CAM = complementary and alternative medicine; PACT = Patient Aligned Care Team.

Figure 2. Reasons the CAM modalities were offered at surveyed VA facilities (n = 125).

Order 13147 to develop legislative and administrative recommendations that would assure public policy maximized potential benefits to American consumers of CAM.[7] In 2002, the WHCCAMP issued a report providing legislative and administrative recommendations to ensure public policy maximized the potential benefits of CAM to all citizens. The report (1) urged support for and coordination of high-quality CAM research and encouraged federal agencies to conduct such research; (2) laid a path for collaborative patient care by advising the integration of CAM and conventional medicine into provider education in both fields; (3) encouraged easy access to accurate information about CAM, as well as assurance of the safety of CAM services and products; (4) acknowledged that CAM has an important role to play in attaining the nation's health goals; and (5) recommended the establishment of an office to coordinate federal CAM activities and to facilitate the integration of safe and effective CAM practices and products into the nation's health care system.

The report called on federal agencies, including the VA, to assist in implementing these recommendations. Nineteen of the 29 White House Commission recommendations were applicable to the VA. In response to the White House Commission's recommendations, VHA formulated the National CAM Field Advisory Board. The CAM Field Advisory Board was initially formed to identify strategies to implement recommendations from the Commission. In July 2004, VA chartered a Field Advisory Committee to identify practices that could be considered for integration into VA care, to promote and integrate CAM therapies into clinical practice guidelines, to identify where additional research was needed to determine the safety and efficacy of CAM practices, and to establish standards for the training and credentialing of CAM providers.

In 2011, the VHA Field Advisory Committee, in collaboration with the Health Care Analysis and Information Group (HAIG), surveyed the 153 VAMCs in hopes of better understanding what CAM modalities were being offered, the reasons for offering CAM, the conditions being treated, the types of providers administering CAM, the education and training of CAM providers, and the process used to credential and privilege them.[8] The questions covered 30 CAM modalities in the domains of mind-body medicine, biologically based practices, manipulative and body-based practices, energy medicine, and whole body systems. The 153 VAMCs were managed by 141 administrative parent facilities. Survey results were tabulated for the 141 administrative parent facilities. The survey was web based, and the results were obtained for all 141 administrative parent facilities.

A prior survey on CAM use within VA was conducted in 2002 by the HAIG.[9] At that time, 111 of the 132 responding VA facilities (84%) were offering some form of CAM. At the time of the 2002 survey, chiropractic care was considered to be a form of CAM. Since then, Congress mandated regional on-station chiropractic care for veterans eligible for VHA care in Public Law 107-135. As a result, chiropractic care was not considered CAM for the 2011 survey. Even with that change, in 2011, 125 of 141 facilities (89%) offered some form of CAM. In addition, they offered more CAM modalities per facility than they did in 2002, and more of the CAM was offered by VA providers. In 2002, of the 111 facilities that offered CAM, only

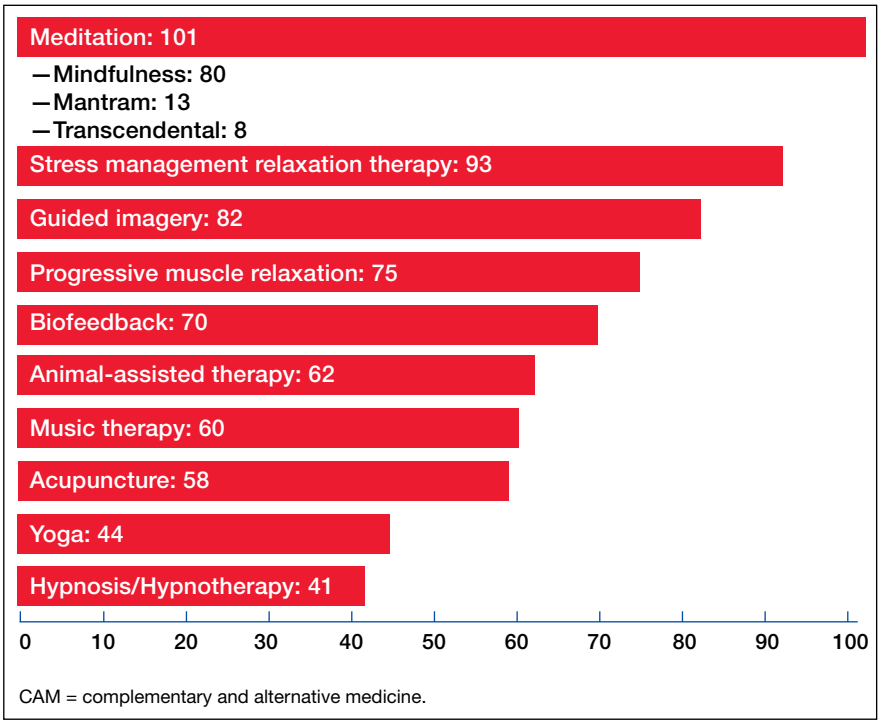


Figure 3. Most commonly provided CAM modalitiles by number of facilities that report using CAM (n = 125).

2 offered more than 10 modalities. In 2011, 31 facilities offered more than 10 CAM modalities, with 6 offering 16 or more modalities (Figure 1). When asked why facilities offered CAM, the primary reasons provided were to promote wellness, to meet patient preferences, to provide an adjunct to chronic disease management, and because they believed it was clinically effective (Figure 2).

Of the CAM modalities offered, those most commonly provided were in mind-body medicine. The most popular modalities were meditation, stress management relaxation therapy, guided imagery, progressive muscle relaxation, and biofeedback (Figure 3). These modalities were offered at the most facilities and were estimated by facilities to be provided to the largest number of patients. The top 5 conditions for which CAM was used in the VA were stress management, anxiety, PTSD, depression, and back pain.

The most common place for CAM to be delivered was the outpatient arena with 44% of CAM being delivered in this setting. The inpatient setting had 30% of CAM use, and residential settings, such as community living centers (nursing homes) and residential rehabilitation centers, had 21%. Of the sites that offered CAM, 12% of them offered it as part of an integrative clinic. However, of the sites that offered CAM which did not already have an integrative clinic, half were interested or had already begun plans for an integrative clinic. When CAM was incorporated into VA care, 72% of the time it was used as an adjunct to usual care and only 22% of the time as a stand-alone treatment. When CAM was provided, it was estimated that it was documented in the medical record with a progress note 73% of the time. However, there was likely to be a procedure code assigned only 40% of the time.

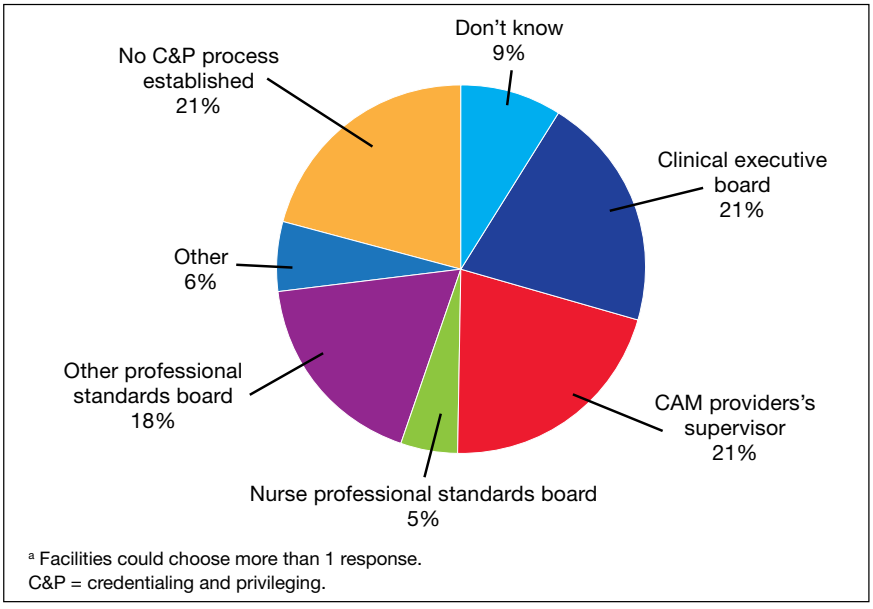
The most common category of CAM practitioners identified across all modalities was midlevel providers. This category included nurse practitioners, clinical nurse specialists, and physician assistants. This group represented 22% of the provider classes across all facilities and all modalities. The most common single category of providers was psychologists. They represented 18% of all provider categories. The next most common was physicians at 9%; CAM-specific providers represented only 6% of the identified provider classes.

The 2011 survey again revealed that there was a great deal of heterogeneity in the way providers were granted privileges to practice CAM within VA facilities. Privileges were granted by an established facility professional standards board 44% of the time that included: the Clinical Executive Board (CEB) in 21% of facilities, a Professional Standards Board (PSB) in 18% of facilities, and in 5% of facilities CAM clinical privileges were approved by the Nursing Professional Standards Board. However, in 21% of facilities, the approval to deliver CAM was granted by the provider's supervisor and of interest, 21% of facilities reported no established credentialing and privileging process. The responses of "Don't know" and "other" made up the remaining 15% (Figure 4). The CEB was the most consistent approving board for the modalities of biofeedback, hypnosis/hypnotherapy, acupuncture, and acupressure. Forty percent or greater of facilities reported that these privileges were granted through this body. In terms of how the decision was arrived at to grant privileges, the presence of special training was cited by 28% of facilities,

evidence of licensure by 24%, demonstrated performance by 22%, and evidence of certification by 21%.

In making the determination to provide CAM, 68% of facilities reported using scientific evidence to support the use of various CAM modalities, and 62% of facilities reported that anecdotal or experiential evidence was used to support the use of CAM. About 8% of facilities reported offering CAM without evidence to support its use. However, when considering each CAM modality, there was a wide variation in the number of facilities that reported using scientific or experiential evidence in support of a modality (Figure 5).

As noted earlier, integrative medicine combines treatment from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness. The survey results showed that there was significant interest across the country in VA facilities to provide integrative medicine clinics. At the time of the survey, 12% of facilities reported delivering CAM services in an organized, integrative medicine clinic. Of the 88% of facilities who did not have an integrative medicine clinic, 8% were in the process of developing one, and 42% expressed an interest in doing so.



[a] Facilities could choose more than 1 response.
C&P = credentialing and privileging.

Figure 4. Responsibility of reviewing and approving clinical privileges for providers delivering CAM modalities at the number of faclities providing CAM (n = 125).[a]

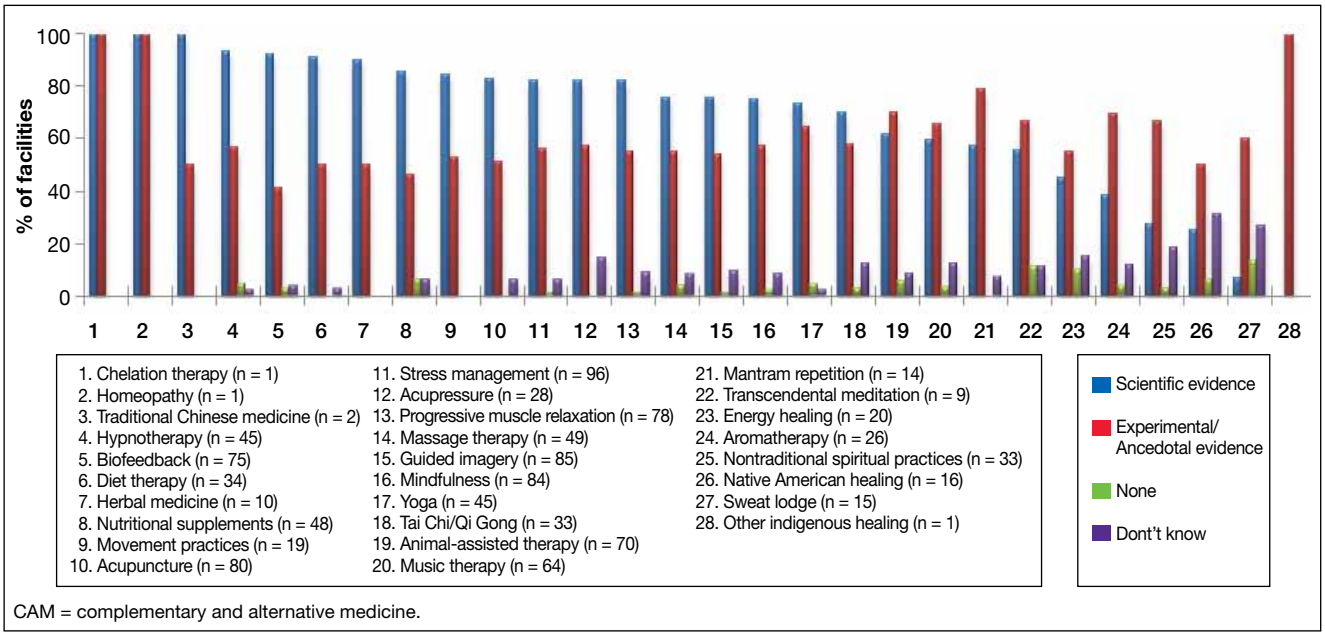
DISCUSSION

The 2011 survey revealed CAM use seems to have grown substantially in VA facilities; however, how much it is used and how it is used needs further clarification. Although CAM-specific procedure codes exist, they are relatively few in number, do not cover all CAM modalities, and are not always used in the VA. This makes it difficult to extract accurate data on CAM usage from patient charts.

The variability in the granting of CAM privileges suggests that facilities may not be aware of all the modalities and ways that CAM is being used. In addition, as the understanding and science of CAM evolves, what is considered allopathic care is subject to change. It is possible that some care being delivered within the VA, while considered CAM for the purposes of this survey, was not considered CAM by its practitioners and may not have been reported. Mental health conditions comprise some of the major reasons CAM is used within the VA. Modalities such as biofeedback and guided imagery are considered to be within the scope of practice of mental health practitioners and are considered part of the usual allopathic care. This may reflect why psychologists were the single largest group of CAM providers within the VA.

The relative paucity of CAM-specific providers (6%) is indicative of the challenges in credentialing and privileging of providers in the provision of CAM. In the VA, care is delivered by licensed providers who are practicing within the scope of their license. Except for a few CAM modalities, such as acupuncture, there are no standardized training programs, national certifying bodies, and state licensing bodies for all specific CAM modalities. Lack of standardization presents a huge challenge in ascertaining whether a prospective CAM practitioner is properly trained, licensed, or certified to practice. Many licensed clinicians within the VA can provide specific CAM modalities under their current license and scope of practice.

In addition, the lack of recognized occupational classes for CAM-specific providers in the VA (eg, licensed acupuncturists and massage therapists) means qualification standards and standardized hiring mechanisms do not currently exist for these CAM-specific providers. In some cases, this may be overcome by hiring a CAM provider who is in



CAM = complementary and alternative medicine.

Figure 5. Types of evidence used to support CAM (n = 125).

a licensed occupational class that exists within the VA and whose license would allow them to practice the CAM modality. For example, in most states, physician licensing allows the physician to practice a modality such as acupuncture. However, licensing in most states would not allow a nurse to do the same. There is currently no mechanism to hire a licensed acupuncturist in the VA. To address this specific barrier, the VA is actively pursuing the establishment of an occupational series for licensed acupuncturists. This may provide guidance on how to establish other CAM occupations within the VA.

Veteran Affairs values have emphasized health promotion, disease prevention, chronic disease management, and the practice of evidence-based medicine. Many CAM modalities, with their focus on health promotion, prevention, and well-being, seem to offer promise as an adjunctive and integrative measure to the VA's disease prevention and chronic disease management efforts. The scientific evidence to support CAM's use continues to grow, but clearly, further research in this area is needed. The fact that 68% of facilities stated they used scientific evidence in support of their decision to offer CAM is encouraging. However, given the current state of scientific evidence of all CAM modalities, the survey findings likely represent an overestimation of the evidence in some areas. There are a number of CAM-related research projects underway in the VHA and, in particular, mindfulness meditation for veterans with PTSD. In addition, the NCCAM funds several CAM-related research projects across the country.

Although the HAIG survey produced much information on what the VA offered, the conditions treated, and the relative usage of each modality, the survey was directed to and answered by facilities. It did not directly address the issue of what services veterans were seeking, which services would they find to be of most value or in which they would have the most interest. Recognizing how veterans value CAM therapies is an important area to explore.

If one looks at CAM as treatment vs a wellness activity, it could influence who provides it, how it is provided, and the evidence needed to support its use. If CAM is delivered as a specific intervention prescribed or delivered by a practitioner to treat a specific disease that is expected to produce specific and defined outcomes, it is a treatment and should be held to the same standards and expectations as allopathic treatments. An example of CAM as a treatment would be acupuncture. If CAM is self-directed or facilitated by a caregiver and the focus is to produce a sense of general well-being but may produce effects that are beneficial to a disease or condition, it can be considered a wellness activity. When used as a treatment activity, it should be expected that the CAM modality has proof of safety and effectiveness and is delivered by properly credentialed, trained, and licensed providers. If it

has sufficient proof of effectiveness, it could be considered for provision by the VA, either through VA providers or by community providers at VA expense. It would be expected that such treatments are incorporated into the medical record. Wellness activities would not be expected to be held to the same standard of evidence as treatments but would require evidence of appropriate training of practitioners providing the service. The potential benefit of CAM as a wellness activity needs further exploration. Of note, the promotion of wellness was the most frequently listed reason the VA facilities provided CAM.

As the VA moves forward in examining and incorporating CAM into VA care, several issues will need to be addressed. CAM providers delivering CAM as a treatment for a disease or condition need to be subject to similar credentialing and privileging standards as allopathic providers. This requires that there be a distinction made between those modalities or circumstances when CAM is used for purposes of wellness vs treatment. When CAM is to be used as a treatment, there must be a method to assess the qualifications of the CAM provider, including the primary source verification of education and licensure. This may involve establishing what the minimum educational requirements for various CAM providers are when there are no national educational standards or a lack of state or national certifying bodies. In addition, there needs to be a determination made if the practice of a CAM modality is within the scope of practice of allopathic providers for those modalities where no such determination already exists. It will also require the setting of a level of evidence that should be met to incorporate CAM into VA treatment, as well as the promotion of research into CAM in areas of clinical interest to the VA to establish whether CAM is a potential therapeutic option for veterans. These measures will be essential to reduce the variability that exists in CAM implementation and use within VA. When CAM is to be used as a treatment, it needs to be documented in the medical record and appropriate procedure codes used to capture this clinical activity. This will require educating providers on the existence of CAM procedure codes. If we are to be able to fully understand the use of CAM within the VA, it may be necessary to develop additional procedure codes to cover the full breadth and use of CAM and to identify the providers, situations, and practice settings in which it is used.

As the VA continues its efforts to become more patient centered and aims to improve the health and well-being of veterans, there may be important lessons to be learned from CAM providers on how to promote well-being, motivate, and partner with patients on these issues of treatment and wellness. ●

Author disclosures

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