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Department of Veterans Affairs
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Office of the Assistant Deputy Under Secretary for
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Complementary and Alternative Medicine

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Prologue

Defining Complementary and Alternative Medicine (CAM) is difficult, because the field is broad and constantly changing. The National Institutes of Health's 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) is medicine as practiced by holders of M.D. (medical doctor) and D.O. (doctor of osteopathic medicine) degrees and by allied health professionals, such as physical therapists, psychologists, pharmacists, and registered nurses. The boundaries between CAM and conventional medicine are not absolute, and specific CAM practices may, over time, become widely accepted. "Complementary medicine" refers to use of CAM **together with** conventional medicine, such as using meditation in addition to usual care in the treatment of PTSD. "Alternative medicine" refers to use of CAM **in place of** conventional medicine.

"Integrative medicine" (also called integrated medicine) refers to a practice that combines both conventional and CAM treatments for which there is evidence of safety and effectiveness and example of this would be the use of acupuncture in addition to usual care to help lessen pain.

The tremendous growth in utilization of CAM services has generated increased interest and inquiries from Congress and the Secretary of Veterans Affairs (VA). Because the nature of CAM service provision and tracking is unclear, a group of clinicians gathered to conduct a survey of all Veterans Health Administration (VHA) facilities to determine the extent of CAM offered in VHA. The analysis of these survey data, as well as findings and recommendations based on these data are provided in this report. It is noteworthy that in 2002, chiropractic care was considered a CAM modality, but has since been re-classified as mainstream practice. Therefore, all references to chiropractic care were removed for 2011, and the 2002 data were updated to reflect the removal of this modality.

Margaret C. Hammond, MD
Acting Chief Patient Care Services Officer

Patricia Vandenberg, MHA
Assistant Deputy Under Secretary for
Health for Policy and Planning

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Background

The use of Complementary and Alternative Medicine in the United States is widespread. National surveys since the early 1990's have shown that Veterans and other health care consumers are going outside of conventional medicine to assist with management of chronic conditions, wellness and health promotion [1-7].

The Office of Alternative Medicine (OAM) was established by Congress in 1993 within the National Institutes of Health (NIH) to facilitate the evaluation of alternative medical treatment modalities, to determine their effectiveness, and to help integrate effective treatments into mainstream medical practice. In 1997, Congress replaced OAM with the National Center for Complementary and Alternative Medicine (NCCAM). At about the same time that OAM was established, the New England Journal of Medicine (*NEJM*) published a landmark study by Eisenberg et al. on unconventional medicine, which was based on a telephone survey of 1,539 adults[1]. The survey found that 34 percent of respondents reported using at least one CAM therapy in the year of the study, the majority of which were for chronic medical conditions. The authors estimated that in 1990, Americans made 425 million visits to CAM providers, which exceeded the number of visits to all U.S. primary care physicians. Of the estimated $13.7 billion in expenditures, 30 percent was knowingly or unknowingly reimbursed by third party payers. Many people who used CAM therapies did not disclose this use to their physicians with only 39.8 percent of the participants reporting usage of CAM therapies in 1990[1].

In November 1998, Eisenberg, et al. published the results of a follow-up study, which indicated a marked increase in the number of individuals using alternative therapies between 1990 and 1997[2]. CAM use had increased to 42.7 percent of the population and the estimated number of visits had increased to 629 million visits with expenditures of $21.2 billion. The estimate for total out-of-pocket expenditures for alternative therapies was $27 billion. There was only a slight increase in the number of people (38.5%) who reported using CAM to their conventional medicine physician. None of the changes in insurance coverage for CAM between 1990 and 1997 were statistically significant.

The Eisenberg surveys were followed by surveys conducted by the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics. The survey conducted by the CDC in 2002 indicated that 36 percent of adults used some form of CAM therapy during the past 12 months[4]. The CDC survey reported that CAM therapies were used primarily for the treatment of chronic illness, back pain, back problems, neck pain, joint pain or stiffness, anxiety or depression, and treatment of head and chest colds. The National Health Interview Survey of 2007 estimated CAM use at 38 percent of adults (83 million) and 11.8 percent of children (8.5 million)[5]. The estimated expenditure on CAM use was $33.9 billion with two thirds of this expenditure on self care and one third on provider visits. The estimated expenditure on CAM provider visits still represents 25 percent of the out of pocket costs for care received from allopathic physicians and 38.1 million adults made 354.2 million visits to CAM practitioners.

Complementary and Alternative Medicine within the VA Health care system and the Federal system

The Klemm Analysis group (1998) at the request of VA Central Office (1998) conducted the first benchmark survey of CAM use amongst Veterans[6]. The Veterans Health Administration (VHA) commissioned the study to answer the questions: "Should VHA offer what is often referred to as alternative medicine treatment? If so, how can VHA ensure that any alternative medicine therapies it offers to supplant or complement traditional therapies are appropriate, of high quality, and equitably available throughout the system?" The Klemm study consisted of a CAM literature review,

selected site visits to ten VHA Medical Facilities and two benchmark integrated facilities to assess understanding and usage of CAM therapies as well as barriers and opportunities for implementation. In addition, a survey of VHA providers across all 22 VISNs was conducted to supplement the understanding and usage of CAM therapies identified in the initial five site visits. Lastly, expert opinion of various individuals practicing CAM therapies to assist with determining CAM benefit coverage, or designing integrated medical programs was reported.

The results of the Klemm study showed that every selected VA site reported some use of CAM therapies. However, conventional medical providers felt they had insufficient knowledge of CAM to use CAM or refer patients for CAM treatment. There also was variability among providers within facilities in beliefs about CAM. Internal communication within the surveyed sites about CAM was minimal, with education and communication noted as critical barriers. The Klemm analysis reported that Veterans had chronic conditions that were not responding well to conventional treatments, and that a large proportion of Veterans were using CAM for management of chronic conditions. The specific survey recommendations included:

1. VHA should systematically understand patient-initiated usage of CAM therapies among VHA patients.
2. VHA should fund / participate in research on CAM therapies on the same grounds as all other treatments / procedures and utilize consistent criteria for introducing and eliminating treatments. VHA should consider performing research on specific CAM therapies for conditions prevalent in VHA patients for which conventional treatments have not been effective and / or involve extensive drug treatments. VHA should seriously consider introducing new therapies once research suggests the therapies are as effective and safe as current treatments.
3. VHA should extend analysis of the survey and literature data collected and establish a process for continued updating and analysis of relevant literature.
4. VHA should eliminate the current discrepancy between the formulary and many VHA medical facility retail stores.
5. VHA should systematically monitor the volatile health care coverage environment so that VHA can learn from other health care providers and consider incorporating relevant, successful therapies, including CAM and other new services offered by other providers

In March 2000, the President and Congress responded to public demand and public need and created the White House Commission on Complementary and Alternative Medicine Policy that was established by Executive Order 13147. The Commission's mandate was to develop legislative and administrative recommendations that would help public policy maximize potential benefits of CAM therapies to consumers of American health care. The findings of the report were released in 2002 with a total of 29 recommendations covering four main areas of focus. The recommendations in the four main areas included: coordination of research to increase knowledge of CAM; education and training of CAM health care providers; provision of reliable and useful information about CAM practices; guidance for appropriate access to and delivery of CAM; and information about CAM products, standards, access and delivery, and to ensure public policy maximizes potential benefits of CAM. The report focused on the need to move toward whole person care, individualization of treatment, evidence of safety and efficacy, partnership, prevention, wellness / health promotion, and self-care as guiding principles. All federal agencies were required to respond. Nineteen of the 29 White House Commission recommendations were applicable to VA.

At the same time, researchers in VA locations across the U.S. were beginning to report CAM use by Veterans as well as the reasons for CAM use. In 2002, the Southern Arizona VA Health Care System (SAVAHCS) and the University of Arizona surveyed 389 randomly selected military Veterans receiving primary care at

SAVAHCS[7]. Approximately half of the Veterans surveyed reported that they used CAM for the treatment of chronic pain and illness and for wellness and health promotion. CAM practices used were diverse and included mind-body therapies, energy medicine, Chinese medicine, botanical, nutritional, and spiritual modalities. At the time of the survey only 1 out of 4 Veterans indicated that their VA primary care provider served as a resource for CAM information. The investigators also conducted a qualitative study in an effort to understand the perceptions of the conventional medical care system and why Veterans enrolled in the SAVAHCS used CAM therapies. The results indicated although study participants were generally satisfied with their conventional care, there were particular aspects of the conventional care system of which they were critical. Dissatisfaction with aspects of conventional care included the reliance on prescription medications which was an important component in the motivation to use CAM. The study results also suggested that the lack of a holistic approach (inadequate information regarding diet, nutrition and exercise, and ignorance of social and spiritual dimensions) was an important reason to go outside of conventional care toward CAM therapies.

The growth of CAM raises important issues of access, quality, and outcomes within the VA system. VA agreed that efforts should be made to identify those CAM practices which might be of benefit to Veterans and to integrate those therapies into VA care. In May 2002 VA commissioned the Healthcare Analysis and Information Group (HAIG) to collect information on Complementary and Alternative Medicine practices already being delivered within VA. This survey showed that CAM was already widespread within VA, with 84 percent of the responding facilities providing some form of CAM. In July 2004, VA chartered a Field Advisory Committee to identify practices which should be considered for integration into VA care, to promote and integrate CAM therapies into clinical practice guidelines, to identify where additional research is needed to determine the safety and efficacy of CAM practices and to establish standards for the training and credentialing of CAM providers.

In the past decade VA has increased its focus on providing patient centered therapies, having patients focus on wellness, disease prevention, and chronic disease management. VA's interests and the potential for CAM interventions to help manage chronic diseases, promote wellness, and disease prevention appears to have led to increased interest and visibility of CAM within VA.

A 2010 analysis of the Veterans Health Information Systems and Technology Architecture (VistA) patient treatment file database estimated that as many as 23 percent of patients in VA extended care settings participate in some form of CAM and these activities represent 12 percent of all patient encounters in this setting. In addition, the increasing prominence of CAM was in evidence at the 2010 Senior Management Conference where there were multiple displays and presentations given by CAM practitioners.

In light of these developments the Field Advisory Committee on Complementary and Alternative Medicine requested in 2010 that an updated survey be performed by the HAIG. It is hoped that this survey will result in better understanding of the current state of CAM use within VA, the education and training of the providers, the credentialing and privileging of providers, and the disease modalities most commonly managed with CAM therapies. It is hoped that this survey will assist in identifying which practices might be of most interest to VA as well as identifying key issues in the delivery of these CAM practices.

References

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Methodology

Data were collected using a self-administered web-based survey tool. The web-based survey, administered by the HAIG, was distributed by VISN offices to facility chiefs of staff to complete. The chiefs of staff were asked to collaborate with a variety of staff in their medical centers, including the following, if applicable: Facility CAM Champion, Rehabilitation, Spinal Cord Injury / Disorders, Primary Care, Mental Health, Medicine, Pharmacy, Nutrition / Dietetics, Pain Management, Chaplain, Nursing, Extended Care, Anesthesia, Recreation Therapy, Physical Therapy, Planetree Coordinators, and Dental Service.

The survey was in the field January through February, 2011. The survey was sent to 153 VA Hospitals within 141 consolidated VA Medical Centers and Health Care Systems. Responses were tabulated for the Health Care Systems rather than individual hospitals, resulting in 141 unique responses. Thus, the response rate was 100 percent. Where obvious errors were noted, data were validated with respondents. However, questions may be subject to individual interpretations by respondents and the scope of VHA services did not permit independent confirmation of all data.

Findings

Current Spread of CAM:

- One hundred twenty-five VHA facilities provide and / or refer patients to CAM service providers.
- On average, if a facility offers any CAM therapies, it offers more modalities than in 2002 (see maps in Appendix C and Appendix D).
- CAM is increasing in prevalence in the United States from 34 percent in 1990 to 38-40 percent in 2011(see Background).
- A majority of providers in VHA that offer CAM therapies have conventional health care training (not CAM-specific).

- From 2002 to 2011, there was an increase in the number of CAM modalities offered within VHA, with a greater number of providers offering Mind-Body Medicine modalities than in any other NCCAM category.
- CAM is generally used in an adjunctive and integrated fashion with allopathic medicine (not as a primary treatment).
- There is significant interest in establishing Integrative clinics within VHA.
- Overall, there is no single Credentialing and Privileging (C&P) process for CAM modalities that all facilities have in common; some facilities have an established process while 21 percent of facilities have no established C&P process. Acupuncture is a notable exception with the Clinical Executive Board (CEB) in over 70 percent of facilities approving clinical privileges (see Figure 27).

- Certification or licensure was reported to be used by 45 percent of respondents as part of their C&P process.
- Seventy-two percent of facilities identified general wellness as a reason for providing CAM modalities. This may help explain the more informal processes for C&P, documentation, strength of evidence processes, etc.
- Facilities are trying to use an evidence base to support CAM, but for some modalities the research evidence at this time may be limited.
- The likelihood that CAM care is documented in a progress note varies widely by modality with a range from 25% to 100% . On average, 39% of CAM modalities are associated with a procedure code.
- While there are not specific procedure codes indicating that these CAM modalities are being provided to patients, health care providers may be documenting their patient encounters using progress notes and encounter codes assigned to other consultation or office visit codes.

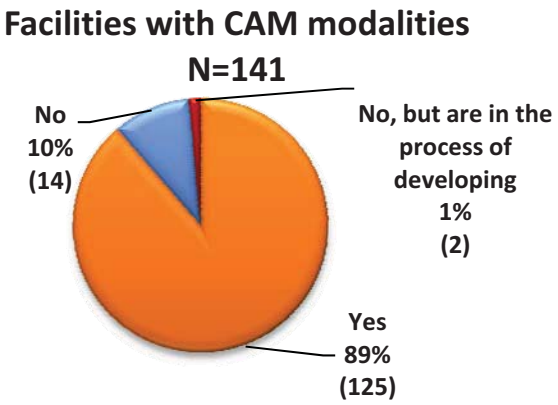
Recommendations

- While we know about CAM provided in VHA, and we have information about CAM utilization in the general populace, we do not have information on the interests and utilization of CAM by Veterans who use VHA services. A survey of Veterans who have had CAM treatments would be useful for determining their interests and use of CAM in assessing if VHA is meeting their needs and expectations.
- The lack of occupational classes for CAM providers in VHA limits the ability to track CAM provider availability and activity. Where licensure does exist for CAM providers, VA should pursue legislative approval for occupational codes that would allow the hiring of licensed CAM providers such as licensed acupuncturists.
- A distinction needs to be made between CAM used for treatment of disease versus that which is used for general health benefits as this could have potential implications on the need for licensure, credentialing, and certification of providers.
- Further research into the efficacy of CAM modalities and how they should be integrated with allopathic care is warranted.
- There needs to be a more systematic method to capture provision of CAM within VHA, both in terms of what is offered, and who is offering it. This would allow the ability to compare treatment outcomes of patients treated with combined modalities.
- Mental Health conditions are heavily represented as areas of CAM utilization and may be an area where further outcome study should be undertaken.
- There needs to be a standard process for credentialing and privileging CAM providers who will be delivering CAM treatment of disease and for ensuring that all CAM providers hold appropriate licensure.
- Guidance should be provided on how CAM care delivery should be documented, including specific guidance on procedure codes to be used for various modalities and therapies would be beneficial to ensure that 1) all health care providers are aware of CAM treatments being received by their patients, and 2) VA can systematically track where, when, and how much CAM therapy is being delivered by VA providers.
- The VHA CAM survey should be repeated at regular intervals in order to track changes in CAM service delivery.

Survey Questions and Results

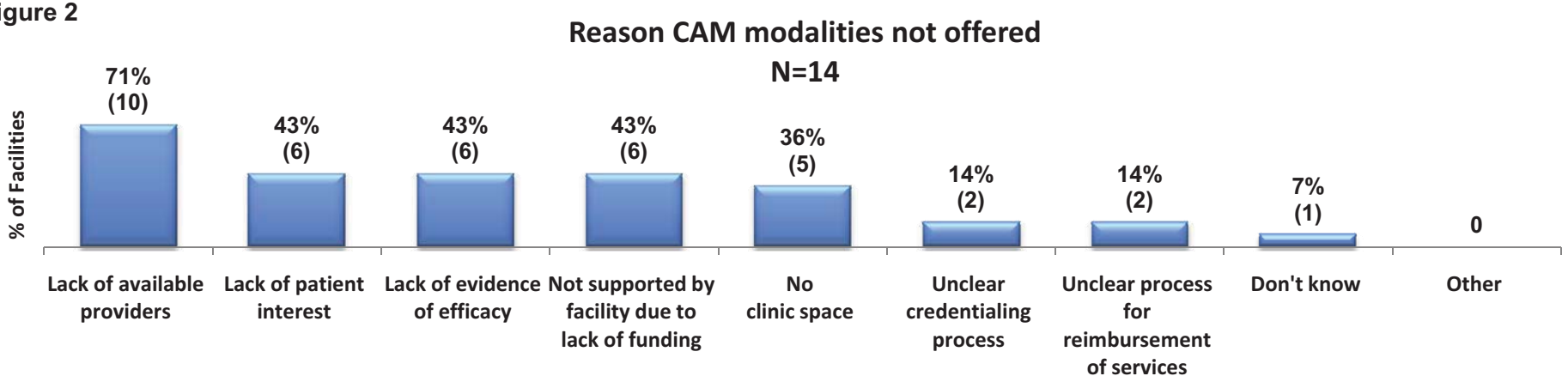
As Figure 1 below depicts, of the 141 sites surveyed, 89 percent reported offering some type of CAM.

Figure 1



Of the ten percent of facilities that were *not* offering CAM, the primary reason was lack of available providers (71%), followed by lack of patient interest (43%), lack of efficacy of evidence (43%), and not having funding support by facility (43%). (See Figure 2 below.) Facilities could choose more than one response. Therefore, Figure 2 represents the percentage of facilities, and the responses do not total 100 percent.

Figure 2



Of the 125 sites that offered CAM, the top five reasons for providing CAM included: (1) promote wellness (83%), (2) patient preferences (80%), (3) as an adjunct to chronic care (78%), (4) proven clinical effect (73%), and (5) provider request (65%) as shown in Figure 3 below. Other reasons cited include: reflects facility's mission, has providers that volunteer their services to provide CAM, consistent with Patient-Aligned Care Team (PACT) model, promotes cost savings, reflects cultural preferences, and attracts new patients. Facilities could choose more than one response. Therefore, the percentages in Figure 3 do not equal 100 percent.

Figure 3

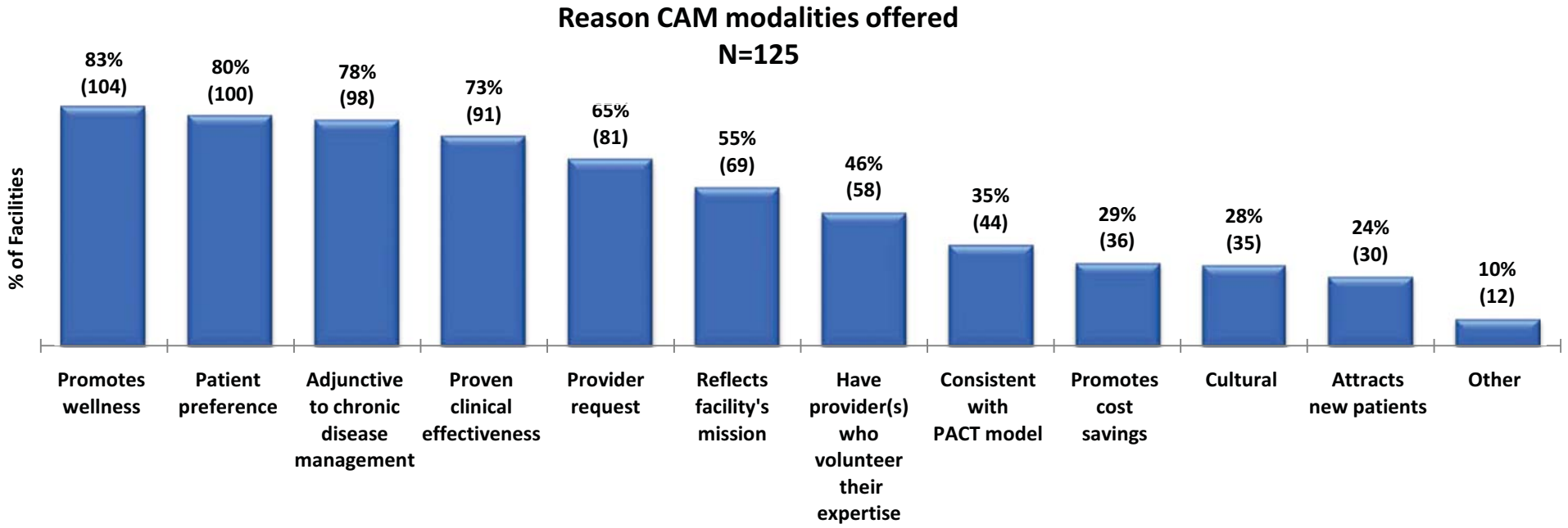


Table 1 below illustrates the number of facilities providing a range of CAM modalities overall. Between 2002 and 2011, the number of facilities only offering 1-5 CAM modalities decreased by half, and the number of facilities providing more than five CAM modalities more than doubled. Clearly, many facilities offer more CAM modalities in 2011 than in 2002. In 2011, only one facility reported referring all CAM to non-VA providers, rather than providing it directly on-site.

Table 1. Range of CAM Modalities Provided Per Location

	2002 N=111	2011 N=125
Provides 1-5 CAM Modalities	70 Facilities	34 Facilities
Provides 6-10 CAM Modalities	39 Facilities	59 Facilities
Provides 11-15 CAM Modalities	2 Facilities	25 Facilities
Provides 16-20 CAM Modalities	0 Facilities	6 Facilities
Provides 21-26 CAM Modalities	0 Facilities	0 Facilities
Referred all CAM to non-VA provider	0 Facilities	1 Facility

Figure 4 and Figure 5 below demonstrate the frequency with which the top CAM modalities are provided and referred. Meditation is provided most frequently on-site, whereas Acupuncture is the most frequently referred CAM modality.

Figure 4

Most Commonly Provided Modalities By Number of Facilities

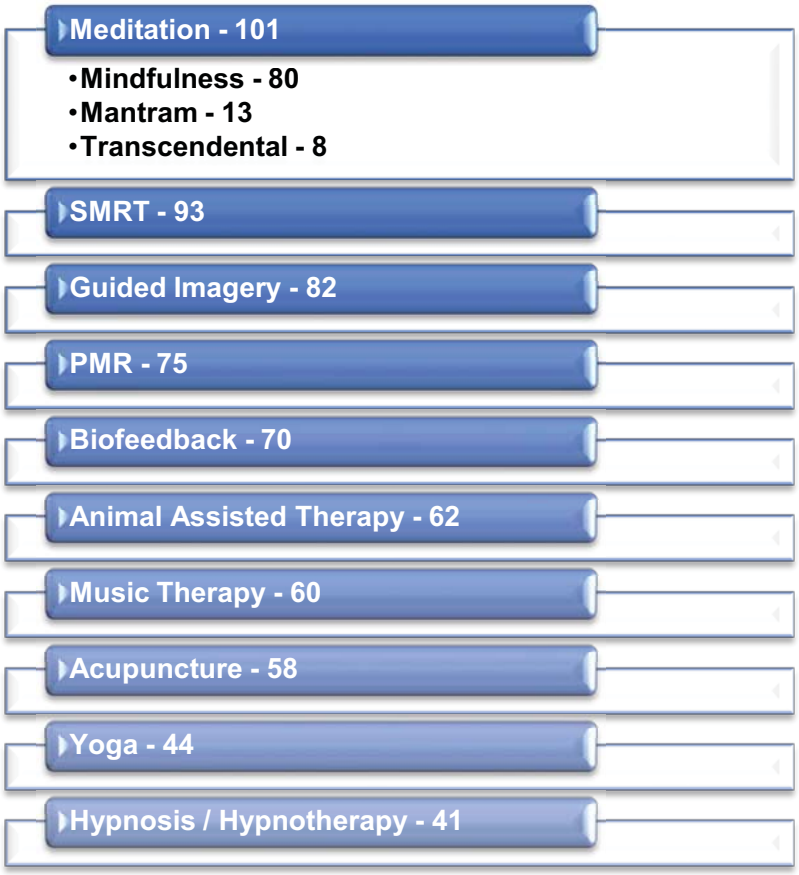


Figure 5

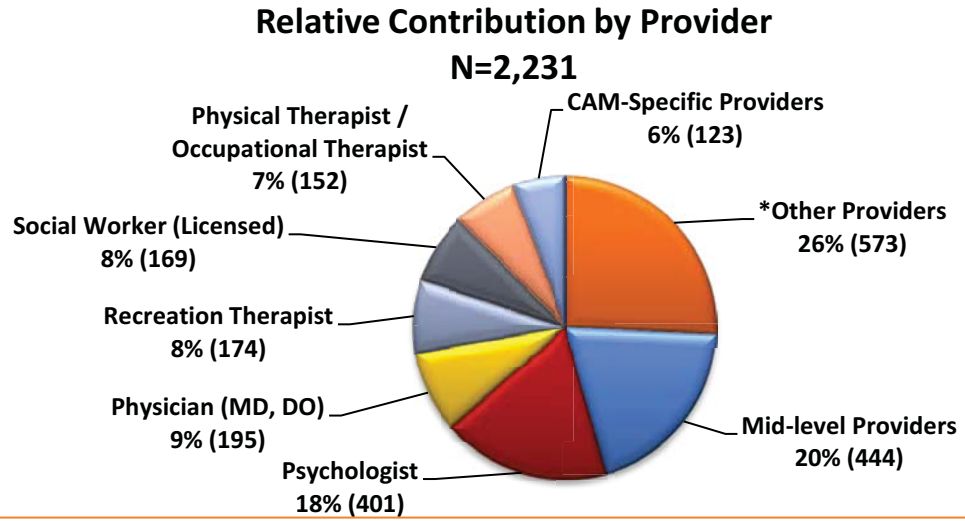
Most Commonly Referred Modalities By Number of Facilities

Provider Characteristics

Figure 6 displays the contribution of each provider category across all of the modalities. When combining the results for nurse practitioner, nurse - clinical specialist, and physician assistant into one category called "mid-level providers," this category of providers represented the largest percentage of provider types distributed across all CAM modalities. Psychologists were the single largest category, representing nearly one-fifth of the provider categories identified. By comparison, the next largest category, physicians, represented only 9 percent of providers. The seeming over-representation of psychologists may be due to the inclusion of standard psychological practices in the Mind-Body Medicine category of CAM. Stress management techniques, for example, may be seen as standard practice for psychologists, which may in turn contribute to the substantial number of facilities that reported psychologists were using them. It is unknown how many sites may have treated these modalities as standard practices and excluded them. As such, the representation of CAM providers in mental health may be understated.

Facilities could choose more than one response. Therefore, the graphs in Figures 6-11 represent the number of facilities which utilize each mechanism for credentialing and privileging providers, not the frequency of modality use. The primary data is provided in Appendix G, Table G-1.

Figure 6

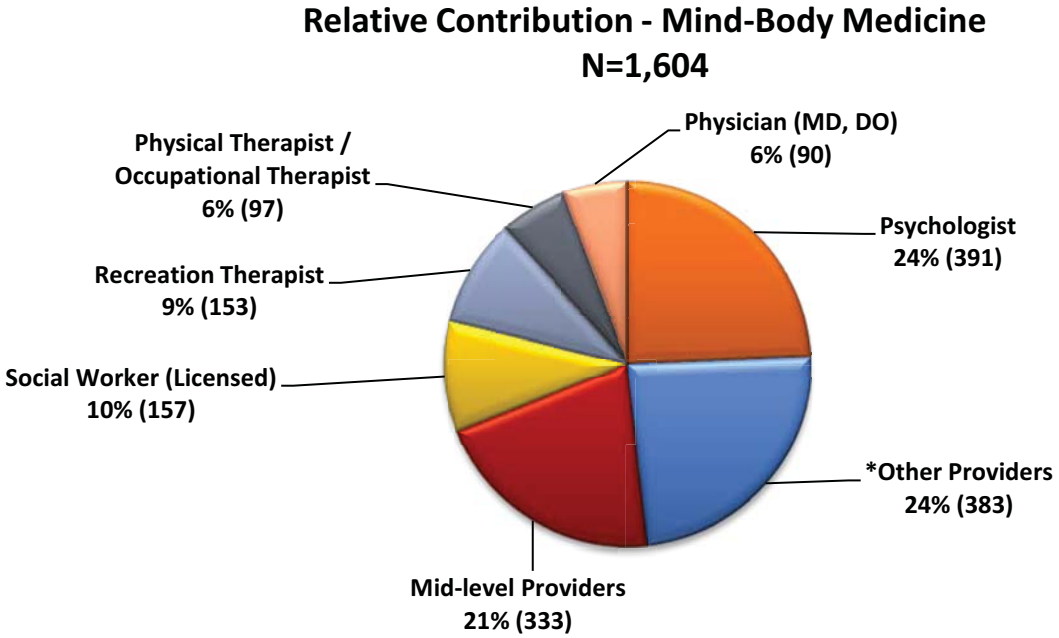


*Other Providers: Other (5%); RN (4%); Chaplain, Clergy, Spiritual Leader (4%); Dietitian (4%); Acupuncturist (3%); Professional Counselor (2%); Massage Therapist (2%); Chiropractor (1%); Pharmacist (.40%); Dentist (.31%); Marriage and Family Therapist (.18%)

Mind-Body Medicine

Figure 7 displays the relative contribution of each provider category across the mind-body modalities. Psychologists are the most commonly reported providers, followed by mid-level providers, and social workers.

Figure 7



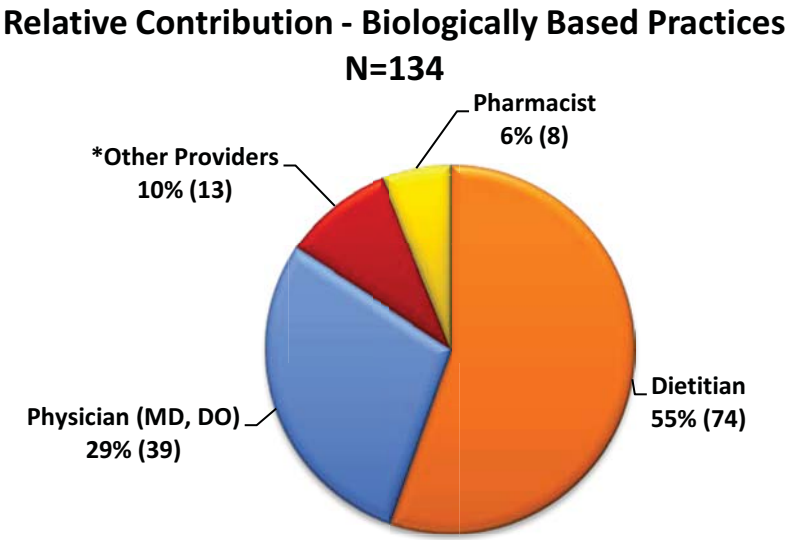
*Other Providers: CAM - Specific Provider (5%); Other (4%); Chaplain, Clergy, Spiritual Leader (4%); RN (4%); Professional Counselor (3%); Acupuncturist (1%); Massage Therapist (1%); Chiropractor (.50%); Dietitian (.37%); Dentist (.31%); Marriage and Family Therapist (.25%); Pharmacist (.06%)

Biologically Based Practices

Figure 8 represents the relative contribution of each provider category across the biologically based practices.

The dietitian provider category represented the single largest contributor to biologically based practices (CAM natural products).

Figure 8



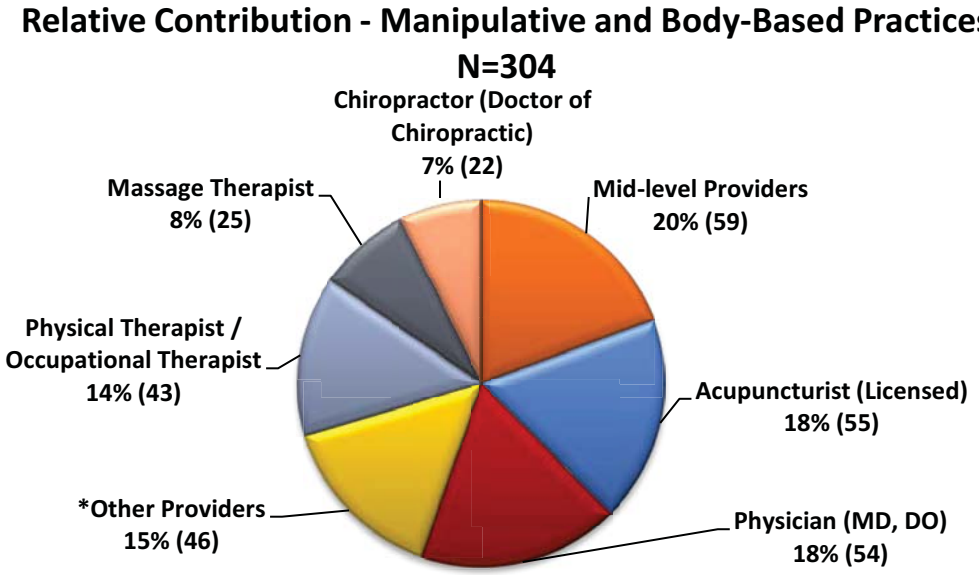
*Other Providers: RN (3%); Recreation Therapist (1%); Dentist (1%); Psychologist (1%);
Physical Therapist /Occupational Therapist (1%); Other (1%); Chiropractor (1%); Mid-level providers (1%)

Manipulative and Body-Based Practices

Figure 9 represents the relative contribution of each provider category across the manipulative and body-based practices.

Facilities identified acupuncturists and physicians as the most common provider types participating in body-based practices. Physicians and acupuncturists were identified in relatively equal numbers. Mid-level providers, as a combined provider category, participate most frequently in body-based practices (20%).

Figure 9



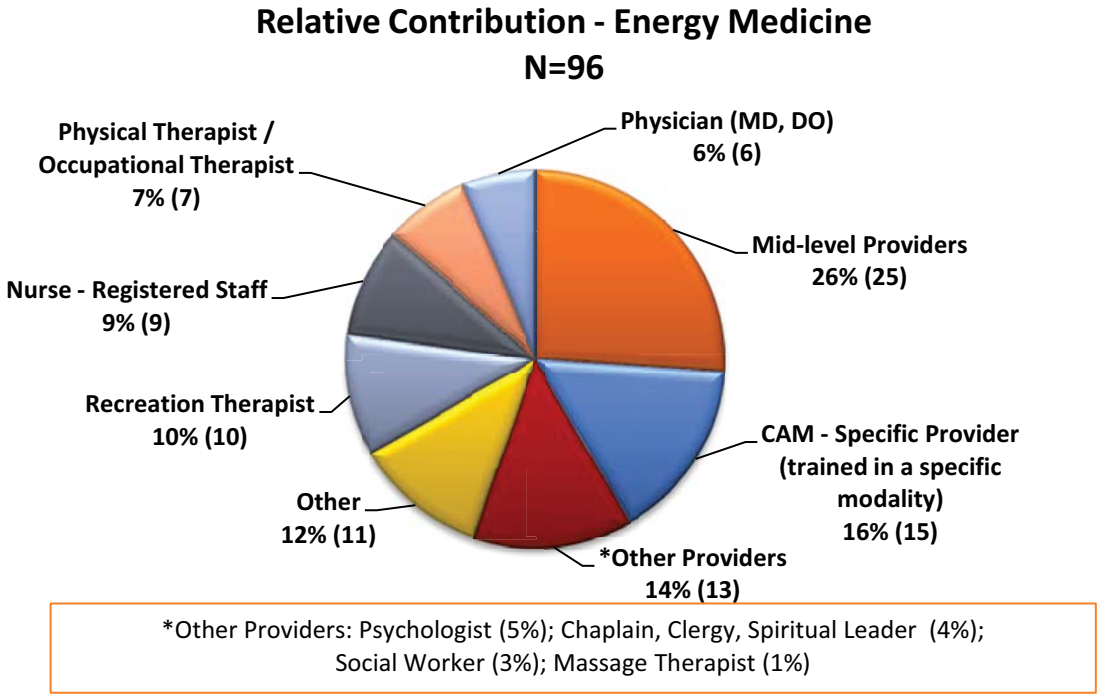
*Other Providers: CAM Specific Provider (4%); RN (4%); Recreation Therapist (3%); Other (2%); Psychologist (1%); Social Worker (1%); Chaplain, Clergy, Spiritual Leader (.33%)

Energy Medicine

Figure 10 represents the relative contribution of each provider category across the energy medicine modalities.

The energy medicine category was unique in that it did not appear that any one provider category was a dominant contributor to the category. Recreation therapists, CAM-specific providers, physicians, and mid-level providers played an equal role in offering these modalities.

Figure 10



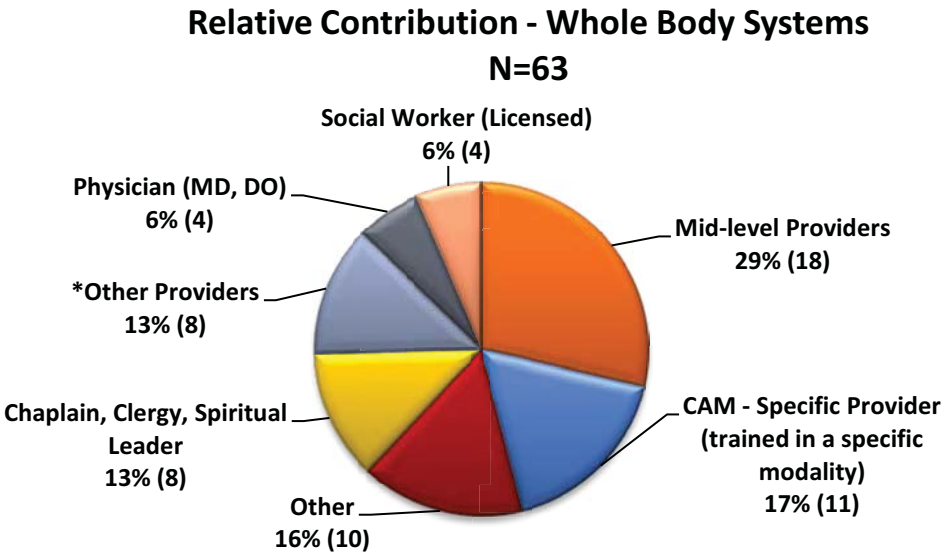
*Other Providers: Psychologist (5%); Chaplain, Clergy, Spiritual Leader (4%); Social Worker (3%); Massage Therapist (1%)

Whole Body Systems

Figure 11 represents the relative contribution of each provider category across the whole body systems modalities.

Whole body medicine is primarily the domain of mid-level providers, CAM-specific practitioners and clergy / spiritual leaders.

Figure 11



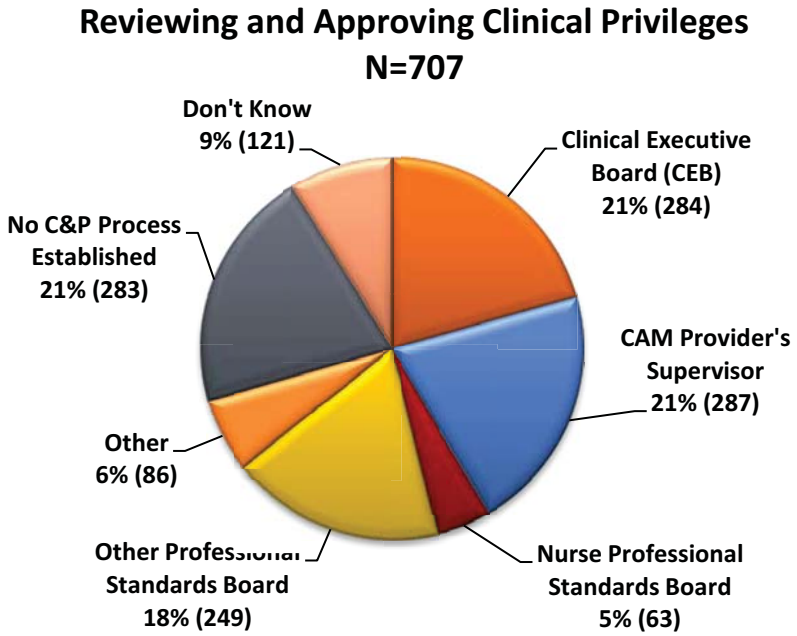
*Other Providers: Physical Therapist / Occupational Therapist (5%); Acupuncturist (3%); RN (2%); Professional Counselor (2%); Chiropractor (2%)

Credentialing and Privileging (C&P)

The responsibility for reviewing and approving clinical privileges for providers delivering CAM modalities is heterogeneous across the system. Figure 12 displays the contribution of those responsible for reviewing and approving clinical privileges across all of the modalities. Twenty-one percent of the time, the Clinical Executive Board (CEB) holds these responsibilities, 21 percent of the time, it is held by the CAM provider's supervisor, while another 21 percent noted no C&P process for CAM has been established. Professional Standards Boards, including nursing standards boards and standards boards from other professions, were reported to hold this responsibility 23 percent of the time. Other or don't know represented the remaining 15 percent.

Facilities could choose more than one response. Therefore, the graphs in Figures 12-17 represent the number of facilities which utilize each mechanism for credentialing and privileging providers, not the frequency of modality use.

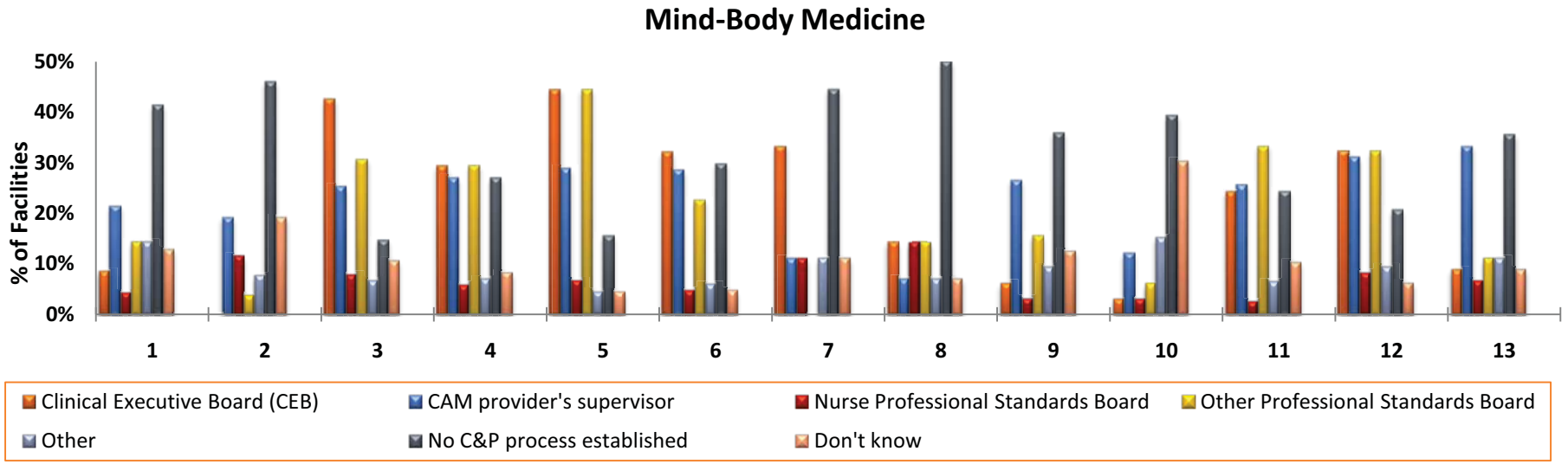
Figure 12



Mind-Body Medicine

The two mind-body medicine practices that required the CEB to review and approve clinical privileges by more than 40 percent of respondents were biofeedback and hypnosis / hypnotherapy. A number of mind-body modalities had no C&P process reported by over 40 percent of respondents including animal assisted therapy, aromatherapy, transcendental meditation, mantram repetition, and non-traditional spiritual practices. There was significant heterogeneity within all the mind-body modalities in terms of where responsibility lies for reviewing and approving clinical privileges for providers offering these modalities. (See Figure 13 below or Appendix G, Table G-3 for details.)

Figure 13

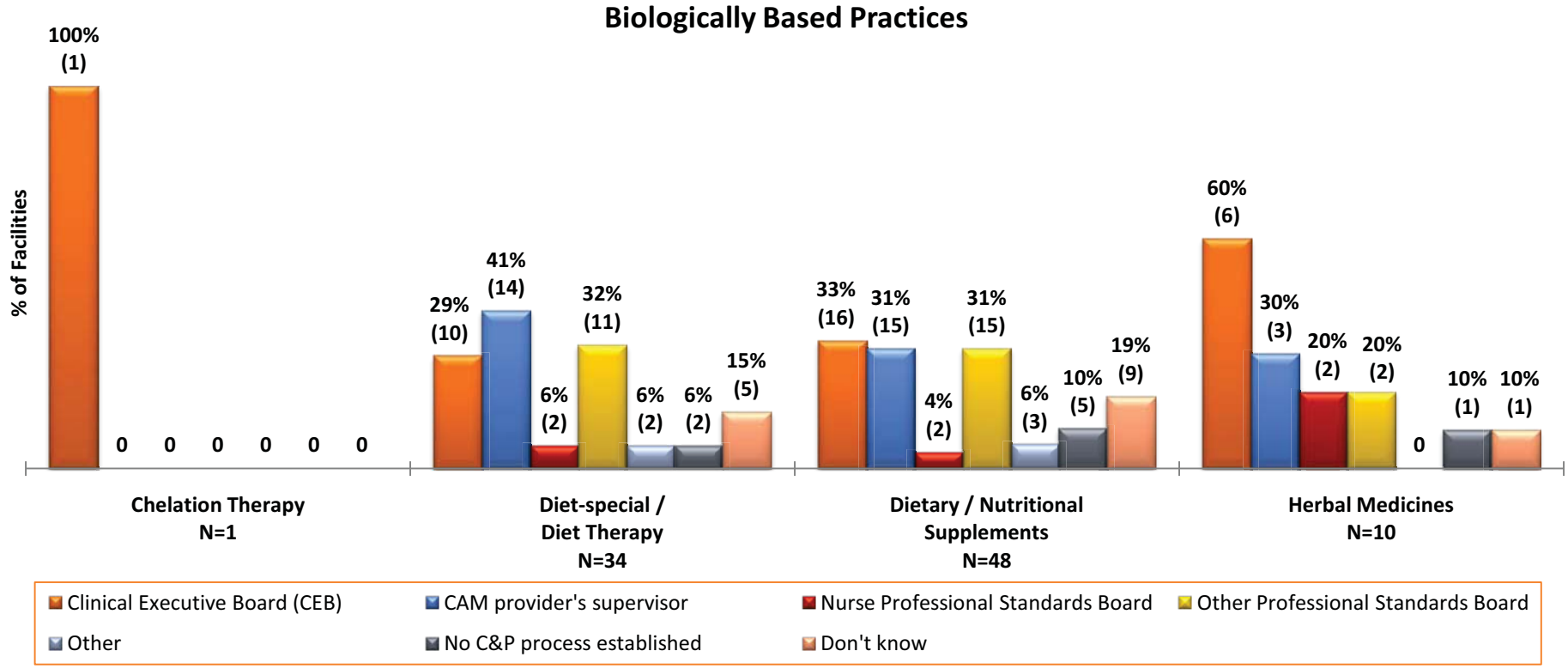


1. Animal Assisted Therapy (N=70)
2. Aromatherapy (N=26)
3. Biofeedback (N=75)
4. Guided Imagery (N=85)
5. Hypnosis / Hypnotherapy (N=45)
6. Mindfulness (N=84)
7. Transcendental Meditation (N=9)
8. Mantram Repetition (N=14)
9. Music Therapy (N=64)
10. Non-traditional Spiritual Practices (N=33)
11. Progressive Muscle Relaxation (N=78)
12. Stress Management / Relaxation Therapy (N=96)
13. Yoga (N=45)

Biologically Based Practices

Biologically based practices also displayed significant heterogeneity in the C&P process. Herbal medicine use was noted by over half of the respondents to require the Clinical Executive Board to review and approve clinical privileges for providers providing this modality. Over 30 percent of respondents noted that the CAM provider's supervisor held this responsibility for the majority of the biologically based practices. Again, Individual Professional Standard Boards also played a role at some facilities in approving clinical privileges for providers providing biologically based practices. (See Figure 14 below.)

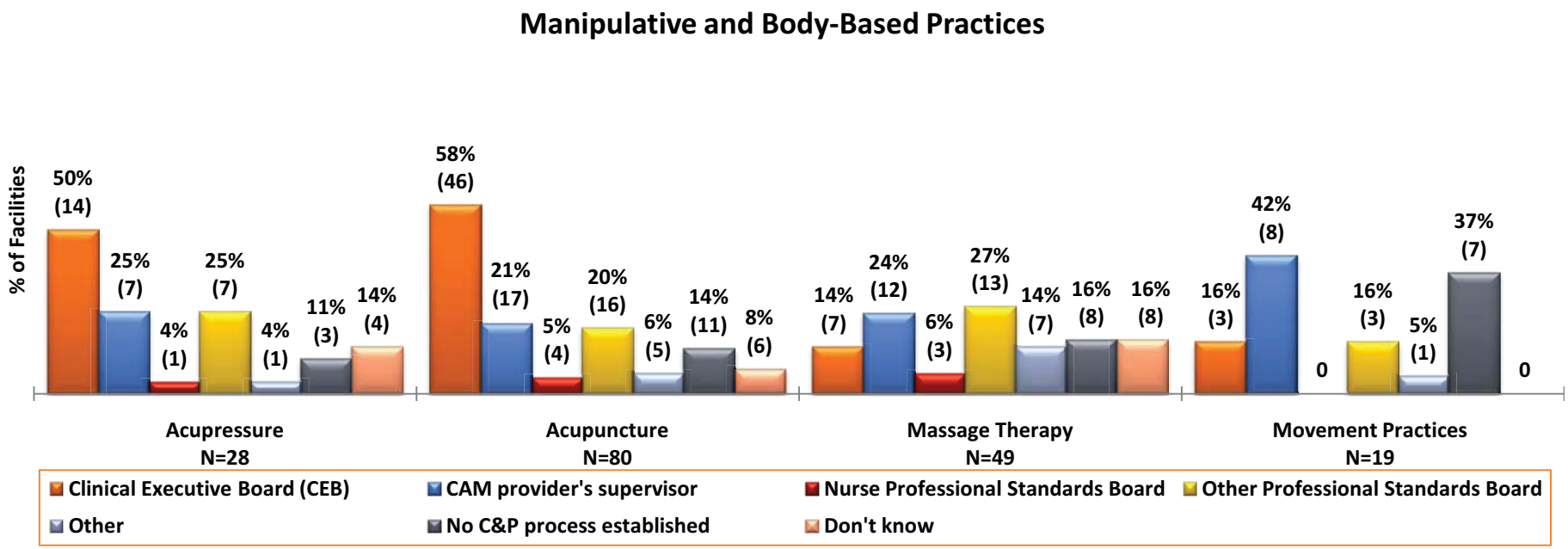
Figure 14



Manipulative and Body-Based Practices

In over 50 percent of facilities, the CEB provides clinical privileges to acupressure and acupuncture providers. Between 20 percent and 30 percent of respondents also noted CAM provider's supervisor and other Professional Standards Boards held privileging responsibility for those providing acupressure and acupuncture. For massage therapy, very few answered that this required approval by the CEB. CAM provider's supervisor and other Professional Standards Boards including Nurse Professional Standards Board made up an additional 24 percent and 33 percent of responses respectively regarding privileges for massage therapy. The majority of those providing movement practices had either no C&P process established or required a provider's supervisor approval to provide this service. (See Figure 15 below.)

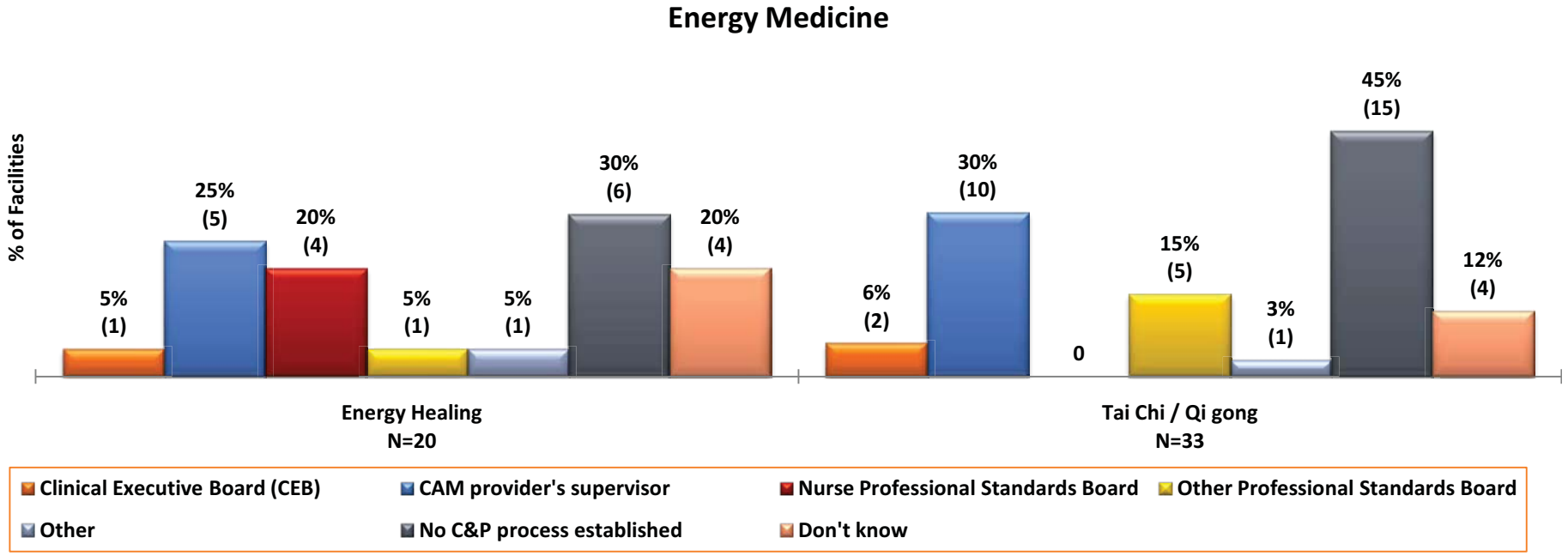
Figure 15



Energy Medicine

In the 20 facilities that responded that energy healing was provided at their medical center, 30 percent noted no C&P process established. Twenty-five percent of respondents stated the CAM provider's supervisor was responsible for reviewing and approving providers. Another 20 percent responded that privileging responsibilities were provided by Nursing Professional Standards Boards. Twenty percent of respondents did not know how privileging was granted for energy healing and only 5 percent required CEB oversight of the privileging process. (See Figure 16 below.)

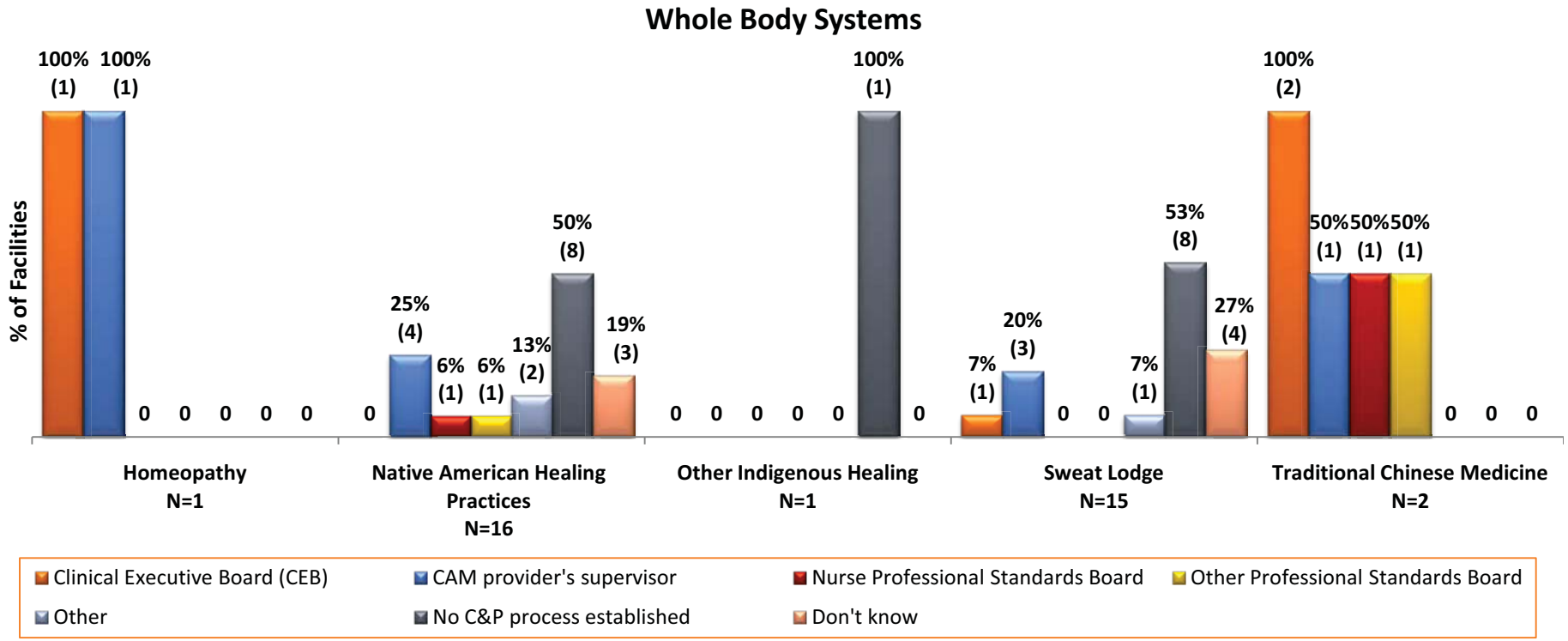
Figure 16



Whole Body Systems

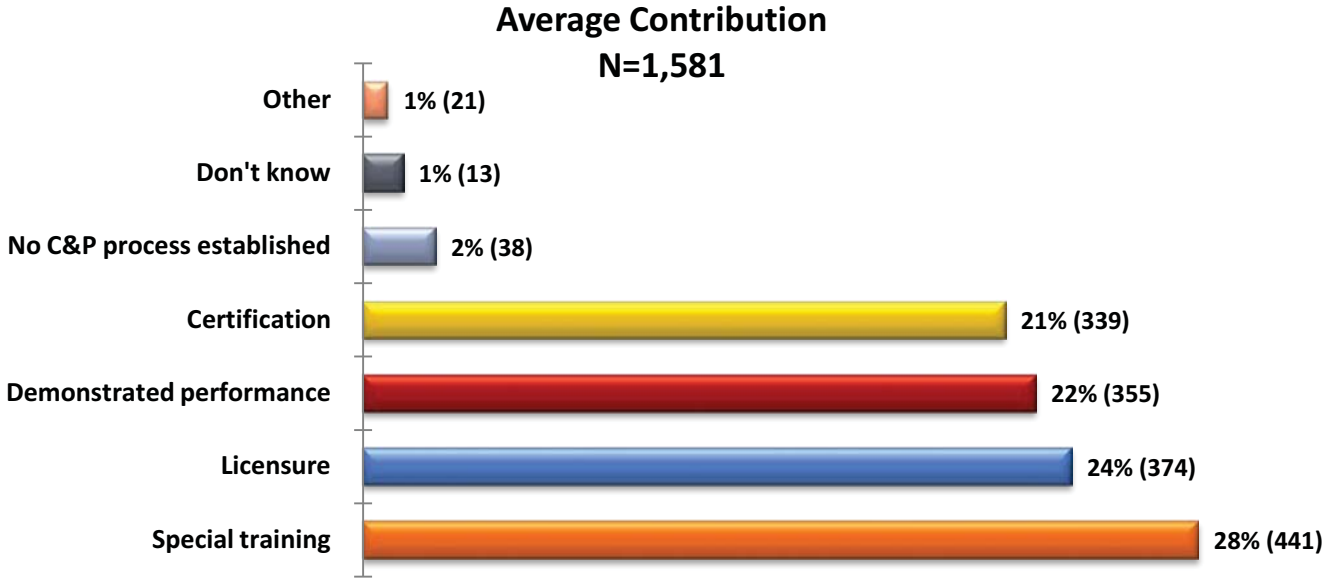
Only one respondent noted that homeopathy was provided at their facility which did require CEB oversight for granting clinical privileges, and one reported other indigenous healing modalities where no C&P process was established. Two respondents reported availability of Traditional Chinese Medicine (TCM) and both reported the CEB was responsible for reviewing and approving clinical privileges for providers providing TCM. Native American healing practices and sweat lodges were reported by 16 and 15 respondents respectively. In facilities providing Native American healing practices, CAM provider's supervisor approval for clinical privileges was used 25 percent of the time and 20 percent indicated there was no C&P process. In facilities offering sweat lodges, CEB involvement occurred 7 percent of the time. CAM provider's supervisor approval was used 20 percent of the time, and 53 percent reported no C&P process was established to provide this modality. (See Figure 17 below.)

Figure 17



As shown in Figure 18, special training was the primary criterion used during the C&P process to determine if C&P should be granted for a provider to practice various CAM modalities, with 28 percent of respondents reporting this criterion. Licensure was noted to be the criterion used by 24 percent of respondents, and demonstrated performance and certification by 22 percent and 21 percent respectively. No C&P process, don't know, or other was reported by two percent of respondents. Facilities could choose more than one response. Therefore, the graphs in Figures 18-23 represent the number of facilities which utilize each mechanism for credentialing and privileging criteria, not the frequency of modality use.

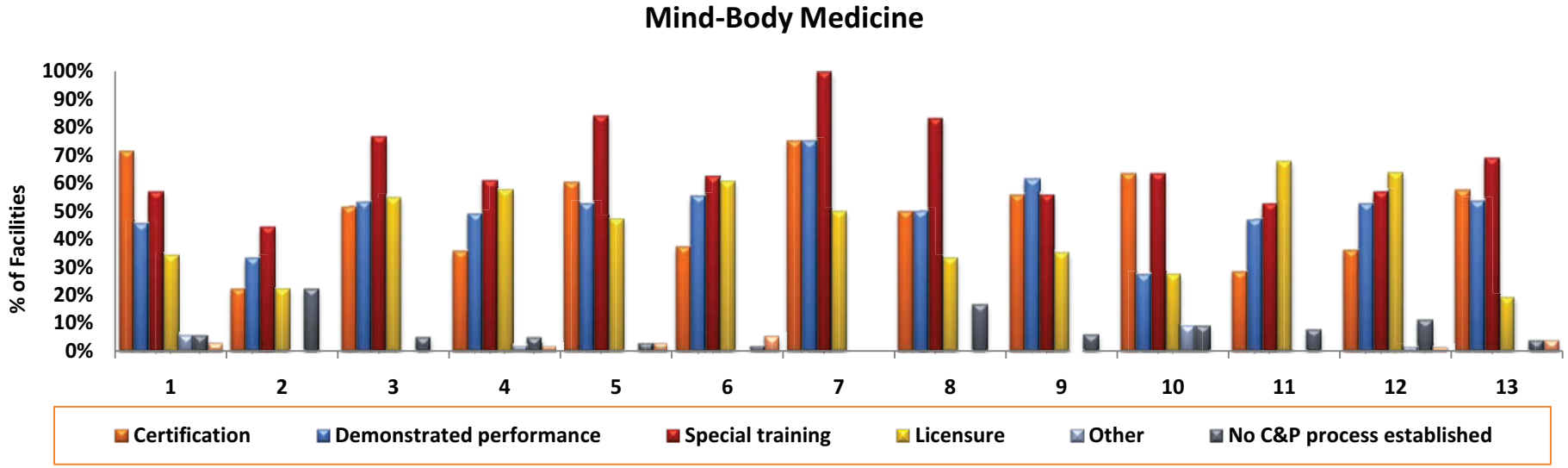
Figure 18



Mind-Body Medicine

The majority (9 of 13) of mind-body modalities used depend upon specialized training of a practitioner in order to receive C&P approval to provide the modality. Exceptions are animal assisted therapy, where 70 percent noted certification is required, music therapy, where demonstrated performance was reported by the majority, progressive muscle relaxation and stress management therapy, where it was noted by respondents that licensure was primarily used for C&P determination. Some level of C&P process was established for the majority of all the mind-body medicine modalities. (See Figure 19 below or Appendix G, Table G-4 for details.)

Figure 19

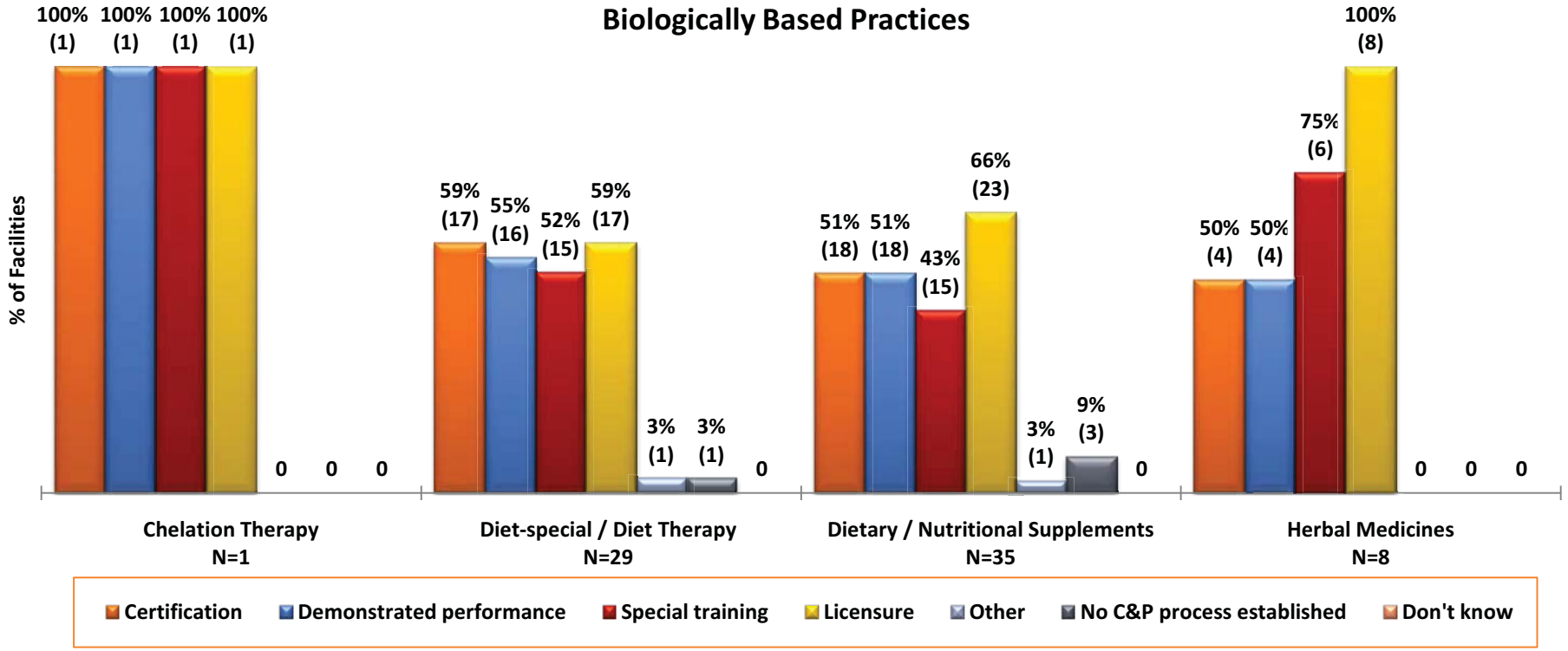


1. Animal Assisted Therapy (N=35)
2. Aromatherapy (N=9)
3. Biofeedback (N=60)
4. Guided Imagery (N=59)
5. Hypnosis / Hypnotherapy (N=38)
6. Mindfulness (N=56)
7. Transcendental (N=4)
8. Mantram Repetition (N=6)
9. Music Therapy (N=34)
10. Non-traditional Spiritual Practices (N=11)
11. Progressive Muscle Relaxation (N=53)
12. Stress Management / Relaxation Therapy (N=72)
13. Yoga (N=26)

Biologically Based Practices

In biologically based practices, licensure stood out as the primary criterion used for the C&P determination process. In both chelation therapy and herbal medicine therapy, licensure was reported 100 percent of the time as criteria used for C&P process. In dietary therapy and nutritional supplement therapy, certification, demonstrated performance, special training and licensure were all significant considerations used for C&P determination. (See Figure 20 below.)

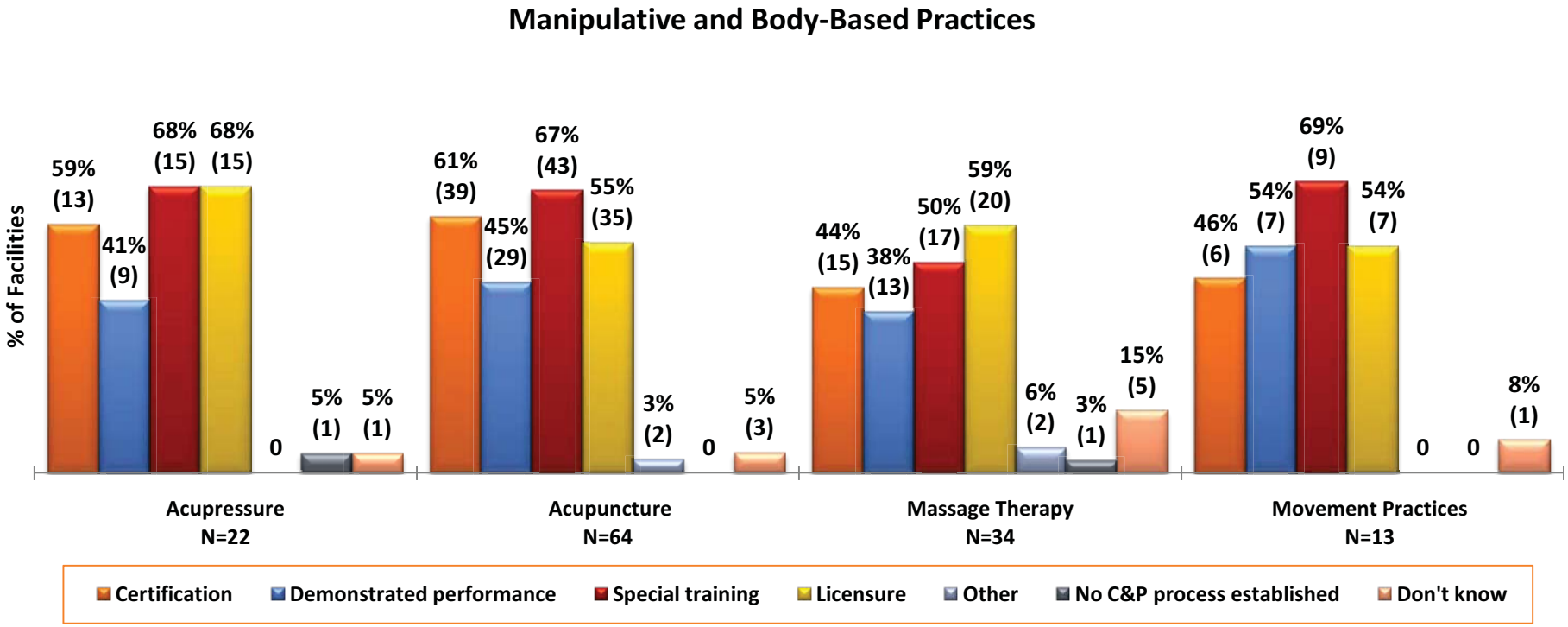
Figure 20



Manipulative and Body-Based Practices

Criteria used for consideration during the C&P process for acupuncture and acupressure reported by over 50 percent of respondents included certification, specialized training, and licensure. In movement practices, the majority of respondents reported specialized training (69%), licensure (54%) and demonstrated performance (54%). Very few reported no C&P process for these modalities. (See Figure 21 below.)

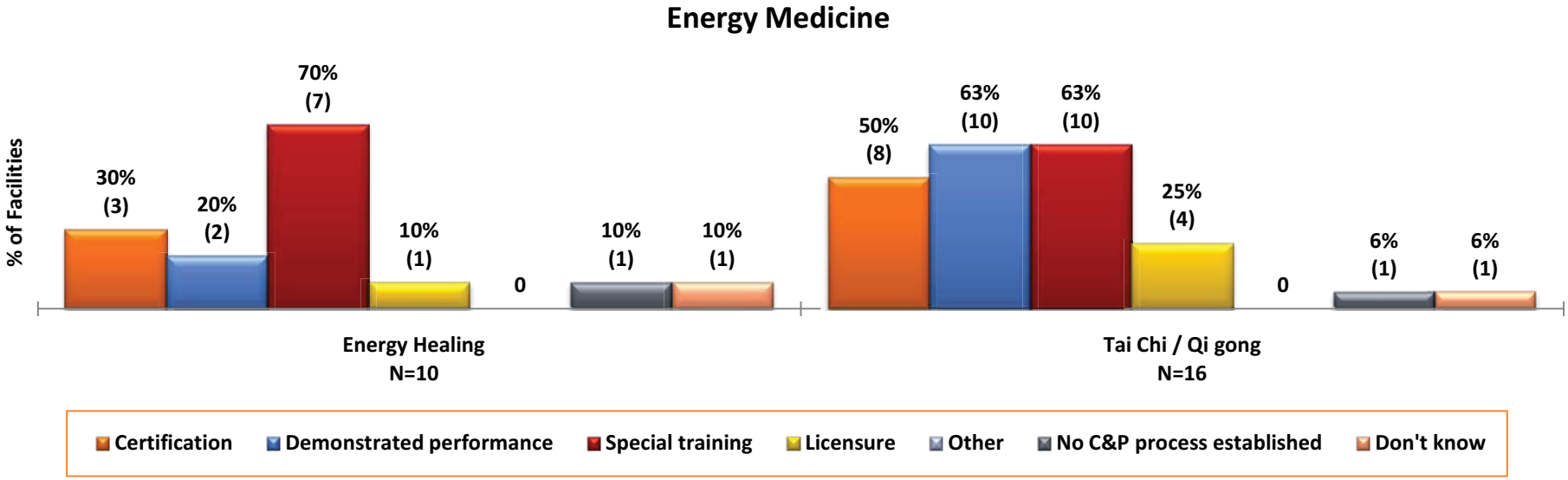
Figure 21



Energy Medicine

There were ten facilities who responded to this question regarding energy healing and 16 who responded regarding Tai Chi and Qi gong. Specialized training for energy healing was reported by 70 percent of respondents as a criterion used during the C&P process, 30 percent used certification, and less than 25 percent used demonstrated performance or licensure. Both specialized training and demonstrated performance were reported at 63 percent by respondents as criteria used for consideration during the C&P process for Tai Chi / Qi gong, and 50 percent reported certification as a consideration. Licensure was reported as a criterion by 25 percent of respondents. (See Figure 22 below.)

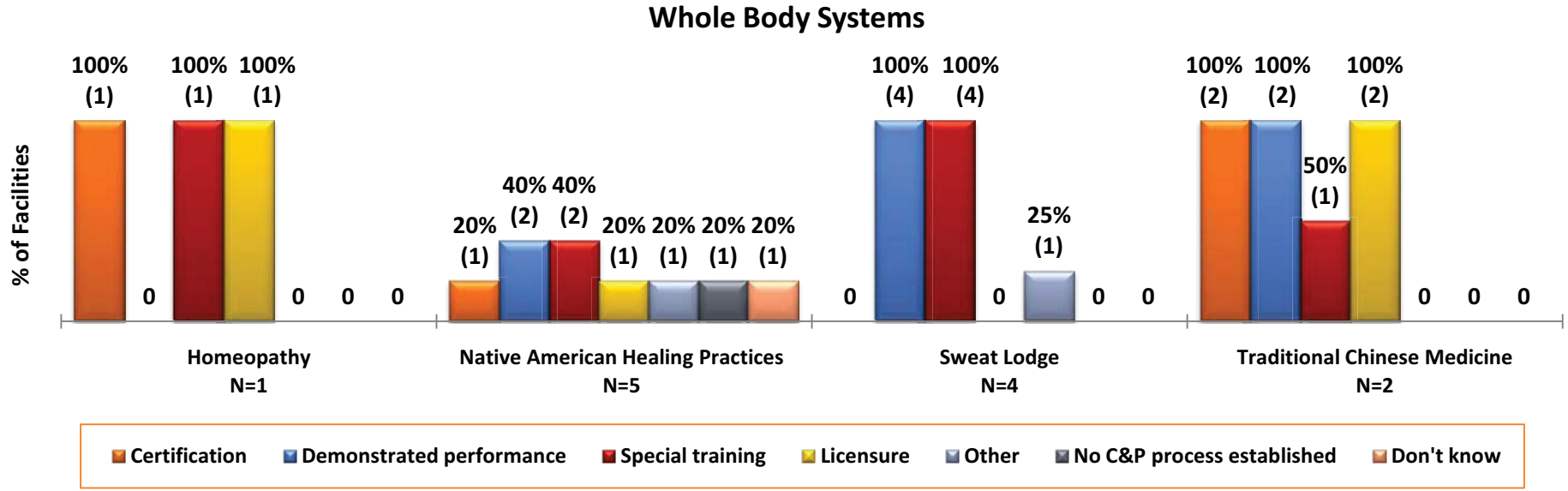
Figure 22



Whole Body Systems

Whole body systems including homeopathy, Native American healing practices, sweat lodges and TCM were reported by five or fewer respondents. Overall, demonstrated performance for sweat lodges and TCM, along with certification and licensure for TCM were reported as criteria used for the C&P process by 100 percent of respondents. Specialized training in sweat lodges was a criterion reported by all four respondents in this category. Regarding Native American healing practices, of the five respondents, 40 percent reported demonstrated performance and specialized training to be the criteria used for the C&P process. (See Figure 23 below.)

Figure 23



Conclusions

Overall, findings are heterogeneous in terms of responsibilities for reviewing and approving Clinical Privileges for providers delivering CAM and for criteria used during the C&P process across the VHA system. A minority of respondents (44%) reported CEB, nursing or other Professional Standards Board as having the responsibilities for reviewing and approving Clinical Privileges for providers providing various CAM modalities. Despite lack of uniformity across the system in terms of who reviews and approves C&P for providers, the vast majority had criteria used during the C&P process for determination if a provider can be privileged to provide specific CAM modalities. Overall, certification or licensure was reported to be used by 45 percent of respondents, and demonstrated performance or specialized training was used as criteria as reported by 49 percent of respondents. Ninety-four percent used at least one of the four criteria during the C&P process (certification, demonstrated performance, special training and / or licensure).

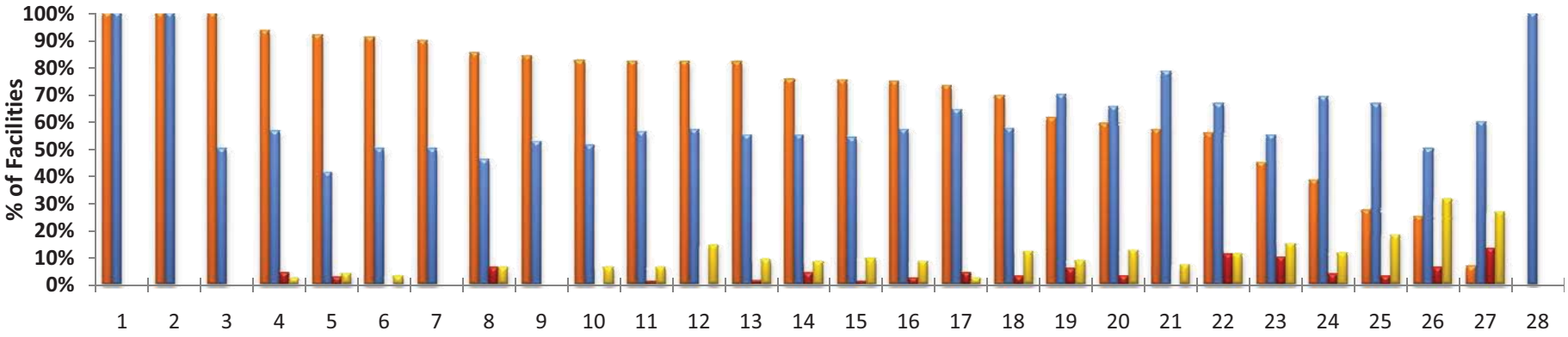
Type of evidence

On average, 68 percent of facilities reported having scientific evidence to support the use of their CAM modalities. Similarly, an average of 62 percent of facilities reported having experiential or anecdotal evidence to support their CAM usage. An average of eight percent of facilities reported offering CAMs without any evidence to support their use. Figure 24 below depicts all CAM modalities offered by the VA arranged in order of descending scientific evidence.

In general, most facilities report having scientific evidence to support the use of CAM, with only six modalities having less than 50 percent of facilities citing scientific evidence supporting the use of CAM. As the number of facilities citing scientific evidence declined, the number of facilities reporting the use of anecdotal / experiential evidence became a more significant factor in the support of the use of the CAM modality. Overall, facilities base their decision to use CAM modalities on some type of evidence, either scientific or anecdotal / experiential. (See Appendix G, Table G-4 for details.)

Facilities could choose more than one response. Therefore, the graphs in this section represent the number of facilities which use each type of evidence, not the frequency of modality use.

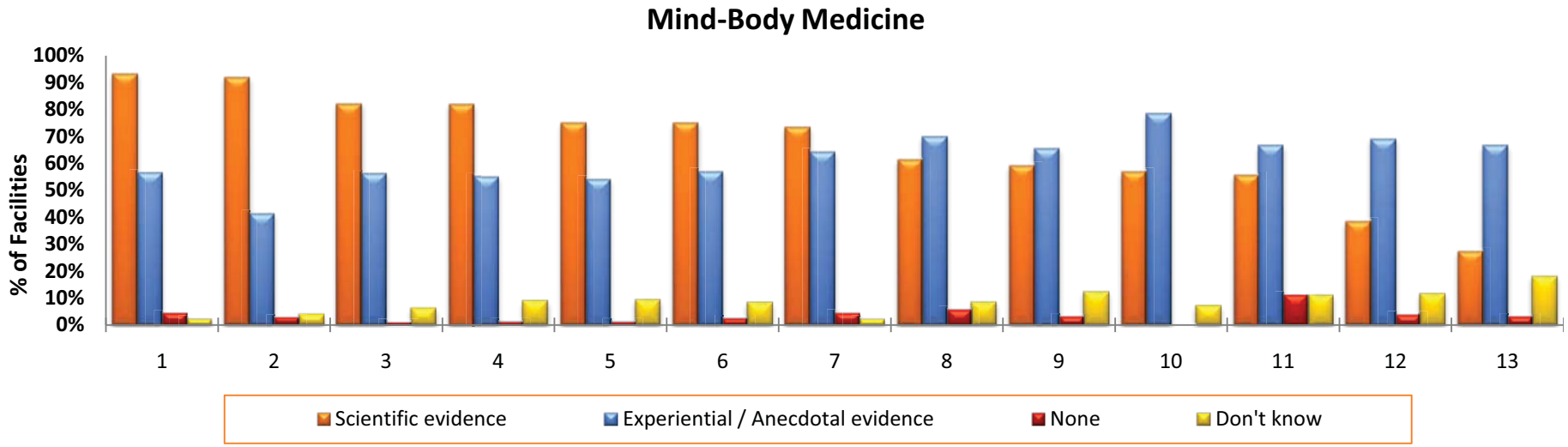
Figure 24



Mind-Body Medicine

Figure 25 below depicts that mind-body medicine encompassed thirteen different modalities with an average of 67 percent of facilities reporting scientific evidence for their use. Figure 25 below shows each of the modalities in descending order of scientific evidence reported. Those modalities that are most closely incorporated in Mental Health fields, such as hypnosis / hypnotherapy, biofeedback, stress management / relaxation therapy, progressive muscle relaxation, guided imagery, and mindfulness have the highest reported percentages of scientific evidence support. (See Appendix G, Table G-4 for details.)

Figure 25

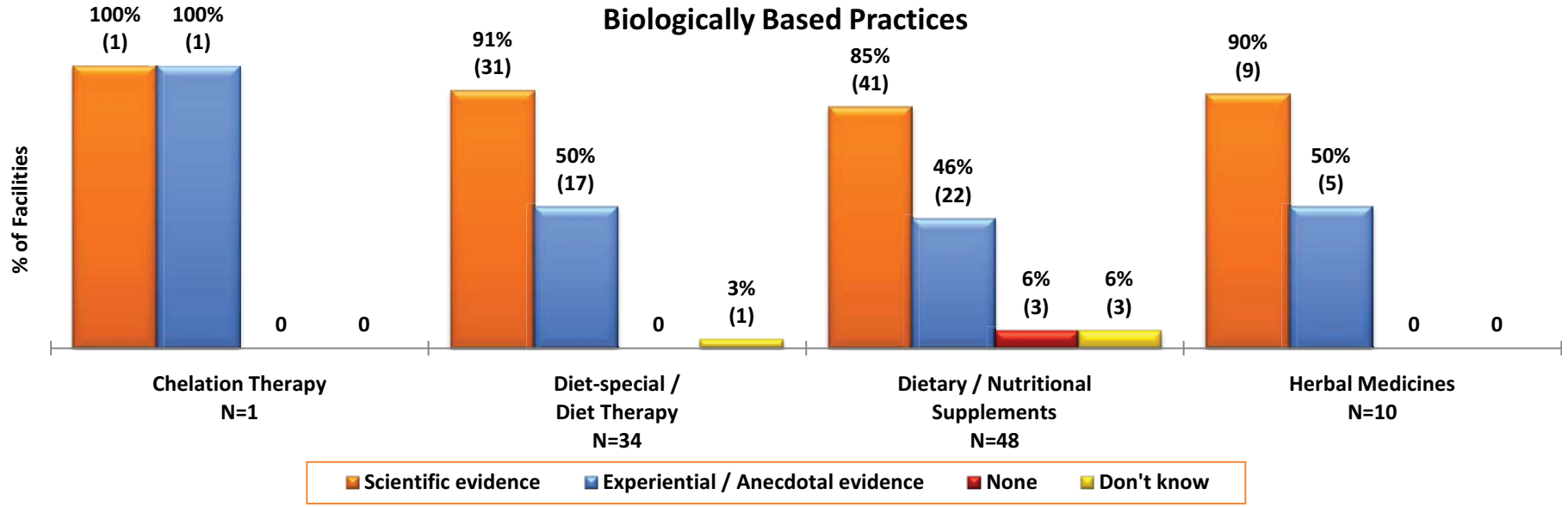


1. Hypnosis / Hypnotherapy (N=45)
2. Biofeedback (N=75)
3. Progressive Muscle Relaxation (N=78)
4. Stress Management / Relaxation Therapy (N=96)
5. Guided Imagery (N=85)
6. Mindfulness (N=84)
7. Yoga (N=45)
8. Animal Assisted Therapy (N=70)
9. Music Therapy (N=64)
10. Mantram Repetition (N=14)
11. Transcendental Meditation (N=9)
12. Aromatherapy (N=26)
13. Non-traditional Spiritual Practices (N=33)

Biologically Based Practices

In biologically based practices, scientific evidence was cited by almost all (85% - 100%) of facilities offering these modalities, as shown in Figure 26 below. The use of these CAM modalities was bolstered by the use of anecdotal / experiential evidence in nearly half as many of the facilities despite the already high levels of scientific evidence cited.

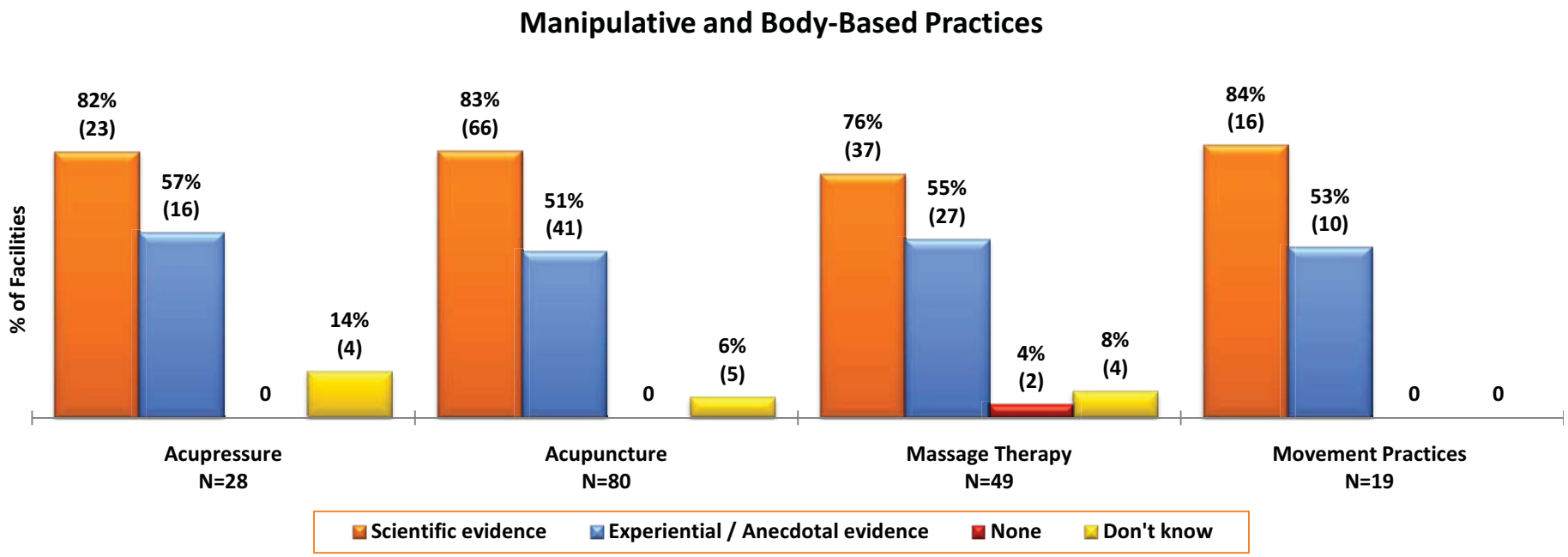
Figure 26



Manipulative and Body-Based Practices

Figure 27 below shows that between 76 and 84 percent of facilities report using scientific evidence as the support for providing manipulative and body-based practices. There is also a high ratio of anecdotal / experiential evidence to scientific evidence to support the use of these CAM modalities.

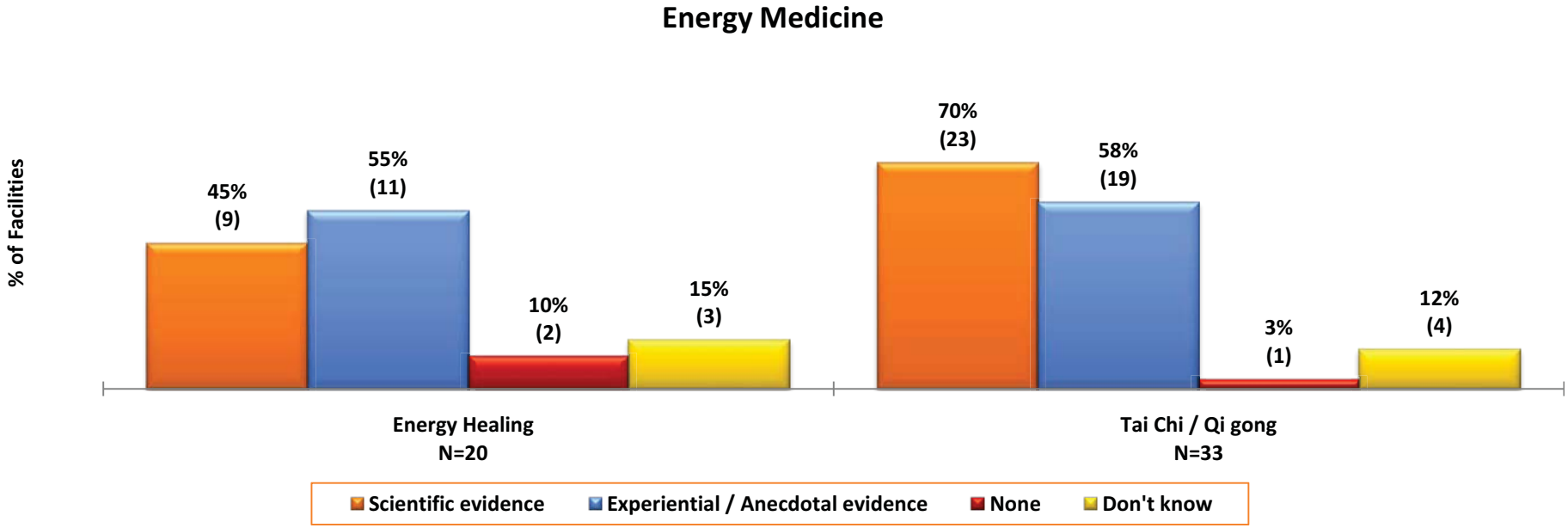
Figure 27



Energy Medicine

As shown in Figure 28 below facilities report anecdotal / experiential evidence at par with scientific evidence to support the use of the Energy Medicine modalities.

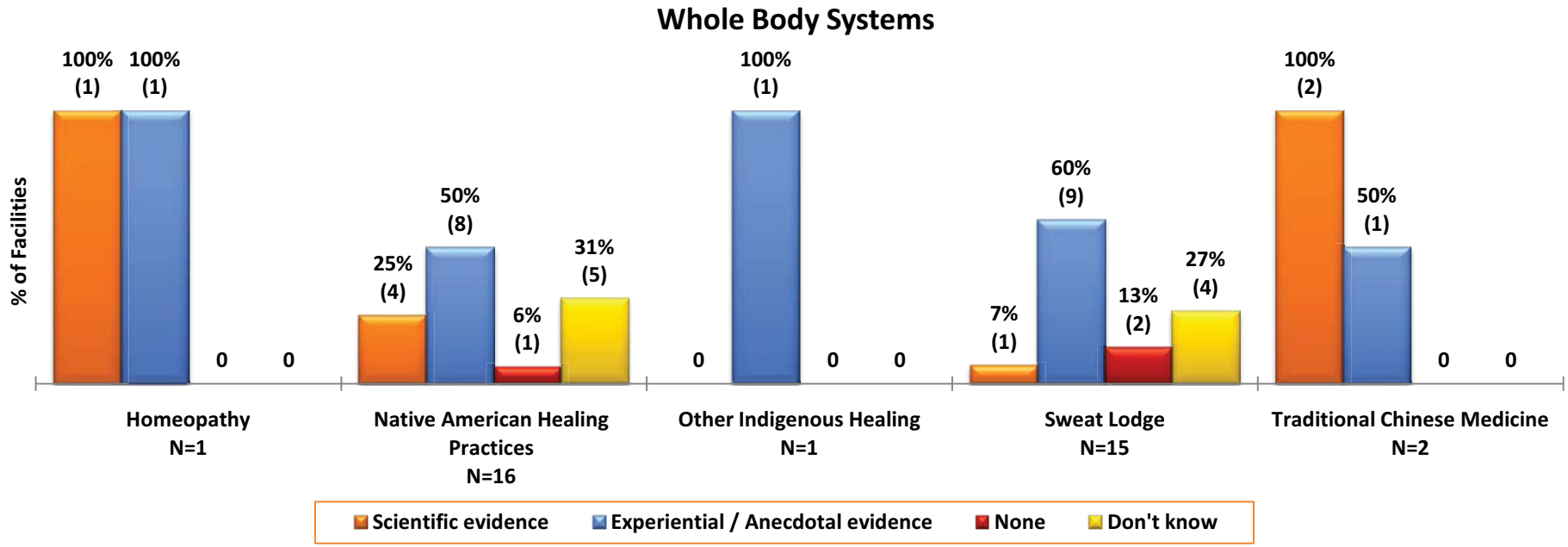
Figure 28



Whole Body Systems

With the exception of TCM, anecdotal / experiential evidence forms the primary support for the use of whole body systems modalities. "None" and "Don't Know" responses exceed the levels of scientific evidence supporting the use of Native American healing practices and Sweat Lodge. (See Figure 29 below.)

Figure 29



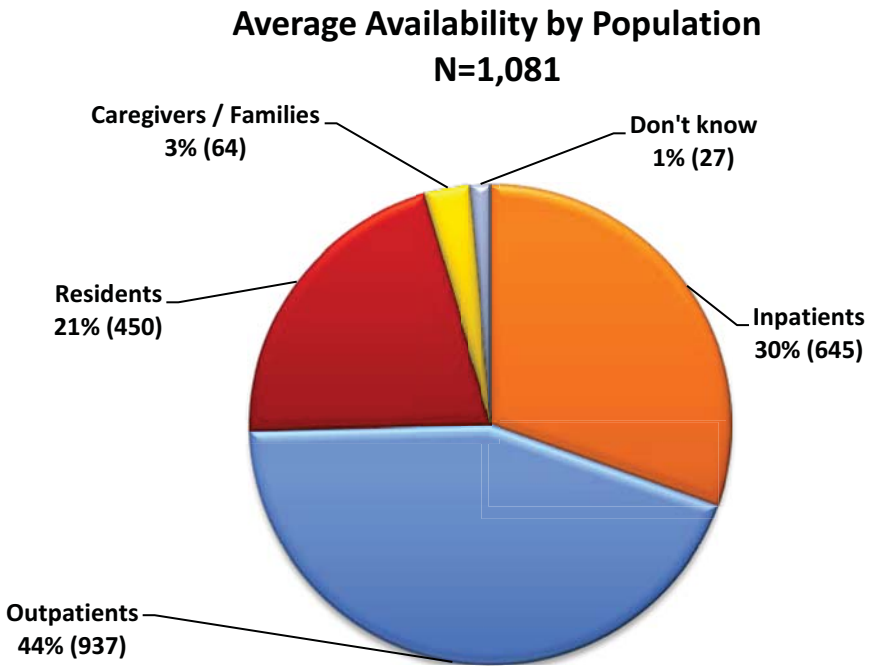
Conclusions

Few facilities reported using modalities with no evidence to support their deployment, although some (Sweat Lodge and Energy Healing in particular) were outliers that demonstrated lower levels of evidence-based usage. The survey allowed facilities to select more than one type of evidence as support for each CAM offered. The resulting overlap in responses between scientific and experiential / anecdotal could range from a minimum of 30 percent to a maximum of 72 percent. The overlap suggests that a significant number of facilities reported only one of the types of evidence in support of each modality. Overall, the responses suggest that the majority of CAM usage at the VA is supported by some form of evidence.

Patient Population

The pie chart below (Figure 30) represents the distribution of the types of population served by facilities across all CAM modalities. Facilities were allowed to select more than one response, so the total number of responses is 1,081. Due to rounding, the percentages do not add to 100 percent. The survey did not specify whether "Residents" were living in Residential Rehabilitation, Community Living Centers, or other residential facilities. CAM modalities are offered to outpatients most frequently, followed by inpatients, residents, then caregivers / families.

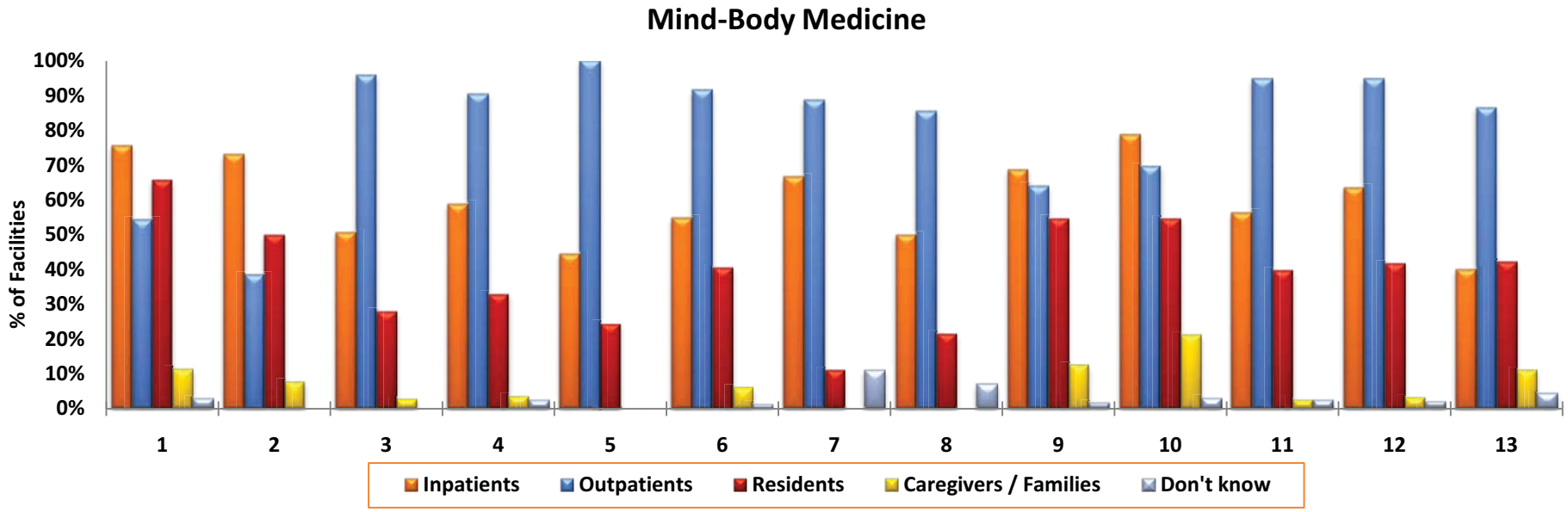
Figure 30



Mind-Body Medicine

Of those facilities offering mind-Body Medicine, several of the modalities are offered more frequently to outpatients than to any other population as depicted in Figure 31 below. They include: biofeedback (96% of facilities), guided imagery (91%), hypnosis / hypnotherapy (100%), mindfulness meditation (92%), transcendental meditation (89%), mantram repetition (86%), progressive muscle relaxation (95%), stress management / relaxation therapy (95%), and yoga (87%). The CAM modalities that are most frequently offered to inpatients include: animal assisted therapy (78%), aromatherapy (73%), music therapy (69%), and non-traditional spiritual practices (79%). Though at a much lower percentage, caregivers are offered the opportunity to participate in some CAM modalities, including non-traditional spiritual practices (21%), music therapy (13%), yoga (11%), and animal-assisted therapy (11%). (See Appendix G, Table G-5 for details.)

Figure 31

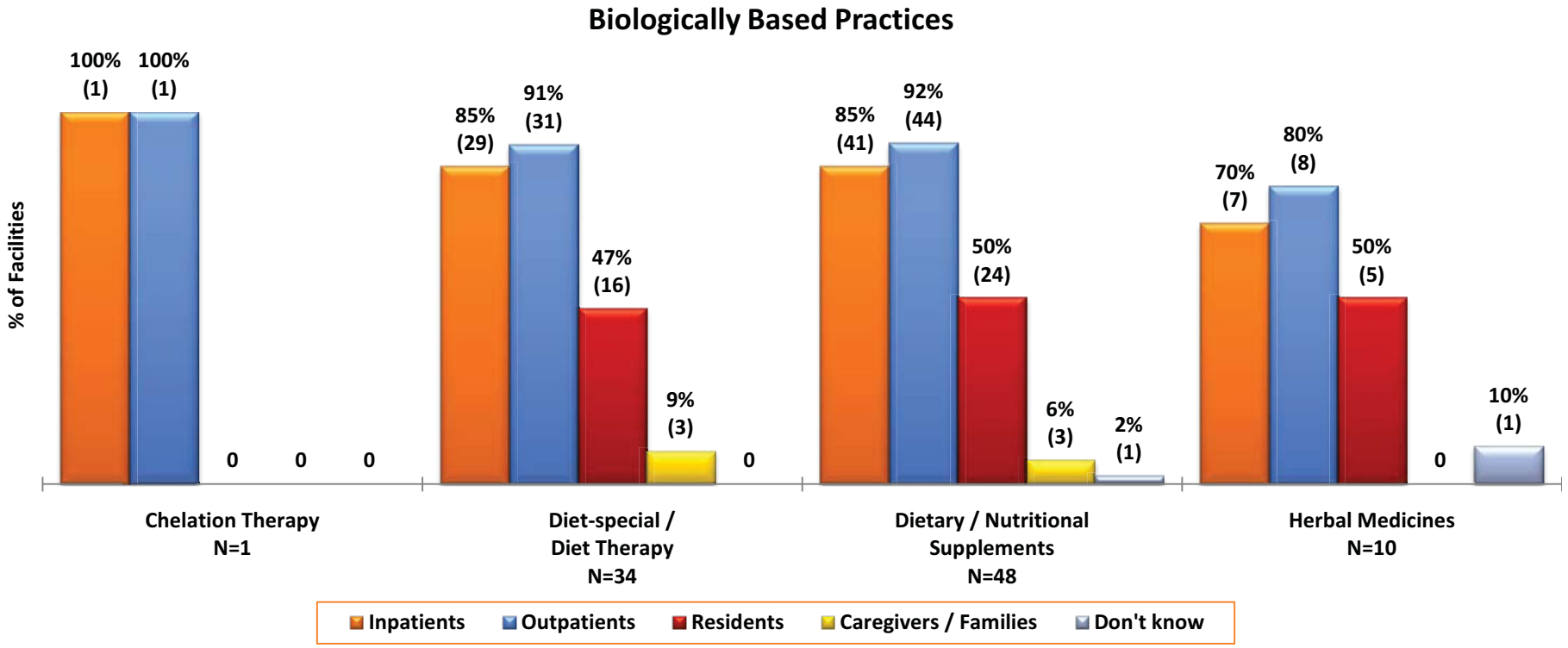


1. Animal Assisted Therapy (N=70)
2. Aromatherapy (N=26)
3. Biofeedback (N=75)
4. Guided Imagery (N=85)
5. Hypnosis / Hypnotherapy (N=45)
6. Mindfulness (N=84)
7. Transcendental Meditation (N=9)
8. Mantram Repetition (N=14)
9. Music Therapy (N=64)
10. Non-traditional Spiritual Practices (N=33)
11. Progressive Muscle Relaxation (N=78)
12. Stress Management / Relaxation Therapy (N=96)
13. Yoga (N=45)

Biologically Based Practices

As with mind-body medicine, biologically-based practices are most frequently offered to outpatients, followed by inpatients, residents, and caregivers / families. The relative availability of biologically based practices to inpatients versus outpatients is higher than any other NCCAM category. The figure below (Figure 32) displays the percentage of facilities offering each modality to each population.

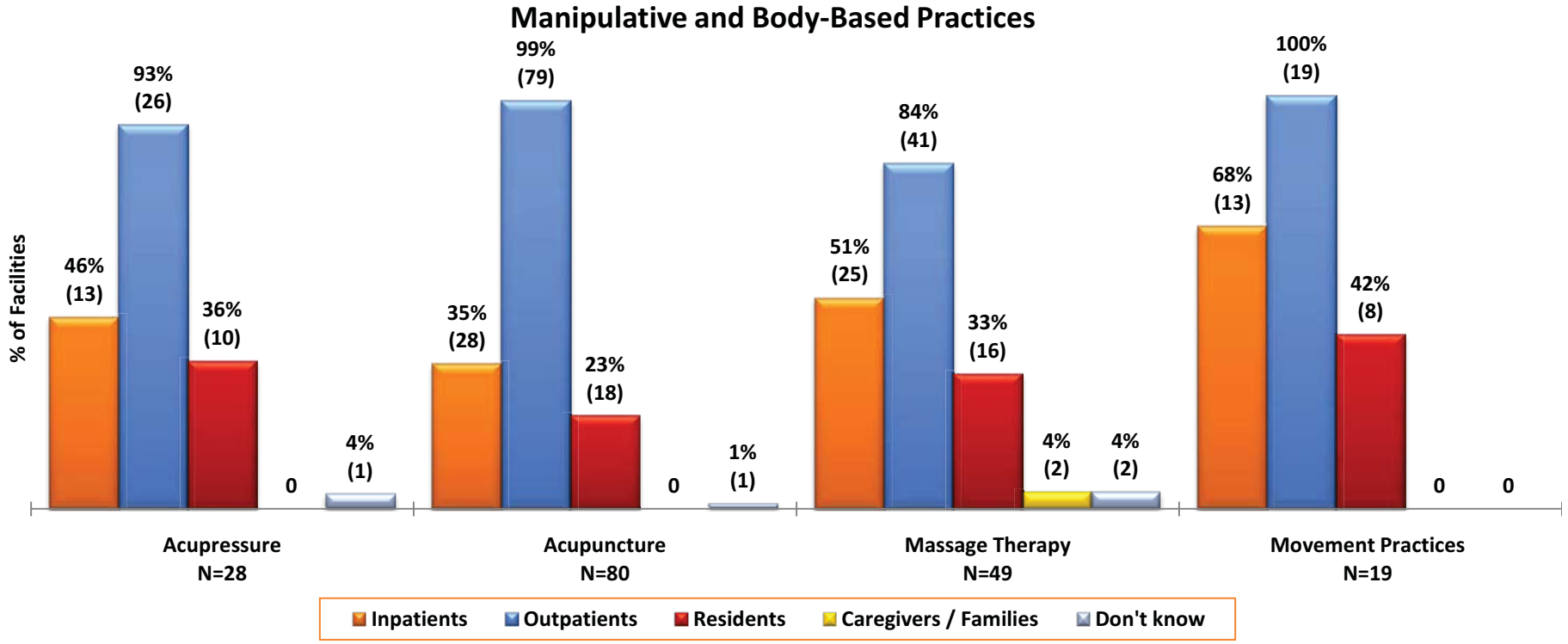
Figure 32



Manipulative and Body-Based Practices

Manipulative and body-based practices are offered to outpatients in a relatively larger proportion than all other NCCAM categories. (See Figure 33 below.)

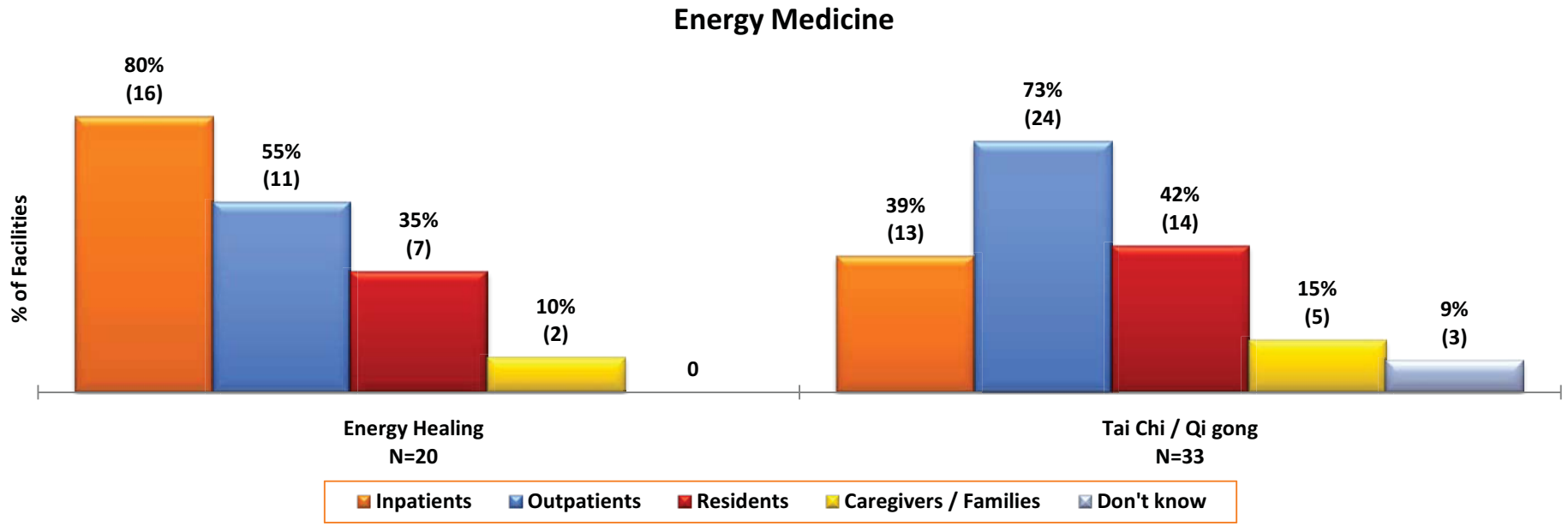
Figure 33



Energy Medicine

Energy healing, a provider-driven CAM modality, is offered to inpatients more often than outpatients, or others, as opposed to the self-directed CAM modality Tai Chi / Qi gong. Tai Chi / Qi gong is offered to outpatients at nearly twice as many facilities than inpatients or residents. (See Figure 34 below.)

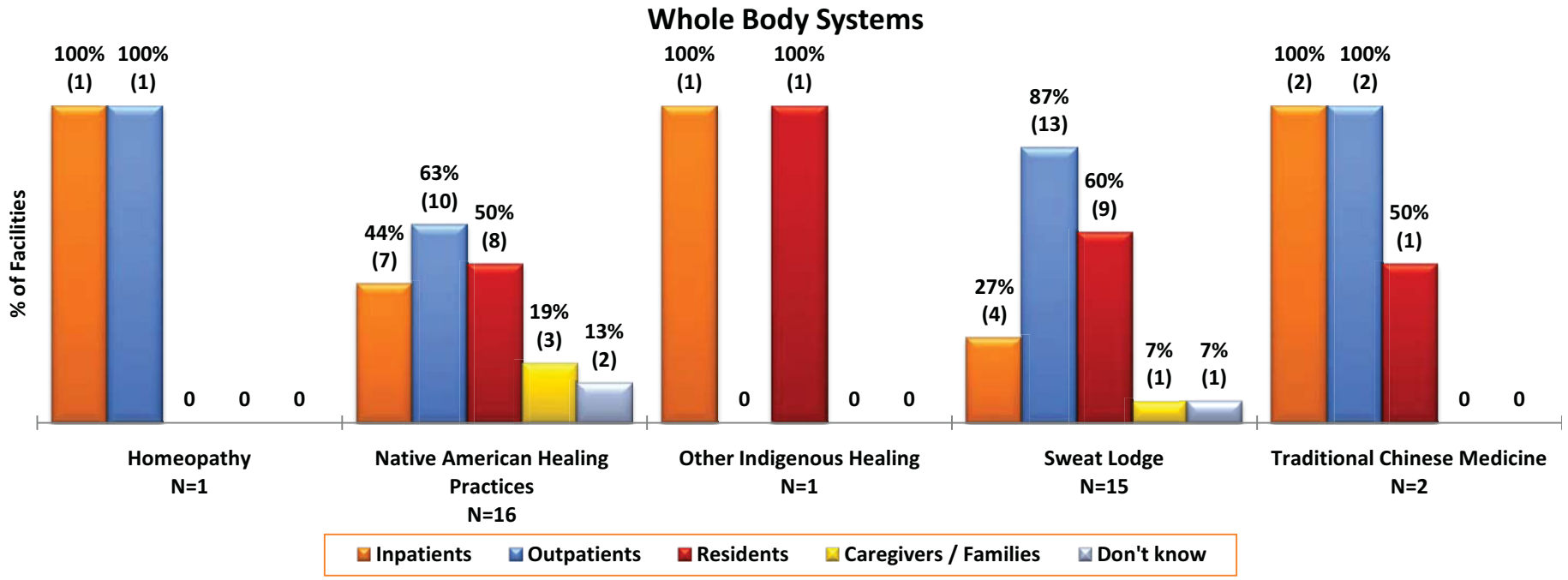
Figure 34



Whole Body Systems

Overall, whole body system CAM modalities are offered less frequently (small N), so quantitative analysis is not possible. The figure below (Figure 35), however, depicts Native American Healing Practices and Sweat Lodge are offered most frequently to outpatients, following the general trend of most CAM modalities.

Figure 35



Conclusions

Overall, CAM modalities are offered more frequently in outpatient rather than other settings, though they appear to be well represented in all clinical arenas.

Relative use of Modalities (Volume)

Facilities were most likely to estimate that they provided a given CAM modality to 21-200 patients per year (57% of modalities offered), and least likely to estimate they provided a CAM modality to fewer than 20 patients per year (16%) as shown in the Figure 36 below. More than a quarter of CAM modalities offered were estimated to be provided to more than 200 patients (27%). CAM modalities differed in both the volume of patients treated with the modality and in their likelihood of being offered at the facility. Generally, the more facilities that offered a CAM modality the greater the number of patients who would receive that modality.

Figure 36

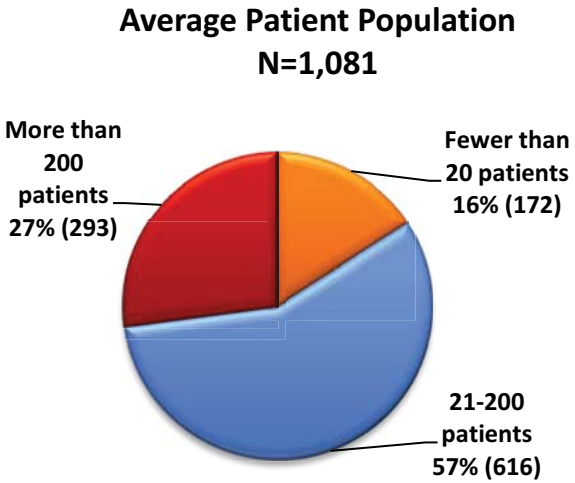


Figure 37

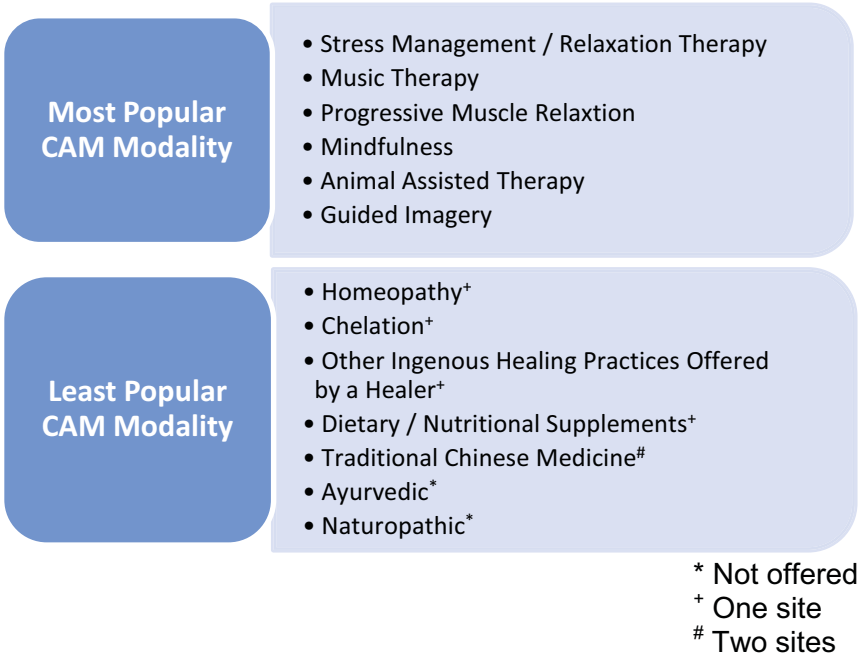
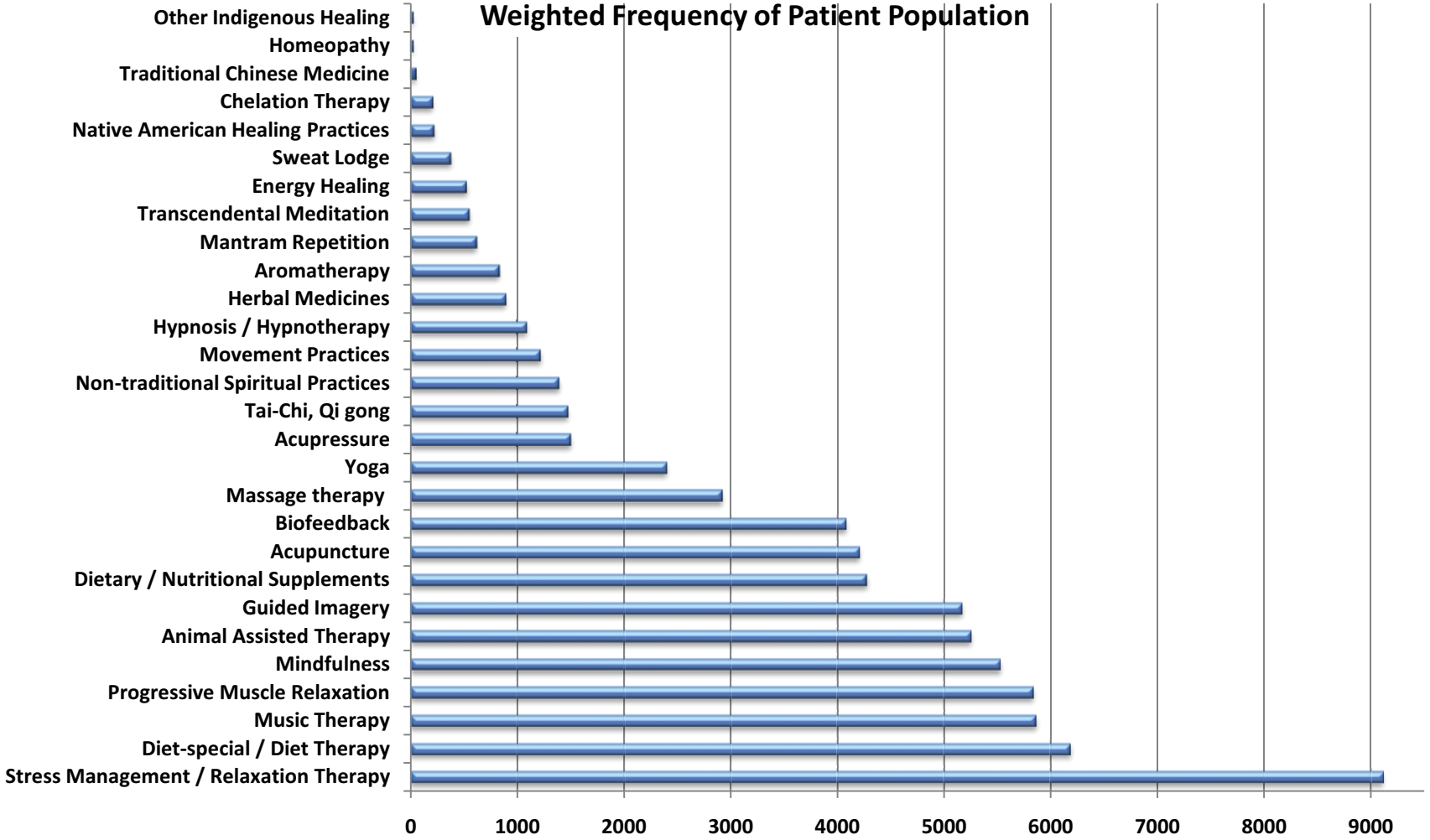


Figure 38 below represents the overall patient volume extrapolated from the weighted response to the number of patients participating in each CAM modality multiplied by the number of facilities providing that modality. Based on the weighted frequency, stress management relaxation therapy was offered to the most patients within VHA, followed by dietary / nutritional supplements, music therapy, progressive muscle relaxation, and mindfulness. The CAM modalities offered to the fewest patients were: other indigenous healing, homeopathy, Traditional Chinese Medicine, chelation therapy, and Native American healing practices.

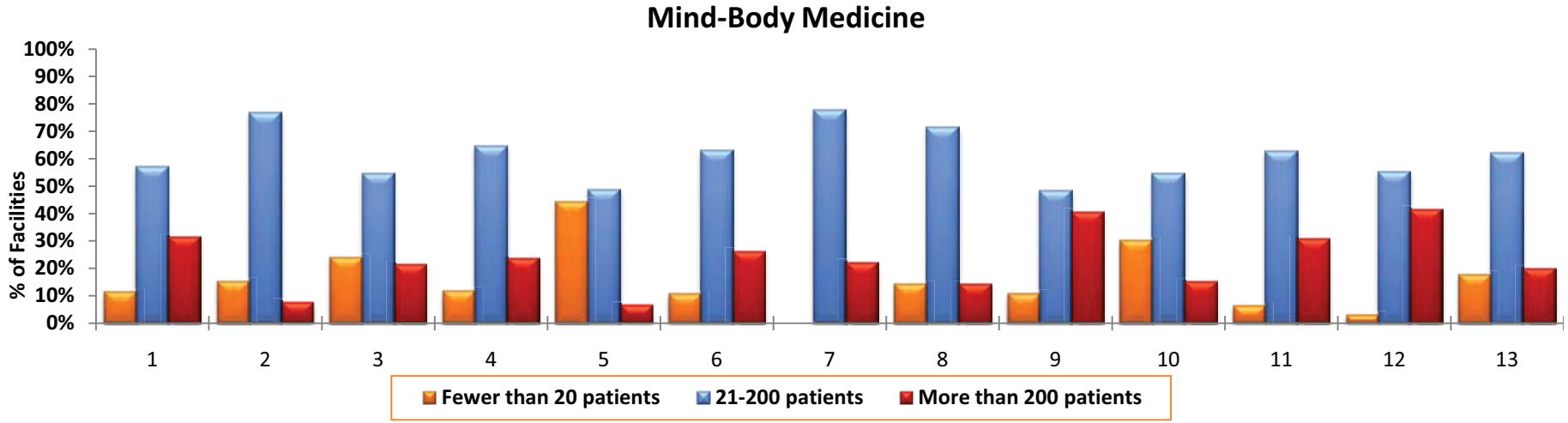
Figure 38



Within the 13 modalities in the mind-body medicine cluster (Figure 39 below) more than half of VA facilities offered stress management / relaxation therapy, guided imagery, mindfulness, progressive muscle relaxation, and biofeedback. (See Appendix G, Table G-6 for details.) At facilities where these treatments were offered, between 21 and 42 percent of facilities estimated they provided these treatments to more than 200 patients a year. With the exception of biofeedback, nearly 90 percent of facilities that offered these modalities treated more than 20 patients with this modality.

Notably, these higher prevalence, higher volume CAM modalities all represent therapies that have been either incorporated into manualized psychotherapy protocols or studied in combination with manualized psychotherapies in clinical trials for pain, anxiety or other disorders. Protocols for use of these CAM modalities in combination with evidence-based psychotherapies may facilitate their uptake and implementation by psychologists or other mental health providers. Animal assisted therapy and music therapy demonstrate a similar pattern of prevalence, but are not manualized into protocols.

Figure 39

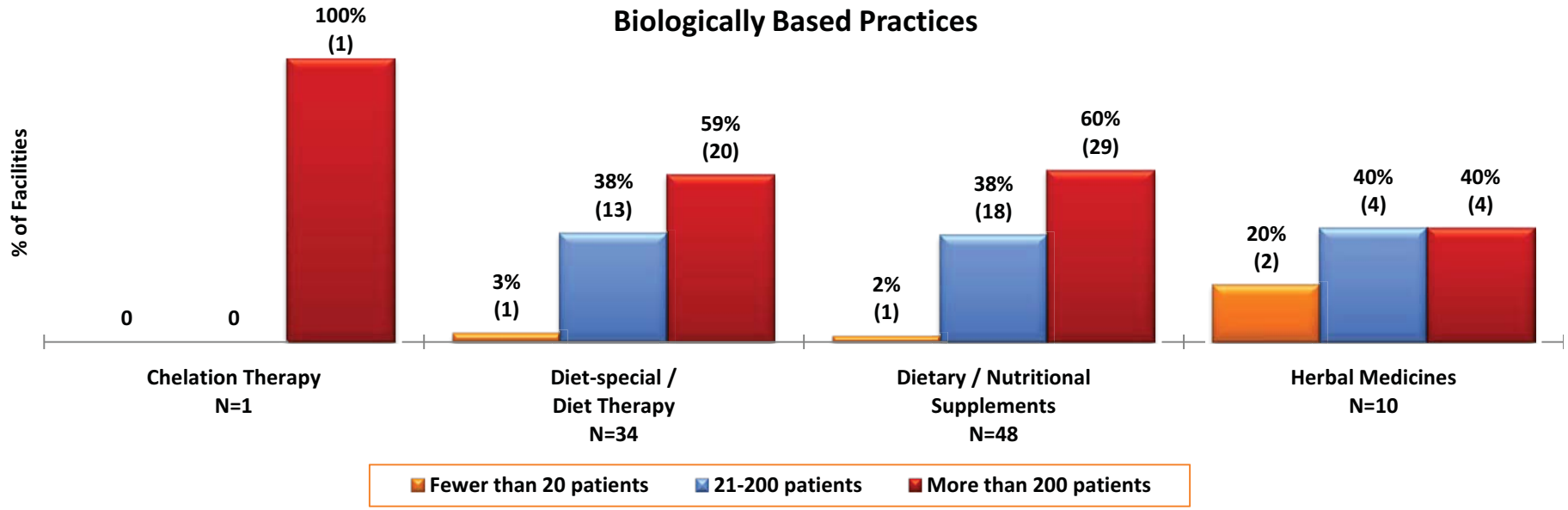


1. Animal Assisted Therapy (N=70)
2. Aromatherapy (N=26)
3. Biofeedback (N=75)
4. Guided Imagery (N=85)
5. Hypnosis / Hypnotherapy (N=45)
6. Mindfulness (N=84)
7. Transcendental Meditation (N=9)
8. Mantram Repetition (N=14)
9. Music Therapy (N=64)
10. Non-traditional Spiritual Practices (N=33)
11. Progressive Muscle Relaxation (N=78)
12. Stress Management / Relaxation Therapy (N=96)
13. Yoga (N=45)

Biologically Based practices

Dietary / nutritional supplements and diet-special / diet therapy were offered at 34 percent and 24 percent of facilities, respectively (Figure 40 below). For both of these CAM modalities, 60 percent of facilities reported that they provided the service to more than 200 patients a year, and all facilities but one reported that they provided them to more than 20 patients a year.

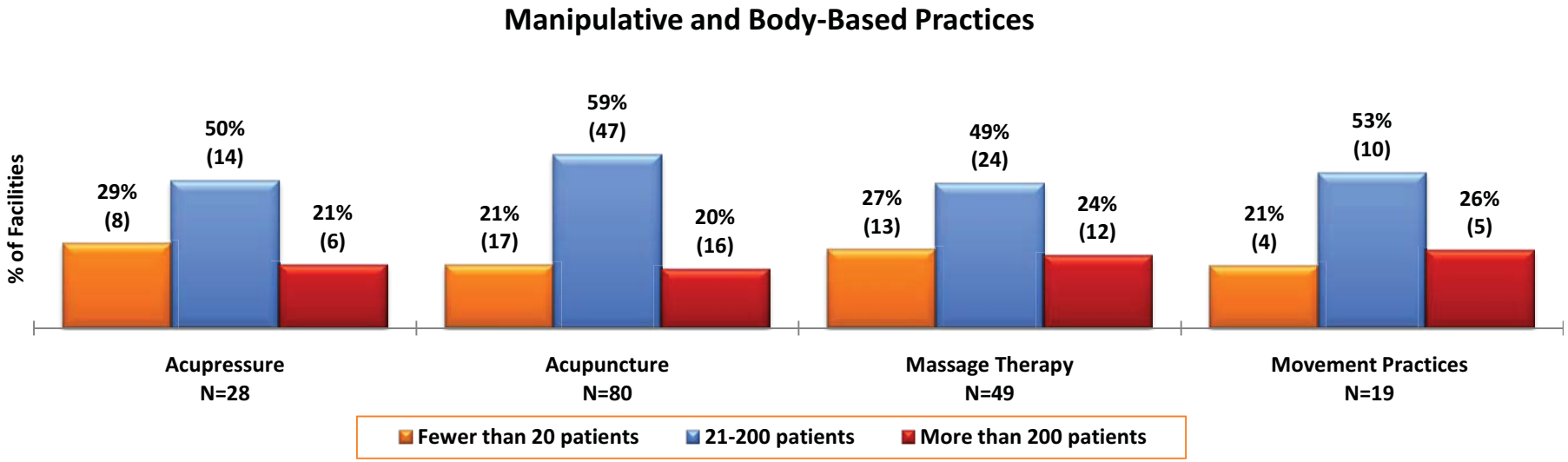
Figure 40



Manipulative and Body-Based practices

Acupuncture was the most widely reported manipulative and body-based CAM modality (57% of facilities) (Figure 41 below). Of the facilities that offered any of the four manipulative and body-based practices, between 20 and 26 percent reported that they provided this service to more than 200 patients a year and between 71 and 79 percent reported they provided it to more than 20 patients a year.

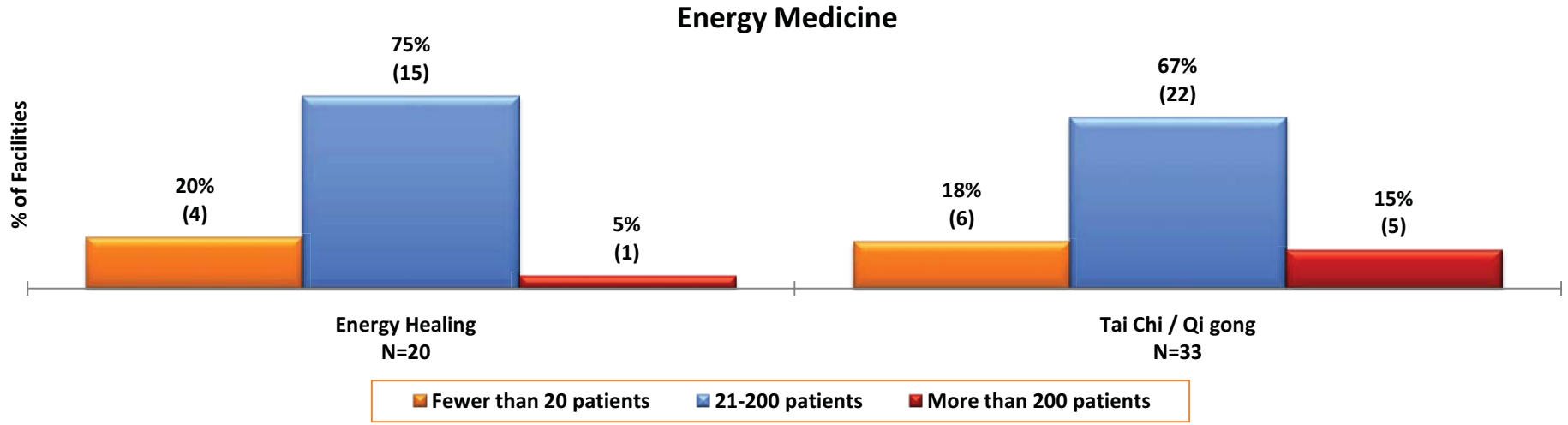
Figure 41



Energy Medicine

Tai-chi, Qi gong was offered at 23 percent of facilities, but primarily to 20-200 patients at these facilities. These modalities were rarely estimated to be provided to more than 200 patients (Figure 42 below). This was also true for energy healing, offered at 14 percent of facilities.

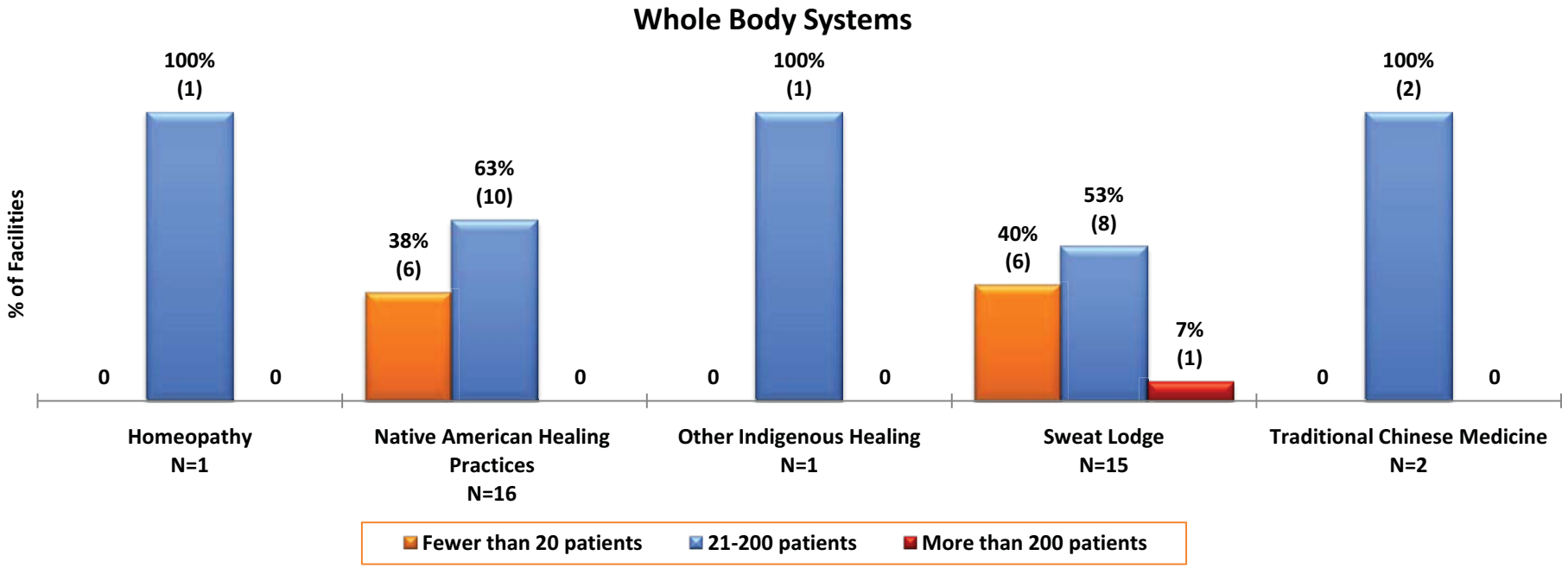
Figure 42



Whole Body Systems

All whole body system CAM modalities were offered rarely at VA facilities (Figure 43 below). The most commonly available modalities were Native American healing practices and sweat lodges (11% of all 141 facilities), and virtually all facilities that provided these estimated that they provided them to either 21-200 patients or fewer than 20 patients.

Figure 43



Conclusions

Seven CAM modalities were offered at more than half of VA facilities, and all but one (acupuncture) were in the mind-body medicine cluster. It was common for facilities offering these modalities to estimate that they provided the modality to more than 200 patients. A total of 15 CAM modalities were provided at 20 percent or fewer of all VA facilities, including modalities from all five clusters. (See Appendix G, Table G-6 for details). However, while these treatments were not commonly provided at VA facilities, some were provided to large numbers of patients at the rare VA facility that offered them. Fifteen facilities reported 11 high volume CAM modalities, indicated by more than 200 patients a year being treated with it. These 11 modalities were acupressure, aromatherapy, energy healing, movement practices, Native American healing practices, sweat lodge, mantram repetition, herbal medicine, transcendental meditation, traditional Chinese medicine, chelation therapy, homeopathy, and other indigenous healing (four of the five CAM modalities in the whole body systems cluster were rarely used). For

example, a single facility offered energy healing, sweat lodge and chelation therapy to more than 200 patients; two facilities each offered mantram repetition and transcendental meditation to more than 200 patients; four facilities each offered herbal therapy to more than 200 patients, and five facilities offered movement practices to more than 200 patients. Similarly, there were eight CAM modalities that were offered at a moderate number of facilities (21-50%) and all had multiple facilities that estimated more than 200 patients a year were treated with the modality: music therapy, massage therapy, dietary / nutritional supplements, hypnosis / hypnotherapy, yoga, diet therapy, non-traditional spiritual practices, and Tai Chi / Qi gong. This suggests that VA does have model facilities where each of these therapies has been incorporated into regular use. These sites might provide opportunities to study the risks and benefits of these treatments for VA patients.

Coding and Documentation

On the survey there were two questions that investigated the extent to which CAM modalities were being documented in the medical record and in workload analyses conducted by VA (See question l. and m.; Appendix A; page A-6.)

Not all CAM modalities have specific procedure codes available for documenting care delivery. While there are a number of non-specific procedure codes that might be used to code CAM activities (e.g. CPT code 97150 ("Therapeutic procedure(s), group [2 or more individuals]"), there are specific procedure codes to indicate delivery of a number of CAM modalities. These procedure codes are of 3 types: 1) CPT codes, which can only be used by licensed providers in outpatient settings, 2) HCPCS Level II Codes which can be used by both licensed and non-licensed providers in outpatient settings, and 3) ICD-9 procedure codes, which can be used in inpatient settings. These CAM specific codes are indicated in Tables 2-4. Some of these treatments may also be documented through pharmacy orders, and VA Drug Class HA000, "Herbs / alternative therapies" may also provide information in VA administrative datasets about delivery of some CAM treatments.

Table 2. CAM activities captured in CPT codes

NCCAM domain	CAM activity	CPT code & summary of definition
Mind body medicine	Biofeedback	90901, 90911, 90875, 90876 Individual **biofeedback** training by any modality, with or without psychotherapy, ranging from 20 to 50 minutes.
Mind body medicine	Hypnotherapy	90880 **Hypnotherapy**
Manipulative & body based practices	Massage	97124 15 minutes increments of **massage**, including stroking, compression, percussion
Manipulative & body based practices	Acupuncture	97810, 97811, 97813, 97814 15 minute increments of **Acupuncture** involving 1 or more needles, with or without electrical stimulation

Source: American Medical Association - 2010 Current Procedural Terminology (CPT): Professional Edition

Table 3. HCPCS Level II Codes for CAM Services

NCCAM domain	HCPCS Code	Meaning
Mind body medicine	G0176 H2032	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) Activity Therapy, Per 15 Minutes
Manipulative & body based practices	S8940	Equestrian / hippotherapy, per session
Mind body medicine	S9454	Stress management classes, non-physician provider, per session
Mind body medicine	S9900	Services by authorized Christian Science practitioner for the process of healing, per diem; not to be used for rest or study; excludes in-patient services

Table 4. CAM procedures captured in ICD-9 codes

NCCAM domain	Code and procedure	CAM activity defined in the code
Manipulative and body based practices	99.92 Other- acupuncture	
	93.35 Other- heat therapy	Acupuncture with smoldering moxa, Moxibustion
Mind body medicine	93.81 Recreation therapy	Play therapy
Mind body medicine	93.84 Music therapy	
Mind body medicine	94.32 Hypnotherapy	Hypnosis
Mind body medicine	94.33 Behavior therapy	Relaxation training
Mind body medicine	94.39 Other individual psychotherapy	Biofeedback

Averaged across modalities, 73 percent of CAM care is reported to be documented in progress notes in the medical record (Figure 44 below). Substantially less, 40 percent, is documented using a procedure code which would allow this care to be detected via workload analyses and VA databases (Figure 45 below). The likelihood that a given CAM modality is documented – either in progress notes or with a procedure code – varies substantially.

Figure 44

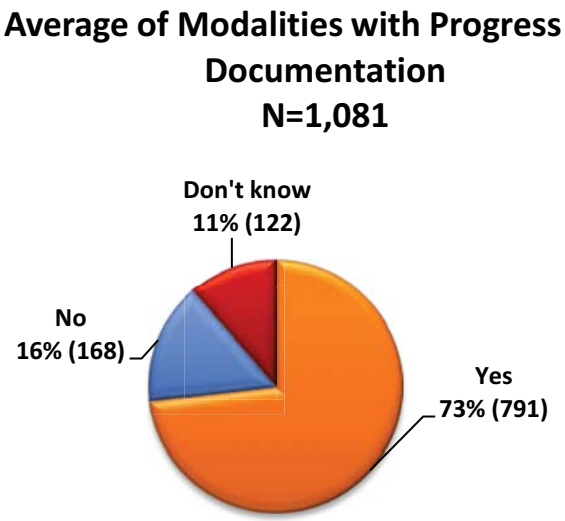
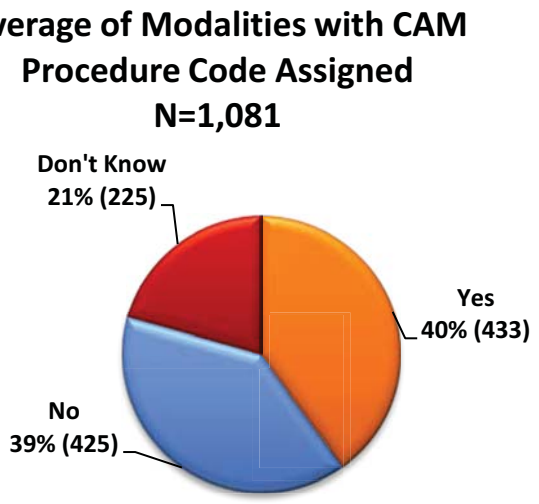


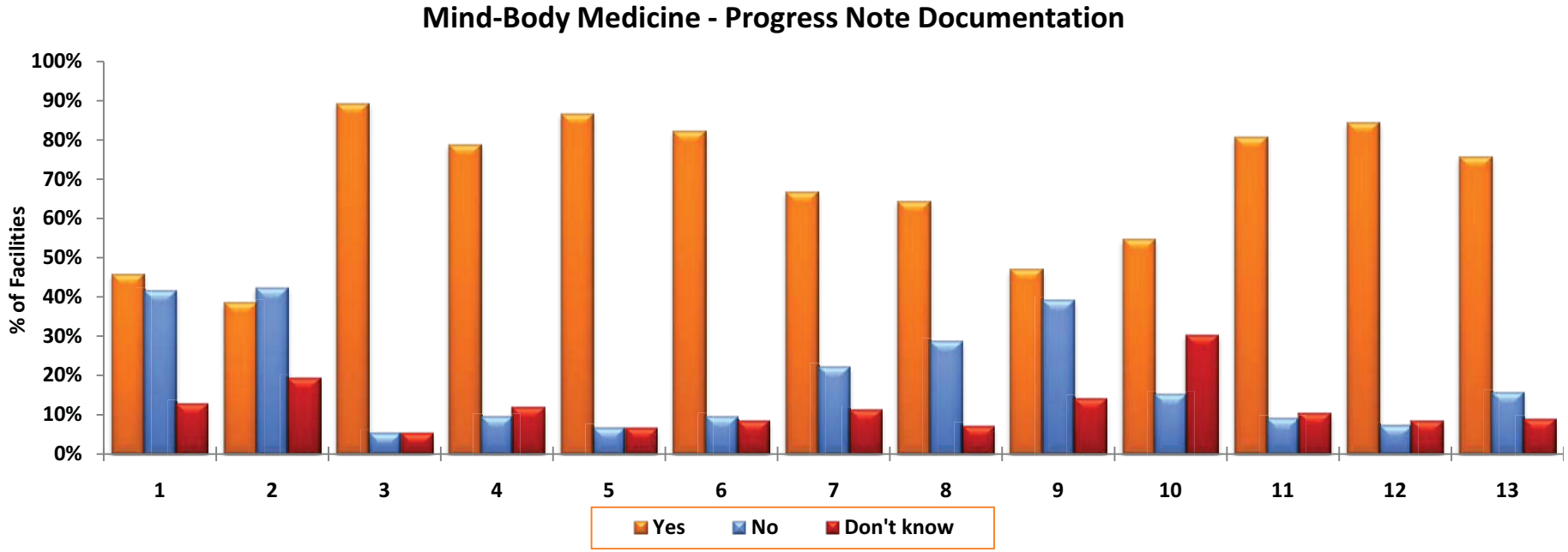
Figure 45



Mind-Body Medicine

Among CAM modalities in this domain, animal assisted therapy, aromatherapy, and music therapy were frequently not documented in progress notes in the medical record (Figure 46 below). Non-traditional spiritual practices, mantram repetition, and transcendental meditation were offered at relatively few facilities and documented at only moderate rates. In contrast, other modalities (particularly those that have been adopted by psychology) including hypnosis / hypnotherapy, biofeedback, and stress management were all reported to be documented in progress notes by more than 80 percent of programs offering them. (See Appendix G, Table G-7 for details.)

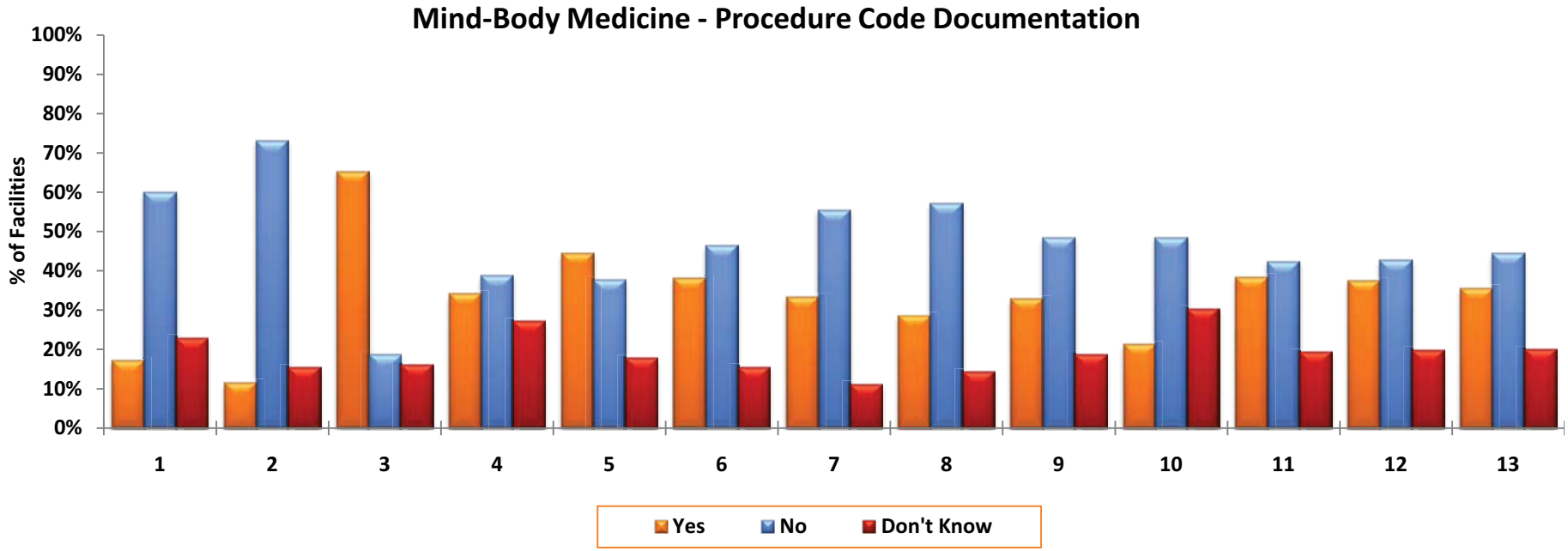
Figure 46



1. Animal Assisted Therapy (N=70)
2. Aromatherapy (N=26)
3. Biofeedback (N=75)
4. Guided Imagery (N=85)
5. Hypnosis / Hypnotherapy (N=45)
6. Mindfulness (N=84)
7. Transcendental Meditation (N=9)
8. Mantram Repetition (N=14)
9. Music Therapy (N=64)
10. Non-traditional Spiritual Practices (N=33)
11. Progressive Muscle Relaxation (N=78)
12. Stress Management / Relaxation Therapy (N=96)
13. Yoga (N=45)

All modalities in this cluster were much less likely to be coded with a procedure code than documented in a progress note. The most likely modality to receive a procedure code was biofeedback at 65 percent. At least one facility that offered each modality did report that they assigned a procedure code to encounters of that modality (Figure 47 below). This is interesting given that specific procedure codes only exist for biofeedback, hypnosis / hypnotherapy, music therapy, and stress management. (See Appendix G, Table G-8 for details.)

Figure 47



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9. Music Therapy (N=64)
10. Non-traditional Spiritual Practices (N=33)
11. Progressive Muscle Relaxation (N=78)
12. Stress Management / Relaxation Therapy (N=96)
13. Yoga (N=45)

Biologically Based Practices

Among the three primary CAM modalities in this domain, the majority of facilities that offered them reported that they documented the modality in a progress note (Figure 48 below), but only approximately half or fewer of the facilities reported assigning a procedure code to these encounters (Figure 49 below). The most widely offered modality, dietary / nutritional supplements, was the least likely to be documented or to have a procedure code assigned.

Figure 48

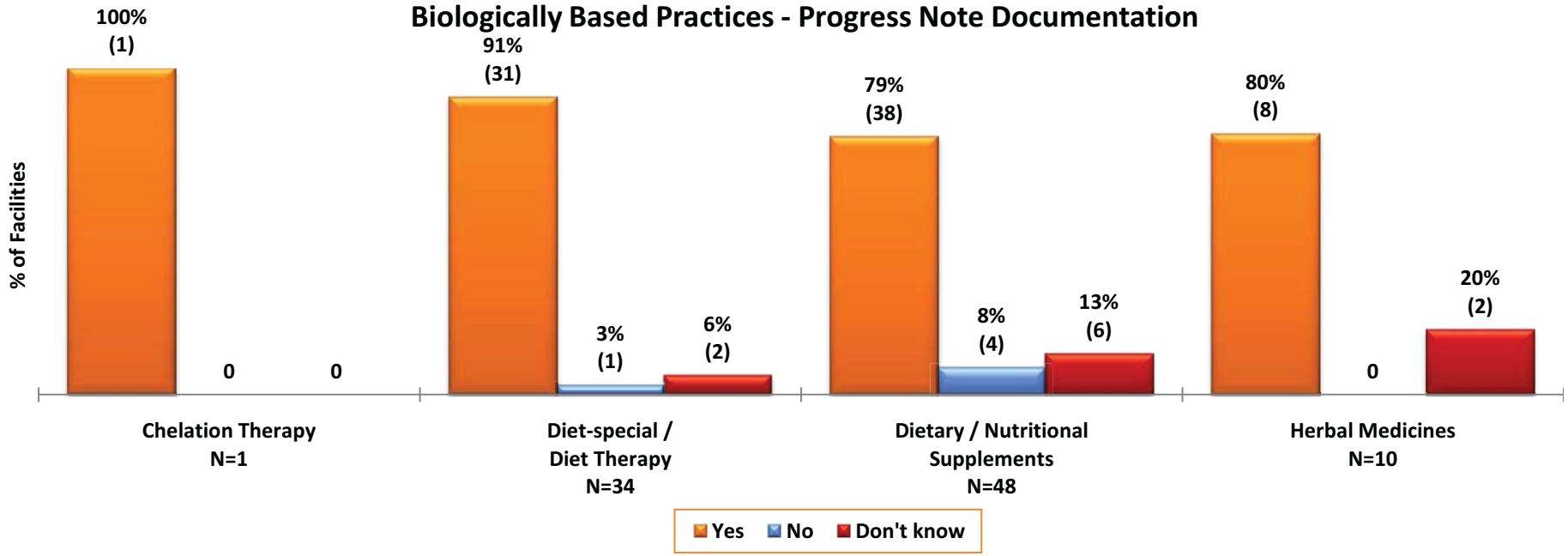
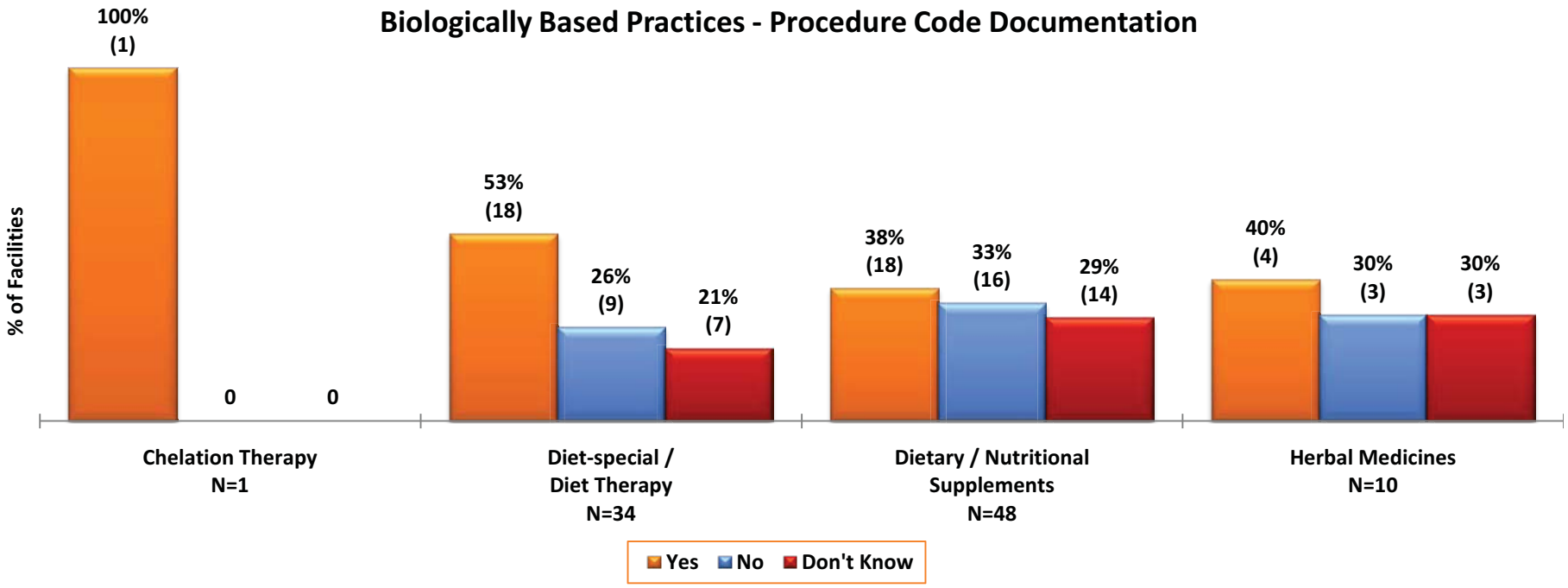


Figure 49


Biologically Based Practices - Procedure Code Documentation
% of Facilities
100% (1)
0
0
53% (18)
26% (9)
21% (7)
38% (18)
33% (16)
29% (14)
40% (4)
30% (3)
30% (3)
Chelation Therapy N=1
Diet-special / Diet Therapy N=34
Dietary / Nutritional Supplements N=48
Herbal Medicines N=10
Yes
No
Don't Know

Manipulative and Body-Based Practices

The CAM modalities in this domain were all reported to be documented in progress notes at relatively high rates (78% to 95%) (Figure 50 below), but with the exception of acupuncture (74%) only about half of programs reported that a procedure code was assigned to these encounters (Figure 51 below). This low rate of documentation with procedure codes is particularly surprising for massage therapy and to a lesser extent for acupuncture because there are existing procedure codes for both modalities. Data from a VA wide data pull for FY10 indicate that more than 40,000 outpatient encounters were coded using the procedure code for acupuncture and more than 46,000 outpatient encounters were assigned the procedure codes for massage therapy. Among facilities that indicated on this survey that they provided massage therapy (n = 49), 10 had 0-20 encounters with massage therapy codes assigned.

Figure 50

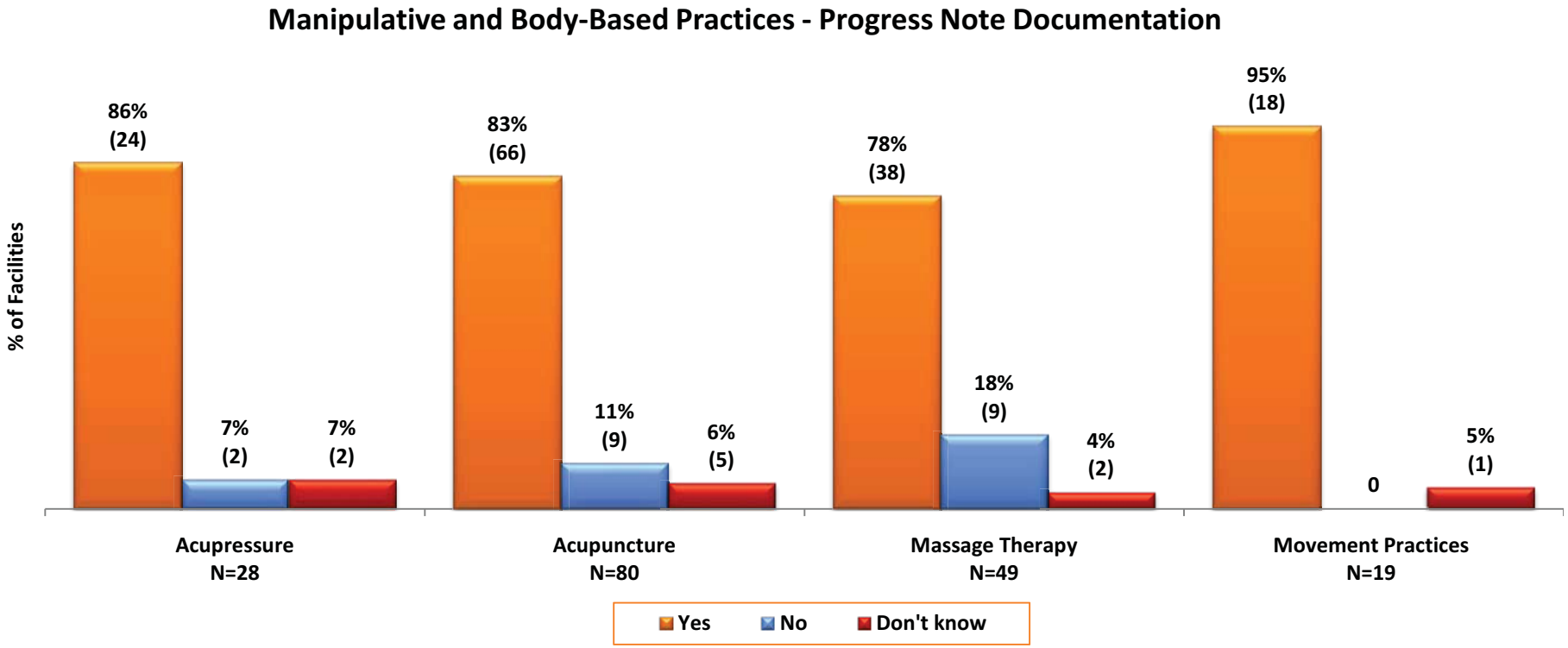
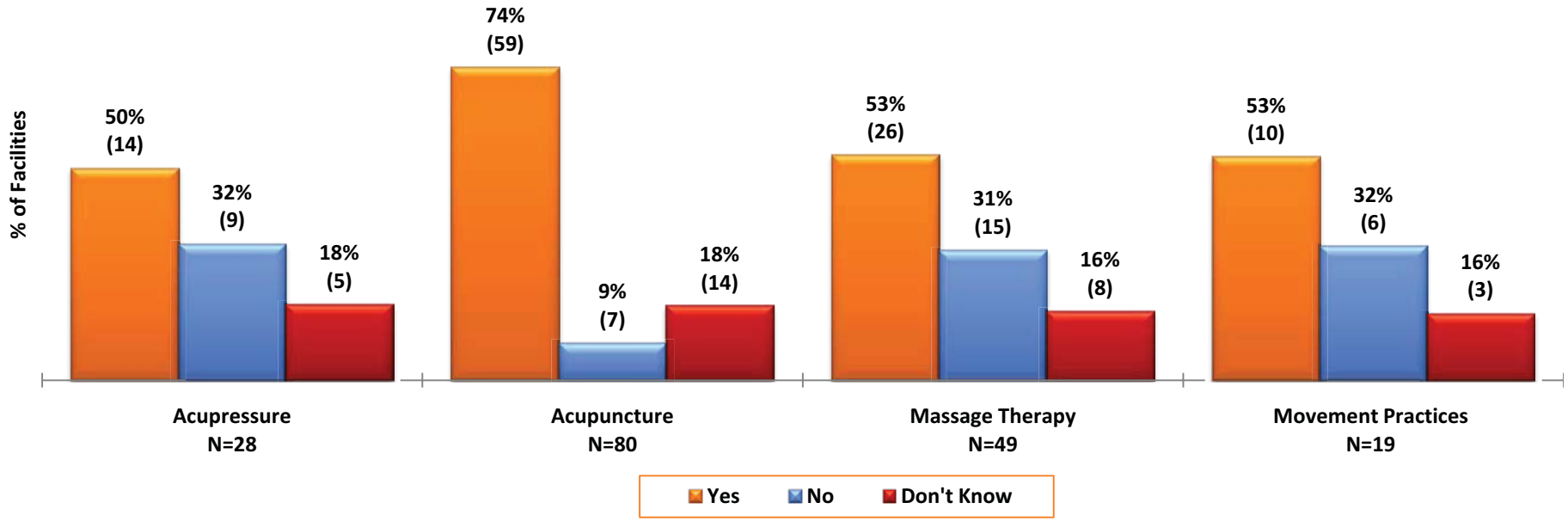


Figure 51

Manipulative and Body-Based Practices - Procedure Code Documentation



Energy Medicine

Of modalities offered at multiple facilities, modalities in this domain were the least likely to be documented either in a progress note (Figure 52 below) or with procedure codes (Figure 53 below). While energy healing was offered at 20 facilities, only 55 percent documented it in a progress note and only 20 percent with a procedure code. Tai Chi / Qi gong were offered at 33 facilities, and 61 percent documented this in a progress note and 42 percent used a procedure code. Again, we do not know what procedure codes these facilities used as there are no specific procedure codes for these modalities in existing procedure coding systems.

Figure 52

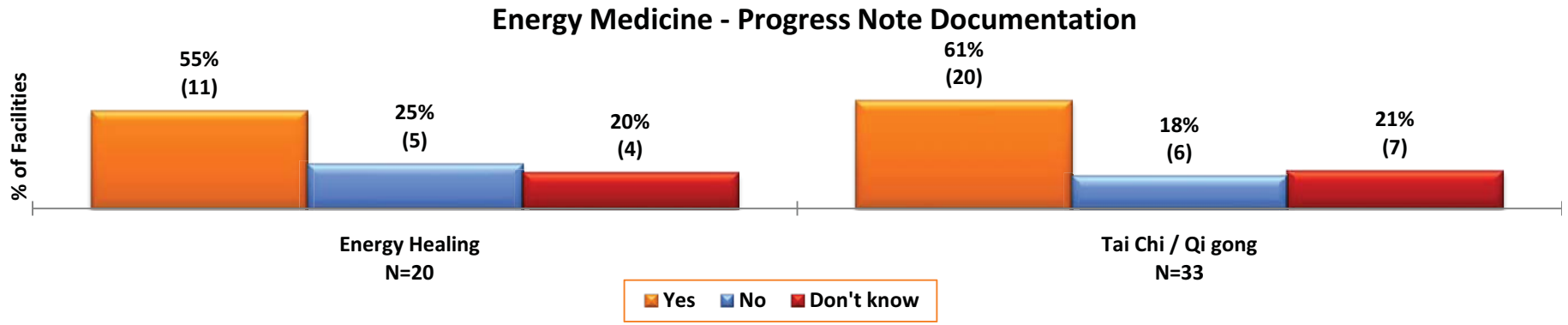
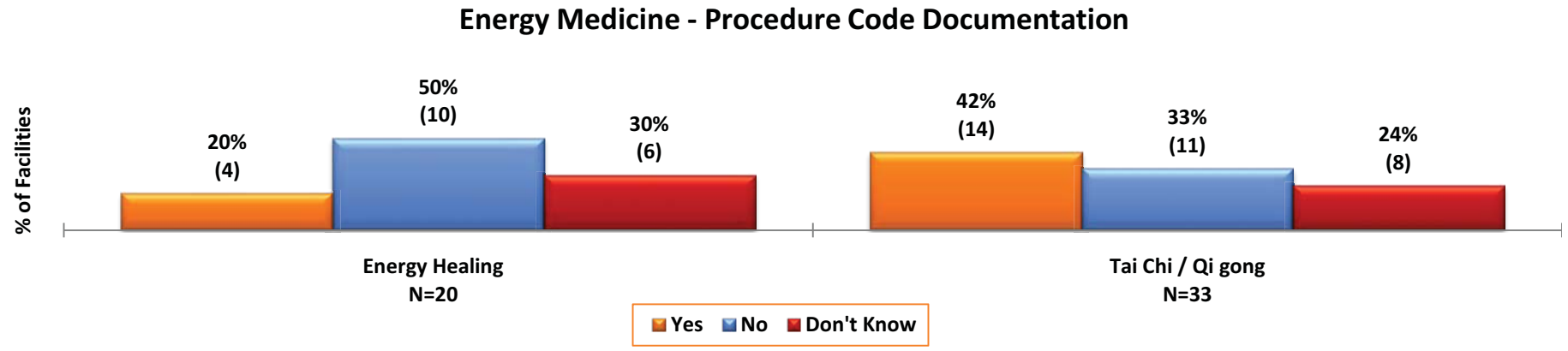


Figure 53



Whole Body Systems

Overall, the CAM modalities in the whole body system domain were the least likely to be offered within the VA. Homeopathy, other indigenous healing, and traditional Chinese medicine were each offered at only 1-2 facilities each and ayurvedic medicine and naturopathy were not offered at any facilities. While the rare facilities that offered these three modalities documented them in progress notes (Figure 54 below), only one program reported documenting traditional Chinese medicine with a procedure code (Figure 55 below). Native American healing practices and sweat lodges were rarely documented in progress notes (25% and 20% respectively) and only one facility offering each modality assigned these encounters a procedure code. Again, no specific procedure codes exist for these modalities.

Figure 54

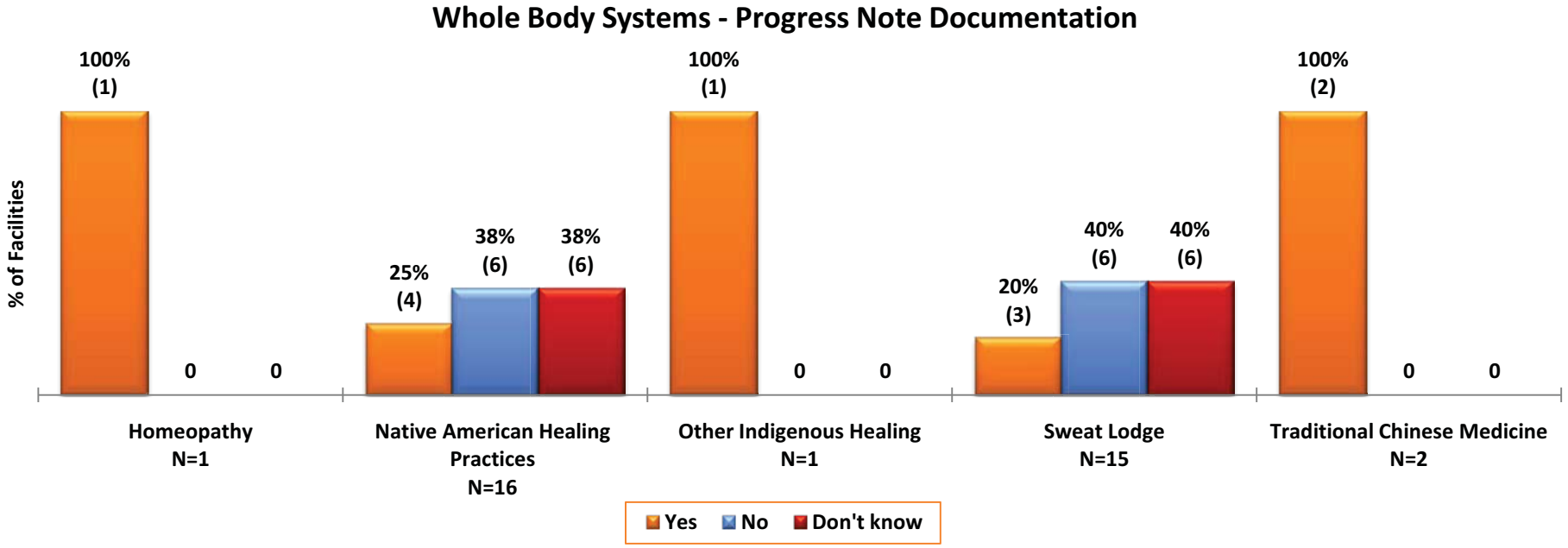
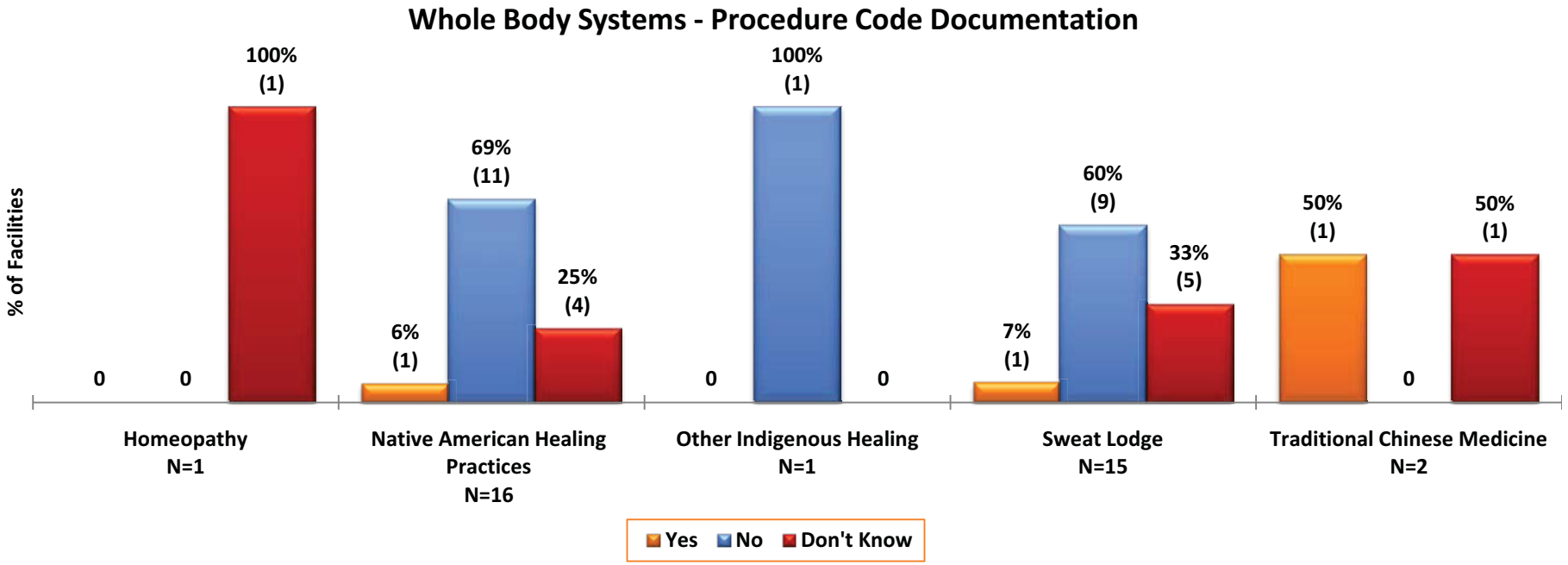


Figure 55



Conclusions

Much of the CAM care delivered in VA is not documented with a procedure code. While 73% of CAM care offered within VA may be documented in a progress note there is great variability between facilities and within CAM categories on how much progress note documentation occurs.

Primary use of Modality

Facilities were asked to identify all the conditions and reasons for offering each CAM modality provided through their facility. The most common conditions treated with CAM modalities in decreasing order of frequency (number of facilities and numbers of modalities) cited were: stress management, anxiety disorders, post-tramatic stress disorder (PTSD), depression, back pain, wellness, headache, arthritis, fibromyalgia, and substance abuse.

The same five modalities (stress management / relaxation therapy (SMRT), mindfulness, guided imagery, progressive muscle relaxation (PMR), and biofeedback) were used to treat four of the top five conditions as shown in Figure 56 below. These modalities were also seen in the fifth most common condition, back pain, with the exception that mindfulness is replaced by acupuncture.

(See Figure 57-61 or Appendix G, Table G-9 for details.)

Figure 56

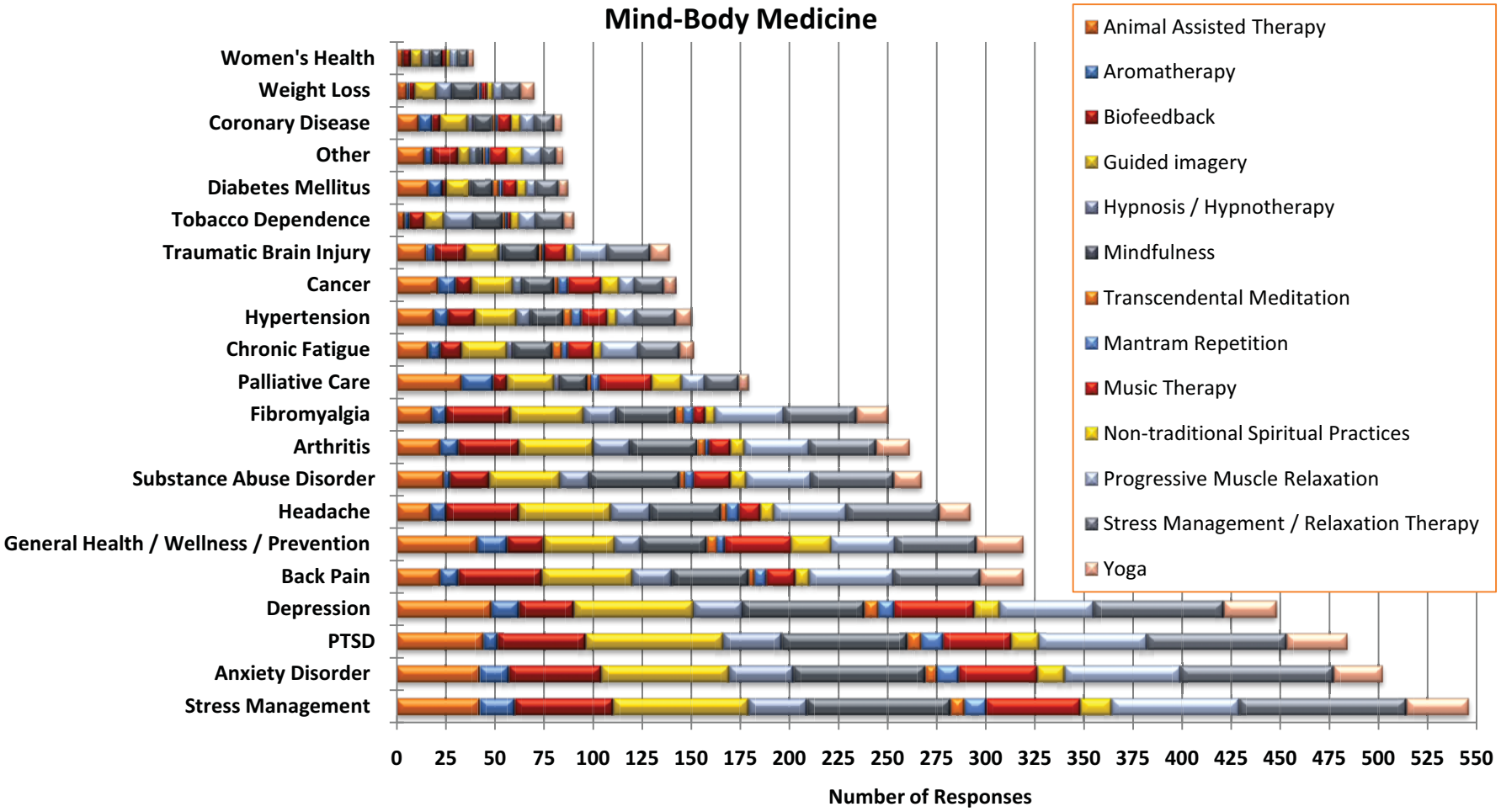
Modality Used to Treat the Most Commonly Treated Conditions

Stress Management	Anxiety	PTSD	Depression	Back Pain
• SMRT - 85	•SMRT - 78	•SMRT - 71	•SMRT - 66	•Acupuncture - 71
• Mindfulness - 73	•Mindfulness - 67	•Guided Imagery - 70	•Mindfulness - 62	•Guided Imagery - 46
• Guided Imagery - 69	•Guided Imagery - 65	•Mindfulness - 64	•Guided Imagery - 61	•SMRT - 44
• PMR - 65	•PMR - 59	•PMR - 55	•PMR - 44	•PMR - 43
• Biofeedback - 50	•Biofeedback - 47	•Biofeedback - 45	•Biofeedback - 41	•Biofeedback - 43

Mind-Body Medicine

Stress management, anxiety disorder, PTSD, and depression were clearly the most frequently reported reasons for offering mind-body medicine modalities (Figure 57 below). The most commonly used modalities used to treat these conditions were SMRT, PMR, biofeedback, guided imagery, and mindfulness. Since these modalities were most frequently offered in facilities, they closely mirror the results across all CAM modalities.

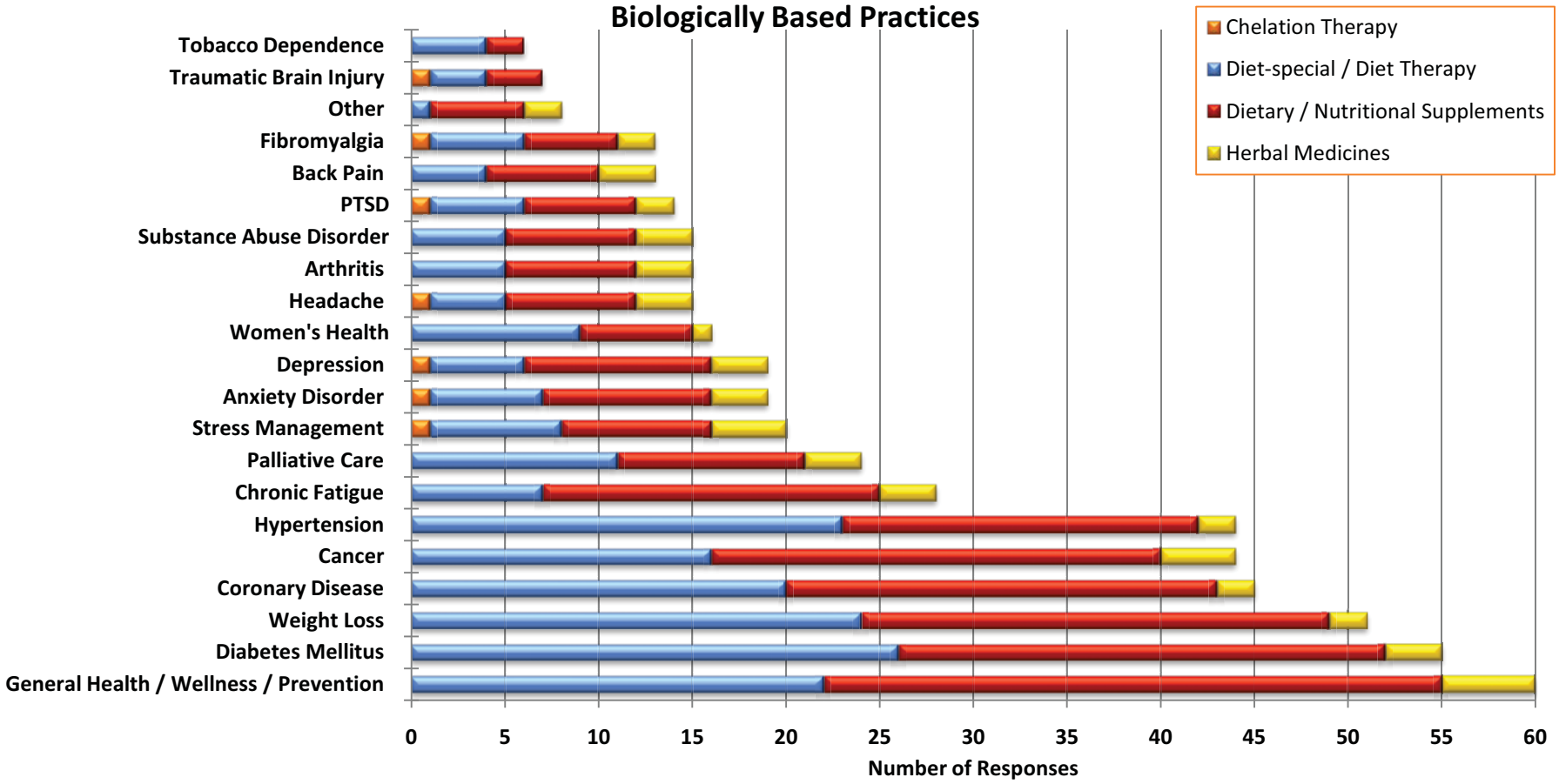
Figure 57



Biologically Based Practices

Diet and nutritional supplements were the primary modalities used in this cluster (Figure 58 below). As might be expected, general wellness, weight loss, and diabetes were the top conditions. The number of responses reflected the sum of facilities and modalities for a given condition. The sum of responses was low compared to mind-body practices. The most popular response in biologically-based practices, general wellness, had a similar number of responses as the least popular condition treated by mind-body practices (women's health).

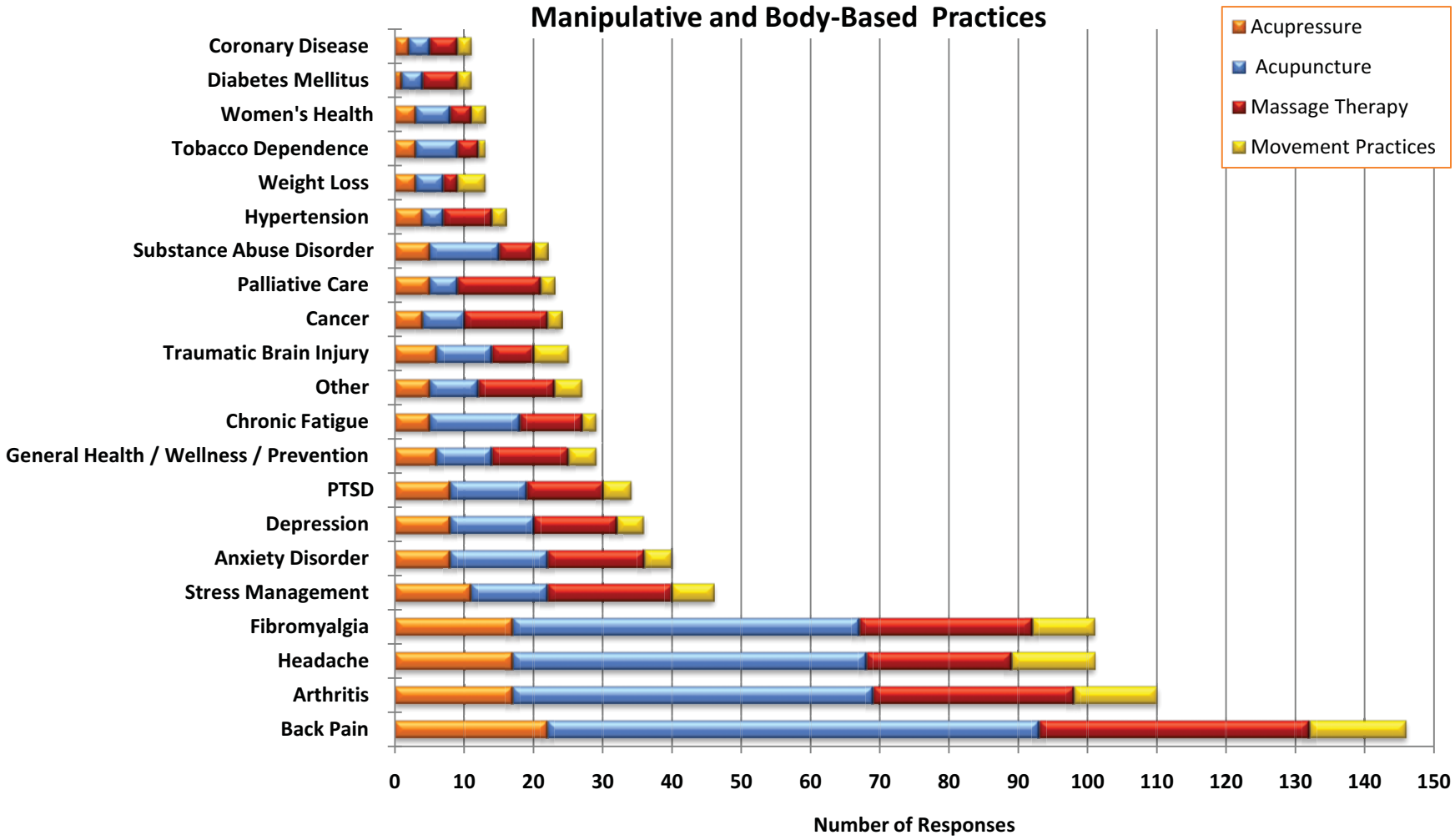
Figure 58



Manipulative and Body-Based Practices

In general, acupuncture and acupressure represented the majority of responses. This cluster was primarily used in managing pain conditions, such as back pain, fibromyalgia, headache, and arthritis (Figure 59 below).

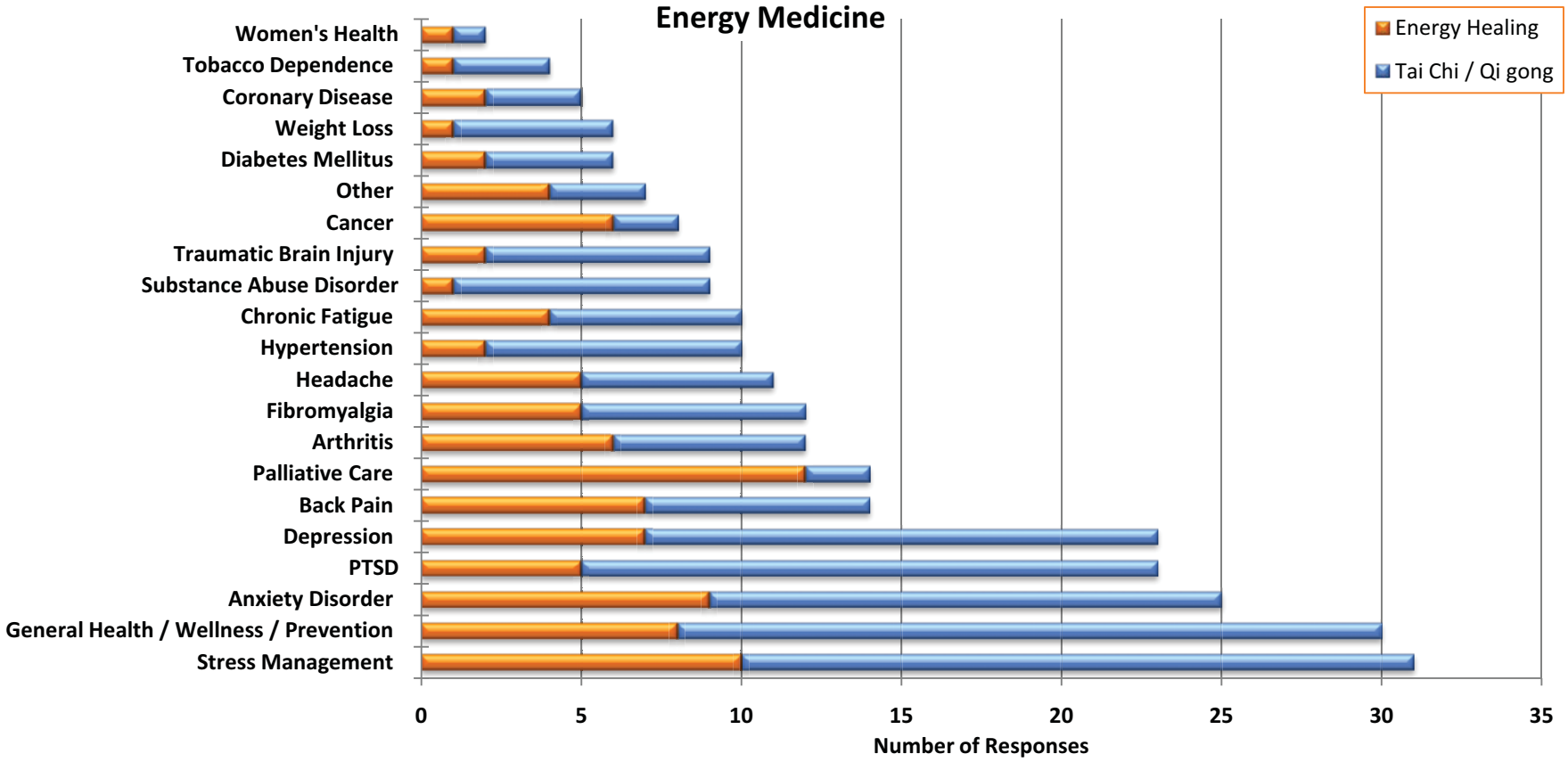
Figure 59



Energy Medicine

The energy medicine cluster had a similar distribution of responses as mind-body cluster, but the number of responses was much smaller (Figure 60 below). The five most common conditions treated by this cluster mirror those in mind-body medicine cluster, with the only exception of back pain replacing general wellness as the fifth most commonly treated condition.

Figure 60

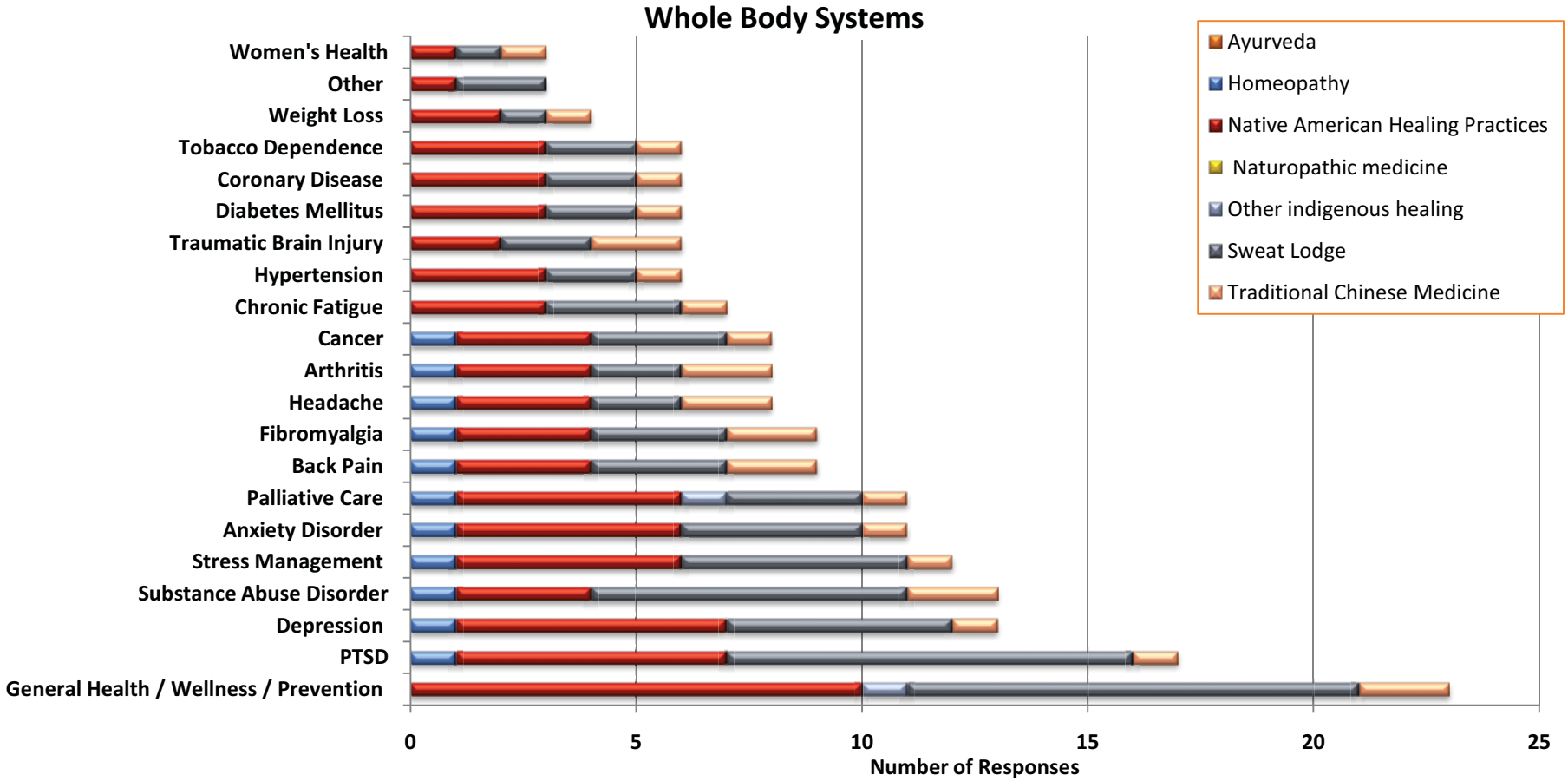


Whole Body Systems

The small number of responses makes quantitative analysis difficult at this level (Figure 61 below). However, the conditions treated by the whole body system modalities closely resembled those of the mind-body and energy medicine clusters.

With the exception of manipulative and body based practices, the mental health conditions were the most common conditions treated by CAM modality clusters.

Figure 61



Integration of CAM into Clinical Practice

Overall, CAM modalities are used as adjunct (72%) rather than primary, stand alone (22%) treatment. Only two modalities with N greater than 3 are used as primary treatment more than one-third of the time: acupuncture (43%) and Tai Chi / Qi gong (39%). Figure 62 represents the average response across all CAM modalities, and Figures 63 through 67 represent the individual modality response by NCCAM category.

(See Figure 63-67 below or Appendix G, Table G-10 for details.)

Figure 62

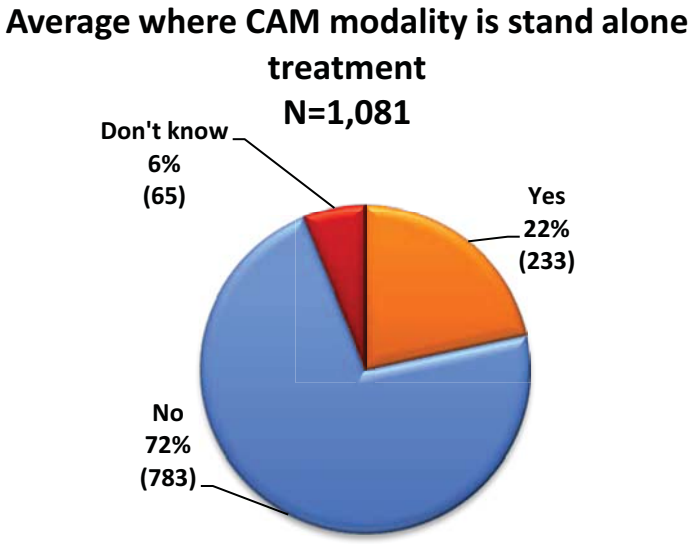


Figure 63

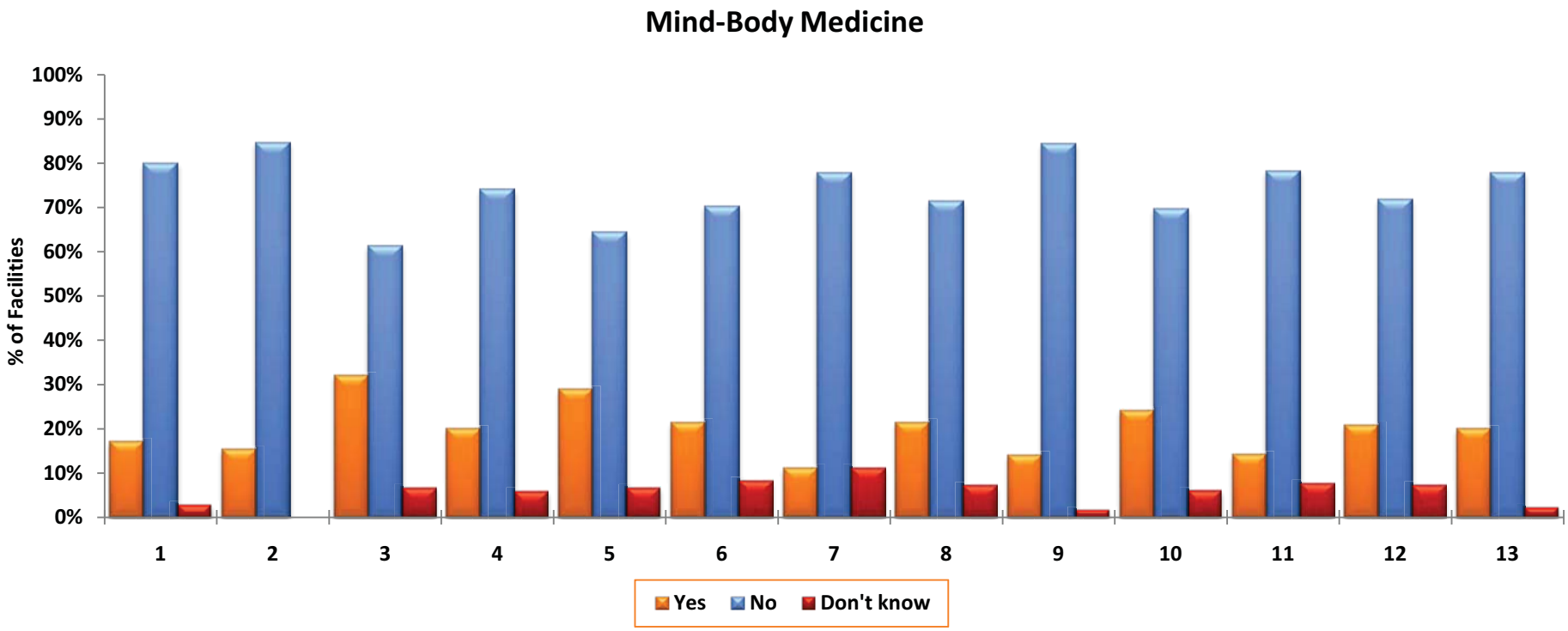


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Figure 64

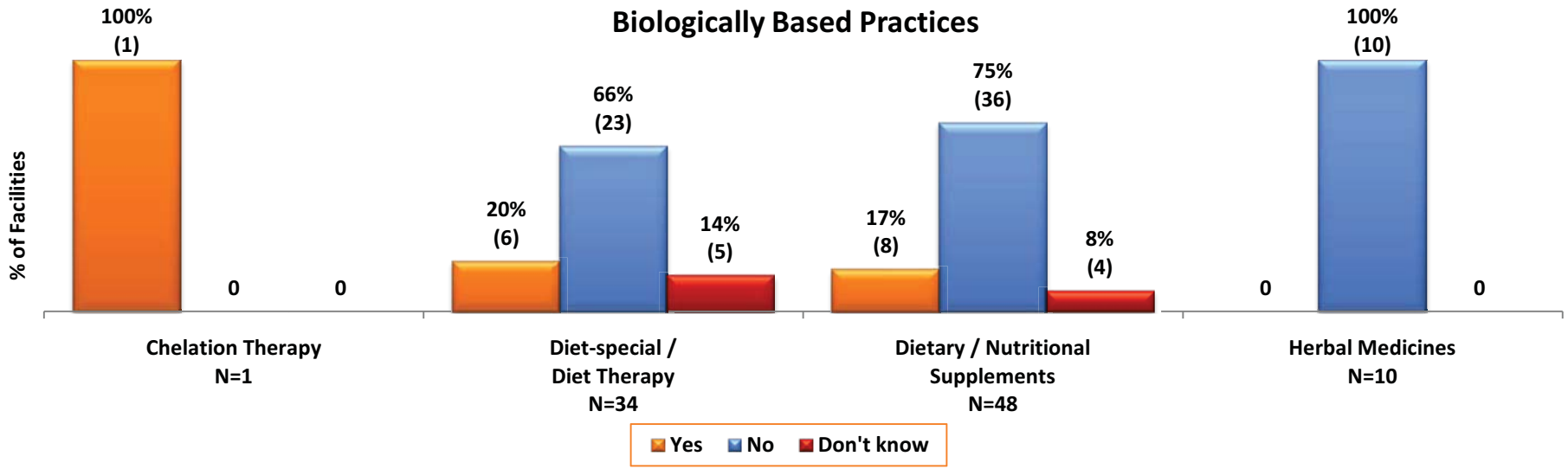


Figure 65

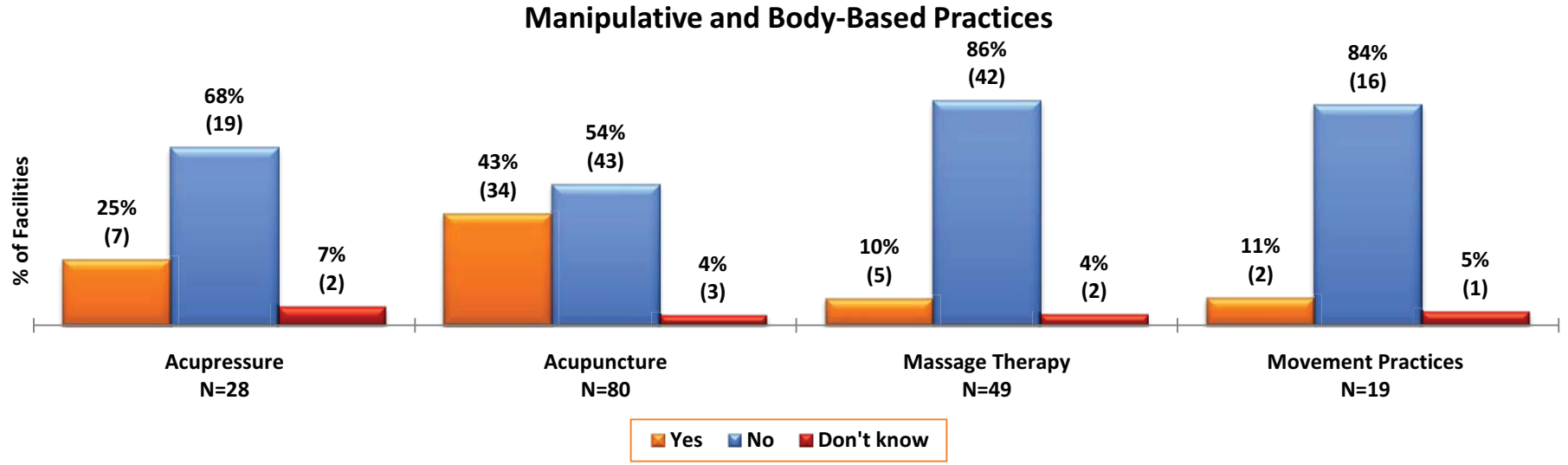


Figure 66

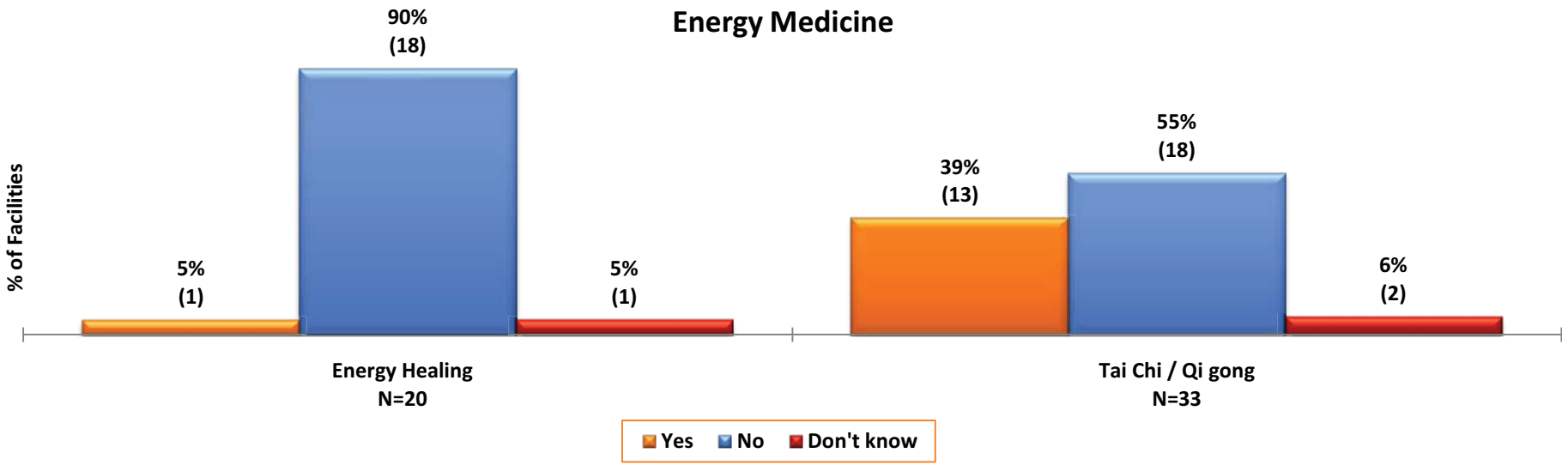
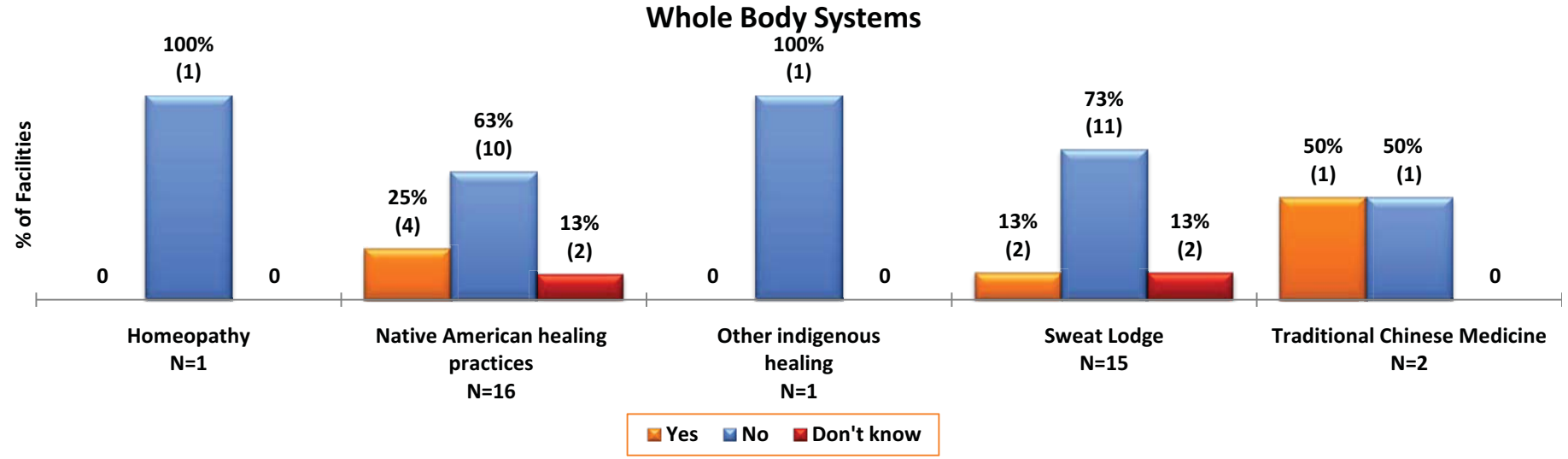


Figure 67



Integrative Clinics

Only 12 percent of facilities reported having a CAM clinic as shown in Figure 68 below. Forty-two percent of those facilities that do not have a CAM clinic stated that they were interested in starting a clinic, but had no specific plans to start an integrated clinic. The remaining 50% of those facilities that did not have an integrated clinic stated they would not be interested in starting a CAM clinic. Fifteen facilities indicated that they offer integrative clinics, three of which provide the services in CAM-only settings (Figure 69 below). Twelve of the 15 facilities co-locate CAM and allopathic modalities. It is unclear if CAM and allopathic modalities are integrated into a uniform treatment plan. Of the 110 facilities that do not have integrative clinics, half are interested in developing integrative clinics (Figure 70 below). Further study is required to determine the significance, structure, and function of the integrative clinic. It may be possible to gain further insight into this survey question by interviewing the points of contact from current integrative clinics.

Figure 68

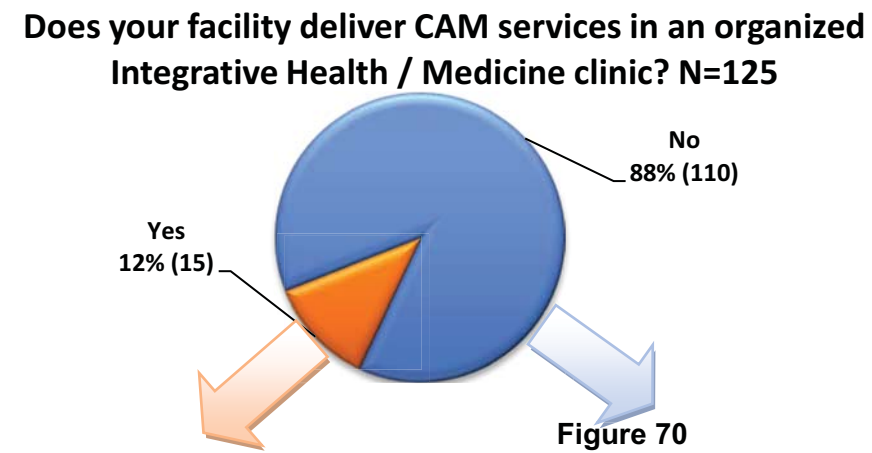


Figure 69

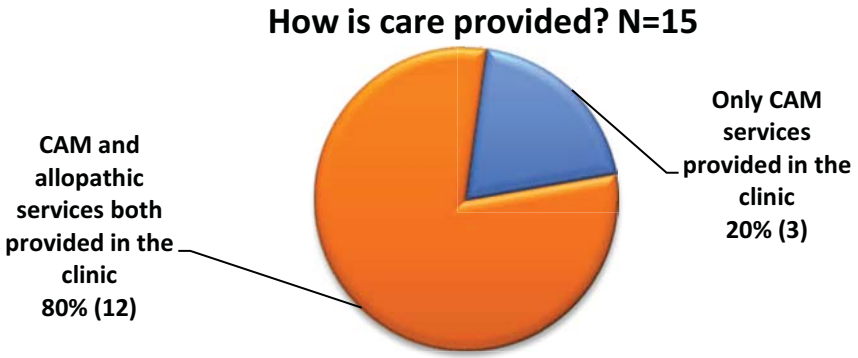
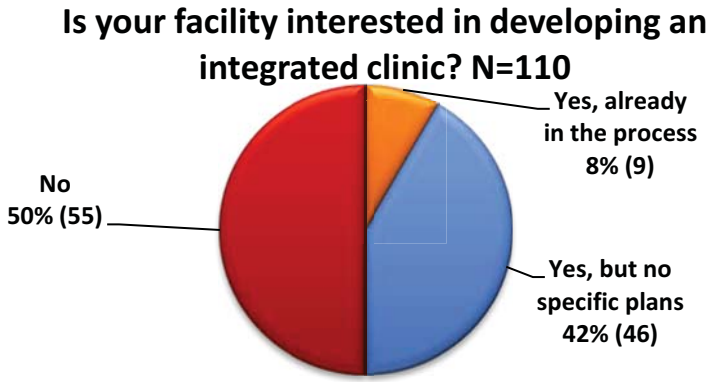


Figure 70



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Many thanks go to the Technical Advisory Group (TAG) who provided oversight in developing the survey instrument, analyzing the data, and reporting the results. Thanks are also due to the staff at the Healthcare Analysis and Information Group (HAIG) who facilitated the survey and analysis process.

Stephen Ezeji-Okoye - Chair
Deputy Chief of Staff
VA Palo Alto Health Care System

Jill Bormann
Research Nurse Scientist
San Diego VAMC

Nathan Claes
Program Analyst
Canandaigua VAMC

Janet Durfee
Deputy Chief Consultant, Public Health SHG
VACO

An-Fu Hsiao
Staff Physician
Long Beach VAMC

Jan Kemp
Chief for Education, VISN 2-Ctr for Excellence
Canandaigua VAMC

Eleanor Lewis
Research Health Science Specialist
Center for Health Care Evaluation
VA Palo Alto Health Care System

Steven Ottariano
Pharmacist
Manchester VAMC

Paula Schnurr
Deputy Executive Director, NCPTSD
White River Junction VAMC

Renata Sierzega
Health Science Specialist
Canandaigua VAMC

Sandra Smeeding
Nurse Practitioner
Salt Lake City VAMC

Krista Stephenson
Research Operations Coordinator
Canandaigua VAMC

Jodie Trafton
Director, VA Program Evaluation and Resource Center
VA Palo Alto Health Care System

HAIG Staff

Tanya Kotar
Project Manager

Amanda Honea
Management Analyst

Julie Kurutz
Program Analyst

Denis Repke
Health Systems Specialist

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Appendix A

2011 VHA Complementary and Alternative Medicine (CAM) Survey

Purpose: To delineate the state of CAM within VHA. To understand what services are offered, the demand for services and how they are delivered, the nature and education of its practitioners and the disorders that are being treated.

Definition of CAM: A group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.

It is suggested that the person completing this survey collaborate with a team comprised of multiple facility staff to submit an accurate, combined facility response. Suggested representatives include but are not limited to: Facility CAM Champion, Rehabilitation, Spinal Cord Injury / Disorders, Primary Care, Mental Health, Medicine, Pharmacy, Nutrition / Dietetics, Pain Management, Chaplain, Nursing, Extended Care, Anesthesia, Recreation Therapy, Physical Therapy, Planetree Coordinators, and Dental Service.

Facility and Point of Contact Information

Point of Contact (POC), where questions may be directed: _ _

POC Title: ___ ____ _

POC Phone Number (including area code): Ext.: _

POC Email Address: _ _

VISN: _ Facility and Station Number: ____ ____ _

1. Are CAM modalities currently being offered to your patients?
( ) Yes
( ) No
( ) No, but are in the process of developing (End Survey)

If no,

1a. In your opinion, why are CAM modalities not being offered to your patients? (Choose all that apply) (End Survey)

[ ] 1. Lack of patient interest
[ ] 2. Lack of evidence of efficacy
[ ] 3. Not supported by facility due to lack of funding
[ ] 4. Lack of available providers
[ ] 5. Unclear credentialing process
[ ] 6. Unclear process for reimbursement of services
[ ] 7. No clinic space
[ ] 8. Don't know
[ ] 9. Other
1a9a. If other, please specify:

If yes,

1b. In your opinion, why are CAM modalities offered by your facility? (Choose all that apply)

[ ] 1. Attracts new patients
[ ] 2. Promotes cost savings
[ ] 3. Proven clinical effectiveness
[ ] 4. Consistent with Patient-Aligned Care Team (PACT) model
[ ] 5. Patient preference
[ ] 6. Provider request
[ ] 7. Have provider(s) who volunteer their expertise
[ ] 8. Reflects facility's mission
[ ] 9. Promotes wellness
[ ] 10. Adjunctive to chronic disease management
[ ] 11. Cultural
[ ] 12. Other
1b12a. If other, please specify:

Please indicate whether you offer the following CAM modalities to your patients. The modalities are clustered into domains developed by the NIH National Center for Complementary and Alternative Medicine (NCCAM). For each modality you offer, please indicate whether you provide it at your facility with VA staff, fee-basis staff, or contract staff; and whether you refer patients outside VA to use VA-selected, or patient-selected providers; or via telemedicine. **You will be asked a series of additional questions for each modality provided (questions g – p).** You may use the supplemental worksheet to track your responses for each modality. (Choose all that apply)

	a. Provided at VA by VA staff	b. Provided at VA by non-VA staff	c. Provided outside VA, VA selects provider	d. Provided outside VA, patient selects provider	e. Provided via tele-medicine	f. Not Provided
NCCAM domain: Mind-body medicine						
2. Animal Assisted Therapy						
3. Aromatherapy						
4. Biofeedback						
5. Guided Imagery						
6. Hypnosis / Hypnotherapy						
Meditation* (See 7-9 below)						
7. Mindfulness*						
8. Transcendental Meditation*						
9. Mantram Repetition*						
10. Music Therapy						
11. Non-traditional Spiritual Practices (provided through VHA Chaplain service)						
12. Progressive Muscle Relaxation						
13. Stress Management / Relaxation Therapy						
14. Yoga**						
NCCAM domain: Biologically based practices						
15. Chelation Therapy						
16. Diet-special / Diet Therapy						
17. Dietary / Nutritional Supplements						
18. Herbal Medicines**						
NCCAM domain: Manipulative and body-based practices						
19. Acupressure**						

	a. Provided at VA by VA staff	b. Provided at VA by non-VA staff	c. Provided outside VA, VA selects provider	d. Provided outside VA, patient selects provider	e. Provided via tele-medicine	f. Not Provided
20. Acupuncture**						
21. Massage Therapy (e.g. Rolfing)						
22. Movement Practices (e.g. Alexander technique, Feldenkreis, Pilates)						
NCCAM domain: Energy medicine						
23. Energy Healing (therapeutic touch, healing touch, Reiki, etc.)						
24. Tai Chi / Qi gong						
Whole Medicine Systems						
25. Ayurveda						
26. Homeopathy						
27. Native American Healing Practices						
28. Naturopathic medicine						
29. Other Indigenous Healing Performed by a Healer (e.g. Botanica, Curandero, Espiritista)						
30. Sweat Lodge						
31. Traditional Chinese Medicine						
Additional Modalities						
32. Other (please specify up to three)***						
33. Other (please specify up to three)***						
34. Other (please specify up to three)***						

* Note: Mindfulness, Transcendental Meditation, and Mantram Repetition all fall in the general category of “Meditation.”
** Note: may be used as part of whole medicine systems.
*** Note: Chiropractic Care is no longer considered CAM, and is classified as a rehabilitation modality.

For **each CAM modality selected**, please answer the following questions:

Which providers are offering this CAM modality? (Choose all that apply)

[ ] 1. Acupuncturist (Licensed)
[ ] 2. CAM - Specific Provider (trained in a specific modality)
[ ] 3. Chaplain, Clergy, Spiritual Leader
[ ] 4. Chiropractor (Doctor of Chiropractic)
[ ] 5. Dentist
[ ] 6. Dietitian
[ ] 7. Marriage and Family Therapist (Licensed)
[ ] 8. Massage Therapist
[ ] 9. Nurse – Clinical Specialist
[ ] 10. Nurse Practitioner
[ ] 11. Nurse – Registered Staff
[ ] 12. Pharmacist
[ ] 13. Physical Therapist / Occupational Therapist
[ ] 14. Physician Assistant
[ ] 15. Physician (MD, DO)
[ ] 16. Professional Counselor (Licensed)
[ ] 17. Psychologist
[ ] 18. Recreation Therapist
[ ] 19. Social Worker (Licensed)
[ ] 20. Other
a. If other, please specify:

g. Who has responsibilities for reviewing and approving Clinical Privileges for providers delivering this CAM modality? (Choose all that apply)

[ ] 1. Clinical Executive Board (CEB)
[ ] 2. CAM provider's supervisor
[ ] 3. Nurse Professional Standards Board
[ ] 4. Other Professional Standards Board
[ ] 5. Other
a. If other, please specify:
[ ] 6. No credentialing and privileging (C&P) process established (skip question h)
[ ] 7. Don't know (skip question h)

h. During the Credentialing and Privileging (C&P) process for providers delivering this CAM modality, which of the following criteria are used? (Choose all that apply)

[ ] 1. Certification

[ ] 2. Demonstrated performance
[ ] 3. Special training
[ ] 4. Licensure
[ ] 5. Other
i5a. If other, please specify:
[ ] 6. No C&P process established
[ ] 7. Don't know

i. What type of evidence was used to support the decision to provide this CAM modality? (Choose all that apply)
[ ] 1. Scientific evidence
[ ] 2. Experiential / Anecdotal evidence
[ ] 3. None
[ ] 4. Don't know

j. Is this CAM modality available to any of the following? (Choose all that apply)
[ ] 1. Inpatients
[ ] 2. Outpatients
[ ] 3. Residents (Those patients residing in residential rehabilitation or domicilary programs)
[ ] 4. Caregivers / Families
[ ] 5. Don't know

k. Please estimate how many patients ***per year*** participate in this CAM modality at your medical center / health care system.
( ) Fewer than 20 patients
( ) 21-200 patients
( ) More than 200 patients

l. Is each episode of this CAM modality documented in a progress note in the medical record?
( ) Yes
( ) No
( ) Don't know

m. Is a CPT or HCPCS procedure code assigned for each episode of this CAM modality?
( ) Yes
( ) No
( ) Don't know

n. For which reason / condition(s) is this CAM modality used? (Choose all that apply)

Chronic Disease Management

[ ] 1. Cancer
[ ] 2. Chronic Fatigue
[ ] 3. Coronary Disease
[ ] 4. Diabetes Mellitus
[ ] 5. Hypertension

Mental Health

[ ] 6. Anxiety Disorder
[ ] 7. Depression
[ ] 8. Post-Traumatic Stress Disorder (PTSD)
[ ] 9. Stress Management
[ ] 10. Substance Abuse Disorder (excluding tobacco dependence)

Pain Management

[ ] 11. Arthritis
[ ] 12. Back Pain
[ ] 13. Headache
[ ] 14. Fibromyalgia

Miscellaneous

[ ] 15. **General Health / Wellness / Prevention**
[ ] 16. Palliative Care
[ ] 17. Tobacco Dependence
[ ] 18. Traumatic Brain Injury
[ ] 19. Weight Loss
[ ] 20. Women's Health (e.g. fertility, menopause)
[ ] 21. Other
o21a. If other, please specify:

o. Is this CAM modality offered as a primary, stand alone treatment?
( ) Yes
( ) No
( ) Don't know

Integrative Health / Medicine

35. Does your facility deliver CAM services in an organized Integrative Health / Medicine clinic?
( ) Yes

( ) No

If yes,

35a. How is care provided?
( ) CAM and allopathic services both provided in the clinic
( ) Only CAM services provided in the clinic

35b. Do you have a point of contact (POC) for this Integrative Health / Medicine Clinic?
(POC may be contacted for further information regarding this clinic)
( ) Yes
( ) No
( ) Don't know

If yes,

35b1. POC Name:
35b2. POC Title:
35b3. POC Phone Number:
(including area code and extension)
35b4. POC Email Address:

If no,

35c. Is your facility interested in developing an integrated clinic?
( ) Yes, already in the process
( ) Yes, but no specific plans
( ) No

36. If you have any comments about CAM services within VHA, clarifications, or questions related to CAM modalities or this survey, please share them below. (Optional. Limit 1000 characters)

Be sure to save and print your responses before you click "Finish" to submit the online form.

Thank you for your time and cooperation with completing this survey.

Appendix B

CAM Glossary

Term	Definition
NCCAM domain: Mind-body medicine	
Animal Assisted Therapy	A type of therapy that involves an animal, other than a service animal, as a fundamental part of a person's treatment.
Aromatherapy	Aromatherapy is a therapy in which the scent of essential oils from flowers, herbs, and trees is inhaled to promote health and well-being.
Biofeedback	Biofeedback uses information from physiological monitoring devices to teach clients how to consciously regulate bodily functions, such as breathing, heart rate, and blood pressure.
Guided Imagery	Any of various techniques (such as series of verbal suggestions) used to guide another person or oneself in imaging sensation – especially in visualizing an image in the mind – to bring about a desired physical response (such as stress reduction).
Hypnosis	Hypnosis is an altered state of consciousness characterized by increased responsiveness to suggestion. The hypnotic state is attained by first relaxing the body, then shifting attention toward a narrow range of objects or ideas as suggested by the hypnotist or hypnotherapist.
Hypnotherapy	The application of hypnosis as a form of medical therapy.
Meditation	A conscious mental process using certain techniques—such as focusing attention or maintaining a specific posture—to suspend the stream of thoughts and relax the body and mind.
• Mindfulness	A form of meditation where the focus of attention is on a physical sensation such as breathing with an intent to increase awareness of the present.
• Transcendental Meditation	A technique of sitting meditation derived from Hindu tradition that promotes deep relaxation through the use of a mantra.
• Mantram Repetition	A form of non-sitting meditation where sacred words or phrases are silently, internally repeated throughout the day as objects of concentration and re-directed attention.
Music Therapy	Music is used to achieve non-musical therapeutic goals.

Term	Definition
Non-traditional (for modern health care) Spiritual Practices (e.g. coordinated through Chaplain)	Alternative Pastoral / Spiritual Care utilizes spiritual interventions or practices provided or facilitated by qualified chaplains that lies outside of traditional religious / faith practices and traditional health care. (By policy, In VA all pastoral / spiritual care for patients is either provided by or facilitated by VA chaplains. For example, if a Native American shaman provides direct patient spiritual care, it is under the management and supervision of a VA chaplain.)
Progressive Relaxation	Progressive Relaxation is used to relieve tension and stress by systematically tensing and relaxing successive muscle groups.
Stress Management / Relaxation Therapy	Relaxation therapy is a broad term used to describe a number of techniques that promote stress reduction, the elimination of tension throughout the body, and a calm and peaceful state of mind.
Yoga*	A course of specific exercises, postures, breathing and meditation to promote well being.
NCCAM domain: Biologically based practices	
Chelation Therapy	Chelation therapy is a chemical process in which a substance is used to bind molecules, such as metals or minerals, and hold them tightly so that they can be removed from the body.
Diet Therapy	Major dietary changes to promote health not related to allergies or intolerance, e.g. blood type diet, raw food diet; may include significant reductions or increases in certain daily nutrient intake requirements.
Dietary / Nutritional Supplements	A product that bears or contains a vitamin, a mineral, botanical or other substance used to supplement the diet.
Herbal Medicines	A plant or part of a plant used for therapeutic properties. Includes flowers, leaves, bark, fruit, seeds, stems, and roots.
NCCAM domain: Manipulative and body-based practices	
Massage Therapy	Pressing, rubbing, and moving muscles and other soft tissues of the body, primarily by using the hands and fingers.
Acupressure	Use of the fingers to press key points on the body's surface of the skin to stimulate the flow of energy.
Acupuncture	Acupuncture is the stimulation of specific points on the body by a variety of techniques, including the insertion of thin metal needles through the skin.
Movement Practices (e.g. Alexander technique, Feldenkreis, Pilates)	A broad range of Eastern and Western movement-based approaches used to promote physical, mental, emotional, and spiritual well-being.

Term	Definition
NCCAM domain: Energy medicine	
Therapeutic Touch	An adaptation of several religious and secular healing traditions and is commonly used in nursing practice for many different conditions. The practitioner passes his or her hands over the body of the person being treated in order to induce relaxation, reduce pain, and promote healing
Healing Touch	A noninvasive technique utilizing the hands to energize and balance the energy within the human body to restore and promote health.
Reiki	A form of treatment based on the belief that there is a universal energy that supports the body's healing abilities. The healing energy is channeled from the practitioner to the patient.
Tai Chi	Tai Chi is a mind-body practice that originated in China as a martial art. A person doing Tai Chi moves his or her body slowly and gently, while breathing deeply and meditating (Tai Chi is sometimes called ''moving meditation'')...
Qi gong	Qi gong is an ancient Chinese discipline combining the use of gentle physical movements, mental focus, and deep breathing directed toward specific parts of the body.
Whole Medicine Systems	
Ayurveda	A whole medical system that originated in India. It aims to integrate the body, mind, and spirit to prevent and treat disease. Therapies used include herbs, massage, and yoga.
Homeopathy	A whole medical system that originated in Europe. Homeopathy seeks to stimulate the body's ability to heal itself by giving very small doses of highly diluted substances that in larger doses would produce illness or symptoms (an approach called "like cures like.")
Native American Healing Practices	A Native American Healer or Medicine Man is a traditional healer who uses information from the ''spirit world'' in order to benefit the patient.
Sweat Lodge	The sweat lodge (also called purification ceremony, sweat house, medicine lodge, medicine house, or simply sweat) is a ceremonial sauna and is an important event in some North American First Nations or Native American cultures.
Other Indigenous Healing Performed by a Healer (e.g. Botanica, Curandero, Espiritista, Hierbero, Yerbera, Shaman, Sobador)	Methods based on indigenous theories, beliefs, and experiences. Healers implement health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

Term	Definition
Naturopathic Medicine	Naturopathic medicine proposes that there is a healing power in the body that establishes, maintains, and restores health. Practitioners work with the patient with a goal of supporting this power through treatments such as nutrition and lifestyle counseling, dietary supplements, medicinal plants, exercise, homeopathy, and treatments from traditional Chinese medicine.
Traditional Chinese Medicine	Traditional Chinese medicine originated in ancient China and has evolved over thousands of years. Practitioners use herbs, acupuncture, and other methods to treat a wide range of conditions.

Appendix C

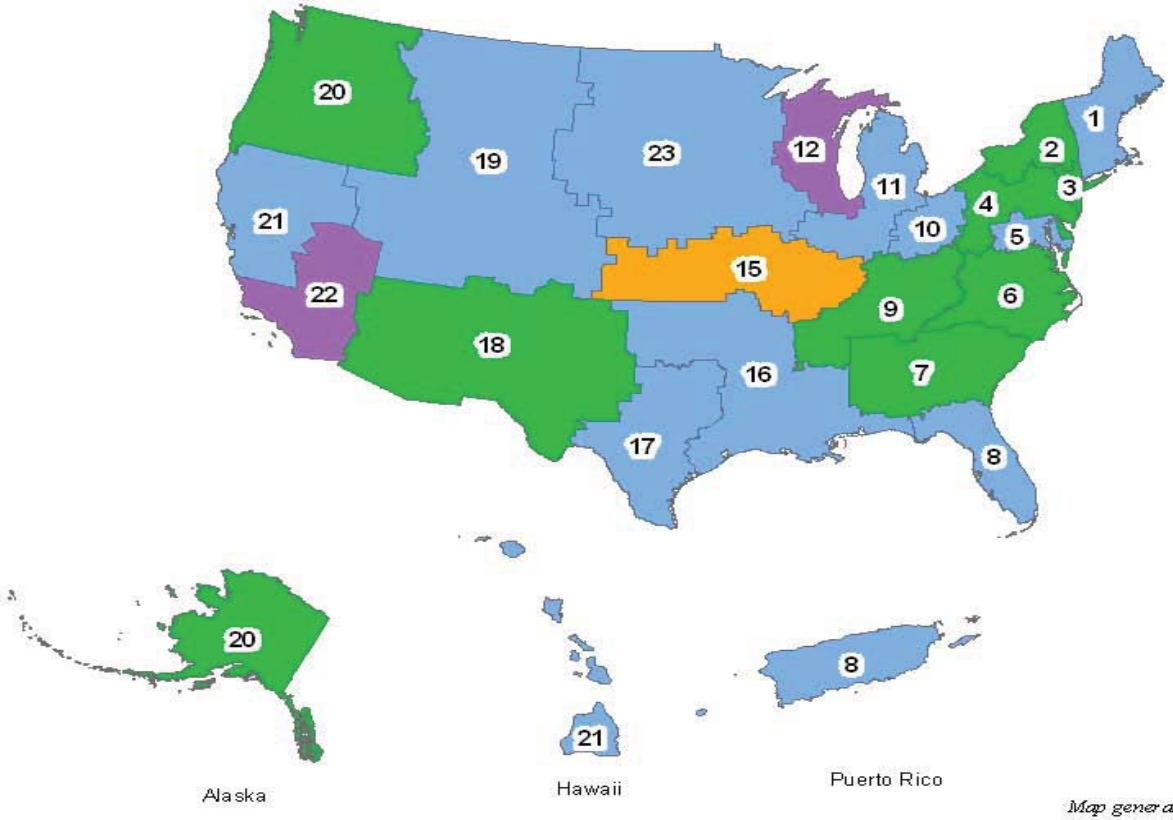
Average Number of Provided CAM Modalities by VISN (2002 and 2011) – Maps

Figure C-1

Department of Veterans Affairs
Veterans Health Administration

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

2011
Provided Average Number of Complementary and Alternative Medicine Modalities per Facility by VISN



Legend

- 3 - 4
- 5 - 6
- 7 - 8
- 9 - 11

VISN	Average
1	9
2	6
3	6
4	5
5	8
6	6
7	6
8	7
9	5
10	7
11	8
12	9
15	4
16	7
17	8
18	6
19	7
20	6
21	8
22	11
23	7

Source: 2011 CAM Survey

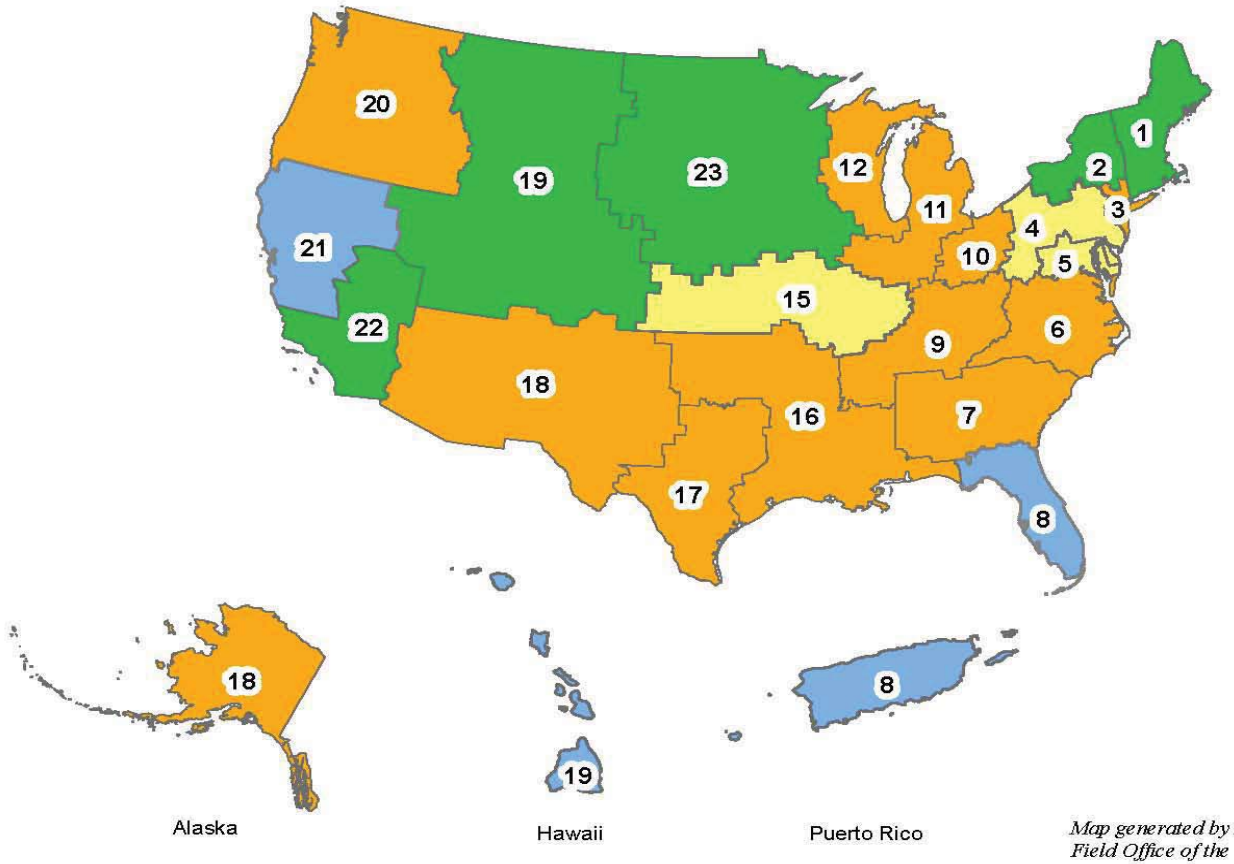
Map generated by Healthcare Analysis & Information Group
Field Office of the Office of the ADUSH for Policy and Planning

Figure C-2

Department of Veterans Affairs
Veterans Health Administration

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

2002
Provided Average Number of Complementary and Alternative Medicine Modalities per Facility by VISN



Legend

- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 8

VISN	Average
1	5
2	4
3	4
4	2
5	1
6	4
7	3
8	8
9	3
10	4
11	4
12	3
15	2
16	4
17	4
18	4
19	4
20	4
21	7
22	6
23	5

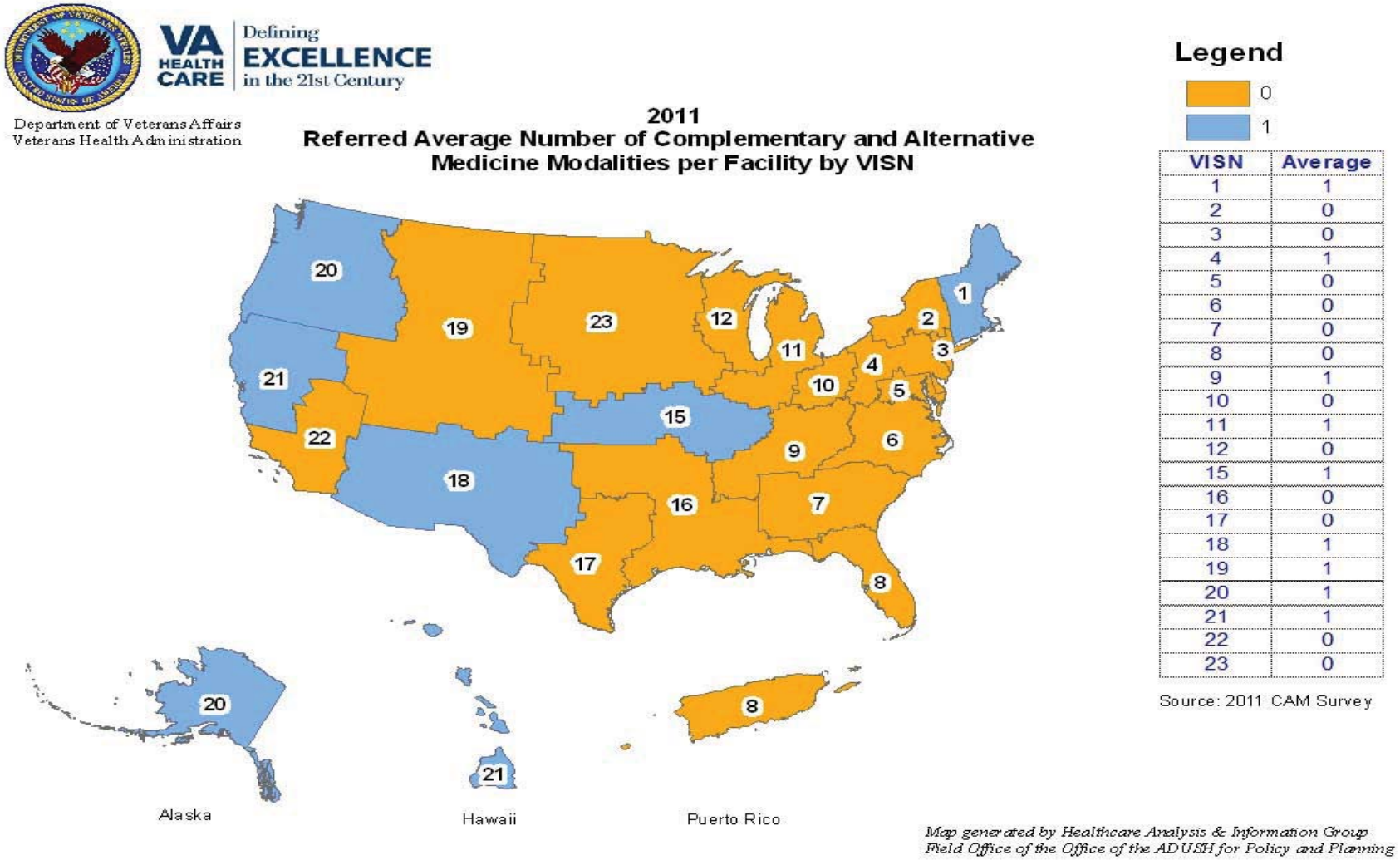
Source: 2002 CAM Survey

Map generated by Healthcare Analysis & Information Group
Field Office of the Office of the ADUSH for Policy and Planning

Appendix D

Average Number of Referred CAM Modalities by VISN (2002 and 2011) – Maps

Figure D-1



VISN	Average
1	1
2	0
3	0
4	1
5	0
6	0
7	0
8	0
9	1
10	0
11	1
12	0
15	1
16	0
17	0
18	1
19	1
20	1
21	1
22	0
23	0

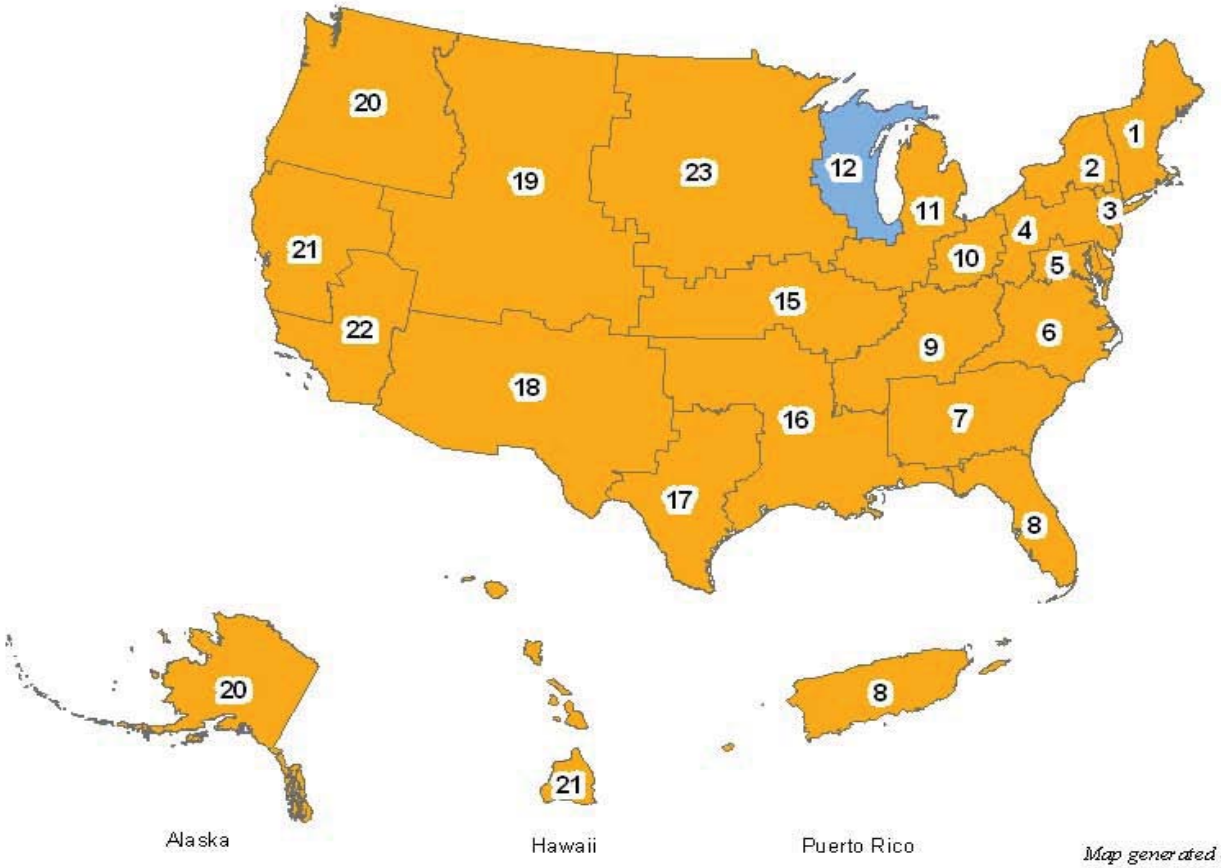
Source: 2011 CAM Survey

Figure D-2

Department of Veterans Affairs
Veterans Health Administration

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

2002
Referred Average Number of Complementary and Alternative Medicine Modalities per Facility by VISN



Legend

0 - 1
2 - 3

VISN	Average
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	0
9	0
10	0
11	0
12	3
15	0
16	0
17	0
18	1
19	1
20	1
21	1
22	0
23	1

Source: 2002 CAM Survey

Map generated by Healthcare Analysis & Information Group
Field Office of the Office of the ADUSH for Policy and Planning

Appendix E, F, and G are available to print separately by following the links below:

- Appendix E: 2002 & 2011 Complementary and Alternative Medicine Modality Provided Comparison
- Appendix F: 2002 & 2011 Complementary and Alternative Medicine Modality Referred Comparison
- Appendix G: Data Tables

You will need 11” x 17” paper to print these documents.