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Perceptions of Providers and Administrators in the Veterans Health Administration Regarding Complementary and Alternative Medicine

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Abstract

Background—The integration of complementary and alternative medicine (CAM) therapies into a large organization such as the Veterans Health Administration (VHA) requires cultural change and deliberate planning to ensure feasibility and buy-in from staff and patients. Currently, there is limited knowledge of VHA patient care providers' and administrators' viewpoints regarding CAM therapies and their implementation.

Objectives—Our purpose was to qualitatively examine knowledge, attitudes, perceived value and perceived barriers and/or facilitators to CAM program implementation among VHA providers and administrators at a large VHA facility.

Research design—We are reporting the qualitative interview portion of a mixed-methods study.

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Subjects—Twenty-eight participants (patient care providers or administrators) were purposely chosen to represent a spectrum of positions and services. Participants' experience with and exposure to CAM therapies varied.

Measures—Individual interviews were conducted using a semi-structured format and were digitally recorded, transcribed, and coded for themes.

Results—Recurrent themes included: a range of knowledge about CAM; benefits for patients and staff; and factors that can be facilitators or barriers including evidence based practice or perceived lack thereof, prevailing culture, leadership at all levels, and lack of position descriptions for CAM therapists. Participants rated massage, meditation, acupuncture, and yoga as priorities for promotion across the VHA.

Conclusions—Despite perceived challenges, providers and administrators recognized the value of CAM and potential for expansion of CAM within the VHA. Interview results could inform the process of incorporating CAM into a plan for meeting VHA Strategic Goal One of personalized, proactive, patient-driven healthcare across the VHA.

INTRODUCTION

Complementary and Alternative Medicine (CAM) therapies are used by millions of Americans including veterans to improve health, wellbeing, and relieve symptoms such as pain and anxiety.[1–6] The Veterans Health Administration (VHA) has supported peer-reviewed research including randomized controlled trials of CAM modalities.[7] Consistent with the commitment of the VHA to provide "personalized, proactive, patient-driven, health care"[8], CAM therapies are being incorporated into the care offered to veterans.[8–10] Like the private sector, implementation of CAM within VHA has been evolving. Providers' attitudes and knowledge about CAM vary and are important factors in the implementation of CAM programs in both the private sector and the VHA. Although there is some research about providers and administrators attitudes in the private sector, there is little known about the attitudes/knowledge of VA providers and administrators.[11–13] The purpose of this qualitative study was to examine the knowledge, attitudes, and perceived barriers and/or facilitators to CAM program implementation among VHA providers and administrators at a large representative VHA facility.

METHODS

After Institutional Review Board approval, VHA patient care providers and administrators were chosen to represent a spectrum of positions and services including direct care providers, department heads, and higher-level administrators. Individuals known or speculated to be supportive of CAM were approached as well as those with potentially negative views toward CAM. Possible participants were first contacted via email. Willing participants provided informed consent and were interviewed in a private location. Semi-structured interviews were digitally recorded by one research team member from April until November 2013. All participants were asked the same open-ended questions (Table 1).

Interviews averaged 15 minutes (range 5–28.5 minutes) depending upon participant response. Interviews were transcribed verbatim by a research assistant and entered into

NVivo (version 10)[14]. Each interview was coded individually by at least two members of the research team to develop an initial set of themes. Three team members then met as a group to refine the codes and continue theme coding until consensus was reached.

RESULTS

Participants are described in Table 2. Whether, to what extent, by whom, and why the VHA should promote CAM was a matter of considerable debate. Responses clustered under 3 general themes, knowledge/opinions, benefits, and barriers and facilitators. Table 3 lists the themes plus brief definitions and excerpts from the transcripts.

KNOWLEDGE/OPINIONS

Knowledge about which CAM therapies were actually available at the site varied widely. Massage therapy was most frequently mentioned. Many were vague about other CAM therapies until shown a non-inclusive list of CAM examples.

Knowledge about CAM also reflected personal experience often cited as what participants had recommended for patients rather than therapies participants had used themselves. When encouraged to describe their own experience, individuals mentioned massage, meditation, and yoga most frequently. ”Personal” experience was also cited as that of a spouse or other family member (Table 2). Only one experience was described negatively.

When asked to rate their top choices for CAM availability to veterans; massage, meditation, acupuncture and yoga were rated highest (Table 4). These choices appeared to track participants’ own experiences or were based upon perceptions of veterans’ familiarity with and/or acceptance of these therapies plus the need to relieve chronic pain. Opinions regarding CAM in the VHA ranged from strongly supportive to qualified to unsupportive. Participants sensed a difference between the attitudes of physicians and nurses. Specifically physicians were generally described as “pretty suspicious” of non-traditional treatments. One physician argued that chiropractic, massage and acupuncture have become standard therapies, so should no longer be called CAM- reflecting the fact that CAM is an evolving field.[15]

BENEFITS

Participants described multiple benefits of CAM for patients and staff that reflect an approach to care of the whole person integrating body, mind and spirit. One participant thought CAM could provide the compassionate aspect of patient care that is sometimes missing in today’s medicine. An administrator saw CAM as a key component in the VHA goal of expanding personalized, proactive patient-centered care.

BARRIERS AND FACILITATORS

Multiple factors were cited with the potential to be either barriers or facilitators to implementing CAM. Lack of evidence in support of CAM was emphasized in most of the interviews. Some providers were concerned that if CAM was included in their practice it would appear to other providers as being “non-scientific”. Most participants seemed

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unaware of existing research publications, including randomized controlled trials, that demonstrate the efficacy of CAM.

The role of leadership was readily acknowledged as both a facilitator and barrier. The need for a champion was mentioned frequently. A nurse manager identified the role of middle management in influencing staff nurses. Lack of understanding by providers about which CAM therapies were available was ascribed to lack of leadership, resulting in piecemeal decisions about patient eligibility and frustration for veterans not receiving CAM. Some participants mentioned development and deployment of a strategic plan as part of leadership's responsibility; for example the former Under Secretary was praised for touting acupuncture nationally to hospital and network directors.

Credentialing of CAM providers within the VHA is currently unresolved and a source of frustration for some participants. Use of contracted practitioners, training staff nurses to do healing touch therapy and training staff physicians in acupuncture were described as work-around solutions. A number of therapies were cited as being problematic. Pet care, misperception about the intent of massage, sensitivity of roommates to aromas, potential adverse interactions between medicines and herbs, and aversion to being touched were all cited as actual or perceived barriers to the use of CAM. Another participant described a patient whose undisclosed use of herbs increased his bleeding time after surgery, emphasizing the need for veterans to feel comfortable disclosing CAM use to providers.

Time, space, funding and staff training/experience were mentioned as both facilitators and barriers to expanding CAM. Nurses were particularly concerned with having enough time to use CAM along with completing their other duties. One participant suggested that specially designated persons on a unit might be more practical than expecting all staff nurses to incorporate CAM into patient care. Several participants advocated temporarily sending veterans to outside CAM providers on a "fee basis" when services cannot be provided internally.

While many participants saw lack of funding as an issue, others thought funding was available in response to a well-planned request. Several individuals pointed out that many CAM therapies are relatively low cost especially if CAM providers are cross-trained in multiple therapies. One participant thought it would be cost effective if less expensive staff were hired, e.g., an acupuncturist rather than a physician to perform acupuncture. Volunteers providing pet therapy and soft touch hand massage were also seen as low cost resources for expanding CAM services.

Examples were cited involving past challenges in staff training and funding. Issues include limited funding for acupuncture training for physicians and lack of compensatory time off for nurses taking healing touch therapy training. Participants thought training/education in providing CAM is not promoted within the VHA due to a lack of "key stakeholders" who understand the benefits of CAM. The importance of stakeholder awareness of the positive impact of CAM upon veterans' quality of life was noted.

Many participants supported a need for cultural change involving both providers and veterans. Providers seemed to be more accepting of CAM if they had personally experienced

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these interventions. One participant suggested that providers be encouraged to personally try CAM as a means to understand how interventions could benefit veterans.

Some participants saw veterans as “demanding” CAM; others feared veterans view CAM as “wishy-washy.” The consensus was that veterans should know CAM is available. In summary, factors identified as impeding CAM as an option included lack of: ownership for promoting CAM; referral criteria; provider knowledge; consistent funding; and insufficient numbers of providers resulting in “luck of the draw” over which veterans receive therapies.

DISCUSSION

As CAM use becomes increasingly prevalent in the general population, the VHA needs to acknowledge and incorporate CAM, a fact that has been recognized at the highest levels of VHA.[16–18] CAM can be a tool to help veterans with self-care/self-management, and is a component of the VHA Office of Patient Centered Care and Cultural Transformation’s Health for Life program.[19] In outpatient settings, expansion of CAM services is consistent with the patient aligned care team model as well as the goals of Planetree[20] emphasizing personalized, patient-driven care. But as illustrated above, CAM implementation in VHA will not occur automatically.

Knowledge limits present a stumbling block. Providers are unsure of which CAM therapies are available and/or whether there is sufficient evidence to support usage despite a growing body of research demonstrating significant impact of CAM on pain and symptom management.[7, 21,22,23] For example, meditation has been shown to affect the mind, brain, body, and behavior in ways that have potential to treat many health problems veterans experience and to promote healthy behavior.[24] Aromatherapy is now available in individual packets or inhalers that are clinically useful without affecting roommates,[25] and pet therapy has been successfully introduced.[26]

Disconnects between perceptions and reality underline the need for focused education for physicians, nurses and administrators on the clinical impact of CAM. Additionally, the suggestion that providers should experience at least one CAM therapy should not be ignored. Participants who had actually used CAM (or had a family member who had done so) were more likely to be positive about promoting CAM for veterans.

Benefits to veterans come from potentially meeting their individual needs while VHA receives value by adding potentially beneficial and cost effective treatments, especially for chronic pain. Promoting CAM therapy administration by nurses[25] is especially promising because once trained, many therapies do not require a practitioner to obtain a physician’s order, e.g. music therapy, soft and healing touch. The lack of job descriptions for hiring massage therapists, acupuncturists, and yoga instructors remains a barrier to CAM expansion in the VHA. Being able to hire people directly into these positions will not only assist in meeting demand, but can also provide a cost saving when the position does not require a nurse or physician.

Barriers to CAM interfere with the implementation of patient-centered care. Our findings demonstrate that the same factor can be either a barrier or facilitator, e.g., proactive

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administration/champion versus lack thereof. Currently implementation of CAM depends heavily upon local efforts and leadership[27], with some VHA facilities offering multiple therapies while other sites struggle to implement programs. The participants in this study were aware that simply declaring CAM "will be promoted" is insufficient. Although national leaders need to promote CAM and pursue position descriptions, to turn barriers into facilitators culture change requires a local leader/champion(s) who facilitates strategic planning, education/experience of providers and long-term commitment.

The millions of veterans treated by the VHA provide both an opportunity and a challenge. Meeting the needs of so many veterans requires multiple modes of service delivery plus targeting specific populations, e.g. those with chronic pain, end-of-life needs, and mental health issues. For inpatients, CAM services could be expanded using an integrated medicine (IM) model similar to that adopted in a private sector healthcare system.[28] Although an array of services may seem an ambitious model for many VHA facilities, results from a 2011 survey indicate that 37 VHA facilities reported offering more than 10 CAM modalities.[16] A summary of recommendations for promoting CAM in the VHA appears in table 5.

Our study may be limited due to the low sample size and that the study was conducted at only one site located in the Midwest. Furthermore, results may not apply to other geographic regions or facilities of a different size. However, conversations with persons either providing or attempting to provide CAM at other VHA facilities lead us to believe the study site is not atypical. CAM therapies promote VHA Strategic Goal One by supporting personalized, proactive, and patient-driven care for significant health problems in the veteran population, e.g., chronic pain and PTSD. The benefits of CAM to veterans outweigh the challenges of making the needed changes within a large bureaucratic organization. Veterans deserve no less.

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References

1. Baldwin CM, Long K, Kroesen K, et al. A profile of military veterans in the southwestern United States who use complementary and alternative medicine: implications for integrated care. Arch Intern Med. 2002; 162:1697–1704. [PubMed: 12153372]
2. Barnes PM, Bloom B, Nahin RL. Complementary and alternative medicine use among adults and children: United States, 2007. Natl Health Stat Report. 2008:1–23. [PubMed: 19361005]
3. Denneson LM, Corson K, Dobscha SK. Complementary and alternative medicine use among veterans with chronic noncancer pain. J Rehabil Res Dev. 2011; 48:1119–1128. [PubMed: 22234716]
4. Eisenberg DM, Davis RB, Ettner SL, et al. Trends in alternative medicine use in the United States, 1990–1997: results of a follow-up national survey. JAMA. 1998; 280:1569–1575. [PubMed: 9820257]
5. Goertz C, Marriott BP, Finch MD, et al. Military Report More Complementary and Alternative Medicine Use than Civilians. J Altern Complem Med. 2013; 19:509–517.

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6. Kessler RC, Davis RB, Foster DF, et al. Long-term trends in the use of complementary and alternative medical therapies in the United States. Ann Intern Med. 2001; 135:262–268. [PubMed: 11511141]
7. Mitchinson AR, Kim HM, Rosenberg JM, et al. Acute postoperative pain management using massage as an adjuvant therapy: a randomized trial. Arch Surg-CHICAGO. 2007; 142:1158–1167. [PubMed: 18086982]
8. 2011 Complementary and Alternative Medicine Survey. Veterans Health Administration, Group HAI; Sep. 2011
9. Open Minds: Meeting convened by VA R&D seeks to expand study of complementary, alternative therapies for PTSD. VA Research Current. 2011:1–4.
10. Libby DJ, Pilver CE, Desai R. Complementary and alternative medicine in VA specialized PTSD treatment programs. Psychiat Serv. 2012; 63:1134–1136.
11. Shorofi SA, Arbon P. Nurses' knowledge, attitudes, and professional use of complementary and alternative medicine (CAM): a survey at five metropolitan hospitals in Adelaide. Complement Ther Clin Pract. 2010; 16:229–234. [PubMed: 20920809]
12. Trail-Mahan T, Mao CL, Bawel-Brinkley K. Complementary and alternative medicine: nurses' attitudes and knowledge. Pain management nursing : official journal of the American Society of Pain Manag Nurs. 2013; 14:277–286.
13. Wahner-Roedler DL, Lee MC, Chon TY, et al. Physicians' attitudes toward complementary and alternative medicine and their knowledge of specific therapies: 8-year follow-up at an academic medical center. Complement Ther Clin Pract. 2014; 20:54–60. [PubMed: 24439646]
14. NVivo. [computer program] Version 10. QSR International; 2012.
15. CAM Basics: Complementary, Alternative, or Integrative Health: What's In a Name? [NCCAM website]. 2013. Available at: http://nccam.nih.gov/health/whatiscam
16. Ezeji-Okoye SC, Kotar TM, Smeeding SJ, et al. State of Care: Complementary and Alternative Medicine in Veterans Health Administration—2011 Survey Results. Fed Pract. 2013:14–19.
17. Gaudet, T. [Accessed March 11, 2014] Our veterans drive the transformation of healthcare [KevinMD website]. 2013. Available at: http://www.kevinmd.com/blog/2013/11/veterans-drive-transformation-healthcare.html
18. Levin, F. VISN 11 Integrative Medicine. Presentation; 2013. In press
19. [Accessed March 10, 2014] Health for Life: Components of Proactive Health and Well-Being [Health For Life website]. Available at: http://healthforlife.vacloud.us/index.php/components-of-proactive-health-and-well-being
20. [Accessed March 7, 2014] About Us [Planetree web site]. Available from: http://planetree.org/about-planetree/
21. Exploring the Science of Complementary and Alternative Medicine: NCCAM Third Strategic Plan 2011–2015. NIH; 2011.
22. Cherkin DC, Sherman KJ, Kahn J, et al. A comparison of the effects of 2 types of massage and usual care on chronic low back pain: a randomized, controlled trial. Ann Intern Med. 2011; 155:1–9. [PubMed: 21727288]
23. Vickers AJ, Cronin AM, Maschino AC, et al. Acupuncture for chronic pain: individual patient data meta-analysis. Arch Intern Med. 2012; 172:1444–1453. [PubMed: 22965186]
24. Dusek JA, Otu HH, Wohlhueter AL, et al. Genomic counter-stress changes induced by the relaxation response. PloS one. 2008; 3:e2576. [PubMed: 18596974]
25. Knutson L, Johnson PJ, Sidebottom A, et al. Development of a hospital-based integrative healthcare program. J Nurs Admin. 2013; 43:101–107.
26. Sehr J, Eisele-Hlubocky L, Junker R, et al. Family pet visitation. Am J Nurs. 2013; 113:54–59. [PubMed: 24284587]
27. Smeeding S, Osguthorpe S. The development of an integrative healthcare model in the Salt Lake City Veterans Affairs Healthcare System. Altern Ther Health M. 2005; 11:46–51. [PubMed: 16320860]
28. Dusek JA, Finch M, Plotnikoff G, Knutson L. The impact of integrative medicine on pain management in a tertiary care hospital. J Patient Safe. 2010; 6:48–51.

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Table 1

Interview Questions Asked to Providers and Administrators

	Questions
1	When you think of complementary/alternative medicine (CAM) therapies, what comes to mind?
2	Are you aware of any complementary/alternative medicine (CAM) therapies currently being used at the VAAAMC? If so, please describe.
3	Here is a list of some of the more common CAM therapies. Would you like to have CAM therapies available to patients at the VAAAMC? If so, which therapies and why would you choose them? If not, why not?
4	What facilitators would promote the expansion of CAM therapies at the VAAAMC?
5	What barriers would make it difficult to offer CAM therapies at the VAAAMC?
6	Have you or has anyone you know used a CAM therapy? If so, what was the experience like?
7	Is there anything else you would like to share with me about CAM therapy? If yes, please feel free to do so.

Abbreviations: CAM = Complementary and Alternative Medicine; VAAAMC = Veterans Affairs Ann Arbor Medical Center.

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Table 2

Demographics of VHA Staff and Administrator Interviewees (n=28)

	n (%)
GENDER	
Male	15 (54)
Female	13 (46)
RACE	
White	22 (79)
Black	3 (11)
Other	3 (11)
OCCUPATION	
Physician	16 (57)
Nurse	6 (21)
Non-clinical staff and administrators	6 (21)
DIRECT PATIENT CAREGIVIER	20 (71)
PERSONAL EXPERIENCE w CAM	
Self	17 (61)
Family and Friends	9 (32)
PROFESSIONAL EXPERIENCE w CAM[a]	12 (43)

[a]Includes those who mentioned providing or prescribing the CAM therapies to patients and/or observing CAM use in their patients.

Abbreviations: VHA = Veterans Health Administration; CAM = Complementary and Alternative Medicine.

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Table 3

Themes, definitions, and sample coded text.

Themes - Definition	Sample Coded Text
Knowledge/opinions	
Knowledge -what the respondent actually knows about CAM at the VHA or CAM in general.	"They have also started offering those in the CLC." "We're doing Tai Chi, yoga, things of that sort." "We pay for some alternative and complimentary measures outside of the VA."
Attitudes/Opinions -a personal point of view not necessarily based upon fact.	"I like adjunct rather than alternative. Alternative implies rather than the proven treatment." "It needs to be scientifically based as much as possible; more clinical trials." "I'm just so excited that we are trying some alternative approach to really help them recuperate or maintain their quality of life."
Information/background -data that assist in understanding the current situation.	"There is a faculty development program in CAM offered by the affiliated university." "That's something being considered for VISN-wide implementation." "It's a big part of VHA's strategic plan for the next 5 years."
Priorities -areas that the respondent thinks should receive attention first.	"I would pick massage therapy and possibly acupuncture." "Physicians want numbers." "Work on the emotional pain and suffering and stress that people are going through."
Benefits to patients and staff	
Values/benefits -how CAM contributes to patient care and well-being.	"There's science behind what we're doing to benefit veterans. There are processes in place." "Massage therapy focusing on our palliative care group. We've had a lot of success." "It's yoga for actually reworking; it's like a physical therapy."
Veterans -issues of particular importance to veterans.	"It gives them some tools so they can take ownership of their pain management." "Many have a strong love for their pets." "Many of them have been suffering from PTSD and other wounds."
Staff satisfaction/wellness -benefits to the practitioner/promotion of practitioner wellness.	"We have a lot of anxious veterans. Their nurses could benefit from having people come work with their patients." "Rewarding and empowering especially when traditional medicine has little else to offer." "Maybe if we bring in more CAM nursing can change culturally to be more into self-care. If we don't take care of ourselves we have nothing to give."
Barriers and facilitators to the promotion of CAM	
Barriers -factors that make it harder to promote CAM in the VHA.	"People's personal biases and prejudices and such." "The medical center needs to be on board too. So that's a potential barrier." "There is no designated job class for massage therapy within VHA."
Facilitators -factors that make it easier to promote CAM in the VHA.	"There would definitely need to be a champion." "To organize it in a way that it's rational, that it respects our resource limitations." "Individuals with the experience who can present their findings or work."

Abbreviations: CAM = Complementary and Alternative Medicine; VHA = Veterans Health Administration; CLC = Community Living Center; VA = Veterans Affairs; PTSD = Post Traumatic Stress Disorder.

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Table 4

Modalities Named as Top Priority for Promotion Within the VHA

Modality	Times Mentioned[a] (% of Participants)
Massage Therapy	22 (79)
Meditation	15 (54)
Acupuncture	12 (43)
Yoga	12 (43)
Hypnosis	11 (39)
Chiropractic	10 (36)
Music Therapy	9 (32)
Healing Touch	8 (29)
Biofeedback	8 (29)
Pet Therapy	5 (18)
Aroma Therapy	4 (14)
Herbal Remedies	3 (11)
Dietary Supplements	3 (11)
Reiki	3 (11)
Homeopathy	2 (7)
Tai Chi	2 (7)
Hand Massage	1 (4)
Qi Gong	1 (4)
Faith-Based Medicine	1 (4)

[a]Total number of interviewees equals 28

Abbreviations: VHA = Veterans Health Administration.

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Table 5

Recommended actions to promote CAM within the VHA.

1	Establish a CAM advisory board at each VHA location.
2	Educate providers about specific CAM therapies and their availability with emphasis upon evidence-based results.
3	Establish VHA-wide position descriptions, e.g. acupuncturist, yoga therapy instructor, so that practitioners may be hired.
4	Provide opportunities for providers to experience CAM therapies on site.
5	Facilitate the introduction of CAM through use of pilot programs/studies.
6	Incorporate CAM into nursing practice, e.g. designating a nurse as a CAM provider on each unit.
7	Cross train CAM providers in therapies like aromatherapy and music.
8	Encourage the use of volunteers to provide therapies such as pet and hand massage.
9	Encourage patients to disclose CAM therapies they already use on their own.
10	Identify experts at each facility who can provide consultations about available CAM modalities.
11	Share best practice both within the VHA and in collaboration with successful private sector CAM programs.

Abbreviations: CAM = Complementary and Alternative Medicine; VHA = Veterans Health Administration.