



Office of Public Health &  
Environmental Hazards



# Complementary and Alternative Therapies for Gulf War Veterans

War Related Illness and Injury Study Center  
East Orange, NJ  
Gudrun Lange, PhD

Presented by the **VA War Related Illness and Injury Study Center (WRIISC)**

# CAM Popularity – Civilians

- Landmark *JAMA* Report (1998)
  - 42% of general population used at least one type of CAM within past 12 months
  - 629 million visits to alternative practitioners.
  - \$21 Billion spent with \$12 billion out of pocket
- National Health Interview Survey (2007)
  - ~38 percent of American adults use CAM

# CAM Popularity cont.

- CDC Report (2004)
  - 36% of adults used some form of CAM
  - 62% of adults 18+ used CAM in the past year
  - 55% CAM + conventional treatments
  - 26% used CAM because a medical professional suggested it
  - \$5 billion on herbal remedies
  - More women than men; higher educated; sicker; with more pain

# White House Commission on CAM (2002)

- Ensure public policy maximizes potential benefits of CAM.
- Emphasis of Report: Whole person care, individualization, evidence of safety and efficacy, partnership, prevention, wellness/health promotion and self-care as guiding principles.

# CAM Popularity – Veterans

- 30% to 50% of Veterans report CAM use (Baldwin et al., 2002; Kroesen et al., 2002)
- OEF/OIF, female, and younger Veterans are more likely to use CAM (Baldwin et al., 2002; Kroesen et al., 2002)
- 84% VA's provide or refer out for CAM therapies (Feldman et al., 2002)
- 76% of CAM non-users would use it if offered at the VA (McEachrane et al., 2006)

# VA's HAIG Report (2002)

- Healthcare Analysis and Information Group (HAIG) Study on CAM Utilization in VHA 2002
  - 84% of VA facilities provide some form of CAM
  - Most common offered modalities
- Acupuncture, biofeedback, chiropractic care, guided imagery, hypnotherapy, meditation, music therapy, progressive relaxation, and stress management.
  - Most provided by conventionally trained practitioners
- Integrated into treatment plans
- Wide variation in process used to credential privilege providers.
- Limited oversight in training, experience, certification and practice of CAM providers.
  - Limited utilization of scientific evidence to support use of CAM or support its safety and efficacy.

# VA's Response

- CAM Workgroup.
  - chartered March 2003 to examine:
    - Appropriateness of CAM practices and process in VHA.
    - Suggest strategies for providing ongoing national guidance related to CAM for VHA facilities and providers.
  - CAM appropriate if safe, efficacious and delivered by practitioners with appropriate training, certification and accreditation.
  - Recommend VA form a Field Advisory Group to promote research, integration, education on CAM within VA.

# VA CAM Field Advisory Committee (2002)

- Establish standards for training, credentialing, scope of practice for CAM practitioners- guidelines completed (2010)
- Identify therapies & practices to be integrated into VA care
- Implementation strategies:
  - therapies, resources, timelines
- Research and Funding: Assist ORD

# CAM FAC General Principles

- Safety of the practice must be ensured.
- Must be proof of effectiveness.
- VHA will establish credentialing standards.
  - Includes education and training.
  - State licensure vs. national or international standard.
  - All practitioners must meet standards.
- Care may be provided by allopathic or CAM providers.
- Same process for evaluating allopathic practices should be applied to CAM.

# Delivering CAM

- All CAM procedures require informed consent.
  - Utilize same standard as allopathic treatments.
- VHA will establish credentialing standards
  - Includes education and training.
  - State licensure may be used as basis for standards where it exists.
  - Education programs must be accredited
    - Must be by state or agency recognized by US Secretary of Education.
  - Certification is desired
  - Must be proof of minimum level of ongoing education and training.

# Delivery cont.

- CAM providers must be credentialed
  - Primary source verification is required
  - Must be recorded in Vetpro
  - CAM scopes of practices must be reviewed by PSB or equivalent body
  
- Approved CAM activities can be provided by VHA employees, of station contract or fee personnel.
  - All care must be ordered by and provided by licensed personnel.
  - VHA employees may only provide CAM if it is allowed within their occupational class.
  
- CAM care must be documented in the medical record.

# WRIISC Commitment to Excellence

- CAM
  - personalized medicine
  - Veteran centered healthcare
  
- CAM Research at WRIISC
  - Rigorous methodological standards
  - Rigorous ethical standards

# Acknowledgements

- Stephen Ezeji-Okoye, MD  
Chair, VHA CO CAM FAC
  
- WRIISC CAM Workgroup
  - Jeanette Akhter, MD
  - Louise Mahoney, MS
  - Kelly McCoy, PhD
  - Anna Rusiewicz, PhD

# References

1. Eisenberg DM, Davis RB, Etner SL, et al. Trends in alternative medicine use in the United States, 1990-1997. *JAMA*. 1998;280:1569-1575.
2. National Health Interview Survey 2007: [nccam.nih.gov/news/camstats.htm](http://nccam.nih.gov/news/camstats.htm)
3. White House Commission on Complementary and Alternative Medicine Policy, Final Report (2002): [www.whccamp.hhs.gov](http://www.whccamp.hhs.gov)
4. Rick C, Feldman J, et al Survey of complementary and alternative medicine (CAM) (2002). Washington, DC: Department of Veterans Affairs Health Administration. Office of Policy and Planning, Healthcare Analysis and Information Group.
5. Baldwin C, Long K, Kroesen K. A profile of military veterans in the southwestern US who use complementary and alternative medicine: Implications for integrated care *Arch. Intern. Med.*(2002) 12:1697-1704.
6. Kroesen K, Baldwin C. et al: U.S. military veterans' perceptions of the conventional medical care system and their use of CAM. *Family Pract.* (2002),19:57-64.
7. McEachrane-Gross, Liebschutz J Berlowitz D., Use of selected complementary and alternative medicine (CAM) treatments in veterans with cancer or chronic pain: a cross-sectional survey *BMC Comple & Alt Med.*. (2006) (6)34:1-7.