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Providers' and Administrators' Perceptions of Complementary and Integrative Health Practices Across the Veterans Health Administration

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Abstract

Objectives: Use of complementary and integrative health (CIH) therapies is being promoted by the Veterans Health Administration (VA), but promotion may not equate to adoption. The purpose of this study was to explore whether perceptions regarding CIH at one VA medical center (VAMC) were similar to perceptions from a sample of other VAMCs.

Design: This article reports a subset of qualitative findings from a mixed-methods study.

Setting/Participants: Sites were recruited through a VA-wide CIH listserver. On the basis of site description (e.g., therapies offered, interest in CIH), sustained site interest, and geographic location, recorded interviews of 22 persons were conducted at 6 sites across the country.

Outcome measures: Interviewees were asked the same questions as the single-site VAMC study respondents.

Results: Variable access to CIH services across the VA created the need for workarounds. Multiple barriers (e.g., limited space and challenging credentialing) and facilitators (e.g., strong champion and high veteran demand) were cited. Respondents described nonpharmacologic pain control, the usefulness in treating mental health and/or post-traumatic stress disorder issues, and improvement of staff morale as additional reasons to promote CIH. Findings confirmed those from the earlier single-site VAMC phase of the study. Even the highest-performing sites reported struggling to meet veterans' demands for delivery of CIH.

Conclusions: Almost half of active-duty military personnel report the use of at least one type of CIH therapy. As active-duty personnel transition to veteran status, both their physical and mental healthcare needs can potentially benefit from CIH therapies. The VA must actively support local enthusiastic CIH proponents and receive congressional support if it is to actually meet its stated goal of providing personalized, proactive, patient-driven healthcare through the promotion of comprehensive CIH services to veterans.

Keywords: complementary and integrative health (CIH), complementary and alternative medicine (CAM), veterans, access, patient-centered care, barriers and facilitators

Introduction

The Veterans Health Administration (VA) has begun actively promoting the use of complementary and integrative health (CIH) therapies, such as acupuncture,[1] mindfulness,[2] and yoga,[3] as a part of personalized, proactive, patient-driven healthcare.[4] Several studies have evaluated the use of CIH therapies by veterans.[5,6] Findings indicate that meditation, relaxation, massage, spinal manipulation, and acupuncture are among the most frequently offered and studied therapies, but implementation appears to be inconsistent.

Successful adoption and long-term use of any new health-related policy or procedure demand active cooperation among clinicians[7] and administrators. However, a review of the literature did not yield studies involving providers and administrators. On the basis of the authors' own experiences and observations, it appeared that at least some of the

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providers and administrators at the authors' VA medical center (VAMC) were ambivalent about CIH, perhaps because of lack of knowledge or experience. The authors' first aim was to examine whether these observations were accurate. Therefore, after Ann Arbor VAMC Institutional Review Board granted approval, qualitative interviews of 28 local providers and administrators within a single VA site were conducted regarding their views about CIH therapies in general and in the VA in particular. Persons who were thought to be both supportive and skeptical of CIH were deliberately included.

The single-site interviews did support the prestudy observations. While some respondents were quite knowledgeable about CIH, others had gaps in their knowledge or pronounced biases, some based on disconnects between perceptions and reality. The local respondents listed multiple facilitators of and barriers to the promotion of CIH.[8] Thus, the subsequent aim was to fill a gap in the literature by investigating whether the varying levels of familiarity with and biases concerning CIH therapies were unique to the authors' local institution or are found in providers and administrators throughout the VA. The findings from the interviews with personnel from the additional VAs are reported in this paper.

Materials and Methods

The methods were chosen for the purpose of conducting an exploratory study. An exploratory study is used to identify variables and develop theories by exploring in detail what is currently occurring.[10] Exploratory findings indicate where further research is needed.

Recruitment

Further institutional review board approval was received to extend the study by interviewing 22 additional providers and administrators employed at various VAMCs across the United States. Initial recruitment took place through a VA-wide listserver for those interested in CIH therapies. The principal investigator (PI) issued an open invitation for anyone to contact her who thought their site, whether self-defined as high performing or struggling, would be interested in study participation. Persons from 15 sites responded. On the basis of site description (e.g., therapies offered, interest in CIH), sustained site interest, and geographic location, purposeful sampling was used[9] to choose the 6 sites (2 in the Eastern, 2 in the Central, and 1 each in the Mountain and Pacific time zones of the United States) where the interviews were conducted. The contact person at each site provided the PI with the names of potential interviewees. The PI then sent each potential interviewee a study description and an invitation to be interviewed.

Although this method resulted in a convenience sample of participants, the interviewees served in a variety of positions (Table 1) with multiple viewpoints. Positions were self-described to promote confidentiality. There were 2–7 interviewees per site. Interviewees included 20 women and 2 men. Whether the disproportionate number of women reflects selection bias on the part of the site contact person or gender bias regarding interest in CIH could not be determined within the scope of the study. To promote anonymity, the authors did not inquire about race/ethnicity.

Table 1. Self-Described Positions and Sex of Respondents ($N=22$)

Variable	*Respondents (*n*)*
Self-described position	
Administrator	1
Advance practice nurse	4
Associate director, patient care services	1
Case manager	1
Charge nurse	1
Chief integrative medicine	1
Hospitalist	1
Integrative health coordinator	1
Nurse manager	1
Physician	3
Program support assistant for CIH	1
Psychiatric clinical nurse specialist	1
Psychologist	1
Recreation therapist	1
Research scientist	1
Social worker	1
Staff nurse	1
Sex	
Female	20
Male	2

To promote anonymity, the respondents were not asked about racial identity.

In addition, the authors interviewed Tracy Gaudet, MD, director of the VA Office of Patient Centered Care and Cultural Transformation.

Data collection

After signing an informed consent form, each respondent was interviewed once by using the same questions that were asked of the single-site VAMC respondents (Table 2). Interviews, which took place from April through July 2014,

Table 2. Interview Questions Asked 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.

At the time the study was conducted, ''CAM'' was the accepted term rather than ''CIH'' (complementary and integrative health).
VAAAMC, VA Ann Arbor Medical Center.

were conducted by phone and were audio recorded. Respondents could take as much time as they chose to answer the questions. Length of the interviews ranged from 6:48 to 48:22 minutes (mean, 18:15 minutes).

Data analysis

Interviews were transcribed by an experienced transcriptionist and were checked for accuracy by the PI. Three members of the research team then individually coded the interviews. The phenomenological approach to data analysis was chosen in order to describe the meaning of the respondents' lived experiences from the viewpoint of the individuals involved,[10] remembering that a person's description is a perception or form of interpretation.[11] The analysts first individually coded emergent themes inductively, then met as a group and compared the themes to derive group codes. By using NVivo software (QSR International Pty Ltd, Doncaster, Australia), discussion and thematic analysis continued, including comparison with the codes used to analyze the previous set of local VAMC interviews until consensus was reached.

Results

Reflecting the importance of CIH to the respondents and the open-ended structure of the questions, the responses covered an exceedingly wide range of topics. These have been classified under the broad headings of ''barriers'' and ''facilitators,'' followed by the observations of Tracy Gaudet. These responses illustrate the multiple challenges to VA administrators and providers as well as the benefits to veterans and staff of truly implementing CIH across the VA. The results are reported according to types of barriers and facilitators (in the following text) and whether they mainly occur at the personal, facility, or system-wide level (Tables 3 and 4).

Barriers to use of CIH therapies

Logistic challenges. Multiple barriers were cited to the promotion of CIH therapies within the VA (Table 3). When asked about available space, a respondent replied, ''We were supposed to be expanding next year but that has been postponed until like 2018.'' Another respondent from the site without a CIH program attributed the deficiency to management lacking vision and not being ''forward thinkers.'' That person was amazed and pleased that a study such as this one would even be conducted within VA.

Inability to incorporate trained volunteers was a frustration for another respondent. However, a different respondent figured out how to set up a program in which people with licenses come into the facility as volunteers and then, through a carefully structured program, are gradually vetted and integrated into the setting until they can provide CIH therapies to veterans.

A nurse described a healing touch clinic that took the nursing group 5 years to set up. She hoped the clinic would be functional within the next few months. Barriers included lukewarm to skeptical receptions from medical leadership, having to find their own space, months of effort to coordinate with another clinic for a clerk to check in patients, establishing the clinic in the electronic medical record, and designing the templates for charting so that data can later be pulled electronically. All of this effort, which took place during ''free'' time, was for a trial clinic expected to treat 10 patients a week for 3 weeks to determine whether patients could be taught 3 interventions to better manage their pain and anxiety.

Variable access to CIH. VAMCs represented in the interviews varied widely in their use and/or promotion of CIH. As a result, access to CIH varied widely. Two VAMCs had extensive programs offering over 10 different therapies, 2 offered 5–10 types of therapies, 1 was developing its first CIH offering, and 1 offered only pet therapy by community volunteers who brought in dogs. However, offerings frequently came with caveats. Many of them were funded by grants or run by volunteers, generally employees, who carved out the time to offer CIH from other job duties. However, not all liked the arrangement. ''I don't think CAM therapy should be a burden on the practitioner…. It really should be given the consideration that this is an important tool.'' Respondents detailed personal costs they bore in order to promote CIH therapies. One described a specialized yoga program for those with physical limitations as led by an outside volunteer who worked with the occupational therapist while ''looking for a paid VA position.'' Others referred to a lack of providers at their location or a physician who is also an acupuncturist but limits acupuncture to her own patients.

As a result of examples like these, CIH therapies were not necessarily offered consistently. This led to some confusion in the respondents as to what was currently available and thus what they could recommend to patients. ''I think there may be yoga but I am not sure.'' ''For a while we had some Reiki going.'' Furthermore, the CIH offerings were almost universally targeted to specific veteran populations. ''We have an aroma therapy pilot … but we're not doing it all over the hospital.'' Often the programs were accessed via a referral from a provider. ''I believe it's just a referral, probably from the Primary Care physician or the Pain Clinic.'' ''A veteran cannot self-select for acupuncture, a veteran needs to be referred'' for resources to be appropriately directed.

One respondent stated that at their VA, most requests for CIH services, such as acupuncture, had to go through the anesthesia department or the pain control clinic to be evaluated first, ''which in and of itself can be sometimes sort of difficult.'' The respondent added that if the patient cannot get through to the clinic, the consult is discontinued. Another described lack of staff to reduce waitlists for CIH therapy that had been ignored for months and were now suddenly being tracked. ''It wasn't a problem before, now suddenly I am getting emails from the Director.'' Another participant praised the recent VA initiative to include any two CIH therapies at every VA[12,13] but saw the challenge as whether VAs only give lip service and check off a list while not providing CIH therapies in a meaningful way.

Working within the system. Reflecting the access issues described above, workarounds for training and/or supporting provision of CIH therapies were described. ''We have nurses that can perform Reiki but we kind of keep it a secret because I do not know whether or not it is approved.'' Another person described an ambitious program for training employees in CIH techniques. When asked about funding

Table 3. Respondents' Descriptions of Barriers to Promotion of Complementary and Integrative Health Within the Veterans Health Administration

Themes	*Sample coded text*
Personal level	
Lack of providers' personal experience with CIH	''It's easier if people in administration or leadership positions have experienced themselves and found out how it can make a difference in somebody's life.''
Having to use personal time or funds to obtain training	''My initial training was all through outside sources that I self-funded.… I have been able to get staff funded through the VA.… They did it on their own time.''
	''The nurses that are involved in the healing touch project; we're all doing it on our own time.''
Practitioners who fear accepting new ideas	''A lot of people are just not … they don't want to know. They don't want to accept it.''
	''It's kind of sad that they prefer oral analgesics when there's alternative treatments.''
Preexisting provider or patient mindsets	''Everyone's afraid to treat pain''
Facility level	
Unsupportive management	''It's nothing that they've brought forth to me … so I am taking some preliminary actions to try to come up with a plan that my VISN might find acceptable.''
	''Our management here doesn't really have much vision.''
Dependence upon volunteers	''We also had students coming from the acupuncture school and it was limited to Neurology only, and it was limited to chronic pain … there was a waiting list.''
	''There is no mechanism that I am aware of that would allow volunteer experts.… These are people that just out of the goodness of their hearts want to do something for vets.''
Therapies available only to targeted groups of veterans	''I don't think you'll find anything that's available to 100% of the veterans.''
	''It's just outpatient at this point.''
Complicated and/or limited availability of referrals	''Veterans can sign up for yoga classes but there's not enough slots and there's waitlists.''
Need for multiple approvals to initiate a program	''It takes a long time to get approvals … the system is not designed to think outside of the box.''
Difficulty incorporating volunteers	''The yoga instructors … there's competencies that they're expected to display … but they're basically volunteers. I wish there was more in the budget so that we could pay those yoga teachers.''
Lack of space, time, or funds	''I'd like to have an entire Pain Center that is integrative …. to manage the huge pain population that we have in the VA.''
	''Space is more of an issue when you have equipment. You need a quiet private spot.''
VA-wide level	
Struggle to provide basic healthcare to overwhelming number of veterans	''The way the scheduling system operates presents a real barrier to make or cancel appointments.''
Cost and/or lack of cost-benefit data	''Data tracking is a very important part of what we do … we need to show results.''
Lack of position descriptions	''We have a provider who has been trained in acupuncture, but has not been credentialed.''
System focused on medications and illness	''At my VA? No, we don't have any alternative therapy.''
	''CPRS is a huge obstacle.… It is absolutely focused on illness and medications.''
Unstable funding (e.g., grants)	''The program … was completely supported by first a postdoc fellow and then research dollars from the NIH followed by research funding through the VA. When that funding ran out the PI tried to get support from mental health and from nursing service, just to keep the clinic open … that program is not offered as widely as it could be.''
Lack of funding from Congress	''There is no funding. We're just doing it.''

CIH, complementary and integrative health; VA, Veterans Health Administration; VISN, Veterans Integrated Service Network; CPRS, computerized patient record system; PI, principal investigator.

Table 4. Respondents' Descriptions of Facilitators to Promotion of CIH Within the VA

Themes	*Sample coded text*
Personal level	
Champion for CIH	''Absolutely key is a … respected person champion … sort of keeps things moving.''
Staff interest	[Without the support of] ''the person on the ground … it would be a much more difficult path for anyone who would try and get things done.''
Strong commitment to use of CIH from clinical providers	''You really have to have the buy-in from the medical providers. They're going to have to be having that discussion with patients.''
Facility level	
Supportive management/ administration	''Equally essential is the support and buy-in from administration.'' ''We have a great Director. He is really into CAM.''
Staff time dedicated to provision of CIH	''Being able to have some time … often time is a huge barrier.''
Staff hired in other positions but also trained in CIH therapies	''We have just had a doctor, an M.D., who is also an acupuncturist who has been hired.''
Experienced practitioners in CIH	''The yoga program started primarily through the interest of one MD and one psychologist who both had a high interest … both for personal and professional reasons.
Education of VA providers regarding CIH	''I've been working with the PTSD clinic to create a program and a manual so that any of the staff members … can teach them gentle stretches [that] can be incorporated into their treatment plan.''
Multidisciplinary teams	''She and I and a team … submitted and obtained a grant for doing research.''
Permanent coordinator	''Finding someone with the energy to do this if it's not their full time job … it's very, very difficult … everything seems to be consuming your time, so it's a resource problem.''
Staff acceptance of less usual practices	''We are very much respectful and promote all kinds of spiritual practices.''
Acceptance of skeptical staff by staff promoting CIH	''You just have to let staff have their skepticism but also encourage them as far as what might be possible.''
Facility-specific directory of CIH therapies	''We don't have any sort of directory that people could use. The primary care providers … would do well if they knew who to refer to or had … a sense of when they were offering it … how to contact the person … what the parameters are for the referral.''
VA-wide level	
Veteran demand	''The vets are super open … in our yoga group…. I hear people wanting to try other things.'' ''Veterans talk to each other and they encourage each other to … indicate their interest in joining the group.''
VA directive to reduce opioid use in veterans	''It wouldn't be another drug that they would have to take.'' ''Our administration is quite well aware they have a lot of chronic pain patients and it is not always necessarily the best thing to treat them with narcotics.''
CIH used in wider community	''It's so backwards in this government system. Private centers are using music therapy and it's like, when is the government going to get with it?''
Realization of effect of CIH upon PTSD	Originally we had a lot of Viet Nam era veterans in that class [for those with PTSD]. We still do, but now we have a lot more of the younger veterans who were in the more recent conflicts.''

CAM, complementary and alternative medicine; PTSD, post-traumatic stress disorder.

the respondent replied, ''We're just doing it…on organization time.'' Some programs used employees hired in other positions to also provide CIH therapies. ''The acupuncture was through our dermatologist, who is an expert.'' However, this workaround did not apply in all cases. When a respondent who is a licensed massage therapist but employed in another capacity was asked about giving massages to veterans while on the job, the answer was, ''I am busy…. I would have to get permission by the chief of my service.'' On a more positive note, a person who works on a rehabilitation unit described the truly integrative ability for a patient on that unit to talk to the medical doctor, followed by a session of relaxation technique therapy, then talk to the pharmacist, and then do some *chi gong*.

Facilitators of use of CIH therapies

Facilitators for promoting CIH therapies were cited as well (Table 4). The VA's recent directive to reduce the prescription of opioids was seen as a facilitator. ''When it became obvious that we were an outlier in the use of opioids, then more attention was drawn to what else we can

do.'' A perhaps unexpected facilitator was institutional willingness to accept varying spiritual practices as a part of promoting healing holistically, especially in areas where Native Americans are prevalent.

Perceptions of improved pain management through use of CIH therapies. Respondents specifically addressed the effect of CIH on improved pain control. A respondent described introducing patients from the new integrated pain clinic to her yoga group. ''The response was just phenomenal. 'That's so great; we're tired of taking pills.''' Another respondent described working with amputees and teaching them how to apply pressure to relieve phantom limb pain, describing it as ''very successful.'' Another stated, ''If we're going to get these people off of their chronic narcotics, we need to offer them some other things to help them out.'' However, another person thought that people are afraid to treat pain with CIH therapies because they are not well trained in them. ''The automatic response, as a physician, is to write a prescription for it…. Then the patients are sort of thinking that way as well.'' The conclusion was that both the provider and patient mindsets can be barriers to treating pain in veterans by using CIH therapies. For patients who want CIH therapies, some sites described long waitlists and lack of providers certified by the VA, even when employees are already certified through nursing or other disciplines.

A nurse practitioner described patients who are upset and angry when their prescriptions for narcotics are reduced but they are not offered another way to relieve their pain. ''I just end up passing the buck to the pain pharmacist.'' A physician at a low-performing site stated, ''I'd like to have an entire Pain Center that is integrative … proven alternative therapies to manage the huge pain population that we have in the VA.''

Another physician who is a pain specialist thought that most patients want to feel better and want to do something other than taking a lot of medications. The physician added that many veterans have explored CIH therapies on their own and want them to be available in the VA. Suggested solutions included offering an array of CIH therapies, being more collaborative and interdisciplinary, increased allocation of resources, breaking down the medical model, and encouraging a holistic approach.

Perceptions of improved mental health treatment through use of CIH therapies. Respondents viewed CIH therapies as a way to treat mental as well as physical pain in veterans, especially as it relates to post-traumatic stress disorder (PTSD). A respondent described a social worker and psychologist, both also certified yoga instructors, who created a therapeutic group. The group begins with mindfulness meditation, followed by a yoga session and then a discussion of whether participants had thoughts or memories of their traumatic experiences during the yoga session and, if so, how they responded. Another respondent who is certified to teach mindfulness-based cognitive therapy obtained a grant to teach mindfulness to veterans at high risk for suicide, as well as doing individual biofeedback sessions with veterans who have high anxiety levels. Smoking cessation was also cited as a place where mind–body strategies are helpful.

Another respondent described biofeedback as ''fabulous'' for anxiety, observing, ''We don't have enough of that'' because of having only one provider at that site. Multiple therapies were mentioned specifically to treat PTSD, anxiety, and mood disorders (Table 5). Spurred by patient demand for better treatment options, a respondent hoped use of CIH therapies to treat PTSD and anxiety will increase because ''What we're doing now is pretty limiting. You can see by the results and the readmissions that we can actually start going ahead and not be so afraid…. Just try it.'' One respondent summed up what CIH therapies can offer to veterans with mental health needs as follows:

> I'm a firm believer that there's other ways of helping people…. Touch, to me is so important, even though I know a lot of these guys don't want to be touched…. You can touch people in other ways than physically … through their mind, through just caring and loving, letting them know that you're there and different ways that they can feel that they're worthy.

Table 5. Modalities Respondents Would Most Like to See Promoted by the VA ($N=22$)

Modality	*No. of times mentioned (% of participants)*
Massage	11 (50)
Acupuncture	9 (41)
Chiropractic	7 (32)
Meditation	6 (27)
Music	6 (27)
Pet therapy	6 (27)
Yoga	6 (27)
Aroma therapy	4 (18)
Hypnosis	3 (14)
Biofeedback	2 (9)
Herbal therapy	2 (9)
Qi gong	2 (9)
Reiki	2 (9)
Therapeutic or healing touch	2 (9)
T'ai chi	1 (5)

Modalities mentioned at least once specific to PTSD and/or anxiety treatment: aroma, biofeedback, drumming, emotional freedom technique, massage, meditation, mindfulness, music therapy, pet therapy, self-awareness strategies, tapping, Trager, yoga.

Effects on staff morale. In addition to CIH benefiting patients, respondents described the benefits for employees. ''I began to learn about Planetree and the different modalities … based on what my patients were telling me…. It just kind of expanded my world.'' Several respondents cited promotion of employee wellness through programs such as massage, *qi gong,* and yoga as an important part of benefits for employees. ''If we don't create a healing environment to be inclusive of ourselves, we're really missing part of the picture.'' Others appreciated the fact that the VA had paid for their CIH training, leading to the expansion of services they could offer veterans and resulting in a chance to uniquely personalize the therapeutic encounter by bringing their caring and healing to a deeper level.

Recommendations for CIH promotion within the VA

Each respondent was asked to specify the three or four CIH therapies they considered most important for the VA to promote as part of veterans' care (Table 5). Massage was named by 50% of the respondents, followed by acupuncture (41%), chiropractic (32%), and meditation, music, pet

therapy, and yoga (27% each). The recommendations reflected their ideal perception of CIH therapies, not necessarily specific therapies offered at the respondent's location.

National director's observations

Tracy Gaudet, MD, director of the VA Office of Patient Centered Care and Cultural Transformation, sees many of the same issues identified by study respondents. She defines The VA's goal of providing personalized, proactive, patient-centered care as care that considers a patient's values as well as their medical diagnosis, includes strategies to help increase their innate capacity to heal, and is driven by what matters to patients and what they want for their health. In Dr. Gaudet's opinion, barriers to adoption of CIH in VA are both philosophical (e.g., the medical model is still considered the ideal by many providers) and practical (e.g., the lack of job descriptions that prevents hiring of CIH practitioners and capture of workload) and include the need for more solid research that supports the use of CIH (e.g., the Acupuncture Mapping Study[1]). By the same token, she sees the enthusiasm of providers, patients, and members of Congress for a more holistic approach to healthcare as a driver for the promotion of CIH in the VA. She views acupuncture, mind–body approaches, movement therapies, and therapeutic massage as examples of approaches worthy of support by the VA (Gaudet T. E-mail communication, October 2014).

Discussion

The multisite results reported in this paper support the findings from the first part of the authors' study, which involved only a single site. In the initial phase, lack of knowledge about the effectiveness of CIH therapies and the therapies available at the authors' particular institution was evident. Some providers worried about whether using CIH therapies would make them appear ''nonscientific,'' and others were concerned about whether use of such therapies such as pet and aroma therapies would cause more problems than they solved. Lack of time, space, funding, and staff training were all listed as challenges, and the need for a strong champion and/or leadership was articulated. At the same time, CIH therapies were viewed as a way to integrate the care of body, mind, and spirit while providing care with compassion. Therapies most often mentioned included massage, meditation, acupuncture, and yoga.[8]

All of these findings were confirmed and extended by the second multisite phase of the study. Although some sites are functioning at a much higher level and providing many more CIH therapies than others, respondents from even the high-performing sites cited challenges involving limited time, space, funding, and staff training. One difference appeared to be that those at high-performing sites had been able to develop more workarounds or made more personal sacrifices to operate within or in spite of the system. However, the factor that seemed to make the most difference in overcoming challenges was the presence of effective leadership. All of the high-performing sites had strong administrators or clinical champions, sometimes both, who actively promoted the use of CIH therapies. In contrast, at the site that did not currently provide any CIH therapy other than volunteers with dogs, there appeared to be a climate of caution with regard to provision of CIH. For example, two physicians at that site who initially expressed interest in the promotion of CIH therapies declined to be interviewed when they learned that a signed consent form and recorded interview were involved, even though they were assured their responses would remain confidential.

The potential contribution of CIH therapies to pain control must not be ignored. Chronic pain, estimated at 26% in the general population, is an even bigger problem for an estimated 44% of veterans.[14] While the VA's initial response to undertreated pain was to encourage the increased prescription of opioids, the result has been the overprescription of opioids for veterans.[15] But as the respondents so clearly described, if opioids are to be withdrawn, then something else effectively mitigating the effects of pain must be used. In another portion of this study reported elsewhere, patients with chronic pain were interviewed about their opinions of and experiences with CIH therapies, especially massage.[16] Patients were clear that even limited exposure to CIH therapies could provide at least temporary relief from both physical and mental pain, relief that they highly valued.

When describing their individual institutions, the respondents ably described the challenges for the VA for promoting the use of CIH therapies. With over 150 hospitals nationwide, the VA obviously represents a very large, complex system. A large system can be used effectively (e.g., to negotiate drug prices through contracts). It can also affect patient care through mandates (e.g., promotion of patient-centered care). But when filtered through widely different circumstances of size, geography, local standards, and priorities, interpretation and implementation of national mandates may not be so easily accomplished. In addition, the VA depends on Congress not only for funding but for the creation of additional positions and credentialing of new types of providers (e.g., acupuncturist or massage therapist). The results are the workarounds described by the respondents (e.g., a physician who incidentally does acupuncture or a social worker who is also certified in yoga).

Until recently the method used by the VA to promote the use of CIH therapies was a ''carrot and stick'' approach. The VA promoted CIH on a national level but also expected individual sites to promote the use of a minimum of two CIH therapies of their choosing. The advantage of this approach is the encouragement of individuality even in a large system. The disadvantage is that sites may not have the necessary leadership, knowledge, or commitment to promote CIH in a meaningful manner. Additionally, although members of Congress may theoretically promote a holistic approach to veterans' healthcare as Dr. Gaudet describes, the current political divides in Congress potentially threaten the actions needed to support CIH for veterans.

To address these issues in 2011, the VA created the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) to promote personalized, proactive, patient-centered health care, but the infrastructure to promote nonconventional strategies, including CIH, did not exist. Thus, in 2014 OPCC&CT was tasked with creating the VHA Integrative Health Coordinating Center (IHCC). Its core functions are to identify and remove system-wide barriers to providing CIH and to serve as a resource for clinical practices and education for veterans and practitioners.[4]

Current areas of focus include (1) policy to provide clarity and guidance regarding CIH services covered and how they fit within care provided by the VA; (2) establishment of new occupations, particularly acupuncturist and massage therapist; (3) business processes, particularly clinic and event capture codes; (4) cultural transformation through communications and outreach to both veterans and staff; (5) preparing the current workforce through multiple education offerings; (6) building the research portfolio; and (7) forming strategic partnerships both in and out of the VA (e.g., with the Department of Defense and non-VA organizations).[17] How successful IHCC is in systematically implementing these goals, including by use of the preliminary findings reported in this paper, can be expected to affect the actual adoption of CIH throughout VA.

In summary, if CIH therapies are to be truly available to veterans system wide, especially for problems such as pain control and PTSD, there needs to be more ''carrot'' for clinicians in the form of permanent positions for CIH practitioners, education for providers about the evidence-based benefits of CIH therapies, hands-on demonstrations of how to promote and use CIH therapies, promotion of forward-thinking leaders, increased space and funding to support CIH classes/clinics, and system improvements to enhance charting and billing when CIH services are rendered, all areas of focus for IHCC.

The findings reported in this paper are preliminary and may be limited by the small number of sites involved and self-selection of respondents due to their interest in CIH. However, they are consistent with the findings from the first portion of the study at the authors' local site.[8] In addition, the sites in the currently reported portion of the study represent a variety of geographic locations and approaches to the use of CIH therapies within the VA. While these preliminary findings cannot be generalized, they suggest that there are significant barriers to the implementation of CIH therapies in VA settings. Barriers may be system wide or unique to particular clinical settings. More research needs to be completed to determine both system-wide and site-specific challenges to implementing CIH therapies in the VA setting.

Conclusions

Over 100 Department of Defense facilities both in the United States and abroad are offering CIH therapies,[18] and 45% of active-duty military personnel report use of at least one form of CIH.[19] As active-duty personnel transition to veteran status, both their physical and mental healthcare needs are often uniquely complicated by the effects of having been in military service. CIH therapies offer a potentially powerful way to address these problems, making it incumbent upon the VA to provide CIH therapies. The respondents clearly articulated both the enthusiasm and the frustration involved with the promotion of CIH therapies within the VA. Their responses provide preliminary data for furthering an understanding of the challenges encountered when attempting to implement new therapies in a large healthcare system, in this case for the purpose of delivering personalized, proactive, patient-driven healthcare. How to meet these challenges emphasizes the need for further research. Veterans should not have to go outside of VA to find the CIH therapies they seek.

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