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VHA DIRECTIVE 1137(2)

Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

AMENDED  
JULY 2, 2021

VHA DIRECTIVE 1137(2)  
Transmittal Sheet  
May 18, 2017

## PROVISION OF COMPLEMENTARY AND INTEGRATIVE HEALTH

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive establishes policy regarding the provision of complementary and integrative health (CIH) approaches, representing a significant change in how care is to be delivered across the VHA system.

**2. SUMMARY OF CONTENTS:** This directive establishes the responsibilities of VHA when offering CIH approaches and integrating them with conventional care.

a. Amendment dated July 2, 2021, updates pronouns in paragraphs 5.c.(7) and 6.b.

b. This directive contains an amendment, dated June 14, 2021, to update:

(1) The vetting process and criteria for CIH services to be recommended for inclusion in the medical benefits package (see Appendix B).

(2) The name of the Whole Health Experience Committee to the Healthcare Delivery Council (see paragraphs 5 and 6).

**3. RELATED ISSUES:** None.

**4. RESPONSIBLE OFFICE:** The Office of Patient Centered Care and Cultural Transformation (12PCCCT) is responsible for the contents of this directive. Questions regarding this policy may be directed to the Office of Patient Centered Care and Cultural Transformation at [VHA12PCCCTPatientCenteredCareAction@va.gov](mailto:VHA12PCCCTPatientCenteredCareAction@va.gov).

**5. RESCISSIONS:** None.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of May 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

Poonam Aliagh, M.D.  
Acting Under Secretary for Health

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## PROVISION OF COMPLEMENTARY AND INTEGRATIVE HEALTH (CIH)

### 1. PURPOSE

This Veterans Health Administration (VHA) directive provides guidance on the integration of Complementary and Integrative Health (CIH) approaches within VHA to advance personalized and patient-centered care. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b); 38 U.S.C. 1710; title 38 Code of Federal Regulations (CFR) 17.38.

### 2. BACKGROUND

a. National surveys since the early 1990's have shown individuals, including Veterans, are using complementary and alternative medicine (CAM), now known as complementary and integrative health (CIH).

b. The National Center for Complementary and Alternative Medicine (NCCAM), a division of the National Institutes for Health, was established by Congress in 1998. Title VI, Section 601 of the Omnibus Appropriations Act of 1999 (Pub.L. 105-277) (1998). The mission of NCCAM has been to define, through rigorous scientific investigation, the usefulness and safety of CAM interventions and their roles in improving health and health care. This body of knowledge continues to grow and is contributing to the evidence and understanding of their utility.

c. In 2000, the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive Order 13147 (March 7, 2000), as amended by Executive Order 13167 (May 7, 2000) (to increase membership). WHCCAMP was required to submit a report to the President that included its detailed legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of CAM. The report called on Federal agencies, including the Department of Veterans Affairs, to assist in implementing its recommendations.

d. Since 2002, the CDC National Health Interview Survey (NHIS) has routinely included questions on the use of CAM.

e. In 2005, the Institute of Medicine (IOM) (now known as the National Academy of Medicine) issued a consensus report in which it evaluated the state of Americans' reliance on CAMs. Per its charge, IOM also helped the National Institutes of Health and the Agency for Healthcare Research and Quality in developing research methods and in setting priorities for evaluating CAM products and methods. Among its recommendations, the IOM suggested that:

(1) Health care should strive to be both comprehensive and evidence-based;

(2) Conventional medical treatments and CAM should be held to the same standards for validating clinical effectiveness; and

(3) Standard educational curriculums for health professions at the undergraduate, graduate, and postgraduate levels incorporate sufficient information about CAM to enable state licensed and certified professionals to competently advise their patients about CAM.

f. Between 2002 and 2012, the use of CAM remained constant, ranging between 32 and 35 percent of US civilian adults. During that time-period, the data show the same five approaches were the most frequently used. They were: Non-vitamin/non-mineral supplements, deep breathing, yoga/tai chi/qi-gong, chiropractic/osteopathic manipulation, and meditation.

g. In 2014, Congress changed the name of the NCCAM to the National Center for Complementary and Integrative Health (NCCIH). Per the Center's Web site: "The change was made to more accurately reflect the Center's research commitment to studying promising health approaches that are already in use by the American public. Since the Center's inception, complementary approaches have grown in use to the point that Americans no longer consider them an alternative to medical care."

h. Based on the report titled, "FY 2015 VHA Complementary & Integrative Health Services (formerly CAM)" (conducted by VHA's Healthcare Analysis and Information Group), the CIH practices in greatest use within VHA were: Acupuncture, animal assisted therapy, biofeedback, guided imagery, hypnosis, meditation, music therapy, progressive muscle relaxation, stress management and relaxation therapy, and yoga. VA recognizes use of these practices may help facilitate the development of a patient's personalized and patient-centric treatment plan.

i. Identification of which approaches are CIH and which are considered to be conventional care is not a static matter; for instance, chiropractic care, which was once considered to be CIH, is now considered to be conventional care. As clinical research and clinical practice in this area continue to evolve, changes between these categories can be expected to occur over time. For this reason, VHA will post sanctioned CIH approaches on a VHA Intranet SharePoint site, which will be updated timely to reflect any changes to the listings.

j. The Office of Patient Centered Care and Cultural Transformation (OPCC&CT) was established in January 2011. The OPCC&CT is working with VHA leadership and other program offices to transform the system of health care from the traditional medical model to a whole health system of care, which is personalized, pro-active, and patient-driven. The mission of OPCC&CT is to catalyze and sustain cultural transformation in healthcare for and with our Veterans. Its stated vision is to transform from a problem-based disease care system to a patient centered health care system. In 2014, OPCC&CT launched its Integrative Health Coordinating Center (IHCC). The two major functions of the IHCC are to: 1) identify and address barriers to providing CIH services across the VA; and 2) serve as a resource for clinical practices, education, and research related to CIH for both Veterans and VA staff.

k. The Under Secretary for Health has identified 5 key strategic priorities for VHA, including improved access to care, employee engagement, business practices, and building high performing healthcare networks as well as restoring pride, public trust, and confidence in VA. An approach to health care that is appropriately personalized and patient-centered aligns with each of these priorities. With respect to the first, it will improve access to care that is patient-centered and, as such, ensure a Veteran is our partner in developing a personalized treatment strategy and plan to optimize the Veteran's health, healing, and sense of well-being. The IHCC believes this integrative approach to health care can have a positive influence on the patient's outcomes, even if its effects on one's overall health may not be measurable using current techniques. VA providers should therefore be proactive in including and offering CIH options, as identified below in paragraph 6, when offering and providing conventional care to enrollees, to further VA's efforts at increasing access to care that promotes and preserves health.

**NOTE:** *The term "Integrative Health" is inclusive of CIH and integrative medicine. It is sometimes referred to as, or considered synonymous with, "Integrative Medicine"; however, the scope of "Integrative Medicine" is narrower than that of Integrative Health. See 3.h. for the full definition of Integrative Health. For this reason, IHCC recommends the term "Integrative Health" be used solely.*

l. VA informed consent requirements and procedures, found in 38 CFR 17.32 and VHA Directive 1004.01, Informed Consent for Clinical Treatments and Procedures, or successor policy, apply to CIH approaches as a part of a Veteran's personalized health plan, and Veterans voluntarily choose to engage in CIH approaches after verbal informed consent. The CIH practitioner or instructor must obtain verbal informed consent prior to delivery of CIH approaches.

### 3. DEFINITIONS

a. **Alternative Medicine.** A type of non-conventional medicine used in place of conventional medicine.

b. **CIH Self-Care Well-Being Practice.** A practice that a Veteran is taught, by a CIH practitioner or an instructor, to perform independently (without the need for assistance from a health care professional or a clinical setting). The practice is recommended as part of the Veteran's personal health plan, to help promote and preserve health, advance the Veteran's sense of well-being, and improve the Veteran's quality of life. An instructor may teach these practices in either a group or an individual setting. Examples of these practices include but are not limited to: Health coaching and facilitator-led whole health educational classes for well-being and empowerment classes (for better health management); group mobility (such as yoga, tai chi, qi gong); energy work (such as healing touch) and mindfulness classes (such as meditation, mindfulness, mindfulness based stress reduction).

c. **Complementary and Alternative Medicine.** A group of medical and health care systems, practices, and products not presently considered to be part of conventional medicine (<http://nccam.nih.gov/health/whatiscom>).

d. **Complementary and Integrative Health (CIH).** CIH is a group of diverse medical and health care approaches and practices that are not considered to be part of conventional or allopathic medicine. CIH practices are synonymous with CIH approaches and this directive uses them interchangeably. Most of these practices are used together with conventional therapies. (NCCIH Strategic Plan 2016). CIH, like Integrative Health and Integrative Medicine, defined below, reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic and lifestyle approaches, health care professionals and disciplines to achieve optimal health and healing. (Academic Consortium for Integrative Medicine and Health 2016)

e. **Complementary Medicine.** A type of non-conventional medicine used in conjunction with conventional medicine (See <http://nccam.nih.gov/health/whatiscom>).

f. **Conventional Medicine.** The prevailing medical system in the United States (allopathic and osteopathic medicine).

g. **Health.** A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

h. **Instructor.** An individual who is trained to perform CIH self-care/well-being approaches that are encouraged or directed by the patient's healthcare team as part of the patient's personal health plan.

i. **Integrative Health.** A comprehensive approach in the delivery of health care that considers each patient from a whole person perspective, taking into account not only what is needed to treat and clinically manage disease but also what may be needed proactively or beneficial, considering the full spectrum of available health care services, to optimize the patient's health and sense of well-being. (This term also subsumes the definition of Integrative Medicine.)

j. **Integrative Medicine.** The practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches and health care professionals and disciplines to achieve optimal health and healing.

k. **Practitioner.** A practitioner is an individual: who has training and expertise in the delivery of a CIH; who is licensed or certified by a state; whose licensure or certification permits the individual to provide such CIH; and whose VA Scope of Practice (SOP) (aligned with their VA credentialing and privileging) permits them to deliver such service to consenting patients.

l. **Proactive.** Acting in advance of a likely future situation, rather than just reacting; taking initiative to make things happen rather than just adjusting to a situation or waiting

for something to happen. For example, CIH often involves using strategies that strengthen the person's innate capacity for health and healing, such as mind-body approaches prior to surgery or chemotherapy.

#### 4. POLICY

It is VHA policy that VA practitioners proactively offer and include, as appropriate (based on the individual clinical facts of each patient), any of the CIH approaches identified in the electronic lists described in paragraph 6, and to effectively integrate their delivery with Veterans' receipt of conventional care. It is VHA policy that CIH is not to be used as an alternative to conventional medicine; it must only be used to complement conventional medicine. VA practitioners are not to offer a CIH approach that is not on one of the two lists described in paragraph 6, below.

#### 5. RESPONSIBILITIES

##### a. Executive Director, Office of Patient Centered Care and Cultural Transformation (OPCC&CT).

(1) Identifies and drives critical strategies to advance VHA's cultural transformation to a "Patient Centered Care and a Whole Health" model of care.

(2) Oversees the Integrative Health Coordinating Center (IHCC).

##### b. Integrative Health Coordinating Center (IHCC).

(1) Serves as the principal advisor to the Under Secretary for Health on CIH-related strategy and operations, to include analysis of any legislation or proposals that would impact or pertain to the delivery of CIH practices within VHA.

(2) Oversees the IHCC Advisory Workgroup (IHCCAW).

(3) Identifies CIH approaches to be included in VA's medical benefits package pursuant to the delegation made by the Under Secretary for Health. See Delegation by Under Secretary of Health Decision Memo dated May 3, 2016 (Appendix A).

(4) Considers and determines which new CIH approaches, including those recommended by the Integrative Health Care Coordinating Center Advisory Workgroup (IHCCAW), should be included in VA's medical benefits package (as found in the electronic lists on the VHA Intranet SharePoint site described in paragraph 6, below), moved from one list to the other, or removed based on new evidence.

(5) Maintains an electronic list (LIST I as identified in paragraph 6) of approved CIH approaches on a VHA Intranet SharePoint site that must be made available to Veterans, either in a VA facility or in the community. Maintains a second electronic list (LIST II as identified in paragraph 6), on the same SharePoint site, of optional CIH approaches that may be provided, within the limits of individual VA medical facilities, because, while less

common, they are still generally considered, among qualified experts, to be safe under the conditions of their intended use when delivered by an appropriate practitioner or instructor.

(6) Is responsible for creating the infrastructure needed to record CIH approaches delivered by VHA (directly or in the community), segregated by facility and VISN, for purposes of evaluation, trending, tracking, and monitoring workload, usage, and costs; for working with facilities and VISN's to ensure, through monitoring and audits, the consistent use of identified primary and secondary stop codes and CHAR4 codes for sanctioned CIH approaches; and for using this information to help identify unmet demand across the system.

(7) Provides guidance to the field regarding the appropriate and proactive integration of approved CIH approaches in integrative health care, to include patient education services.

(8) Maintains and updates VHA's CIH electronic VHA intranet SharePoint site; timely updates the two lists described in paragraph 6, as needed; conducts bi-annual reviews of each list; updates lists when new approaches based on individual requests have been approved through the process outlined in this directive; and timely notifies VISN Directors and VA medical facilities of any changes made to either list as determined by the Executive Director.

(9) Develops and uses the vetting process described in Appendix B to determine which CIH approaches are to be included in the medical benefits package.

(10) Assesses promptly recommendations received from the IHCCAW (stemming from requests by a VISN Director, facility Director, or individual VA practitioner to use a currently unsanctioned CIH approach in a certain case or type of clinical case); submits all positive recommendations to the Healthcare Delivery Council (HDC) and then USH for decision; and directly notifies IHCCAW of denials.

(11) Assesses recommendations from the IHCCAW as to CIH approaches that should be included in, modified, or removed from the medical benefits package based on the IHCCAW's systematic review of available or new evidence.

(12) Develops guidance for CIH integration into clinical care in collaboration with other VHA program offices, including, Health Services Research and Development Evidence Synthesis Program, Office of Quality and Safety, Office of Patient Care Services (PCS), and other needed subject matter experts to create the vetting process for introducing therapeutic CIH approaches and practices into conventional care, as well as to create practice guidelines for delivering CIH approaches and practices as part of integrative health care (referring to VA/DoD Evidence Based Practice Workgroup's "Guideline for Guidelines", which outlines processes for developing clinical practice guidelines, see Appendix A).

(13) Provides education and informational resources to the field about CIH approaches, utilizing information from the Veterans Health Library, maintained by



National Center for Health Promotion and Disease Prevention, as well as the Whole Health Library and other relevant resources.

(14) Assists the Office of Human Resources (HR) in developing, in collaboration with the Office of Patient Care Services (PCS), the Office of Nursing Services (ONS), and other key program offices, appropriate personnel-related and other requirements, such as qualification standards, privileging and credentialing requirements, and VA SOP requirements, for VA CIH practitioners. All such activities are to be done in accordance with VHA Handbook 1100.19, Credentialing and Privileging, VHA Directive 2012-030, Credentialing of Health Care Professionals, and all other applicable VA and VHA policies. Further, occupations to which practitioners are appointed in VHA must allow for the practice of CIH approach.

(15) Promotes proactive, appropriate use of CIH approaches in all clinical settings; promotes education and training resources to the field for facilities to ensure VA practitioners obtain requisite and periodic training and education applicable to those CIH approaches approved for use within their service lines.

(16) Collaborates with the Office of Research and Development to identify CIH research opportunities and help to establish CIH-related research priorities.

(17) Identifies and disseminates CIH best practices to the VISNs and to the field (encouraging their adoption).

(18) Develops necessary clinic and stop codes for sanctioned CIH approaches, consistent with VHA Directive 1731, *Decision Support Services Outpatient Identifiers*, and any other applicable VHA policies, to enable adequate programmatic evaluation and oversight.

**c. IHCC Advisory Workgroup (IHCCAW).**

(1) Includes membership derived from OPCC&CT (12PCCCT), the Office of PCS (10P11), ONS (10A1), and, as needed, other VHA national program offices.

(2) Develops the Vetting Process to be used in assessing and evaluating available evidence on individual CIH approaches.

(3) Posts IHCC's Vetting Process on the VHA intranet SharePoint site where the sanctioned approaches identified in paragraph 6 are also posted.

(4) Reports and recommends to the IHCC additional CIH approaches that it recommends be included in VA's medical benefits package, based on the results of its vetting process (used to analyze available scientific and other evidence/reviews demonstrating their safety and efficacy).

(5) Using the established Vetting Process, systematically reviews the evidence of CIH approaches' effectiveness and develop recommendations for their use within VHA, in line with existing clinical practice guidelines. In support of a positive

recommendation, the evidence must, at a minimum, indicate a promising or potential benefit (as defined by the IHCC's Vetting Process) as well as low potential for harm that is outweighed by the benefits, e.g., there is fair to good evidence a CIH approach improves important health outcomes and its benefits outweigh identified potential harms. Recommendations may also suggest deletion or modification to the current lists of sanctioned approaches based on new evidence or changes in medical practice standards.

(6) Receives and assesses requests from a VISN Director, Facility Director, or an individual VA practitioner to allow use of a currently non-sanctioned CIH approaches in a particular case; submits its recommendation to the IHCC, which will evaluate and process the recommendation in accordance with b.(5) above ; and notifies the requester of the decision outcome.

(7) If a VISN Director, VA medical facility Director, or any other VA practitioner would like to offer a particular patient a CIH approach not included there, they can submit a detailed request with clinical justification to the Integrative Health Coordinating Center Advisory Workgroup (discussed below) (IHCCAW) by sending it to [vhaopcctintegrativehealth@va.gov](mailto:vhaopcctintegrativehealth@va.gov). The IHCCAW serving, in part, as a national consult service for the field will review the request to use the subject CIH and, based on a complete review, will make its clinical recommendation to the Integrative Health Coordinating Center (IHCC). IHCC will forward positive recommendations to the HDC and then to the Under Secretary for Health, who will decide the matter; IHCC may, however, disapprove requests unilaterally. In all cases, IHCCAW will notify the requester of the ultimate outcome. If the Under Secretary for Health approves a request, the electronic Web site identifying sanctioned CIH approaches will be promptly updated (as will also be done in the case of any changes to the listings in paragraph 6).

d. **Office of Patient Care Services and Office of Nursing Services.** The Assistant Deputy Under Secretary for Health for PCS and the Chief Nursing Officer for ONS are responsible for working collaboratively with OPCC&CT in:

(1) Promoting the proactive use of sanctioned CIH approaches (as described in paragraph 6) throughout VHA.

(2) Assists the IHCC in evaluating the evidence base for CIH approaches.

e. **Veterans Integrated Service Network Director.**

(1) Ensures implementation and compliance with this directive at all VA medical facilities in the VISN, to include proper use of assigned stop codes and clinic codes developed in accordance with VHA Directive 1731.

(2) Maintains an up-to-date inventory of the CIH approaches used in the VA medical facilities within the Director's jurisdiction, and ensures all such approaches are limited to those sanctioned by VHA (as described in paragraph 6) and delivered only by appropriate practitioners or instructors.

(3) Maintains an inventory of the CIH approaches purchased by VA facilities in the VISN using Community Care network providers or other contract practitioners.

(4) Promotes proactive use of CIH approaches as part of integrated healthcare in all treatment settings and promotes the provision of requisite and periodic education and training for all CIH practitioners at all VA medical facilities within the VISN.

(5) Maintains an inventory of unmet demand, by type and reason, for sanctioned CIH approaches.

f. **VA Medical Facility Director.**

(1) Maintains an inventory of the CIH approaches delivered by practitioners or instructors located in the facility and in associated community-based outpatient clinics. Ensures CIH approaches are limited to those sanctioned by VHA (as described in paragraph 6) and delivered only by appropriate practitioners or instructors.

(2) Maintains an inventory of the CIH approaches purchased by the facility from Community Care network providers or other contract practitioners.

(3) Maintains an inventory of unmet demand, by type and reason, for sanctioned CIH approaches.

(4) Promotes proactive use of sanctioned CIH approaches in all appropriate treatment settings and promotes the provision of requisite and periodic education and training in these approaches for practitioners at the VA medical facility.

(5) Ensures any testing conducted as part of a practitioner's delivery of a sanctioned CIH approach is done in compliance with VHA Handbook 1106.1, Pathology and Laboratory Medicine Service Procedures, or subsequent policy issue.

(6) Ensures CIH approaches are delivered in compliance with VA's informed consent requirements and policy, see 38 CFR 17.32 and VHA Directive 1004.01, Informed Consent for Clinical Treatments and Procedures.

g. **Facility Chief of Staff (COS) and Associate Director for Patient Care Services /Nurse Executive (ADPCS/NE).**

(1) Ensure the VA medical facility has a process to forward individual practitioners' requests to use currently non-sanctioned requests, i.e., those not described in paragraph 6, to the IHCCAW, to include supporting documentation and clinical justification.

(2) Hire practitioners to provide specified CIH approaches, in accordance with VA Handbook 5005 series, Staffing and Recognized Occupations, and any other applicable VA or VHA policy; and timely updates current practitioners' VA Scope of Practices to include delivery of the specified CIH practice(s), in accordance with VHA Handbook

1100.19, Credentialing and Privileging, or VHA Directive 2012-030, Credentialing of Health Care Professionals, as applicable to the occupation to which they are appointed.

(3) Ensure that clinicians achieve and maintain competencies in the delivery of CIH appropriate to their clinical setting (e.g., primary care, specialty care, inpatient, mental health and long-term care).

(4) Ensure practitioners delivering CIH approaches comply with any education or training requirements needed to competently deliver such approaches, and promote access to such training.

(5) Ensure instructors (who may include VA employees with appropriate scope of practice, volunteers, contractors, without compensation (WOC) staff, and fee basis staff) assigned to provide recommended self care/well-being CIH approaches are appropriately trained and/or certified to provide those approaches.

(6) Ensure and oversee service lines' proper integration of CIH approaches with the delivery of conventional care.

(7) Ensure that the provision of sanctioned CIH approaches are documented appropriately in the Veteran's electronic health record.

## 6. CIH APPROACHES AVAILABLE WITHIN VHA

The National Director of IHCC, within OPCC&CT, as the Under Secretary of Health's delegee, has identified, in List I&II below and on VHA's Intranet SharePoint site found at: <https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Home.aspx>, the following CIH practices/approaches that meet the definition of care in 38 CFR 17.38(b), thereby making them suitable for inclusion in VA's medical benefits package. **NOTE:** *This is an internal VA Web site not available to the public.*

a. **LIST I.** Subject to the clinical caveats 1 and 2 below, and given the level of evidence, this list of CIH approaches must be made available to Veterans across the system, either within a VA medical facility or in the community.

(1) **Clinical Caveat 1:** Adequate evidence exists to support the use of the above-subject practices together with conventional care, reflecting current opinion and practice in the medical community. This listing serves, however, as only guidance: whether any of these CIH approaches is in fact appropriate for a particular Veteran-patient must still be determined by the practitioner (together with the responsible treating provider if the practitioner is not also that) in the exercise of their joint clinical judgment (accounting for the patient's individual clinical factors). Where there is no consensus between them, practitioners will defer to the opinion of the responsible treating provider (who will take into consideration the Veteran's preference, if known, and any contraindications to treatment).

(2) **Clinical Caveat 2:** Because identification of CIH approaches for use in Veterans' personalized health plans is fluid and dynamic with some evolving into

conventional care modalities over time and the potential for some later being pulled from practice, VHA practitioners need to consult VHA's Intranet SharePoint site before delivering a CIH approach, to verify theirs is still on either List I or List II. These listings will be up-to-date and should be relied on over the listings below, which must await formal policy revisions to be updated.

b. **LIST II.** Optional CIH approaches. Subject to Clinical caveats 1 and 2, stated above, in addition to the approaches identified in paragraph (1), the Under Secretary for Health, acting through the IHCC under OPCC&CT, sanctions the optional use of the CIH approaches on this list because they are generally considered, by those in the medical community, to be safe when delivered as intended by an appropriate VHA practitioner or instructor, and may be made available to enrolled Veterans, within the limits of VA medical facilities.

**NOTE:** Consult the local business office or the Office of Community Care to determine if a Veteran is eligible for CIH contract care in the community.

**NOTE:** If a VISN Director, VA medical facility Director, or any other VA practitioner would like to offer a particular patient a CIH approach not included on these lists, they can submit a detailed request with clinical justification to the Integrative Health Coordinating Center Advisory Workgroup (discussed below) (IHCCAW) by sending it to [vhaopcctintegrativehealth@va.gov](mailto:vhaopcctintegrativehealth@va.gov). The IHCCAW serving, in part, as a national consult service for the field will review the request to use the subject CIH and, based on a complete review, will make its clinical recommendation to the Integrative Health Coordinating Center (IHCC). IHCC will forward positive recommendations to the HDC and then to the Under Secretary for Health, who will decide the matter; IHCC may, however, disapprove requests unilaterally. In all cases, IHCCAW will notify the requester of the ultimate outcome. If the Under Secretary for Health approves a request, the electronic website identifying sanctioned CIH approaches will be promptly updated (as will also be done in the case of any changes to the listings in paragraph 6).

## 7. REFERENCES

- a. VA Handbook 5005, Staffing.
- b. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.
- c. VHA Handbook 1100.19, Credentialing and Privileging.
- d. VHA Handbook 1106.1, Pathology and Laboratory Medicine Service Procedures.
- e. VHA Directive 2012-030, Credentialing of Health Care Professionals, or subsequent policy issue.
- f. FY 2015 VHA Complementary & Integrative Health (CIH) Services (formerly CAM). Healthcare Analysis & Information Group (HAIG). Washington, DC. May 2015.[Internal VA Report].

g. Institute of Medicine. Integrative Medicine and the Health of the Public: A Summary of the February 2009 Summit. Washington, DC: The National Academies Press, 2009. <http://www.iom.edu/Reports/2009/Integrative-Medicine-Health-Public.aspx>

h. National Research Council. Complementary and Alternative Medicine in the United States. Washington, DC: The National Academies Press, 2005. <http://www.iom.edu/Reports/2005/Complementary-and-Alternative-Medicine-in-the-United-States.aspx>

i. White House Commission on Complementary and Alternative Medicine Policy (2002, March) Final Report (NIH Publication 03-5411). Washington DC: Government Printing Office.

j. VA/DoD evidence-based workgroup guidelines for guidelines: <https://www.healthquality.va.gov/HEALTHQUALITY/policy/index.asp>

May 18, 2017

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APPENDIX A

**UNDER SECRETARY FOR HEALTH DELEGATION MEMO: ADVANCING  
COMPLEMENTARY AND INTEGRATIVE HEALTH IN VHA**

To view the Under Secretary for Health Delegation Memo, Advancing Complementary and Integrative Health in VHA, dated May 3, 2016, please visit the following Web site, <https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

Additional information related to Patient Centered Care & Cultural Transformation, to include but not limited to updates related to Complementary and Integrative Health can be found at <https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

**EXECUTIVE DIRECTOR, OPCC&CT AND IHCC VETTING PROCESS FOR  
DETERMINING INCLUSION IN VA'S MEDICAL BENEFITS PACKAGE**

The Vetting Process

Background:

Clinical evidence – In 2005, the Institute of Medicine “Complementary and Alternative Medicine Committee” recommended that the same principles and standards of evidence of treatment effectiveness apply to all treatments, whether currently labeled as conventional medicine or CAM. Implementing this recommendation requires that investigators use and develop as necessary common methods, measures, and standards for the generation and interpretation of evidence necessary for making decisions about the use of CAM and conventional therapies. The Committee acknowledges that the characteristics of some CAM therapies—such as variable practitioner approaches, customized treatments, “bundles” (combinations) of treatments, and hard-to-measure outcomes— are difficult to incorporate into treatment-effectiveness studies. These characteristics are not unique to CAM, but they are more frequently found in CAM than in conventional therapies.

The Vetting process and criteria for CIH services to be recommended for inclusion in the medical benefits package are outlined below.

1. Licensing and credentialing
2. Clinical practice guidelines, current evidence, community standards, and potential for harm
3. Veteran demand (although the clinical need and appropriateness of any treatment is based on the clinical judgment of the provider and services are not provided solely at the request or preference of the patient)
4. Supports transformation of healthcare delivery
5. Feasibility and implications of mandating system-wide dissemination

Similar to the evaluation process for conventional modalities, CIH services that will be recommended for integration into VHA care must show evidence of safety and, at a minimum, promising or potential benefit.