Volunteers of America CAM Demonstration Project

A collaborative between Volunteers of America and Northwestern Health Sciences University to provide CAM care services to residents at Edina Care & Rehabilitation and Center and Elder Homestead

Funded by Volunteers of America and in-kind contributions by Northwestern Health Sciences University

Report published: March 2011
Appendices
The appendices are documents developed for the project and have been included for reference.

Appendix 1: Training Checklist For CAM Clinicians ................................................................. 33
Appendix 2: Educational Materials .......................................................................................... 34
  New Partnership to Provide New Services ........................................................................ 34
  Information about therapies offered at VOA ...................................................................... 35
  Acupuncture and Oriental Medicine .................................................................................. 36
  Chiropractic .......................................................................................................................... 37
  Massage .................................................................................................................................. 38
Appendix 3: Consent For Care Forms .................................................................................... 39
  Elder Homestead ................................................................................................................... 39
  Edina Care and Rehabilitation Center ................................................................................ 42
Appendix 4: Care Plan Form .................................................................................................... 45
Appendix 5: Orders for CAM Assessment and Treatment .................................................... 46
Appendix 6: Missed Treatment Form ...................................................................................... 47
Appendix 7: CAM Clinician Checklist ..................................................................................... 48
Appendix 8: Clinician Treatment Notes Forms .................................................................... 49
  AOM Progress Notes ......................................................................................................... 49
  DC Progress Notes ............................................................................................................. 51
  MT Progress Notes ............................................................................................................. 53
Appendix 9: Faces Pain Scale ................................................................................................. 55
Appendix 10: Handgrip Strength (HGS) Test ....................................................................... 56
Appendix 11: Feeling Thermometer ....................................................................................... 57
Appendix 12: Qualitative Interview Script ............................................................................ 58
**Executive Summary**

This report summarizes a collaboration between the Volunteers of America and Northwestern Health Sciences University on a demonstration project to integrate complementary and alternative medicine (CAM) services in two geriatric facilities. The services provided included chiropractic, acupuncture and Oriental medicine (AOM), and massage therapy.

Overall, CAM services were successfully implemented. Chiropractic, AOM, and massage therapy clinicians working as a team safely provided 1033 treatment visits (338 chiropractic, 366 AOM, and 329 massage treatment visits). There were no known serious adverse events related to CAM care.

Over the course of treatment, AOM and chiropractic patients reported decreasing pain and all patients reported an improvement in their self-rated health status. The majority of patients and families interviewed felt CAM treatments were worthwhile and positively affected residents' quality of life. Many of the protocols and processes for care delivery developed for the project can be used to facilitate future efforts.

The rapidly increasing geriatric population will have many healthcare needs. Lessons learned from this project could positively inform geriatric curricula for CAM education and increase the likelihood that future CAM clinicians will provide care to the fragile elderly.
A. Background

In the spring of 2008, an agreement was reached between Northwestern Health Sciences University (NWHSU) and the Volunteers of America (VOA) with the goal to provide complementary and alternative medicine (CAM) services, specifically acupuncture and Oriental Medicine (AOM), chiropractic, and massage to persons residing in two locations: an assisted living facility and a long-term care facility, which included a transitional care unit (TCU). This initiative became known as the Volunteers of America CAM Demonstration Project.

Support for the project was provided through funding by the Volunteers of America and in-kind contributions by NWHSU. This report provides a summary of the project’s background, approach, outcomes, and implications.

Complementary and alternative medicine (CAM) services are commonly used by older adults in the community, however, little is known about the potential for providing CAM clinical care within locations such as assisted living or long term care facilities. The autonomy of nursing home residents to seek CAM care may be limited by their lack of mobility from functional impairments or decreased cognitive abilities. CAM services have rarely been brought into these facilities, and CAM therapies like massage, acupuncture, and chiropractic care are either not covered or are severely limited as benefits under insurance or Medicare.

The most common reason people seek CAM services is to treat chronic or recurring pain associated with musculoskeletal or other conditions. Pain is common in older persons, both those dwelling in the community and those residing in nursing homes. Further, moderate to severe pain is a quality measure for nursing homes mandated by the Center for Medicare Services.

The presence of pain can affect critical functions such as balance, mobility, sleep, mood, and behavior. Medications used to treat pain include analgesics, narcotics, and muscle relaxants; however, these have a narrowed therapeutic window in the frail elderly, resulting in a higher risk-to-benefit ratio compared to that in the general population. Thus, alternative treatment options could play an important role in meeting the healthcare needs of older individuals. There has been little published information regarding the side effects and adverse events of CAM therapies in older persons, but the available evidence suggests, in general, a favorable side effect profile. Consequently, CAM professionals may offer important benefits to older residents in assisted living and long term care facilities.

B. Purpose

The purpose of the Volunteers of America CAM Demonstration Project was to determine the feasibility of developing a sustainable and replicable model for integrated chiropractic, acupuncture, and massage services to improve the overall quality of life for Volunteers of America residents.

To accomplish this, the project introduced CAM services into an assisted living facility (Elder Homestead) and long term care facility (Edina Care & Rehabilitation Center). The specific objectives of the project included:
1. **To address the healthcare needs of older persons:**
   - Decrease the use of medications (for example: sleeping medications, analgesics, antipsychotics)
   - Decrease pain
   - Increase mobility, flexibility, strength, and balance OR decrease the rate of functional decline
   - Support the highest level of independence
   - Reduce symptoms of agitation, anxiety, insomnia, and depression
   - Support VOA institutional initiatives for falls prevention

2. **To collect data on outcomes of care:**
   - Patients’ response to care in areas of pain, quality of life, function, and self-rated complaints
   - Use of medications before and after care
   - Qualitative experiences of patients, families, and staff to the addition of CAM services
   - Safety, adverse events, and side effects of treatment

3. **To increase the number of CAM clinicians skilled in geriatrics to deliver care to the frail elderly:**
   - Focus training on evidence informed clinical care of older individuals
   - Provide experience working with a team of health care professionals to coordinate care
   - Establish best practices in clinical documentation and record keeping
   - Provide useful tools for documenting functional performance indicators and outcomes of care

4. **To disseminate information regarding project implementation and results to a wider audience:**
   - Scholarly presentations at national conferences
   - Speaking engagements with professional groups
   - Published manuscripts in peer-reviewed journals

**C. Personnel**

More than 30 individuals from the Volunteers of America and NWHSU participated in the project. (See Tables 1 and 2.)
Table 1. Project personnel at Volunteers of America and Northwestern Health Sciences University

### Volunteers of America—Lead Personnel

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wayne Olson, LNHA, MBA</td>
<td>Advisory Committee</td>
</tr>
<tr>
<td>Jane Danner, LSW</td>
<td>Co-Principal Investigator: responsible for coordination and conduct of the project within the Volunteers of America; core team</td>
</tr>
<tr>
<td>Dave Woods, BS</td>
<td>Operations Lead: management support, budget; core team</td>
</tr>
<tr>
<td>Nancy Lanz, RN, BC</td>
<td>Edina Care &amp; Rehabilitation Center Clinical Lead: responsible for all Edina-related operations; ad hoc core team</td>
</tr>
<tr>
<td>Patty Krueger, RN</td>
<td>Elder Homestead Clinical Lead: responsible for all Elder-related operations; ad hoc core team</td>
</tr>
</tbody>
</table>

---

### Other Key Contributors (Edina Care & Rehabilitation Center)

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Todd Carsen, LNHA, BA</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Diane Botz, RN, DB</td>
<td>Staff Development/Assistant Director of Nursing</td>
</tr>
<tr>
<td>Barb Mesenbourg, OTR, ADC</td>
<td>Director of Life Enrichment/Social Service</td>
</tr>
<tr>
<td>Priscilla Turner, MSW</td>
<td>(past) Community Relations Director</td>
</tr>
<tr>
<td>Mamie Loiselet, RN, BC, BSN, RAC-CT</td>
<td>MDS Coordinator</td>
</tr>
<tr>
<td>Karen Marinovich, OTR/L, MA, MBA</td>
<td>Director of Rehabilitation</td>
</tr>
<tr>
<td>Ellen Fischer, GNP</td>
<td>Nurse Practitioner/Fairview</td>
</tr>
<tr>
<td>Peggy Griffin, GNP</td>
<td>Nurse Practitioner/HealthPartners</td>
</tr>
<tr>
<td>Robin Bupp, MS, RD</td>
<td>Dietician</td>
</tr>
<tr>
<td>Lenni Colmenero, LPN</td>
<td>Nurse Manager, 3 South</td>
</tr>
<tr>
<td>Sharon Penniman, RN</td>
<td>Nurse Manager, 3 North (Memory Care)</td>
</tr>
<tr>
<td>Mary Beth Wollersheim, RN</td>
<td>Nurse Manager, First Floor</td>
</tr>
<tr>
<td>Willow Warren, RN</td>
<td>Program Director, TCU</td>
</tr>
</tbody>
</table>

---

### Northwestern Health Sciences University—Lead Personnel

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chuck Sawyer, DC</td>
<td>Advisory committee</td>
</tr>
<tr>
<td>Kristine Westrom, MD, MS</td>
<td>Principal Investigator: responsible for overall design, conduct, and coordination of the project; clinical lead; core team</td>
</tr>
<tr>
<td>Roni Evans, DC, MS</td>
<td>Co-principal investigator: responsible for coordinating research-related resources for project, core team</td>
</tr>
<tr>
<td>Debbie Miller, LPN</td>
<td>Operations Lead: start-up, core team</td>
</tr>
<tr>
<td>Corrie Vihstadt, LAc, MOm</td>
<td>Project manager: responsible for data collection and coordination of clinical services</td>
</tr>
</tbody>
</table>

---

### Other Key Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dale Healy, DC</td>
<td>Dean, School of Massage Therapy</td>
</tr>
<tr>
<td>Mark McKenzie, LAc, MOm</td>
<td>Dean, College of Acupuncture and Oriental Medicine</td>
</tr>
<tr>
<td>Mike Wiles, DC, MEd</td>
<td>(past) Dean, College of Chiropractic</td>
</tr>
<tr>
<td>Renee DeVries, DC</td>
<td>Dean, College of Chiropractic</td>
</tr>
</tbody>
</table>
Table 2. Northwestern Health Science University—CAM Clinicians

<table>
<thead>
<tr>
<th>Clinician</th>
<th>CAM Service</th>
<th>Dates of Service</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cara Borggren, DC</td>
<td>Chiropractic</td>
<td>10/08-08/09</td>
<td>ECRC &amp; EHS</td>
</tr>
<tr>
<td>Jodell Skaufel, DC</td>
<td>Chiropractic</td>
<td>10/08-04/10</td>
<td>ECRC &amp; EHS</td>
</tr>
<tr>
<td>Corrie Vihstadt, LAc, MOm</td>
<td>Acupuncture and Oriental Medicine</td>
<td>10/08-04/10</td>
<td>ECRC &amp; EHS</td>
</tr>
<tr>
<td>Lori Baldwin, LAc, MOm</td>
<td>Acupuncture and Oriental Medicine</td>
<td>10/08-04/10</td>
<td>ECRC &amp; EHS</td>
</tr>
<tr>
<td>Deanna Benson, NCTM</td>
<td>Massage</td>
<td>10/08-04/09</td>
<td>ECRC &amp; EHS</td>
</tr>
<tr>
<td>Sarah Gottfried, NCTM</td>
<td>Massage</td>
<td>04/09-04/10</td>
<td>ECRC &amp; EHS</td>
</tr>
</tbody>
</table>

D. Timeline

The project took place from August 2008 to December 2010 and was implemented in two phases: a preparation phase and a clinical phase.

**Preparation phase**

<table>
<thead>
<tr>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-Mar</td>
</tr>
<tr>
<td>VOA contract finalized</td>
</tr>
<tr>
<td>Core team meetings</td>
</tr>
<tr>
<td>Protocols, forms, processes developed</td>
</tr>
<tr>
<td>CAM clinicians hired and trained</td>
</tr>
<tr>
<td>IRB review</td>
</tr>
</tbody>
</table>

**Clinical phase**

<table>
<thead>
<tr>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-Mar</td>
<td>Apr-Jun</td>
</tr>
<tr>
<td>CAM treatments at ECRC (LTC)</td>
<td></td>
</tr>
<tr>
<td>CAM treatments at ECRC (Memory Care)</td>
<td></td>
</tr>
<tr>
<td>CAM treatments at EHS</td>
<td></td>
</tr>
<tr>
<td>CAM treatments at ECRC (TCU)</td>
<td></td>
</tr>
<tr>
<td>Dissemination on aspects of the project</td>
<td></td>
</tr>
<tr>
<td>Data entry, verification, analysis</td>
<td></td>
</tr>
</tbody>
</table>
E. Preparation Phase

As the working relationship between the two institutions was new, substantial time was spent familiarizing the NWHSU project leadership with the VOA. Regular meetings were held along with ad hoc meetings when required with stakeholders and EHS and ECRC staff. Further, considerable effort was expended to recruit and train CAM personnel, obtain necessary approvals, and develop standardized operations. As the CAM clinicians were new to the VOA population, as well as working with one another, special attention was paid to defining their scope of clinical care. Table 3 outlines the tasks and results of the preparation phase.

E.1. Personnel

To meet the project’s clinical service requirements, we needed to recruit qualified CAM clinicians and provide adequate training prior to service implementation. By contract, NWHSU agreed to provide each modality (massage, chiropractic, and AOM) to each facility (ECRC and EHS) two half days per week. Given the modest funding available and the need to provide additional specialized training to CAM clinicians caring for the frail elderly in VOA settings, a decision was made to create a fellowship program in which licensed CAM practitioners would provide clinical care while receiving fellowship training at NWHSU. Additionally, a project manager was employed to facilitate project start up and implementation, manage the project’s day-to-day activities, and facilitate data collection.

E.2. Approvals

Approval from NWHSU’s institutional review board (IRB) for data collection activities was sought and obtained. Approval was granted for medical record review and the collection of non-identifiable patient information. A business associate agreement was signed between the VOA and NWHSU for project personnel to access patient records while VOA remained the custodian of the record. Subsequently, IRB approval was also sought and granted for interviewing patients, families, and staff to gather qualitative information describing the experiences of those participating in the project.

E.3. Operations

As this was the first attempt to integrate CAM into the VOA facilities, substantial attention was paid to identifying the basic operations necessary to provide CAM care while minimizing disruption to normal VOA activities. Protocols for seeking informed consent, securing doctors’ orders, record keeping and data transfer were developed. Printed education materials were designed to inform residents and staff of the CAM services that would be provided, and included descriptions of potential benefits as well as risks. To meet the project goal of collecting outcomes data, measures that could be practically implemented in the VOA population given the available resources were identified. Documentation materials to accurately record the events of the CAM clinical encounter, including the patient-self-rated outcomes, were also developed. Finally, efforts were made to attend to the pragmatic details of site preparation to ensure adequate space allocation and equipment necessary for the provision of CAM care.
E.4. Scope of Care

Although chiropractic and AOM clinicians are licensed in Minnesota to provide clinical services within their scope of practice and are by law capable of independently providing care to nursing home residents, it was the request of the Volunteers of America that treatment only commence within ECRC after an order was received from an attending medical doctor or nurse practitioner.

Further, CAM providers typically employ a wide variety of treatment methods within their scope of practice, which at times overlap among provider types (e.g., chiropractors may deliver soft tissue massage in a similar manner as that provided by massage therapists; AOM practitioners may use Tui Na, which is similar to manual mobilization procedures provided by chiropractors). Potential treatment modalities that could be provided by the project’s CAM clinicians were reviewed to identify those treatments which best fit criteria for safe, evidence-informed geriatric care. Treatments with theoretically greater potential for risk, although perhaps without solid evidence of harm in the fragile elderly, were excluded as a precautionary principle for the duration of this project.
### Table 3. Preparation phase

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Recruited CAM clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 massage therapist</td>
</tr>
<tr>
<td></td>
<td>2 chiropractors (enrolled in geriatric residency at NWHSU)</td>
</tr>
<tr>
<td></td>
<td>2 AOM clinicians</td>
</tr>
</tbody>
</table>

**Recruited Project Manager**

**Trained CAM Clinicians in following areas:**

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Geriatric topics</th>
<th>Nursing home culture</th>
<th>Specific protocols and procedures for delivering CAM care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control</td>
<td>Skin fragility</td>
<td>Membership in healthcare teams</td>
<td>Staff roles</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>Cognition and behavior changes</td>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td>HIPAA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient’s rights</td>
<td>Pain assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk minimization</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functional measures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trained Project Manager in following areas:**

Coordination, facilitation, and documentation of daily project activities

Data collection and management

**Approvals**

Obtained NWHSU Institutional Review Board approvals

**Operations**

Developed protocols

- Consent for care
- Obtaining doctor’s orders*
- Healthcare recordkeeping and storage**
- Secure record transfer

**Designed patient and staff materials**

- Handouts for residents and staff describing CAM services

**Designed documentation materials/forms necessary to provide care**

- Treatment notes for AOM, massage, chiropractic
- Checklists for medical record review
- Consent form for patient and proxy
- Orders for assessment and 6 treatments*

**Prepared care sites**

- Equipment and logistics addressed
- Record storage area secured
- Treatment areas identified
- Treatment tables, AOM supplies brought to VOA

**Informed VOA staff, residents, and families of project, CAM therapies**

- Provided attending MDs informational letter
- Gave presentation to staff on CAM therapies and project
- Gave presentation to patients/families at patient council meeting; sent out newsletter

**Scope of Care**

Defined appropriate massage, AOM, and chiropractic treatment methods for VOA residents

Developed protocols and procedures for delivering CAM care

*Edina Care Center only; **Edina Care Center and Elder Homestead had needs addressed in different ways
F. Clinical Phase Methods

F.1. VOA Locations
The project was carried out at two Volunteer of America locations, Elder Homestead (EHS) and Edina Care & Rehabilitation Center (ECRC). EHS is an assisted-living facility with 39 apartments and 12 memory care units. ECRC consists of 36 transitional care beds, 19 memory care beds, and 70 long term care beds. At inception, chiropractic, massage, and AOM each provided eight hours of care per week to residents at Edina Care & Rehabilitation Center and also the same number of hours at Elder Homestead. Services were implemented first in the non-memory care areas of the facilities, with memory care and the transitional care unit (TCU) to follow. The rationale for this approach was to assure adequacy of protocols prior to providing care to the most vulnerable residents (memory care); additionally, accessing patients in the TCU required relationship building and designing new care processes to accommodate the rapid work flow and residents’ shortened length of stay compared to long term care.

F.2. Request for CAM Services
Pain, sleep disturbance, decline in physical function, or behavior changes such as agitation or depression were the conditions defined as appropriate for CAM care services. The process for requesting CAM assessment and treatment services differed between Edina Care & Rehabilitation Center and Elder Homestead.

**Edina Care & Rehabilitation Center**
Requests for services at Edina Care & Rehabilitation Center could originate from a resident, their family or friend, or Edina Care & Rehabilitation Center staff (most often as a result of facility interdisciplinary care team meetings). An order from the primary medical provider was required prior to a CAM clinician’s involvement. (See Appendix 5: Orders for CAM Assessment and Treatment.) To encourage a culture which respected CAM clinicians’ abilities to apply their professional judgment within their scope of practice, standardized orders allowed for “any or all of the CAM therapies” to assess and treat patients. Medical providers could opt out of the standardized orders and request a specific CAM modality, however, this rarely occurred. Orders included up to six treatment visits, renewable by the medical provider.

**Elder Homestead**
Elder Homestead residents or their family members could request services by expressing their interest to facility staff who then brought it to the attention of the Director of Nursing. The Director of Nursing routed a request for services to the CAM clinician.

F.3. Treatment Space
Space was at a premium at Edina Care & Rehabilitation Center and Elder Homestead, necessitating a creative approach to provide CAM care services.
**Edina Care & Rehabilitation Center**

Residents at Edina Care & Rehabilitation Center were treated in their rooms with curtains drawn for privacy. Patients first had to be found and transported back to their room for care. In general, this was the responsibility of the clinician. Aids assisted with transfers (for instance, from wheelchair to bed) and were willing to help in other ways as time allowed.

A locked file cabinet containing treatment supplies and project documents was located in a room shared with occupational rehabilitation.

**Elder Homestead**

Residents at Elder Homestead often chose to have clinicians treat them in their private apartments. Otherwise, they received care in a room equipped with a multipurpose treatment table. The room housed a locked cabinet containing project supplies and documents and also served as a resident exercise space and staff meeting area. It was the responsibility of the clinician to locate and transport the patient to be treated.

At both sites, a portable AOM cart equipped with acupuncture needles, drapes for a clean field, and a sharps disposal box was set up to facilitate treatment.

**F.4 Consent For Care**

Obtaining consent for care was the first requirement performed by the clinician once an order or request was received. Consent was obtained from the patient, the proxy, or both. If the VOA judged the patient incapable of granting full consent, the process was conducted with a proxy. Family members acting as proxies most often visited residents after hours when CAM clinicians were absent; therefore, a protocol was established by which nursing staff obtained consent from proxies with CAM clinicians following up by phone to answer any questions. In cases where consent was obtained via proxy, the clinician was still required to discuss the risks and benefits of care prior to treatment regardless of the patient’s level of cognitive functioning. (See Appendix 3: Consent For Care Forms.)

**F.5. Assessment**

At the initial assessment, the CAM clinician reviewed the patient's records for precautions to care, their functional status, and history of the presenting complaint. Relative contraindications to care that would require an especially cautious treatment approach (for example, the presence of anticoagulants or infection) were documented by the CAM clinician on a standardized checklist. (See Appendix 7: CAM Clinician Checklist.) As training, licensure, and scope of practice varied between the professions, the assessment also included one of the following: a focused physical examination (chiropractors), a Traditional Chinese Medicine examination (AOM practitioners), or an assessment of soft tissue dysfunction and patient socialization (massage therapist).

**F.6. Treatment**

Table 4 summarizes the specific treatment methods to be included and excluded for each modality as defined during the preparation phase.
Protocols for treatment focused on patient safety. Guidelines for care included:

- Start with the most conservative treatment
- Provide gentle treatment of short duration until proven tolerable
- Modify treatment according to the patient’s response

Table 4. Included/excluded treatment methods by modality

<table>
<thead>
<tr>
<th>Modality</th>
<th>Treatment Methods</th>
<th>Excluded (rationale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture and Oriental Medicine</td>
<td>Acupuncture: sterile needles applied to meridian points</td>
<td>Chinese herbs (potential for interaction with polypharmacy)</td>
</tr>
<tr>
<td></td>
<td>Acupressure: pressure applied to meridian points</td>
<td>Moxabustion (burn risk, lack of proper ventilation)</td>
</tr>
<tr>
<td></td>
<td>Tui Na: body work using manually applied rhythmic compressions</td>
<td>Heat lamps (potential for burns)</td>
</tr>
<tr>
<td></td>
<td>Qi Gong: breathing exercises to move Qi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topical biofreeze</td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Manual manipulation and mobilization of joints</td>
<td>Ultrasound (potential for burns)</td>
</tr>
<tr>
<td></td>
<td>Flexion/distraction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Soft tissue work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Warm packs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active/passive muscle stretching</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervised exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topical biofreeze</td>
<td></td>
</tr>
<tr>
<td>Massage</td>
<td>Classic Western style Swedish massage</td>
<td>Aromatherapy (skin irritation)</td>
</tr>
<tr>
<td></td>
<td>Myofascial techniques</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trigger point therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topical biofreeze</td>
<td></td>
</tr>
</tbody>
</table>

After the assessment, the CAM clinician either treated or referred the patient to a CAM colleague if, in their opinion, the presenting problem would be better served by a different treatment modality. Treatment could continue if the CAM clinician documented patient improvement or, in the case of declining function, stabilization. At ECRC, standardized orders allowed for six treatments, which could be renewed by the medical provider.

**F.7. Integration of CAM**

To foster the project goal of integrated CAM services, two levels of application were implemented: integrating CAM services into existing care processes at VOA facilities and integrating as a team of CAM clinicians practicing different therapeutic modalities.
**Integrating CAM services into existing care processes**

Efforts during the preparation phase to educate staff and residents about the project smoothed the way for introducing CAM clinical services into the facilities. Once on site at the Edina Care & Rehabilitation Center, CAM clinicians were expected to attend the weekly interdisciplinary team meetings in the long term care unit and rounds in the transitional care unit. CAM clinicians also took part in individual care conferences that involved an active patient and were encouraged to attend meetings for the falls prevention initiative.

**Integrating as a team of CAM clinicians**

CAM clinicians met weekly to discuss issues in geriatrics and treatment approaches to VOA patients. They were encouraged to share their expertise on clinical topics, to seek each other’s opinion on individual patients, and were expected to relate to each other in a non-hierarchical manner.

**F.8. Data Collection**

Table 5 outlines the data methods, measures, and collection schedule established for the project.

**F.8.1. Existing Records**

Existing patient records were used to collect non-identifiable descriptive information to obtain a more complete understanding of the population being served. Recorded clinical information from previous VOA assessments that had the potential to impact care was also collected and included the most recent Geriatric Depression Scale, Mini Mental Status test, and descriptors of functional and cognitive status.

**F.8.2. New Records**

Standardized forms for clinician treatment notes were created for the project (see Appendix 8: Clinician Treatment Notes Forms) and used at each clinical visit to document the following:

- Types of treatments provided
- Possible side effects
- Quantitative outcome measures

**F.8.2.1. Quantitative Outcome Measures**

The outcome measures that were administered are common to geriatric clinical practice and were selected as evidence informed tools to guide clinical decision making. Except for hand grip strength, outcome measures were collected at every treatment visit. Due to the likelihood that many of the long term care residents would have impairments in function and cognition, CAM clinicians documented if they had difficulty collecting outcome measures.

*Faces pain scale (FPS)*

The FPS, consisting of seven facial expressions, which represent increasing levels of pain, has been validated for geriatric use.7,12 Patients were asked, “Which face shows how much pain you have today?” (See Appendix 9: Faces Pain Scale.)
**Hand grip strength (HGS)**

This measure is validated in geriatrics and is associated with overall functional status. The HGS was obtained with the subject standing, arm bent at the side; for patients unable to comply, the test was performed seated or lying in bed. It was obtained at first visit, sixth visit (or last visit if care terminated before a sixth visit), and every sixth visit thereafter. (See Appendix 10: Handgrip Strength Test.)

**Quality of life thermometer**

A vertical scale (0–100) was adapted from one used in the EuroQol quality of life measure. (Patients were asked, “If this is the worst possible health (clinician pointing to the bottom) and this is the best possible health (clinician pointing to the top), where is your health today?” See Appendix 11: Feeling Thermometer.)

**Main complaint**

Patients were verbally asked to identify their main complaint the day of treatment and then asked, “On a scale of zero to ten, how would you rate it today?”

F.8.3. Qualitative Interviews

Semi-structured interviews with patients and their family members were conducted after treatment ended to explore their experience of CAM care. Interviews were also conducted with VOA staff at initiation and completion of the project to assess their perceptions of CAM therapies.

Most interviews were conducted in-person at EHRC and EHS. Assisted living residents and family members who could not be on site were interviewed by phone. Interviews were conducted by one of two NWHSU individuals trained to perform them in a uniform manner. They used a semi-structured schedule of questions to keep the interviews on track and consistent. (See Appendix 12: Qualitative Interview Script.)

Participants were assured anonymity and encouraged to speak freely in response to questions. Interviews were digitally audio-recorded with participants’ permission. If participants declined to have their interviews recorded, interviewers documented participants’ answers in writing. The recorded interviews were transcribed for analysis.
### Table 5. Data collection schedule

<table>
<thead>
<tr>
<th>Method of collection</th>
<th>Measure</th>
<th>Before treatment</th>
<th>First treatment</th>
<th>Subsequent treatments</th>
<th>Post treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Existing patient records</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care risks: (active infection, skin or bone fragility, increased likelihood of bleeding)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Geriatric Depression Scale</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Mini Mental Status test</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Patient characteristics</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Clinician treatment notes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatments given</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Main complaint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Side effects</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Outcome Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Faces Pain Scale</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality of Life</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Handgrip strength*</td>
<td>X</td>
<td></td>
<td>X**</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Qualitative interviews</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients’ and family members’ experience with CAM treatment</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>VOA Staff’s views of CAM therapies</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*not obtained in TCU **handgrip strength collected every sixth treatment and last treatment

### F.9. Data Not Collected

**Medication Use**

An initial goal of the project was to explore whether the application of CAM modalities altered the use of medications in VOA residents. A system was set up to count medications for patients receiving CAM therapies but was stopped due to the lack of resources to manually review records and tally medications.

**Minimum Data Set**

The Center for Medicare Services (CMS) does not allow for the collection of data from Minimum Data Set assessments (even though the results are within patient charts) without CMS prior authorization for each individual result on every patient. Insufficient resources were available to obtain this data.

### F.10. Data Management and Safety

During the clinical phase, information on data completeness and number and type of treatment visits was collected and tracked by the project manager. Clinician treatment notes were de-identified prior to
electronic transfer to NWHSU for storage on a computer system with access restricted to project personnel. All outcomes data from treatment notes were double-key data entered into a database managed by NWHSU’s Office of Data Management.

At the end of the clinical phase, the original CAM treatment records were merged with the patient’s medical chart and remained in custody of the Volunteers of America.

G. Clinical Phase Results

G.1. Summary of Population Served

Ninety three residents were enrolled in the project after they or their proxy consented to care. The majority of the patients were at Edina Care & Rehabilitation Center (ECRC), either in long term care (LTC) which included memory care, or the transitional care unit (TCU). (See Figure 1.)

FIGURE 1. Number receiving CAM treatment by location

<table>
<thead>
<tr>
<th>Total # of residents enrolled:</th>
<th>93</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # by site:</td>
<td></td>
</tr>
<tr>
<td>11 EHS</td>
<td></td>
</tr>
<tr>
<td>82 ECC</td>
<td></td>
</tr>
<tr>
<td>53 LTC</td>
<td></td>
</tr>
<tr>
<td>29 TCU</td>
<td></td>
</tr>
</tbody>
</table>

3 residents did not receive care due to scheduling difficulties

6 residents with proxy consent for care declined treatment at assessment
1 resident was receiving acupuncture from an outside provider, which would have been a duplication of services
1 resident discharged prior to treatment commencing

Total # receiving treatment: 8

46
28
G.1.1. Gender
Residents who received CAM clinical services at both facilities were predominantly female. Considering only ECRC, 82% of those receiving CAM care were female. (See Table 6.)

<table>
<thead>
<tr>
<th></th>
<th>EHS</th>
<th>ECRC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>8</td>
<td>44</td>
<td>75</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

G.2.2. Age
The age of residents receiving CAM care varied by facility. In the TCU at ECRC, the majority (52%) of patients were under age 70. In LTC at ECRC, the majority (70%) were age 80 or greater; in fact, nearly 30% of LTC patients were over age 89. Overall, there were fewer residents receiving CAM care at EHS, but the age distribution was similar to LTC at ECRC, with the majority being age 80 or greater. (See Figure 2.)
**G.2. Patient and Treatment Totals**

Table 7 shows the number of patients treated with each CAM modality by location. As some residents received treatment from more than one CAM provider type, the numbers are slightly higher than the enrolled patient numbers. Table 7 also shows the total number of treatments, which were fairly evenly distributed among the three CAM modalities. Patients received a total of 1033 treatments throughout the course of the project. Most of the treatments occurred in the LTC unit at ECRC.

<table>
<thead>
<tr>
<th>Modality</th>
<th># of Patients</th>
<th># of Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EHS ECRC LTC TCU</td>
<td>EHS ECRC LTC TCU</td>
</tr>
<tr>
<td>AOM</td>
<td>3 23 9 35</td>
<td>23 322 21 366</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>3 21 9 33</td>
<td>13 295 30 338</td>
</tr>
<tr>
<td>Massage</td>
<td>6 23 17 46</td>
<td>27 242 60 329</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12 67 35</strong></td>
<td><strong>63 859 111</strong></td>
</tr>
</tbody>
</table>

**AOM** was the most common modality to treat patients in the LTC unit at ECRC. AOM practitioners treated the same number of patients in LTC as did massage therapists (23 patients each) but gave a greater number of treatments (322 versus 242).

**Massage** was the most common modality in the TCU at ECRC. Therapeutic massage patients (17) were nearly twice the number of chiropractic (9) and AOM (9), resulting in at least double the number of treatments (60) compared to chiropractic (30) and AOM (21).

**Integrated CAM Therapies**

For patients receiving care through multiple CAM modalities, clinicians either provided simultaneous care to address a specific problem (e.g., severe contracture and pain) or sequential care if treatment from one modality had not resulted in sufficient benefit. Integrated therapies most frequently occurred in LTC at ECRC, where 17 individuals received more than one type of CAM care. (See Table 8.)

<table>
<thead>
<tr>
<th>Integrated Modalities</th>
<th># of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EHS ECRC LTC TCU</td>
</tr>
<tr>
<td>AOM+Chiropractic</td>
<td>0 6 2</td>
</tr>
<tr>
<td>AOM+Massage</td>
<td>1 4 0</td>
</tr>
<tr>
<td>DC+Massage</td>
<td>1 3 1</td>
</tr>
<tr>
<td>AOM+Chiropractic+Massage</td>
<td>1 4 2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3 17 5</strong></td>
</tr>
</tbody>
</table>

(See Table 8.)
**G.3. Individual Treatment Numbers**

The number of treatments each patient received ranged from 1 to 92. Sixty percent of patients received one to six treatments. As might be expected, TCU residents received far fewer treatments compared to LTC residents. In LTC, there were four residents who each received fifty or more treatments. (See Figures 3 and 4.)

**Figure 3. Number of treatments for each patient, by location**

**Figure 4. Number of treatments for each patient by modality**
**G.4. Side Effects and Adverse Events**

CAM clinicians collected information on possible side effects for each treatment. (See Table 9.) No significant adverse events (e.g., life-threatening) related to treatment were documented. Mild, expected side effects were reported for patients receiving care; however, determining a temporal relationship between treatment and side effects, particularly in patients with extensive co-morbidities, is a difficult and imperfect process. Consequently, these side effects should be interpreted with caution as they may over- or under-estimate true side effects.

**Table 9. Reported side effects by modality**

<table>
<thead>
<tr>
<th>Reported side effect</th>
<th>AOM*</th>
<th>Chiropractic</th>
<th>Massage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35 patients</td>
<td>338 treatments</td>
<td>46 patients</td>
</tr>
<tr>
<td></td>
<td>366 treatments</td>
<td>329 treatments</td>
<td></td>
</tr>
<tr>
<td>Increased pain</td>
<td>24</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>Sleep disturbance or behavior change</td>
<td>30</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Muscle soreness</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Flushing</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

*Eleven residents had infections but none were related to treatment.

**G.5. Quantitative Outcomes of Care**

The outcomes reported are limited patients who had more than one visit, as the comparison is the mean change from the first to last visit. The distribution of data was fairly normal. Thus, results are expressed in means.

**G.5.1. Pain**

The faces pain scale is a zero (no pain) to six (the most pain) numerical scale. Clinicians asked patients to rate their pain on this scale at the start of each treatment. On average, patients who received chiropractic care reported a mean decrease in pain of 1.0. Patients who received AOM care reported a mean decrease in pain of 0.7. In general, these results would be considered a clinically important decrease in pain. For those patients who received massage therapy, a mean change increase of 0.2 was observed. (See Figure 5.)
The reasons massage did not show a mean decline similar to chiropractic and AOM are unclear. One possible explanation for massage therapy patients reporting an average increase in pain is that they differed from AOM and chiropractic patients. In fact, twice as many TCU patients were treated by massage therapy compared to AOM and chiropractic. Patients in TCU were aggressively rehabilitated with a goal of discharge; it is possible that this concurrent treatment contributed to increased pain levels. Another explanation is that AOM and chiropractic patients had higher pain levels to begin with; this gave them more room for improvement.

**G.5.2. Quality of Life**

At the beginning of each treatment, patients were asked to rate their health for that day on a quality of life thermometer, a 0-100 scale where zero represents “the worst possible health” and 100 represents “the best possible health.” Patients reported a mean increase in the quality of life measure from first to last visit in all three CAM modalities. AOM and massage each reported a mean increase of 8; chiropractic had a mean increase of 6. (See Figure 6.)

![Figure 6. Mean change in quality of life ratings by modality](Image)

It is not known whether or not these changes can be considered clinically important; however, the following should be considered: CAM services were provided to a population where prevention of decline is an indication for treatment. Thus observations of even minimal improvement in patient’s self-assessed quality of life could be considered a very positive finding.
G.5.3. Primary Complaint

CAM clinicians asked patients to identify their primary complaint at the start of each treatment. Musculoskeletal pain was the primary complaint at first visit for about half the patients in LTC. Including headache, pain accounted for 55% of primary complaints overall, seconded by complaints of anxiety, depression, agitation and insomnia in 15% of first visits. Functional problems of contractures and range of motion (ROM) limitations came in third, being the main complaint in 11% of first visits. The “other” category includes a respiratory complaint, a genitourinary (GU) complaint, and overall quality of life (QOL). (See figure 7.)

Musculoskeletal pain was also the primary complaint for 82% of ECRC’s TCU patients at their first treatment. Including other pain (e.g., headache), pain overall accounted for 90% of main complaints at first treatment. In contrast to LTC patients, psychosocial complaints such as anxiety and depression were not among the primary complaints in the TCU. Functional problems of contractures and ROM limitations made up the remainder of primary complaints. (See Figure 8.)
Over the course of all treatment visits, musculoskeletal pain remained the most common primary complaint in LTC and TCU regardless of the type of CAM care patients received; however, the second most common primary complaint varied between the three CAM modalities. Contractures and ROM limitations were of primary concern in 15% of chiropractic treatment visits, insomnia was reported as the primary complaint in 16% of AOM visits, and anxiety and quality of life issues were the primary concern in 27% of massage therapy visits. (See Figure 9.)

Figure 9. Primary complaint at each treatment by modality and location

G.6. Qualitative Interviews

One-on-one interviews were conducted with 25 individuals to gain insight into their perceptions of CAM care; sixteen of the respondents were ECRC residents and nine were residents’ family members. Two interviews included both a resident and family member. Not all residents and family members could answer all questions during the interviews.

Fourteen respondents (56%) stated they had no concerns receiving CAM treatment. Eight respondents (32%) stated they had concerns prior to treatment, which were mainly related to safety (specifically acupuncture and chiropractic) and questions related to the treatment itself (what it is, how it works). Four respondents expressed they had concerns, but these were mitigated by perceived benefits of treatment.

Most respondents (18, or 72%) felt CAM treatment positively affected quality of life. Nine respondents thought CAM services provided physical relief, including diminished pain, muscle relaxation, and enhanced joint mobility. Another nine individuals cited psychological and/or social benefit related to touch and personal attention. Five respondents were unsure or thought CAM services did not improve the resident’s quality of life.

Fifteen respondents (60%) want services available in the future. Three respondents cited benefits of treatment and another cited personal attention. Eight respondents (32%) said no to future services or
were unsure. Reasons included no perceived benefit of therapy, the limitations of advancing age, cost-benefit, and expense of future care.

Twenty respondents (80%) felt CAM treatment was worthwhile. The most common reason was the perception that CAM services resulted in benefits, which included relieving discomfort and enhancing function as well as contributing to psychological and social well being through touch, personal attention, and other ways. Five respondents said no or were unsure if CAM treatment was worthwhile. Reasons cited were no perceived benefit and concerns regarding the cost-benefit of the services.

H. Other Results

This project yielded several other results (e.g., beyond those directly associated with VOA residents). These include standardized forms and care processes, varied and far-reaching dissemination of information regarding the project, and educational and training efforts.

H.1. Standardized Forms and Care Processes

Attempts early in the project to obtain protocols and forms from other hospitals using CAM therapies were met with surprising resistance. One local hospital offered to share protocols for a fee. Thus, the core team took on the design of the care processes and accompanying forms, using materials from the Wolfe-Harris Center of Clinical Studies and the VOA as templates. This resulted in CAM-specific clinician treatment forms, educational materials, documentation of consent for care, and other specialized forms. It is anticipated that these materials can be of value to others implementing CAM services in an inpatient setting and have been included in the appendices.

H.2. Scholarly Presentations

The topic of CAM therapies in a geriatric setting was a welcome submission to CAM research conferences at a national level. Several clinicians have presented their work related to the project. (See Table 10.)
<table>
<thead>
<tr>
<th>Conference</th>
<th>Presenters*</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Baldwin LM, Evans R, Westrom KK, Swanson S</strong></td>
<td>Assessing Staff and Family Members Perceptions of AOM, Chiropractic and Massage Therapies In Volunteers of America Assisted Living and Long-Term Care Facilities (Poster)</td>
</tr>
<tr>
<td>Association of Chiropractic Colleges - Research Agenda Conference Mar 2010</td>
<td><strong>Westrom KK, Skaufel J</strong></td>
<td>Design of an integrated care model within a long term care facility (Oral)</td>
</tr>
<tr>
<td></td>
<td><strong>Skaufel J, Borggren LM, Westrom KK, Evans R</strong></td>
<td>Implementation of Chiropractic Care in the Long Term Setting: a pilot study through NWHSU and the VOA (Oral)</td>
</tr>
<tr>
<td></td>
<td><strong>Baldwin LM, Evans R, Westrom KK, Swanson S, Legendre C</strong></td>
<td>Resident and Family Members' Perceptions of Acupuncture and Oriental Medicine, Chiropractic, and Massage Therapies in Long-Term and Assisted Living Facilities (Poster)</td>
</tr>
<tr>
<td></td>
<td><strong>Vihstadt C, Baldwin LM, Westrom KK, Evans R</strong></td>
<td>A research based AOM fellowship program in geriatrics (Poster)</td>
</tr>
<tr>
<td></td>
<td><strong>Westrom KK, Evans R, Gottfried S</strong></td>
<td>Massage as part of an integrative care team: training, implementation, and outcome collection in a long-term care setting (Poster)</td>
</tr>
<tr>
<td></td>
<td><strong>Gottfried SM, Westrom KK, Evans R</strong></td>
<td>Considerations for Implementing Massage Therapy into the Transitional Care Unit of a Nursing Home (Poster)</td>
</tr>
<tr>
<td>Massage Therapy Foundation: Highlighting Massage Therapy in CIM Research May 2010</td>
<td><strong>Gottfried SM, Westrom KK</strong></td>
<td>Massage in the Transitional Care Unit: A Clinical Case Using Quantitative and Qualitative Outcomes (Poster)</td>
</tr>
<tr>
<td>AMTA 2010 National Convention Sept 2010</td>
<td><strong>Gottfried SM, Westrom KK</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Presenter in bold
**H.3. Presentations to Professional Organizations**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Presenters</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairview Hospital Grand Rounds Sept 2010</td>
<td>Westrom KK</td>
<td>Exploring the benefits of integrative care at Edina Care Center: a demonstration project between the Volunteers of America and Northwestern Health Sciences University</td>
</tr>
<tr>
<td>Metropolitan Professional Pharmacists' Association Jan 2011</td>
<td>Westrom KK</td>
<td>Exploring the benefits of integrative care at Edina Care Center: a demonstration project between the Volunteers of America and Northwestern Health Sciences University</td>
</tr>
</tbody>
</table>

**H.4. Manuscripts**

A number of manuscripts are in the process of completion for submission to scholarly journals. Topics include: a case study of massage in the TCU, the qualitative experiences of patients, families, and staff, the implementation and outcomes of the project, and the safety of CAM therapies in long term and transitional care.

**H.5. Training and Internships**

CAM clinicians involved with the project returned to NWHSU with deeper practical knowledge of the application of their treatment modality to a geriatric inpatient population. This has resulted in lectures on geriatrics to students in the massage program and a new lab on adaptive techniques for the fragile elderly for chiropractic students. It has also led to the design and implementation of a new AOM student clinical internship in which 2 students per term participate in a four hour/week clinical experience under the supervision of one of the project’s fellows (Lori Baldwin). The internship, at Edina Care and Rehabilitation Center, fills a previously unmet need by teaching hands-on care for the fragile elderly in an inpatient setting.

**I. Discussion**

This section describes the successes, challenges, lessons learned and implications of the project’s overall purpose and specific objectives.

**I.1. Purpose**

*Design a replicable and sustainable model for integrative CAM therapies*

**Successes**

During the clinical phase of the project, over a thousand CAM treatments were safely provided to VOA residents. Processes of care were designed that seem to work well in long term care and have great potential for transitional care. Such processes could feasibly be used in other settings. Contributing to success was the acceptance of the CAM clinicians by staff at ECRC; this was instrumental for the smooth implementation of the project and enrollment of residents, which was enthusiastically championed by
nurse managers at that facility. Importantly, a majority of VOA residents and their family members felt positively about the addition of CAM services as identified through qualitative interviews. This, along with generally positive outcomes of care (e.g., decreased pain, increased quality of life) suggests that CAM services are of value to VOA residents.

Challenges
Some of the challenges we encountered to develop a replicable and sustainable model of integrated CAM care may be considered by future parties attempting to implement CAM services in similar settings. Challenges included difficulty in enrolling sufficient patients at EHS, an unsustainable overuse of services by some LTC patients, lack of readily available information about the cost of care, and physical barriers to providing CAM treatments.

Patient enrollment at Elder Homestead
Multiple issues arose early in the implementation of CAM services at Elder Homestead. CAM clinicians were underutilized; even after residents requested and consented to care they often missed appointments. CAM clinicians went to residents’ apartments to provide services but at times patients did not open their doors and, being private apartments, the clinicians could not enter. Clinicians expressed a sense that the lack of a visible clinic space led to CAM services being valued less than “real” healthcare. Attempts to improve utilization produced little benefit; consequently, services were transferred to ECRC after three months, where there was greater need and more accessible patients.

Overuse of services
Despite the requirement for renewing orders for CAM services every six visits, a few patients became high utilizers of services in LTC at ECRC. Possible explanations include: preventing or slowing decline was considered an indication for continuing care, CAM clinicians were not trained in recognizing and dealing with psychosocial issues or personality disorders associated with care seeking, and a secondary gain by LTC staff could have contributed to a culture of overuse if ongoing CAM treatments relieved overburdened staff of the most demanding patients.

Cost of care
A cost analysis was beyond the scope of the project; however, sustainability cannot be addressed without considering the cost of services; reimbursement likely varies between locations (assisted living, transitional care, and long term care). It also differs for each CAM profession (massage, AOM, and chiropractic). Along with the cost of care is consideration of the value placed on the service by patients and families, the parent organizations, payers, and policy makers. These issues are critical to address.

Physical barriers
All three CAM professions most often provide care to patients who are positioned on specialized treatment tables. For several reasons, this was difficult to accomplish for the project; therefore, providers were required to modify their treatment delivery methods in ways they considered to be less than optimal. It is not known whether the care they were able to provide resulted in the same benefits afforded by customary care. At Elder Homestead, a treatment table was set up in a multipurpose room and the lack of privacy was at times a barrier. Additionally, the physical dysfunctions of patients impeded transfers on and off tables, requiring positioning restrictions and extra assistance when available staff was lacking. At Edina Care and Rehabilitation Center, there was no suitable room for a treatment table and the considerable staff resources required to assist during provision of CAM
treatments did not exist. Instead, CAM clinicians spent part of their time finding and transporting patients to their rooms for treatment, which certainly is not cost-efficient nor sustainable in the long term.

Lessons and Implications

- For assisted living facilities, the following should be considered to successfully integrate CAM services:
  - Designated and visible clinical space is required, both to provide reliable access to necessary equipment but also to reassure residents that the clinical services are “real”
  - A sufficient population is needed to sustain the service
  - A system is required to ensure patients set and keep appointments
  - Sufficient staff is necessary to assist with the provision of care

- For long term care facilities, CAM clinicians should be trained in recognizing the psychosocial aspects of care. CAM clinicians would also benefit from understanding the role of psychological and social services available in long term care which could assist in preventing over-utilization and inefficient use of CAM services.

- For all facilities, attention should be drawn to the potential for reimbursement for different CAM services and patients’ and family members’ willingness to pay. Some CAM treatments are reimbursed by health plans.

- For all facilities, purposeful planning and resource allocation will be required to address needs for physical space and hands-on assistance from facility staff to deliver optimal care that is cost-effective.

I.2. Objective 1

To address the healthcare needs of older persons

Successes
The frail elderly, dwelling in the community or inpatient settings, have multiple co-morbidities for which many CAM therapies are indicated. This project confirmed that treating musculoskeletal pain is of primary importance to the VOA residents. CAM clinicians successfully and safely provided care to a fragile population, including those with a history of bone fragility fractures, decreased cognitive function, and those taking blood thinners.

Challenges
CAM services in TCU were hampered by the requirement for orders prior to assessment. Rapid turnover in TCU meant that valuable time was lost awaiting orders. Tight schedules of TCU patients enrolled in rehabilitation made it difficult to schedule CAM treatments. There was a also a potential for overlap in reimbursement for physical therapy (PT) and occupational therapy (OT), which had unclear consequences. While acceptance of CAM clinicians was demonstrated by referrals from the
rehabilitation department, integration of the CAM providers into TCU and within PT/OT was not optimized.

**Lessons and Implications**

For TCU: All three CAM modalities use treatment methods which can be viewed as complementary to PT/OT to treat pain and improve function. To best coordinate efficient use of services, standardized protocols for CAM treatments (either before or after PT/OT) should be developed to maximize patient benefit. To expedite communication and CAM service delivery, we propose two models in which CAM providers address pain and function alongside PT/OT, with the potential benefit of shorter TCU stays:

1. A CAM provider (specifically AOM or massage) works on a single team in TCU; the CAM clinician is empowered to assess patients at admission and to devise treatment plans in coordination with the interdisciplinary team. The role of the CAM clinician is to treat pain and maximize function, coordinating the timing of treatments to gain the most benefit from PT/OT treatments.

2. A chiropractor (trained in geriatrics) works closely with PT/OT to co-manage patients; the team consists of PT/OT and chiropractor, working to maximize function of TCU patients with a goal of timely discharge. The main indication for treatment would be joint dysfunction along with pain. TCU patients often have compensatory musculoskeletal dysfunctions related to prior immobilization for which chiropractic treatments are indicated.

**I.3. Objective 2**

To collect data on outcomes of care

**Successes**

For the most part, CAM clinicians successfully collected patient-oriented outcomes, including pain and quality of life measures, from those patients able to respond. Additionally, qualitative interviews were conducted, which captured important insight into residents’ and family members’ views of CAM services. Data on modalities and number of treatments were also collected.

It is important to note that the nature of the data collection process does not allow for definitive treatment group comparisons (e.g., did one treatment do better or worse than another?). It also does not allow for definitive conclusions regarding the effectiveness or efficacy of any of the CAM treatments.

Overall, the data indicates patients who received CAM therapies experienced decreased pain levels and increased quality of life. This may be due to several factors including the potential effectiveness of the CAM therapies, increased attention by CAM providers, and a common tendency for individuals to improve under observation. Further, some of the data collection methods (e.g., administration of outcomes by providers) have an inherent limitation of bias. Providers themselves might unconsciously solicit feedback that is more positive; further, patients often do not want to disappoint their providers. That being noted, the data collection methods reflect what was possible given the resources available and are typical of what may occur in practice settings.

The qualitative interviews, which were administered by a clinician who was unfamiliar to the patient, provided important perspective of residents’ and family members’ views of CAM therapies.
Challenges
There are several inherent challenges to collecting outcomes data in LTC facilities:

- Lack of validated measures for the population
- Incomplete data collection due to low cognitive function or functional impairments
- Lack of an electronic record
- Self-assessment measures depend upon the cognitive function of the patient; on the other hand, relying on caregivers to rate for the patient is open to bias

Additionally, we experienced specific challenges with the outcome measures we chose to collect:

- While the faces pain scale has been tested for use in geriatric populations, patients often expressed confusion as to the meaning of the faces. In one instance, a gentleman with intact cognition but in obvious pain selected the smiling face (representing no pain). The puzzled clinician asked him to explain his choice. His answer: “Well, I am hurting on the inside, but I am smiling on the outside.”

- The hand-grip strength test, considered an objective measure of overall function and a predictor of morbidity and mortality, proved difficult to administer in LTC in a fashion that would provide valid data. Standard protocol requires subjects to be in a standing position; we modified this to allow the patient to be in a wheelchair or in bed; however, clinicians continued to have difficulties administering the test. Problems included patients’ inability to follow verbal instructions as well as advanced dysfunction (from arthritis, generalized weakness, and sarcopenia), which interfered with grasping the dynamometer. Further, although clinicians were trained to perform the test, it is also likely they did not perform it as systematically as what is considered optimal for valid data collection.

- Accurate documentation of medication use was difficult due to the lack of electronic medication records. As standing orders are common, simply collecting information on medications ordered is insufficient. Laborious medical record review would have been required to hand count medications actually dispensed to patients for a period of time before and after CAM treatment. Such review would have required greater resources than those available during the project.

Lessons and Implications

- For long term care facilities, the hand-grip strength test is a poor objective measure of overall function.
- For all facilities, accurate documentation of medication use would be facilitated by an electronic pharmacy record. Comparing the amount of pain medications before and after care or tracking the use of psychotropic drugs are highly desirable outcomes independent of the patient’s ability to self-report.

I.4. Objective 3

To increase the number of CAM clinicians skilled in geriatrics to deliver care to the frail elderly

Successes
We trained six CAM clinicians to provide care to the frail elderly. Importantly, the clinicians integrated as a CAM care team, as evidenced by mutual treatment of patients and consultation with one another; they also became part of the VOA team, particularly in interdisciplinary rounds in LTC and TCU. Three of
the project’s CAM clinicians have since assumed teaching responsibilities at Northwestern in various capacities, providing further, ongoing training of future CAM clinicians in evidence informed geriatric care.

Challenges
We experienced some significant challenges in working towards the goal of increasing the number of CAM clinicians skilled to deliver care to the frail elderly. Noteworthy was the huge void of geriatric specific training materials in each of the CAM fields, particularly materials related to necessary modifications of therapeutic approaches to ensure patient and provider comfort and safety. Additionally, the majority of CAM clinicians have little inpatient training working with frail elderly in institutional settings, which poses a vastly different set of clinical circumstances than those to which they are accustomed. The CAM providers trained for this project had little previous experience in how to integrate into inpatient allopathic settings. Substantial effort was required during the preparation phase to train CAM clinicians in areas unrelated to geriatrics (e.g., best practices in medical records, the role of various staff and departments, infection control, safety, etc.). Finally, it proved somewhat difficult to train providers in a specialized area when there is no assurance for long term reimbursement for such skills.

Lessons and Implications
- For all CAM professions, educational programs should develop geriatric specific competencies and learning objectives for outpatient and inpatient settings. Importantly, hands-on practical training with frail elderly patients must be included. Clinical internships or student rotations in long term care or transitional care settings can build off work done on this project.

- The CAM clinicians who participated in this project gained a wealth of knowledge and skills. Those clinicians should be sought out and encouraged to create educational materials specific to geriatrics in their fields.

I.5. Objective 4

To disseminate information regarding project implementation and results to a wider audience

Successes
The successful presentations on aspects of the project speaks to the hunger for reliable and evidence informed information regarding CAM therapies in geriatrics in general, and more specifically, in long term and transitional care. Future published manuscripts on the project, including the safety of CAM care for this population, will benefit a wide audience interested in geriatric care.

Challenges
The process of writing, submitting, and publishing manuscripts is time-consuming. Additionally, CAM clinicians involved in the project require substantial mentoring and resources to complete manuscripts in their field.

Lessons and Implications
It is likely the various project stakeholders have different needs regarding the dissemination of results of the project. NWHSU has made substantial in-kind contributions to the project and will continue to do so. Additionally, mentoring of CAM clinicians will continue, with a tangible goal of further dissemination of information to each CAM field.
J. Conclusion
There is a substantial need for healthcare services in the growing geriatric population; CAM professionals offer treatments that address primary health concerns for this group. The Volunteers of America CAM Demonstration Project successfully and safely provided over one thousand AOM, massage, and chiropractic treatments within a transitional care unit and long term care unit (including memory care). The project suggests that integrated CAM services are both replicable and sustainable if attention is paid to the following areas:

- Efficient application of services (for instance, additional ancillary staff to expedite transport of patients and provision of care)
- Prevention of overuse of care
- Population and site specific training of CAM practitioners
- Adequate equipment and space for efficient, private, and safe care delivery
- Maximization of CAM clinicians’ integration within the entire care team
- Exploration of reimbursement from patients and insurers

CAM professionals in general are known for “low tech, high touch” care. Compassionate, competent, geriatric care by CAM clinicians is a natural fit wherever the frail elderly reside, whether in the community or in inpatient settings. If we wait for the day when Medicare reimbursement includes CAM professionals’ full scope of practice, an opportunity is lost to creatively assert AOM, massage, and chiropractic’s logical place as geriatric caregivers; however, it cannot be claimed that CAM clinicians are at present fully competent to enter inpatient settings and provide safe care to the frail elderly. This project has expanded the boundaries of knowledge in the application of CAM services for geriatrics. It is our hope it also will encourage the teaching of safe and effective geriatric-specific treatment methods for the benefit of both patients and clinicians.
K. References


5. Teno JM, Weitzen S, Wettle T, Mor V. Persistent pain in nursing home residents. JAMA 2001;285:2081


## Appendix 1: Training Checklist For CAM Clinicians

### Training for the VOA

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Adequate Training</th>
<th>Clinician Initials</th>
<th>Supervisor Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Handgrip Strength</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Faces Pain Scale</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>QOL Thermometer</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New Patient</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow Up Visit</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EHS Consent for Care</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECC Consent for Care</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident Care Form</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinician Checklist Form</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Progress Notes</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment Log</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Educational Materials

New Partnership to Provide New Services

Volunteers of America, Elder Homestead, is excited to announce a new partnership with Northwestern Health Sciences University of Bloomington MN to provide additional services to our residents.

Starting in January we will be offering Massage Therapy, Acupuncture and Oriental Medicine, and Gentle Chiropractic Therapies.

Common Questions

Why are these services being provided?
This partnership is a pilot project to determine the effectiveness of these treatments in Senior Living. Studies have shown that these services may help to alleviate pain levels, help with motion, decrease depression, and help with insomnia.

How do I participate?
These services will be provided to residents who are eligible and wish to participate. We will need permission from you and your doctor for you to receive these services.

Will there be a charge for this?
We are providing these services free of charge in conjunction with Northwestern Health Sciences University during this pilot project. Your feedback and results will be helpful to our project.

Who will be providing the services?
Fully trained and certified or licensed clinicians that have completed their training at the University will be coming to our facility weekly.

How do I find out more?
We will be providing informational meetings and demonstrations of these services soon. Please let us know if you are interested in more information.

If you are interested in getting more information, please let Patty or Gwen know.
Information about therapies offered at VOA

**Acupuncture and Oriental Medicine:** Treatment may include acupuncture (the insertion of fine disposable sterilized needles through the skin at specialized point on the body), acupressure (pressure on certain spots of the body), Tui Na (a form of Oriental manual therapy similar to massage), and breathing techniques.

- **Potential Benefits** are an improvement in body functions, better sleep, relief from pain and enhanced overall well-being.

- **Potential Risks** include bruising, soreness, flushing and sometimes nausea. A broken needle or infection is possible but is rare.

**Chiropractic Care:** Treatment may include gentle mobilization or manipulation (a careful movement or push of a joint) and stretching of the soft tissue.

- **Potential Benefits** are an improvement in function and relief of pain.

- **Potential Risks** include soreness, bruising, dizziness or nausea. A broken bone such as a rib is possible but is rare.

**Massage Therapy:** Treatment may include stroking the hands and feet or other parts of the body where there is muscle tightness and tension. There are several different massage strokes, and the amount of pressure is adjusted for the patient. Lotion is often used during the massage to help reduce friction on the skin.

- **Potential Benefits** are relief from muscle pain and tightness. Massage therapy may also help with sleep disturbance, relaxation, and a sense of well being.

- **Potential Risks** are bruising, soreness, swelling, and a skin reaction to the lotion.
Acupuncture and Oriental Medicine

What is Oriental Medicine?

Oriental Medicine refers to traditional medical practices developed several thousand years ago in Asia. These practices are based on the theory that the human body is healthy when it has sufficient *qi* (vital energy) that is free-flowing along pathways known as *meridians*. A blockage in the flow of *qi* results in pain or dysfunction. Some common treatments in Oriental medicine include *acupuncture, acupressure and tui na, and qi gong*.

What is expected with this form of therapy?

<table>
<thead>
<tr>
<th>Time for each session</th>
<th>30-60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sessions</td>
<td>Typically once a week; the patient and practitioner will determine the number of sessions needed.</td>
</tr>
<tr>
<td>What happens</td>
<td>One or more of the following therapies might be used in each session: Acupuncture is the insertion of sterile, disposable, hair-thin needles into specific points along the meridians in the body. Acupressure is application of pressure to a specific point for 1 to 3 minutes. It is acupuncture without needles. Tui Na is a type of Chinese medical massage. It uses rhythmic compression on different areas of the body, often along the meridians, to move <em>qi</em>. Qi Gong is a breathing exercise that uses meditation and gentle movement to help move <em>qi</em> in the meridians.</td>
</tr>
</tbody>
</table>

What are the known benefits?

Research has shown that acupuncture helps with pain. It may help arthritic joints, sleep disturbance, and overall sense of well being.

What are the known risks?

**Common:** There might be some soreness or a little pain with acupuncture needling. Some people have felt flushed or nauseous, and some have fainted (usually if they have not eaten before a treatment or if they are sick). The most common risks of tui na and acupuncture are bruising.

**Rare:** Infection is a rare risk. All needles used in VOA facilities are sterile, one-time use only and are disposed of in proper sharps containers.
Chiropractic

What is Chiropractic?

Chiropractic is a form of health care that focuses on the relationship between the body's structure and function. In this project the chiropractors will use gentle manual therapies including manipulation and mobilization.

What can I expect from this form of therapy?

<table>
<thead>
<tr>
<th>Time for each session</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sessions</td>
<td>Typically once a week; the patient and practioner will determine the number of sessions needed.</td>
</tr>
<tr>
<td>What happens</td>
<td>The chiropractor will examine the patient’s joints and see how they move. Treatments can include manipulation or mobilization, both of which involve gentle manual pressure to the joints. Treatment of the soft tissue can also be performed.</td>
</tr>
</tbody>
</table>

What are the known benefits?

Chiropractic care is expected to decrease pain and increase mobility in the spine and other joints.

What are the known risks?

Some people have sore muscles after a treatment. Bruising could also occur.
**Massage**

**What is massage therapy?**

Massage therapy is a hands-on technique that works on the muscles and other soft tissues of the body. It uses different levels of pressure and movement to help relax muscles.

**What is expected with this form of therapy?**

<table>
<thead>
<tr>
<th>Time for each session</th>
<th>30-60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of sessions</strong></td>
<td>Typically once a week; the patient and therapist will determine the number of sessions needed.</td>
</tr>
<tr>
<td><strong>What happens</strong></td>
<td>During a session, the therapist may focus on the hands and feet, or may treat another part of the body. Broad, flowing strokes are often used to help with relaxation, or other strokes may address areas of muscular tension. Lotion is used during the massage to help reduce friction on the skin.</td>
</tr>
</tbody>
</table>

**What are the known benefits?**

Massage therapy can provide relief from joint and muscle pain and tightness. It also helps with sleep disturbance, relaxation, and a sense of well being.

**What are the known risks?**

Some people feel muscle tenderness and soreness. Sometimes there is bruising and swelling. Some people are sensitive or allergic to the massage lotions.
Appendix 3: Consent For Care Forms

Resident: _______________ MR#: __________ Room # __________ Physician: _______________

**Elder Homestead**

**INFORMED CHOICE CONSENT FOR COMPLEMENTARY AND ALTERNATIVE THERAPIES**

I REQUEST TO RECEIVE THE FOLLOWING:

- [ ] Acupuncture/Oriental medicine
- [ ] Chiropractic care
- [ ] Massage

______________________________________________________________________________

The following information has been explained to me:

1. The potential benefits and risks, including possible side effects (see attached).
2. The fact that I may refuse consent now or change my mind at any time.
3. The fact that these services are being provided without cost.
4. I have been given the names and telephone numbers of people to contact if questions arise.

☐ I give approval as outlined above. ☐ I do not give my approval.

☐ For Healthcare Proxy only: Family requests more information prior to approval: best times and #s for clinician to call during the DAY: __________________________________________

Individual Giving Consent (Print): _________________________________________________

Relationship to Resident: _______________________________________________________

For (Resident’s Name): _________________________________________________________

________________________________________________ _______________________
Signature of Resident/Responsible Party             Date

________________________________________________ _________________________
Staff Member Signature              Date
At the first visit for any of these therapies, the practitioner and patient will discuss the care plan, which might include one or a series of treatments.

(check topics discussed)

- **Acupuncture and Oriental Medicine:** Treatment may include acupuncture (the insertion of fine disposable sterilized needles through the skin at specialized point on the body), acupressure (pressure on certain spots of the body), Tui Na (a form of Oriental manual therapy similar to massage), and breathing techniques.

  Potential Benefits are an improvement in body functions, better sleep, relief from pain and overall well-being.

  Potential Risks include bruising, soreness, flushing and sometimes nausea. A broken needle or infection is possible but is rare.

- **Chiropractic Care:** Treatment may include gentle mobilization or manipulation (a careful movement or push of a joint) and stretching of the soft tissue.

  Potential Benefits are an improvement in function and relief of pain.

  Potential Risks include soreness, bruising, dizziness or nausea. A broken bone such as a rib is possible but is rare.

- **Massage Therapy:** Treatment may include stroking the hands and feet or other parts of the body where there is muscle tightness and tension. There are several different massage strokes, and the amount of pressure is adjusted for the patient. Lotion is often used during the massage to help reduce friction on the skin.

  Potential Benefits are relief from muscle pain and tightness. Massage therapy also helps with sleep disturbance, relaxation, and a sense of well being.

  Potential Risks are bruising, soreness, swelling, and a skin reaction to the lotion.
For any further questions, please contact one of the following at Elder Homestead:

**Licensed Acupuncturists:**
- Corrie Vihstadt, L.Ac., M.Om
- Lori Baldwin, L.Ac., M.Om

**Certified Massage Therapist:**
- Sarah Gottfried, NCTM

**Chiropractors:**
- Cara Borggren, D.C.
- Jodell Skaufel, D.C

Elder Homestead phone number: 952-933-1752
Edina Care and Rehabilitation Center
INFORMED CHOICE CONSENT FOR COMPLEMENTARY AND ALTERNATIVE THERAPIES

I have been informed that the attending MD/NP and the facility’s Interdisciplinary Care Planning Team recommend for the purpose of reaching the highest level of physical and psycho-social well-being the following service:

(check one or more recommended treatments)

- Acupuncture/Oriental medicine
- Chiropractic care
- Massage

The following information has been explained to me:

1. The potential benefits and risks, including possible side effects (see attached).
2. The fact that I may refuse consent now or change my mind at any time.
3. The fact that these services are being provided without cost.
4. I have been given the names and telephone numbers of people to contact if questions arise.

☐ I give approval as outlined above. ☐ I do not give my approval.

☐ For Healthcare Proxy only: Family requests more information prior to approval: best times and #s for clinician to call DURING THE DAY: ______________________________

Individual Giving Consent (Print): _______________________________________________________

Relationship to Resident: ____________________________________________________________

For (Resident’s Name): ________________________________________________________________

________________________________________________ ________________________
Signature of Resident or the Responsible Party Date

________________________________________________ ________________________
Staff Member Signature Date
At the first visit for any of these therapies, the practitioner and patient will discuss the care plan, which might include one or a series of treatments.

(check topics discussed)

- **Acupuncture and Oriental Medicine:** Treatment may include acupuncture (the insertion of fine disposable sterilized needles through the skin at specialized point on the body), acupressure (pressure on certain spots of the body), Tui Na (a form of Oriental manual therapy similar to massage), and breathing techniques.

  **Potential Benefits** are an improvement in body functions, better sleep, relief from pain and overall well-being.

  **Potential Risks** include bruising, soreness, flushing and sometimes nausea. A broken needle or infection is possible but is rare.

- **Chiropractic Care:** Treatment may include gentle mobilization or manipulation (a careful movement or push of a joint) and stretching of the soft tissue.

  **Potential Benefits** are an improvement in function and relief of pain.

  **Potential Risks** include soreness, bruising, dizziness or nausea. A broken bone such as a rib is possible but is rare.

- **Massage Therapy:** Treatment may include stroking the hands and feet or other parts of the body where there is muscle tightness and tension. There are several different massage strokes, and the amount of pressure is adjusted for the patient. Lotion is often used during the massage to help reduce friction on the skin.

  **Potential Benefits** are relief from muscle pain and tightness. Massage therapy also helps with sleep disturbance, relaxation, and a sense of well being.

  **Potential Risks** are bruising, soreness, swelling, and a skin reaction to the lotion.

Signature of provider: ____________________________  Date: ____________________________

With whom did you discuss risks/benefits? ____________________________________________
For any further questions, please contact one of the following at Edina Care & Rehabilitation Center:

**Licensed Acupuncturists:**
- Corrie Vihstadt, L.Ac., M.Om
- Lori Baldwin, L.Ac., M.Om

**Certified Massage Therapist:**
- Sarah Gottfried, NCTM

**Chiropractors:**
- Cara Borggren, D.C.
- Jodell Skaufel, D.C.

**Edina Care & Rehabilitation Center phone number:** 952-925-8500
## Appendix 4: Care Plan Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Problem</th>
<th>Goal</th>
<th>Interventions</th>
<th>Disciplines Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resident participating in complementary treatment program:</td>
<td>Resident will exhibit improved quality of life as evidenced by</td>
<td>1) Resident will participate in treatment program following consent.</td>
<td>Nsg, SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) Staff and fellows will introduce themselves and provide explanation of treatment</td>
<td>Nsg, SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) Monitor for changes in mood and behavior</td>
<td>Nsg, SS, RT,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4) Observe for pain/discomfort</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5) Contact MD, NP, family PRN</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6) Educate resident on treatments</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7) Encourage resident to express feelings</td>
<td>Nsg, SS, RT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8) Encourage resident to utilize relaxation techniques</td>
<td>Nsg, SS, RT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9) Medications as ordered</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10) Monitor site for redness or swelling PRN</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11) Review recommendations of health professional with resident and family</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) Staff and fellows will introduce themselves and provide explanation of treatment</td>
<td>Nsg, SS, SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) Monitor for changes in mood and behavior</td>
<td>Nsg, SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4) Observe for pain/discomfort</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5) Contact MD, NP, family PRN</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6) Educate resident on treatments</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7) Encourage resident to express feelings</td>
<td>Nsg, SS, RT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8) Encourage resident to utilize relaxation techniques</td>
<td>Nsg, SS, RT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9) Medications as ordered</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10) Monitor site for redness or swelling PRN</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11) Review recommendations of health professional with resident and family</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) Staff and fellows will introduce themselves and provide explanation of treatment</td>
<td>Nsg, SS, SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) Monitor for changes in mood and behavior</td>
<td>Nsg, SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4) Observe for pain/discomfort</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5) Contact MD, NP, family PRN</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6) Educate resident on treatments</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7) Encourage resident to express feelings</td>
<td>Nsg, SS, RT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8) Encourage resident to utilize relaxation techniques</td>
<td>Nsg, SS, RT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9) Medications as ordered</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10) Monitor site for redness or swelling PRN</td>
<td>Nsg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11) Review recommendations of health professional with resident and family</td>
<td>Nsg</td>
</tr>
</tbody>
</table>

- **Resident participating in complementary treatment program:**
  - Massage therapy
  - Oriental medicine
  - Chiropractic care

- **Goal:**
  - Decreased pain
  - Decreased anxiety
  - Improved mood
  - Improved functioning
  - Improved health

- **Interventions:**
  1) Resident will participate in treatment program following consent.
  2) Staff and fellows will introduce themselves and provide explanation of treatment.
  3) Monitor for changes in mood and behavior.
  4) Observe for pain/discomfort.
  5) Contact MD, NP, family PRN.
  6) Educate resident on treatments.
  7) Encourage resident to express feelings.
  8) Encourage resident to utilize relaxation techniques.
  9) Medications as ordered.
  10) Monitor site for redness or swelling PRN.
  11) Review recommendations of health professional with resident and family.
Appendix 5: Orders for CAM Assessment and Treatment
Appendix 6: Missed Treatment Form

VOA Pilot Study Missed Treatment Form

<table>
<thead>
<tr>
<th>Name, DOB</th>
<th>ID Number</th>
</tr>
</thead>
</table>

DATE: ______________________

Patient was Unavailable because
- [ ] Hospitalized
- [ ] Activities Event
- [ ] Out of Building (not hospitalized)
- [ ] Other Obligations
- [ ] Unable to locate patient
- [ ] Interpreter Unavailable
- [ ] Other ______________________

Patient Declined Treatment due to
- [ ] Illness
- [ ] Behavioral Issues/Mood
- [ ] Other ______________________

CLINICIAN SIGNATURE: ______________________________
Appendix 7: CAM Clinician Checklist

<table>
<thead>
<tr>
<th>Name, DOB</th>
<th>ID Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>MD/NP order signed</strong> (ECC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Consent for care obtained</strong> (ECC) and (EHS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Medical record review</strong> (ECC and EHS):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PATIENT HAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Coumadin/Levonex or bleeding disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. History of fragility fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Skin precautions (____________________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. MRSA/VRE/CDIFF</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Position restriction (__________________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Resident Care Form completed</strong> (ECC):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. <strong>Risks and Benefits for CAM therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**RECORD FROM PATIENT CHART**
*CIRCLE N/A IF NOT AVAILABLE (EHS)*

1. Geriatric depression scale (0-15): _____________ date obtained ____ N/A
2. MiniMentalStatus (0-30): _________________ date obtained____ N/A

Clinician Signature ____________________________ DATE ________________
## Appendix 8: Clinician Treatment Notes Forms

### AOM Progress Notes

**NAME:** ___________________________  **DOB:** ______________  **DATE:** ______________

<table>
<thead>
<tr>
<th>NO. OF VISITS FROM MD ORDER:</th>
<th>THIS VISIT NO.:</th>
<th>OF</th>
<th>TOTAL VISIT NO.:</th>
</tr>
</thead>
</table>

### A. STANDARDIZED STUDY QUESTIONS

#### 1. Any problems since last visit?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-report</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*IF YES, SPECIFY BELOW:

- **a. Increase in pain?**
  - No
  - Yes
- **b. Worsening of behavior or sleep disturbance?**
  - No
  - Yes
- **c. Pain and discomfort from acupuncture?**
  - No
  - Yes
- **d. Flushing/nausea/fainting from acupuncture?**
  - No
  - Yes
- **e. Burn?**
  - No
  - Yes
- **f. Infection?**
  - No
  - Yes
- **g. Other, please specify:**
  - No
  - Yes
- **h. Other, please specify:**
  - No
  - Yes

#### 2a. Any new injuries or accidents?

- **No**
- **Yes**

*Point @ Worst* If this is the worst possible health *Point at Best* and if this is the best possible health, where is your health today?

#### 3a. Feeling thermometer (separate page)

- **Performed**
- **Did not perform**

#### 3b. Did you have any difficulty collecting this measure?

- **No**
- **Yes, please specify:**

#### 4a. Hand Grip Strength (separate page):

- **Performed**
- **Did not perform**

#### 4b. Did you have any difficulty collecting this measure?

- **No**
- **Yes, please specify:**

Obtained 1st and every 6th visit thereafter.

### 5a. FACES PAIN SCALE: Which face shows how much pain you have today?

- **0**
- **1**
- **2**
- **3**
- **4**
- **5**
- **6**

#### 5b. Did you have any difficulty collecting this measure?

- **No**
- **Yes, please specify:**

#### 5c. Did you have any difficulty collecting this measure?

- **No**
- **Yes, please specify:**

### 6a. Main Complaint:

- **Self-report**
- **Other**

### 6b. “On a scale of 0-10 how would you rate it today?”

- **Self-report**
- **Other**

### 7a. Second Complaint:

- **Self-report**
- **Other**

### 7b. “On a scale of 0-10 how would you rate it today?”

- **Self-report**
- **Other**

### B. CLINICIAN SOAP NOTES:

<table>
<thead>
<tr>
<th>Subjective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

49
B. CLINICIAN SOAP NOTES, cont.:

Objective:

Tongue:

Pulse:

Assessment

Procedure/Plan

Points:

Number of needles retained: ____________ Number of needles removed: ____________

Patient Position: □ Sitting □ Supine □ Prone

C. PROCEDURES SUMMARY

1. Acupuncture □ Performed □ Did not perform
2. Acupressure □ Performed □ Did not perform
3. Tui Na □ Performed □ Did not perform
4. Qi Gong □ Performed □ Did not perform
5. Self-Care Recommendations □ Performed □ Did not perform
6. Biofreeze □ Performed □ Did not perform
7. Heat □ Performed □ Did not perform

D. TREATMENT PLAN & NEXT APPOINTMENT DATE

Was there something you wanted to use in treatment that was not available to you? □ Yes □ No

If YES, explain: ________________________________________________________________

Clinician Signature ___________________________ DATE: ________________
DC Progress Notes

NAME: ___________________________ DOB: ___________________ DATE: ____________________

NO. OF VISITS FROM MD ORDER: _________ THIS VISIT NO.: _______ OF _______ TOTAL VISIT NO: _________

A. STANDARDIZED STUDY QUESTIONS

1. Any problems since last visit?
   [ ] Self-report [ ] Other [ ] No [ ] Yes*
   *IF YES, SPECIFY BELOW:
   a. Increase in pain?
      [ ] No [ ] Yes
   b. Bruising?
      [ ] No [ ] Yes
   c. Worsening of behavior or sleep disturbance?
      [ ] No [ ] Yes
   d. Other, please specify:
      [ ] No [ ] Yes
   e. Other, please specify:
      [ ] No [ ] Yes
   f. Other, please specify:
      [ ] No [ ] Yes

2a. Any new injuries or accidents?
   [ ] No [ ] Yes

2b. If yes, please specify:
   *Point @ Worst* If this is the worst possible health *Point at Best* and if this is the best possible health, where is your health today?
   3a. Feeling thermometer (separate page)
      [ ] Performed [ ] Did not perform
   3b. Did you have any difficulty collecting this measure?
      [ ] No [ ] Yes, please specify:

4a. Hand Grip Strength (separate page):
    [ ] Performed [ ] Did not perform
   4b. Did you have any difficulty collecting this measure?
      [ ] No [ ] Yes, please specify:

Obtained every other visit.

5a. FACES PAIN SCALE: Which face shows how much pain you have today?

5b. [ ] Performed [ ] Did not perform
5c. Did you have any difficulty collecting this measure?
    [ ] No [ ] Yes, please specify:

6a. Main Complaint:
   [ ] Self-report [ ] Other
6b. “On a scale of 0-10 how would you rate it today?”
   [ ] Self-report [ ] Other

7a. Second Complaint:
   [ ] Self-report [ ] Other
7b. “On a scale of 0-10 how would you rate it today?”
   [ ] Self-report [ ] Other

B. CLINICIAN SOAP NOTES:

Subjective

_________________________ ___________________________ ___________________________ ___________________________
NAME: ___________________  DOB: ___________________  DATE: ________________

B. CLINICIAN SOAP NOTES, cont.:

Objective:

Assessment

Procedure/Plan

C. PROCEDURES SUMMARY

1. Manipulation (HVLA)  ____________________________
   □ Performed  □ Did not perform
2. Mobilization  ____________________________
   □ Performed  □ Did not perform
3. Flexion Distraction  ____________________________
   □ Performed  □ Did not perform
4. Soft tissue work  ____________________________
   □ Performed  □ Did not perform
5. Biofreeze  ____________________________
   □ Performed  □ Did not perform
6. Hot pack  ____________________________
   □ Performed  □ Did not perform
7. Active/passive muscle stretching  ____________________________
   □ Performed  □ Did not perform
8. Recommendations for self-care  ____________________________
   □ Performed  □ Did not perform
9. Supervised exercise  ____________________________
   □ Performed  □ Did not perform
10. Other (please specify):  ____________________________
    □ Performed  □ Did not perform

D. TREATMENT PLAN & NEXT APPOINTMENT DATE

Was there something you wanted to use in treatment that was not available to you?  □ Yes  □ No

If YES, explain: ____________________________________________

________________________________________________________

Clinician Signature  ____________________________  DATE: ________________
MT Progress Notes

NAME: __________________________ DOB: ___________ DATE: ___________

NO. OF VISITS FROM MD ORDER: __________ THIS VISIT NO.: __________ OF __________ TOTAL VISIT NO.: __________

<table>
<thead>
<tr>
<th>A. STANDARDIZED STUDY QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any problems since last visit?</td>
</tr>
<tr>
<td>[ ] Self-report [ ] Other</td>
</tr>
<tr>
<td>[ ] No [ ] Yes*</td>
</tr>
<tr>
<td>*IF YES, SPECIFY BELOW:</td>
</tr>
<tr>
<td>a. Increase in pain?</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>b. Bruising?</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>c. Worsening of behavior or sleep disturbance?</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>d. Unusual or increased muscle soreness?</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>e. More fatigue than usual?</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>f. Other, please specify:</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>g. Other, please specify:</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>2a. Any new injuries or accidents?</td>
</tr>
<tr>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>2b. If yes, please specify:</td>
</tr>
</tbody>
</table>

*Point @ Worst* If this is the worst possible health *Point at Best* and if this is the best possible health, where is your health today?

3a. Feeling thermometer (separate page) [ ] Performed [ ] Did not perform
3b. Did you have any difficulty collecting this measure? [ ] No [ ] Yes, please specify:

4a. Hand Grip Strength (separate page): [ ] Performed [ ] Did not perform
4b. Did you have any difficulty collecting this measure? [ ] No [ ] Yes, please specify:

Obtained every other visit.

5a. FACES PAIN SCALE: Which face shows how much pain you have today?

![Faces Pain Scale Image]

5b. [ ] Performed [ ] Did not perform
5c. Did you have any difficulty collecting this measure? [ ] No [ ] Yes, please specify:
B. CLINICIAN SOAP NOTES

Subjective
6a. Main Complaint: [□] Self-report [□] Other
6b. “On a scale of 0-10 how would you rate it today?” [□] Self-report [□] Other

7a. Second Complaint: [□] Self-report [□] Other
7b. “On a scale of 0-10 how would you rate it today?” [□] Self-report [□] Other

Symptoms/Location/Intensity/Frequency

Objective: Areas addressed/position/Techniques

Assessment: visual/palpable observations

Changes Due To Massage:

Plan:

C. PROCEDURES SUMMARY

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Performed</th>
<th>Did not perform</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Classic Western Style Swedish Massage</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. Trigger Point Therapy</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3. Myofascial Technique</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

D. TREATMENT PLAN & NEXT APPOINTMENT DATE

Was there something you wanted to use in treatment that was not available to you? [□] Yes [□] No
If YES, explain: ____________________________________________________________________________
_____________________________________________________________________________________

Clinician Signature ___________________________ Date: _______/_______/_______
Appendix 9: Faces Pain Scale

Which face shows how much pain you have today?
Appendix 10: Handgrip Strength (HGS) Test

<table>
<thead>
<tr>
<th>Name, DOB</th>
<th>ID Number</th>
</tr>
</thead>
</table>

HANDGRIP STRENGTH : First visit and every other visit

<table>
<thead>
<tr>
<th>Grip Size</th>
<th>Dominant/Functional hand (circle)</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand</td>
<td>Trial 1:</td>
<td>kg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trial 2:</td>
<td>kg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trial 3:</td>
<td>kg</td>
<td></td>
</tr>
</tbody>
</table>

Did you have any difficulty collecting this measure?

- [ ] No
- [ ] Yes, please specify

Signature: ________________________________ Date: _____ / _____ / ______

Lying down in bed

Sitting with arm supported

Sitting without support
Appendix 11: Feeling Thermometer

Date: _______________  Patient ID: _______________

BEST

WORST
Appendix 12: Qualitative Interview Script

**VOA Resident or Family Member Interview Questions**

1. **VOA Resident**: Did you have concerns about receiving (Acupuncture and Oriental medicine, chiropractic, or/and massage) therapies?

1a. (If Yes) Were your concerns addressed?

OR

1. **Family Member**: Did you have concerns about your family member receiving (acupuncture and Oriental medicine, chiropractic, or/and massage) therapies?

1a. (If Yes) Were your concerns addressed?

Probes: How so? Tell me more…anything else?

2. **VOA Resident**: Do you think receiving (acupuncture and Oriental medicine, chiropractic, or/and massage) treatments has had an affect on your day to day quality of life?

OR

2. **Family Member**: Do you think receiving (acupuncture and Oriental medicine, chiropractic, or/and massage) treatments has had an affect on your family member’s day to day quality of life?

Probes: Why or why not? How so? Tell me more…Can you think of an example? …Anything else?

3. **VOA Resident**: Would like these therapies available to you in the future?

OR

3. **Family Member**: Do you think your family member would like these therapies available to them in the future?

Probes: Why or why not? How so? Tell me more…Anything else?

4. Overall, do you think that these therapies (acupuncture and Oriental medicine, chiropractic, or/and massage) are worthwhile for Volunteers of America (VOA) to make available to residents?

Probes: Why or Why not? Tell me more…Anything else?