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Original Research

Hospital based massage therapy specific competencies

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ABSTRACT

As massage therapy experiences a resurgence of use for hospitalized patients, it is appropriate to consider the competencies needed by practitioners to practice safely and effectively in the inpatient setting. Hospitals differ vastly from other massage practice locations such as private offices, spas, and sports clubs. The variety of conditions encountered in an acute care setting require the knowledge and ability to adapt massage protocols appropriately. The Academic Collaborative for Integrative Health (ACIH) created the Hospital Based Massage Therapy (HBMT) Task Force to determine if there is a need for HBMT specific competencies and then, if needed, to develop peer reviewed competencies that hospital staff, massage therapy educators, and massage therapists all may find useful.

The members of the task force identified massage therapists who worked in hospitals generally, as well as in hospitals known to have HBMT programs. A spreadsheet was created listing the individuals and a survey was distributed to those on the spreadsheet. These individuals were also asked to identify others who might be interested in participating in the project. The purpose of the survey was to assess various elements of HBMT programs such as educational/experience requirements, employment model, orientation, and supervision. 32 out of 37 hospitals (87%) completed the survey. The Task Force considered the high response rate and the extent to which respondents provided in-depth answers to the open-ended questions as evidence of the need for specific competencies for safe and effective massage therapy for hospitalized patients.

In addition to the survey, the task force used a Delphi technique to engage survey participants and other experts in the field to shape the initial draft of the competencies. As these competencies are shared with hospitals, massage therapists, and massage educators, the Task Force members expect that additional development of the competencies will take place as various groups implement them.

1. Introduction

1.1. Competencies for massage in hospitals

Massage therapy in hospital settings was a routine part of patient care provided by nurses for decades up until the recent past. The American Journal of Nursing published papers in the early 1900's detailing the training, qualifications, basic competencies, and physiological effects related to HBMT practice (Bartlett, 1901; Biermann, 1907; Churchill, 1915). While those elements for practice may have been appropriate for nurses decades ago, they are not likely to be appropriate for today's HBMT practitioners.

An increasing number of hospitals are providing Integrative Health or Integrative Health and Medicine (IH or IHM) disciplines, including massage therapy. There are many terms in addition to IH and IHM that have been used to describe the provision of healthcare services that historically had not been part of mainstream medicine, such as Complementary and Alternative Healthcare or Medicine as well as Complementary and Integrative Healthcare or Medicine (Clugston et al, 2017; Rosenthal et al, 2014). In this article, we have chosen to use the term IHM.

Massage Therapy was found to be the second most popular IHM service by the American Hospital Association (AHA) through a survey conducted by their research division, Health Forum. (American Hospital Association, 2007). The AHA also noted that massage therapy can be beneficial for hospitalized patients in

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addressing some of the common symptoms experienced such as pain, stress, anxiety, and insomnia. As hospitals strive to meet measures established by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in the United States, including pain management, massage therapy may become even more prevalent for patient care. New initiatives to reduce opioid use may also lead to an increase in providing massage therapy for pain reduction, decreasing anxiety, and enhancing health related quality of life (Crawford et al., 2016). Additionally, the Joint Commission R3 Report (August 2017) requires accredited hospitals in the United States to provide non-pharmacological pain management treatments:

> While evidence for some nonpharmacologic modalities is mixed and/or limited, they may serve as a complementary approach for pain management and potentially reduce the need for opioid medications in some circumstances. The hospital should promote nonpharmacologic modalities by ensuring that patient preferences are discussed and, at a minimum, providing some nonpharmacologic treatment options relevant to their patient population. When a patient's preference for a safe nonpharmacologic therapy cannot be provided, hospitals should educate the patient on where the treatment may be accessed post-discharge. Nonpharmacologic strategies include, but are not limited to: physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and physical therapy), relaxation therapy, and cognitive behavioral therapy.

Several aspects of the hospital setting require skills beyond those generally taught in massage therapy schools including disease symptoms and management, psychological stressors, the healthcare environment itself, and the multidisciplinary collaboration that is necessary for patient care. While some massage schools have created HBMT programs, there is no consistent curriculum for these programs or any standard set of competencies.

1.2. ACIH HBMT task force

The HBMT Task Force was created in 2012 as a subset of the ACIH Clinical and Education Working Groups to address the current lack of specific competencies to prepare practitioners for work in the hospital environment, so that therapists, massage educators, and hospitals would have a framework from which to work. ACIH is an interdisciplinary collaborative of five licensed IHM practices including massage therapy. Others represented are Acupuncture and Oriental medicine, Chiropractic, Direct-entry Midwifery, and Naturopathic Medicine.

Over the past 20 years, there has been a growing list of resources for those interested in HBMT services. The Hospital Based Massage Network (2001) was first established in 1995 and offered a wide range of information about hospitals offering massage therapy as well as other resources for HBMT programs. While it can still be accessed, it is outdated. Gayle McDonald's (2004) text, “Massage for the Hospital Patient and Medically Frail Client” is a valuable resource of information for HBMT practice and is scheduled to be updated and published in 2019. While these have been beneficial for HBMT proponents, the Task Force noted that specific and widely-accepted competencies for massage therapists to practice in hospital settings are missing.

1.3. Task force goals

The ACIH HBMT task force initially gathered baseline data about HBMT training and implementation by surveying representatives at hospitals known to have HBMT programs. We asked those representatives for recommendations of others known by them to be involved in HBMT to ensure we engaged those most likely to provide information critical to our work. Using the ACIH *Competencies for Optimal Practice in Integrated Environments* (https://integrativehealth.org/competencies-integrated-practices/) as a foundation for our work, we sought to develop competencies specifically for HBMT. The *Competencies for Optimal Practice in Integrated Environments* provided some broad categories from which to frame and focus our set of HBMT competencies. As the competencies were being developed, we used a mixed methods approach to gather feedback, using both a survey and a Delphi technique of gathering input and incorporating feedback to the competencies from those identified as being involved in HBMT programs.

The HBMT specific competencies may be used in several ways by massage therapists, massage schools, continuing education providers, and hospitals. Massage therapists could use the competencies to determine if HBMT is a good fit for them and if they have the skills to work in this environment. Massage schools and continuing education providers could use them to develop hospital based massage therapy training programs and the competencies might also provide a framework for specialty certification for HBMT. Hospitals could use the competencies to inform the interviewing and credentialing process of massage therapists. They might also remove a barrier for hospitals seeking to develop massage therapy programs, by providing a list of standards for massage therapists.

2. Methods

2.1. Survey design

The HBMT task force created an online survey which was sent to 37 HBMT programs identified by the Task Force members. The focus of the survey was to gather broad information on their current HBMT practices related to hiring, employment status, orientation, supervision, education requirements, patients served, and payment sources. We designed the survey to gather foundational concepts as well as some basic information about the types of practice models being used. The Task Force then intended to focus more deeply on training programs once the initial data collection had been completed.

2.2. Survey collection

In addition to the list of HBMT programs and individuals identified by Task Force members and survey recipients, announcements of the competency project were made at the International Congress for Educators in Complementary & Integrative Medicine conference in 2012 and the Massage Therapy Foundation's International Massage Therapy Research in 2013. At both conferences, information about individuals who worked with or had knowledge about HBMT programs was requested. The survey link was sent in mid-May 2013 to individuals at 37 hospitals.

Once the draft competencies were created, conference calls were held to share our progress with those who responded to the survey and other identified interested parties. The purpose of the calls was to solicit input and feedback on the competencies. We also encouraged feedback through email discussions. This approach of reviewing the draft competencies served to stimulate thoughts about what should be included in the competencies.

Participants involved in discussions expressed a high level of agreement with the draft competencies and provided feedback which helped shape the final competencies. The task force determined that these final competencies would serve as common entry

level HBMT standards for practice rather than being specific to any one HBMT program. It was also decided that individual hospitals or educational programs could add competencies as needed to meet institutional or external regulatory agency requirements. For example, if a hospital requires all practitioners to have knowledge of some basic pharmaceuticals, the hospital could add that competency.

3. Results

3.1. Summary of responses

Sixty-six percent of respondents have training or orientation ranging from 20 h to up to 500 h for massage therapists. This training or orientation was reported to be an internship, shadowing, or on-the-job training. The median response to the question regarding orientation is the hospital standard orientation and shadowing a practitioner for 16–20 h.

84% of respondents indicated they have a job description for massage therapists and competencies are included in 66% of those. In responding to the question about required massage therapy training or credentials, these were identified: Graduation from a massage therapy program (81%); Massage Therapy training required by state or local regulations (75%); Licensure (75%); Additional training (44%); National Certification (38%). Hospital based or oncology massage is most often preferred by those who responded that they require additional training. Maternity or pediatric massage specific training is required by some respondents. 31% of the respondents affirmed that their massage therapy service was affiliated with a training program or school.

In exploring the need for competencies, the Task Force noted that 32% of respondents do not feel that massage therapists are prepared to provide HBMT prior to their employment. Specific competencies identified as missing include the following: Documentation of patient assessment and treatment plan; Oncology specific training; Hospital environment; Multidisciplinary collaboration and communication; Hospital etiquette (culture); Safety issues including infection control; Electronic health records (EHR); Appropriate therapeutic relationships; Medical terminology; Understanding of medical devices and precautions; Contraindications for massage.

4. Discussion

4.1. Implications of findings

This review of programs offered across the United States confirmed that there is a wide range of HBMT delivery and practice standards. Along with differences in HBMT models such as who is able to access massage therapy and the employment status of therapists, specific competencies do not exist for the massage therapists. While some programs surveyed did require specific education of the therapists related to work in a hospital setting with patients, this was not the norm. The Task Force determined that the results of the survey pointed to the need for further study and the development of competencies for HBMT.

4.2. The competencies

The Task Force discussed at length the best way to format and display the final competencies. Most notably we debated how best to incorporate the competencies into the broader set of ACIH *Competencies for Optimal Practice in Integrated Environments*. We agreed that virtually all the ACIH competencies could reasonably apply to a massage therapist practicing in a hospital setting. We decided to include only the ACIH competencies most applicable to massage therapists practicing in a hospital setting with the new HBMT specific competencies. Thus, the final set of HBMT specific competencies include some of the ACIH Competencies most relevant to HBMT and additional competencies that specifically address practical issues relevant to HBMT practice: Hospital Environments, Massage Practice, and Therapeutic Presence.

HBMT Competency 1, Hospital Environment (HE) General Competency Statement: Work with patients, families, staff, and individuals of other professions to maintain a climate of mutual respect, shared values, and safety within a hospital environment. The specific competencies include: Values and ethics; Charting; Medical terminology; Communication with hospital staff; Evidence informed decision making; Roles and responsibilities; Necessary credentialing; The concept of informed consent.

HBMT Competency 2, Massage Protocols (MP) General Competency Statement: Demonstrate understanding of massage protocols within a hospital environment. This competency focuses on understanding medical conditions and appropriately adjusting massage protocols as well as understanding indications, contraindications, and precautions, ability to work around medical equipment, demonstrating correct body mechanics, and recognizing one's limitations in this environment.

HBMT Competency 3, Therapeutic Presence (TP) General Competency Statement: Demonstrate therapeutic presence within a hospital environment. This competency focuses on communicating with confidence, clarity and respect; Recognizing how one contributes to the working relationships; Identifying signs of patient stress, anxiety, pain, grief and/or trauma; Describing appropriate boundaries, and Maintaining self-care practices.

4.3. Future applications

The process undertaken by the Task Force to develop the competencies could inform other IHM professions which practice or seek to practice in hospital environments. We believe our process of 1) creating a team of individuals with experience in the various elements of hospital practice; 2) clearly defining our purpose; 3) gathering input from the community through a survey and Delphi model of gathering feedback, worked very well and could serve other professions in their journey toward hospital-based competencies for practice. The competencies themselves could also be directly adapted to suit other IHM professions.

4.4. Limitations of the survey

We acknowledge that those surveyed may be a "HBMT-friendly" group by our use of a convenience sample. Many of those who participated may be supportive of the need for specific HBMT competencies due to our selection of participants. This group may not be a true representative sample of all hospitals with HBMT programs.

We also acknowledge that our sample size was small. While the response rate was impressive, the final number of respondents limited the statistical methods that could be used to analyze the data. The strength of conclusions drawn is therefore somewhat limited. As such, this could be considered a pilot project that can lead to a more in-depth study.

4.5. Conclusions

In summary, the survey was developed to gain a better understanding of the need for HBMT specific competencies. The survey also served to inform participants about ACIH's mission and the Competencies for Optimal Practice in Integrated Environments.

There was an indication that there are no current HBMT standards based on the varied responses to key survey questions. Safer and more effective HBMT services could be provided as facilities adopt a standard set of competencies.

We feel that the high response rate (87%) and the extent to which respondents provided in-depth information to the open-ended questions indicates interest in and a recognized need for HMBT competencies. The subsequent iterative Delphi method of gathering feedback from experts in the field proved invaluable in focusing the competencies to a final list which has broad input from the community.

Declarations of interest

One author is a staff member of Academic Collaborative for Integrative Health (ACIH), and three of the authors are members of ACIH Working Groups. One author is a member of the Education Committee of the Society for Oncology Massage (S4OM) and Founder of Tague Consulting which offers educational courses in hospital based massage therapy and consulting services to hospitals and clinics. One author is a Commission on Massage Therapy Accreditation (COMTA) and ACIH board member and oversees the HBMT training program at Northwestern Health Sciences University (NWHSU). One author is the S4OM Board President and Chair of the Integrated Healthcare Committee at Atrium Health University City.

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