A SURVEY OF FINANCIAL ASPECTS, STAFFING AND SERVICE TRENDS OF MUSIC THERAPY IN HOSPICE PROGRAMS

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The purpose of this study was to compile quantitative data to determine how hospice programs fund music therapy services, and to identify staffing trends (number of music therapists and employment status) and service trends (caseload, frequency, and length of sessions) for hospice programs with music therapy in the Great Lakes Region. Thirty-six music therapists completed the survey and qualified for the study. Participants were asked to complete a one-time online survey with 26 questions pertaining to basic demographic and staffing information, music therapy services provided and session information, and funding.

Results of this survey indicate that there are differences in the ways that traditional hospice services and music therapy services are funded, that the number of music therapists does not appear to influence service trends, that employment status does appear to influence service trends, and that size of the hospice program influences staffing and service trends. The author was unable to determine if service area influenced staffing or service trends as there was significant overlap in service areas. It is hoped that this study will clarify financial and logistical issues related to initiating and expanding music therapy services within hospice programs.

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by

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CHAPTER I

INTRODUCTION

Need for Study

Music therapy is a holistic approach to healthcare that uses music as a therapeutic tool to address physical, cognitive, social, emotional, and spiritual needs. Similarly, hospice care is a comfort-focused, holistic approach to address the physical, psychosocial, emotional, and spiritual needs of patients at the end of life. With common goals and purposes, music therapy naturally fits as a valuable part of the hospice interdisciplinary team.

In a comparative study of large hospice programs administrators' awareness and use of music therapy, Hilliard (2004a) found that the number of hospice programs currently employing music therapists increased from 6% in 1995 to 10% in 2001. Hospice administrator's awareness of music therapy increased from 88% to 95% (Hilliard). While this increase is encouraging, the percentage of programs currently employing music therapists remains low. Hilliard found that 39% of administrators would like to employ music therapists and 47% are uncertain. Identified limitations to hiring music therapists included insufficient funds, insufficient information, no available music therapist, and uncertainty regarding reimbursement. Starr (1999) notes that music therapy is "considered a luxury due to lack of insurance reimbursement, it is unfortunate that this highly effective treatment modality is omitted due to lack of funds" (p. 739). A "survey of Australian Hospice Care Administrators revealed that all those who answered the

questionnaire except one had heard of music therapy with terminally-ill patients and that most would like a music therapist on their staff" (O'Callaghan, 1989, p. 33). Most administrators responded that they did not have enough funds to employ a music therapist (O'Callaghan).

The literature suggests that larger (average daily census of 100 or more), financially well-managed hospice programs are more likely to be able to afford music therapy (Hilliard 2004a; Hilliard, 2005). Hilliard (2005) also suggests that location of service, competition among hospice programs, timing of last targeted medical review, tax status, certification and accreditation status, stability of the agency, physical structure(s) of the program, and community relationship also influence the hospice programs ability to afford music therapy.

While many hospice programs do not offer music therapy, several clinical studies, case studies, and descriptive research studies have demonstrated the efficacy of music therapy to addresses common physical, psychosocial, emotional, and spiritual goals of hospice care (Gallagher & Steele, 2001; Hilliard, 2003b; Hilliard, 2004b; Hilliard, 2005; Krout, 2000; Krout, 2001). In a clinical study of homecare hospice patients with cancer diagnoses, patients who received music therapy had improved quality of life scores over the course of hospice care even though they became sicker; patients who did not receive music therapy had decreased quality of life scores (Hilliard, 2003b). Hilliard (2004b) found that music therapists seeing hospice patients in nursing homes spent more time in direct care and had more frequent visits than social workers, were the only members of the interdisciplinary treatment team examined that routinely address holistic needs of

nursing home patients, were able to meet needs that were not otherwise addressed, and were also able to decrease agitation in patients.

The extant literature also provides evidence of the financial benefits associated with the existence of music therapy within hospice programs (Hilliard, 2005). In his evaluation of four hospice programs that initiated music therapy into their programs, Hilliard found an average daily census increase of 3%-6% and corresponding increases in revenue. Hospice programs with music therapy may also increase charitable donations received due to the highly visible and social nature of music therapy, and increased satisfaction in services. In his evaluation of hospice programs with music therapy, Hilliard found that when effectively implemented and marketed, revenue generated from music therapy programs exceeds expenses resulting in profits for the hospice agencies.

The above literature provides a few examples supporting the financial and clinical benefits of employing music therapists in hospice care. In the following literature review, a comprehensive look at existing resources and research will be examined. Unfortunately, no sources that compared staffing and service trends with size of program, number of music therapists, location of program, or employment status were found by the author. Additionally, information addressing what staffing trends allow for appropriate caseloads, frequency, and length of visits were not found. Having access to this information would further support the feasibility and benefits of music therapy in hospice programs, and assist in identifying what staffing and service trends are best able to meet patient and program needs.

Current literature supports the theoretical foundation for and clinical benefits of music therapy within hospice care. Hilliard (2003a) states that “the small but steady

increase in the provision of music therapy in hospices and palliative care settings appears to be related to the ability of music therapy to meet the multifaceted needs of patients and families" (p. 127). As discovered by Hilliard (2004a), there is a desire to incorporate music therapy into hospice care. However, administrators are uncertain as to the financial and logistical feasibility of music therapy in their programs. With education about the feasibility, clinical, and financial benefits of hiring music therapists, there is potential for increased music therapy jobs and services in hospice programs. It is hoped that surveying music therapists within hospice programs that provide music therapy will help clarify some of these issues and provide music therapists that do not currently work with this population with the information necessary to educate administrators.

Research Problem and Sub-Questions

A review of literature related to music therapy in hospice care showed that there is a lack of quantitative data available to determine how hospice programs are funded. Staffing trends (number of music therapists and employment status) and service trends (caseload, frequency, and length of sessions) for hospice programs with music therapy are other key pieces of information needed in order to support the case for the inclusion of music therapy in hospice programs. Obtaining this valuable information is a necessary and logical step toward increasing administrators' understanding of financial and logistical factors involved in initiating music therapy into their agencies. For the purpose of this study a hospice program is defined as an organization or provider which

supplements basic patient care by providing comfort-focused, holistic care to patients at the end of life. Five sub-questions have been identified and are listed below:

1. What are the funding sources for music therapy services and are they different from funding sources for traditional services in hospice programs (medical director, nursing, chaplaincy, home health aid, volunteer, social worker, and bereavement counselor)?

2. Does number of music therapists employed influence service trends (caseload, frequency, and length of sessions) in hospice programs?

3. Does full-time, part-time, or contractual status of music therapists influence service trends (caseload, frequency, and length of sessions) in hospice programs?

4. Does size of the hospice program influence staffing trends (number of music therapists and employment status) and service trends (caseload, frequency, and length of sessions) in hospice programs?

5. Does location of the hospice program (country/rural, small towns, city/metro) influence staffing trends (number of music therapists and employment status) and service trends (caseload, frequency, and length of sessions) in hospice programs?

Assumptions

There are several assumptions made by the author in this research study. The first assumption is that the author will be able to identify hospice programs with music therapy. Secondly, music therapists within these programs will need to be identified. Lastly the contact information for these music therapists will need to be obtained.

CHAPTER II

LITERATURE REVIEW

Current Research and Writings

Current research and writings on music therapy and end-of-life care consists of the history of music therapy in hospice care, literature reviews, theories and mechanisms of music therapy, program descriptions, case studies, clinical studies, research techniques, clinical problems and goals addressed, demographic information, reason for referrals, assessments, music therapy techniques utilized, type of music utilized, methods of documentation and data collection, techniques for measurement of treatment effectiveness, therapeutic outcomes, themes of songwriting, role of music therapy as a member of a holistic interdisciplinary treatment team, management of pain and suffering, music therapy combined with other approaches to address multiple goals, ways to transfer applications to clinical settings, spirituality, hope, grief, bereavement, specific populations served, administrator's knowledge of music therapy, education and presentations, and personal reflections working with this population (Aldridge, 1995; Gallagher & Steele, 2001; Hartley, 2001; Hilliard, 2001; Hilliard, 2003a; Hilliard, 2004a; Hilliard, 2004b; Krout, 2000; Lane, 1992; Mandel, 1991; Mandel, 1993; Porchet-Munro, 1993; Rykov & Salmon, 1998; & Salmon, 2001). These topics will be addressed in the following literature review.

Hospice Philosophy and Background

Hospice care is a team-oriented approach to holistic medical care, pain and symptom management, and emotional and spiritual support tailored to meet specific patient and family needs and wishes (National Hospice and Palliative Care Organization, 2003). The goal of hospice care is to provide comfort care, rather than curative treatment, in the patient's home environment whether it be a private home, apartment, nursing home, long term care facility, group home, assisted living, hospital, or hospice house. The hospice philosophy:

- Affirms life
- Promotes self-determination, as patients and families participate in their plan of care
- Provides education to help patients and families provide appropriate care
- Promotes understanding and accepting that the journey of life eventually leads to death, and encourages people to view this experience as an opportunity for growth
- Emphasizes palliation, which includes physical, psychological and spiritual comfort delivered by a multidisciplinary staff (Harrison, n.d., http://www.cancersupportivecare.com/hospice.html.)

Hospice services are available to anyone regardless of age, religion, race, illness, or gender if a physician certifies that he or she has a life expectancy of six months or less,

and the patient and family agree to follow an approach of comfort care rather than curative treatment (National Hospice and Palliative Care Organization, 2003). The interdisciplinary treatment team formed for each patient may consist of physicians, nurses, home health aids, homemakers, social workers, bereavement counselors, volunteers, pharmacists, chaplains, dietary counselors, speech language pathologists, physical therapists, occupational therapists, music therapists, art therapists, massage therapists, and pet therapy.

In the 1950s, most people with terminal illnesses died in hospitals because that is where treatments were available. At that time cancer was a "feared diagnoses" as at least three quarters of patients endured pain (St. Christopher's Hospice, n.d.). It was not until Dame Cicely Saunders introduced the concept of hospice care to medical students, nurses, social workers, and chaplains at Yale University in 1963 that a shift in the focus of treating or curing changed (National Hospice and Palliative Care Organization, n.d). This process was facilitated by some key events. One of these key events was Florence Wald, the Dean of the Yale School of Nursing, enlisting Saunders as a visiting faculty member in 1965. St. Christopher's Hospice, the first modern hospice designed specifically to provide specialized care for the dying, was developed by Saunders in a residential suburb of London in 1967 to provide practical solutions to these challenges (National Hospice and Palliative Care Organization, n.d.). St. Christopher's Hospice's emphasis was placed on education, research, and excellence in clinical care.

Elizabeth Kübler-Ross wrote a book entitled *On Death and Dying* in 1969, based on interviews with over 500 dying patients. In this book, Kübler-Ross promoted patient and family right to choose their own destiny for care during the dying process, and

identified the primary goal of therapy to support patients and families as they work through the stages of dealing with death: denial, anger and resentment, bargaining, depression, and acceptance (Gilbert, 1977).

In 1974 the first hospice legislation was introduced to provide funding for hospice (National Hospice and Palliative Care Organization, n.d). During this same year, the Connecticut Hospice, Inc., the first hospice program in the United States, accepted their first patient (Connecticut Hospice, n.d.). In 1979 the Health Care Financing Administration (HCFA) initiated demonstration programs at 26 hospices around the country to assess cost effectiveness of hospice care and to help clarify potential benefits of hospice care. Congress created a provision for a Medicare hospice benefit in the Tax Equity and Fiscal Responsibility Act of 1982, with a 1986 sunset provision. Hospice accreditation was initiated by the Joint Commission of Accreditation of Hospitals in 1984. In 1986 the Medicare Hospice Benefit was made permanent by Congress, a 10% increase in reimbursement rates was given to hospices, and hospice care was made available to nursing home residents. Federal involvement has continued over the years to address issues of funding, accountability, appropriate utilization of hospice services, education, expanded benefits and services, and other end of life issues.

History of Music Therapy in Hospice Care

The connection between music and health is longstanding. Monroe and Mount (1978) reviewed the role of music in primitive societies in the priest-practioner's powers; reviewed the role of music for the Greeks in conjunction with oracular utterances;

reviewed the role of music for Pythagoras to make a "salutary contribution to one's health" (p. 1029); reviewed the role of music by Aristotle to purge or purify the emotions; and reviewed the role of music during the Renaissance to influence breathing, blood pressure, muscular activity and digestion.

Music therapy in hospice began to develop in the mid 1970s with Gilbert's (1977) review of the nature of death and dying in contemporary society, the needs of the dying patient and family, and how music therapy can enhance services offered to the dying. This was followed by Monroe and Mount (1978) who defined music therapy and the role and training of the music therapist in hospice. Monroe and Mount also described possible sessions for music therapy in hospice; list criteria for involving the music therapist; list uses by physical, psychologic, social, and spiritual domains; and provide case reports. More comprehensive writings on music therapy in hospice and related topics began to appear in the 1980s. Since then, the number of articles written on music therapy and hospice has dramatically grown. In his survey of music therapy and hospice and palliative care literature between 1978-1999, Krout (2000) found 111 sources. Many of these writings will be addressed throughout this paper.

Theoretical Foundations for Music Therapy in Hospice Care

Several sources identify a multitude of theoretical foundations for music therapy in hospice care. Included in these are psychospiritual, Nordoff & Robbins Creative Music Therapy, Analytical Music Therapy, Music-Based Individualized Relaxation Training, Physioacoustics, Psychotherapy, Bonny Method of Guided Imagery and Music,

Applied Behavior Analysis, Nonverbal and ISO-Based Interpersonal, Supportive Therapy, and others (Krout, 2000; Salmon, 2001). Additional models identified for use in medical music therapy include behavioral/cognitive, behavioral medicine (mind-body model), communication therapy, developmental, anthroposophic, existential, gestalt, homeoodynamic, humanistic, medical, neurological, psychodynamic, physics, psychological, transpersonal/spiritual, wellness, and cognitive music psychotherapy (Dileo, 1999b). It is this author's belief that the variety of theoretical foundations for music therapy in hospice care is related to the variety of needs, goals, and techniques utilized for different patients in hospice.

Salmon (2001) discusses the containing or sacred space of music therapy for psychospiritual process. According to Salmon, containing or creating a sacred space provides patients with a safe, non-threatening place to increase psychospiritual awareness and ultimately to connect "that which is psychologically and spiritually significant for the patient, thereby transforming experiences of suffering into those of meaning" (p. 142). The author continues by describing the elements and process of the containing space. With this framework music therapy can help patients evoke…

> feelings, emotions, ideas, insights, revelations, understandings, conflicts, resistances, etc., which can lead to a newer understanding of one's life, to a healing of long held grudges, to old tears and new tears aching to be shed, to taking realistic action… (Bonny, 1978 as cited in Salmon, 2001, p. 144).

Through the psychospiritual music therapy process patients may find meaning, relatedness, humor, nourishment, peace, acceptance, love, faith, beauty, hope, creativity, and awareness (Salmon).

Unique Features of Music Therapy and Mechanisms of Music Therapy

A common theme in articles discussing music therapy in hospice care is the ability of music therapy to facilitate rapid and sometimes profound movement through otherwise challenging areas. Much has been written about the mechanisms of music therapy in attempt to explain this. Through appropriate administration of music, music therapists are often able to reach and influence patients in unique ways. The natural, subconscious response to music and the music therapist's unique training are in large part responsible for this. In addition, since music is frequently a part of everyday life and many people consciously or unconsciously utilize music for support in one form or another, music therapy is usually non-threatening and well received, even for patients who are sometimes resistive to other treatments.

By nature, humans respond physically and subconsciously to the basic components of music: melody, harmony, tone color, frequency, intensity, intervals, rhythm, and tempo (Porchet-Munro, 1993). "It [music] relates to body, mind, and spirit and has its own unique therapeutic potential" and "touches human emotions beyond cerebral command" (Porchet-Munro, p. 40). "It [music] communicates, motivates, soothes, alleviates pain and anxiety, lifts the spirit, and sometimes gets to the heart of

deeply perplexing emotional, spiritual, and interpersonal problems, thereby releasing energies for healing" (Brown, 1992, p. 13).

> Music seems to reach a different level - a different depth in the brain and the emotions and frequently, the unresponsive respond, the crusty and belligerent cooperate, the closed and guarded open up, those in pain are relieved, the hopeless find renewed meaning… It [music] has an uncanny capacity to draw people in a household together, spanning generations and often helping to heal hurts which have existed between family members for years. (Brown, 1992, p. 14- 15).

"Music bridges the gap between experience and understanding" (Lochner & Stevenson, 1988, p. 116). "The musical experience thus functions as a catalyst for reflection, introspection, and interpersonal exchange" (Porchet-Munro, p. 40). Art and music experiences "open the channel for expression in ways uninhibited by words and manners" (Trauger-Querry & Haghighi, p. 29).

Like emotion, music is primarily a nonverbal phenomenon. "Music can be a way for patients to express themselves when they cannot or may not want to talk" (Ohlsen Read, 2000, p. 24). Music provides the structure and space to safely feel, release, and communicate difficult emotional material allowing patients to connect with feelings and work through them (Salmon, 1993). Music also has the potential to express diverse themes simultaneously allowing those in music therapy to address the mixed emotions that are frequently present in hospice. Music therapy can structure communication about

conflicts and ambivalences to be reconciled, and the expression of feelings about impending separation from loved ones (Pilsecker as cited in Gilbert, 1977).

Music helps to structure time, bring form out of chaos, hold thoughts, maintain focus, and "relive" previous times (Aldridge, 1995). Association through contiguity occurs when hearing a particular piece or style of music triggers memories of a specific event (Davis, Gfeller, Thaut, 1999). When this occurs, hearing the music can elicit emotions, feelings, and memories of a time, place, and/or situation. Sears (as cited in Gilbert, 1977) states "music can produce extra-musical ideas and associations, and can thus be a springboard to discussion about present or past concerns apart from the music being played" (p. 169). Music with distinctive lyrics "can assist the patient in remembering, and can open lines of communication between therapist and patient, among patients, or between patient and family" (Sears, as cited in Gilbert, 1977, p. 169-170).

Musical associations with life events frequently allow the music therapist to assist patients with reminiscence and life review, and can "bring patients back" to positive times in their lives. Music assisted reminiscence and life review is frequently very helpful in acknowledging accomplishments, may help process unresolved conflicts in a new light, and frequently gives new meaning to life and aids in preparation for death (O'Callaghan, 1993). It also stimulates "the awareness of living, in the face of dying…" (Aldridge, 1995, p. 107). In addition, "Many times it can provide strength and insights that verbal therapy alone does not" (Ohlsen Read, 2000, p. 24). Music can "lead to insightful reflection on existential purpose and meaning" (Magill, 2001, p. 168). Bennett and Mass (as cited by O'Callaghan) found that music based life review is more effective

in promoting life satisfaction, and is viewed to be more helpful and enjoyable than verbal life review alone.

By focusing attention, music therapy may also help decrease perception of long periods of time allowing medications to take effect or families to partake in vigils with increased ease (Porchet-Munro, 1993). This ability to structure time and interaction with families, particularly during the actively dying phase, by providing meaningful experiences through music therapy, can be particularly helpful. Family members may find it to be frustrating, challenging, or troubling when patients are unable to respond to them or their physical appearance or breathing has changed (Krout, 2003). Through individualized interventions, music therapists can increase physical, emotional, and spiritual comfort of patients and families; allow active involvement; and allow for validation, identification, normalization, and expression of feelings during sessions with imminently dying patients and families (Krout).

Different components of music are processed in different areas of the brain. Rhythm, frequency changes, melody recognition (among musicians), recognizing legato, lyric performance while singing, analysis of music sequences, receptive musical behavior and general musical ability (among musicians) are processed in the left hemisphere (Taylor, 1997). Pitch, melody perception (among non-musicians), visual pattern recognition (reading music), auditory pattern recognition (tonal memory and timbre), discriminating sound intensity changes, perception of chords, melody while singing, attack, musical gestalt, and expressive rhythmic and melodic behavior are processed in the right hemisphere (Taylor). Since music is processed in different areas of brain, if

patients have impaired brain function, it is believed that information can be re-accessed or cross-referenced through alternate pathways when music is involved.

During music therapy interventions, patients with dementia of the Alzheimer's type frequently "exhibit strong reactions and focused attention, even with significant progression of the disease. These reactions include bodily movements, dancing along with the musical stimulus, singing, increased socialization, decreased agitation, and increased enjoyment" (Taylor, 1997, p. 47). It has been suggested that "when perceiving and responding to music, Alzheimer's patients may use unique or alternate neural processes for cognition and memory" (Taylor, 1997, p.47). Silber and Hes (as cited by Taylor) suggest that "Creative [song] writing appears to utilize an intact portion of the brain and thus partially compensates for the affected areas" (p. 47).

Further evidence of the ability for patients with Alzheimer's disease to be able to respond more successfully with music than without music is provided by Prickett and Moore (1991) who found that patients with probable Alzheimer's disease were able to recall words to songs dramatically better than spoken words (including rhymed speech) or spoken information, with the highest recall of information in familiar songs. When asked to perform tasks of auditory discrimination of pure tones, timbre, rhythm and interval discrimination, detection of meter shift, and discrimination of open and closed harmonic endings for chord progressions, patients with Alzheimer's disease demonstrated neural and cognitive ability to perform such tasks despite known cognitive declines (Swartz, Walton, Crummer, Hantz, & Frisina, 1992). This suggests that musical processing is less significantly impaired than nonmusical processing in patients with dementia, although responses are somewhat slower than in healthy subjects. In addition,

individual music therapy sessions with patients with Alzheimer's disease significantly increased social behaviors including continuous participation, smiling, eye contact, and verbalizations ($p < .001$), as well as increasing displays of physical energy, positive affect, animation, and verbal feedback expressing pleasure in the activities (Pollack & Namazi, 1992).

In the U.S. Senate's Special Committee on Aging report, Sacs (as cited by Sambandham & Schirm, 1995) notes that:

> …it is not an actual loss of memories but a loss of access to these-and music, above all, can provide access once again, can constitute a key for opening the door to the past, a door not only to specific moods and memories, but to the entire thought-structure and personality of the past (p. 80).

Due to the physiological response to music, people who are otherwise unresponsive can benefit from music therapy since:

> musical sounds traveling as nerve impulses, even in the absence of consciousness, activate the auditory system and, through their inevitable passage through the RAS [Reticular Activating System], create cortical arousal effects in the cerebrum that result in elevated skeletal muscle tonus (Taylor, p. 39).

Taylor notes that visual, auditory, and tactile stimuli are not accessible for unresponsive patients since motivated attending is necessary for these senses.

The Role of the Music Therapist

In addition to training in methods of assessment, treatment, documentation, clinical issues, and the role of each member of the interdisciplinary treatment team, music therapists are specially trained to understand and predict the impact different elements of music have on people. The music therapist's task is to determine which aspects of music facilitate the desired outcomes, and to systematically apply the appropriate music and techniques to achieve them.

Music therapists can provide direct services to patients and families, develop techniques that can be utilized when the therapist is unavailable, and provide services during the bereavement period (Mandel, 1993). In addition, music therapists in hospice programs are involved in team meetings, rounds, developing resources, and providing education (Mandel). Monroe and Mount (1978) state "Its [music's] impact often has far reaching emotional and psychologic effects that need to be observed and channeled appropriately" (p. 1033). Similar words of caution expressing the need for trained music therapists to facilitate and process interventions are found throughout relevant literature (Trauger-Querry & Haghighi, 1999). Magill (2001) states "it is important for therapists to explore reactions, as this will enable them to find music and therapeutic interventions that may bring about desired results" (p. 169).

After interviewing Dr. Ina Ajemian, Acting Director of the Royal Victoria Hospital's P.C.U., about unique qualities music therapists brought to the facility that music volunteers or other staff could not fulfill, O'Callaghan (1989) reported:

> Dr. Ajemian said that music therapists have a trained, psychological knowledge base which allows them to assess emotional problems affecting patients, are able to help patients work them through, and can present relevant patient information in a meaningful way to other staff…music therapists usually have a diverse range of musical skills that can be applied more appropriately (p. 35).

Unique Issues for the Music Therapist in Hospice Care

Music therapists working in hospice care must be prepared for significant diversity. For example, diversity among patient interests and musical preferences, and changing patient needs as time progresses. In each session, music therapists must bring a strong awareness of the therapeutic potential of music, and the ability to assess immediate patient needs (Martin, 1989a). The therapist must be able to take leads from patients as to appropriate level of processing. Some patients may want or need to leave expression in the music while others can engage in verbal exploration of material brought up in the music (Martin).

Music therapists in hospice care frequently have the opportunity to work and treat not only the patient, but family, friends, associates, care givers, and other members of the interdisciplinary treatment team as well. In a study by Demmer and Sauer (2002), 20% of primary care givers of patients who received hospice care responded that complementary therapies should be provided to family members as well. Music is frequently a social event and can therefore reach multiple people simultaneously. Since music therapy is primarily presented as an auditory stimulus, anyone present can benefit.

This provides many outstanding opportunities and challenges. While the music therapist can address the needs of everyone involved, caution must be taken to avoid family and staff projections on patient's needs and desires and maintain an appropriate balance of patient's and others' needs.

Another issue music therapists in hospice care routinely face is exposure to extreme emotions and delicate situations. Gilbert (1977) notes that music therapists witness anger, depression, guilt, and fear in other settings as well. However, the source of these emotions in hospice care is death rather than more transient problems. "Since the source and manifestations of these emotions are unique, the therapeutic treatment and approach must be tailored to suit the unique needs of the dying patient" (Gilbert, 1977, p. 168). As such, specialized training on specific psychosocial and spiritual issues; recognizing the difficulties and struggles of dying patients and their families; and recognizing the impact of repeated exposures to atrocities of disease, death, and suffering is necessary (Porchet-Munro, 1993). "Any therapeutic tasks must concentrate on the restoration of hope, accommodating feelings of loss, isolation and abandonment, understanding suffering, forgiving others, accepting dependency while remaining independent and making sense of dying" (Aldridge, 1995, p. 107). Porchet-Munro recommends utilizing music therapy techniques to care for the caregiver and therapist as well. O'Callaghan (1989) recommends guidelines specifically for students and therapists working with the terminally ill.

Referral and Assessment

Gallagher & Steele (2001) reported that the most common reasons for referral to music therapy included improving mood, decreasing perception of pain, decreasing anxiety, decreasing agitation, providing enjoyment, providing family intervention, and decreasing shortness of breath. Mandel (1993) found that the most common reasons for referral to music therapy included musical interests; anxiety, restlessness, respiratory difficulties, and insomnia; depression or withdrawal; long-term prognosis or need for diversion or motivation; and difficulty expressing feelings or interacting with others. Multiple reasons for referral are often selected and registered nurses were the most common referral source (Mandel). Hilliard (2003) noted that referrals come from various members of the interdisciplinary treatment team. In the inpatient setting referrals can come from physicians, team members, patients, families, or interdisciplinary team meetings (Gallagher, Huston, Nelson, Walsh, & Steele, 2001). Gallagher, Huston, Nelson, et al. also provided guidelines for documentation of sessions and emphasize the need for objective measurement.

Demmer and Sauer (2002) found that 26% of primary care givers of patients who received hospice care believed that complementary therapies should be started sooner. According to Bailey (as cited by Krout, 2000):

> Music therapy can be most beneficial when implemented as soon as possible after a hospice admission or terminal diagnosis/prognosis is made. Music therapy implies a process-oriented relationship between patient and therapist that may

take time to develop. Aspects/stages of therapy such as contact, awareness, and resolution are a result of the processing of thoughts, issues, and feelings, and must unfold naturally (p. 45-46).

Initiating music therapy at the time of admission allows the therapist to develop a more comprehensive relationship with the patient and family and address a wider range of patient needs.

Music therapy specific assessments may include a patient's previous exposure and experience with music; preferred style of music, songs, artists/groups, and radio station; challenges associated with their medical situation; perceptions of how music effects them; what coping mechanisms they utilize; and what energizes and empowers them (Gallagher & Steele, 2001; Lane 1992).

Goals of Music Therapy with Hospice Patients

There are a variety of goals that can be addressed in music therapy in hospice care (Gallagher & Steele, 2001; Hilliard, 2003a; Krout, 2000; Trauger-Querry & Haghighi, 1999). Goals can be divided into five general domains: physical, cognitive, social, emotional, and spiritual needs. Physical goals of music therapy in hospice care include: *improving* respirations; *increasing* relaxation, cooperation with medical procedures, energy, and tolerance of stimuli; *decreasing* stress, anxiety, depression, shortness of breath, nausea and vomiting, agitation, and perception of pain; and *facilitating* physical interaction, sleep, and/or movement. Social, emotional, and cognitive goals include:

improving mood and self esteem; *increasing* participation, interaction, motivation, normalization, insight, understanding, decision making, coping, and acceptance of the music therapist; *facilitating* communication with the family, social interaction, imagery, movement, creativity, reminiscence, and life review; *decreasing* confusion and isolation; *heightening* cognitive ability; *rekindling* and *promoting* creativity; *enriching* the environment; and *providing* opportunity for self-expression, expression of feelings, sensory stimulation, distraction, diversion, and comfort for families when they feel there is nothing else they can do for their loved one. Spiritual goals include: *providing* emotional support, spiritual support, and solace; and *affirming* religious and/or spiritual beliefs, self, meaning, and purpose. Many of these goals overlap general domains. For example, decreasing anxiety improves emotional comfort as well as physical relaxation, and increasing coping skills results in improvements in all domains.

Additional goals and benefits include music therapy's ability to "transform adversity into a more positive experience, and can elicit rediscovered or new self-awareness…" (O'Callaghan, 2001, p. 158). Magill (2001) found that music can "transport" patients and "can take the mind off pain into the pleasing, environing sensations, and carry attention into the images associated with the melodies, harmonies, and rhythms" (p. 170). Magill further states that "Music can bring the gift of balance, order, and pleasure to a person experiencing pain, distress, sorrow, and fear" (p. 170). "Participating in the creative process… may help the patients and their families realize that dying is not dead" (Martin, 1989a).

Music therapy seeks to enhance or complement traditional interventions such as pain medication, and enhance the treatment team's ability to treat the whole person

(Hilliard, 2003a). Music therapy can incorporate many interdisciplinary goals into a single session increasing the success and effectiveness of each goal which in turn increases overall cost-effectiveness. Hilliard finds that music therapists are frequently referred by nurses to enhance their work in controlling nausea and vomiting, shortness of breath, and pain; counselors and social workers to complement work on psychological needs such as depression, anxiety, and anticipatory grief, and to address family problems when verbal therapy interventions failed; and chaplains to complement work in providing spiritual support.

Music Therapy Techniques and Approaches in Hospice Care

A variety of interventions have been utilized for patients in hospice programs. These techniques include live or recorded music listening, singing, song selection, song dedication, music based life review, movement to music, instrument playing, improvisation, lyric analysis, verbal processing, entrainment of breathing, music assisted relaxation, meditation, music-imagery, Guided Imagery and Music, matching, toning, chanting, music and drawing/painting/clay work, music and writing, music therapy combined with other therapies (art, occupational, speech and language), therapeutic touch, songwriting, creation of music legacies, and planning funeral music (Gallagher & Steele, 2001; Krout, 2000; Magill, 2001; Salmon, 2001).

Music therapists offer patients and families choices of techniques and music to best meet their specific needs during each session. Attention must be given to changes in patient tolerance and attention span for all techniques. Therapists should not assume that

music will or will not be helpful for any given patient at any given time, and should check in with patients to ensure accurate reading on responses when patients have cognitive or affective impairments (O'Callaghan, 1996). Music therapists should also be open to patient and family needs and not have a particular agenda or plan for each session. Therapists should also be aware that patients and families may want time in private to say goodbye.

Music assisted relaxation is an approach that can be highly effective and facilitate many desired responses such as decreased tension and pain perception; decreased fear, anxiety, and resistance; increased ability to engage in discussion and processing; and facilitating an overall sense of stability and calm. A variety of relaxation tapes with music and scripts can be created by patient and therapist for patients to utilize for various needs when the therapist is unavailable (Trauger-Querry & Haghighi, 1999). Utilizing imagery and music that is meaningful and pleasant to the patient is important (Martin, 1989a).

Nicholson (2001) described a comprehensive program for relaxation training with imagery and music available to patients, caregivers, and staff at the Vancouver Centre of the British Columbia Cancer Agency. This article reviews sources of stress and trauma, benefits of relaxation, and describes the group experience. In her review of literature Nicholson found that relaxation training can encourage receptivity to treatment, create a hypometabolic state and provide an opportunity for rest and replenishment, strengthen coping skills, increase self-discovery and healing, release tension, reduce anxiety, and encourage the balance in physiological rhythms and functions.

Another effective technique, an adapted form of the Bonny Method of Guided Imagery and Music, has been successfully utilized with this population. The Bonny Method of Guided Imagery and Music is a "depth psychotherapy model which uses programmed classical music to access and support internal processes" (Skaggs, 1997, p. 39). Adaptation may be necessary if patients have compromised emotional or physical energy, or decreased ability to focus and concentrate (Skaggs). The author also notes that use of direction, which is not typically involved in this method, may be helpful with certain issues such as pain control. Seeking patient input for imagery can help balance the use of direction. Primary goals of therapy in this context are to address issues of grief and spiritual issues present at end of life, managing physical symptoms, positively influencing quality of life, and assisting in preparation for death to allow the patient to "die well" (Skaggs, p. 41).

Music composition and songwriting are other techniques utilized by music therapists that may provide an easier and more spontaneous nonverbal way to help to portray feelings, images, dreams, and fantasies; facilitate communication; facilitate and validate self expression; promote physical and social well-being; encourage singing and social interaction; enhance learning and creativity; offer opportunities for counseling; enhance pride and self-esteem; and result in personal growth, and refuge from medical situations (Clements-Cortés, 2004; Magill-Levreault, 1993; O'Callaghan, 1996b; O'Callaghan, 1997). Song selection or dedication can offer patients and families opportunities for choice; provide a less threatening way to express conscious and unconscious fears, concerns, hopes, wishes, or memories; increase self-esteem and regain self-identity; and structure communication and self expression (Clements-Cortés; Martin,

1989a). Patients frequently sing along which may help improve articulation, fluency, breath control, and decrease tension (Clements-Cortés, O'Callaghan, 1997). Lyric analysis and discussion may also provide an indirect way to facilitate expression of numerous end of life issues (Clements-Cortés).

O'Callaghan (1997) describes the process of songwriting with this population. The author notes that songwriting can be modified to meet patients where they are and adjust for various physical, cognitive, and emotional limitations. For example, patients can write an original song including lyrics, melody, instrumentation, and all other components of the song; rewrite existing melodies; or complete fill in the blank songs among other techniques. Modifying level of structure, offering choices or providing yes/no questions, and requesting concrete information may allow patients with moderate to severe cognitive impairments to engage successfully in songwriting (O'Callaghan).

In her analysis of 64 songs written by palliative care patients O'Callaghan (1996b) identified eight themes and seven categories. Lyrical themes of songs included self-reflections, compliments, memories, reflections upon significant others (including pets), self-expression of adversity, imagery, and prayers. Recurring categories included compliments to family members, staff, other patients and friends about their personal qualities and their impact upon the patients' lives; messages of positive feelings for and experiences with people, including love, care and that one needs people; memories of relationships with people, both living and deceased; existing in the future; expressions of adverse experiences resulting from living with the illness; descriptions of stories and nature imagery scenes; and gratitude to family members, staff, and God.

Music Therapy with Specific Populations

Several articles focus specifically on the effectiveness, techniques, and approaches related to specific populations in hospice care. These populations include individuals with brain injuries, individuals who are indigent, individuals who are children, individuals with AIDS, and contraindications for music therapy.

Music Therapy for Individuals with Brain Injuries

O'Callaghan (1993) has described her work with patients with brain impairments in palliative care. Since language is primarily a function of the left hemisphere of the brain and music is processed on both sides of the brain, utilizing music and language together increases opportunities to activate intact neurological pathways, and provides an alternate and creative way to communicate with patients with brain impairments. O'Callaghan notes that utilizing music therapy with these patients and their families often enhances communication, reduces isolation, and provides emotional support.

Suggested techniques to enhance communication with this population include musically supported counseling, musically based life review, encouragement of patient music performance and songwriting, and music-based family sessions (O'Callaghan, 1993). Patients who exhibit word-finding difficulty tend to sing or repeat words with particular poignancy; may request that songs be repeated to allow for personal reflection; are often able to vividly recall events associated with music based memories; and frequently address issues of loss, anger, and fear about uncertain future. Providing two choices and cues is recommended.

Music Therapy for Individuals Who are Indigent

Mramor (2001) wrote about music therapy for persons who are indigent and terminally ill. The author notes that these patients are not only dealing with end of life issues but are doing so

> within the context of abandonment by family and friends, histories of chemical dependency, abuse, mental illness, mental retardation, illiteracy and, for many, utter aloneness. These complicating factors reduce their capacity for having healthy relationships with others and for coping with their dying process in an emotionally healthy manner (p. 182).

The therapist must be aware that it may take longer for patients to learn to trust and accept the therapist with this population than others. Mramor described a model of service within a collaborative housing and treatment setting for these patients and presented case studies.

Music Therapy for Individuals Who are Children

Writings on music therapy and children in hospice/palliative care include information on the pediatric oncology setting (Bellemy, 1990; Brodsky, 1989; Lane, 1996a, Lane 1996b); grief and bereavement (Burke, 1991; Carrol & Griffen, 1996); anxiety, fear, and distress (Fagan, 1982; Malone, 1996); verbalization behavior (Froehlich, 1984); techniques (Marley, 1984; Mayers, 1995); immune function (Lane,

1994); pediatric pain (Loewy, 1997); and general information on music therapy with terminally ill children (Daveson, 2000; Froehlich, 1996; Ibberson, 1996).

Music Therapy for Individuals with AIDS

Writings on music therapy and HIV/AIDS includes general information and issues for music therapists (Maranto, 1988); pediatric AIDS patients (McCauley, 1996); hope and meaning (Aldridge, 1993); techniques (Bruscia, 1991; Bruscia, 1992; Lee, 1996; Lee 1995); and general information (Lee, 1996, Rykov & Hewitt, 1994).

Contraindications for Music Therapy

Music, or specific songs, may be contraindicated in some instances. Some patients with right temporal lobe damage from cerebral metastases or lesions from ischemic attacks may hear music as distorted and experience physical pain when listening to it (O'Callaghan; 1993; O'Callaghan, 1996a). Patients with dementia may have catastrophic reactions in the form of withdrawal, depression, anxiety, or distress when faced with tasks they are unable to accomplish (O'Callaghan, 1996a). Altering music is recommended in this instance. Musicogenic epilepsy should be considered if a patient has a seizure during music.

Bibliographies, Compilations, and Books

Several bibliographies, compilations, and books have been written about hospice and/or palliative care and music therapy. Rykov and Salmon (1998) provided a comprehensive bibliography of 161 music therapy sources in palliative care from 1963-1997. Categories for selections of this bibliography included music therapy in palliative care: general; methods and techniques; pain and symptom management; stress reduction, mood alteration, and relaxation; HIV/AIDS; children; grief and bereavement; and related resources. Krout (2000) provided a comprehensive survey of music therapy and hospice and palliative care literature between 1978-1999.

Some of the books about hospice and/or palliative care written or edited by music therapists include Aldridge (1999), Bright (1986), Hilliard (2005), Krout (1999), Lee (1995), Martin (1989b), Munro (1984), Rykov and Hewitt (1994), and Whittal (1990). These compilations are often quite comprehensive. For example, in *Lonely Waters,* Lee compiled proceedings of the 1994 international conference on music therapy in palliative care in Oxford. Within this compilation there are numerous articles on education and support, techniques and approaches, philosophy and spirituality, guided imagery and music, collaboration, neurological conditions, and improvisation. Hilliard's *Hospice and Palliative Care Music Therapy: A Guide to Program Development and Clinical Care* provides an introduction to hospice and palliative care, addresses specific clinical needs of people with a terminal illness and their loved ones, describes the use of music therapy in meeting clinical needs, describes the process of conducting a music therapy macro-assessment, and provides a protocol for marketing music therapy and developing the

business plan. Dileo and Loewy (2005) edited an extensive book entitled *Music Therapy at the End of Life* which addresses clinical issues and specialized populations, music therapy methods, and professional issues.

In addition, chapters are dedicated to hospice and palliative care music therapy or related issues in numerous books. Dileo (1999a) created a compilation of articles on theoretical and clinical applications of music therapy and medicine. This compilation includes articles on receptive approaches, improvisational and re-creative processes, song approaches, and combined approaches. Other books with related chapters include Pratt and Grocke (1999), Pratt and Spintge (1996), and Spintge and Droh (1992) among others.

Music Therapy for Pain and Symptom Management

Since pain control is a primary focus in medical management, much has been written on music therapy and pain management and a variety of research and theories exist to justify reduced pain perception when listening to preferred music. This literature is particularly important for music therapy in hospice since pain and symptom management are major components of the "comfort care" approach to hospice care. Standley (as cited in Lane, 1992, p. 864) identified four of these theories:

- Auditory stimulation occupies some of the neurologic pathways to the brain, resulting in fewer neurotransmitters being available to transmit pain messages.
- Music can evoke intense emotions, thereby affecting our autonomous nervous system, which triggers the release of hormones and endorphins, the body's natural opiates.
- Music may reduce muscular tension by masking sounds that are unsettling to patients…
- Feelings of helplessness may be decreased by giving a patient music that allows increased control in a setting that is often invasive and depersonalizing.

Magill-Levreault (1993) summarizes these theories stating "By altering affective, cognitive, and sensory processes, music may decrease pain perception by distraction, change in mood, increased control, use of prior skills, and relaxation" (p. 42). Achterberg (as cited by Skaggs, 1997) reported that:

> auditory tracts passing directly into the reticular activating system (RAS) of the brain stem coordinate sensory input and alert the cortex to incoming information. Sound traveling through this system can activate the entire brain and theoretically compete for cognitive awareness (p. 41).

In the affective domain, "Music may alter the mood disturbances associated with long-term and life-threatening illnesses such as anxiety, depression, fear, anger, and sadness.

Music can lift depressive symptoms, promote relaxation, and thus diminish tension and anxiety" (Magill-Levreault, p. 43).

O'Callaghan (1996a) addressed four theoretical perspectives to explain why patients report reduced pain sensation after music therapy. These theories incorporate two identified by Standley (as cited in Lane, 1992), are not mutually exclusive, and include:

- Spinal mechanisms involved in pain modulation
- Role of endorphins
- Psychological relationship between music and pain
- Psychophysiological theory

Pain has been identified as multifaceted, complex, and all-encompassing and is influenced by physiological, psychological, emotional, social, and spiritual factors (Magill, 2001). Pain is a subjective sensory or emotional experience (O'Callaghan, 1996a). Psychological influences include memories of previous experiences, understanding of the origin of the pain and its consequences, sociocultural factors, spiritual views, presence of competing stimuli or distractions, level of anxiety, suggestion, personality variables of the patient and professional caring for the pain, perceived reward or psychological gratification from pain behaviors, attitudes of fatalism or heroism, and expectation (Magill, O'Callaghan).

"Music can alleviate the cycles of anxiety and fear that exacerbate pain experiences while refocusing attention on to pleasing sensations" (Bailey, 1986, p. 25). Music also facilitates emotional and physical release and induces relaxation. Spinal

mechanisms involved in pain modulation include the Gate Control Theory which theorizes a "cellular gating mechanism" in the spinal chord which regulates potentially painful impulses" (O'Callaghan, 1996a, p. 45). Music may "stimulate brain stem centers either directly via the auditory pathway or by indirect cortical mechanisms which include the psychological/cognitive processes" (O'Callaghan, p. 45) resulting in signals inhibiting pain perception. Music also releases endorphins into the bloodstream which help reduce pain from noxious stimuli.

Suffering is often associated with the uncertainty surrounding the pain experience, impending loss, increased dependency, lessened understanding of one's purpose in life, and diminished hope and meaning in life (Magill, 2001; O'Callaghan, 1996a). Components of suffering in chronic pain include nociception (tissue damage); mood changes such as increased depression and anxiety; spiritual issues; financial concerns; role changes; increased hospitalizations or medical care; lack of communication with caregivers; social isolation; fears; and losses (O'Callaghan). Suffering may result in anxiety, demoralization, feelings of isolation, anger, depression, increased dependency, and decreased involvement in daily activities and often results in complicated pain management.

Comprehensive management of pain and suffering should include the entire interdisciplinary treatment team in attempt to improve comfort, peace of mind, and quality of life; deepen awareness and expand communication. Trauger-Querry and Haghighi (1999) emphasize the ability of art and music therapy to work in conjunction with traditional medical care to provide holistic treatment of pain in the hospice setting. Music therapy can be utilized to reduce pain and suffering by both patients and family.

Music therapy for pain and symptom management can be used to decrease anxiety; to facilitate relaxation; to improve mood, comfort, and sense of inner well being; provide distraction; increase sense of control and active involvement in pain management; and to support psychotherapy (Bailey, 1986; O'Callaghan, 1996).

Careful and ongoing assessment of patient needs and current state is necessary for effective use of music therapy for pain and symptom management. This assessment should involve understanding of the patient's whole experience: physical, psychological, and social needs; skills; medical history; current medical and physiological status; general mood state; view, level, and type of pain; impact of pain; degree of isolation; coping abilities; verbal and nonverbal expression and communication; interpersonal dynamics; and psychological variables such as feelings of loss, helplessness, and hopelessness (Bailey, 1986; Magill, 2001; Magill-Levreault, 1993). The therapist must be aware of presence of other symptoms such as nausea, insomnia, aphasia, or neurological impairments as well. The therapist must be able to modify interventions to meet the patient's changing needs and to process reactions with patients. Interventions that are meaningful and enjoyable for the patient should be created. Therapists must be sensitive to the fact that some patients find music to be counterproductive. Patient selection of music and trial of music, especially if recorded music is to be left with patients unable to adjust music, is important.

Audioanalgesia is a pain and symptom management technique that utilizes music listening in medical/dental practice. In her meta-analysis of medical/dental literature, Standley (1996) found that audioanalgesia has been successfully utilized to decrease anxiety, struggling and delirium, vomiting, overt pain reactions; need for sedatives, and

results in faster emergence from anesthetic states. In this meta-analysis Standley found that music is most effective when some pain is present than when it is not a usual symptom of the diagnosis, and that music becomes less effective as pain increases. Brody (as cited by Whittall, 1989) recommends the use of music "when a patient experiences physical discomfort (such as pain or dyspnea)" to help the patient relax (p. 69). Brody further explains that "the use of slow music (received by the right brain) can cause the pituitary gland to release endorphins, thus potentiating the effects of medication or even relieving pain itself" (p. 69). In summary, music therapy can decrease the perception of pain, increase the effectiveness of pain medication, decrease the amount of pain medications necessary, and therefore decrease costs.

Music Therapy with Spirituality, Religion, and Hope

The fundamental relationship between music and religion allows music therapists to provide comfort and reassurance, draw patients and families closer to their God, and reinforce a sense of assurance through faith. Music therapists must be sensitive to patient and family's individual beliefs and desire for involvement of faith, and must never bring their own religious agenda into sessions. Even if the family does not wish to incorporate religion into sessions, supporting spiritual needs and hope can often be incorporated into treatment.

Hiatt (as cited in Aldridge, 1995) stated that "Spirit refers to that non corporeal and non mental dimension of the person that is the source of unity and meaning, and 'spirituality' refers to the concepts, attitudes, and behaviors that derive from one's

experience of that dimension" (p. 104). Aldridge emphasized the role of spirituality in transcending the moment, specifically crisis and suffering. He further noted that while "management of pain is often a scientific and technical task, the relief of suffering is an existential task" (p. 104).

> Spiritual care helps people to maintain personal relationships and relationship to a higher authority, God or life force (as defined by that individual), identify meaning and purpose in life and transcend a given moment. This idea of transcendence, the ability to extend the self beyond the immediate context to achieve new perspectives, is seen as important in the last phases of life where dying patients are encouraged to maintain a sense of well-being in the face of imminent biological and social loss (Aldridge, 1995, p. 105).

Ross (as cited by Aldridge, 1995) identified three necessary components to spirituality: the need to find meaning and purpose, the need for hope, and the need for faith in self, others, and God. Benefits of a team approach to spiritual care include decreased anxiety, improvement in feelings of well being, and increasing spiritual awareness (Kaczorowski, as cited by Aldridge, 1995). "Spirituality and religion, then, appear to be mediating factors for coping with an impending loss of life and to be positive factors for maintaining well-being, particularly in older patients" (Aldridge, p. 105).

Aldridge (1995) noted that positive emotions such as hope, joy, beauty, and unconditional love, are known to assist in coping with the diagnosis of cancer and

throughout the treatment process. Aldridge emphasized the ability of music therapy to allow patients to express themselves without limitation by disease; to creatively define themselves however they choose; offer opportunities for intimacy within a creative relationship; and support an open, nonjudgmental and equal relationship.

A common theme in writings on palliative care and hospice is allowing patients to maintain hope. Aldridge (1995) parallels dimensions for fostering of hope within the music therapy context. In this framework the interpersonal context or relationship with others is seen though the therapeutic relationship in music therapy; spiritual base through uplifting music, the traditional role of sacred music, and transcending the moment; personal attributes through being creative and musical; light-heartedness through play in therapy; uplifting memories through listening to music, playing and singing remembered songs; and affirmation of worth through the mutual music making process. Also identified were hope-hindering categories of abandonment and isolation, uncontrollable pain and discomfort, and devaluation of personhood which can each be decreased through music therapy with structured social interaction; increased relaxation and distraction; and reaffirmation of worth and accomplishments through reminiscence, life review, and successful experiences.

Music Therapy in Bereavement

Music therapy can be involved in bereavement services in a variety of capacities. Many levels of involvement have been identified in writings including planning and participating in funerals, co-facilitating bereavement support groups, and making home

visits following a patient's death (Mandel, 1993). Mandel (1993) found that during an initial bereavement home visit most people were not ready to hear music of any kind, and that during bereavement support groups music assisted relaxation in provided "an effective bridge from the intense personal sharing within the group to the demands of everyday living" (p. 38). Music assisted relaxation may provide a respite from thoughts, worries, and grief; increase energy to allow for better coping with everyday life; and allow therapists to pace sharing and processing to allow the bereaved time to absorb.

Clinical Studies on Music Therapy in Hospice

There are many challenges to conducting research with patients who are terminally ill. The dying process is a very personal and sensitive experience. In addition, "The experience of each dying person is unique, and the needs of the patient (i.e. dependent variables) may change during each session, as well as across the time frame of a controlled study" (Krout, 2000, p. 105). With these challenges, there are limited clinical studies on music therapy in hospice care.

In his examination of hospice and palliative care literature from 1978–1999, Krout (2000) found 23 research studies. Some of these studies, which will be discussed throughout this paper, were on related topics relevant to clinicians in hospice and palliative care settings. Dependent variables included changes in mood, mood states, physical comfort, pain perception and intensity, pain relief, motivation, psychological well-being, relaxation, anxiety, communication, group cohesion, contentment, perception of nausea, episodes of vomiting and mean pause time following chemotherapy, essences

of sessions, speech pause time as an indicator of depression, salivary immunoglobulin-A, patient opinion of session, song lyrics, engagement, participation, imagery, attitudes about cancer, movement, verbal interaction, skin color, emotional trauma and tension, extremity temperature, heart rate, and respiration rate (Krout).

Many of the treatments in research studies included preferred music listening (frequently specifying relaxing music) alone compared to 60-cycle hum, hospital sounds, or no music; or music listening paired with visual imagery, contingent using operant procedures, and relaxation music therapy interventions including guided imagery, deep breathing, and progressive muscle relaxation listening to pre-selected relaxing music with positive suggestions for pain reduction (Krout, 2000). Additional treatments included progressive relaxation and exercises; group songwriting versus group game playing and control; music movement, music playing, listening, and verbal processing; single music therapy session with various experiences/approaches; songwriting; session introduction; message from physician audiotaped over music background; and live versus record music (Krout).

Krout (2001) found that single live active or passive music-based music therapy interventions resulted in pre- to post-session improvements at the $p \leq .001$ level for observed pain control, physical comfort, and relaxation. He also found pre-to post-session improvements at the $p \leq .005$ level for self-reported pain control, physical comfort, and relaxation of hospice patients in 90 music therapy sessions.

In their examination of 90 initial sessions on a palliative care unit, Gallagher & Steele (2001) found significant levels of improvement of patient-rated scores for pain ($p=.008$), anxiety ($p=.012$), and mood ($p<.001$). Shortness of breath did not improve

significantly. This pilot study also found significant improvements in facial expressions ($p<.001$), movement ($p=.002$), sleep ($p<.001$), and verbalizations ($p<.001$) pre- and post-session.

Hilliard (2003b) conducted a clinical study on homecare hospice patients with cancer diagnoses. Patients were matched for age and gender and randomly assigned to either a routine hospice care group or routine hospice care and music therapy group. Hilliard found a statistically significant improvement in quality of life scores, as measured by the Hospice Quality of Life Index-Revised, for patients in the music therapy group and a decrease in quality of life scores in the control group. Patients in the music therapy group increased quality of life with more sessions even as they became sicker.

Curtis (1986) examined the effect of personalized recorded relaxation music on nine terminally ill patient's perceived degree of pain relief, physical comfort, relaxation, and contentment. While the author found no significant difference in dependent variables under experimental conditions, contentment scores approached significance ($p < .069$) and graphic analysis of individual responses show positive ratings during the music condition. Background hospital sounds appeared to have a negative effect in all cases.

Hilliard (2004b) utilized an ex-post facto design to analyze the use of music therapy for 80 hospice patients, 40 of whom received music therapy, in the nursing home setting. Hilliard found that there was no difference on time of death in relation to last visit by hospice professional ($p > .05$). However, he found that participants received significantly more music therapy sessions than social work sessions ($p < .001$), music therapists spent significantly more time in direct care with participants than social workers during each visit ($p < .001$), and participants who received music therapy lived

longer than those who did not receive music therapy ($p < .001$). The average length of music therapy visit for participants in the nursing home was 36.76 minutes. Longer length of life in hospice for participants receiving music therapy could have been related to referral issues.

Hilliard (2004b) also found that cognitive and physiological needs were addressed most frequently by the nurse followed by the music therapist, emotional needs were addressed slightly more but nearly equally by the music therapist than social worker, all social needs were addressed by the music therapist and not by nurse or social worker, case management needs were addressed most frequently by the social worker followed by the music therapist, and music therapists were more likely than nurses or social workers to address spiritual needs for hospice patients in the nursing home setting. Hilliard noted that music therapists were also frequently decreasing agitation in participants. Agitation in residents of nursing homes is a major challenge since other residents tend to feed off each others' discord, and it can utilize a great amount of time and energy to alleviate these symptoms. This study shows that music therapists treat holistic needs that may otherwise be untreated by the interdisciplinary treatment team.

Whittall (1989) found that mean heart rate scores and respiration rates decreased, anxiety decreased, relaxation increased, and extremity temperature increased pre- to post-session in a pilot study with palliative care patients. These results may be due to emphasis or changes, passively or actively, on breathing during 30 minute music therapy interventions involving guided imagery, deep breathing, and progressive relaxation exercises (Whittall).

Colwell (1997) presented a case study of a woman with chronic pain due to multiple medical procedures for severe endometriosis. The author found that music listening, imagery and relaxation, and vocal and instrumental rehearsal resulted in a 23% reduction in pain perception, 50% increase in self-management coping skills, 40% decrease in helplessness, 33% reduction in reliance on social supports, and a 33% reduction in need for medical remedies. Self reported frequency of pain episodes, pain level, and narcotic ingestion all decreased over the 15 week period. The patient terminated services after 14 weeks of treatment because she felt adequately trained to continue interventions in the home environment.

Measurement of Effectiveness

In their preliminary research of published articles on cancer patients, Gallagher & Steele (2001) found that only eight out of 85 articles on Medline included objective measurement of music therapy protocol effectiveness. In his evaluation of 88 clinical reports on hospice and palliative care Krout (2000) found that behavioral observation and verbal self report were clearly the most frequently utilized methods of evaluation of effectiveness. Krout found that content analysis of patient lyrics, content analysis of improvised music, and ground theory analysis were used in at least two reports. Amount of pain medication administered, automated event recording, content analysis of patient creative writing, physiological measurement, and survey of music therapists were used in one report each. Gallagher & Steele (2001) described a computerized database designed to evaluate clinical practice.

Funding

In the 2005 American Music Therapy Association (AMTA) Sourcebook, 9% of respondents stated that they did not know how their positions were funded. AMTA states that "understanding the basics about reimbursement is essential regardless of the employment setting and situation" (p. 216). Since Krout (2004), Hilliard (2004a), Starr (1999), and O'Callaghan (1989) found that a major limitation to employing music therapists from an administrative perspective was uncertainty of funding sources, it seems that if music therapists took responsibility for knowing potential sources of funding for music therapy in hospice programs this barrier might decrease.

In his experience initiating music therapy in hospice programs, Hilliard (2004a) found funding through private donations, grants, and marketing. In his evaluation of four hospice programs which initiated music therapy into their programs, Hilliard (2005) found an average daily census increase of 3%-6% and corresponding increases in revenue. If families and health care workers know about and see the benefits of music therapy services within a hospice program, they are likely to increase referrals to that program bringing greater financial stability. Hospice programs with music therapy may also increase charitable donations due to the highly visible and social nature of music therapy, and increased satisfaction in services. In his evaluation of hospice programs with music therapy, Hilliard found that when effectively implemented and marketed, the revenue generated through incorporation of music therapy exceeds the cost of music therapy services.

Cost Effectiveness

As health care costs rise and funding becomes tighter, awareness of cost effectiveness, or the ratio of resources spent (or consumed) to treatment outcome, is critical. This is especially crucial for music therapists since music therapy is not a required service for hospice care. As such, music therapists must be proactive in demonstrating cost effectiveness. Music therapists are frequently able to complement and enhance the effectiveness of other services and can play a unique role in the holistic treatment of patients and families. As overall funding decreases and costs increase for hospice care, music therapy may be cut from the relatively few hospice programs that utilize it if these effects are not well documented. Awareness of cost effectiveness validates worth of a service and encourages accountability of the therapist (Dziwak & Gfeller, 1988). Dziwak and Gfeller note that therapists who provide clear documentation of the beneficial outcome and reasonable cost for service will stand a better chance of survival in healthcare.

Calculating cost effectiveness involves gathering information about resources (time and dollars) used, the processes that make up treatment, and the outcome or effectiveness of these procedures (Dziwak & Gfeller, 1988). Cost effectiveness is typically measured as a ratio of units such as therapist hours per percent change. To measure cost effectiveness cost of treatment must be able to be measured in monetary terms, effectiveness of treatment must be measurable, and patient outcome must, at least in part, be attributable to the treatment program (Goldschmidt, as cited by Dziwak & Gfeller, 1988). Treatment objectives should be operationally defined for a particular

population, clear and standardized for that population, and measures should be appropriate indicators of outcome (Dziwak & Gfeller). If more than one objective is present, the therapist may weigh objectives based on importance as an indicator of treatment outcome. Experimental or quasi-experimental comparison of effectiveness of various models of treatment is recommended. The evaluator should be aware of variables related to outcome: those associated with the actual treatment program, those associated with the patient, and those associated with the environment (Dziwak & Gfeller).

Factors influencing cost include labor (salary, therapist contact hours, group versus individual treatment, and length of time in treatment), facilities, and equipment with adjustment for inflation and depreciation. Data for cost analysis must be specific to particular treatment setting. Cost-effectiveness can be determined for the program as a whole or patient groups depending on level of homogeneity of patients (Dziwak & Gfeller, 1988).

In addition to emphasis on cost effectiveness, finding interventions that enhance effectiveness of other treatment modalities or decrease need for additional services may enhance quality of care and help reduce costs. Music therapy has been shown to do this. Lane states "We've seen that it [music therapy] can enhance and improve care. It can make the physician's work easier and improve the patient's quality of life" (Ohlsen Read, 2000, p. 22). Birk, McGrady, MacArthur, & Khuder (2000) found that patients with HIV who received combined massage and biofeedback stress management once per week reported significantly decreased ($p < .05$) medical care utilization and significantly improved ($p < .05$) health perceptions. It should be noted that patients in the massage alone group did not show a significant change for the quality-of-life measure which may

imply that stress management was primarily responsible for this change (Birk, et al.). These findings suggest that complementary therapies may result in fewer unnecessary visits to a health care provider for patients with HIV which could lead to reduced health care costs. Music therapy can also be utilized for pain, anxiety, and stress management and may result in similar trends not to overuse or strain services.

Satisfaction and Perceptions of Effectiveness

Gallagher & Steele (2001) reported results from a staff survey on impressions of effectiveness of music therapy. While this survey indicated that staff had positive impressions of music therapy, this information was based on a 38% return rate, or 18 staff members. Further investigation of level of staff support of music therapy is warranted with a larger sample.

O'Callaghan (2001) compiled patients', visitors', and staff members' experiences of music therapy over a three-month period in a cancer hospital. Of particular interest in this study were the impact of music therapy and describing memories triggered from music. Of the 207 patients who received music therapy, 128 patients completed the survey. Virtually all respondents indicated that music therapy was a positive experience, no patients responded that it was a negative experience, and one patient responded that it did nothing for them (O'Callaghan). While this study provides evidence of strong support of music therapy, the author addressed the fact that cancer patients tend to respond to studies in a positive manner (O'Callaghan). O'Callaghan further states

"Experiencing short-term symptom relief or positive psychosocial moments when one is negotiating a life threatening or terminal illness is worthwhile in and of itself" (p.159).

Orzechowski (1996) emphasizes the importance of satisfaction of patients, families, physicians, discharge planners, hospital and physician office staff, nursing home administrators, and anyone else in the community who may make a hospice referral or speak about hospice services. High levels of customer satisfaction are desirable for continued and increased referrals and improving and maintaining program reputation. Music therapy is frequently a highly visible intervention involving not only the patient but facility staff and family members, and has the potential to increase overall satisfaction with the hospice program. Milton (1998) suggests that learning about and integrating complementary therapies into nursing practice not only helps patients, "but also may help nurses increase effectiveness and satisfaction with their practice" (p. 454).

Service differentiation is also crucial for increasing referrals (Orzechowski, 1996). Unique and highly effective services such as music therapy may help to develop this. Demmer and Sauer (2002) found that patients who received complementary therapies (massage, music therapy, therapeutic touch, reflexology, harp music, aromatherapy, guided imagery, yoga therapy, Reiki, hypnotherapy, the Feldenkrais method, or art therapy) were generally more satisfied with overall hospice services. The same study found that primary care givers viewed complementary therapies to be helpful (43%) or definitely helpful (43%) in relation to other hospice services received. Primary caregivers perceived improvements in quality of life due to complementary therapies for 58% of respondents. Offering more services, particularly complementary therapies, to patients and families allows for greater choice and therefore increased control (Milton,

1998). It also increases the ability to meet more challenging needs of patients and their families.

Areas in Need of Further Study

Extant literature in hospice music therapy suggests further study is needed on potential funding sources for music therapy in hospice, financial benefits of music therapy in hospice care, ways in which qualitative and quantitative evaluation of clinical effectiveness can be used to secure funding for music therapy in hospice, patient and family needs that music therapy are able to address uniquely from other members of the interdisciplinary treatment team, use of other therapies with music therapy, objective measurement of effectiveness of music therapy protocol; effectiveness of specific music therapy techniques, effects of music in conjunction with the therapeutic personality, influence of patient attitude and perception of status on efficacy of music therapy treatment, clarification of professional roles, aspects or functions that are most important to quality music experiences, benefits of adding music therapy to hospice, effects of live versus recorded music on pain and anxiety with the terminally ill, frequency and effectiveness of specific techniques on specific objectives, length of benefit following music therapy sessions, longitudinal studies on benefits of music therapy, and optimal number of sessions (Curtis, 1986; Gallagher & Steele, 2001; Hilliard 2001; Hilliard, 2004a; Hilliard, 2005; Krout, 2000; Krout, 2001).

CHAPTER III

METHODOLOGY

The purpose of this study is to compile quantitative data to determine how hospice programs fund music therapy services, and identify staffing trends (number of music therapists and employment status) and service trends (caseload, frequency, and length of sessions) for hospice programs with music therapy. Obtaining this valuable information is a necessary and logical step needed to increase administrators' understanding of financial and logistical factors involved in initiating music therapy into their programs.

Participants

Music therapists in the Great Lakes Region (Indiana, Michigan, Ohio, Wisconsin, Illinois, and Minnesota) who are affiliated with hospice programs which provide music therapy were surveyed for this study. Four sources were utilized to identify music therapists to serve as participants: (1.) music therapists within the Great Lakes Region who identified themselves as working with the terminally ill in the 2005 American Music Therapy Association (AMTA) Sourcebook (American Music Therapy Association, 2005); (2.) music therapists who reported working in hospice programs during two hospice and palliative care Continuing Music Therapy Education Courses (CMTE) during the 2005 Great Lakes Region Music Therapy Conference; (3.) music therapists who were identified as working in hospice programs by the president, membership, or

public relations representatives of each state; and (4.) music therapists who were identified as working in hospice programs by hospice representatives of each state. Multiple sources were used to decrease the likelihood that some music therapists affiliated with hospice programs would accidentally be omitted from the population. Eighty-six music therapists who are affiliated with hospice programs which provide music therapy in the Great Lakes Region were identified through the above sources for this study.

To participate in this study, music therapists identified must currently be working in a hospice program (inpatient or home hospice) in the Great Lakes Region (Indiana, Michigan, Ohio, Wisconsin, Illinois, or Minnesota). Exclusionary criteria included not currently working in hospice; not employed (full time, part time, or contractually) by a hospice program or hospital with inpatient hospice program or home hospice), and/or not working in the Great Lakes Region (Indiana, Michigan, Ohio, Wisconsin, Illinois, or Minnesota). See procedure section for details.

Survey Instruments

Since the author was unable to locate surveys that addressed related questions, a survey was designed based on questions raised from related literature for utilization in this study (See Appendix A). Nine music therapists working in hospice programs, and three members of the author's thesis committee were asked to review drafts of this survey to determine validity of the instrument. Revisions were made as appropriate. The final

version of the survey was adapted to an internet web page using an online survey company, SurveyMonkey.

The survey was comprised of 26 multiple choice, yes/no, and brief fill in the blank questions. Questions pertained to basic demographic and staffing information, services provided and session information, and funding. The demographics and staffing section asked questions related to kind of program, average daily census, location of service, how long music therapy has been a part of the program, number of music therapists, employment status, hours worked, and music therapy internship programs. The services provided and session information section asked questions related to caseload, session frequency, session length, waiting list, ability to meet patient needs, and desired frequency and caseload. The funding section asked questions related to non-profit or for-profit status, funding sources, start up costs and resources, donations, and beliefs related to importance of understanding the funding process.

Procedure

The author first attempted to obtain a list of hospice programs that have music therapy and music therapists who worked at each program through the National Hospice and Palliative Care Organization (NHPCO). This attempt was unsuccessful as NHPCO would not distribute the names of its members.

Next, music therapists in the Great Lakes Region (Indiana, Michigan, Ohio, Wisconsin, Illinois, and Minnesota) who were affiliated with hospice programs which provide music therapy were identified to be participants in this study. Four sources were

utilized to identify music therapists to serve as participants: (1.) music therapists within the Great Lakes Region who identified themselves as working with the terminally ill in the 2005 American Music Therapy Association (AMTA) Sourcebook; (2.) music therapists who reported working in hospice programs during two hospice and palliative care CMTE courses during the 2005 Great Lakes Regional Music Therapy Conference; (3.) music therapists who were identified as working in hospice programs by the president, membership, or public relations representatives of each state; and (4.) music therapists who were identified as working in hospice programs by music therapy hospice representatives of each state. Multiple sources were used to decrease the likelihood that some music therapists affiliated with hospice programs would accidentally be omitted from the population due to non-inclusion in the AMTA directory or work in private practice. Permission was gained from AMTA and other sources in Appendix D to utilize email address for research.

The AMTA "listing by population" in the 2005 Sourcebook (p. 179) provided a listing by state of music therapists who reported working with the terminally ill. Music therapists who worked within the Great Lakes Region were selected from this list. This list did not include all music therapists within the Great Lakes Region who work in hospice. This list also included some music therapists who work with the terminally ill but do not work in hospice programs (i.e. are employed by a nursing home). Additional sources (e.g. CMTE courses; and/or president, membership, public relations, or hospice representatives of each state) were utilized to provide a more complete and accurate listing of music therapists who work in hospice programs in the Great Lakes Region.

Participants from the CMTE courses were asked if they worked in a hospice program. If so, participants were asked to identify the program name, music therapists in their hospice program, and contact information. The author needed to identify that this information was being collected for a study to obtain consent to collect names and contact information and utilize information. The author was not specifically recruiting participants at this time but identifying music therapists that worked in this area and obtaining information for study feasibility.

The president, membership, and public relations representatives of each state were contacted to request access to state networking directories, names of members of hospice support groups, or a representative who works in hospice. Appendix B contains a table depicting contacts and sources of email lists for subject recruitment. Initial letters of inquiry for subject recruitment (Appendix C) were sent to state representatives and AMTA as identified in the table. Indicated representatives forwarded the initial letter of inquiry to hospice representatives or state membership. Networking directories did not exist or were not available to people outside of each state. The author was put into contact with music therapist(s) who worked in hospice programs for each state. This representative provided the author with names of music therapists who worked in hospice and consented to have names and emails released for this study. Permission was gained to utilize email address for research. Letters of permission from these sources are contained in Appendix D. While the author knew who potential participants were from the above process, confidentiality was maintained through utilization of the online survey. The writer did not know which potential participants responded to the survey. The letter of invitation/consent is included in Appendix E.

Following approval from the thesis committee, the study protocol was submitted to and approved by the Western Michigan University Human Subjects Institutional Review Board (WMU HSIRB) for feedback. The letter of approval from the HSIRB is included in Appendix F.

Once approved by the HSIRB, the survey was uploaded to SurveyMonkey, an online web survey company. SurveyMonkey was used to increase security of surveys and data, decrease time necessary for dissemination of surveys, decrease time needed for participants to complete the survey, eliminate additional data entry, reduce costs, and simplify data reporting.

The letter of invitation/consent (Appendix E) and a link to the survey in online form was submitted via email to 86 music therapists who work in hospice programs in the Great Lakes Region. Participants were asked to complete a one-time anonymous survey which took approximately 10-15 minutes to complete. The survey was open for responses for a total of 2 weeks with a reminder/thank you email given to all participants after 1 week (Appendix G). Data from SurveyMonkey was downloaded for further statistical analysis.

Outline for Data Analysis

Following completion of the survey, graphs and narrative descriptions of all survey question responses were compiled. Pivot tables and graphs, when appropriate, were compiled for research questions comparing related variables. Statistical analysis was not completed due to the low number of responses within each category of questions. This issue will be addressed in greater detail in the discussion section.

CHAPTER IV

RESULTS

Response

Eighty-six invitations to participate in the survey were sent via email to music therapists identified as working in hospice programs in the Great Lakes Region. Of these 86 invitations, five were returned due to invalid email addresses. These five participants were dropped from the study resulting in 81 potential participants. Forty-eight or 59% of these 81 music therapists responded to the survey.

Twelve of these 48 respondents did not meet the eligibility requirements for the study because they were not currently employed full-time, part-time, or contractually by a hospice program or a hospital with an inpatient hospice unit. Of these 12 participants who did not qualify for the study: two did not work in hospice, one worked in a college, three worked in long term care, one worked in day services for people with developmental disabilities, one completed their internship in hospice and no longer worked in this setting, three worked in palliative care only without hospice care, and one worked in oncology only without hospice care. The surveys completed by the remaining thirty-six music therapists met the eligibility requirements and were included in the data analysis. Percentages throughout the results and discussion sections are based on a response total of 36 participants.

Demographic and Staffing Information

In What Kind of Program/Facility Do You Work?

All options were identified as program/facility type in which participants worked. Eleven participants (31%) identified that they worked in home hospice only, six (17%) identified that they worked in inpatient hospice only, and 19 (53%) identified that they worked in a combination of programs/facilities. Thirteen (36%) participants identified that they worked in both home hospice and inpatient hospice. As such, percentages of responses in Figure 1 do not equal 100%.

Home hospice (n = 28, 78%) was the most frequently identified program/facility type, followed by inpatient hospice (n = 18, 50%), long term care (n = 8, 22%), other (n = 7, 19%), and only oncology without hospice care (n = 1, 3%) (See Figure 1). Reponses given in the "other" category included: music therapy focuses specifically on hospice patients living in residential care facilities: nursing homes, assisted living, and memory care; contracted hospitals; palliative care and hospice organization which provides services in our residential facility, private homes, hospice units in hospitals, assisted livings, group homes, and nursing facilities; alternative setting as well such as nursing homes and long-term care settings; outpatient and inpatient oncology; throughout a large hospital in which palliative and hospice services are provided to babies, children, and adults; and hospice in nursing homes and assisted living facilities. One participant consulted to a home/inpatient hospice, helped develop the therapeutic music program, and facilitated monthly staff support groups.

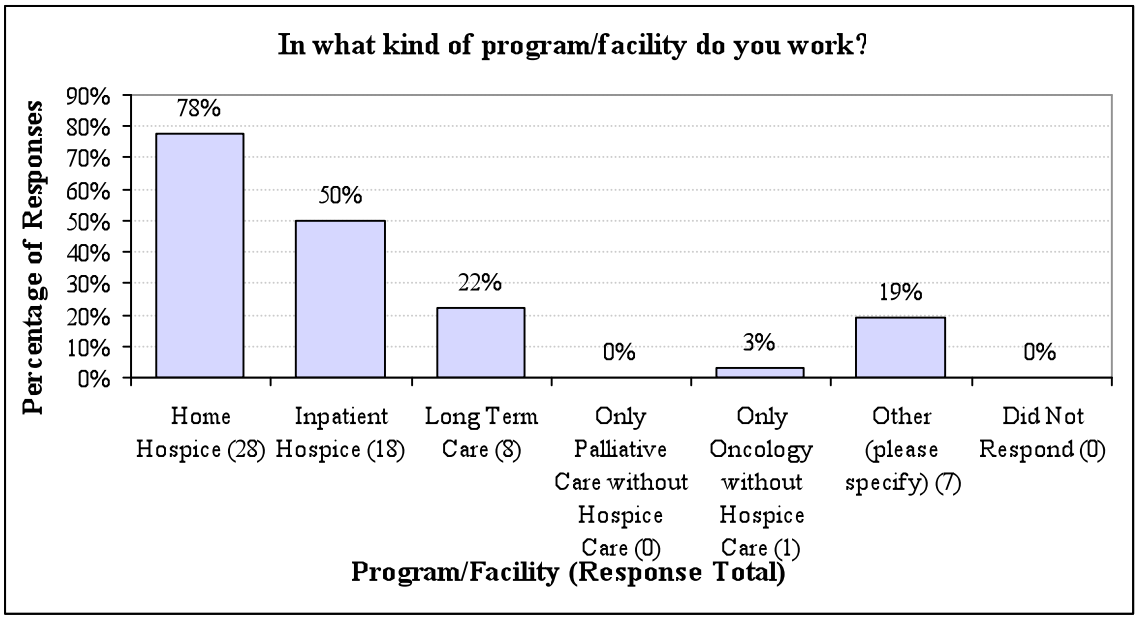

Figure 1. Program/Facility Type.

What is Your Average Daily Census?

Average daily census (ADC) refers to the average number of patients served by the hospice program as a whole. Due to the nature of hospice and goal for hospice to provide services for patients in whatever location "home" is for them, these patients are likely to be in a variety of different locations and/or facility types (private homes, assisted living, nursing homes, etc.). ADC varied among respondents. As seen in Figure 2 the most frequent response for ADC was 100-149 patients identified by 9 participants (25%); followed by an ADC < 49 identified by 7 participants (19%); ADC 150-199 identified by 5 participants (14%); ADC >351 identified by 4 participants (11%); an ADC of 50-99, 250-299, and 300-350 identified by 2 participants each (6%); and an ADC of 200-249 identified by one participant (3%). Four participants did not respond to this question.

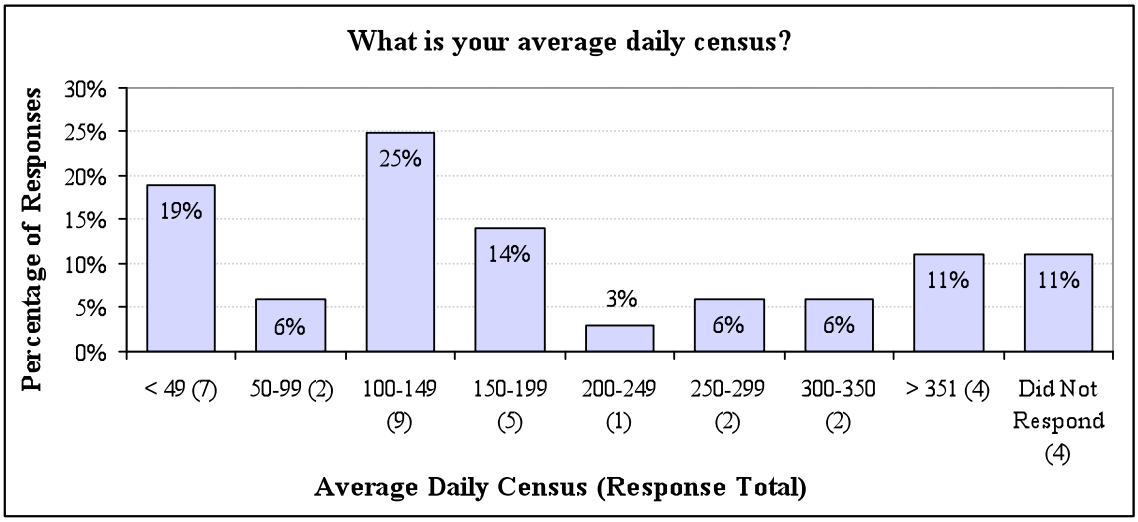

Figure 2. Average Daily Census.

For the purposes of this paper a small hospice program will be classified as an ADC equal to or lower than 99 (9 programs), a medium hospice program will be classified as an ADC between 100-199 (14 programs), and a large hospice program will be classified as an ADC of 200 to greater than 351 (9 programs).

In What Type of Area(s) Does Your Hospice Program Serve?

Participants responding to this question identified that hospice services are being provided in all three areas: 30 (83%) participants identified working in city/metro areas, 22 (61%) participants identified working in small towns, and 20 (56%) participants identified working in country/rural areas (See Figure 3). Eighteen (50%) participants identified that they worked in all three areas, 10 (28%) participants identified that they worked in city/metro only, two (6%) participants identified that they worked in both country/rural areas and small towns, and two (6%) participants identified that they

worked in both small towns and city/metro areas. Four participants did not respond to this question.

The author was unable to address question 5 (Does location of the hospice program/service area [country/rural, small towns, city/metro] influence staffing trends [number of music therapists and employment status] and service trends [caseload, frequency, and length of sessions]), due to the overlap of services areas. Since over half of the participants reported working in all three areas and no participants identified working in only one service area, it was impossible to identify distinct service trends with country/rural, small towns, and city/metro areas in this study.

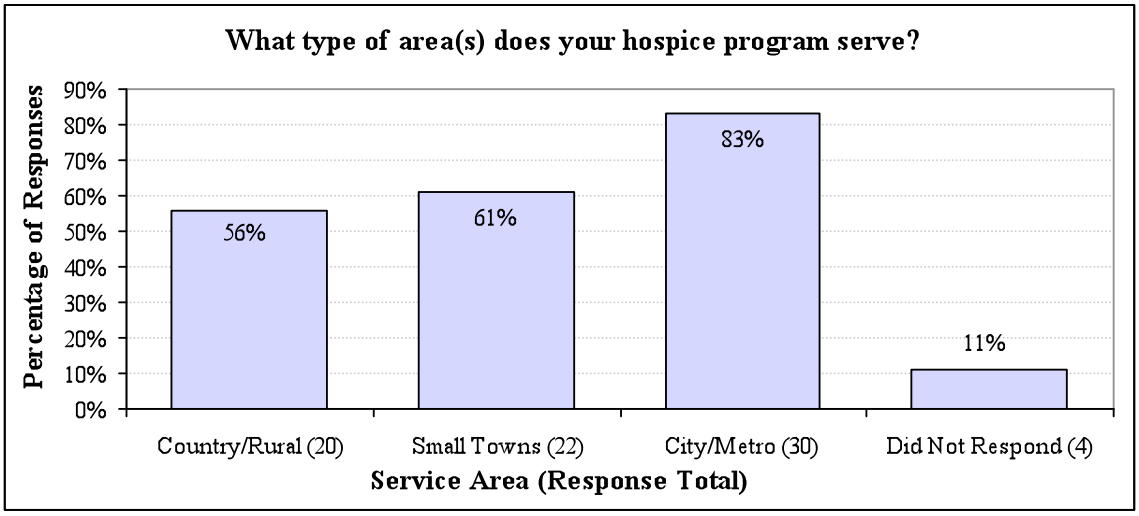

Figure 3. Areas Served.

What Type of Location(s) Does Your Hospice Program Serve?

Participants reported working in a wide variety of locations including: nursing homes (n = 31, 86%), private homes (n = 30, 83%), assisted living facilities (n = 29, 81%), hospitals (n = 23, 64%), residential hospices (n = 18, 50%), group homes (n = 18,

50%), board and care facilities (n = 11, 31%), and foster care facilities (n = 9, 25%) (See Figure 4). Four participants did not respond to this question.

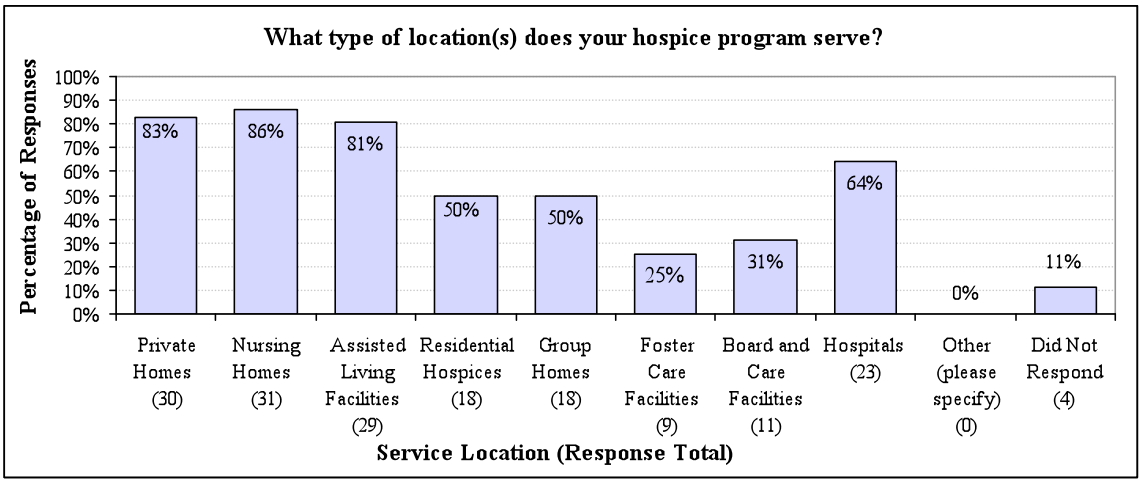

Figure 4. Service Location.

How Long Has Music Therapy Been Offered in Your Program?

The length of inclusion of music therapy services in each program varied with slightly more programs developing in the outlying years. The largest number of programs initiated music therapy within the last year (n = 8, 22%), followed by offering of music therapy services 2-3 years (n = 6, 17%), and more than 10 years (n = 5, 14%) (See Figure 5). Four participants (11%) stated that music therapy has been offered for 4-5 years, 6-7 years, and 8-9 years each. Five participants did not respond to this question.

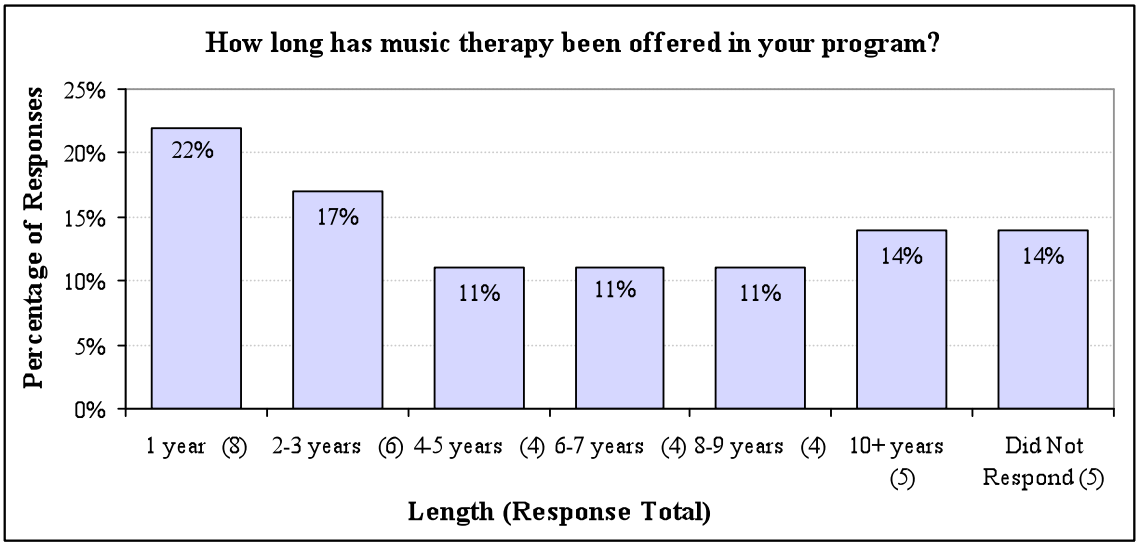

Figure 5. Length of Time Music Therapy has Been Offered in Program.

How Many Music Therapists Work for Your Hospice Program?

Figure 6 represents the number of music therapists working in each hospice program. The first number listed indicates the response group (i.e. number of music therapists in each program) and the second number represents the percentage of responses. Twelve (33%) participants reported being the only music therapist in their hospice program, followed by 11 (31%) with 2-3 music therapists, 8 (22%) with 4-5, and 1 (3%) with 6-7 music therapists (See Figure 6). Four participants did not respond to this question.

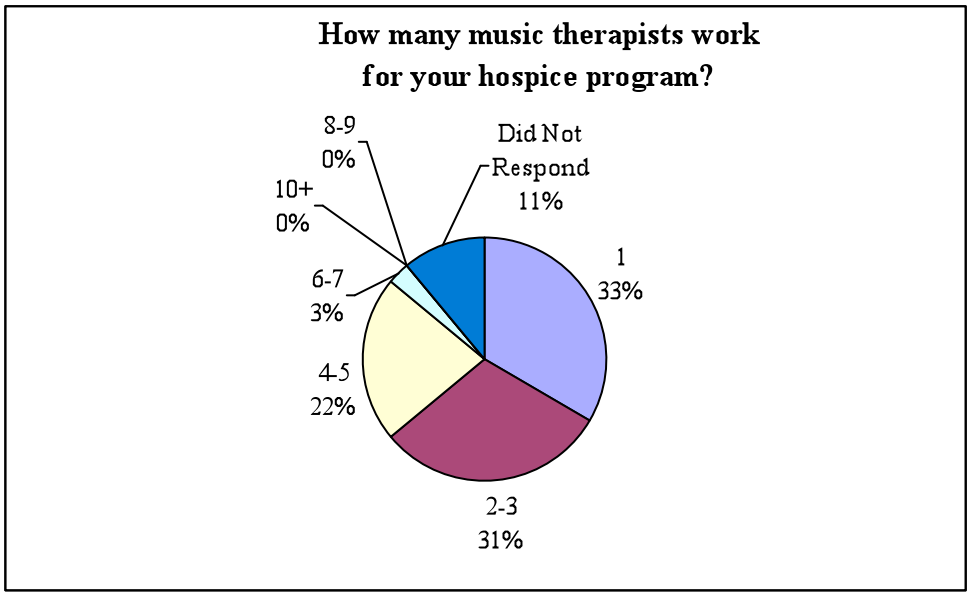

Figure 6. Number of Music Therapists.

What is Your Employment Status?

Twenty (56%) participants responded that they worked full-time (See Figure 7). Part-time employment status (n = 7, 19%) and contractual employment status (n = 5, 14%) were fairly close in response. Four participants did not respond to this question.

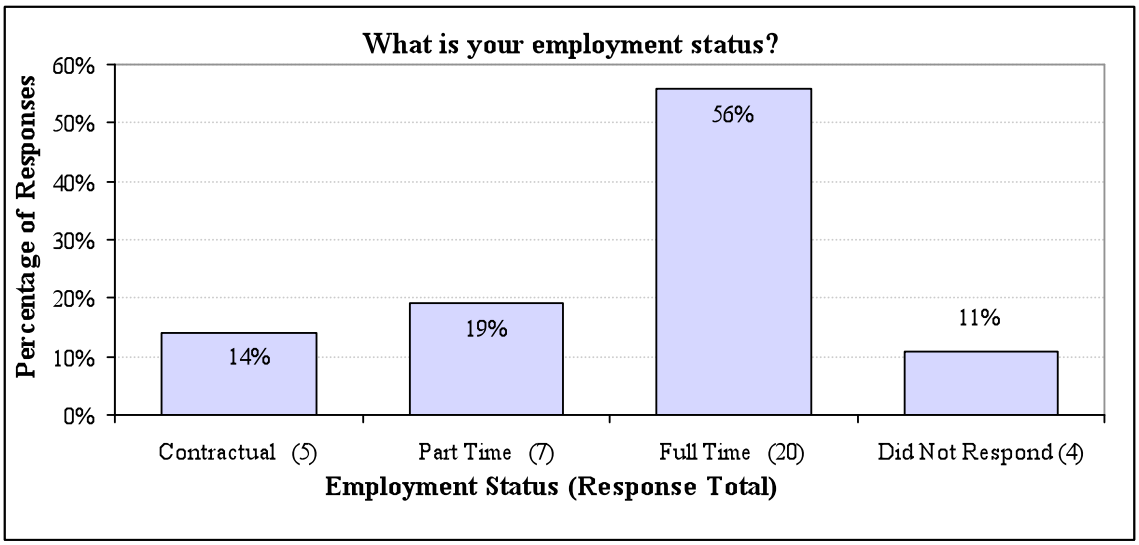

Figure 7. Employment Status.

How Many Hours Per Week Do You Work?

Twenty-two (61%) participants reported working 30-40 hours per week (See Figure 8). Remaining participants reported working 20-29 hours per week (n = 7, 19%), followed by 9 hours or less (n = 2, 6%), and 10-19 hours per week (n = 1, 3%) (See Figure 8). Four participants did not respond to this question.

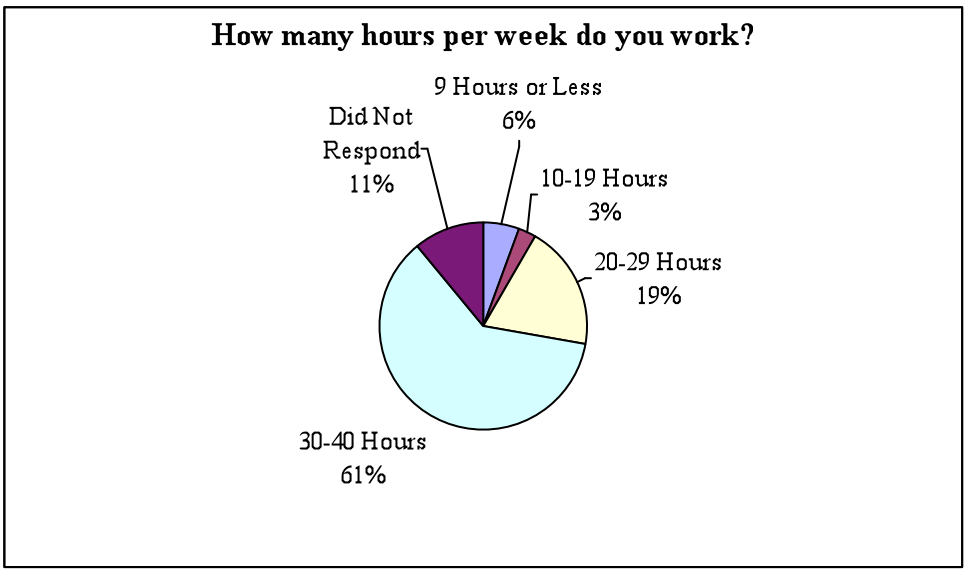

Figure 8. Hours Worked.

Do You Have a Music Therapy Internship Program?

The majority of participants reported that they do not have an internship program (n = 26, 72%) (See Figure 9). Six (17%) participants responded that they do have a music therapy internship program (See Figure 9). One participant had recently submitted a proposal for internship development and was trying to convince their administrator that a stipend is a useful inducement to attract good interns. Four participants did not respond to this question.

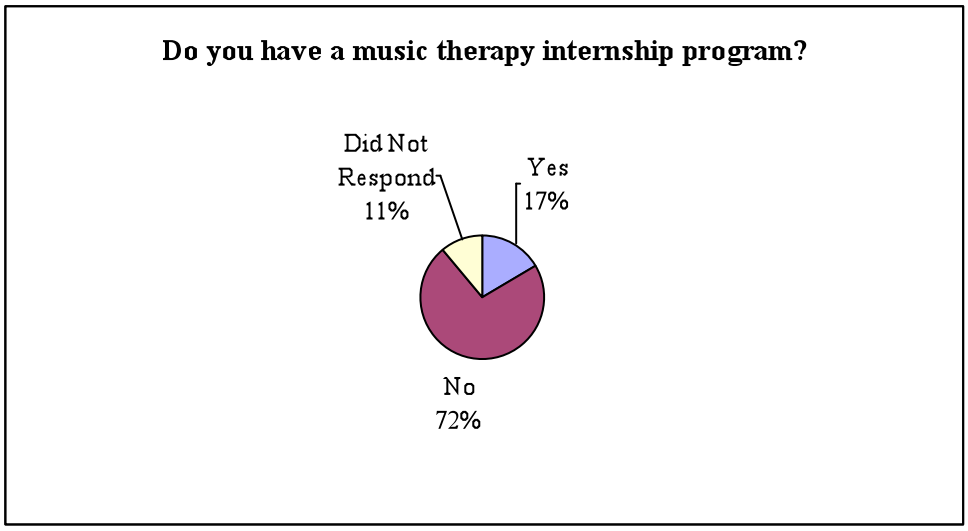

Figure 9. Music Therapy Internship Program.

If Yes, How Many Music Therapy Interns Do You Have at a Time?

Of the 6 participants that stated that they have music therapy interns, 3 (8%) reported having one intern at a time, 3 (8%) reported having 2-3 interns at a time, and 1 (3%) reported having 4-5 interns at a time (See Figure 10). In the "other" category one participant stated that interns are shared with three other music therapists, one participant stated that they are hoping to have an internship program by next year, and another participant stated that they had interns in their hospital job not their hospice job.

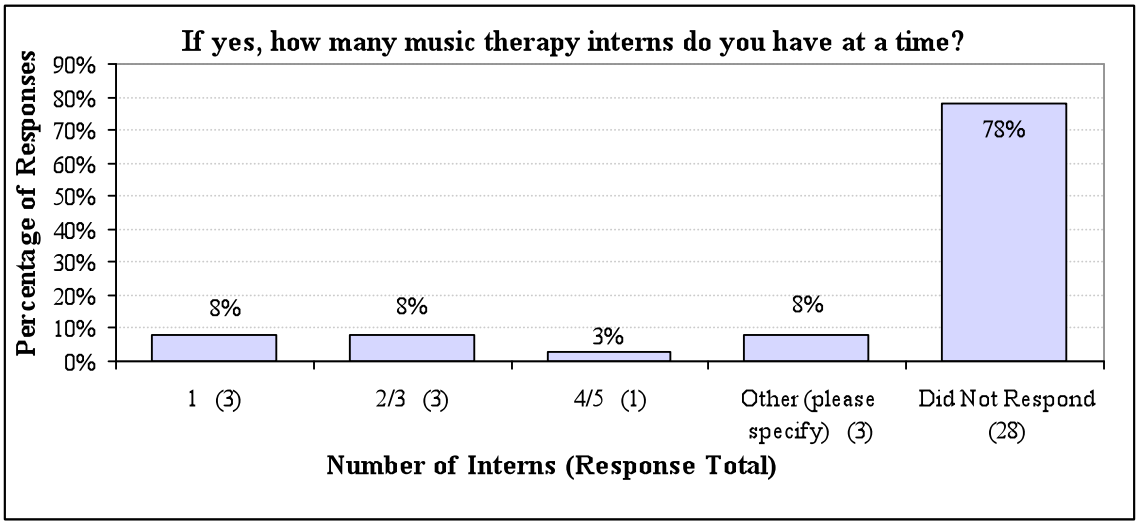

Figure 10. Number of Music Therapy Interns.

Services Provided and Session Information

What is the Average Caseload That You Carry?

The response to the average caseload carried question resulted in a great deal of variety. Ten (28%) participants reported carrying 30-39 patients, 7 (19%) reported carrying 20-29 patients, 6 (17%) reported carrying 10-19 patients, 3 (8%) reported carrying greater than 50 patients, 2 (6%) reported carrying 1-9 patients, and 1 (3%) reported carrying 40-49 patients (See Figure 11). Seven participants did not respond to this question.

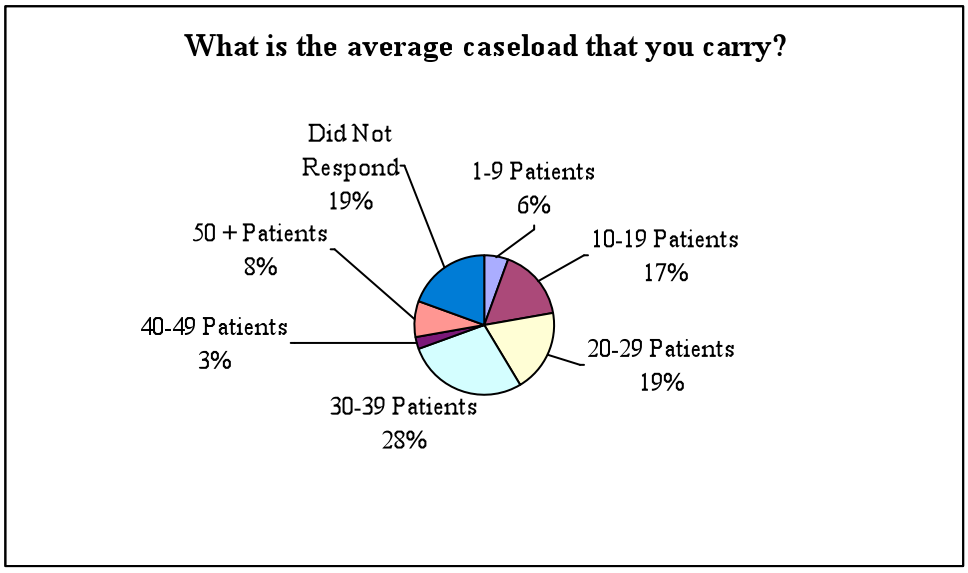

Figure 11. Average Caseload.

What is the Average Frequency of Visits?

Bimonthly visits (n = 16, 44%) were most frequently selected for average frequency of visits, followed by weekly visits (n = 11, 31%), Other (n = 5, 14%), monthly (n = 4, 11%), and PRN (as needed) (n = 2, 6%) (See Figure 12). Responses in the "other" category for average frequency of visits included varying average frequency of visits based on assessment, patient and family needs, and requests from the interdisciplinary treatment team for visits for symptom management. Many participants selected multiple responses for this question. Seven participants did not respond to this question.

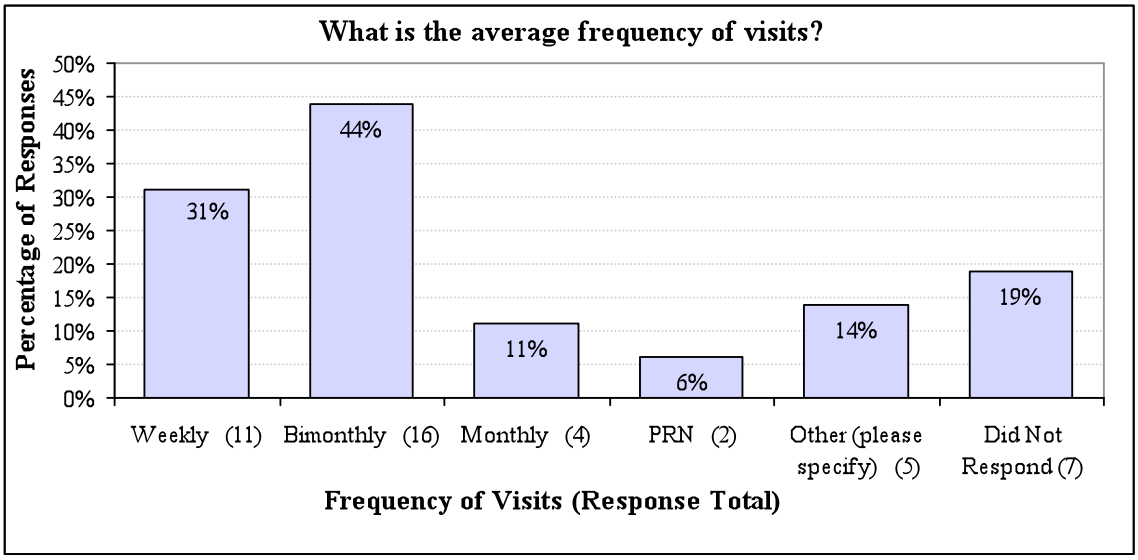

Figure 12. Average Frequency of Visits.

What is Your Typical Session Length?

The most frequent response for typical session length was 45-59 minutes (n = 16, 44%) (See Figure 13). The remainder of participants stated that typical session length was 30-44 minutes (n = 6, 17%), 60-89 minutes (n = 4, 11%), and less than 29 minutes (n = 3, 8%) (See Figure 13). Seven participants did not respond to this question.

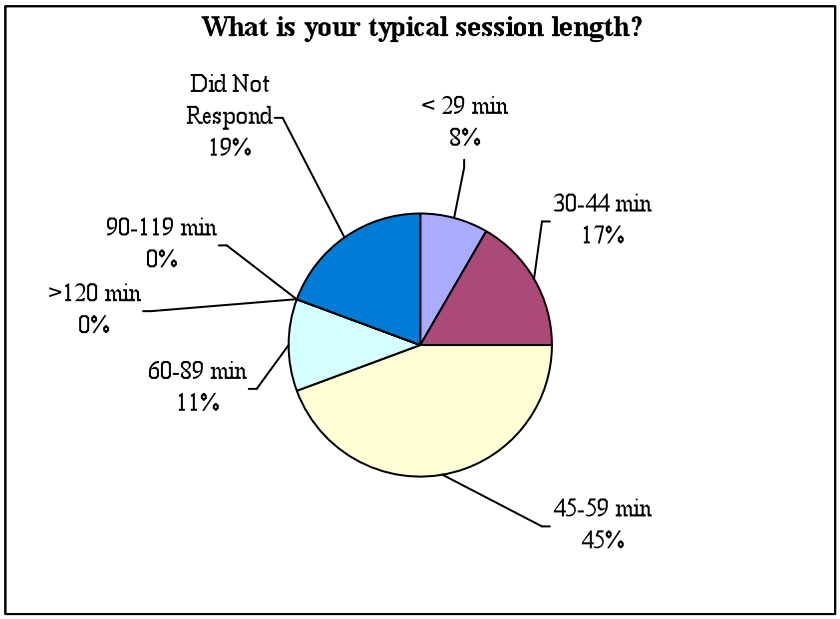

Figure 13. Typical Session Length.

Table 1 organizes service trends (caseload, frequency, and length of sessions) by employment status (contractual, full-time, or part-time). From this data there appears to be a slight difference in average caseload in relation to employment status, with contractual employees carrying smaller caseloads and full-time employees carrying larger caseloads (See Table 1). No trends were identified in relation to average frequency of visits or typical session length and employment status.

Average Caseload	Average Frequency of Visits	Typical Session Length	Contractual	Full Time	Part Time
1-9 Patients	Bimonthly	45-59 Min			1
	Weekly	Less than 29 Min		1	
10-19 Patients	Bimonthly	30-44 Min	1		
		45-59 Min			3
	Weekly	30-44 Min	1		
		45-59 Min	1		
20-29 Patients	Bimonthly	30-44 Min		1	
		45-59 Min			1
	Other	45-59 Min		2	
	Weekly	30-44 Min		1	
		60-89 Min	1	1	
30-39 Patients	Bimonthly	30-44 Min		1	
		45-59 Min		4	1
		60-89 Min		1	
		Less than 29 Min		1	
	Weekly	45-59 Min		1	
		60-89 Min		1	
40-49 Patients	Weekly	Less than 29 Min		1	
50 + Patients	Monthly	45-59 Min		1	
	Other	30-44 Min			1
		45-59 Min		1	
No Response	No Response	No Response	1	2	

Table 1. Service Trends Versus Employment Status.

There appear to be differences in service trends (employment status and number of music therapists) related to average daily census (ADC). As seen in Figures 14 and 15 the number of music therapists in each program typically increases as the ADC increases. The highest number of participants reported having an ADC of 100-149 (9 participants), less than 49 (7 participants), or 150-199 (5 participants) resulting in groupings of higher response totals in these areas. Hospice programs with an ADC of less than 99 were more likely to have only one music therapist and the only hospice program identified that employed 6-7 music therapists had an ADC of over 351 (See Figure 14). Eight participants reported that their hospice programs, with an ADC over 100, had 4-5 full time music therapists (See Figure 14).

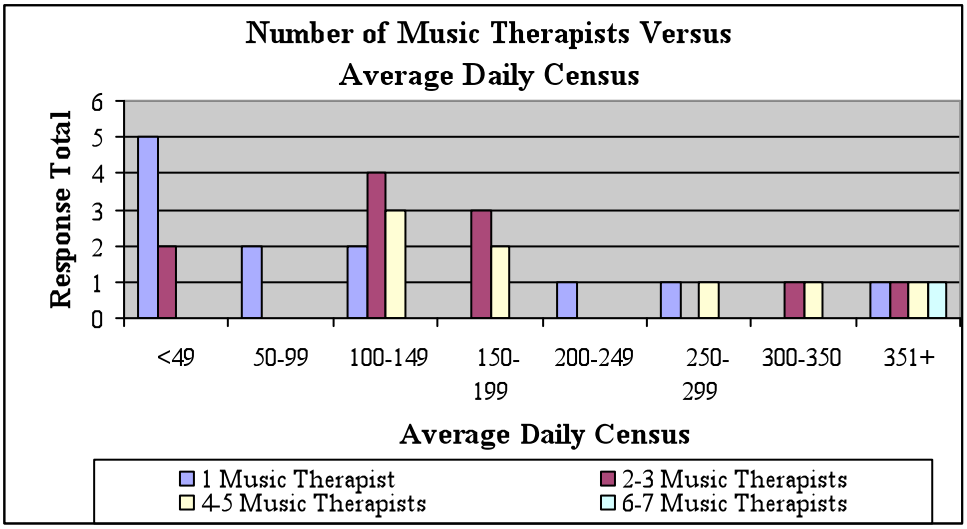

Figure 14. Number of Music Therapists Versus Average Daily Census.

Employment status also appears to be influenced by ADC. Contractual music therapists were only utilized in hospice programs with an ADC of less than 99 (See Figure 15). Three of these contractual music therapists worked for hospice programs with an ADC of less than 49 and 2 contractual music therapists worked for hospice

programs with an ADC of 50-99. Hospice programs with an ADC of greater than 100 employed more full-time than part-time music therapists (See Figure 15). As seen in Figure 16 there is a trend for total music therapy hours worked to increase as ADC increases. The average total music therapy hours worked was determined by taking the average of the range of number of music therapists identified by each participant multiplied by the average of the range of hours worked. One participant working in a hospice program with an ADC of 200-249 noted that they are the only music therapist working for their program (See Figure 14) and one participant, working in a hospice program with an ADC of 50-99 is employed contractually for 10-19 hours.

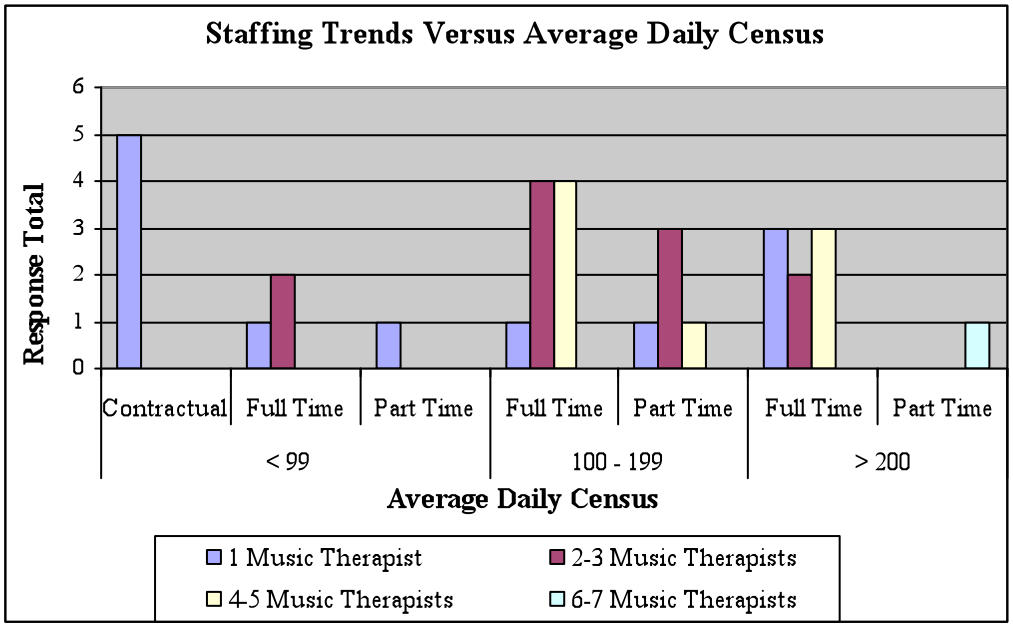

Figure 15. Staffing Trends Versus Average Daily Census.

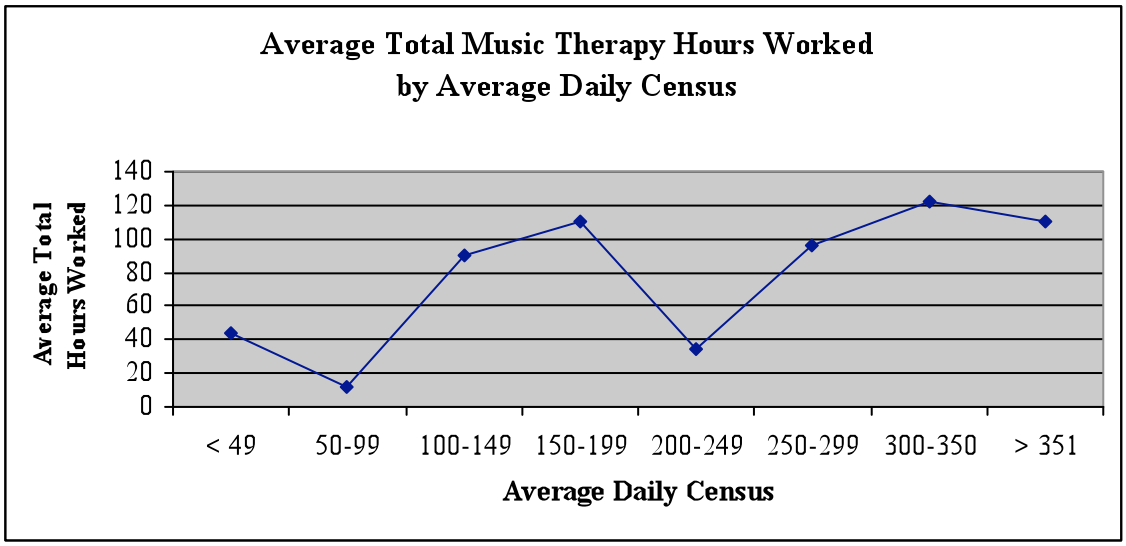

Figure 16. Average Total Music Therapy Hours Worked by Average Daily Census.

Table 2 organizes services trends (caseload, frequency, and length of sessions) by ADC. Music therapists in hospice programs with an ADC of less than 99 appear to have lower caseloads and higher frequency of visits (See Table 2). Music therapists in hospice programs with a larger ADC tend to have bimonthly visits (See Table 2). There was no observed trend for length of session compared to ADC.

Table 3 organizes participant response in relation to services trends (caseload, frequency, and length of session) compared to number of music therapists in the hospice program. From this data no trends emerged regarding the number of music therapists and average caseload, average frequency of visits, or typical session length.

Average Caseload	Average Frequency of Visits	Typical Session Length	< 99	100 - 199	> 200
1-9 Patients	Bimonthly	45-59 Min	1		
	Weekly	Less than 29 Min	1		
10-19 Patients	Bimonthly	30-44 Min	1		
		45-59 Min		2	1
	Weekly	30-44 Min	1		
		45-59 Min	1		
20-29 Patients	Bimonthly	30-44 Min		1	
		45-59 Min		1	
	Other	45-59 Min		1	1
	Weekly	30-44 Min		1	
		60-89 Min	1		1
30-39 Patients	Bimonthly	30-44 Min		1	
		45-59 Min		4	1
		60-89 Min			1
		Less than 29 Min		1	
	Weekly	45-59 Min			1
		60-89 Min		1	
40-49 Patients	Weekly	Less than 29 Min	1		
50 + Patients	Monthly	45-59 Min			1
	Other	30-44 Min		1	
		45-59 Min			1
No Response	No Response	No Response	2		1

Table 2. Service Trends Versus Average Daily Census.

Average Caseload	Average Frequency of Visits	Typical Session Length	1 Music Therapist	2-3 Music Therapists	4-5 Music Therapists	6-7 Music Therapists
1-9 Patients	Bimonthly	45-59 Min	1			
	Weekly	Less than 29 Min		1		
10-19 Patients	Bimonthly	30-44 Min	1			
		45-59 Min		2		1
	Weekly	30-44 Min	1			
		45-59 Min	1			
20-29 Patients	Bimonthly	30-44 Min		1		
		45-59 Min			1	
	Other	45-59 Min		1	1	
	Weekly	30-44 Min			1	
		60-89 Min	1		1	
30-39 Patients	Bimonthly	30-44 Min			1	
		45-59 Min		2	3	
		60-89 Min	1			
		Less than 29 Min	1			
	Weekly	45-59 Min		1		
	Weekly	60-89 Min		1		
40-49 Patients	Weekly	Less than 29 Min	1			
50 + Patients	Monthly	45-59 Min	1			
	Other	30-44 Min	1			
		45-59 Min		1		
No Response	No Response	No Response	2	1		

Table 3. Services Trends Versus Number of Music Therapists.

Is There a Waiting List for Music Therapy Services?

Half (n = 18, 50%) of the participants stated that there is not a waiting list for music therapy services (See Figure 17). However, 11 (31%) participants stated that there was a waiting list for music therapy services (See Figure 17). Seven participants did not respond to this question.

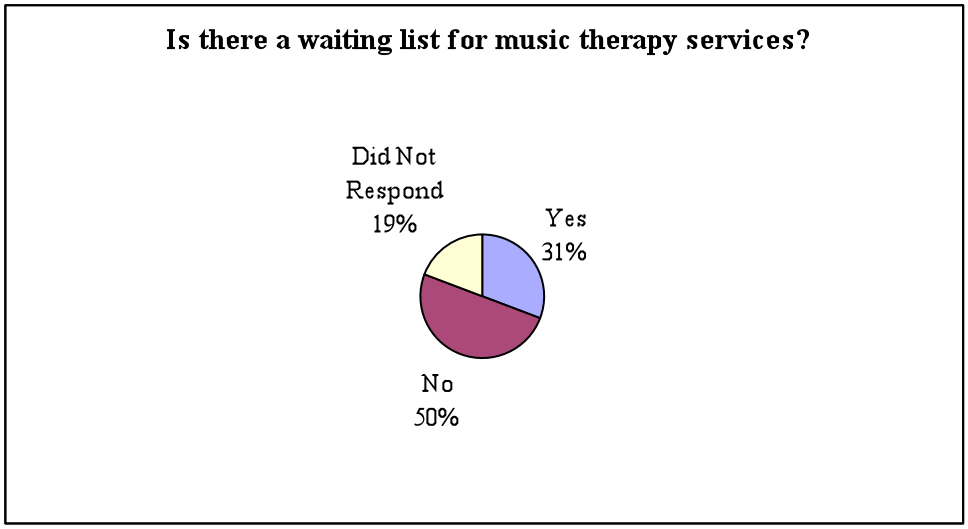

Figure 17. Waiting List for Music Therapy Services.

Do You Feel That You Are Able to Meet the Music Therapy Needs of Patients and Families With Your Current Staffing?

The majority of participants stated that they do not feel that they are able to meet the music therapy needs of patients and families with their current staffing (n = 18, 50%) (See Figure 18). Eleven (31%) participants stated that they felt they were able to meet the music therapy needs of patients and families with their current staffing (See Figure 18). Seven participants did not respond to this question.

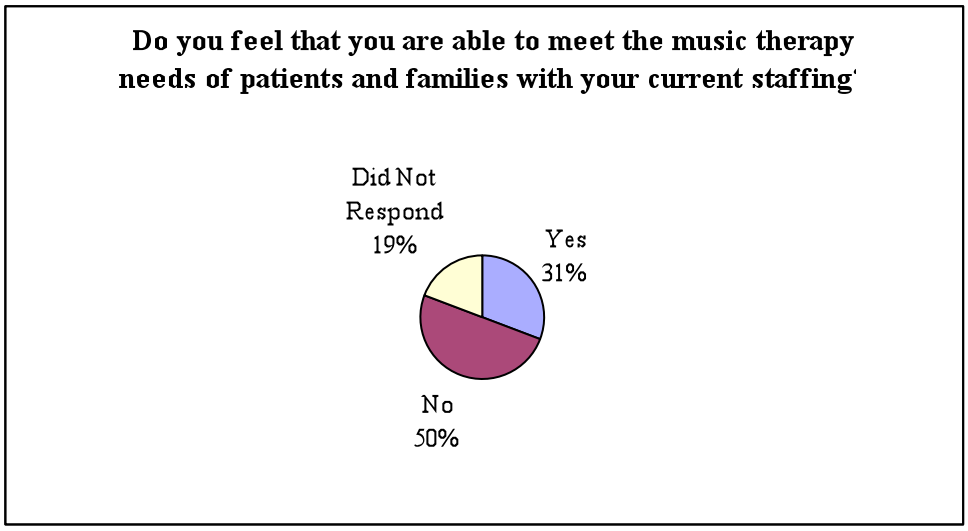

Figure 18. Ability to Meet Music Therapy Needs of Patients and Families with Current Staffing.

For a 40 Hour Music Therapy Position, What Do You Believe is an Ideal and Realistic (Able to Build a Strong Therapeutic Relationship With Patients While Meeting Budgetary Needs) Frequency of Visits?

Twelve participants (33%) each were split between weekly and bimonthly visits as the ideal and realistic frequency of visits (able to build a strong therapeutic relationship with patients while meeting budgetary needs) (See Figure 19). PRN was selected by 1 (3%) participant as the ideal and realistic frequency of visits (See Figure 19). Other comments regarding determining ideal and realistic caseload included the need to take into account and adjust for varying patient needs, changes in condition, symptom management needs, acute physical needs such as pain or dyspnea, individuals working on the "tasks of dying", and special projects; differing patient needs and abilities due to various diagnoses; and various therapeutic goals for each patient. One participant working in inpatient hospice stated that they would prefer 2-3 visits per week for 30 minutes each. Many participants stated that they would like to have a general goal of bimonthly visits plus additional PRN visits as needed. This was identified in the "other"

narrative responses rather than in selection of PRN visits as the ideal. Eight participants did not respond to this question.

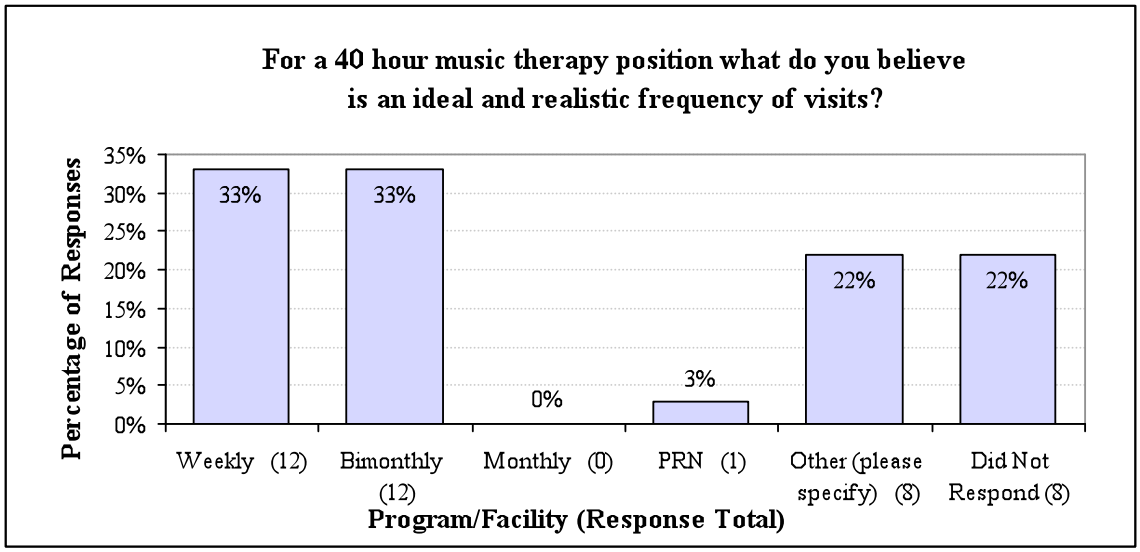

Figure 19. Ideal Frequency of Visits.

For a 40 Hour Music Therapy Position, What Do You Believe is an Ideal and Realistic (Able to Build a Strong Therapeutic Relationship With Patients While Meeting Budgetary Needs) Caseload?

Slightly more than half of the participants (n = 19, 53%) stated that they believed 20-29 patients was the ideal and realistic (able to build a strong therapeutic relationship with patients while meeting budgetary needs) caseload for a 40 hour music therapy position (See Figure 20). The remaining participants stated that they believed 30-39 (n = 6, 17%), 40-49 (n = 2, 6%), or 10-19 (n = 1, 3%) was the ideal and realistic caseload (See Figure 20). No participants selected over 50 patients as an ideal and realistic caseload (See Figure 20). Eight participants did not respond to this question.

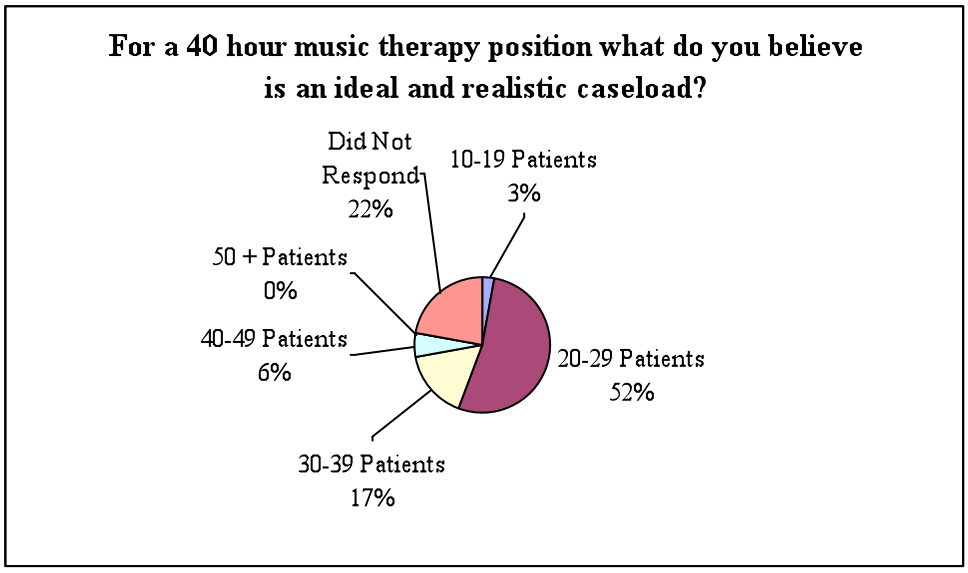

Figure 20. Ideal and Realistic Caseload.

Funding

What Kind of Organization Do You Work For?

The majority (n = 21, 58%) of the participants reported working for non-profit hospice programs (See Figure 21). Seven (19%) of participants reported working for for-profit organizations. Eight participants did not respond to this question.

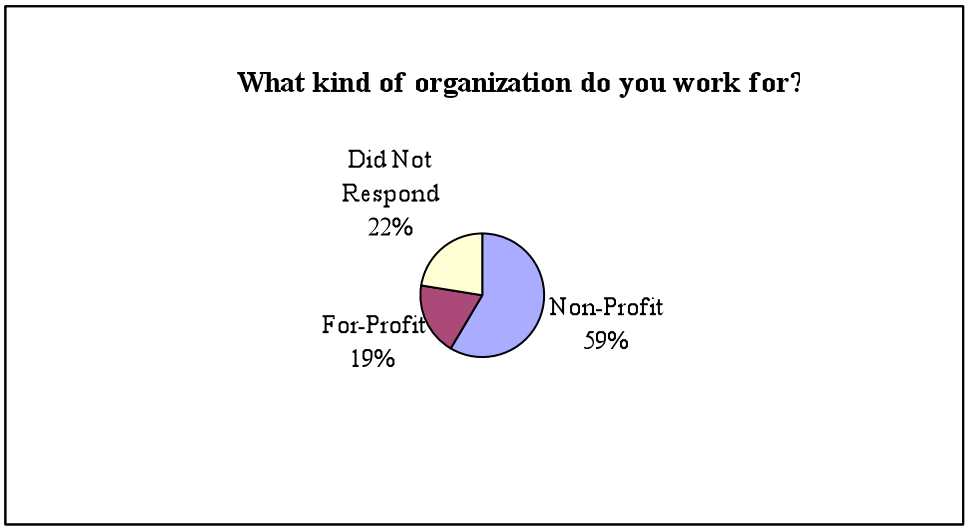

Figure 21. Kind of Organization.

Funding for Traditional Hospice Services (Medical Director, Nursing, Chaplaincy, Home Health Aid, Volunteer, Social Worker, and Bereavement Counselor) Comes From (Choose All That Apply)

Three-quarters of the participants (n = 27, 75%) reported that funding for traditional hospice services (medical director, nursing, chaplaincy, home health aid, volunteer, social worker, and bereavement counselor) comes from the hospice per diem rate (Medicare, Medicaid, private insurance, or private pay) (See Figure 22). Additional funding sources identified for traditional hospice services included philanthropic or family donations (n = 12, 33%), private or public foundations (n = 10, 28%), fundraising (n = 9, 25%), grants (state, federal, internal, foundation, or corporation) (n = 8, 22%), endowments (n = 3, 8%), fee for service/contractual (n = 2, 6%), do not know (n = 2, 6%), or Other (n = 2, 6%) (See Figure 22). One participant clarified that their foundation is designed to manage donations. Eight participants did not respond to this question.

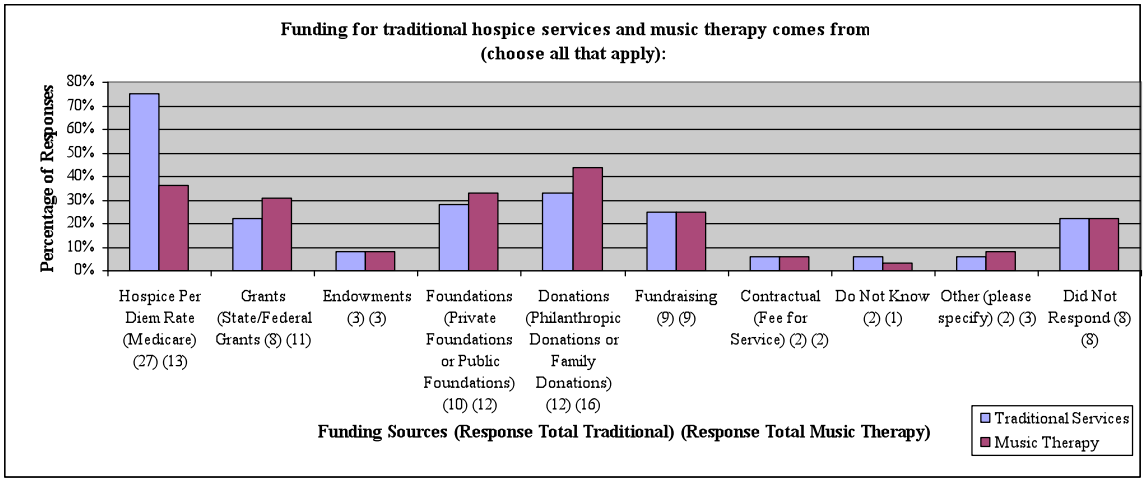

Figure 22. Funding Sources for Traditional Hospice Services and Music Therapy Services.

Funding for Music Therapy Services Comes From (Choose All That Apply)

Philanthropic or family donations (n = 16, 44%) was the most frequently identified funding source for music therapy services (See Figure 22). Additional funding sources for music therapy services included the hospice per diem rate (Medicare, Medicaid, private insurance, or private pay) (n = 13, 36%), private or public foundations (n = 12, 33%), grants (state, federal, internal, foundation, or corporation) (n = 11, 31%), fundraising (n = 9, 25%), endowments (n = 3, 8%), Other (n = 3, 8%), fee for service/contractual (n = 2, 6%), do not know (n = 1, 3%) (See Figure 22). In the "other" category, one participant stated that the hospice organization funded music therapy; one participant stated that their hospice program has elected to place the music therapy funding cost in the operating budget every year, and one participant stated that they were unaware whether other sources of funding are utilized. One participant stated "with funding the way it is (based on donations) it is difficult for the organization to set criteria

for when to hire another music therapist. Census drives other hires." Eight participants did not respond to this question.

From the results of this survey there does appear to be a difference in predominant funding sources for traditional hospice services (medical director, nursing, chaplaincy, home health aid, volunteer, social worker, and bereavement counselor) and the ways that music therapy services are funded. Three-quarters of the participants stated that traditional hospice services are funded through the hospice per diem rate (n = 27, 75%) while slightly more than a third (n = 13, 36%) of the participants identified the hospice per diem rate as a funding source for music therapy services (See Figure 22). In addition, outside sources such as donations, foundations, and grants were identified more frequently as a funding source for music therapy services than traditional hospice services (n = 16, 44% music therapy for donations: n = 12, 33% traditional hospice services for donations; n = 12, 33% music therapy for foundations: n = 10, 28% traditional hospice services for foundations; n = 11, 31% music therapy for grants: n = 8, 22% traditional hospice services for grants) (See Figure 22). Responses were similar between endowments, fundraising, fee for services, and do not know responses between music therapy and traditional services.

If Music Therapy Funding Comes From Grants, Endowments, Foundations, or Marketing, Approximately What Percentage of Costs are Covered Through These Sources?

Ten (28%) participants did not know what percentage of music therapy funding comes from grants, endowments, foundations, or marketing (See Figure 23). Seven (19%) of the participants reported receiving 75-100% of their funding from grants,

endowments, foundations, or marketing, 4 participants (11%) reported that this was not applicable, 2 participants (6%) reported receiving less than 24% of funding through these sources, and 1 (3%) reported receiving 50-74% of funding through these sources (See Figure 23). Twelve participants did not respond to this question.

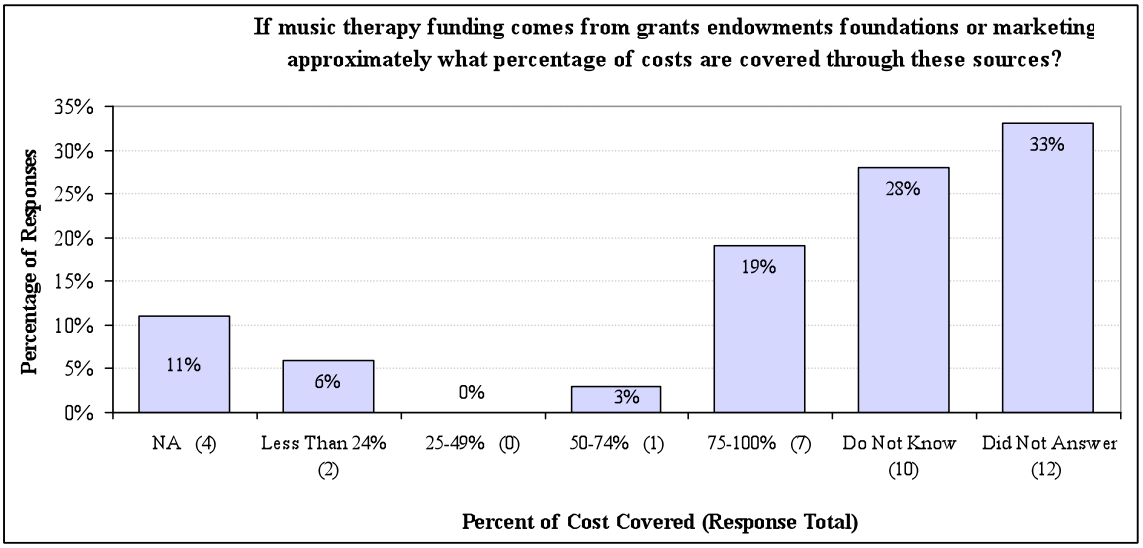

Figure 23. Percentage of Music Therapy Funding from Grants, Endowments, Foundations, or Marketing.

How Much Were You Allocated for Start Up Costs for Your Program?

Nine (25%) participants did not know how much they were allocated for start up costs for their programs (See Figure 24). Eight (22%) participants reported receiving less than $499, 6 (17%) reported receiving $1,000-1,499, 2 (6%) reported receiving more than $2000 or $500-999, and 1 (3%) reported receiving $1,500-1,999 (See Figure 24). Eight participants did not respond to this question.

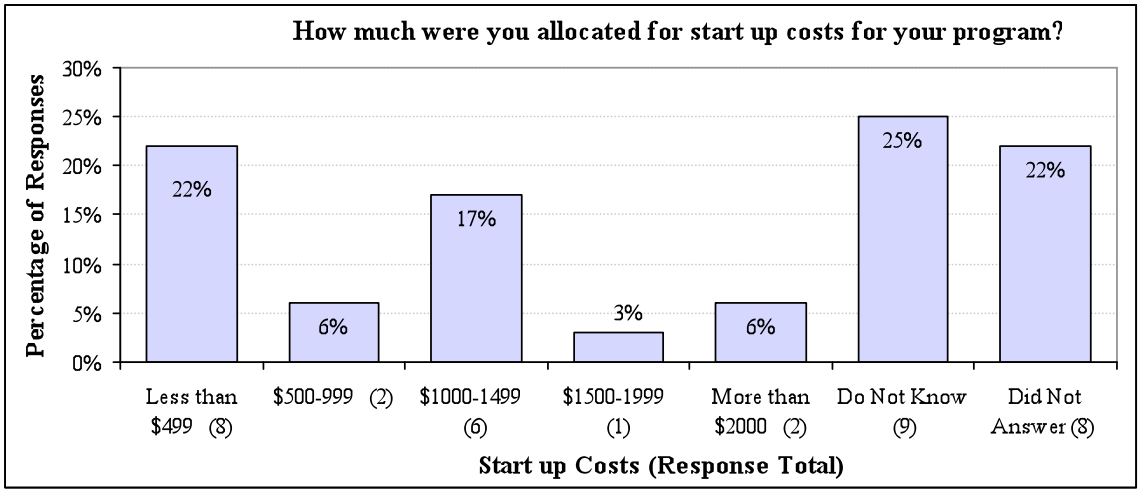

Figure 24. Start Up Funding.

How Much Are You Allocated Annually for Maintenance, Replacement, and Additions to Resources?

One third (n = 12, 33%) of participants reported that they are approved by individual expense annually for maintenance, replacement, and additions to resources (See Figure 25). Remaining participants responded with Other (n = 5, 14%), $1,000-1,499 (4, 11%), $100-499 or less than $99 (n = 3, 8%), and $500-999 or as much as needed (n = 1, 3%) (See Figure 25). In the "other" category, one participant reported that the supervisor of expressive therapies directs these issues; one participant reported that they have no set budget, but have a visa account to purchase needed equipment, music, etc.; one participant reported that they build these expenses into fees as a contractor as they do for many expenses; one participant reported that they receive $100 for education for each music therapist, can perform repairs as needed, have a wish list for needs, and can use donated money for needs as well; and one participant reported that they were unsure. Eight participants did not respond to this question.

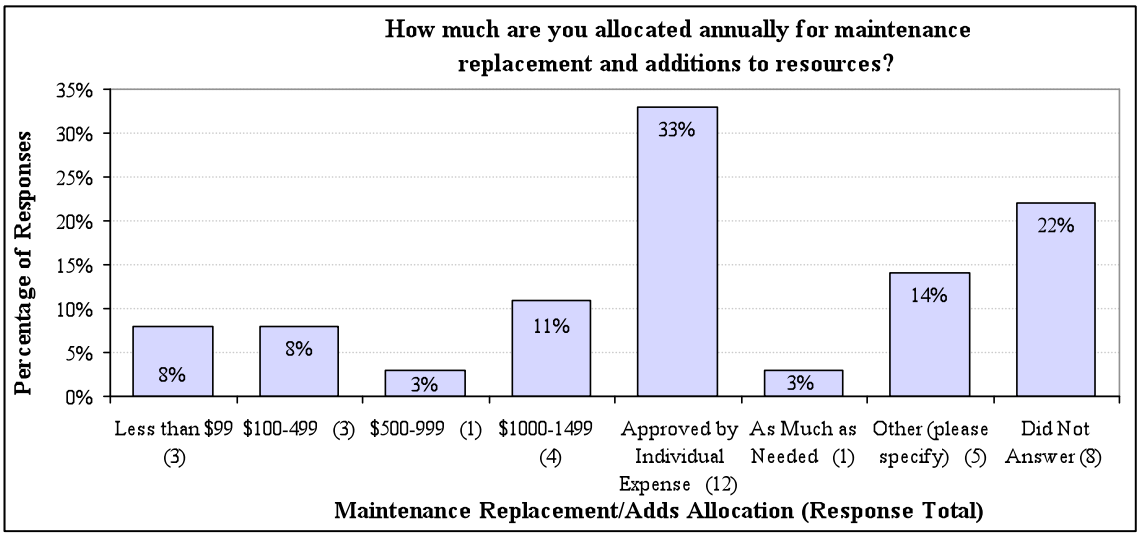

Figure 25. Annual Allocations for Maintenance, Replacement, and Additions to Resources.

Do You Receive Monetary Donations for Music Therapy Services?

Sixteen (44%) participants reported that they receive monetary donations for music therapy services (See Figure 26). Six (17%) participants reported that they do not receive monetary donations for music therapy services and 6 (17%) did not know (See Figure 26). When asked to identify how much they receive annually in monetary donations many participants reported that they were not sure of the amount as they do not always flow through them. Specific amounts given for annual monetary donations for music therapy services included $1,000-1,500, $1,800, between $300-$3,000, and approximately $2,565. Eight participants did not respond to this question.

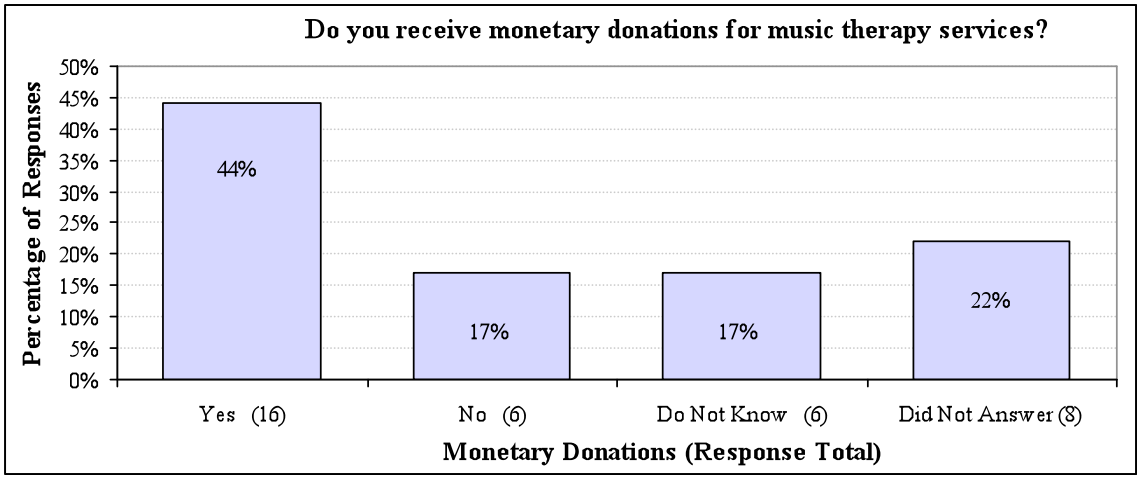

Figure 26. Monetary Donations for Music Therapy Services.

Do You Believe That it is Important for Music Therapists to Understand the Funding Process for Music Therapy in Hospice Programs? Why or Why Not?

Of the participants that answered this question, all (n = 28, 100%) stated that they believe it is important for music therapists to understand the funding process for music therapy in hospice programs. Eight participants did not respond to this question. Table 4 lists reasons given by participants.

Do you believe that it is important for music therapists to understand the funding process for music therapy in hospice programs?	
Response	**Why or why not?**
Yes	It is important for music therapists to understand funding to expand existing programs and create new programs.
Yes	It is required to have an understanding in order to raise the awareness of patients and/or their families that the music therapy services are available only through contributions to our foundation.
Yes	Because it is often not part of per-diem reimbursements and at our organization. It can be periodically under private insurances.
Yes	Our jobs depend upon it. I believe we need to embrace the extent to which we function as PR and a marketing tool for our agencies and use it to grow our programs, and hence our services.
Yes	Absolutely! Music, like it or not, is a business. Caring for those at end of life, like it or not, is a business. It has to keep running in order for us to serve the people we do in this important and sacred work. It is crucial that we understand were every penny comes from that sustains this work. It is crucial that we work with our programs to keep the financial and community support present. This includes working with them on things like fundraising and yes... marketing. I have spoken to too many music therapists in many populations who don't know where their funding is coming from and that is a mistake. It is also of vital importance that we understand the impact of larger forces, such as government and politics, on our programs. In this current political climate of "lower taxes" and "Medicare reform", we need to also be vigilant against those who would cut basic Medicare services, which could eventually shove us out of our roles because foundation funds will need to be spent to have enough nursing visits. Let's hope no one lets that happen!
Yes	Will empower MT to know where there job stands. Can allow MT's to be active in fundraising process; taking pride and ownership and sharing education with community and staff of role of music therapy process in Hospice setting.
Yes	To promote it and to meet with the funding group personally to provide cases of impact directly from music therapy
Yes	You cannot make a case for increasing the number of music therapists employed by the hospice if you do not understand how MT is funded.
Yes	In order to inform other music therapists so that MT in hospice can continue to grow
Yes	We need to be aware of the various existing funding sources in order to create and maintain jobs.
Yes	Enables the MT to speak to leadership using the same language, and enables MT to better understand financial concerns of agency.
Yes	In order to collect the correct data to support future funding.
Yes	Funding is an issue for every position in hospice. Music therapists must show they are an active part of the team by helping secure funds and show an interest in budget needs. Hospice work is team work and funding is no exception.
Yes	To better support how a MT program can be funded, to get additional staff, to be better integrated into the business aspect of the hospice
Yes	Yes! We need to know what to tell administrators who want to fund MT. Also, we need to know so that we can lobby for more MT in a realistic and educated way.
Yes	The better informed music therapists are, the more respected they are to administrators and better able to serve clients.
Yes	To be able to clearly articulate how music therapy is funded to administrators, hospice staff, and any family or referral sources that ask. To be able to approach administrators with professional business proposals for feasibility and implementation of music therapy in their programs
Yes	Need to be able to speak to funding needs, and to competently discuss how MT services positively impact the bottom line of the hospice

Table 4. Importance of Understanding the Funding Process.

Please Feel Free to Add Any Additional Comments About Your Agency's Music Therapy Program That Related to This Survey

Eleven participants responded to this question with various comments. These comments are discussed throughout the results and discussion sections. Twenty-five participants did not respond to this question.

Summary of Survey Responses

Table 5 and Table 6 provide the most frequent responses to survey questions.

Survey Question	Most Frequent Responses	Second Most Frequent Responses
Demographic and Staffing Information		
In what kind of program/facility do you work?	Home Hospice - 28, 78%	Inpatient Hospice - 18, 50%
What is your average daily census?	100-149 - 9, 28%	Less Than 49 - 7, 22%
What type of area(s) does your hospice program serve?	City/Metro – 30, 94%	Small Towns - 22, 69 Country/Rural – 20-63%
What type of location does your hospice program serve?	Nursing Homes - 31, 97% Private Homes - 30-94%	Assisted Living - 29, 91% Hospitals - 23, 72%
How long has music therapy been offered in your program?	1 Year - 8, 26% 2-3 Years 6, 19%	10 + Years - 5, 16%
How many music therapists work for your hospice program?	1 Music Therapist- 12, 38% 2-3 Music Therapists - 11, 34%	4-5 Music Therapists - 8, 25%
What is your employment status?	Full Time - 20, 63%	Part Time - 7, 22%
How many hours per week do you work?	30-40 Hours - 22, 69%	20-29 Hours – 7, 22%
Do you have a music therapy internship program?	No - 26, 81%	Yes - 6, 19%
If yes, how many music therapy interns do you have at a time?	2-3 Music Therapy Interns - 3, 38%	1 Music Therapy Intern - 1,38%
Services Provided and Session Information		
What is the average caseload that you carry?	30-39 Patients - 10, 35%	20-29 Patients -7, 24%
What is the average frequency of visits?	Bimonthly - 16, 55%	Weekly -11,38%
What is your typical session length?	45-59 Min - 16, 55%	30-44 Min - 6, 21%
Is there a waiting list for music therapy services?	No - 18, 62%	Yes - 11, 38%
Do you feel that you are able to meet the music therapy needs of patients and families with your current staffing?	No - 18, 62%	Yes - 11, 38%
For a 40 hour music therapy position, what do you believe is an ideal and realistic (able to build a strong therapeutic relationship with patients while meeting budgetary needs) frequency of visits?	Weekly - 12, 43%	Bimonthly – 12, 43%
For a 40 hour music therapy position, what do you believe is an ideal and realistic (able to build a strong therapeutic relationship with patients while meeting budgetary needs) caseload?	20-29 Patients - 19, 68%	30-39 Patients - 6, 21%

Table 5. Summary of Survey Responses. Part A.

Survey Question	Most Frequent Responses	Second Most Frequent Responses
Funding		
What kind of organization do you work for?	Non-Profit - 21, 75%	For-Profit - 7, 25%
Funding for traditional hospice services (medical director, nursing, chaplaincy, home health aid, volunteer, social worker, and bereavement counselor) comes from (choose all that apply):	Hospice Per Diem Rate - 27, 96%	Donations – 12, 43%
Funding for music therapy comes from (choose all that apply):	Donations - 16, 57%	Hospice Per Diem Rate - 13, 46%
If music therapy funding comes from grants, endowments, foundations, or marketing, approximately what percentage of costs are covered through these sources?	Do Not Know - 10, 42%	75-100% - 7, 29%
How much were you allocated for start up costs for your program?	Do Not Know - 9, 32%	Less Than $499 - 8, 29% $1,000-1,499 - 6, 21%
How much are you allocated annually for maintenance, replacements, and additions to resources?	Approved by Individual Expense - 12, 43%	Other - 5, 18%
Do you receive monetary donations for music therapy services? If so, typically how much per year?	Yes - 16, 57%	$1,000-1,500, $1,800, $300-3,000, $2,565
Do you believe that it is important for music therapists to understand the funding process for music therapy in hospice programs?	Yes - 18, 100%	

Table 6. Summary of Survey Responses. Part B.

CHAPTER V

DISCUSSION AND SUMMARY

Limitations

Forty-eight or 59% of the 81 music therapists with valid email addresses that were invited to participate in this study responded to the survey. While using an online survey provided many with added speed, efficiency, and convenience of survey completion, some respondents may have been hesitant to complete the survey due to lack of familiarity with this method of survey completion or may not have checked their email, resulting in missing the date of completion deadline. Using an online survey also excluded music therapists who do not have a working email address or computer access. Five of the surveys sent were returned due to invalid email addresses. These potential participants were dropped from the study rather than sent paper surveys, which resulted in some music therapists who work in hospice programs in the Great Lakes Region being excluded from the study.

In addition, there was potential to inadvertently exclude some music therapists due to the many steps necessary to identify music therapists who work in hospice programs. Multiple sources were utilized to identify participants to attempt to decrease this risk. Twelve participants responded who did not qualify for the study. As such, it is clear that not all sources for identifying music therapists accurately identified music therapists currently working with this population. Some of this inaccuracy was expected due to the inclusion of the AMTA Sourcebook listing for music therapists who work with the terminally ill rather than hospice specific listings. Since there is no centralized listing

of all music therapists who currently work in hospice programs, the actual number of music therapists who work in this population is unknown. The author was made aware of new positions that were filled for music therapists in hospice programs in the Great Lakes Region during the course of the study. These music therapists did not have the opportunity to participate in this particular study.

Due to the difficulties encountered in accurately identifying music therapists who currently were employed full-time, part-time, or contractually by a hospice program there is uncertainty regarding significance of response rate. Twelve music therapists responded that they did not work in hospice programs at this time. It is possible that additional music therapists who were contacted with the letter of invitation to participate in this study also did not work in hospice programs and therefore did not respond to the survey. However, it is also possible that all remaining non-responding participants did qualify for the study and simply did not choose to participate. Therefore, it is difficult to know if those responding to the survey provide an accurate representation of music therapists currently in hospice programs in the Great Lakes Region.

Many participants did not respond to all questions throughout the survey. All participants answered the first question regarding kind of program/facility. Most questions pertaining to demographic and staffing information were not answered by 4-5 participants, 7-8 participants did not respond to questions pertaining to services provided and session information, and 8 participants did not respond to questions pertaining to funding. Twelve participants did not respond to one more specific question about funding sources. Having the option to skip questions throughout the survey is a requirement of the HSIRB. However, not having questions answered with such a small number of

participants resulted in significant limitations in data analysis. Questions in each subsequent section of the survey became more specific and required increased awareness of the music therapy program. It is possible that more participants simply skipped the funding section of the survey since they did not know information about funding for their program. It is also possible that 26 questions were too many for participants to maintain focus and attending for such a specific survey.

Statistical analysis was not completed due to the low number of responses within each category of questions. Five responses were required in each category to complete statistical analysis successfully. Combining categories would have resulted in increased numbers of responses in each category. However, with the topics addressed in this survey combining categories would not have provided the most useful information. In fact, as addressed later in the discussion, increasing the number of categories, specifically providing individual responses rather than ranges for response groups (i.e. 2 music therapists, 3 music therapists rather than 2-3 music therapists), would have made the descriptive analysis more accurate and easier to compile. To increase the number of responses in each category allowing for statistical analysis it is recommended that this survey be replicated, with the modifications found throughout the discussion, on a national level. In addition, greater generalizability would be achieved if staffing and service trends were compared between different locations of service (private homes, nursing homes, assisted living, hospitals, etc.).

Summary of Research Question Findings

1. What are the Funding Sources for Music Therapy Services and Are They Different From Funding Sources for Traditional Services in Hospice Programs (Medical Director, Nursing, Chaplaincy, Home Health Aid, Volunteer, Social Worker, and Bereavement Counselor)?

There appears to be a difference in predominant funding sources for traditional hospice services and the ways that music therapy services are funded. Three-quarters of the participants (n = 27, 75%) stated that traditional hospice services are funded through the hospice per diem rate while slightly more than a third of the participants (n = 13, 36%) identified the hospice per diem rate as a funding source for music therapy services (See Figure 22). Outside sources such as donations, foundations, and grants were identified more frequently as a funding source for music therapy services than traditional hospice services (n = 16, 44% music therapy for donations: n = 12, 33% traditional hospice services for donations; n = 12, 33% music therapy for foundations: n = 10, 28% traditional hospice services for foundations; n = 11, 31% music therapy for grants: n = 8, 22% traditional services for grants) (See Figure 22). Responses were similar between endowments, fundraising, fee for services, and do not know between music therapy and traditional services.

As noted in the Literature Review, AMTA states that "understanding the basics about reimbursement is essential regardless of the employment setting and situation" (p. 216). All participants agreed to this statement. Table 4 lists reasons participants felt it was important to understand the funding process. Frequent themes listed include creating and expanding music therapy programs, importance of family and community donations, music therapy's impact on marketing, communicating to leadership in the same language,

and awareness of financial concerns of the program as a whole. It appears as though more participants are concerned with expanding existing programs then developing new ones. Three participants made comments regarding importance of understanding the funding process to create new programs; six participants commented on expanding programs; and nine participants commented on financial responsibility, awareness, and/or fundraising.

In the 2005 American Music Therapy Association (AMTA) Sourcebook, 9% of respondents stated that they did not know how their positions were funded. Only 2 participants (6%) were unaware of funding sources for traditional hospice services and only 1 participant (3%) was unaware of funding sources for music therapy services. The higher percentage of music therapists in hospice programs who are aware of funding sources is encouraging. Krout (2004), Hilliard (2004a), Starr (1999), and O'Callaghan (1989) found that a major limitation to employing music therapists from an administrative perspective was uncertainty of funding sources. Since music therapists who currently work in hospice programs are generally aware of funding sources, they may be able to identify possible funding sources for others who wish to initiate music therapy services in hospice programs.

Nine (25%) participants did not know how much money had been allocated for start up costs for their music therapy program (See Figure 24). It is possible that music therapists responding to this survey were employed after the music therapy program was established. If other music therapists are to develop new programs in hospice agencies it would be helpful to understand what is considered a reasonable amount of money to request to adequately initiate music therapy services. One-third of the participants

(n = 12, 33%) stated that they were approved by individual expense for resources (See Figure 25).

2. Does Number of Music Therapists Influence Service Trends (Caseload, Frequency, and Length of Sessions) in Hospice Programs?

The data show no apparent trends between the number of music therapists and average caseload, average frequency of visits, or typical session length. This finding is somewhat unexpected. The author anticipated that if there were more music therapists in each program that there would be lower caseloads, higher frequency of sessions, and longer sessions. From this data it appears as though Average Daily Census (ADC) is a more influential factor for service trends. One participant reported struggling to meet all referral requests as a large hospice with an ADC of over 1,000 and only five music therapists. Additional issues relating to service trends will be addressed in the following section.

One participant reported having 2-3 music therapists at their program, although the full time employees equal less than two. The issue of full time employees and ranges given in response groups for number of music therapists presented a challenge for determining exactly how many hours of music therapy were provided for each program. The author compensated for this by compiling the total music therapy hours worked data in Figure 16.

To determine trends between comparable programs in future surveys asking separate questions regarding the number of full time employees and the number of total music therapy hours provided, the average number of hours per month each patient receives music therapy services, and identifying full-time employment as 33-40 hours per

week would be helpful. Additionally providing single numbers rather than ranges for response groups would identify more subtle differences between programs and make data analysis easier.

3. Does Full-Time, Part-Time, or Contractual Status of Music Therapists Influence Service Trends (Caseload, Frequency, and Length of Sessions) in Hospice Programs?

There appears to be a slight difference in average caseload in relation to employment status with contractual employees carrying smaller caseloads, and full-time employees carry larger caseloads (See Table 1). Two contractual employees reported working less than 9 hours, one reported working 10-19 hours, one reported working 20-29 hours, and one reported working 30-40 hours. Contractual employees typically worked fewer hours and may have had proportionally lower caseloads to match the hours worked.

No trends were apparent in relation to average frequency of visits or typical session length and employment status. The lack of observed trends in relation to frequency and length of sessions may be related to the diversity of type of program participants work in. Participants worked in a comparable mix of home hospice (n = 28, 78%) and inpatient hospice (n = 18, 50%) (See Figure 1). It would be interesting to examine staffing and services trends in relation to type of hospice program. It is anticipated that there would be differences in service trends between the two program types.

Two participants commented on the challenges associated with contractual employment. One participant reported being contracted 2 days a week for a hospice program and not having designated time to develop in-house resources or to complete

work in the office. Another participant reported that it would be preferable to be on staff part-time instead of contractually and noted that there are pitfalls for the hospice program to have them as a contractor. Unfortunately, the participant did not elaborate on this but did mention that they are approaching management on this issue.

Frequency

While AMTA standards of practice do exist for music therapy services, there are no nationally recognized official standards for caseload and frequency of music therapy services in hospice care. These standards do exist for other disciplines providing hospice care. Almost half (n = 16, 44%) of the participants reported an average frequency of visits of bimonthly and four (11%) reported an average frequency of visits of monthly. In 2004, the national average length of stay on hospice was 53.1 days and the median length of stay was 19 days (National Hospice and Palliative Care Organization, 2005). If patients are only seen two times per month and most patients are only on hospice for one to two months, music therapy cannot be utilized to its fullest potential. Twelve participants (33%) each were split between weekly and bimonthly visits as the ideal and realistic frequency of visits (able to build a strong therapeutic relationship with patients while meeting budgetary needs) (See Figure 19). Many participants who selected bimonthly visits also commented that additional PRN visits were necessary to meet patient needs. Given current average and median length of stay data, this frequency of visits appears warranted.

The Literature Review has noted that music therapists can provide a valuable and active role in pain and symptom management; structuring interaction; and increasing

physical, emotional, and spiritual comfort of patients and families (Bailey, 1986; Krout, 2003; Lane, 1992; Magill-Levreault, 1993; O'Callaghan, 1996a; Standley, 1996). Music therapists can help facilitate the validation, identification, normalization, and expression of feelings during sessions with imminently dying patients and families (Krout). Music therapists are also able to facilitate the above objectives with patients that begin, or are in, the actively dying phase shortly after admission to a hospice program. However, music therapy "implies a process oriented relationship between patient and therapist that may take time to develop" (Bailey as cited by Krout, 2000, 45).

If patients can be admitted months rather than weeks before their death, and music therapy is initiated earlier and sessions occur more frequently, a much greater range of benefits may be reached. When music therapy is initiated earlier in a patient's prognosis, the music therapist can establish a stronger relationship with the patient and family, more effectively structure communication and interaction, gain adequate time for the completion of reminiscence and life review, process issues associated with death and dying, create musical legacies and other special projects, provide additional emotional and spiritual support, increase physical and emotional comfort, improve quality of life, and provide a greater level of peace and preparation for the final stages of life (Gallagher & Steele, 2001; Hilliard, 2003a; Krout, 2000; Trauger-Querry & Haghighi, 1999). The above-mentioned benefits could be utilized as a strong marketing tool for encouraging admission to hospice sooner, which may result in increased quality of care for patients and families and increases in the average daily census.

Session Length

Sixteen participants (44%) reported that their typical session length is 45-59 minutes and 4 (11%) reported a typical session length of 60-89 minutes (See Figure 13). Hilliard (2004b) found an average length of music therapy visits for participants in nursing homes was 36.76 minutes. It is possible that this increase in session length is due to an increase in homecare and inpatient music therapy visits by participants. It would be interesting to compare service trends (caseload, frequency, and session length) between nursing homes, assisted livings, private homes, and inpatient settings. According to the Conditions of Participation by the Centers for Medicare and Medicaid Services (CMS) hospice patients in nursing homes and homecare settings are required to receive equal treatment in terms of average frequency and length of visits (L. Abicht-Swensen, personal communication, February 27, 2006). Average frequency and length of visits in different settings may be an area requiring increased awareness for music therapists to meet regulatory standards. Replication of studies examining service trends may be helpful in verifying these trends and in establishing appropriate caseloads.

Caseload

More than half of the participants (n = 19, 53%) stated that they believed 20-29 patients was the ideal and realistic (able to build a strong therapeutic relationship with patients while meeting budgetary needs) caseload for a 40 hour music therapy position (See Figure 20). For music therapists to have the ability to see patients bimonthly plus PRN, or weekly; and to attend family care conferences, rounds, and team meetings, 20-29 patients appears to be a realistic caseload. As identified by many participants, additional

factors in determining caseload include the location of patients, patient needs, and service area. If many patients are routinely in the same facility or in close proximity, higher caseloads may be acceptable. If there are more patients residing in separate locations or the service area is extensive, smaller caseloads may be necessary.

Staffing Standards

Half of the participants (n = 18, 50%) reported that they did not feel they were able to meet the music therapy needs of patients and families with their current staffing (See Figure 18) and 11 (31%) participants reported that there is a waiting list for music therapy services (See Figure 17). Music therapists with waiting lists have stated during conferences and support groups that many patients die before they are able to be moved to the active patient list. If referral sources and the community find that music therapy services are offered but not provided after referrals are made, a significant negative effect on referrals may occur.

4. Does Size of the Hospice Program Influence Staffing Trends (Number of Music Therapists and Employment Status) and Service Trends (Caseload, Frequency, and Length of Sessions) in Hospice Programs?

Size of hospice program appears to influence staffing trends. The number of music therapists in each program typically increases as the ADC increases (See Figures 14 and 15). Hospice programs with an ADC of less than 99 were more likely to have only one music therapist (See Figure 14). The only hospice program identified that employed 6-7 music therapists had an ADC of over 351 (See Figure 14). Contractual music therapists were only utilized in hospice programs with an ADC of less than 99 (See

Figure 15). Hospice programs with an ADC of greater than 100 employed more full-time than part-time music therapists (See Figure 15). Eight participants reported that their hospice programs, with an ADC over 100, had 4-5 full-time music therapists (See Figure 14). There is a trend for total music therapy hours worked to increase as ADC increases (See Figure 16). The average total music therapy hours worked was determined by taking the average of the range of number of music therapists identified by each participant multiplied by the average of the range of hours worked.

Size of hospice program also appears to influence service trends. Music therapists in hospice programs with an ADC of less than 99 appear to have lower caseloads and higher frequency of visits (See Table 2). Music therapists in hospice programs with a larger ADC tend to have bimonthly visits (See Table 2). There was no observed trend for length of session compared to ADC.

The literature suggests that larger (ADC of 100 or more), financially well-managed hospice programs are more likely to be able to afford music therapy (Hilliard 2004a; Hilliard, 2005). Two participants (6%) reported providing music therapy services for hospice programs with an ADC of 50-99 and 7 participants (19%) reported providing music therapy services for hospice programs with an ADC of less than 49 (See Figure 2). In addition, 2 participants (6%) reported having 2-3 music therapists at their hospice program with an ADC of 50-99 (See Figure 14). While it may be easier for programs with an ADC of over 100 to fund music therapy services, the preceding data demonstrates that such a high ADC is not required. Financial stability, philosophy and mission of the hospice program, and desire to incorporate innovative, holistic, and

complimentary approaches may play an important role in willingness to incorporate music therapy into hospice programs.

5. Does Location of the Hospice Program (Country/Rural, Small Towns, City/Metro) Influence Staffing Trends (Number of Music Therapists and Employment Status) and Service Trends (Caseload, Frequency, and Length of Sessions) in Hospice Programs?

The author was unable to address this question as over half of the participants reported working in all three service areas and no participants identified working in only one service area. It is impossible to identify distinct service trends for country/rural, small towns, and city/metro areas in this study due to overlap in service areas. Such a result was not anticipated. This survey demonstrates that hospice programs in the Great Lakes Region are doing well at serving historically underserved small towns and rural/country areas.

Implications and Recommendations

Marketing Edge

Hilliard (2004a) found that the number of hospice programs currently employing music therapists has increased from 6% in 1995 to 10% in 2001. There are several implications to this small increase in number of programs utilizing music therapy. Previously the inclusion of music therapy could provide a marketing edge over other programs that did not offer music therapy (Hilliard, 2005). If more programs have music therapy, hospice programs without music therapy may be viewed as inferior to programs that do. The mere inclusion of music therapy as an available service may not provide a significant enough marketing edge over other programs. Hospice programs that employ

music therapists with more specialized training in hospice, end of life issues, and appropriate advanced interventions; time, resources, knowledge, and technology to provide more comprehensive and advanced interventions; and the ability to provide music therapy services as frequently as needed or desired will provide the new marketing edge.

In-services and presentations on the benefits of music therapy to hospice staff, referral sources, and the community may demonstrate that the hospice program is on the cutting edge of excellence in service and provide much needed service differentiation (Orzechowski, 1996). Topics for in-services and presentations could include music therapy techniques, mechanisms of music therapy, interventions, benefits of initiating hospice services sooner, and goals that can be achieved (Gallagher & Steele, 2001; Hilliard, 2003a; Krout, 2000; Trauger-Querry & Haghighi, 1999). In addition, music therapists could address the ability of music therapy to enhance the effectiveness of pain medications, decrease the amount of pain medication necessary, decrease costs, enhance the effectiveness of other treatment modalities, make the work of other members of the treatment team easier, enhance quality of care, increase quality of life, decrease tendency to overuse or strain services, and decrease costs (Bailey, 1986; Birk, McGrady, MacArthur, & Khuder, 2000; Krout, 2003; Lane, 1992; Magill-Levreault, 1993; Milton, 1998; O'Callaghan, 1996a; Ohlsen Read, 2000; Standley, 1996). As addressed in the Literature Review, incorporation of music therapy services may result in increased satisfaction with overall hospice services (Demmer and Sauer, 2002). Satisfaction with services is crucial to continue and increase referrals, and improve and maintain program reputation (Orzechowski, 1996).

Internship Programs

Very few hospice programs reported having internship programs (n = 6, 17%) (See Figure 9). There are multiple reasons to increase the number of hospice music therapy internship programs. As addressed in the Literature Review, music therapists working in hospice care are faced with many unique issues and challenges (Aldridge, 1995; Gilbert, 1977; Hilliard, 2004a; Martin, 1989a; O'Callaghan, 1989; Porchet-Munro, 1993). These issues are best addressed through a combination of text learning, observation, and clinical supervision that can only be achieved when working directly with music therapists in hospice programs.

Hilliard (2004a) found that hospice administrator's awareness of music therapy has increased from 88% to 95% between 1995 and 2001, and that 39% of administrators would like to employ music therapists and 47% are uncertain. One limitation identified to hiring music therapists was no available music therapist. Hilliard found that several administrators tried to employ a music therapist but that the music therapists hired were not clinically trained in end-of-life care. Given the sensitive nature of care provided in hospice programs it is more than reasonable that administrators should have access to employees who are professionals trained in hospice and palliative care. This training cannot occur if training sites do not exist.

Hospice programs with internship programs also provide benefits in staffing and volunteer hours. Training and supervising music therapy interns initially takes time from staff music therapists. However, as interns become more advanced they are able to carry a caseload and decrease demands on staff music therapists. Music therapy interns are required to complete 1,040 hours in the internship. Once the volunteer training is

completed, these hours can be counted towards the hospice programs federally required volunteer hours.

Coordination of Hospice Music Therapists

This survey demonstrates that music therapy is being utilized in hospice programs in the Great Lakes Region. A major challenge to the advancement of knowledge and literature in hospice programs is difficulty identifying hospice programs that have music therapy and the music therapists within these programs. The National Hospice and Palliative Care Organization does not distribute names and contact information of those in its membership. The American Music Therapy Association does not have an accurate listing of those that work in hospice programs. If music therapists who work in hospice programs were to organize themselves in a more public manner and coordinate communication and education about programs, research, and services, they might be able to make more rapid advancements in acceptance, education, and efficacy of music therapy in hospice programs.

Since there are more hospice administrators that would like to utilize music therapy services than hospice programs that do utilize them, music therapists must mobilize towards increased clinical training, increased education on logistical issues of starting and maintaining music therapy programs in hospice, and increased awareness of the financial viability of music therapy in hospice programs (Hilliard 2004a). To expand music therapy programs several participants noted that music therapists must document the demand for music therapy services and must document the effectiveness of music therapy services. As overall funding decreases and costs increase for hospice care, music

therapy may be cut from the relatively few hospice programs that utilize it if these things are not done. Awareness of financial issues associated with hospice care is essential for survival in today's healthcare environment (Dziwak & Gfeller, 1988).

More studies on efficacy of music therapy in hospice care, cost effectiveness, financial benefits of music therapy in hospice, improvements in staff and caregiver morale, and other benefits of music therapy in hospice must be established. Music therapists in hospice care must share the results of these studies with others to develop a more comprehensive pool of knowledge and research. For music therapy to become more of a standard of care for hospice programs, music therapists must advocate for reimbursement and national recognition of the incorporation and effectiveness of music therapy in hospice, and for appropriate staffing and service standards for music therapy.

Summary

Thirty-six music therapists completed this survey and qualified for the study. Participants included music therapists in the Great Lakes Region who are currently employed full-time, part-time, or contractually by a home hospice agency or hospital with an inpatient hospice unit. Participants were asked to complete a one-time online survey with 26 questions pertaining to basic demographic and staffing information, services provided and session information, and funding.

Results of this survey indicate that there are differences in ways that traditional hospice services and music therapy services are funded, that the number of music therapists does not appear to influence service trends, that employment status appears to

influence service trends, and that size of the hospice program influences staffing and service trends. The author was unable to determine if service area influenced staffing or service trends as there was significant overlap in service areas. It is hoped that this study will clarify financial and logistical issues for initiating and expanding music therapy services within hospice programs.

The typical participant works in a non-profit home hospice program with an ADC of 100-149 serving patients nursing homes, private homes, and assisted living facilities in city/metro, small towns, and country/rural settings. Music therapy has been offered in their program for one year and they are the only music therapist at their program. They work full time, 30-40 hours per week, and do not have an internship program. The typical participant has an average caseload of 30-39 patients which are seen bimonthly for 45-59 minutes a session. There is not a waiting list for music therapy services at their program, but they do not feel they are able to meet the music therapy needs of patients and families with current staffing. The typical participant believes that an average caseload of 20-29 patients and weekly, or bimonthly plus PRN visits is the ideal (able to build a strong therapeutic relationship with patients while meeting budgetary needs). Traditional hospice services are funded through the hospice per diem rate, while music therapy funding comes from donations. The typical participant does not know what percentage of funding comes from which sources or what start up costs were for the music therapy program. Additions, replacements, and maintenance of resources are approved on an individual basis. The typical participant believes that it is important for music therapists to understand the funding process for music therapy in hospice programs (See Table 5 and Table 6).

Recommendations for service standards based on this study for hospice music therapists include an average caseload of 20-29 patients and an average frequency of music therapy visits of weekly, or bimonthly plus PRN. Full-time employment is also recommended to increase the ability to meet patient and family needs and to increase the music therapist's ability to contribute as an active member of the interdisciplinary treatment team. Additional education about end of life care in university training programs needs to be added, and more hospice music therapy internship programs need to be developed to adequately prepare music therapists to meet the demand for music therapy in hospice programs. Replication of this survey on a national level might increase the number of participants responding, and provide a more accurate picture of the funding sources and staffing and services trends for music therapy in hospice programs throughout the country. This is particularly important since there appears to be significant diversity in hospice programs throughout the country.

Additional marketing efforts could be made to emphasize the ability of music therapy to improve quality of life and comfort for patients referred earlier to hospice, which may result in increased quality of services and financial stability of the hospice program. Hospice programs that employ music therapists with more specialized training in hospice, end of life issues, and appropriate advanced interventions; time, resources, knowledge, and technology to provide more comprehensive and advanced interventions; and the ability to provide music therapy services as frequently as needed or desired will provide the new marketing edge. Music therapists who work in hospice programs need to be vigilant about demonstrating demand, benefits, and efficacy of music therapy in hospice programs to expand existing programs. Music therapists who work in hospice

programs also need to organize themselves in a more public manner and coordinate their efforts for education, research, program development, and services in order to make more rapid advancements in acceptance, understanding, and efficacy of music therapy in hospice programs.

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Appendix A

Survey to Music Therapists on Financial Aspects, Staffing and Service Trends of Music Therapy in Hospice Programs

Demographic and Staffing Information
Please select any and all answers that apply for the following questions

1. **In what kind of program/facility do you work?**

   Home Hospice _____ Inpatient Hospice _____ Long Term Care _____
   Only Palliative Care without Hospice Care _____
   Only Oncology without Hospice Care _____
   Other _____

2. **What is your average daily census?**

   <49 _____ 50-99 _____ 100-149 _____ 150-199 _____
   200-249 _____ 250-299 _____ 300-350 _____ >351 _____

3. **What type of area(s) does your hospice program serve?**

   Country/Rural _____ Small Towns _____ City/Metro _____

4. **What type of location(s) does your hospice program serve?**

   Private Homes _____ Nursing Homes _____ Assisted Living Facilities _____
   Residential Hospices _____ Group Homes _____ Foster Care Facilities _____
   Board & Care Facilities _____ Hospitals _____
   Other_____

5. **How long has music therapy been offered in your program?**

   1 year _____ 2-3 years _____ 4-5 years _____
   6-7 years _____ 8-9 years _____ 10+ years _____

6. **How many music therapists work for your hospice program?**

   1 _____ 2-3 _____ 4-5 _____ 6-7 _____ 8-9 _____ 10+ _____

7. **What is your employment status?**

   Contractual _____ Part Time _____ Full Time _____

8. **How many hours per week do you work?**

   9 hours or less _____ 10-19 hours ____ 20-29 hours ____ 30-40 hours _____

9. **Do you have a music therapy internship program?**

   Yes _____ No _____

10. If yes, how many music therapy interns do you have at a time?

1 _____ 2-3 _____ 4-5 _____ Other _____

Services Provided and Session Information

11. What is the average caseload that you carry?

1-9 Patients _____ 10-19 _____ 20-29_____
30-39 _____ 40-49 _____ 50 + _____

12. What is the average frequency of visits?

Weekly _____ Bimonthly _____ Monthly _____ PRN _____ Other _____

13. What is your typical session length?

Less than 29 Minutes _____ 30-44 Minutes _____ 45-59 Minutes _____
60-89 Minutes _____ 90-119 Minutes _____ More than 120 Minutes _____

14. Is there a waiting list for music therapy services?

Yes _____ No _____

15. Do you feel that you are able to meet the music therapy needs of patients and families with your current staffing?

Yes _____ No _____

16. For a 40 hour music therapy position, what do you believe is an ideal and realistic (able to build a strong therapeutic relationship with patients while meeting budgetary needs) frequency of visits?

Weekly _____ Bimonthly _____ Monthly _____ PRN _____ Other _____

17. For a 40 hour music therapy position, what do you believe is an ideal and realistic (able to build a strong therapeutic relationship with patients while meeting budgetary needs) caseload?

10-19 _____ 20-29_____ 30-39 _____ 40-49 _____ 50 + _____

Funding

18. What kind of organization do you work for?

Non-Profit _____ For-Profit _____

19. Funding for traditional hospice services (medical director, nursing, chaplaincy, home health aid, volunteer, social worker, bereavement counselor) comes from (choose all that apply):

Hospice Per Diem Rate (Medicare, Medicaid, Private Insurance, or Private Pay) _____
Grants (State/Federal Grants, Internal Grants, Foundation Grants, Corporation Grants) _____
Endowments _____
Foundations (Private Foundations or Public Foundations) _____
Donations (Philanthropic Donations or Family Donations) _____
Fundraising _____
Contractual (Fee for Service) _____
Other _____
Do Not Know _____

20. Funding for music therapy comes from (choose all that apply):

Hospice Per Diem Rate (Medicare, Medicaid, Private Insurance, or Private Pay) _____
Grants (State/Federal Grants, Internal Grants, Foundation Grants, Corporation Grants) _____
Endowments _____
Foundations (Private Foundations or Public Foundations) _____
Donations (Philanthropic Donations or Family Donations) _____
Fundraising _____
Contractual (Fee for Service) _____
Other _____
Do Not Know _____

21. If music therapy funding comes from grants, endowments, foundations, or marketing, approximately what percentage of costs are covered through these sources?

NA _____ Less Than 24% _____ 25-49% _____
50-74% _____ 75-100% _____ Do Not Know _____

22. How much were you allocated for start up costs for your program?

Less than $499 _____ $500-999 _____ $1000-1499 _____
$1500-1999 _____ More than $2000 _____ Do Not Know _____

23. How much are you allocated annually for maintenance, replacement, and additions to resources?

Less than $99 _____ $100-499 _____ $500-999 _____
$1000-1499 _____ $1500-1999 _____ More than $2000 _____
Do Not Know _____ Approved by Individual Expense _____
As Much as Needed _____
Other _____

24. Do you receive monetary donations for music therapy services?

Yes _____ No _____ Do Not Know _____

If so, typically how much per year? _____

25. Do you believe that it is important for music therapists to understand the funding process for music therapy in hospice programs? Why or why not?

Yes _____ No _____
_____
_____
_____
_____

26. Please feel free to add any additional comments about your agency's music therapy program that relate to this survey.

_____
_____
_____
_____

Thank you for taking the time to complete this survey!

Submitting the survey indicates your consent for use of the answers you supply

SUBMIT

Appendix B

Source of Email Lists for Subject Recruitment

State	AMTA Source-book	State President	State Member-Ship Rep-resentative	State Public Relations Rep-resentative	Hospice Rep-resentative	Hospice Support Group	Consent Given to Use Email Addresses
OH	Yes	+ Lisa Gallagher	+ Lisa Gallagher	+ Lisa Gallagher	+ Lisa Gallagher	No	Yes Consent given by AMTA, individuals, &/or hospice rep-resentative
IL	Yes	+→Leigh Ann Walberg	+→ Patricia Klancy	-Patricia Barret	+ Laura Pawuk + Heather Hodorowski + Kathryn Taylor	Yes	Yes Consent given by AMTA, individuals, &/or hospice rep-resentative
IN	Yes	-Melissa Reinhardt	-Diane Parker	+Ann Hauman +→Deb Cordell (Secretary)	+Ruthann Ritchie	No	Yes Consent given by AMTA and/ or individuals
MN	Yes	Bridget Doak	Sarah MacDonald	Jennie Delisi	+→ David Melbye	Yes	Yes Consent given by AMTA, individuals, &/or hospice rep-resentative
MI	Yes	-Robin Hurt	-Elizabeth Raleigh	+→ Deb Koepele	-Marilyn Largin	No	Yes Consent given by AMTA and/ or individuals
WI	Yes	+→ Kathy Schumacher	+Jill Kiesau	-Jonnie Fogerty	Individual Responses by Multiple Music Therapists	No	Yes Consent given by AMTA and/ or individuals

+ Responded to initial letter of inquiry found in APPENDIX B
- Did not respond to initial letter of inquiry found in APPENDIX B
→ Forwarded inquiry to hospice representative

Appendix C

Initial Letters of Inquiry

To Great Lakes Region Representatives

I am completing a survey on music therapy in hospice in the Great Lakes Region for my masters thesis and am trying to get email addresses for all music therapists who work in this population.

Minnesota has a networking directory which lists contact information for music therapists by population, including hospice. Music therapists working in hospice programs also get together regularly and maintain contact information for those of us working in hospice.

Does your state compile similar networking directories? Do music therapists working in hospice get together in a similar fashion? If so, would it be possible for me to acquire a copy of the directory and/or a list of music therapists working in hospice programs in your state for use in this research? If not, are you aware of any music therapists working in hospice that may have a better idea of others working with this population?

Thank you very much for your assistance.

Sincerely,
Melissa Hirokawa, MT-BC

3100 James Ave S #3
Minneapolis, MN 55408
952-240-6130
melissahirokawa@hotmail.com

To AMTA

To whom it may concern:

I am a graduate student from Western Michigan University. As part of my masters thesis I am conducting a survey on financial aspects, staffing and service trends in hospice programs in the Great Lakes Region. One source I am using to recruit participants is the 2005 Sourcebook. A list of music therapists working with the terminally ill is provided on page 179 of the 2005 Sourcebook. On the sample survey listed on page 218 of the Sourcebook, it appears as though consent is given to distribute email addresses for referral purposes but I do not see specific consent for using email addresses for research purposes. Is consent implied for use of email addresses found in the Sourcebook for this purpose or do I need to acquire it in another fashion? If you could provide guidance on this issue or forward this question on to someone who could answer my questions I would greatly appreciate it.

Sincerely,
Melissa Hirokawa, MT-BC

Appendix D

Letters of Permission

American Music Therapy Association
8455 Colesville Rd., Ste. 1000 • Silver Spring, Maryland 20910
Tel. (301) 589-3300 • Fax (301) 589-5175 • www.musictherapy.org

To: Melissa Hirokawa, Western Michigan University
Fr: Andrea Farbman, Ed.D., AMTA Executive Director
Date: January 11, 2006

Re: Limited approval to use AMTA email listings

Per your request, AMTA grants approval to you for one-time use of the AMTA email listings for a study regarding music therapy in hospice care. This approval is predicated on the fact that your study is under the direction of an AMTA-approved faculty member and that it is subject to review by the university's IRB. If you require additional information, please let me know.

Best wishes for a productive study.

AMTA Executive Director

HOSPICE OF THE TWIN CITIES

January 2, 2006

To whom it may concern:

I write to inform you that I assisted Melissa Hirokawa in the gathering of email addresses for hospice music therapists in Minnesota related to Ms. Hirokawa's pursuit of her thesis. All of the music therapists have granted Ms. Hirokawa permission to contact them with an invitation to participate in her study.

Sincerely,

David Melbye, MT-BC

David Melbye, MT-BC

Hospice of the Twin Cities

10405 6th Avenue North, Suite 250, Plymouth, Minnesota 55441 763-531-2424 Fax 763-531-2422

Ohio Association for Music Therapy

December 20, 2005

Dear Ms. Hirokawa,

Thank you for writing the Ohio Association for Music Therapy (OAMT) for the contact information for our members who work in hospices in Ohio. We are providing you with the information you requested, and you have our permission to contact them to invite them to participate in your survey. We wish you good luck with your project. Please let us know if we can be of any further assistance.

Sincerely,

Lisa M. Gallagher, MA, MT-BC

Lisa M. Gallagher, MA, MT-BC
OAMT President

Illinois

December 19, 2005

Hello Melissa,

I have contacted all the hospice MT's in the greater-Chicago area asking them if they would permit me to give their contact info to you. I explained that you are surveying hospice MT's. No one declined. You have my permission to use their addresses.

If you have any questions, please don't hesitate to contact me.
-Laura Pawuk

Wisconsin, Michigan, and Indiana
Consent given by AMTA or individuals

Appendix E

Letter of Invitation/Consent With HSIRB Stamp

WESTERN MICHIGAN UNIVERSITY
H. S. I. R. B.
Approved for use for one year from this date:

JAN 13 2006

x _____
HSIRB Chair

Western Michigan University, Department of Music
Principle Investigator: Brian Wilson, MM, MT-BC
Student Investigator: Melissa Amy Hirokawa, BA, MT-BC

"A Survey of Financial Aspects, Staffing and Service Trends of Music Therapy in Hospice Programs"

Dear Hospice Colleague,

You are invited to participate in a research project entitled "A Survey of Financial Aspects, Staffing and Service Trends of Music Therapy in Hospice Programs" designed to obtain information on funding for music therapy in hospice programs and identify staffing and service trends for music therapy in hospice programs. This research is being conducted by Brian Wilson, MM, MT-BC and Melissa Hirokawa, BA, MT-BC from Western Michigan University, Department of Music. This study is being conducted as part of the masters thesis requirements for Melissa Hirokawa.

This survey is comprised of 26 multiple choice, yes/no, and brief fill in the blank questions and will take approximately 10-15 minutes to complete. If using the same computer, you can begin the survey and return later to complete it. The inconvenience of completing the survey and disclosure of information on services provided are potential risks. Your replies will be completely anonymous, so do not put your name or identifying information anywhere on the survey. An online survey format has been utilized to increase ease and efficiency of survey completion. Questions relate to demographic and staffing information (such as age of music therapy program, average daily census and number of music therapists in your program); services provided and session information (such as average caseload, frequency of visits, and session length); and funding (such as non-profit or for-profit status, funding sources for basic hospice services, funding sources for music therapy services, start up costs, and annual music therapy budget).

If you no longer work in hospice or work with people who are terminally ill but are not directly employed by a hospice program or hospital with a hospice unit (i.e. you are employed by a nursing home) you may respond to question one only in the survey, or respond to this invitation with "not hospice" in the subject heading. If you choose not to participate in this survey, either do not open the survey or do not click the SUBMIT button. You may choose to not answer any question and simply leave it blank. Submitting the survey indicates your consent for use of the answers you supply.

Completing the survey will not necessarily benefit you personally; however it is hoped that the results of this study will clarify financial and logistical issues of music therapy in hospice programs, and may be useful in future support and development of music therapy within hospice programs.

If you are willing to participate, please click on the link below to access the online survey. You will be asked to click on your responses, and for some questions to type short responses. The survey will be open for response until _____ (2 weeks).

WESTERN MICHIGAN UNIVERSITY
H. S. I. R. B.
Approved for use for one year from this date:

JAN 13 2006

x _____
HSIRB Chair

If you have any questions about this survey or this study in general, please feel free to contact Melissa Hirokawa at (952) 240-6130 or melissahirokawa@hotmail.com, or my faculty advisor Brian Wilson at (269) 387-4724 or brian.wilson@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board (269) 387-8293 or hsirb@wmich.edu, or the Western Michigan University Vice President for Research (269) 387-8298 if you have questions or problems arise during the course of the study.

This study has been reviewed and approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) of Western Michigan University.

Thank you in advance for your time and consideration in this project.

Sincerely,
Melissa Hirokawa, MT-BC

Link to online survey:

Appendix F

Letter of Approval from the Western Michigan University
Human Subjects Institutional Review Board

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: January 13, 2006

To: Brian Wilson, Principal Investigator
Melissa Amy Hirokawa, Student Investigator for thesis

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 05-12-08

This letter will serve as confirmation that your research project entitled "A Survey of Financial Aspects, Staffing, and Service Trends of Music Therapy in Hospice Programs" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: January 13, 2007

Walwood Hall, Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276

Appendix G

Reminder/Thank You Letter

Dear Hospice Colleague,

I would like to thank all of you who have already responded to this invitation. It is hoped that your participation will be valuable in future support and development of music therapy in hospice programs. This survey will be open for response until **Wednesday February 1** (one week later). I have attached the original message bellow.

Link to online survey:

http://www.surveymonkey.com/s.asp?u=515101679404

Thank you for your time and assistance.

Sincerely,
Melissa Amy Hirokawa, MT-BC

Western Michigan University, Department of Music
Principle Investigator: Brian Wilson, MM, MT-BC
Student Investigator: Melissa Amy Hirokawa, BA, MT-BC

"A Survey of Financial Aspects, Staffing and Service Trends of Music Therapy in Hospice Programs"

Dear Hospice Colleague,

You are invited to participate in a research project entitled "A Survey of Financial Aspects, Staffing and Service Trends of Music Therapy in Hospice Programs" designed to obtain information on funding for music therapy in hospice programs and identify staffing and service trends for music therapy in hospice programs. This research is being conducted by Brian Wilson, MM, MT-BC and Melissa Hirokawa, BA, MT-BC from Western Michigan University, Department of Music. This study is being conducted as part of the masters thesis requirements for Melissa Hirokawa.

This survey is comprised of 26 multiple choice, yes/no, and brief fill in the blank questions and will take approximately 10-15 minutes to complete. If using the same computer, you can begin the survey and return later to complete it. The inconvenience of completing the survey and disclosure of information on services provided are potential risks. Your replies will be completely anonymous, so do not put your name or identifying information anywhere on the survey. An online survey format has been utilized to increase ease and efficiency of survey completion. Questions relate to demographic and staffing information (such as age of music therapy program, average daily census and number of music therapists in your program); services provided and session information (such as average caseload, frequency of visits, and session length); and funding (such as non-profit or for-profit status, funding sources for basic hospice services, funding sources for music therapy services, start up costs, and annual music therapy budget).

If you no longer work in hospice or work with people who are terminally ill but are not directly employed by a hospice program or hospital with a hospice unit (i.e. you are employed by a nursing home) you may respond to question one only in the survey, or respond to this invitation with "not hospice" in the subject heading. If you choose not to participate in this survey, either do not open the survey or do not click the SUBMIT button. You may choose to not answer any question and simply leave it blank. Submitting the survey indicates your consent for use of the answers you supply.

Completing the survey will not necessarily benefit you personally; however it is hoped that the results of this study will clarify financial and logistical issues of music therapy in hospice programs, and may be useful in future support and development of music therapy within hospice programs.

If you are willing to participate, please click on the link below to access the online survey. You will be asked to click on your responses, and for some questions to type short responses. **The survey will be open for response until Wednesday February 1 (2 weeks).**

If you have any questions about this survey or this study in general, please feel free to contact Melissa Hirokawa at (952) 240-6130 or melissahirokawa@hotmail.com, or my faculty advisor Brian Wilson at (269) 387-4724 or brian.wilson@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board (269) 387-8293 or hsirb@wmich.edu, or the Western Michigan University Vice President for Research (269) 387-8298 if you have questions or problems arise during the course of the study.

This study has been reviewed and approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) of Western Michigan University.

Thank you in advance for your time and consideration in this project.

Sincerely,
Melissa Hirokawa, MT-BC

Link to online survey:

http://www.surveymonkey.com/s.asp?u=515101679404