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Digital Object Identifier: <https://doi.org/10.13023/etd.2018.314>

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THE EFFECT OF GROUP MUSIC THERAPY ON PATIENT SATISFACTION
IN A BEHAVIORAL HEALTH SETTING

THESIS

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Music in
the College of Fine Arts at the University of Kentucky

By

Madelyn Lindsley LaPrade

Lexington, Kentucky

Director: Dr. Lorna Segall, Professor of Music Therapy

Lexington, Kentucky

2018

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ABSTRACT OF THESIS

THE EFFECT OF GROUP MUSIC THERAPY ON PATIENT SATISFACTION IN A BEHAVIORAL HEALTH SETTING

Patient satisfaction has become increasingly important to medical facilities as a result of reimbursement rates being tied to patient satisfaction scores. Music therapy's potential to enhance patient satisfaction scores has been explored and several studies exist examining its impact in the medical setting. No studies exist, however, examining how music therapy contributes to patient satisfaction scores in the behavioral health setting. Therefore, the purpose of this study was to compare overall patient satisfaction scores of inpatient psychiatric patients who received group music therapy services with those at the same facility who did not receive group music therapy services.

Participants who attended music therapy group ($n=14$) received an anonymous, voluntary survey with 10 questions based on the facility's satisfaction survey and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Participants who did not attend music therapy group ($n=15$) received the same survey.

Results showed that patients who attended music therapy group reported overall satisfaction scores that were on average 3.02 points higher than participants who did not attend music therapy group. Age correlation and gender differences which may affect patient satisfaction scores are described. The implications for future research and current clinical practice are also discussed.

KEYWORDS: Music Therapy, Patient Satisfaction, Behavioral Health

Madelyn L. LaPrade

July 5, 2018

THE EFFECT OF GROUP MUSIC THERAPY ON PATIENT SATISFACTION
IN A BEHAVIORAL HEALTH SETTING

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July 5, 2018

To my family -

Thank you for your unconditional love and support.

ACKNOWLEDGEMENTS

Words cannot express the gratitude I feel towards everyone who has helped me get to this point in my life. I am incredibly thankful for each person who has supported me thus far.

First, to my music therapy classmates: Nora, Laura, Taylor, Marissa, Chris, and Rachel. This journey would not have been the same without all of you. I am often reminded of how fortunate I am to have had the opportunity to work with and learn from such talented, brilliant, and loving people. I am so thankful for our friendships and am so grateful to have you all as a support system.

Next, to my wonderful music therapy professors: Dr. Yinger and Dr. Segall. Thank you, Dr. Yinger, for your support, motivation, and inspiration. Dr. Segall, thank you for always reminding me to believe in myself and for guiding me to see my strengths and potential as a music therapist. I am forever grateful for your reminders to stay positive during stressful moments. Your support for each of your students is incredible and I am so appreciative to have had the opportunity to learn from you.

And finally, to my wonderful family: Mom, Dad, Andrew, and Emily. Without your love and support, daily phone calls and texts, and frequent visits, I truly would not be where I am today. You believed in me even in moments when I didn't believe in myself and your constant encouragement helped me achieve my dream. Thank you for inspiring me to be the best that I can be and for teaching me the value of hard work, dedication, and perseverance.

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CHAPTER ONE

INTRODUCTION

In the past decade, patient satisfaction has become increasingly important due to its direct ties to healthcare reimbursement rates (Geiger, 2012). Federal insurance companies such as Medicare and Medicaid provide reimbursements to hospitals based directly on patient satisfaction scores from standardized surveys such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the Press Ganey Inpatient Survey (PGIS).

Patient satisfaction scores are impacted by overall experience in the hospital, relationships with physicians and staff members, and quality of care. In the healthcare setting, music therapy research has shown to be an effective method of increasing patient satisfaction (Krautz, 2015; Mandel, Davis, & Secic, 2014; Yinger & Standley, 2011). Patients who received music therapy services during their hospital stay reported higher patient satisfaction and were more likely to recommend the healthcare facility to other patients (Mandel et al, 2014; Yinger & Standley, 2011).

Though research involving patient satisfaction within the medical setting exists, the focus is on general hospital settings and does not portray the impact of music therapy services in a behavioral health setting. Because music therapy has shown to be an effective treatment within the behavioral health setting, there is a need for research in the area of patient satisfaction within this setting.

Operational Definitions

Patient Satisfaction describes interactions and experiences that patients have with the healthcare system and indicates the overall performance of the health care facility. Patient

satisfaction evaluates whether or not the patient's health care expectations were met (Agency for Healthcare Research and Quality, 2017; Black & Kowal, 2016).

Medicare “is the federal health insurance program for: people who are 65 or older; certain younger people with disabilities; and people with End-Stage Renal Disease” (Medicare.gov, 2018, para 1).

Medicaid is a health insurance plan that provides coverage to low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is “administered by the states, according to federal requirements” (Medicaid.gov, 2018, para 1).

Patient-centered care is an approach to care that “shift[s] the focus from the specific ailment or disease to a more holistic look at supporting [the patient]” (U.S. Department of Veterans Affairs, 2017, para 1). Patient-centered care focuses the patient's overall experience and on what matters most to each patient personally.

Music therapy is an evidence-based therapeutic approach that uses music to achieve non-musical goals through individualized interventions provided by a board-certified professional. After assessing the client, music therapists provide treatment through musical interventions such as listening to music, creating music, and moving to music. Clients are able to generalize the skills learned in their music therapy treatment process into other areas of their lives. Music serves as a means of communication for individuals who have difficulties communicating or expressing themselves (AMTA, 2018).

Purpose

The primary purpose of this study was to compare overall patient satisfaction scores of inpatient psychiatric patients who received group music therapy services with

those at the same hospital who did not receive group music therapy services. Research questions include:

1. Do music therapy services impact patient satisfaction scores in an inpatient psychiatric hospital?
2. Do patient satisfaction scores differ based on gender?
3. Is there a correlation between patient age and satisfaction scores?

CHAPTER TWO
REVIEW OF LITERATURE

Patient Satisfaction

Patient satisfaction is an indicator of the quality of patient-perceived experiences during a hospital stay, visit to physician, or medical treatment. Patient satisfaction is also a measure of the success of hospitals and doctors (Prakash, 2010). In 2007 Medicare and Medicaid began providing reimbursements to hospitals based on the results of their patient satisfaction, thereby compelling facilities to focus on measures relating to patient satisfaction scores. The HCAHPS survey is a standardized survey tool introduced in 2006 that measures patient experiences and perspectives. The HCAHPS survey is directly tied to the Inpatient Prospective Payment System (IPPS), which considers patient satisfaction reports and hospital ratings to determine percentage of reimbursement (Centers for Medicare and Medicaid Services, 2017).

In addition to reimbursement rates, patient satisfaction scores improve patient retention and increase recommendations of certain healthcare facilities or providers to other potential patients (Accreditation Association for Ambulatory Health Care, Inc., 2015; Prakash, 2010). A loss of a patient due to dissatisfaction with services can cost up to \$200,000 over the lifetime of a practice. Higher patient satisfaction also leads to less staff turnover, reduced malpractice risks, and improved staff satisfaction (Prakash, 2010).

Patient satisfaction scores with a healthcare facility or healthcare professional can be determined by factors such as: empathetic attitudes from physicians (Brody, Miller, Lerman, Smith, Lazaro, & Bloom, 1989; Campbell, Auerbach, & Kiesler, 2007; Moore, Hamilton, Krusel, Moore, & Pierre-Louis, 2016), patient involvement in the treatment

process and a patient-centered care approach to treatment (Brody et al., 1989; Campbell et al., 2007; Hallock, Rios, & Handa, 2017; Lane, Hamilton, MacDonald, Ellis, & Howie, 2015), overall communication with doctors (Lane et al., 2015; Maisels & King, 2005; Marco, Davis, & Secic, 2015; Prakash, 2010), socio-demographic variables (Devoe, Wallace, & Fryer, 2009; Foss, 2002; Quintana, Gonzalez, Bilbao, Aizpuru, Escobar, Esteban, San-Sebastian, de-la-Sierra, & Thompson, 2006) and the quality of care received and overall hospital experience (Lane et al., 2015; Marco et al., 2015; Moore et al., 2016).

Factors that Influence Patient Satisfaction Scores

Patient Involvement/Patient-Centered Care

An overwhelming amount of research indicates patient involvement or incorporating patient-centered care as the primary contributing factor to patient satisfaction (Brody et al., 1989; Campbell et al., 2007; Hallock et al., 2017; Lane et al., 2015; Prakash, 2010). The United States Department of Veterans Affairs defines patient-centered care as looking at the patient as a whole rather than as an illness as physicians aim to focus on what matters most to the patient rather than asking “what is the matter” (U.S. Department of Veteran’s Affairs). Patient-centered care involves the patient throughout the treatment process and keeps the patient informed of their prognosis while viewing the patient as a person rather than identifying them solely by their diagnosis.

Lane, Hamilton, MacDonald, Ellis, and Howie’s (2015) study determined that communication between physicians and patients was one of three primary factors influencing patient satisfaction. Researchers determined that patients desired doctor’s who listened to their concerns and communicated with them about their treatment

options. Results of the study showed that effective communication directly impacted the patient's perception of their hospital experience, even when the patient reported poor physical outcomes (Lane et al., 2015). Patients who felt well informed and were consulted with about their care were more satisfied than patients who were not (Marco et al., 2015). College-aged patients seeking treatment in a university-based healthcare facility "strongly desired to be informed by their providers regarding their condition, diagnosis, and available treatments, and to have their preferences considered in the decision-making process" (Campbell et al., 2007, p. 338). Patients who had higher levels of participation in their treatment and care reported higher patient satisfaction scores.

Patient involvement through procedural education and treatment options can impact the patient's satisfaction with their physician and overall experience. Today's patients are increasingly more educated about their illness and medical concerns due to access to the internet (Prakash, 2010). Patients expect their physicians to involve them in their treatment planning in a language the patient can understand. Hallock, Rios, and Handa found that patient education and informed consent from physicians was associated with higher patient satisfaction scores. Patients who were provided with knowledge of success rate of their procedure, risks of procedure, and were able to explain their procedure to someone else had significantly higher patient satisfaction scores than those who were not provided with that information (Hallock, 2017).

In a study by Brody et al. in 1989 examining the relationship between patients' satisfaction with physicians and perceptions about interventions they desired and received, researchers found that informed patients had increased patient satisfaction scores. Patients who felt more educated about their medical problems had higher patient

satisfaction scores than those who did not feel educated. Patients who received the care and interventions that they wanted from their physician also reported higher patient satisfaction (Brody et al, 1989).

Empathy/Care and Concern from Physicians

Empathy and concern from doctors has shown to significantly increase patient satisfaction scores (Brody et al., 1989; Campbell et al., 2007; Moore et al., 2016; Prakash, 2010). Patients expect physicians to express care and concern while also being professional and courteous (Prakash, 2010). Patients were more satisfied with physicians who tended to their more personal needs and who showed respect towards the patient's personal welfare (Brody et al, 1989).

Patient interactions with friendly physicians and staff members with positive attitudes influence patient satisfaction more than interactions with hostile physicians and staff with negative attitudes (Campbell et al., 2007; Lane et al., 2015). In an open-ended survey provided to patients asking for recommendations for improving patient satisfaction, many patients requested better interpersonal interactions from their physicians. (Moore et al., 2016). Patients wanted health care providers who were "courteous, respectful, caring, attentive listeners, and patient" (Moore et al., 2016, p. 361). Patients also expected their doctor to be punctual, cordial, and communicate in a way the patient could understand (Prakash, 2010). Satisfaction scores from family members of patients receiving care are also important to take into consideration.

The expression of care and concern for the family by a hospital staff member significantly increased parents' satisfaction of their child's hospital experience. In Lane's study, parents with children in the hospital were visited daily by a "facilitator," a hospital

staff member who was not the child's doctor. The researchers suggested that "offering a sympathetic and understanding ear and answering questions" can contribute to overall patient satisfaction within the medical facility (Maisels & Kring, 2005, p. 800).

Socio-demographic Variables

Gender, age, and education level serve as predictors of patient satisfaction (Quintana et al, 2006). Quintana et al in 2006 found that older patients and patients with no or little education reported higher satisfaction scores. Men tended to have higher satisfaction scores than women (Quintana et al, 2006). Foss in 2002 also found that female patients were less satisfied with nursing staff than male patients. Female patients were not satisfied with their interactions with nursing staff and felt that they did not have enough opportunities to communicate with staff about their condition (Foss, 2002).

Devoe, Wallace, and Fryer suggest that age is associated with interactions between patients and health care providers. Their research shows that patients older than age 65 were more satisfied with interactions with staff and patients between the ages of 25 and 44 were less satisfied with staff communication. Patients between the ages of 18 and 24 were "less likely to report that their provider 'always' listened to them, 'always' explained things, 'always' showed respect, or 'always' spent enough time with them" (Devoe et al, 2009, p. 130).

Quality of Care/Overall Experience

Overall experience and quality of care such as: feasible wait times, pain management, and care from nursing staff influence patient satisfaction scores (Marco et al., 2015). Moore's survey examining recommendations for increased patient satisfaction scores showed patient desires for not feeling rushed through their medical appointment or

time spent with a physician. Participants also revealed that physicians who were perceived as incompetent influenced satisfaction. Patients wanted a healthcare provider who would take the time to follow the necessary diagnostic procedures to accurately diagnose an illness, rather than simply prescribing a medication and sending the patient home. Patients who were only prescribed medications often had unresolved health care problems, resulting in lower patient satisfaction (Moore et al., 2016).

Dissatisfaction with overall experience can be attributed to multiple relocations and transitions throughout a hospital and lengthy wait times, compromising patient/staff rapport (Lane et al., 2015). Extended wait times increase anxiety and stress prior to a procedure or treatment. Post-operative pain perception influenced patients' overall perception of quality of care. Patients who had pain following a surgery had lower satisfaction with the facility and were "disappointed" with the results of their surgery, while patients with no pain following a surgery had higher satisfaction and perceived their surgeons to be more competent (Lane et al., 2015).

Music therapy in the medical setting is individualized and specific for each medical diagnosis and course of treatment (AMTA, 2018). Due to its patient-centered nature and ability to address psychosocial and physiological goals, music therapy is an effective way to increase patient satisfaction scores.

Music Therapy in Patient Satisfaction

Music therapy addresses goals directly impacting patients' experiences while in the hospital such as: increasing normalization in the hospital environment, elevating mood, increasing relaxation, decreasing pain, and enhancing coping skills (Goodling, 2014). Patients who receive music therapy services while hospitalized report higher

levels of patient satisfaction than those who do not receive services (Yinger & Standley, 2011).

Mandel, Davis, and Secic (2014) explored the use of music therapy as an intervention to increase patient satisfaction in a medical facility. Individual music therapy sessions using a variety of music interventions were provided. Each participant in the study also received a complimentary music-assisted relaxation and imagery (MARI) CD and a CD-player to use during their hospital stay. Patient satisfaction was measured using questions selected from the HCAHPS survey. The survey revealed that patients who received music therapy were more likely to recommend that hospital to friends and family and demonstrated higher quality of life scores. Music therapy patients reported less pain post-hospitalization, which may be because of the coping and relaxation techniques learned during music therapy sessions (Mandel et al., 2014).

Music listening in a mental health clinic waiting room may increase patient satisfaction and encourage patients to return for services (Waldon & Thom, 2015). While participants completed clinical paperwork, the experimental group listened to 30 minutes of recorded background music and the control group completed the paperwork in silence. Results showed that music in the waiting room was associated with higher levels of patient satisfaction. The authors noted that satisfied patients were more likely to return for services, which is often a challenge in the mental health setting. Perhaps using music to increase satisfaction in the waiting room will lead to higher patient retention rates (Waldon & Thom, 2015).

Music is often used as a distraction technique, particularly in the medical setting, during procedural support or when patients are experiencing pain. Music therapy is

beneficial during procedural support because of the music therapist's ability to constantly assess the patient and alter treatment plans based on observed changes throughout the procedure (Yinger, Walworth, & Gooding, 2014). Recorded music in a post-anesthesia care unit during immediate postoperative period reduced recovery time, improved overall patient satisfaction, and showed a trend for decreased pain medications (Krautz, 2015). Patients undergoing a hand procedure lasting between one and three hours listened to preferred music with headphones in addition to receiving a local anesthetic during their procedure. Patients reported that listening to music improved their overall satisfaction by increasing relaxation, decreasing anxiety, and providing a sense of peace during the procedure (Trangeburg & Stromberg, 2013). Music therapy distraction techniques for children experiencing minor to moderate pain due to musculoskeletal trauma reported higher patient satisfaction rates than those who received standard care combined with ibuprofen. The children who received distraction interventions had a choice between playing with toys and listening to music. While 67% chose listening to music during this study, 100% reported wanting to listen to music during future emergency visits. The researchers reported that a combination of distraction techniques, ice, and medication may be the best option for pain management in this population (Tanabe et al., 2002). It's worth noting that the study by Tanabe et al (2002) was not implemented by a board-certified music therapist. In a study by Barton in 2008, parents of children receiving music therapy as procedural support implemented by a board-certified music therapist were significantly satisfied with music therapy (Barton, 2008).

Music therapy has not only been effectively utilized in the medical setting, but also in the behavioral health setting.

Music Therapy in Behavioral Health

Music therapy is an effective treatment for various psychiatric symptoms and has shown to be an effective intervention in behavioral health settings. Music aids clients in communication and expression through musical interactions such as music making, music listening, and discussion (AMTA, 2018).

When comparing the effectiveness of music therapy with other psychoeducational programming available, patients reported that music therapy was significantly more helpful to them than any other educational or rehabilitative programming at their hospital. Patients described music therapy as relaxing, fun, and motivating. Music therapy increased communication, self-esteem, anger management, mood, and self-expression. More than half of the participants in this study identified music therapy as their favorite group and the group where they felt the most comfortable (Silverman, 2006).

Music therapy is an effective intervention in detoxification units (Silverman, 2011; 2012; 2015). Motivation and treatment readiness in particular are crucial variables for this population (Silverman, 2012). Songwriting and lyric analysis interventions have both shown to be effective interventions when addressing these variables and song writing has shown to be as effective as verbal therapy. Patients who attended group music therapy sessions had lower depression scores, increased overall participation, and perceived music therapy to be “more enjoyable and helpful than traditional therapy” (Silverman, 2011). In addition, patients who participated in lyric analysis interventions had increased problem recognition and increased desire for help (Silverman, 2015).

Ulrich, Houtmans, and Gold (2007) examined the effects of group music therapy with patients with schizophrenia. Music interventions such as group music making, music

listening, movement to music, and lyric discussion reduced negative symptoms and improved positive interactions with others. The researchers concluded that music therapy seems to be especially effective for patients when their symptoms are a central part of their diagnosis. Researchers also noted that skills learned in music therapy could aid with transitioning back into the community after discharge from the hospital (Ulrich et al., 2007).

Summary

Patient satisfaction scores are an important aspect of healthcare as they affect reimbursement rates, likelihood of patients to continue receiving services, and to recommend services to others (Prakash, 2010). Factors that increase patient satisfaction include empathy from healthcare providers, patient involvement in treatment, communication with physicians and staff, and overall quality of care. (Brody et al., 1989; Campbell et al., 2007; Hallock et al., 2017; Lane et al., 2015; Maisels & King, 2005; Marco et al., 2015; Moore et al., 2016; Prakash, 2010). Music therapy can be used to increase patient satisfaction because of its ability to address all of the factors previously mentioned. Music's capacity to establish rapport through preferred music in a patient centered environment increases perceptions of patient empowerment and feelings of involvement, and communicates empathy from the music therapist. Research exploring the impact of music therapy on patient satisfaction scores in the behavioral health setting is nonexistent.

Therefore, the purpose of this study was to compare overall patient satisfaction scores of inpatient psychiatric patients who received group music therapy services with

those at the same hospital who did not receive group music therapy services. Research questions include:

1. Do music therapy services impact patient satisfaction scores in an inpatient psychiatric hospital?
2. Do patient satisfaction scores differ based on gender?
3. Is there a correlation between patient age and satisfaction scores?

CHAPTER THREE

METHOD

This study was submitted to the Institutional Review Board (IRB) of the University of Kentucky for expedited, non-medical review as the study posed no more than minimal risk and collected no identifying information. Approval was received from the University of Kentucky IRB, Office of Research Integrity (Appendix A) prior to conducting this study.

This study presents no more than minimal risk as the survey requires no identifying information. Patients received a cover letter outlining the survey procedures, benefits, and potential risks (Appendix B). The survey itself served as the written consent and no identifying information other than patient demographics was provided by participants on the survey. Therefore, the IRB granted approval for a waiver of the requirement for documentation of informed consent.

Setting

This study took place at a short-term acute care state facility that included 167 staffed beds in six units located in the southeastern United States. Data was collected in the behavioral health unit of the facility, which included 31 staffed beds. One music therapist provided group music therapy services once per week to patients in the behavioral health unit.

Participants

Participants in this study included admitted patients in an inpatient behavioral health unit at a hospital in the southeastern United States. The total number of

participants was 29, with 15 participants in the control group and 14 participants in the experimental group.

Experimental Group

All patients on the unit had the opportunity to attend the weekly music therapy sessions, but attendance was not required. Criteria for the experimental group included patients who attended at least one music therapy session during their hospital stay. Exclusion criteria for the experimental group included patients who were (a) not present at the end of the music therapy session when the survey was administered due to removal for medical concerns, (b) removed from the group due to behavioral concerns, or (c) re-hospitalized during the research period.

Only participants with the capacity for providing their own informed consent participated in this study because the survey required the participant to fully understand the questions in order to provide accurate data for the study. The hospital staff provided the researcher with recommendations of any patient who may have impaired consent due to difficulty in comprehension or who have complex medical diagnoses or behavioral issues.

Control Group

Criteria for the control group included patients who did not attend any music therapy session during their hospital stay. Exclusion criteria for the control group included patients who were: (a) with other medical professionals during time of recruitment, (b) were asleep during time of recruitment, or (c) re-hospitalized during the research period.

Design

This study was a quasi-experimental, non-equivalent control group design (Patten, 2005). In this design, the independent variable in the study was the music therapy group session. Those in the experimental group participated in the music therapy session while individuals in the control group did not. The participants, however, were not randomly assigned. The experimental and the control group received the same survey (Appendix D). Data were collected during an allotted one-hour period once per week for eight weeks. Data were analyzed using descriptive statistics. The rationale for this approach is that the descriptive data provided insight into the effectiveness of music therapy versus no music therapy on patient perception of hospital experience.

The statistical website VassarStats was used to compute group differences, survey measures, and the correlation between measures. Given the small sample size, nonparametric statistical tests were used. The Man-Whitney U Test was used to compare the experimental with the control group on survey scores on the overall average satisfaction scores.

Survey Instrument

The instrument used in this study consisted of a survey administered to participants in the experimental group and the control group (Appendix D). Since the survey for both groups was identical, the experimental group received the survey on a blue piece of paper while the control group received the survey on a green piece of paper in order for the researcher to distinguish between the two groups. The survey consisted of 13 questions. Ten questions regarding satisfaction with patient experience, hospital staff, therapy groups, and overall care and three questions regarding demographics of the

participant designed by the researcher (Appendix D). Questions were based on the hospital's own satisfaction survey and from the HCAHPS survey. Participants were asked to respond by identifying whether they agreed or disagreed with each statement by rating on a scale of one through five. The survey listed the responses as follows: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. Responses to the survey questions were based on a 5-point Likert scale, which were then converted to a 100-point scale for comparison purposes (Yinger & Standley, 2011).

The survey concluded with three questions regarding participant demographics. Information was requested regarding age range of participants, gender identification, and ethnicity. Patients were asked to check a box corresponding to the answers they most identified with in each question.

Procedure

Control Group

A music therapy group led by a board-certified music therapist occurred weekly, lasting one hour. Participants were recruited verbally by the researcher with a written script as approved by the IRB (Appendix C). Participants were notified that their participation in the survey was anonymous and voluntary. For 55-minutes while the music therapist was conducting the music therapy group session, the researcher approached patients on the unit not attending the music therapy group and invited them to complete the survey. The researcher used a script approved by the IRB for recruitment (Appendix C). Patients were typically located in a day-room or in their own patient rooms. If the patient agreed to complete the study, the researcher gave the survey and letter of consent to the participant. The researcher offered to read the letter of consent

aloud or gave the participant the option to read independently. The researcher allowed participants to spend the time they needed to complete the survey, but completion typically lasted between three and five minutes. Immediately following the music therapy group, the researcher recruited any other patients who were not in the music therapy group and had not yet completed the survey.

Experimental Group

During the last five minutes of the music therapy group, the music therapist invited the researcher into the room to introduce the survey using the approved script. The music therapist was not present during the administration of the survey. The researcher distributed the surveys and letters of consent to patients who agreed to participate. The researcher offered to read the letter of informed consent or gave the participants the option to read independently, and then allowed participants time to complete the survey. Although no time limit was imposed, the experimental group also took 3-5 minutes to complete the survey. As participants finished, the researcher collected the surveys by hand as they exited the room.

Music Therapy Intervention

The music therapy session consisted of a 40-minute group music making intervention and a 10-minute lyric discussion. During the group music making intervention, the music therapist presented a list of songs with a common theme. Patients had the opportunity to choose their favorite song from the list. The music therapist played guitar and sang the chosen song, and patients were invited to sing along and play hand percussion instruments. During the 10-minute lyric discussion, the patients identified the common theme and participated in a discussion related to the theme.

CHAPTER FOUR

RESULTS

Demographic Information

Of the 29 participants who completed the survey, 17 (58%) were female and 9 (31%) were male. One (3%) participant identified as gender variant and one (3%) participant identified as other. One participant selected more than one gender, and therefore the question could not be counted (Figure 1).

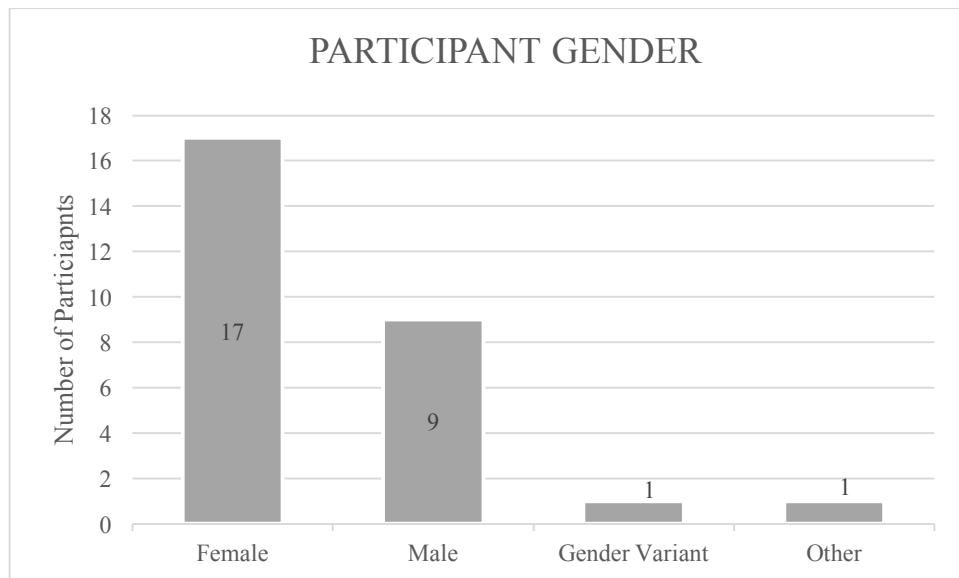


Figure 1: Participant Gender

All participants were over the age of 18, with eight (27%) between the ages of 18 and 25 years, eight (27%) between the ages of 26 and 35 years, five (17%) between the ages of 36 and 45 years, four (13%) between the ages of 46 and 55 years, and four (13%) between the ages of 56 and 65 years (Figure 2).

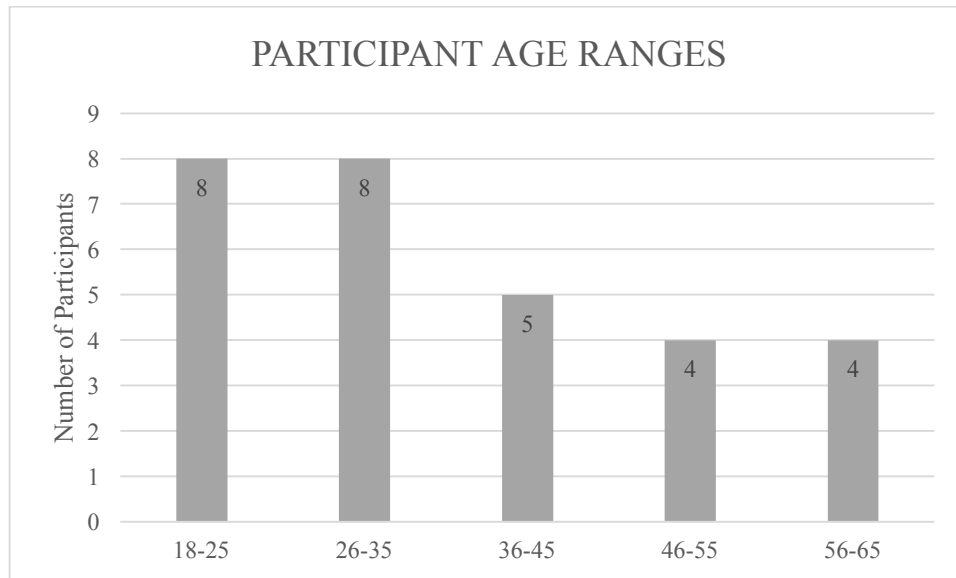


Figure 2: Participant Age Ranges

The majority of participants identified as white ($n=17$, 58%), with the remainder identifying as Asian ($n=1$, 3%), Black or African American ($n=4$, 13%), or other ($n=4$, 13%). Three participants identified themselves as more than one ethnicity and therefore their results to this question could not be counted (Figure 3).

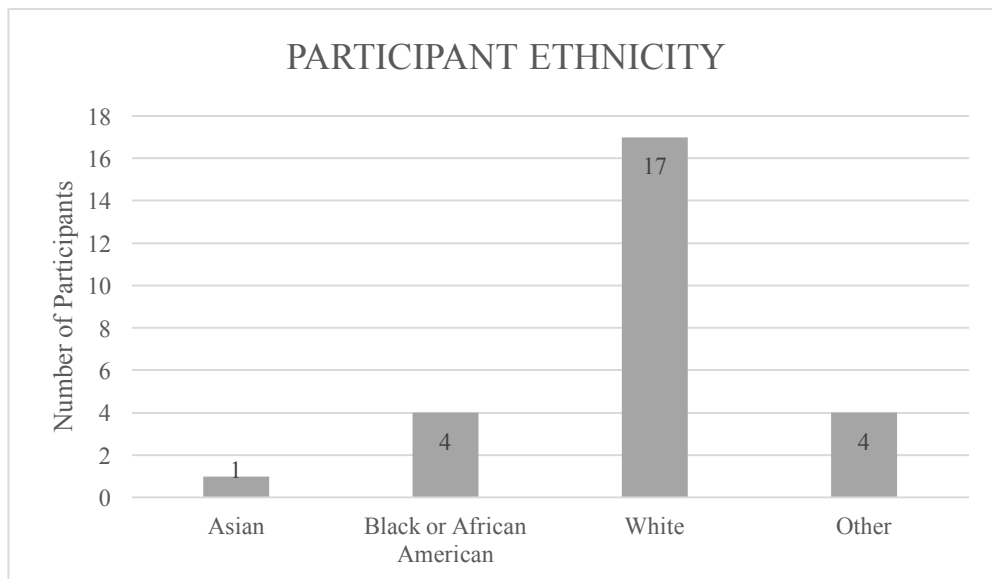


Figure 3: Participant Ethnicity

Results

Means and standard deviations of ratings from the patient satisfaction survey are reported in Table 2.

Table 1

Means and Standard Deviations of Patient Satisfaction Scores

Questions	Experimental Group				Control Group			
	<i>M</i>	<i>SD</i>	Min	Max	<i>M</i>	<i>SD</i>	Min	Max
I am satisfied with my stay at Good Samaritan Hospital.	75	28.86	0	100	73.3	34.67	0	100
The staff was friendly.	91.07	12.43	75	100	83.33	27.82	0	100
The staff fully involved me in my treatment plan.	76.78	26.79	25	100	76.67	33.36	0	100
The staff always communicated clearly with me.	80.35	28.04	0	100	81.67	27.49	0	100
The staff made me feel safe and secure.	85.71	23.44	25	100	85	26.39	0	100
The treatment team provided me with quality care.	75	27.76	0	100	76.67	31.99	0	100
I feel better now than when I was admitted.	75	28.87	25	100	73.21	22.92	50	100
I was treated with dignity and respect.	89.28	16.16	50	100	80	28.66	0	100
Therapy groups were helpful to me.	76.78	30.17	50	100	78.57	27.49	25	100
Staff were sensitive to my language, cultural, and spiritual needs.	89.28	16.16	0	100	76.67	30.57	0	100

Research Question 1

Do music therapy services impact patient satisfaction scores in an inpatient psychiatric hospital?

The results of this study indicated that the impact of participating in music therapy services on patient satisfaction scores was not statistically significant ($p=.65$). Although not statistically significant, results showed that patient satisfaction scores of participants in the music therapy group were 3.02 points higher than those who did not receive music therapy. Similarly, music therapy participants reported higher satisfaction with the friendliness of staff (7.74 points higher), with feeling like they were treated with dignity and respect (9.28 points higher), and with staff sensitivity to language, cultural, and spiritual needs (12.62 points higher). Patient satisfaction scores of each question can be seen in Figure 4.

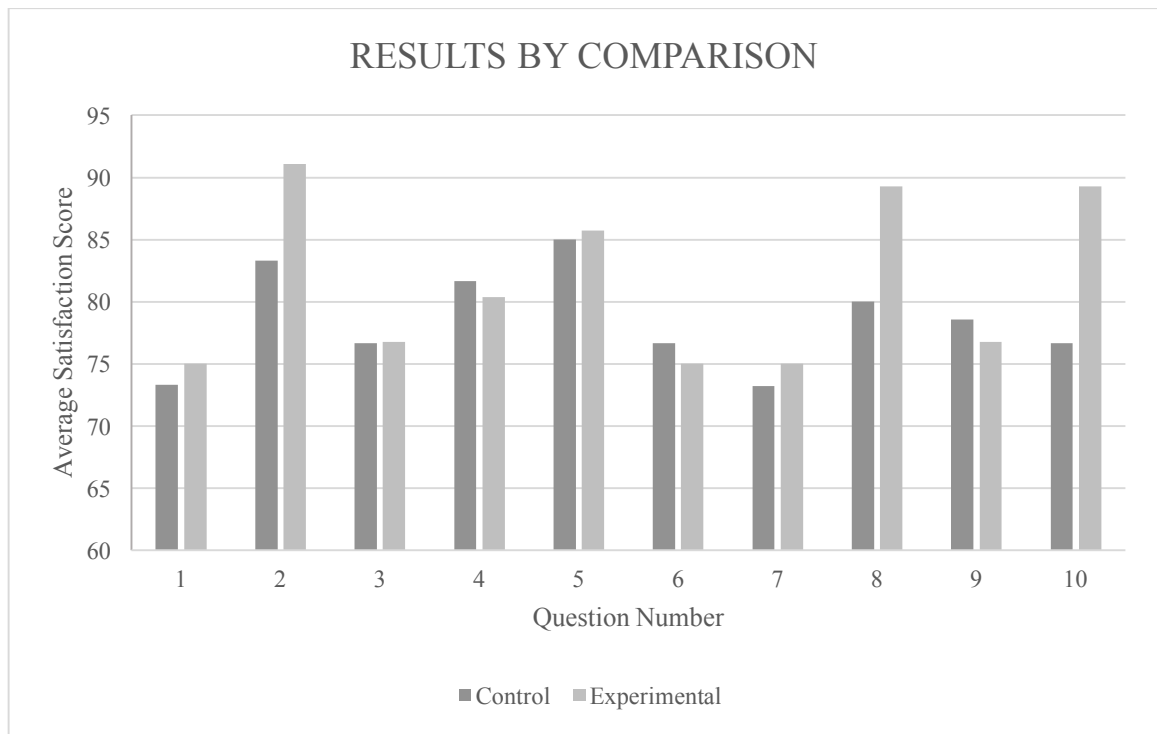


Figure 4: Patient Satisfaction Score Results by Question

Research Question 2

Do patient satisfaction scores differ based on gender?

Patient satisfaction score results based on gender were analyzed using descriptive statistics due to the small sample size. As previously mentioned, the majority of participants were female ($n=17$), followed by nine male participants. One participant identified as gender variant and one participant identified as other. In the experimental group, males were the most satisfied, followed by other, females, and gender variant, respectively. Males were more satisfied with their stay than females (7.07 points higher). It is important to note that only one participant identified as gender variant and one identified as other, so their scores do not indicate an average score.

In the control group, females were more satisfied than males in the control group (13.58 points higher).

Table 2

Mean Satisfaction Scores and Standard Deviations by Gender

	Experimental Group		Control Group	
	Mean	Standard Deviation	Mean	Standard Deviation
Male	86.38	18.16	67.5	38.57
Female	79.29	17.60	81.08	18.38
Gender Variant	77.5	N/A	N/A	
Other	80	N/A	N/A	

Females

Of the 17 females who participated in this study, ten were in the control group and seven were in the experimental group. Female participants in the control group were more satisfied than the female participants in the experimental group, although results

were not statistically significant. Female participants in the experimental group were more satisfied than participants in the control group with the friendliness of the staff (4.28 points higher), helpfulness of therapy groups (14.29 points higher), and staff sensitivity to language, cultural, and spiritual needs (12.86 points higher). A detailed analysis of each question comparing results of female participants in the control group with female participants in the experimental group can be seen in Figure 5.

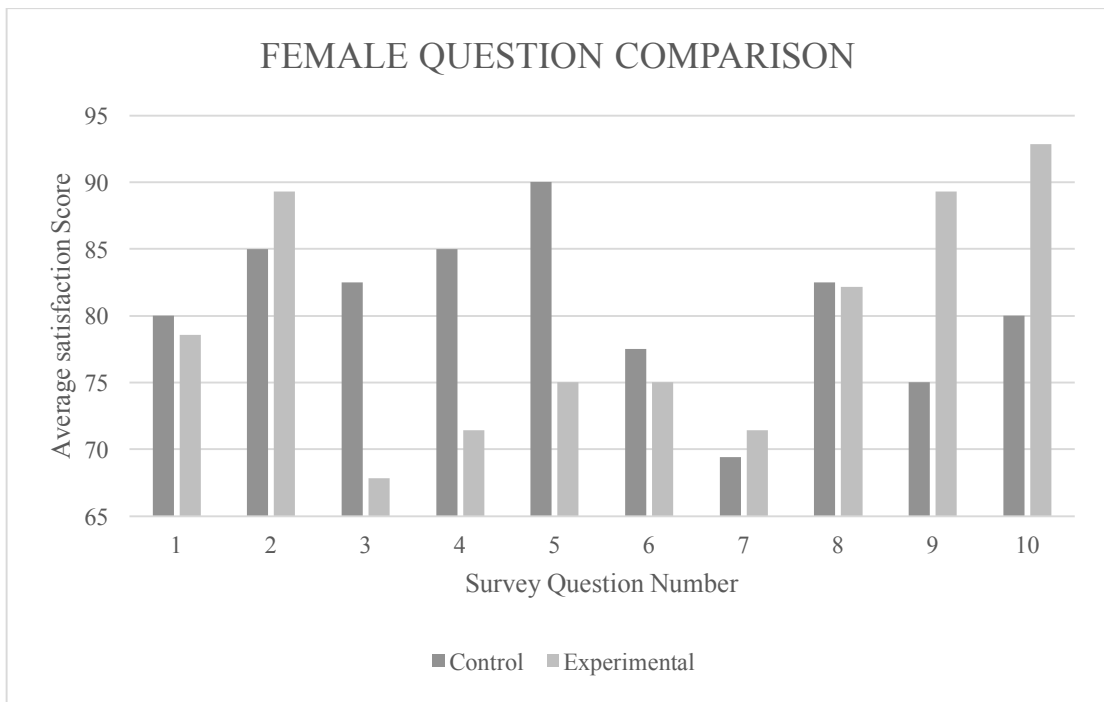


Figure 5: Group Comparison of Individual Questions by Female Participants

Males

Males in the experimental group reported satisfaction scores 18.86 points higher than males in the control group. Males in the experimental group reported higher satisfaction scores than males in control group in 9 out of 10 questions. Males in the experimental

group were less satisfied with helpfulness of therapy groups than males in the control group. An analysis of the satisfaction of males by question can be seen in Figure 6.

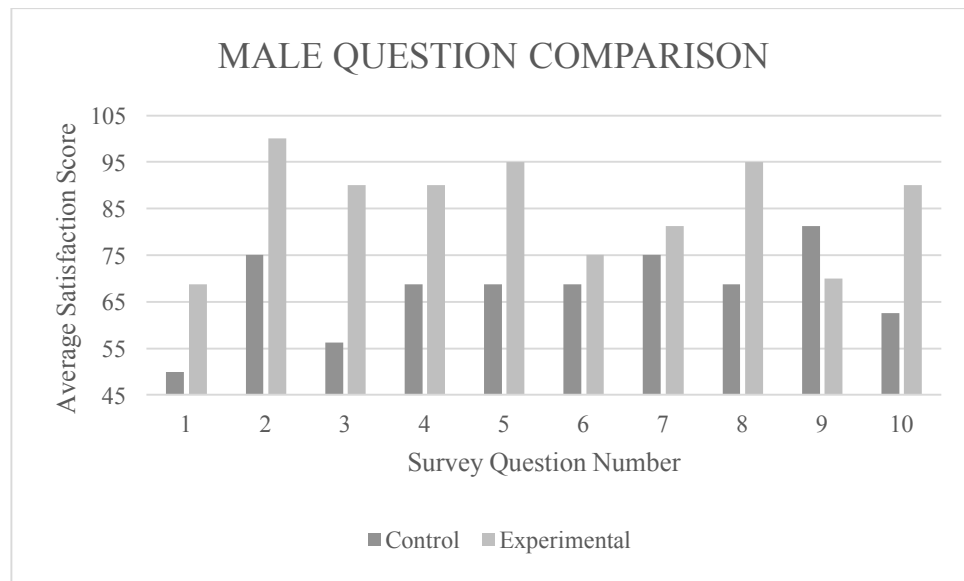


Figure 6: Group Comparison of Individual Questions by Male Participants

Research Question 3

Is there a correlation between patient age and satisfaction scores?

The results of this study did not indicate a significant correlation between patient age and satisfaction scores (experimental $p=0.49$, $t=-.03$, $df=12$; control $p=0.14$, $t=1.13$, $df=13$). Results did indicate a trend in younger age groups attending music therapy groups. The greatest number of participants in the experimental group were between the ages of 18-25 ($n=6$; 42.86%). The majority of participants in the control group were between the ages of 25-85 ($n=4$; 26.67%). In the experimental group, 10 out of 14 (71.43%) participants were under the age of 35 while only 6 out of the 15 (40%) participants in the control group were under the age of 35, showing a trend in younger age groups attending music therapy group. In the experimental group, only 4 out of 14

(28.57%) were older than 36 while in the control group, 9 out of 15 (60%) participants were older than 36.

In the experimental group, participants between the ages of 18-25 were the most satisfied (score of 86.98 (SD=12.88)) and participants between the ages of 55-65 were the least satisfied (score of 55). In the control group, participants between the ages of 46-55 were the most satisfied (score of 91.67 (SD=8.78)), while participants between the ages of 26-35 were the least satisfied (score of 67.43 (SD=41.92)). The average overall satisfaction score per age group can be seen in Figure 7.

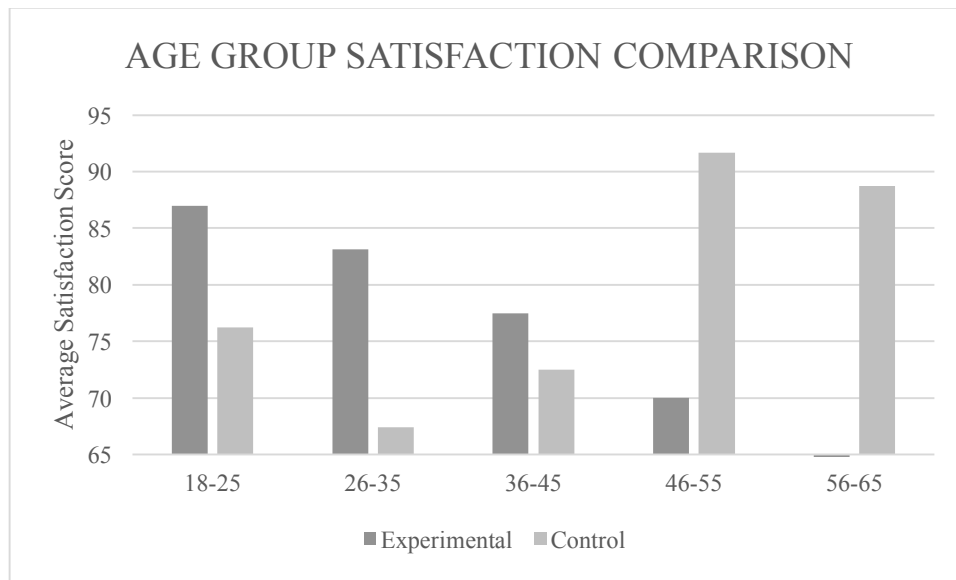


Figure 7: Overall Satisfaction Per Age Group

CHAPTER FIVE

DISCUSSION

The purpose of this study was to determine whether or not music therapy had an effect on patient satisfaction scores in a behavioral health facility; to examine the effects of gender on patient satisfaction scores, and; to determine if a correlation exists between patient age and satisfaction scores.

Research Question 1

Do music therapy services impact patient satisfaction scores in an inpatient psychiatric hospital?

Participants in the music therapy group reported satisfaction scores that were an average of 3.02 points higher than participants in the control group. Although results were not statistically significant, the data indicate trends highlighting the potential for music therapy to affect patient satisfaction scores. These results are similar to the 2011 study by Yinger and Standley which showed that patients who received music therapy in a medical facility reported average overall patient satisfaction scores that were 3.4 points higher than scores of those who did not receive music therapy.

Participants who received music therapy were most satisfied with friendliness of staff (91.07). Studies show that empathy, care, and concern from physicians increase patient satisfaction scores (Brody et al., 1989; Campbell et al., 2007; Moore et al., 2016; Prakash, 2010). Specifically, patient satisfaction scores increase with friendly and positive interactions with physicians and staff members (Campbell et al, 2007; Lane et al, 2015). Patients who received music therapy in the present study may have had more positive and friendly interactions with the music therapist because of the music

therapist's ability to establish rapport and develop a clinical relationship throughout the session.

Participants who received music therapy indicated that they felt more respected than participants who did not receive music therapy. This may be attributed to the ample opportunities for autonomy that music therapy provides to patients or the patient-centered treatment model that music therapy often encompasses. As noted previously, patient involvement in the course of their own treatment increases satisfaction ((Brody et al., 1989; Campbell et al., 2007; Hallock et al., 2017; Lane et al., 2015; Prakash, 2010). By providing participants in the music therapy group with opportunities to make choices, they may have felt more involved in their treatment, and, therefore, increasing patient satisfaction

Participants in the experimental group felt that staff were more sensitive to their language, culture, and spiritual needs. According to the American Music Therapy Association Code of Ethics, the music therapist must respect others' differing values, attitudes and opinions and practice with integrity, honesty, fairness, and respect (AMTA, 2015). As found in Brody, et al in 1989, patient satisfaction scores increased when physicians showed respect towards the patient's personal welfare.

Research Question 2

Do patient satisfaction scores differ based on gender?

As shown in Figure 1, the majority of participants identified as female, followed by male, gender variant, and other, respectively. Overall, male participants who received music therapy were more satisfied than female participants who received music therapy, (7.07 points higher), although data were not statistically significant. Results indicate that

more females attended music therapy than males, and that males who attended music therapy sessions reported higher satisfaction scores than the females.

It is important to note that the facility's census during the research period was particularly female-dominated. This may be because of the notion that females are more likely to seek therapeutic help than males. According to Winerman (2005), the ideal of a man, described as "tough, independent, and unemotional," is not compatible with therapy (Winerman, 2005, p. 57). Winerman goes on to suggest that men are not in-tune with their emotions and feel that society will undermine a man who attends therapy. Additionally, conducting research within an active clinical environment offers real-life challenges. The transient and unpredictable nature inherently found in these facilities lends itself to inconsistency, therefore making continuity difficult.

Research Question 3

Is there a correlation between patient age and satisfaction scores?

As shown in Table 1, the majority of participants were between the ages of 18-25 and 26-35. Although no statistical correlation exists between age groups and satisfaction scores, the results do indicate a positive trend in the age of participants attending music therapy groups. As noted previously, the majority of participants who attended music therapy groups were younger than the majority of participants who did not attend the music therapy group. In the experimental group, 10 out of 14 total participants (71.43%) were under the age of 35 while only 6 out of 15 participants in the control group (40%) were under the age of 35. In the control group, 9 out of 15 participants (60%) were 36 or older while only 4 out of 15 (28.57%) were 36 or older in the experimental group. This data suggests a positive trend of a younger population attending the music therapy group.

A benefit of younger populations receiving care may result in higher retention rates in the future. The Accreditation Association for Ambulatory Health Care, Inc. (2015) and Prakash (2010) report that higher patient satisfaction scores improve patient retention. Younger patients who are satisfied with their care and have positive experiences with physicians, staff, and overall care may be more likely to return for services and continue receiving care at a later time.

Limitations

This study is one of the first involving patient satisfaction scores in a behavioral health setting. The primary limitation of this study was the limited sample size. At this facility during the research period, the size of the census and the number of participants each week varied dramatically, generating an unpredictable number of participants each week. Data were collected at a single facility and therefore caution should be taken when generalizing the results to the larger behavioral health population. A larger sample size may result in the detection of additional important findings.

Another limitation of this study was the lack of random assignment of participants. Every patient at this facility is given the option of attending the music therapy group at their own discretion. Patients are not referred by staff members, but are rather recruited by staff by announcing the start of the session throughout the unit. Therefore, random assignment was not possible for this research design. Since patients were able to self-select whether or not to attend music therapy, it is possible that any differences between the two groups are due to differences in patients who choose to attend music therapy or choose to not attend music therapy, rather than the result of the music therapy intervention itself.

Future Research

Results of this study warrant further investigation examining the impact of music therapy groups on patient satisfaction scores in the behavioral health setting. Future research should allow for a larger sample size from multiple behavioral health facilities in order to accurately generalize the results to a larger population.

Future surveys may benefit from a mixed-methods design including a qualitative section to evaluate the patients' specific experiences. The researcher received feedback from patients expressing a desire to share more about their experiences with staff members and treatment options rather than giving an average score as on this survey, due to a combination of both negative and positive experiences. These qualitative comments may offer facilities further insight into how patients are responding to the services available. Patients could provide specific examples of what they enjoy most about their treatment and the researcher could evaluate whether or not music therapy is included in their answers. Future research might also examine the therapeutic treatments received by each patient, including a question asking which groups the patient has attended prior to taking the survey.

Better recruitment procedures may also be beneficial for future music therapists looking to increase participants in their groups. At this particular facility, patients were simply gathered, and were often not encouraged to attend music therapy. Nursing staff would wander throughout the unit informing patients that it was "time for music therapy group," and interested patients would leisurely enter the group room. Staff who understand the benefits of music therapy may result in increased patient participation in

music therapy and seen less as an “optional” service at this facility. Staff education to increase understanding of music therapy may be valuable.

Conclusion

The purpose of this study was to initiate a conversation for exploring patient satisfaction scores in the behavioral health setting. The results of this study indicate that music therapy has the potential to increase satisfaction within this population. Further exploration of patient satisfaction with this population is vital as it relates to healthcare reimbursement rates, patient retention rates, facility recommendations, and increased staff satisfaction. In addition, other behavioral health facilities looking to add music therapy or music therapists hoping to develop a program within a behavioral health facility may find this information useful.

APPENDICES

Appendix A: Letter of Approval from UK IRB



Initial Review

Approval Ends:
2/26/2019

IRB Number:
43299

TO: Madelyn LaPrade, Master of Music
PI phone #: 4344663505
PI email: madelyn.laprade@uky.edu

FROM: Chairperson/Vice Chairperson
Non Medical Institutional Review Board (IRB)

SUBJECT: Approval of Protocol

DATE: 2/27/2018

On 2/27/2018, the Non Medical Institutional Review Board approved your protocol entitled:

The Effect of Group Music Therapy on Patient Satisfaction in a Behavioral Health Setting.

Approval is effective from 2/27/2018 until 2/26/2019 and extends to any consent/assent form, cover letter, and/or phone script. If applicable, the IRB approved consent/assent document(s) to be used when enrolling subjects can be found in the "All Attachments" menu item of your E-IRB application. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review Report Form which must be completed and submitted to the Office of Research Integrity so that the protocol can be reviewed and approved for the next period.

In implementing the research activities, you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol. It is the principal investigator's responsibility to ensure any changes planned for the research are submitted for review and approval by the IRB prior to implementation. Protocol changes made without prior IRB approval to eliminate apparent hazards to the subject(s) should be reported in writing immediately to the IRB. Furthermore, discontinuing a study or completion of a study is considered a change in the protocol's status and therefore the IRB should be promptly notified in writing.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research" available in the online [Office of Research Integrity's IRB Survival Handbook](#). Additional information regarding IRB review, federal regulations, and institutional policies may be found through [ORI's web site](#). If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at 859-257-9428.

Appendix B: Survey Cover Letter

IRB Approval
2/27/2018
IRB # 43299
ID # 16516

Consent to Participate in Research Study

Dear Participant,

You are being invited to take part in a research study about your patient experience at Good Samaritan Hospital.

The purpose of this study is to determine the satisfaction of your stay at Good Samaritan. You will be asked to answer 10 questions regarding your care, therapy services, interaction with staff, and overall stay. The survey should take approximately 3-5 minutes to complete.

Your response to the survey is anonymous which means no names will appear or be used on research documents or be used in presentations or publications. The research team will not know that any information you provided came from you or even whether you participated in the study. When we write about the results from the study, we will write about the combined information from all participants. Your information collected for this study will NOT be used or shared for future research studies.

Although you will not get personal benefit from taking part in this study, your responses may help us evaluate the care and resources available to you and to future patients at Good Samaritan Hospital, and may help similar hospitals determine what types of service may increase their own patient satisfaction scores.

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits, or rights you would normally have if you chose not to volunteer. You may withdraw from this survey at any time.

The person in charge of this study is Madelyn LaPrade, MT-BC of the University of Kentucky College of Fine Arts. If you have any questions, suggestions, or concerns regarding this study, her contact information is: Madelyn.laprade@uky.edu. The principal investigator is being guided in this research by Dr. Lorna Segall of the University of Kentucky, College of Fine Arts.

If you have any questions, suggestions, or concerns about your rights as a volunteer in this research, contact staff in the University of Kentucky Office of Research Integrity (ORI) between the business hours of 8 am and 5 pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428.

Thank you in advance for your assistance with this important project.

Sincerely,
Madelyn LaPrade, MT-BC
Department of Music Therapy
University of Kentucky
Madelyn.laprade@uky.edu

Lorna Segall, PhD, MT-BC
Thesis Advisor
University of Kentucky
lorna.segall@uky.edu

Appendix C: Survey Administration Script

Experimental Group

At the end of the music therapy session, the music therapist will exit the room and the principal investigator will enter:

Principal Investigator:

Hello, everyone. My name is Madelyn LaPrade and I am here to administer this survey as part of my master's thesis research through the University of Kentucky. The survey focuses on your patient experiences here at Good Samaritan Hospital. Your responses may help us evaluate the care and resources available to you and future patients at Good Samaritan Hospital.

Your participation in this survey is entirely optional and will only take approximately 3-5 minutes to complete. Your answers will remain anonymous as no identifying information will be asked. You may skip an item and you stop at any time during the administration process.

If you would like to participate in this survey, please remain in the room. If you do not want to participate in this survey, please exit the room now.

[Hand out surveys].

The first page of the survey provides a detailed letter of consent. It outlines the study procedures as well as provides you with my contact information and the contact information of my research advisor, Dr. Lorna Segall.

[Pause for participants to read letter of consent, or read aloud if needed].

Please turn to the second page of the survey. It contains 10 questions asking about your experiences here at Good Samaritan Hospital. You will indicate your answer on a scale from 1-5. 1 means you strongly disagree with the statement, 2 means you disagree with the statement, 3 means you have a neutral response to the statement, 4 means you agree with the statement, and 5 means you strongly agree with the statement.

At the bottom of the survey, please answer the demographic questions asking your age range, your gender, and your race.

Please answer all questions on the survey honestly based on your experiences at THIS hospital only. When you are finished with the survey, please bring them to me and you are welcome to quietly exit the room.

Please take as long as you need to finish this survey. If you need any clarification on any of the questions, please let me know.

Thank you for taking the time to participate in this research study. I appreciate your participation!

[Collect surveys as participants finish].

Control Group

The principal investigator will approach patients individually in the unit who did not receive music therapy services.

Principal Investigator:

Hello! My name is Madelyn LaPrade and I am here to administer an entirely anonymous survey as part of my master's thesis research through the University of Kentucky. The survey focuses on your patient experiences here at Good Samaritan Hospital and will only take approximately 3-5 minutes to complete. Your responses may help us evaluate the care and resources available to you and future patients at Good Samaritan Hospital. Would you be willing to participate?

[If patient says no:]

Thank you very much for your consideration, have a great day!

[If patient says yes:]

Your participation in this survey is entirely optional and will only take approximately 3-5 minutes to complete. Your answers will remain anonymous as no identifying information will be asked. You skip any item and you may stop at any time during the administration process.

[Hand out survey].

The first page of the survey provides a detailed letter of consent. It outlines the study procedures as well as provides you with my contact information and the contact information of my research advisor, Dr. Lorna Segall.

[Pause for participant to read letter of consent, or read aloud if needed].

Please turn to the second page of the survey. It contains 10 questions asking about your experiences here at Good Samaritan Hospital. You will indicate your answer on a scale from 1-5. 1 means you strongly disagree with the statement, 2 means you disagree with the statement, 3 means you have a neutral response to the statement, 4 means you agree with the statement, and 5 means you strongly agree with the statement. Please answer all questions on the survey honestly based on your experiences at THIS hospital only.

At the bottom of the survey, please answer the demographic questions asking your age range, your gender, and your race.

[Collect survey when participant is finished].

Thank you for taking the time to participate in this research study. I appreciate your participation!

Appendix D: Survey

Thank you for agreeing to take part in this voluntary and anonymous survey measuring patient satisfaction at Good Samaritan Hospital. Your participation in this survey serves as your consent for the answers you provide to be used in a research study. This survey should take 3-5 minutes to complete. All answers you provide will be kept in confidentiality. You may choose to discontinue at any time.

#	Question	Survey Scale: 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree				
1	I am satisfied with my stay at Good Samaritan Hospital	1	2	3	4	5
2	The staff was friendly.	1	2	3	4	5
3	The staff fully involved me in my treatment plan.	1	2	3	4	5
4	The staff always communicated clearly with me.	1	2	3	4	5
5	The staff made me feel safe and secure.	1	2	3	4	5
6	The treatment team provided me with quality care.	1	2	3	4	5
7	I feel better now than when I was admitted.	1	2	3	4	5
8	I was treated with dignity and respect.	1	2	3	4	5
9	Therapy groups were helpful to me.	1	2	3	4	5
10	Staff were sensitive to my language, cultural, and spiritual needs.	1	2	3	4	5

What is your age? 18-25 26-35 36-45
 46-55 56-65 66 and older

To which gender do you most identify? Female Male Gender Variant/Non Conforming
 Transgender Male Transgender Female
 Other: Prefer Not to Answer

How would you describe yourself? American Indian or Alaska Native Asian
 Black or African American White
 Native Hawaiian or Other Pacific Islander
 Other

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