MUSIC AND QUALITY OF LIFE:
THE STATUS OF MUSIC IN OHIO NURSING HOMES

DISSERTATION

Presented in Partial Fulfillment of the Requirements for

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By

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ABSTRACT

The purpose of this study was to investigate and analyze the status of the use of music in Medicare and Medicaid-certified nursing homes in the State of Ohio. Areas of concern included qualifications of personnel planning activities; sources of ideas for planning; available materials and equipment; frequency and duration of activities; types of activities, trips or performances; intergenerational and community activities; and purposes for including music activities. To obtain this information a questionnaire was sent by U.S. Mail to the activity directors of all Medicare and Medicaid-certified nursing homes in the State of Ohio.

Networking, books, and volunteer expertise were the most frequent sources of ideas. Music instruments reported were pianos, rhythm band and small percussion. Electronic equipment and media were cassette tapes, videotapes, compact discs (CDs), and karaoke machines. More large nursing homes reported owning computers than did small homes.

Activities occurred between daily and 3-5 times per week and lasted between 30-60 minutes. One third of all facilities reported having outsiders perform weekly. Listening to recorded music, singing, and listening to live performed music were the most frequent activities. These were offered on site with very few trips.

While children performed at the majority of facilities, there were few reported intergenerational activities. Homes that employed professional musicians and music therapists reported more than average intergenerational activities. Church and volunteers were the most frequent community groups providing music. Gospel was the most popular genre with slight regional variations. Music therapy sessions involved groups and individuals, relaxation techniques, reminiscence, and sensory stimulation. Success of activities was measured by participation in facilities of all sizes, areas, and certification. Pleasure was the number one purpose for engaging residents in music activities, followed by social interactions.

Other than public school music and private instrumental lessons, activity directors received music instruction as part of their activity training and from experience. Activity directors are largely responsible for providing music within their quality of life programs. More research is needed in the area of music training for professional activity directors.

Dedicated to Margaret

and the activity personnel who provide quality of life opportunities

for her and others in nursing homes

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FIELDS OF STUDY

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Graduate Interdisciplinary Specialization in Aging

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INTRODUCTION

> **"**Old age is respectable so long as it asserts itself, maintains its rights, is subservient to no one, and retains its sway to the last breath. I like a young man who has a touch of the old, and I like an old man who has a touch of the young. A man who cultivates this principle may be old in body, in mind never."
>
> Cicero

Background & Setting

Seventy million baby boomers were born between 1947 and 1965 in the United States and another ten million have immigrated from other countries (Light, 1988). Because of the population boom, this cohort was labeled the baby boomers. As this generation aged, the culture and economy of the United States changed to reflect their wants, needs and desires. As this generation reaches older adulthood, long-term care concerns are replacing child-care concerns. Baby boomers are now caring for their aging parents. Because they are experiencing first hand the confusion and dissatisfaction with the current health care system for their parents, they want changes to be made before they become the consumers for their own needs. The 107th Congress, 2001-2002, generated eighty-five records in the Congressional Record about the effect of the baby boom on the public policies on aging. The increased numbers of older adults in this aging population will increase the need for long-term care.

One of the main goals of long-term care is to maintain a good quality of life. It is even required by law: The current U.S. Code Title 42, Chapter 7, Subchapter XVIII, Section 1395i-3 requires that "a skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident" (U.S. Code, 2000). Defining quality of life is much more difficult than requiring it. According to Kane, Kane, and Ladd (1998), one of the necessary factors is providing for social well-being and meaningful activities.

Medicare offers a checklist to help evaluate nursing homes (Nursing Home Checklist, 2002). "Residents may choose from a variety of activities that they like" was one of the twelve suggested evaluation points under quality of life. Under U.S. Code Title 42, skilled nursing facilities are required to provide "an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident" (U.S. Code Title 42, Chapter 7, Subchapter XVIII, Section 1395i-3).

While only 5.43% of the over 65 Ohio population lived in nursing homes in 2000, the state of Ohio spent 92% of its money ear-marked for long-term care on nursing homes (Administration on Aging, 2001). In 2001, there were 995 Medicare and Medicaid-certified nursing homes in the state of Ohio housing 81,321 residents (American Health Care Association, 2001). Nursing homes dominate the long-term care facilities in Ohio making it an appropriate state for research on quality of life programs.

A 1952 study of homes for aged conducted by the Ohio Citizens' Council, found that "real effort is being made to make the lives of their residents more purposeful and more satisfying – to fill with meaningful activity some of the empty hours which too

often bring despair and misery to our older citizens. What older people need is something to do that will give them a feeling that life still is worthwhile" (Ohio Citizens' Council for Health and Welfare, 1952, p. 19). Among the activities frequently found were: listening to the radio, community singing, and musical programs. These and the other activities were provided by volunteer groups and public and private agencies. Left on their own, the residents just "sit around and do nothing" (Ohio Citizens' Council for Health and Welfare, 1952, p. 27). Leadership and planning was necessary to combat the problem of "idleness and loneliness of the older people in Ohio" (Ohio Citizens' Council for Health and Welfare, 1952, p. 1).

Leadership and planning is just one of the responsibilities of members of the National Association of Activities Professionals (NAAP). Founded in 1981, their mission is to "promote standards of excellence, provide support systems, foster research and assure educational opportunities to its members" (Foster, 1990. p. xiii). The language in the U.S. Code that requires professional activities directors is a result of their efforts. All nursing facilities that receive federal money are required to hire a qualified activities director. Their responsibilities include the development of a monthly activity calendar, assessment, and individualized program planning (Snyder, 1989). "Purposeful activities motivate residents and keep them functioning at their optimum level both physically and mentally. Learning is a lifelong process and makes any activity more stimulating and more exciting and fun" (Williams & Down, 1991, p. 1).

Just as in the 1950's in Ohio, music, active and passive, is a common activity in nursing homes today. Some homes offer weekly sing-a-longs, rhythm bands, and performances. Music is used as part of an activities program and some facilities offer

music therapy – the prescribed use of music by a qualified person to effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health problems (American Music Therapy Association, 1999). Prickett (2000) reviewed one hundred and twenty-three research based articles on the therapeutic uses of music for older people and found almost half were on uses of music therapy for persons with Alzheimer's disease and other forms of dementia. Research in music therapy and older adults has addressed ways in which music can be used to ameliorate problems associated with aging, memory, reminiscence, and a variety of other physical and social concerns.

In the Music Educators National Conference's Research Agenda for Music Education, there is a call for research in outreach programs that will provide lifelong music learning, the extensions of programs to older adults, and exploration of opportunities for intergenerational participation (Lindeman, 1999). In the past, music education researchers have looked at vocal range and repertoire in older adults' singing, examined the effects of intergenerational music participation on age-related problems, and described model or experimental music program for older adults.

The activities, music education, and music therapy professions have been researching and developing what appear to be parallel programs using music to improve the quality of life for older adults. The use of music by activities, music education, and music therapy professions has several points where there is an overlap. According to the Williams and Down (1991), activity professionals, learning makes an activity more stimulating, fun, and exciting. The goals are to support the resident in pleasurable, and personally satisfying experiences. Music educators promote lifelong learning in music

for it's pleasurable, socialization and recreational aspects. The music therapy and activity profession both use music for socialization, physical activity, emotional release, relaxation, and reminiscence. Clearly, the value of music in nursing homes is well recognized as evidenced through its inclusions among the priorities of diverse professions.

The purpose of this study was to investigate and analyze the status of the use of music in nursing homes in the state of Ohio. To obtain this information a questionnaire was sent by U.S. Mail to all Medicare and Medicaid-certified nursing homes in the state of Ohio as listed in the Nursing Home compare database accessible on the Official U.S. Government Site for People with Medicare (Nursing Home Compare, 2002).

Research Questions

1. What is the status of music in Ohio nursing homes including materials, activities and personnel?
2. How many long-term care facilities in Ohio receive services by Licensed Music Therapists or persons with music degrees?
3. Are there apparent differences in music activities in facilities categorized by size, accreditation, and region?
4. What are the reasons cited by facilities personnel for the inclusion of music activities? What are the intended outcomes?

Definitions

Activities Of Daily Living (ADLs): personal activities that include bathing, eating, dressing, mobility, transferring, and toileting. ADLs are used as a measurement for dependency and capacity for self-care.

activity director: person whose responsibilities include assessing, planning, arranging, and evaluating activities for residents in a long-term care facility for the purpose of diversion, rehabilitation, maintenance and education.

activity professional: an individual who provides activity services to residents in long-term care settings including those who are certified activity assistant, certified activity consultant, certified activity director, art therapist, dance therapist, horticultural therapist, registered music therapist, registered occupational therapist, registered occupational therapy assistant, certified recreational therapist, or social worker (Cunninghis & Best-Martini, 1995).

activity theory: successful aging is dependent on replacing lost roles with new ones and maintaining activity level (Hooyman & Kiyak, 1999).

administrative and medical staff: administrators, assistant administrators, physicians, dentist, dietitians, or nutritionist.

androgogy: science of teaching adults.

assisted living: a group facility that offers residence and assistance to persons who need help with up to three activities of daily living.

bed: a bed that is set up and staffed for use by a resident.

care plan: written documentation of type and frequency of long-term care services.

certified bed: a bed that is certified under the Medicare program, the Medicaid program or both.

continuing care communities: offers continuum of care from independent living and assisted living to skilled nursing care.

continuity theory: people age successfully if they maintain the same activities and behaviors throughout their lives (Hooyman & Kiyak, 1999).

custodial or personal care: assistance with Activities of Daily Living as well as medication and diet.

dementia: a disease characterized by memory loss and other declines in cognitive functioning, includes Alzheimer's disease.

disengagement theory: older adults disengage from outside activity as a preparation for death (Hooyman & Kiyak, 1999).

gerontogogy: the art of teaching older adults.

independent living: rental unit in which services are not included but may be available for additional fee.

Instrumental Activities Of Daily Living (IADLs): household/independent living tasks, which include telephone, medications, money management, housework, meals, laundry, and shopping .

long-term care facility: any one of several types of group living facilities that requires residents to be of a certain age. includes independent living, continuing care communities, nursing – both skilled and custodial care, and assisted living.

long-term care: "any personal care and assistance that an individual might receive on a long-term basis because of a disability or chronic illness that limits his or her ability to function" (Kane & Kane, 1987).

MDS: Minimum Data Set –admission patient screening tool.

Medicaid: Federal/State program of medical assistance to low-income persons of all ages.

Medicare: Federal health program for persons age 65 and over. (Title XVIII).

music therapist: person who is board certified by the American Music Therapy Association to use music as a therapy.

nursing home: facility licensed by the state that offers residents 24 hour personal and skilled care – nursing care, custodial care, room and board, supervision, medication, therapies, recreation, and rehabilitation.

nursing staff: registered nurses, licensed practical nurses, licensed vocational nurses and nurse's aides or orderlies.

older adults: people who have lived past age 65.

organic brain syndrome: includes, dementia, and any other cognitive problems that are caused by brain dysfunction or damage.

Planning and Service Area (PSA): A geographical area in a state or state jurisdiction that is designated for purposes of planning, development, delivery and overall administration of services under an area plan that is administered by an Area Agency on Aging (AAA). Ohio has 12 Planning and Service Areas (Ohio Association of Area Agencies on Aging).

proprietary facility: a facility operated under private commercial ownership.

quality of life: a concept with individual outcomes in the following domains: (a) sense of safety, security, and order, (b) physical comfort, (c) enjoyment, (d) meaningful activity, (e) relationships, (e) functional competence, (g) dignity, (h) privacy, (i) individuality, (j) autonomy/choice, and (k) spiritual well-being (Kane, 2001).

recreation therapist: person who plans activities and recreation to meet needs of resident.

resident: person formally admitted to or confined in and who slept there last night (National Center for Health Statistics, 1965).

role theory: performance of age expected roles shapes an individual's behavior and self-concept and that successful performance of these roles produces adjusted older adults (Hooyman & Kiyak, 1999).

skilled nursing: care that requires specialized training or services to be provided by trained medical professionals (doctors, nurses, therapists).

socioenvironmental theory: adjustment to activity is based on the relationship between resources and social expectations (Crepeau, 1986).

special care units: units within a long-term care facility for patients with dementia, or other disorders.

symbolic interaction theory: continued interaction with community, family, friends, and leisure pursuits (Hooyman & Kiyak, 1999).

Title XIX (Medicaid): a joint federal and state program designed to pay for medical care to low-income people; part of the Title XIX of the 1965 Social Security Act.

Title XVII (Medicare): a joint federal and state program; part of the 1965 Title XVIII of the Social Security Act; Part A covers hospital and related costs for older adults

financed through the social security payroll tax and Part B is supplementary medical insurance program financed through monthly premiums.

treatment plan (care plan): written document that includes treatment goals for a specific time period.

CHAPTER 2

REVIEW OF RELATED LITERATURE

The purpose of this chapter is to provide an examination of the history, philosophy, theories, and expert practices of the use of music with residents of long-term care facilities. Guiding questions are as follows: Who was in nursing homes in 1950? 2000? And why? When and how did nursing homes begin and how have they changed? What prompted these changes? What was the philosophy guiding their choices in daily activities? What theories guided these choices? What research has been done to defend or to improve the activity quality and why? How were these philosophies and theories reflected in the activity/recreation literature? What were the reasons for including music? How and why did the medical, geriatric, and activity/recreation profession use music with older adults? How did the music and music therapy professions use it? What research has been done using music with the nursing home population?

Nursing Home Profile

Between 1950 and 2000 the population of the United States grew from 150 million persons to over 281 million persons. During this same time period, the U.S. population over the age of 65 grew from 12 million to almost 35 million. This reflects a steady growth of population until the 1990's when the over 65 population decreased by one tenth of a percent. The number of residents in nursing homes reflects a doubling of

resident population during the 1960's and steady growth from the 1970's through the 1980's. This doubling of population in the 1960's corresponds to the advent of legislation governing nursing homes and Medicare/Medicaid reimbursements. During the 1990's there was a significant decline in the number of nursing home residents. There were three possibilities for this decline: (a) Trends suggest that "older persons may already be living in the community longer and entering nursing homes later and sicker than before" (Sayhoun, Pratt, Lentzner, Day & Robinson, 2001, p 6); (b) The growth in options such as home health care, assisted living and continuing care communities; and (c) The decline or slowed growth of the older population during the 1990's, because fewer babies were born during the Great Depression. This decline is only temporary. The older population "will mushroom as the baby boom generation reaches age sixty-five between the years 2010 and 2030" (Sayhoun, Pratt, Lentzner, Day & Robinson, 2001, p 6).

Ohio followed these population trends with one exception: In the 1990's the population over 65 increased by .3%. Even though the older adult population increased, nursing home residents decreased by 1.3% compared with only a .6% decrease in the United States nursing home residents. Since 1996, the State of Ohio has had a moratorium on nursing home beds in an effort to increase the amount of less expensive home health care (Coleman, Fox-Grage, & Folkemer, 2002).

Year	Population Total	65+		Nursing Home	
		Number	Percent	Number	Percent
1950	150,697,000	12,269,000	8.1	296,000[a]	2.4
1960	179,323,000	16,560,000	9.2	470,000	2.8
1970	203,302,000	19,980,000	9.8	1,076,000	5.4
1980	226,546,000	25,550,000	11.3	1,396,000	5.5
1990	248,710,000	31,079,000	12.5	1,772,000	5.7
2000	281,422,000	34,992,000	12.4	1,720,000	4.9

Table 2.1: U.S. Nursing Home Populations

Year	Population Total	65+		Nursing Home	
		Number	Percent	Number	Percent
1950	7,946,000	709,000	8.9	22,000	3.1
1960	9,706,000	897,000	9.2	43,000	4.8
1970	10,652,000	998,000	9.4	53,000	5.3
1980	10,798,000	1,169,000	10.8	68,000	5.8
1990	10,847,000	1,407,000	13.0	94,000	6.7
2000	11,353,000	1,508,000	13.3	82,000	5.4

(U.S. Bureau of the Census, Statistical Abstracts)

Table 2.2: Ohio Nursing Home Populations

In 1950, 14% of all persons over 65 were unable to perform their regular duties because of a disability, and eight percent were disabled from major chronic illness or impairments (U.S. Committee on Aging, 1952). The leading illnesses of nursing home residents were "disease of the heart, arteriosclerosis, hypertension, diabetes, arthritis, kidney disorders, neurological conditions, disturbances of vision and hearing"

a Residents in nursing homes were not reported until the year 1960, before that they were called residents in institutions for the aged or dependent. At this time elderly were also housed in mental hospitals.

(Nicholson, 1954, p. 124). During this time older adults were admitted to hospitals for mental disease resulting from cerebral arteriosclerosis and senility (U.S. Bureau of the Census, 1950). Homes where the ill elderly resided went by many names. Among them were: convalescent homes, rest homes, nursing homes, boarding homes, homes for incurables, infirmaries, sanitariums, health resorts, guest homes, and homes for the aged. "The names under which they operate do not provide a valid basis for distinguishing one type of facility from another" (Nicholson, 1954, p. 124).

By 2000, the leading diagnoses for residents of nursing homes were diseases of the circulatory system (hypertension, heart disease, stroke) followed by cognitive and mental disorders (organic brain damage, anxiety, depression) (Gabrel, 2000). Alzheimer's disease and cerebrovascular disease were the two main sources of cognitive difficulties.

The most recent data for the nursing home population was compiled by the American Health Care Association (2001) using data from the Health Care Finance Administration and the U.S. Census Bureau Statistical Abstract. According to this data, there were a total of 17,086 nursing facilities funded by Medicare and Medicaid in the United States. Of these 12.9% were certified by Medicaid only, 7.3% were certified by Medicare only and 79.8% were certified by both. In these Medicare/Medicaid nursing facilities, there were 1,846,522 beds of which 45.64% were Medicaid only certified, 3.4% Medicare only beds, 44.9% dual certification beds, and 6.1% were non-certified. Non-certified beds are for those patients who are not Medicaid eligible and need custodial

care. These facilities housed a total of 1,490,155 patients averaging 88 patients per facility. Of these facilities, 12.4% were hospital–based, 65.2% for-profit, 28.3 % nonprofit and 6.5% Government operated.

2000	Facilities	Medicaid	Medicare	Dual
U.S.	17,023	2,196 (12.9%)	1,243 (7.3%)	13,584 (79.8%)
Ohio	1,012	122 (12.1%)	69 (6.8%)	821 (81.1%)

Table 2.3: Certification of Facilities

2000	Beds	Medicaid	Medicare	Dual	Non Certified
U.S.	1,846,522	84,1458 (46%)	62,675 (3.4%)	827,040 (45%)	112,349 (6%)
Ohio	122,887	45,510 (37%)	2,349 (1.9%)	47,050 (38%)	27,978 (23%)[b]

Table 2.4: Certification of Nursing Home Beds

2000	Hospital-based	For-Profit	Non-Profit	Government
U.S.	12.4%	65.2%	28.3%	6.5%
Ohio	8.2%	72.6%	24.1%	3.3%

Table 2.5: Ownership of Facilities

2000	Residents	Medicaid	Medicare	Other Pay
U.S.	1,490,155	1,008,835 (67.7%)	129,643 (8.7%)	350,186 (23.5%)
Ohio	81,654	54,218 (66.4%)	6,940 (8.5%)	20,495 (25.1%)

Table 2.6: Residents by Payment Type

[b] Even though it appears that Ohio has more non-certified beds than the U.S. within these Medicare/Medicaid facilities, the percentage of residents in non-certified beds is actually close as seen in the Other Pay column of Table 2:6.

In Ohio there were 1,012 facilities funded by Medicare and Medicaid programs containing 104,817 beds, caring for 81,654 patients with each facility averaging 81 patients. Of the facilities, 12.1% were Medicaid certified, 6.8% Medicare only, and 81.1% dually certified. Thirty-seven percent of the beds in these facilities were Medicaid only, 1.9% Medicare only, 38% dually certified, and 23% non-certified beds. Seventy-two percent were for-profit, 24% nonprofit, 8.2% hospital-based and 3% government owned.

The typical nursing home resident was over 82, white, single, female, with chronic disability, deteriorating mental and physical capacities, and difficulties with activities of daily living (American Association of Homes and Services for the Aging, 2002; Sayhoun, Pratt, Lentzner, Dey, & Robinson, 2001). Bathing (96%) and dressing (87%) were the activities that most often required assistance and eating (45%) the least often.

History, Philosophy, Theory, and Expert Practice

The role of the government in providing care for the elderly unable to care for him/herself has grown from requiring housing (poorhouses), providing funding (1935 Social Security), nursing home regulations (1950's), quality of care (1965 Titles 18 & 19) and finally to legislated quality of life (Omnibus Budget Reconciliation Act). The following is a brief examination of this history and of the attitudes towards older adults reflected in the documents resulting from national and state conferences, from research, from gerontological theories of older adult development, and recreation/activity texts by government agencies and by medical, activities, and music professionals.

In early America, poorhouses were built to house the people who could not support themselves. In 1805, the State of Ohio passed an act requiring all townships to appoint overseers of the poor. The overseer decided whether to give a person aid or to send him/her to the poorhouse. Ohio legislated the name change from county poorhouse to county infirmary in 1850. In addition to the elderly and disabled, county infirmaries also housed the mentally ill, persons with epilepsy, and orphan children (Plain, 2002). Specialized institutions were legislated in the late 1880's and 1890's as efforts to improve living conditions for the orphans, mentally ill, mentally retarded, criminals and the blind. The senile elderly continued to be housed with the mentally ill. In the 1872 book New York and Its Institutions, Richmond wrote: "in this home of refinement, Christian influence and comfort, relieved from toil and anxiety, they pleasantly spend the evening twlight of time, and serenely wait the coming of their Lord" (Richmond, 1872, p. 464). Old age meant being useless and preparing to die[1].

By 1919 the name "county infirmary" was changed to "county home" and was only for those people who were permanently disabled. "Eventually the poorhouses evolved almost exclusively into nursing homes for dependent elderly people" (Crannel, 2002). Prior to the 1930's there were few nursing homes in the United States. This continued until the implementation of the 1935 Social Security Act that provided federal old-age assistance to elderly who lived at home or with others. Because of the conditions of the public poorhouses, Congress mandated that this aid be withheld from older persons who resided in public institutions (Moss & Halamandaris, 1977). The residents turned

[1] Cummings and Henry (1961) developed Disengagement Theory that articulated this preparation for death as a way of orderly transferring power from the old to the young. The older adult disengages from outside activity to become more in tune with their inner life .

over their Social Security checks to the owner of the home in exchange for care. As nurses were added, these homes were transformed into nursing homes. Most nursing homes in the 1930's were rooming houses that served meals with no safety or care quality regulations (Tedrick & Green, 1995). With no one regulating body, different groups began inspections to enforce fire prevention laws, hospital laws, and health department laws.

Willem Van De Wall wrote in Music in Institutions "ever since modern welfare institutions began to be operated on the principle that they should furnish a wholesome environment, recreation has become an important phase of their life. In principle it is accepted as a necessary activity for every human being, including those under institutional care" (Van De Wall, 1936, p. 36). Homes for the aged, convalescent homes, and general and mental hospitals were among the institutions listed. Recreation was to be adapted to fulfill specials needs and the programs were to grow out of the setting and "fulfill the following functions to restore, to develop, to preserve, and to prevent the breakdown of potential and energy" (Van De Wall, 1936, p. 39). "On the whole, in spite of environmental limitations, a recreation program can be made to provide interest and inspiration and create an atmosphere of friendliness, anticipation, comradeship, and joy" (Van De Wall, 1936, pp. 40-41).

The 1945 survey on the uses of music in hospitals by Hamilton and Van de Wall (1946) found that 79% of hospitals surveyed had a music budget and that musicians, occupational therapists, or recreational aides were in charge of planning and implementing the activities. The activities were classified as recreational (16%), therapeutic (13%), and recreational and therapeutic (71%).

It wasn't until the 1950's that amendments to the Social Security Act required states to establish licensing for nursing homes and allowed federal assistance to residents of public facilities. The ban on providing benefits to residents of public facilities was lifted and money was paid directly to health care providers. Federal law provided grants for the construction of nursing homes in conjunction with a hospital in an attempt to improve the quality of care. This change meant that nursing home construction was modeled after hospitals and transformed nursing homes from part of the welfare system to part of the health care system (U.S. Department of Health, Education and Welfare, 1961).

In 1950, the first national conference on aging was convened at the request of President Truman to focus attention on the needs of the older population with the theme "having made life longer, we must now work to make longer life worthwhile" (Ewing, 1951, p. 4). One of its specific objectives was "to promote research on aging in such fields as employment, health, education, recreation, rehabilitation, and social and psychological adjustment (Thurston, 1951, p. 10). A basic premise guiding the Creative and Recreation Activities Committee of this conference, was that the aging person needed meaningful activity to promote a feeling of accomplishment and give purpose to life. The kinds of activities suggested were arts and crafts; social, physical, cultural and educational programs; community services; and citizen participation.

Concurrent with the federal governments investigations into the problems of aging, the states also investigated the activity and welfare of their senior citizens. According to the 1952 Ohio Citizens' Council for Health and Welfare's study of 48 homes for the aged the guiding philosophy behind including activity programs is to

"make the lives of their residents more purposeful and more satisfying – to fill with meaningful activity some of the empty hours which too often bring despair and misery to our older citizens" (Ohio Citizens' Council for Health and Welfare, 1952, p. 19). Music activities reported were listening to the radio, religious programs, community singing, visits by children, concerts by bands, choirs, soloists, and children.

The first of the training manuals for persons who plan recreation/activity programs for residents in care facilities, was the result of Wahlstrom (1953) visiting homes for the aging across the country. She found that recreational participation by older adults aided in the acceptance of their "role as a resident" (Wahlstrom, 1953, p. 11).[2] Music should be included according to Wahlstrom because "music is good medicine" (Wahlstrom, 1953, p. 18) and a "popular program activity that most patients enjoy" (Wahlstrom, 1953, p. 63).

The recommendations resulting from the 1961 White House Conference On Aging resulted in the 1965 passing of Title 18 (Medicare) and Title 19 (Medicaid) of the Social Security Act; The Older Americans Act of 1965, which created the Administration on Aging and the establishment of an official agency of aging in each State (Area Agencies on Aging); training and research programs; the Age Discrimination Act; deinstitutionalization of the mentally ill resulting in older people being transferred to nursing homes; and establishment of the National Institute on Aging and a Special Committee on Aging in the House (U.S. National Advisory Committee, 1961). For this conference, as a basis for discussion, each state was required to "collect facts, inventory

[2] Cottrell developed role theory based on the belief that the performance of age expected roles shaped an individual's behavior and that successful performance of these roles produced adjusted older adults (Hooyman & Kiyak, 1999).

its resources and facilities, locate and identify where services were adequate and where there were gaps and to recommend new approaches and programs" (U.S. National Advisory Committee, 1961, p. 1).

A serious concern to many states was the "shortage of recreational programs for older patients in nursing homes" (U.S. National Advisory Committee, 1961, p. 104). Because the "old" were seen as having too "little to do, too many hours of loneliness and nowhere to go" (U.S. National Advisory Committee, 1961, p. 44)[3], the states recommended that institutions for the aging should provide space for free-time activities; make free-time activities available; research methods of providing productive activities; and develop recreational or leisure time activities (U.S. National Advisory Committee, 1961).

The 1960's brought more manuals written for the person responsible for creating recreation programs in homes for the aging. The purpose of these programs was to "maintain the physical, social, and emotional functioning of residents at its highest level" (Merrill, 1969, p. ix). Activity and socialization of the residents was totally dependent on the increased efforts of the staff. Lucas advised that activities were important in combating the "loss of stature, isolation, and idleness of old age" and were necessary to insure that the "sunset years are colorful and bright" (Lucas, 1962, p. v).

Music was included because "almost everyone enjoys music. It has been used as a therapy with great success" (Lucas, 1962, p. 24). Music activities in the 1960's texts

[3] This reflects the 1950's Activity Theory that suggested older people who were more active were better adjusted: they had replaced their lost roles with new ones (Hooyman & Kiyak, 1999).

included community sings, music appreciation classes, performances by residents, music from the community, rhythm band, and SINGO (a bingo like game using names of songs)" (Merrill, 1969, p. 172-174).

The 1971 White House Conference on Aging included a mini conference sponsored by the National Recreation and Park Association on Recreation, Leisure and Physical Fitness. The National Therapeutic Recreation Society had become a branch of the Parks Association in 1966. Until that time there was a philosophical division on activities for older adults between these recreation professionals. One group promoted the use of recreation as a therapeutic tool and the other that recreation met a human need and was necessary for quality of life (National Therapeutic Recreation Association, 2003).

Quality of life as the philosophical basis for recreation programs in nursing facilities appeared in the 1970's (Vicery, 1972, Moran, 1979). The need for quality social and recreational activity programs designed to attain and maintain the quality life of the aged was the philosophy behind Moran's (1979) guidebook. Music activities as therapy, recreation or both reappeared (Moran, 1979). Music therapy was mentioned as a useful alternative therapy and information seekers were referred to the National Association for Music Therapy. Possibilities suggested in these texts for musical participation during the 1970's included bell-ringing, instrumental music programs, instrument instruction, and music appreciation classes. (Icani, Seward, & Sigler, 1977).

A 1985 report by the Institute of Medicine on nursing home regulation became the basis for the legislation contained in the Omnibus Budget Reconciliation Act (OBRA) that was the largest overhaul of federal regulations for nursing homes. This was

the first law to mandate criteria for quality care in nursing homes. All states were required to follow OBRA regulations. Some of the most important provisions included: "(a) emphasis on a resident's quality of life as well as the quality of care, (b) uniform certification standards for Medicare and Medicaid homes, and (c) remedies to be applied to certified nursing homes that fail to meet minimum federal standards" (Turnham, 2002, p. 2).

National Association of Activity Professionals (NAAP) began with an exploratory meeting in Chicago, IL on March 21, 1981 involving 20 activity professionals from 11 states (Foster, 1991, p. xv). The following June, a steering committee accepted draft bylaws and charter members. In October the first bi-monthly newsletter was published. NAAP's first political action campaign in February 1982 was against federal deregulation of activities and long-term care. By 1983 NAAP was aligned with the American Health Care Association and aligned with the National Therapeutic Recreation Society (NTRS) in 1984. This became the certifying agency for activities directors and assistants.

Guidelines began to appear in the recreation/activity texts for meeting federal and state regulations and for providing recreational intervention to fill social, spiritual, physical, and intellectual needs (Wapner, 1981; Hastings 1981; Simper, 1985; Peckham & Peckham, 1982; Flatten, Wilhite & Reyes-Watson, 1988; Williams and Downs 1984). According to Wapner, "it is not sufficient to divert, amuse, entertain, or fill the day but recreation intervention must fill some very fundamental needs"— social, physical, and intellectual (Wapner, 1981, p.10). The purpose of therapy is to build skills; the purpose of activity programming is to maintain and reinforce skills for the participants (Crepeau, 1987.)

In the 1980's music activities recommended by the activity profession encompassed performance, appreciation, and composition of music. Their purposes of including music in a recreational program were creativity, physical conditioning, cognitive, and social (Shivers & Fait, 1980). According to Hastings, music is an important part of an activities program because it has universal appeal; its ability to elicit some response from the resident whether they participate actively or passively; its versatility since it can be conducted with every cognitive and physical level; and because "participation increases socialization, raises spirits, and increases group solidarity" (Hastings, 1981, p. 144). Music was also seen as being a hobby, as accompaniment for exercise, opportunities for creative expression, relief of self-concern, and stimulation of memory (Flatten, Wilhite, and Reyes-Watson, 1988). Music was viewed as being both part of a therapeutic activity program and as a separate therapy. Music activities during this decade included listening and music appreciation, sing-along, musical games, and rhythm and instrumental bands (kazoo, recorder, bells, harmonica) choirs, and whistling (Peckham & Peckham, 1984; Hasting, 1981).

After the Omnibus Budget Reconciliation Act (OBRA), cognitive measurable approaches were required of the activity department in the nursing home. Even though the same type of activities could be offered, they had to fit within the context of each resident's assessment and care plan and their effectiveness had to be assessed from a psychosocial standpoint. No longer was the activity director a planner of activities; she was the manager of a therapeutic activity program (Avery, 1997). Objectives were written for each patient, data gathered, and outcomes assessed. Several manuals became available offering guidelines on writing objectives; analyzing activities in areas of

physical, cognitive, and social behavior; and providing for systematic process of patient "assessment, activity analysis, planning, implementation, and evaluation." (Hawkins, May, and Roger, 1996; Elliot & Sorg-Elliott, 1991; Cunninghis & Best-Martini, 1996).

In the 1990's, some of the purposes of including music in the activities programs were emotional release, physical activity, socialization and stimulating sensory awareness and reminiscence (Parker, Will, & Burke, 1993; Erickson, 1993). Music was a popular activity choice because of its association with social, religious, and cultural events; its use both as an active or a passive activity; its power to elicit memories; and as a means of creative expression. Music therapy was recommended to provide "meaningful substance to an already accepted activity" (Avery, 1997, p. 114). Activities suggested by the activity profession were sing-alongs, rhythm and kitchen bands, concerts, games (Singo, Complete The Line), reminiscence, drawing or moving to music, dining mood enhancement, songwriting, and music appreciation activities.

Long-term care certification by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began in 1966. JCAHO offers voluntary accreditation to health care organizations seeking to improve performance. JCAHO accredited facilities are surveyed to see how they can improve and how they meet the standards rather than meeting minimum regulations. In some states, it is a status symbol for quality (Joint Commission on Accreditation of Health Care Organizations, 2002). Consumers can look on the JCAHO website at the 177 accredited long-term care homes in Ohio and view the latest performance report and history of accreditation. Required for each resident is the assessment of "education needs, preferences, abilities and readiness to

learn" (Joint Commission on Accreditation of Health Care Organizations, 2002). This is in addition to activities status, needs, potential hobbies, interests, and ability to participate in structured and group activities.

The National Therapeutic Recreation Society in its 2000 manual wrote: "The major role of therapeutic recreation in long-term care facilities is to support the resident in continuing to strive for self-identifying, pleasurable, comforting and personally satisfying experiences" (National Therapeutic Recreation Society, 2000, p. 3). According to the National Therapeutic Recreation Society (2003), leisure contributes to quality of life. While leisure should be enjoyable, as a contributor to quality of life, it may help prevent illness, prevent further deterioration, and promote functional abilities.

Beginning in April 2002, Ohio, along with Florida, Colorado, Maryland, Rhode Island, and Washington State joined the Nursing Home Quality Initiative sponsored by the Centers for Medicare and Medicaid Services. This pilot program gathers and reports more detailed quality measures on each nursing home than is currently offered by the Medicare Nursing Home compare website. The information gathered is based on the MDS 2.0 (Minimum Data Set), an assessment of each resident's condition required by all Medicare or Medicaid certified nursing facilities. MDS 2.0 Section N. Activity Pursuit Patterns requests information in time awake, average time involved in activities, preferred activity setting, and general activity preferences. Choices listed, in no particular order, were cards/other games, crafts/arts, exercise/sports, music, reading/writing, spiritual/religious activities, trips/shopping, walking/wheeling outdoors, watching TV, gardening or plants, talking or conversing, and helping others.

A new model of nursing home that places the resident at its center is starting to appear as a result of the grassroots movement known as the Pioneer Network. Individuals from each of four groups that had independently developed approaches to improve the quality of life for their residents were invited to a session on pioneering approaches at the 1995 national conference of The National Citizens' Coalition for Nursing Home Reform. The results of this session was the "yellow book" Meeting of Pioneers in Nursing Home Culture Change and their being labeled the Pioneer Network. Many other individuals and groups have joined them in pioneering a culture change in the nursing home – "change in governmental policy and regulation; change in individual's and society's attitudes toward aging; change in elders' attitudes toward themselves and their aging; and change in the attitudes and behavior of cares toward those for whom they care" (Pioneer Network, 2003). As a result of this network, "the transmission of a new nursing home culture is beginning. One day every nursing home will be an open, diverse, caring community, providing those who live there with individualized care based on their choices and personal control, unlimited opportunities for growth in spirit, mind and body, and continued involvement with family, friends, and the outside world" (Lustbader, 2001, p.201).

The Eden Alternative is the most widespread member of this group. Of the 240 registered Eden Alternative nursing facilities, 16 are in Ohio. According to their philosophy, activities must be meaningful. "Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health" (Eden Alternative).

Quality Of Life

Definition

What is quality of life? Even though the term was used earlier, The Index Medicus didn't list quality of life as a heading until 1977 (Bech, 1993). Separating quality of life and health-related quality of life is very difficult because of the mediating effect of health on self-perceived life quality. Despite attempts at measuring the components of a life of quality, defining it becomes difficult because of its subjective nature: "The type of life the patient wants to lead will depend on the sort of man he or she is" (Bech, 1993, p. 397). The following definitions range from holistic and subjective to objective components that can be assessed.

According to the World Health Organization, "quality of life (QOL) is a popular term that conveys an overall sense of well-being, including aspects of happiness and satisfaction with life as a whole. It is broad and subjective rather than specific and objective. What it actually means is somewhat different for each individual" (Centers for Disease Control and Prevention, 2000, p. 5).

After Bennett (1990) went undercover in the 1970's as a nursing home resident he defined quality of life as how well the living environments of residents satisfied their basic human needs. These basic needs were individual. The better individual needs were met, the higher that person's quality of life. Iso-Ahola (1989) determined that the individual perceived quality of life and his/her own perceptions created the definition of quality of life.

McDonald's (1983) definition was composed of a description of components that must be provided for in every nursing home. He stated: "Nursing homes do not provide

quality of life. They set the conditions, make the opportunities available, and encourage self determination" (McDonald, 1983, p. 23). These conditions were as follows: physical well-being, interpersonal relations, social activities, personal development, recreational activities and spiritual and transcendental activities. "There is a shift from medical quality of care model to a health model of quality of life" (McDonald, 1983, p. 5).

Abele, Cox, Gift and Ory's (1994) definition was composed of several areas: behavioral, perception, environment, psychological, and health all of which were influenced by psychological, social and economic factors. Bearon (1988) referred to quality of life as a life worth living and an ideal for service delivery that focuses on life quality which includes social, psychological and spiritual needs above and beyond those of quality care which focuses on base physical needs.

Romsa, Bondy, & Blenman (1985) combined both physical and personal needs in their definitions. Using Maslow's Hierarchy of Needs as the guideline, they determined that quality of life needs were belonging, love and self-actualization. The "most important needs that explain leisure participation were socializing, self-fulfillment, physical exercise, being close to nature and learning, in that order" (McAvoy, 1979, p. 46).

Brod, Stewart, and Walton listed the following "determinants of quality of life" (Brod, Stewart, & Walton, 1999, p. 26): clinical status, health care, lifestyle, social environment, community environment, and personality, socioeconomic, and demographic characteristics. George & Bearon (1980) combined objective definitions consisting of personal assets, health status, and financial security with subjective perceptions of life

experiences. Their definition included both the conditions and the experiences of life stating the quality of life "encompasses adequate material well-being, perceptions of well-being, basic level of satisfaction or contentment and a sense of self-worth" (George & Bearon, 1980, p. 2).

Measurements

Regulating agencies have attempted to measure quality of life by using the descriptors dignity, independence, and exercise of options (Sourcebook on Aging, 1979). The "transformation of the vague concepts of quality of life (morale, happiness, good adjustment and well-being) into a set of conditions began in the late 1940's and early 1950's" (McDonald, 1983 p.8). Ruth Cavan's Chicago Attitude Inventory was the first standardized test to measure Quality of Life, which was defined as positive adjustment to life situations. Life Satisfaction Indexes A and B by Neugarten, Havighurst, and Tobin measures life satisfaction in older persons. Attitudes found to be associated with life satisfaction were "(a) zest for life as opposed to apathy, (b) resolution and fortitude as opposed to resignation, (c) congruence between desired and achieved goals, (d) high physical psychological and social self-concept, and (e) happy optimistic mood tone" (Svirbely & Siram, 2002, p. 1). Joyce (1987) found that of the fifty rating scales purporting to measure quality of life published between 1966 and 1985 eighty-four percent measured clinical disability or social adjustment. The components covered in these scales were physical, cognitive, affective, and social and economic issues. These were similar to those of the clinical disability scales. The theorists in the 1990's took a more interdisciplinary approach by considering education level, gender, race, and socioeconomic class and the way each individual constructs his own reality. Each of the

variables – education, gender, race and class – affects the construction of identity and successful aging.[4] In examining quality of life for nursing home residents, life narratives of the residents were used rather than predefined tests and scales. High education and socioeconomic class created opportunities for interest development other than work. The terms successful aging and quality of life became used to define an individual condition of well-being.

Research

The majority of research on quality of life and leisure/recreation/activities for older adults can be grouped into three areas: frequency of activities, choice or control, and satisfaction or self-perception.

The Kansas City Adult study by Havinghurst (1957) was the first of several studies on the amount of activity participation and its correlation to quality of life. Subsequent studies also showed a positive relationship (Howe, 1988; Riddick & Daniel, 1984; Riddick, 1985) between amount of activity and quality of life. Ragheb and Griffith (1982) and Broderick & Glazer (1983) used the activity theory of aging as framework for research and observed that a satisfied older person was one who was physically, socially, and mentally active and has frequent interaction with all aspects of society. The more active an older person, the more that person was able to deal with the losses of roles common to advanced aged (Riddick & Daniel, 1984). Activity involvement promoted life satisfaction and lead to competence and independence in the older adult. Leisure participation and activity played an important role in the life of the older adult and contributed to the quality of life and life satisfaction (Boley, 2001).

[4]Also referred to as Life Review Theory (Hooyman & Kiyak, 1999).

Activity theory also suggested that being more active was better than being less active. Evard's (1999) research did not support this premise. Her data found that no relationship between total number of activities or number of routine activities existed with the concept well-being as tested on the self-administered Affect Balance Scale (ABS). "Older adults need to feel connected either socially or emotionally when engaging in activities to enhance well-being. A few well-chosen activities may have a greater impact on older adult well-being than many activities engaged in to fill the hours in a day" (Evard, 1999, 336-337). Other studies supported recreation activity frequency not being a predictor of quality of life (Larson, 1978; Stock, Okun, Haring, & Witter, 1983; Bull & Aucorn, 1975; Lemon, Bengtson, & Peterson, 1972; Russell, 1987).

Russell examined the relationship between recreation and quality of life and found that while sex, education, religiosity, marital status, and age were related to recreation participation and satisfaction, the only "direct predictor of quality of life" was satisfaction with recreation (Russell, 1990, p. 282). Other studies consistently resulted in satisfaction with activity being a predictor of quality of life (Ragheb & Griffith, 1982; Russell, 1987; Sneegas, 1986). Brown, Grankel, & Fennell (1991) used Bradbury's Affect Balance Scale to measure psychological well-being as an indicator of quality of life and its relationship to satisfaction with leisure choices. There was a "clear indication that what we do (the specific activities in which we engage) is less important than how we feel about doing as a predictor of well-being" (Brown, Grankel, & Fennel, 1991, p. 390).

Duncan-Myers & Huebner (2000) tested the correlation between perception of personal control and quality of life using the Quality of Life Rating (QoLR originally

designed for use on patients with cancer) and the Duncan Choice Index (DCI). The DCI measured the amount of choice available in self-care and in leisure activities. The correlation found between the amount of perceived choice and the Quality of Life Rating suggested that enabling choices in everyday tasks could increase self-perceived quality of life. Kurzt & Propst (1991) found that perceived leisure control correlated positively with life satisfaction. "It is not recreational activity in itself which is crucial but the extent to which such activity provides a sense of control and predictability over one's environment and entire life (Iso-Ahola, 1989, p. 354). Bocksnick & Hall (1994) compared the perceptions of the nursing home administrators and recreation therapists with the nursing home residents whether or not they were given free choice and the purpose of the activities. Older adults who resided in institutions were often "expected to adopt someone else's view of their needs and services as opposed to being active participants in decisions affecting their own lives" (Bocksnick & Hall, 1994, p. 2). Amount of choice in leisure activities correlated with perceived quality of life (Duncan-Myers Huebner, 2000). Enhancing nursing home residents' perceived control increased their activeness, interpersonal activity, mental alertness and psychological well-being in general (Iso-Ahola, 1989). The role of activity programs according to Cunninghis was "enhancement of the environment and provision of means to meet needs and interests of the resident – a realm where the resident can exercise choice, independence, and decision- making (Cunninghis, 1993, p. 6). The decision of choice to participate was more important than the choice of activity (Savell, 1988, p. 70).

Successful aging, therefore, was the process of reaching goals, which in turn then ensured the maintenance of quality of life (Baltes, 1994). Indicators of successful aging

used in the literature ranged from subjective – life satisfaction through control and choice to objective indicators – frequency of participation and measurements on tests (Baltes, 1994). Baltes recommended a shift from product or outcome to process oriented perspective, which produced a change in research questions from "what was successful aging to how, was it achieved" (Baltes, 1994, p. 187). Thomas posited that measuring quality of life by standards of care needed to be changed to measuring quality of life with "human and spiritual yardsticks" making it easy to create a new model of long-term care that met individual needs and "teams with biological and social diversity and answers to the rhythms of life rather than the schedules of planners" (Thomas, 1993, p. 22). "The laws and regulations only set minimal standards of what practitioners must do, it is ethical standards that prescribed what we should do" (Cunninghis, 1995, p. 3). Achieving quality of life was difficult because of the medical model on which long-term care was based. Quality of Life would be easier to achieve on an individual basis. "In the institution, as in the community, recreation serves as a way of improving the quality of life" (Weiner, Brok, & Snadowsky 1987, p. 135). As a result of his research, Iso-Ahola concluded that "recreation programming in the institutionalized settings was not to be a means of simply filling the patients' time; the objective is to induce residents to look forward to their future and enjoyable living" (Iso-Ahola, 1980, p. 355).

Other Recreation/Activities Research

While quality of life was the main reason given in the research for recreation therapy and activity programs in nursing homes, other areas of research included surveys of activities participation (Leitner & Leitner, 1985; Savell, 1988; Bocksnick & Hall, 1994); training of nursing assistants in activities (Martichusik, Bell, & Bradshaw, 1996);

effect of daily schedule on activity planning (Kleemeier, 1961); importance of socialization (Weiner, Brok, & Snadowsky, 1987); federal and state regulations of activities (Fenstermacher, 1976); activity directors' responsibilities (Snyder, 1989); and administrator philosophy (Tedrick & Green 1995). In 1959, a pilot program to develop activities rather than busy work was developed by the Veterans Administration Center in Wood, Wisconsin. Assessment of the individual's needs and preferences was the basis on which the activities were planned (Filer, 1959).

Even in a nursing home where the enhancement of quality of life through activity was the goal, 53% of the residents responded that the benefit of participation was to fill time and alleviate boredom. The gap between philosophy and practice seemed to be caused by the resident's lack of knowledge about the purpose and effects of therapeutic recreation and activities (Bocksnick & Hall, 1994).

Music's Role in Quality of Life Programs

All people around the world have created music as an expression of experiences, values, and beliefs. Music has served many functions – emotional expression, aesthetic enjoyment, entertainment, and the "maintenance of the cohesiveness of society," while enriching life and bringing beauty in to the daily existence of the individual (Abeles, Hoffer, & Klotman, 1991, p. 143). Throughout history, magical powers have been credited to music. The idea of music as a healing influence which could affect health and behavior is at least as old as the writings of Aristotle and Plato. Literature has many references that attribute healing powers to music, such as: music is able to heal and "hath charms to soothe the savage breast" (from Congreve, The Mourning Bride. Act I. Sc. 1 as

cited in Bartlett, 1919, 100/212.1) and "'Tis good; though music oft hath such a charm To make bad good, and good provoke to harm" (from Shakespeare, Measure for Measure. Act 4, Sc. 1).

The 20th century discipline of music therapy began after World War I and World War II when community musicians went to veterans' hospitals to play. The patients' physical and emotional responses led the doctors to request the hiring of musicians by the hospital. The demand then grew for a college curriculum to train these hospital musicians resulting in Michigan State University offering the first music therapy degree program in 1944 (American Music Therapy Association, 2003).

According to Alice Clair in Therapeutic Uses of Music with Older Adults, the definition of "therapeutic" must be made in the context of an individual's specific needs. "What is therapeutic is defined by what treats or cures diseases or disorders, rehabilitates, maintains or restores health or benefits one's mental state. Music is therapeutic in older individuals when it provides relief from physical, social, or emotional discomfort, and when it contributes to their ability to function. It is also therapeutic when it provides an individual with some personal control over the environments, physical functions, physical responses, emotional reactions and feelings, and management of social interactions and isolation" (Clair, 1996, p. 20).

Health Care Financing Administration now includes music therapy as a reimbursable service under certain conditions in Medicare's partial hospitalization policies and is reimbursed by Medicaid on a case-by case basis. Quality of Life programs involving cognitive and functional skills, social relationships, and the feeling of well-being are required in residential facilities that are Medicare/Medicaid certified. Because

music permeates our lives, it is an important medium in any quality of life program. The position of the American Music Therapy Association is that music activities in a nursing home need to be purposeful, age-appropriate and individually prescribed activities to meet the needs of each resident and that only a licensed music therapist is qualified to provide these opportunities.

As stated by the America Music Therapy Association, the sensory and intellectual stimulation of music can help maintain a person's quality of life (American Music Therapy Association, 2003). Music therapists use music as a tool to "effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health or educational problems" (American Music Therapy Association, 2003). In the aging population, quality of life and effecting positive changes overlap. Just as a thin line was found in the activities literature between recreational and therapeutic, it also has been found in the music literature for older adults. "A distinction between the recreational and therapeutic applications of music is theoretical and academic and, that in practice, both uses overlap" (Clair & Bernstein, 1994, p.119).

The Music Educators National Conference states that the primary purpose of music instruction was "to improve the quality of life for all students by developing their capacities to participate fully in their musical culture" (MENC, 1994, p.2). While most of the efforts of music educators have been on developing music skills in children, music for a lifetime and enhancing the quality of life have been recurring themes. As early as 1934, Mary Ireland wrote that "educators are taking this matter of adult or continuous education seriously" by reaching the adult of limited early opportunities as well as the "more fortunate man who desires to continue to study" (Ireland, 1934, p. 11). Listing

three contributing factors: (1) rapid changes in the world, (2) increased leisure and (3) that men and women in mature years can still learn quickly and effectively, Ireland supports her position by stating: "Education must be a continuous process through adult life" (Ireland, 1934, p. 11). In A Research Agenda for Music Education, there was a call for research in outreach programs that will provide lifelong music learning, the extensions of programs to older adults, and exploration of opportunities for intergenerational participation (Lindeman, 1999).

Research on music and older adults exists in the gerontology, medical, activity/recreation, music education, and music therapy literature. Music therapy has addressed ways in which music can be used to ameliorate problems often associated with aging, memory and reminiscence, and a variety of other physical and social concerns. Music education researchers have looked at vocal range and repertoire in older adults' singing, examined the effects of intergenerational music participation on age, and described model or experimental music programs for older adults. The area of music preference has received attention from the music education, music therapy, and gerontology fields. The nursing profession has examined the uses of music listening as a nursing intervention. Psychologists have studied the effects of aging on music and memory. The results of a literature search on music and older adults fell into descriptive, experimental, and discussion papers with recurring themes of aptitude, desire, attitudes, and preferences for style and for activity, lifelong learning, bereavement, age-related issues not from dementia, and persons with dementia.

Aptitude, Desires, Attitude

There was an ill-founded but widely accepted belief that older adults could no longer develop the psychomotor skills to play an instrument and that their minds could no longer function effectively in absorbing new information. After administering Gordon's Music Aptitude Profile to 119 older adults, Gibbons (1982a) concluded there was no decline in musical ability associated with aging. Standifer (1981) found that only physical disability, and not age, limits the ability to perform.

Long-term memory for songs exists and recall of songs in older adults was found to be better with title or lyric cues than with melody alone (Bartlett & Snelus, 1980). The most favorite songs were also the most familiar (Smith, 1991). Lyric recall was facilitated by tempo, word duration and total number of words and found to be lower for nursing home residents than for well older adults (Smith, 1996). .

Many of the vocal physiologic changes observed in older adults were found to be the result of medical conditions rather than aging (Hawkshaw, Rose, Sataloff & Spiegel, 1997). In examinations, the vocal range of older adult women was discovered to be either from "f" or a# below middle C to either G or C above and an octave lower for men (Greenwald & Salzberg, 1979; Moore, Stuam, & Brotons, 1991). Men's voices typically get slightly higher overtime and women's get considerably lower (Xue & Deliyski, 2001).

Preference for Style and Activity

Since musical taste was found to be set by late adolescence and remain stable throughout life (Larson, 1983), older adults were found to most prefer music that was popular during their early adulthood (Gibbons, 1977; Gilbert & Beal, 1982; Bartlett &

Snelus,1980; Lathom, Peterson & Havilicek, 1982; Jonas, 1991; Kramer, 1996; LeBlanc, Obert, Siivola & Sims 1996). Patriotic, hymns, and big band/jazz were among the most preferred genres discovered (McCullough, 1981; Lathom, Peterson & Havilicek, 1982; Moore, Staum & Brotons, 1992). Educational level and past musical experience were the strongest influences on choice of style, with the most educated preferring symphonies or opera (Lathom, Petersen, Havlicek, 1982). Other variables influencing style preferences were music training outside of school and community size where a person grew up (Jonas, 1991). According to Radocy & Boyle (1979), preferences result from a complex mixture of musical and human characteristics and are influence by cultural experiences.

Older adults have stated that music provided a source of activity, comfort, and stimulation (Flowers & Murphy, 2001) and have found it to be both recreational and personally fulfilling (McCullough, 1981). Music's importance increased as they became older (McCullough, 1981). Favorite music activities of older adults were found to be listening to older popular music and singing church hymns (Gilbert & Beal, 1982; Moore, Staum & Brotons, 1992). In one study older adults were found to be more interested in performing music than in listening to lectures about music (Robertson, 1996). But another study discovered that many preferred observational activities to experiences involving more active participation (Gilbert & Beal, 1982). Live music was found to be preferred over recorded music (Gilbert & Beal, 1982; Moore, Staum & Brotons, 1992). Enthusiastic presentation, personal contact or background accompaniment was not found to be as appealing as live singing (Moore, Staum, & Brotons, 1992). Other than residents

in nursing homes, there was a high preference for physical movement anddancing. Older adults were found not to like loud music (Smith, 1989; Reigler, 1980b; Jonas, 1992) and to prefer slow tempi (Moore, Staum, & Brotons, 1992).

Intergenerational activities, as an area of interest in providing programs to the elderly, were found to benefit both generations involved. The participants improved attitudes toward each other and established meaningful relationships. Research has been done with intergenerational choirs and other music activities involving children from preschool age through college age (Leitner 1991; Bowers, 1998; Darrow, Johnson, and Ollenberger, 1994; Frego, 1995; Newman, 1992; Emmons, 1998). A supportive administrator articulated, "The youngsters lighten the burden of old age" (Lindquist, 1986).

Lifelong Learning

Merely providing music programs is not the same as providing an education in music. "Lifelong music education refers to music learning that occurs as a result of deliberate effort and conscious long-term involvement" (Nazareth, 1999). Elderhostel programs, designed for individuals fifty-five years and older, were found to offer many opportunities for music learning (McCullough-Brabson, 1995; Smith 2000). Other examples of research in lifelong learning included composition (Moss, 1995; Bowles, 1996), improvisation (Bowles, 1996), band and instrumental lessons (Emmons, 1998; Ernst, 2001; Curran, 1982; Chiodo, 1997), and choir participation (Wise, Harmann, Fisher, 1992). Several general music classes for older adults emphasized the socialization and recreational aspects (Tatum, 1985; Kellmann, 1984). Other programs emphasized increasing musical skills and knowledge (Bernhart, 1991; Edgington, 1992;

Gibbons, 1984; Conda, 1997). Music being used to improve the quality of life was seen in several model programs designed by researchers (Gibbons, 1985; Nazareth, 1999; Edgington, 1992). Older adults listed the most important benefits of participation in music learning as self-expression, fun, and personal enrichment (Chiodo, 1997).

Childhood home musical environment was the best predictor of music activity level (Patchen, 1986; Darrough, 1990). Gibbons (1985) wrote that programs based on erroneous assumptions concerning the older adults musical behaviors inhibit participation. Programs that include opportunities for more active music participation usually require the minimum music skills usually learned in childhood. Despite this possible child-like skill level, activities, materials, equipment and instruments should be age appropriate and should take into account the capabilities of the participants (Coates, 1984; Nazareth, 1998; Jellison, 1999). "Rhythm band, kitchen band, and sing-alongs are diversions that can create demeaning situations without regard for individual dignity" (Gibbons, 1985, p. 50).

In adult education, technology was researched as a curriculum, a delivery mechanism, a complement to instruction and an instructional tool (Imel, 1998). This also applies to music – courses on how to use the technology preceded using the technology for instruction. Adult music education programs were produced by the Cleveland Symphony and broadcast on the radio in the 1930's. Piano and guitar and other music lessons have been shown over the television and recorded for playing on VCR's (Giles, 1981). Research has been done on using technology to teach piano (Keenan, 1995; He 1995; Shender, 1998). Older adults have reported using the computer as a database for music collections (White & Weatherall, 2000). SeniorNet (2002), an on-line website for

people over 55, has posted a music trivia game, information site, and discussion group on several areas of music. Even with the number of older adult computer users increasing each year, there were few studies exploring their use and attitudes.

Bereavement

The inevitability of death creates the predictability of grief and of mourning. People all around the world and in all cultures have developed rituals to memorialize and commemorate the deceased and console those who mourn. Throughout our lives music was used to "soundtrack" our experiences. Dees and Vera (1978) explored the correlation between types of music and social occasions to show how music was used to define the situation. Music used as a therapy in aiding elder patients to complete their grief work has been shown effective both in the spiritual counseling explored by Berger (1993) and in the music therapy done by Bright (1986), Clair (1996), West (1994), and McClellan (1988). Music as a soundtrack of life, can aid in the working through the grief by evoking memories and creating an avenue of expression for those who have difficulty finding words to express their emotions. "With the simple touch of music, deep feelings are evoked, forgotten memories remembered, and soul-depth responses stirred" (Berger, 1993, p. 5).

Age-Related Issues Not From Dementia

"There are two principal ways of doing music therapy: 'active music therapy' which requires that the patient or a group of patients play musical instruments or sing with the therapist, and 'passive music therapy' whereby the patient or group of patients listen to the therapist, who plays live or recorded music to them" (Aldridge, 2000, p. 140). Passive music therapy has dominated the nursing research where music listening

has been found to have a positive effect on lowering stress and on the psychological state of patients in critical care environments, in surgical settings, in mental healthcare, and in pain control (Biley, 2000).

Studies found specific to nursing home residents were on preferences (Jonas, 1991), program planning (Weissman, 1981) status reports (Hylton, 1983; Davidson, 1970), individualized music (Burack, Jefferson, & Libow, 2002), and music therapy (Prickett, 2000). In both status reports, music activities were found to be organized by activity directors with little musical expertise, community volunteers, and music teachers. The most frequently reported activities were singing, listening to recorded music, and hymnsings. In one study, researchers found that nursing home residents who received two 45-minute music therapy sessions per week for five weeks, showed significant gains in quality of life indicators of life satisfaction, attitude, and self-concept (Prickett, 2000).

Compared to the research in music therapy on dementia, the body of active music therapy research on other medical issues was quite small. Promising music therapy research on issues of aging included: reality orientation (Smith, 1990; Riegler, 1980a; Bumanis & Yoder, 1987), depression (Hanser, 1990; Suzuki, 1999; Williams & Dorrow, 1983), reduction of abusive behavior (Meddaugh, 1986), and hand grasp strength (Confrancesco, 1985). Music therapy has been shown to be effective in gait therapy (Staum, 1983). The "physiological response of music caused by entrainment is music's greatest medical therapeutic value" (Hoffman, 1997, p. 52). Entrainment is the body's ability to synchronize its rhythms with the rhythms of vibrating bodies around it. The "rhythmic stimulation delivered by metronome pulses embedded in the music improved the mobility of patients with stroke or Parkinson's" (Marwick, 2000, p. 279).

Because music can trigger memories associated with a particular time in a person's life, it is frequently used in reminiscence therapy (Smith 1990; Wylie, 1990; Tolhust, Hollien, & Leeper, 1984). "If an old song does not initiate reminiscence it may be that the elderly have no personal memories associated with the stimulus. Subjects reminisce about personally experienced events and activities in which subjects participated or by which they were affected. Letting subjects choose the music may give them more control over the process" (Wylie, 1990, p. 10). Music and reminiscence has also been used to alleviate depression in persons with dementia (Ashida, 2000).

Dementia

According to Brotons (2000), clinical research in the area of music therapy and dementia began in 1986. Norberg, Melin & Asplund (1986) observed the mouth and eye movements of persons with end stage Alzheimer's disease and found that music was the only stimulus to elicit a response. The highest number of publications appeared between 1992-1994, just after the 1991 hearing before the Senate Special Committee on Aging. Music therapists, clients and spouses, physicians, and musicians gave testimonies on the therapeutic uses of music. Health professions other than music therapists wrote over half of these publications (Brotons, 2000).

A review of the literature available on music therapy and dementia supports the benefits of use of music therapy in treating or managing dementia symptoms. Music therapy for the elderly in institutions can be described as "quality of life therapy" (Kirkland & Munroe, 1996, p. 9). "Quality of life expectations become paramount in any management strategy, and music therapy appears to play an important role in enhancing the ability to take part actively in daily life" (Aldridge, 2000, p. 161). For the person

with Alzheimer's disease, music " has the power to provide a sense of accomplishment, to energize and stimulate, to trigger words, and to soothe and comfort" (Smith 1990, p. 59). The familiarity of music triggers access to the skills, and performing a remembered song provides the person with a sense of pride and accomplishment and a link to their past that remains intact, despite the decline in cognitive ability (Clair, 1996).

For people in middle stage dementia, music has been found to provide structured reality, order, predictability and familiarity (Clair, 1999; Smith-Marchese, 1994; Whitcomb, 1989). Singing has been found in many studies to continue even when the patient can no longer speak (Millard & Smith 1989; Christie, 1992; Clair & Bernstien, 1990, Prickett & Moore, 1991; Whitcomb, 1993). Even after singing and speaking have stopped, some people have continued to be able to dance or produce rhythmic responses (Clair & Bernstein 1990; Clair, Bernstien & Johnson; 1995; Garand, Gfeller, Hanson, Swason, & Woodworth, 1996). The use of music has been found to enhance eating environments (Sutton, 2000) and establish a secure environment for bathing (Schiemann, 2000; Clair & Bernstein, 1994; Thomas, Heitman, & Alexander, 1997).

Music that makes no cognitive demands has been used to calm and quiet agitated people in late-state dementia (Clair & Bernstein, 1994). Individualized Music based on the residents specific music preferences, has been an effective intervention for agitation with those persons had a prior appreciation for music (Gerdner, 1999). Socialization patterns and skills have been found to increase as a result of music therapy sessions (Pollack & Namazi 1992). Structured music activities have been found effective in reducing wandering (Groene 1993). Agitation has been shown to decrease during and

after a music session (Meddaugh, 1986). Providing music experiences has been promoted as a way that caregivers can still interact with the patient (Clair, 1996).

Music therapists surveyed in three southern states agreed that music therapy was effective in improving the quality of life of patients with Alzheimer's disease by aiding in the following areas: decreased wandering, improved memory and recall, decreased disruptive behaviors, improved social functioning and behaviors, improved eating and sleeping habits, decreased stress agitation, anxiety and fear, improved communication with less aphasia and improved bathing routine and other activities of daily living (McLemore, 2000).

Kelleher (2001) offers the following suggestions for facilities that cannot afford a full-time formal music therapy program: seek volunteers with musical talents, offer internships and work-study opportunities for music therapy students, and share the services of a music therapist across several site and programs. She adds that there are benefits to using a professional music therapist that can set up a science-based program with plans, goals and assessment. By way of explanation she writes that a sensitive good-hearted neighbor can help a depressed friend, but can't do the same things as a psychiatrist (Kelleher, 2001).

Recently research has shifted from case studies and anecdotal testimonies to empirical design studies done by researchers in music therapy and in medicine. A recent study performed by the University of Miami School of Medicine measured increased levels of melatonin[5] following music therapy in patients with Alzheimer's disease, which

[5] Melatonin is a derivative of serotonin, with which it works to regulate the sleep cycle, and is being used experimentally to treat jet lag, SADS, and insomnia in shift workers and the elderly (Concise Medical Dictionary).

indicated a relaxed, calm mood (Kumar, Tims, Cruess, Mintzer, Ironson, Loewenstein, Cattan, Fernadez, Eisdorfer & Kuma, 1999).

Summary

In the texts, training manuals, and recreation/activity literature, the term "quality of life" did not appear until the 1970's. Purposes given for including activities began with preservation of life, "add to sunset years," rehabilitation and diversion, and settled on therapy in the 1980's. Theories of aging were reflected in the literature as long ago as the 1930's – role, activity and continuity theories being the most prevalent. Music therapy was not recognized in the activity profession literature as a valuable profession until the 1960's. Most texts referred to music as another useful and important activity for the activity leader to include. The texts and manuals grew from 1950's cookbook style models describing the attributes of the activity worker, materials, and directions for activities to the 2000 quality assurance plan on how to meet the new federal guidelines on quality of care and quality of life.

Even though the nursing home population has been declining, the baby boom population is aging and expectations for an increase in the need for long-term care is expected within the next decade. The leading diagnosis of circulatory system disease has not changed between 1950 and 2000.

The current role of government legislating quality of life in the OBRA regulations developed over the past fifty years from providing care for the care in poor houses, providing funding for the poor, and regulating quality of care and facilities. Activities were seen as a way to keep residents happy and making life worthwhile in the 1950's.

This changed in the 1970's to recreation meeting human need and necessary for quality of life.

Quality of Life is the overarching philosophy guiding the development of activity programs. Though many definitions exist and each individual constructs his/her own definition, Quality of Life is generally perceived as self determined. Long-term care facilities provide the conditions and the individual must choose to accept them. Dignity, independence and freedom to choose are considered conditions of quality of life programs. Choice and satisfaction by the individual according to the research is more of a determinant of quality of life than frequency of participation in activities.

In the 1800's the "aged: were seen as "waiting to die." By the 1950's the "old" were to be helped accept their new role as an aging member of society. During the 1960's the "oldsters" needed to be kept busy to keep their minds off their illnesses. By the 1970's quality of life was the goal of activity programs for the "senior citizens." Activities as therapy became prevalent in the 1980's for the "elderly." Activities added variety and quality of life to the "older adults" in the 1990's. The goals of restoring, developing and preserving functional abilities, and slowing the rate of decline have not changed from 1930 to the present.

Music has always been a part of the lives of residents in long-term care facilities. How it is used is dependent on the person who implements the program. The activities and recreation leaders in the facility value and utilize music as one aspect of their program to aid in insuring quality of life for their residents. The music therapy profession positions it as a viable allied medical therapy useful in ameliorating problems of aging.

CHAPTER 3

PROCEDURES

Research Design

The purpose of this study was to investigate and analyze the status of the use of music in nursing homes in the state of Ohio. Areas of concern included qualifications of personnel planning activities; sources of ideas for planning; available materials and equipment; frequency and duration of activities; types of activities, trips, or performances; intergenerational and community activities; and purposes and philosophical view on including music activities. To obtain this information a questionnaire (Appendix A) consisting of nineteen questions was sent by U.S. Mail to all Medicare and Medicaid-certified nursing homes in the state of Ohio. The specific purposes of this questionnaire for the nursing homes in the state of Ohio were as follows:

1. What is the status of music in Ohio nursing homes including materials, activities and personnel?
2. How many long-term care facilities in Ohio receive services by Licensed Music Therapists or persons with music degrees?
3. Are there apparent differences in music activities in facilities categorized by size, accreditation, and region?

4. What are the reasons cited by facilities personnel for the inclusion of music activities? What are the intended outcomes?

The questionnaire was designed to be completed within fifteen minutes. Of the eighteen questions, eleven were multiple choice with the category "other" to elicit related information. Seventeen questions examined concrete facts asking who, what, where, when, and how. The other question was more intangible asking why.

Subject Selection

The population was a census of every Medicare and Medicaid-certified nursing home in the state of Ohio listed in the Nursing Home Compare database accessible on the official U.S. Government Site for People with Medicare. The State of Ohio has such a large population of nursing homes that it is divided into two sections- East/North and West/South. In the summer of 2002, there were 995 Medicare and Medicaid-certified nursing homes in the state of Ohio. The names and addresses of each facility were copied and saved into an Excel spreadsheet from which mailing labels for the envelopes were made.

Each questionnaire was coded by size of facility, Ohio county, and certification by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Facilities with fewer than 50 certified beds were classified as small, 50-99 as medium, 100-199 as medium/large and over 200 as large. The questionnaires sent to facilities certified by the JCAHO were marked with small letter "j" on page 1 top right hand corner. Questionnaires sent to small facilities were printed on yellow paper, medium in pink, medium/large in blue, and large in green. All counties in the state of Ohio were

alphabetized and numbered sequentially. This identifying number appeared in the upper right hand corner of page one.

Outcome Measures

Using the readability level option available on Word from Microsoft Office 2000, the Flesch-Kincaid [6]score for the questionnaire was Grade Level 9. Each readability score bases its rating on the average number of syllables per word and words per sentence. Most standard documents aim for a score of approximately 7.0 to 8.0. A grade level of 9 is not too high for a document targeted to a responder who is a professional.

To write the questions, several sources (Ary, Jacobs & Razavieh, 1996; Weisberg & Krosnick, Bowen, 1996; Miller, 1999) were consulted and the following guidelines were developed: (a) Questions should be short; (b) Terminology used in questions should be understood by the target audience and have the same meaning for both researcher and responder; (c) Meaning of question should be the same to responder and to researcher (unambiguous); (d) Questions should not offend; (e) Answers should include all possibilities; (f) Responder should have space and option to add additional information; and (g) Questions should provide answers to research questions.

To strengthen content validity, the draft questionnaire (Appendix A) was given to two music education faculty and a gerontology faculty member at Ohio State University and to a former nursing home administrator. These experts evaluated the questionnaire

[6] "This is a readability test designed to show how easy or difficult a text is to read. The Flesch-Kincaid Index uses the following formula: 0.39 x Average No. of words in sentences + 11.8 x Average No. of syllables per word - 15.59" (Flesch-Kincaid Index, 2003).

on organization, ambiguity, redundancy, possibility of offense, and terminology. The final survey was the result of three revisions incorporating suggestions from each of the reviewers.

Assuring confidentiality increased validity of responses. The cover letter informed the respondents that their facility and their responses would not be identified in any report of the collected data.

Further refinement of the survey instrument was accomplished in the fall of 2002 by field-testing the questionnaire. The researcher asked for appraisal of the questionnaire from activity directors employed by four Medicare/Medicaid-certified nursing homes from each of four cities in the State of Virginia – Fairfax, Fredericksburg, Richmond, and Alexandria (n=16). They were asked to comment on the amount of time it took to complete questionnaire; any terms or questions that were ambiguous; suggestions for possible improvement; ease of answering questions; interest in the topic; and clarity of instructions. There was a 50% return rate (n=8) with an average of 10 minutes to complete the questionnaire and no additional suggestions for improvement.

To increase return rate, the questionnaire was kept to two pages. Facility information that could be determined by other means was not included. The cover letter was on Ohio State University letterhead and explained the purpose of the project and the importance of participation. A list of music resources and activities was included in appreciation for completion. A self-addressed stamped envelope was included for returning the completed questionnaire. A reminder post card was sent two weeks after the initial mailing to all facilities. At the bottom of the questionnaire was an offer to send results if a name and address were included on a separate piece of paper. One hundred

thirty-three respondents requested copies of the results and/or further information on the uses of music. Since only 356 facilities returned the questionnaire in December 2002, for a return rate of 35% after the first mailing and the reminder card, a second mailing went out two weeks later in January 2003, to the 639 facilities who had not responded. This time a "Buckeye" sticker from Ohio State University was included as a thank you. An additional 371 facilities responded for a total of 727 (73%).

Comparing early to late respondents and comparing respondents to non-respondents on known characteristics achieved control for non-response error. Research has shown that non-respondents are often similar to late respondents (Goldhor, 1974). There was no difference in responses between early and late respondents. Respondents in general were typical of the population (Ary, Jacobs, Razaveih, 1996). There were fairly equal percentages returned by sizes, areas, and certification types.

Exemption from review by the Institutional Review Board of Ohio State University was received on August 19, 2002, Protocol Number 02E0280. No changes were made to the research design, the selection of subjects, the informed consent process or the instrumentation during the course of the study.

Data Analysis

Data classified by county, size and certification responses were entered into an Excel Spreadsheet. Using the county code, each facility was recoded according to the Area Agency on Aging's twelve Planning and Service Areas (PSA). Each size, certification, and PSA category was then pasted onto its own Excel spreadsheet and the data from each question were analyzed using Excel statistical tools within that

classification. The totals from each category were combined for each question into a separate Excel workbook. JCAHO facilities responses were listed side by side with non-JCAHO facilities. Responses from small, medium, medium/large, and large facilities were presented along with the responses from each location within the state. A summary of the responses was presented descriptively and with charts through frequency, means, and percentages. "In designing an analysis, the researcher must decide whether to employ significance tests and what types to employ. When dealing with large samples, researchers often decide not to employ formal significance tests and instead simply describe the sample results" (Weisberg, Krosnick, & Bowen, 1996, p. 187). "Surveys typically don't require complex statistical analyses. Data analysis may simply consist of determining frequencies and percentages of responses for the questions of the study" (Ary, Jacobs, Razaveih, 1996, p. 463).

Additional questions were answered pertaining to materials, activities, and personnel. All descriptive data was reduced placing the keywords first and using the "text to column" and "consolidate" features of Excel. The resulting most frequent appearing keywords were used to reduce the descriptive data into categories. Finally all descriptive data was broken down into the size, certification, and PSA designations using the "conditional sum" wizard of Excel.

CHAPTER 4

RESULTS

The purpose of this study was to investigate and analyze the status of the use of music in nursing homes in the state of Ohio. A survey instrument was designed to (a) obtain information on the status of music in Ohio nursing homes, (b) determine how many employ licensed music therapists, (c) examine attitudes of activity directors towards use of music, and (d) examine the music equipment and activities offered by size of facility, accreditation by the Joint Commission on Accreditation of Healthcare Organizations (abbreviated as JCAHO), and Planning and Service Areas (PSA) within the state. This chapter is a presentation of the data resulting from the preparation and return of the survey questionnaire and is organized into four sections: Facilities Information, Materials, Music Activities, and Personnel. Additional comments, advice, and descriptions offered by the facilities are included in Appendix E.

Facilities Information

Following the classification used by the National Center For Health Statistics and other agencies of the federal government, facilities with fewer than 50 certified beds were classified as small; 50-99 as medium; 100-199 as medium/large; and over 200 as large. The data reported in this section were obtained from an analysis of the facility information provided by Medicare, the JCAHO listing of certified nursing homes, the

Ohio Association of Area Agencies on Aging, and the administration of a questionnaire to the 995 Medicare/Medicaid-certified nursing homes in the state of Ohio. Of the 995 questionnaires, "Uses of Music in Ohio Nursing Facilities," sent to nursing facilities in the State of Ohio, seven were returned for incorrect addresses and 727 were returned completed.

	Small	**Medium**	**M-Large**	**Large**	**Total**
Surveys Mailed	161	360	428	46	**995**
Mail Returned	0	5	2	0	**7**
Adjusted Total	161	355	426	46	**988**
Survey Returned	109	266	321	31	**727**
Return Rate	68%	74%	75%	67%	**73%**

Table 4.1: Facilities Response Rate by Size

Of the total number of facilities from which surveys were returned, fifteen percent were certified by JCAHO. Three of the survey instruments were returned with the identifying code numbers on the envelopes and questionnaires removed. Two were colored coded blue (counted as medium/large) and one was green (counted as large) and all three were classified as PSA Unknown. Only sixty-nine percent of the JCAHO-certified facilities returned the questionnaires compared to seventy-four percent of non-JCAHO-certified nursing homes.

	Total Sent		Total Returned	
JCAHO	154	15%	107	69%
Non-JCAHO	841	85%	620	74%

Table 4.2: Facilities Response Rate by Certification

The state of Ohio has a total of eighty-eight counties. These counties are assigned to one of twelve PSA's (Planning and Service Areas) by the Ohio Department of Aging. The divisions snake through the state from the southwest corner to the northeast corner and are as follows: District 1 (Cincinnati Area), District 2 (Dayton Area), District 3 (Lima Area), District 4 (Toledo Area), District 5 (Mansfield Area), District 6 (Columbus Area), District 7 (Rio Grande Area), District 8 (Athens/Marietta Area), District 9, Cambridge Area), District 10a (Cleveland Area), District 10b (Akron Area), and District 11 (Youngstown Area).

A chart showing these divisions is included as Appendix D. District 8 (Athens/Marietta) had the highest return rate, followed by District 4 (Toledo), and District 3 (Lima). District 1 (Cincinnati) had the lowest return rate, followed by Cleveland (PSA 10a) and Akron (PSA 10b). Districts 2 (University of Dayton), 10b (College of Wooster), 8 (Ohio University), and 10a (Baldwin-Wallace) have schools that are approved by the American Music Therapy Association to offer degree programs in music therapy (AMTA School Directory, 2003).

PSA	1	2	3	4	5	6	7	8	9	10a	10b	11	?	TOTAL
Sent	132	100	49	87	63	98	52	23	58	166	96	71		**995**
Returned	83	77	40	73	49	72	38	20	44	111	65	52	3	**727**
Return Rate	63%	77%	82%	84%	78%	73%	73%	87%	76%	67%	68%	73%		**73%**

Table 4.3: Facilities Response Rate by Planning & Service Area

Materials

The first section of questions consisted of five items designed to provide information on the sources and types of materials available in each of the facilities.

Question 1. Where do you get ideas for music programs?

Networking (54%), volunteer expertise (49%), books (48%), and workshops (38%) were the top choices for music program ideas, followed by newsletters, professional publications, "other," staff meetings and web-based materials. JCAHO facilities responded with the same choices as the total. Large facilities reported more books, networking, and workshops while the small facilities, reported more volunteer expertise. Ninety percent of PSA 8 (Athens/Marietta) responded "volunteer expertise." PSA 7 (Rio Grande) had a higher than average response for books; PSA 9 (Cambridge) responded higher than average for books and volunteers; PSA's 3 (Lima) and 4 (Toledo) had higher response rates than average for network and volunteers; PSA 2 (Dayton) and 5 (Mansfield) had higher responses for volunteers.

Creative Forecasting was the most frequent written response (19%) for type of publication, followed by A New Day, Eldersong, Activities Director Guide, and music therapy journals. The medium (49%) and medium/large facilities (53%) reported

Creative Forecasting twice as often as did the small (19%) and large facilities (2%). The medium/large and the JCAHO facilities reported 3% using music therapy publications, as did PSA 1 (Cincinnati). Other areas reporting using music therapy publications were PSA 2 (Dayton) and PSA 10a (Cleveland) (complete table available in Appendix F).

The most frequently written "other" responses were, in order, community resources (churches, library, and newspapers), musicians'advertisements, "self", residents and their families, non-specified "other" and professional (other facilities and activities directors). Less frequent resources were music therapists, staff, and catalogs. JCAHO facilities reported using music therapist and "self" more than other facilities. Non-JCAHO reported less of everything except volunteers and others.

Ideas	Small		Medium		M-Large		Large		Total	
Books	47	43%	119	45%	167	52%	19	61%	**352**	**48%**
Networking	43	39%	139	52%	188	59%	19	61%	**389**	**54%**
Newsletter	27	25%	100	38%	112	35%	9	29%	**248**	**34%**
Publications	30	28%	83	31%	98	31%	13	42%	**224**	**31%**
Staff Meeting	20	18%	60	23%	66	21%	13	42%	**159**	**22%**
Volunteer	50	46%	139	52%	156	49%	12	39%	**357**	**49%**
Web-based	18	17%	49	18%	54	17%	7	23%	**128**	**18%**
Workshops	40	37%	92	35%	132	41%	14	45%	**278**	**38%**
Other	29	27%	69	26%	62	19%	7	23%	**167**	**23%**

Table 4.4: Idea Sources by Size

Ideas	JCAHO		Non-JCAHO		Total	
Books	**59**	**55%**	293	47%	352	48%
Networking	**72**	**67%**	317	51%	389	54%
Newsletter	**38**	**36%**	210	33%	248	34%
Publications	**35**	**33%**	189	30%	224	31%
Staff Meeting	**29**	**27%**	130	21%	159	22%
Volunteer	**48**	**45%**	309	49%	357	49%
Web-based	**28**	**26%**	100	16%	128	18%
Workshops	**47**	**44%**	231	37%	278	38%
Other	**22**	**21%**	145	23%	167	23%

Table 4.5: Idea Sources by JCAHO

Ideas	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Books	41	49%	38	49%	16	40%	34	47%	20	41%	34	47%	24	63%
Networking	57	69%	41	53%	19	48%	41	56%	19	39%	40	56%	11	29%
Newsletter	30	36%	34	44%	15	38%	26	36%	13	27%	23	32%	12	32%
Publications	31	37%	27	35%	14	35%	22	30%	13	27%	22	31%	9	24%
Staff Meeting	23	28%	17	22%	8	20%	13	18%	8	16%	16	22%	6	16%
Volunteer	33	40%	45	58%	19	48%	41	56%	31	63%	36	50%	21	55%
Web-based	18	22%	17	22%	10	25%	8	11%	8	16%	13	18%	6	16%
Workshops	37	45%	29	38%	14	35%	31	42%	20	41%	22	31%	10	26%
Other	22	27%	18	23%	9	23%	7	10%	11	22%	17	24%	7	18%

Ideas	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Books	12	60%	25	57%	54	49%	29	43%	24	46%	1	33%	352	48%
Networking	5	25%	17	39%	69	62%	39	57%	29	56%	2	67%	389	54%
Newsletter	6	30%	16	36%	28	25%	25	37%	19	37%	1	33%	248	34%
Publications	11	55%	16	36%	33	30%	14	21%	9	17%	2	67%	224	31%
Staff Meeting	5	25%	7	16%	24	22%	18	26%	13	25%	1	33%	159	22%
Volunteer	18	90%	24	55%	44	40%	23	34%	21	40%	1	33%	357	49%
Web-based	2	10%	6	14%	25	23%	8	12%	7	13%	0	0%	128	18%
Workshops	8	40%	19	43%	49	44%	20	29%	18	35%	1	33%	278	38%
Other	2	10%	9	20%	30	27%	17	25%	19	37%	0	0%	167	23%

Table 4.6: Idea Sources by Area

Question 2. Which musical instruments are available for use by residents in your facility?

Eighty-nine percent of the facilities responded affirmatively to having pianos and 11% left the question blank. After pianos, instruments reported in order of frequency

were organs, handbells/chimes, electronic keyboards, percussion instruments, harmonicas, and guitars. Small and JCAHO facilities reported bells and electronic keyboards more than organs, as did PSA's 6 (Columbus), 7 (Rio Grande), and 10a (Cleveland).

There were an average of 1.4 pianos per facility ranging from zero to ten. The larger the facility, the more pianos were reported. Rhythm band and small percussion instruments were the most frequent written response under "other," followed by electronic equipment and autoharp, q-chord (digital combination of an autoharp, piano, guitar), and omnichord-type instruments. Others less frequently written were dulcimer, accordion, kazoo, keyboard, and harp (Appendix F). Larger facilities had more total instruments available than did smaller.

Recorders were included as an option in the survey but not included in the results. There also was no discussion of recorders being used in any programs or activities later in the survey. Facilities that responded having recorders also wrote electronic equipment in "other."

Instruments	Small		Medium		M-Large		Large		Total	
Electronic Keyboard	38	35%	87	33%	110	34%	26	84%	**261**	**36%**
Guitar	13	12%	28	11%	34	11%	8	26%	**83**	**11%**
Handbells/chimes	46	42%	126	47%	165	51%	21	68%	**358**	**49%**
Harmonicas	11	10%	33	12%	45	14%	8	26%	**97**	**13%**
Organ	35	32%	138	52%	171	53%	23	74%	**367**	**50%**
Percussion	24	22%	80	30%	101	31%	14	45%	**219**	**35%**
Piano	80	73%	237	89%	302	94%	31	100%	**650**	**89%**
Other	**23**	**21%**	37	14%	45	14%	8	26%	**113**	**7%**

Table 4.7 Instruments by Size

Instrument	JCAHO		Non-JCAHO		Total	
Electronic Keyboard	**41**	**38%**	220	36%	261	36%
Guitar	**10**	**9%**	73	12%	83	11%
Handbells/chimes	**52**	**49%**	306	50%	358	49%
Harmonicas	**10**	**9%**	87	14%	97	13%
Organ	**47**	**44%**	320	52%	367	50%
Percussion	**37**	**35%**	182	29%	219	35%
Piano	**103**	**96%**	547	89%	650	89%
Other	**19**	**18%**	94	15%	113	7%

Table 4.8 Instruments by JCAHO

Instrument	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Electronic Keyboard	27	33%	29	38%	16	40%	28	38%	13	27%	24	33%	16	42%
Guitar	9	11%	8	10%	4	10%	5	7%	4	8%	8	11%	4	11%
Handbells/chimes	44	53%	35	45%	20	50%	31	42%	24	49%	37	51%	18	47%
Harmonicas	9	11%	10	13%	4	10%	8	11%	3	6%	6	8%	6	16%
Organ	49	59%	44	57%	27	68%	43	59%	27	55%	30	42%	8	21%
Percussion	32	39%	14	18%	16	40%	16	22%	12	24%	22	31%	6	16%
Piano	70	84%	72	94%	37	93%	69	95%	45	92%	68	94%	33	87%
Other	14	17%	14	18%	7	18%	12	16%	6	12%	10	14%	9	24%

Instrument	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Electronic Keyboard	5	25%	10	23%	47	42%	24	35%	19	37%	3	100%	**261**	36%
Guitar	3	15%	6	14%	18	16%	10	15%	4	8%	0	0%	**83**	11%
Handbells/chimes	6	30%	15	34%	63	57%	36	53%	27	52%	2	67%	**358**	49%
Harmonicas	4	20%	6	14%	16	14%	12	18%	12	23%	1	33%	**97**	13%
Organ	9	45%	20	45%	45	41%	36	53%	27	52%	2	67%	**367**	50%
Percussion	4	20%	13	30%	40	36%	25	37%	18	35%	1	33%	**219**	30%
Piano	19	95%	41	93%	95	86%	54	79%	45	87%	2	67%	**650**	89%
Other	2	10%	7	16%	22	20%	4	6%	6	12%	0	0%	**113**	16%

Table 4.9: Instruments by PSA

Question 3. Does your facility have computers available for use by the residents?

About 2/3's of the total facilities (67%) reported they did not have computers for patient use. Larger facilities were more likely to respond "yes" (55%) than weresmaller (26%). The ratio between JCAHO "yes" and "no" responses was closer (57%/42%) than the Non-JCAHO (69%/30%). PSA's 2 (Dayton) and 3 (Lima) responded "yes" most often and PSA's 5 (Mansfield), 7 (Rio Grande), 8 (Athens), and 9 (Cambridge) had the most "no's."

Despite 32% of facilities reporting computer use, 66% had no response and 27% responded "none" to the question about available music software. For those who did report having software, music listening programs and "other" (games, internet) were the most popular choices. Large facilities (13%) and PSA 3 (Lima) (15%) reported more music listening programs than average (5%) .

Computers	**Small**		**Medium**		**M-Large**		**Large**		**Total**	
Responses	108	99%	262	98%	319	99%	31	100%	**720**	**99%**
Yes	28	26%	83	31%	104	32%	17	55%	**232**	**32%**
No	80	73%	179	67%	215	67%	14	45%	**488**	**67%**

Table 4.10: Computers by Size

Computers	**JCAHO**		**Non JCAHO**		**Total**	
Responses	**106**	**99%**	614	99%	720	99%
Yes	**45**	**42%**	187	30%	232	32%
No	**61**	**57%**	427	69%	488	67%

Table 4.11: Computers by JCAHO

Computers	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Responses	83	100%	75	97%	40	100%	73	100%	49	100%	71	99%	37	97%
Yes	28	34%	32	42%	19	48%	25	34%	10	20%	24	33%	5	13%
No	55	66%	43	56%	21	53%	48	66%	39	80%	47	65%	32	84%

Computers	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Responses	20	100%	44	100%	110	99%	63	97%	52	100%	3	100%	720	99%
Yes	5	25%	9	20%	34	31%	20	31%	18	35%	3	100%	232	32%
No	15	75%	35	80%	76	68%	43	66%	34	65%	0	0%	488	67%

Table 4.12: Computers by PSA

Software	Small		Medium		M-Large		Large		Total	
Listening Programs	3	3%	13	5%	19	6%	4	13%	**39**	**5%**
Learning Programs	0	0%	1	0%	2	1%	0	0%	**3**	**0%**
Music Writing Program	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Piano Lesson Program	0	0%	1	0%	1	0%	0	0%	**2**	**0%**
None	27	25%	66	25%	92	29%	11	35%	**195**	**27%**
Other (games, internet)	1	1%	7	3%	5	2%	4	13%	**17**	**2%**
No response	78	72%	181	68%	208	65%	12	39%	**479**	**66%**

Table 4.13: Software by Size

Software	JCAHO		Non JCAHO		Total	
Listening Programs	**5**	**5%**	34	5%	39	5%
Learning Programs	**1**	**1%**	2	0%	3	0%
Music Writing Program	**0**	**0%**	0	0%	0	0%
Piano Lesson Program	**1**	**1%**	1	0%	2	0%
None	**27**	**25%**	168	27%	195	27%
Other (games, internet)	**4**	**4%**	13	2%	17	3%
No response	**69**	**64%**	410	66%	479	66%

Table 4.14: Software by JCAHO

Software	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Listening Programs	7	8%	5	6%	6	15%	0	0%	2	4%	3	4%	2	5%
Learning Programs	0	0%	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%
Music Writing Program	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Piano Lesson Program	0	0%	0	0%	1	3%	0	0%	0	0%	1	1%	0	0%
None	26	31%	22	29%	10	25%	24	33%	11	22%	22	31%	4	11%
Other (games, internet)	1	1%	2	3%	0	0%	2	3%	0	0%	2	3%	0	0%
No response	49	59%	48	62%	24	60%	48	66%	36	73%	45	63%	32	84%

Software	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Listening Programs	1	5%	2	5%	5	5%	3	5%	3	6%	0	0%	39	5%
Learning Programs	0	0%	0	0%	0	0%	0	0%	2	4%	0	0%	3	0%
Music Writing Program	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Piano Lesson Program	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2	0%
None	4	20%	11	25%	29	26%	15	23%	14	27%	3	100%	195	27%
Other (games, internet)	0	0%	0	0%	5	5%	4	6%	1	2%	0	0%	17	2%
No response	15	75%	31	70%	73	66%	44	68%	34	65%	0	0%	479	66%

Table 4.15: Software by PSA

Question 4. What kind of electronic equipment is available for use by residents?

With the exception of tape players, the larger the facility the more likely it responded "yes" to having each of the most common types of electronic equipment. Radios, karaoke, and talking book machines were the most frequently mentioned "other." Televisions and VCRs were in 98% percent of the facilities, followed by tape players (95%), CD players (92%) and record players (45%). Only 113 (16%) total facilities reported owning DVD players. Dayton (PSA 2) responded with the most DVD players and Lima (PSA 8) and Youngtown (PSA 11) with the most record players.

Electronic	Small		Medium		M-Large		Large		Total	
CD player	97	89%	247	93%	296	92%	30	97%	**670**	**92%**
DVD player	9	8%	35	13%	59	18%	10	32%	**113**	**16%**
Record player	32	29%	119	45%	153	48%	20	65%	**324**	**45%**
Tape player	105	96%	249	94%	311	97%	28	90%	**693**	**95%**
Television	108	99%	258	97%	315	98%	31	100%	**712**	**98%**
VCR Player	107	98%	259	97%	312	97%	31	100%	**709**	**98%**
Other	20	18%	40	15%	61	19%	4	13%	**125**	**17%**

Table 4.16: Electronic Equipment by Size

Electronic	JCAHO		Non JCAHO		Total	
CD player	**95**	**89%**	575	93%	670	92%
DVD player	**18**	**17%**	95	15%	113	16%
Record player	**55**	**51%**	269	44%	324	45%
Tape player	**101**	**94%**	592	96%	693	95%
Television	**102**	**95%**	610	99%	712	98%
VCR Player	**105**	**98%**	604	98%	709	98%
Other	**21**	**20%**	105	17%	125	17%

Table 4.17: Electronic Equipment by JCAHO

Electronic	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
CD Player	79	95%	74	96%	36	90%	66	90%	47	96%	69	96%	37	97%
DVD Player	15	18%	20	26%	6	15%	11	15%	7	14%	13	18%	4	11%
Record Player	37	45%	35	45%	19	48%	29	40%	20	41%	32	44%	9	24%
Tape Player	80	96%	72	94%	39	98%	68	93%	49	100%	66	92%	35	92%
Television	82	99%	75	97%	40	100%	71	97%	49	100%	69	96%	37	97%
VCR Player	83	100%	74	96%	40	100%	72	99%	49	100%	70	97%	37	97%
Other	15	18%	13	17%	6	15%	16	22%	8	16%	14	19%	6	16%

Electronic	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		UNKNOWN		TOTAL	
CD Player	18	90%	36	82%	97	87%	57	88%	51	98%	3	100%	670	92%
DVD Player	3	15%	2	5%	11	10%	12	18%	9	17%	0	0%	113	16%
Record Player	11	55%	19	43%	54	49%	29	45%	28	54%	2	67%	324	45%
Tape Player	20	100%	43	98%	107	96%	61	94%	50	96%	3	100%	693	95%
Television	20	100%	44	100%	109	98%	61	94%	52	100%	3	100%	712	98%
VCR Player	20	100%	44	100%	106	95%	59	91%	52	100%	3	100%	709	98%
Other	4	20%	11	25%	15	14%	13	20%	4	8%	0	0%	125	17%

Table 4.18: Electronic Equipment by PSA

Question 5. What kind of electronic media is available for use by residents?

Cassette tapes, videotapes, and compact discs were in the majority of facilities. Large facilities and those in PSA 2 (Dayton) (25%) responded with more DVDs than average (15%) and PSA's 7 (Rio Grande) (8%) and 9 (Cambridge) (5%) reported less. PSA's 8 (Athens/Marietta) (55%), 9 (Cambridge) (50%), 10a (Cleveland) (46%) and 10b (Akron) (48%) reported more records than the average 42%).

Media	Small		Medium		M-Large		Large		Total	
Cassette Tapes	105	96%	255	96%	305	95%	30	97%	**695**	**96%**
Compact Discs (CDs)	88	81%	227	85%	283	88%	27	87%	**625**	**86%**
DVDs	12	11%	28	11%	56	17%	11	35%	**107**	**15%**
Records	31	28%	108	41%	148	46%	17	55%	**304**	**42%**
Videotapes	102	94%	255	96%	306	95%	31	100%	**694**	**95%**

Table 4.19: Media by Size

Media	JCAHO		Non-JCAHO		Total	
Cassette Tapes	**103**	**96%**	592	96%	695	96%
Compact Discs (CDs)	**90**	**84%**	535	87%	625	86%
DVDs	**16**	**15%**	91	15%	107	15%
Records	**47**	**44%**	257	42%	304	42%
Videotapes	**103**	**96%**	591	96%	694	95%

Table 4.20: Media by JCAHO

Media	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Cassette Tapes	79	95%	73	95%	39	98%	71	97%	48	98%	69	96%	35	92%
CDs	73	88%	66	86%	33	83%	62	85%	42	86%	65	90%	34	89%
DVDs	13	16%	19	25%	7	18%	12	16%	7	14%	10	14%	3	8%
Records	31	37%	31	40%	18	45%	28	38%	19	39%	28	39%	11	29%
Videotapes	82	99%	71	92%	38	95%	70	96%	47	96%	68	94%	37	97%

Media	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Cassette Tapes	20	100%	41	93%	103	93%	63	97%	51	98%	3	100%	695	96%
CDs	17	85%	35	80%	92	83%	55	85%	48	92%	3	100%	625	86%
DVDs	3	15%	2	5%	12	11%	11	17%	8	15%	0	0%	107	15%
Records	11	55%	22	50%	51	46%	31	48%	21	40%	2	67%	304	42%
Videotapes	20	100%	43	98%	105	95%	59	91%	51	98%	3	100%	694	95%

Table 4.21: Media by PSA

Music Activities

The next nine questions were designed to determine what music activities were provided and how often.

Question 1. How often are music activities offered?

Thirty-five percent of all responding facilities offered music activities daily and thirty-five percent offered them 3-5 times per week. Twenty-three percent reported 1-2 times per week. Few facilities answered "rarely" and no facility answered "never." JCAHO facilities were no different. PSA's 1 (Cincinnati), 2 (Dayton), 8 (Athens/Marietta), and 10a (Cleveland) replied 3-5 times per week more often than daily.

Frequency	Small		Medium		M-Large		Large		Total	
Responses	107	98%	260	98%	317	99%	31	100%	**715**	**98%**
Daily	36	33%	89	33%	118	37%	12	39%	**255**	**35%**
3-5 times per week	27	25%	98	37%	123	38%	10	32%	**258**	**35%**
1-2 times per week	31	28%	62	23%	64	20%	7	23%	**164**	**23%**
Rarely	8	7%	2	1%	4	1%	0	0%	**14**	**2%**
Never	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
No Response	2	2%	6	2%	4	1%	0	0%	**12**	**2%**
Multiple responses	5	5%	9	3%	8	2%	2	6%	**24**	**3%**

Table 4.22: Frequency of Activities by Size

Frequency	JCAHO		Non-JCAHO		Total	
Responses	**106**	**99%**	609	98%	715	98%
Daily	**37**	**35%**	218	35%	255	35%
3-5 times per week	**36**	**34%**	222	36%	258	35%
1-2 times per week	**29**	**27%**	135	22%	164	23%
Rarely	**1**	**1%**	13	2%	14	2%
Never	**0**	**0%**	0	0%	0	0%
No response	**3**	**3%**	9	1%	12	2%
Multiple responses	**1**	**1%**	23	4%	24	4%

Table 4.23: Frequency by JCAHO

Frequency	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Responses	82	99%	75	97%	40	100%	73	100%	48	98%	70	97%	37	97%
Daily	23	28%	25	32%	18	45%	15	21%	18	37%	26	36%	17	45%
3-5 times per week	37	45%	23	30%	12	30%	27	37%	17	35%	20	28%	15	39%
1-2 times per week	15	18%	23	30%	8	20%	30	41%	10	20%	21	29%	5	13%
Rarely	3	4%	2	3%	1	3%	0	0%	1	2%	0	0%	0	0%
Never	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
No response	1	1%	2	3%	0	0%	0	0%	1	2%	2	3%	1	3%
Multiple responses	4	5%	2	3%	1	3%	1	1%	2	4%	3	4%	0	0%

Frequency	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Responses	20	100%	44	100%	109	98%	62	95%	52	100%	3	100%	715	98%
Daily	6	30%	18	41%	38	34%	22	34%	28	54%	1	33%	255	35%
3-5 times per week	10	50%	17	39%	44	40%	20	31%	15	29%	1	33%	258	35%
1-2 times per week	4	20%	6	14%	21	19%	14	22%	6	12%	1	33%	164	23%
Rarely	0	0%	1	2%	3	3%	3	5%	0	0%		0%	14	2%
Never	0	0%	0	0%	0	0%	0	0%	0	0%		0%	0	0%
No response	0	0%	0	0%	2	2%	3	5%	0	0%		0%	12	2%
Multiple responses	0	0%	2	5%	3	3%	3	5%	3	6%		0%	24	3%

Table 4.24: Frequency of Activities by PSA

Question 2. How long does the typical music activity last?

Overall, slightly more facilities replied that the typical music activity lasted 30-45 minutes than those that replied 45-60 minutes. More JCAHO, medium/large and large facilities reported 45-60 minute activities than did non-JCAHO, small, and medium facilities. PSA's 4 (Toledo), 8 (Athens/Marietta), 10B (Akron) and 11 (Cambridge) reported more 45-60 minutes activities than average. Areas 3 (Lima), 5 (Mansfield) and 7 (Rio Grande) reported more 30-45 minute activities than average.

Length	Small		Medium		M-Large		Large		Total	
Responses	107	98%	261	98%	315	98%	31	100%	**714**	**98%**
45-60 minutes	31	28%	97	36%	130	40%	12	39%	**270**	**37%**
30-45 minutes	38	35%	117	44%	124	39%	11	35%	**290**	**40%**
15-30 minutes	23	21%	21	8%	31	10%	2	6%	**77**	**11%**
Other	6	6%	6	2%	10	3%	0	0%	**22**	**3%**
Multiple	9	8%	20	8%	20	6%	6	19%	**55**	**8%**
No Response	2	2%	5	2%	6	2%	0	0%	**13**	**2%**

Table 4.25: Duration of Activities by Size

Length	JCAHO		Non JCAHO		Total	
Responses	**106**	**99%**	608	98%	714	98%
45-60 minutes	**45**	**42%**	225	36%	270	37%
30-45 minutes	**43**	**40%**	247	40%	290	39%
15-30 minutes	**8**	**7%**	69	11%	77	10%
Other	**4**	**4%**	18	3%	22	3%
Multiple	**6**	**6%**	49	8%	55	9%
No Response	**1**	**1%**	12	2%	13	2%

Table 4.26: Duration of Activities by JCAHO

Length	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Responses	82	99%	75	97%	40	100%	72	99%	49	100%	70	97%	37	97%
45-60 minutes	33	40%	31	40%	11	28%	31	42%	10	20%	20	28%	3	8%
30-45 minutes	35	42%	29	38%	22	55%	28	38%	28	57%	31	43%	18	47%
15-30 minutes	5	6%	7	9%	4	10%	6	8%	6	12%	6	8%	11	29%
Other	1	1%	1	1%	0	0%	5	3%	1	0%	3	4%	2	5%
Multiple	8	10%	7	9%	3	8%	2	8%	4	8%	10	14%	3	8%
No response	1	1%	2	3%	0	0%	1	1%	0	0%	2	3%	1	3%

Length	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Responses	20	100%	44	100%	108	98%	62	95%	52	100%	3	100%	**714**	98%
45-60 minutes	8	45%	14	32%	56	34%	28	43%	25	48%	0	0%	**270**	37%
30-45 minutes	9	10%	17	39%	27	40%	25	38%	19	37%	2	67%	**290**	40%
15-30 minutes	2	0%	7	16%	11	19%	6	9%	5	10%	1	33%	**77**	11%
Other	0	0%	2	0%	6	3%	1	2%	0	0%		0%	**22**	3%
Multiple	1	5%	4	14%	8	1%	2	3%	3	0%	0	0%	**55**	8%
No response	0	0%	0	14%	3	4%	3	5%	0	6%		0%	**13**	2%

Table 4.27: Duration of Activities by PSA

Question 3. What kind of music activities are the residents offered?

Listening to recorded music, singing and listening to live performed music, respectively, were the three top music activities reported by 91-93% of the total respondents. Watching performances on television and moving to music (exercising and dancing) were the next most frequent answers. Playing instruments (60%), discussing music (36%) and "other" were the next three activities in order of responses. Included in "other" were games, therapy, karaoke, bell choirs, and kitchen bands. Most frequently reported games were "Name that Tune," "Music Bingo," and "Music Trivia." One hundred percent of the facilities reported singing in the Athens/Marietta area (PSA 8). One hundred percent of the facilities in PSA 9 (Cambridge) reported listening to live

music. Facilities that have musicians on their staff with music therapy or other music degrees reported listening to live performances (83%), listening to recorded music (81%) and singing (77%). Playing instruments (66%) and discussing music (62%) were also frequent responses among facilities with musicians.

Activity	Small		Medium		M-Large		Large		Total	
Discussing music	38	35%	99	37%	107	33%	21	68%	**265**	36%
Listening to live music	86	79%	246	92%	304	95%	29	94%	**665**	91%
Listening to recorded music	92	84%	251	94%	305	95%	30	97%	**678**	93%
Moving to music/Dancing	67	61%	199	75%	272	85%	29	94%	**567**	78%
Playing instruments	52	48%	162	61%	196	61%	23	74%	**433**	60%
Singing	88	81%	242	91%	307	96%	30	97%	**667**	92%
Televised performances	83	76%	204	77%	256	80%	30	97%	**573**	79%

Table 4.28: Music Activities by Size

Activity	JCAHO		Non-JCAHO		Total	
Discussing music	**47**	**44%**	218	35%	265	36%
Listening to live music	**103**	**96%**	562	91%	665	91%
Listening to recorded music	**104**	**97%**	574	93%	678	93%
Moving to music/Dancing	**89**	**83%**	478	77%	567	78%
Playing instruments	**71**	**66%**	362	58%	433	60%
Singing	**99**	**93%**	568	92%	667	92%
Televised performances	**91**	**85%**	482	78%	573	79%

Table 4.29: Music Activities by JCAHO

Activity	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Discussing music	32	39%	30	39%	20	50%	22	30%	18	37%	20	28%	12	32%
Listening to live music	79	95%	66	86%	38	95%	67	92%	41	84%	66	92%	34	89%
Listening to recorded music	75	90%	72	94%	36	90%	71	97%	46	94%	67	93%	32	84%
Moving to music/Dancing	68	82%	64	83%	31	78%	46	63%	37	76%	57	79%	29	76%
Playing instruments	50	60%	42	55%	25	63%	41	56%	34	69%	44	61%	19	50%
Singing	76	92%	70	91%	38	95%	66	90%	44	90%	65	90%	34	89%
Televised performances	64	77%	59	77%	36	90%	56	77%	39	80%	55	76%	27	71%

Activity	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Discussing music	6	30%	15	34%	50	45%	21	32%	19	37%	0	0%	**265**	36%
Listening to live music	18	90%	44	100%	100	90%	59	91%	50	96%	3	100%	**665**	91%
Listening to recorded music	19	95%	42	95%	102	92%	63	97%	50	96%	3	100%	**678**	93%
Moving to music/Dancing	16	80%	37	84%	87	78%	48	74%	44	85%	3	100%	**567**	78%
Playing instruments	8	40%	29	66%	67	60%	41	63%	31	60%	2	67%	**433**	60%
Singing	20	100%	42	95%	99	89%	60	92%	50	96%	3	100%	**667**	92%
Televised performances	17	85%	35	80%	89	80%	52	80%	41	79%	3	100%	**573**	79%

Table 4.30: Music Activities by PSA

Question 4: What types of music trips were offered during the past 12 months?

Several facilities wrote that they did not have transportation for trips; others wrote that their residents were too frail. A total of fourteen marked answers and then wrote in the margins that all activities were offered on site. Only 4% responded in a way that demonstrated their answers were definitely off-site trips; twenty-nine percent reported none, leaving the other 67% of responses questionable. Despite that, the information gave insight into the genre of music enjoyed the most, in order, church, musicals, big band/ jazz, recitals, orchestra, and pops. Bluegrass, country & western, oldies, and school were the most reported "other" possible trips taken. Big band/jazz was more

popular in the Cleveland (10a) and Akron (10b) areas than anywhere else and recitals were more popular in East and Central Ohio. "None" was the most frequent answer in the Athens/Marietta (8) area. Pops concert responses were lower than average in PSA's 8 (Athens/Marietta) and 9 (Cambridge); orchestra concerts were low in PSA's 3 (Lima), 7 (Rio Grande) and 8 (Athens/Marietta).

Trips	Small		Medium		M-Large		Large		Total	
Big Band/Jazz	25	23%	84	32%	108	34%	16	52%	**233**	**32%**
Church/Synagogue	40	37%	142	53%	166	52%	20	65%	**368**	**51%**
Musicals, Plays	33	30%	100	38%	134	42%	14	45%	**281**	**39%**
Orchestra concerts	17	16%	52	20%	61	19%	14	45%	**144**	**20%**
Pops concerts	12	11%	28	11%	46	14%	5	16%	**91**	**13%**
Recitals	21	19%	79	30%	85	26%	9	29%	**194**	**27%**
None	38	35%	79	30%	86	27%	5	16%	**208**	**29%**
Other	21	19%	49	18%	30	9%	2	6%	**102**	**14%**

Table 4.31: Music Trips by Size

Trips	JCAHO		Non-JCAHO		Total	
Big Band/Jazz	**31**	**29%**	202	33%	233	32%
Church/Synagogue	**46**	**43%**	322	52%	368	51%
Musicals, Plays	**42**	**39%**	239	39%	281	39%
Orchestra concerts	**25**	**23%**	119	19%	144	20%
Pops concerts	**16**	**15%**	75	12%	91	13%
Recitals	**26**	**24%**	168	27%	194	27%
None	**37**	**35%**	171	28%	208	29%
Other	**8**	**7%**	94	15%	102	14%

Table 4.32: Music Trips by JCAHO

Trips	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Big Band/Jazz	29	35%	28	36%	14	35%	23	32%	19	39%	22	31%	9	23%
Church/Synagogue	42	51%	44	57%	20	50%	37	51%	28	57%	30	42%	26	68%
Musicals, Plays	41	49%	29	38%	22	55%	30	41%	20	41%	23	32%	12	32%
Orchestra concerts	18	22%	18	23%	3	8%	15	21%	13	27%	17	24%	2	5%
Pops concerts	14	17%	10	13%	4	10%	8	11%	8	16%	7	10%	2	5%
Recitals	30	36%	21	27%	15	38%	25	34%	14	29%	22	31%	6	16%
None	22	27%	18	23%	12	30%	18	25%	9	18%	28	39%	8	21%
Other	8	10%	11	14%	3	8%	7	10%	18	37%	7	10%	8	21%

Trips	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Big Band/Jazz	1	3%	9	23%	35	88%	21	53%	22	42%	1	33%	233	32%
Church/Synagogue	9	45%	21	48%	52	47%	29	45%	28	54%	2	67%	368	51%
Musicals, Plays	5	25%	20	45%	30	27%	21	32%	26	50%	2	67%	281	39%
Orchestra concerts	1	5%	8	18%	22	20%	14	22%	12	23%	1	33%	144	20%
Pops concerts	1	5%	3	7%	17	15%	7	11%	8	15%	1	33%	90	12%
Recitals	3	15%	11	25%	25	23%	12	18%	10	19%	1	33%	195	27%
None	10	50%	14	32%	36	32%	21	32%	11	21%	1	33%	208	29%
Other	3	15%	6	14%	17	15%	4	6%	10	19%	0	0%	40	6%

Table 4.33: Music Trips by PSA

Question 5. In the past 12 months, how often have groups or individuals from the community performed for the residents in your facility?

Individuals and groups from the community performed weekly in 33% of all facilities. Sixteen percent responded “monthly” and “holiday.” “Weekly,” “weekly and holiday,” and “monthly" were the most reported answers by size, certification, and area. PSA 8 (Athens/Marietta) reported “weekly” higher than the average.

Community	Small		Medium		M-Large		Large		Total	
Daily	0	0%	0	0%	2	1%	2	6%	**4**	1%
Weekly	25	23%	83	31%	114	36%	16	52%	**238**	33%
Monthly	12	11%	39	15%	56	17%	7	23%	**114**	16%
Holidays	19	17%	17	6%	12	4%	1	3%	**49**	7%
Other	7	6%	14	5%	11	3%	2	6%	**34**	5%
No Response	3	3%	11	4%	8	2%	0	0%	**22**	3%
And Holiday	41	38%	89	33%	110	34%	1	3%	**241**	33%

Table 4.34: Frequency of Performers by Size

Community	JCAHO		Non-JCAHO		Total	
Daily	**2**	**2%**	2	0%	4	1%
Weekly	**39**	**36%**	199	32%	238	33%
Monthly	**20**	**19%**	94	15%	114	16%
Holidays	**7**	**7%**	42	7%	49	7%
Other	**6**	**6%**	28	5%	34	5%
No Response	**3**	**3%**	19	3%	22	3%
And Holiday	**19**	**18%**	222	36%	241	33%

Table 4.35: Frequency of Performers by JCAHO

Community	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Daily	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%	1	3%
Weekly	34	41%	20	26%	15	38%	28	38%	11	19%	26	36%	11	29%
Monthly	14	17%	17	22%	4	10%	12	16%	5	8%	11	15%	2	5%
Holidays	6	7%	3	4%	2	5%	3	4%	4	7%	4	6%	3	8%
Other	4	5%	4	5%	0	0%	1	1%	2	3%	2	3%	0	0%
No Response	0	0%	2	3%	4	10%	3	4%	1	2%	3	4%	2	5%
And Holiday	21	25%	27	35%	16	40%	25	34%	22	37%	22	31%	19	50%

Community	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Daily	0	0%	0	0%	0	0%	0	0%	2	4%	0	0%	**4**	1%
Weekly	11	55%	14	32%	29	26%	19	29%	18	35%	2	67%	**238**	33%
Monthly	1	5%	7	16%	20	18%	13	20%	7	13%	1	33%	**114**	16%
Holidays	0	0%	1	2%	14	13%	4	6%	5	10%	0	0%	**49**	7%
Other	0	0%	1	2%	9	8%	8	12%	3	6%	0	0%	**34**	5%
No Response	0	0%	1	2%	4	4%	2	3%	0	0%	0	0%	**22**	3%
And Holiday	8	40%	19	43%	32	29%	15	23%	15	29%	0	0%	**241**	33%

Table 4.36: Frequency of Performers by PSA

Question 6. In the past 12 months, how often have residents been invited to participate in music activities with groups or individuals who have visited?

The residents in 34% of the facilities were invited to participate with the performers on a weekly basis and 20% reported monthly participation. Less than 20% marked one of the choices and holiday. "Weekly" and "monthly" were the most popular choices for all sizes, certification and areas except for PSA 5 (Mansfield), which indicated "monthly and holiday." Several facilities wrote that all residents were invited to participate in all activities. PSA's 1 (Cincinnati), 6 (Columbus) and 8 (Athens/Marietta) reported weekly more than the average.

With	Small		Medium		M-Large		Large		Total	
Daily	2	2%	6	2%	18	6%	3	10%	**29**	**4%**
Weekly	35	32%	91	34%	108	34%	14	45%	**248**	**34%**
Monthly	17	16%	58	22%	77	24%	6	19%	**158**	**22%**
Holidays	16	15%	17	6%	32	10%	4	13%	**69**	**9%**
And Holiday	17	16%	51	19%	59	18%	0	0%	**127**	**17%**

Table 4.37: Resident Participation by Size

With	JCAHO		Non-JCAHO		Total	
Daily	**6**	**6%**	23	4%	29	4%
Weekly	**35**	**33%**	213	34%	248	34%
Monthly	**27**	**25%**	131	21%	158	22%
Holidays	**12**	**11%**	57	9%	69	9%
And Holiday	**10**	**9%**	117	19%	127	17%

Table 4.38: Resident Participation by JCAHO

With	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Daily	3	4%	3	4%	4	10%	3	4%	1	2%	1	1%	3	8%
Weekly	42	51%	22	29%	11	28%	19	26%	10	20%	32	44%	12	32%
Monthly	16	19%	19	25%	9	23%	17	23%	11	22%	15	21%	7	18%
Holidays	5	6%	4	5%	1	3%	11	15%	2	4%	4	6%	4	11%
And Holiday	11	13%	14	18%	11	28%	13	18%	17	35%	9	13%	8	21%

With	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Daily	0	0%	1	2%	6	5%	2	3%	2	4%	0	0%	**29**	**4%**
Weekly	8	40%	15	34%	38	34%	22	34%	15	29%	2	67%	**248**	**34%**
Monthly	4	20%	10	23%	22	20%	17	26%	10	19%	1	33%	**158**	**22%**
Holidays	2	10%	7	16%	14	13%	8	12%	7	13%	0	0%	**69**	**9%**
And Holiday	3	15%	7	16%	18	16%	5	8%	11	21%	0	0%	**127**	**17%**

Table 4.39: Resident Participation by PSA

Question 7. Do children perform or participate in music activities with your residents?

The responses to question seven were divided into two sections – where the children came from and what they did when they were there. The majority came from schools, churches and community organizations (Scouts, 4-H, and private music and dance studios) followed by preschools and daycare centers. Southeast Ohio (PSA 8) responses indicated that children came from the churches more than from the schools. Two percent reported on-site daycare centers with planned regular intergenerational activities both in the daycare facility and the nursing home facility. Five percent of all facilities reported intergenerational activities. JCAHO facilities were slightly higher with 7%. Seventeen percent of facilities with musicians reported having intergenerational activities. Singing was the most reported type of performance. Forty-seven percent of facilities reported children "performing for" compared to 13% "performing with" residents. Intergenerational was considered a separate activity from "performing with."

Children	Small		Medium		M-Large		Large		Total	
Responses	101	93%	246	92%	309	96%	29	94%	**685**	94%
Who Comes										
Church	22	20%	61	23%	86	27%	8	26%	**177**	24%
Community	29	27%	55	21%	67	21%	9	29%	**160**	22%
Family	4	4%	3	1%	6	2%	1	3%	**14**	2%
Intergenerational	5	5%	9	3%	22	7%	2	6%	**38**	5%
On-site day care	2	2%	3	1%	6	2%	2	6%	**13**	2%
Preschool	9	8%	43	16%	58	18%	5	16%	**115**	16%
School	45	41%	107	40%	150	47%	14	45%	**316**	43%
Home School	3	3%	5	2%	7	2%	0	0%	**15**	2%
When?										
Holiday	31	28%	70	26%	98	31%	4	13%	**203**	28%
What they do										
Perform for	33	30%	116	44%	176	55%	18	58%	**343**	47%
Perform with	17	16%	43	16%	34	11%	4	13%	**98**	13%

Table 4.40: Children Participation by Size

Children	JCAHO		Non-JCAHO		Total	
Responses	**99**	**93%**	586	81%	685	94%
Who Comes						
Church	**30**	**28%**	147	20%	177	24%
Community	**28**	**26%**	132	18%	160	22%
Family	**3**	**3%**	11	2%	14	2%
Intergenerational	**7**	**7%**	31	4%	38	5%
On-site day care	**2**	**2%**	11	2%	13	2%
Preschool	**17**	**16%**	98	14%	115	16%
School	**45**	**42%**	271	38%	316	43%
Home School	**1**	**1%**	14	2%	15	2%
When?						
Holiday	**39**	**36%**	164	23%	203	28%
What they do						
Perform for	**44**	**41%**	299	42%	343	47%
Perform with	**19**	**18%**	79	11%	98	13%

Table 4.41: Children Participation by JCAHO

Children	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Responses	82	99%	72	94%	37	93%	68	93%	45	92%	67	93%	35	92%
Who Comes														
Church	19	23%	20	26%	8	20%	15	21%	16	33%	15	21%	13	34%
Community	18	22%	17	22%	5	13%	14	19%	10	20%	19	26%	5	13%
Family	2	2%	0	0%	0	0%	1	1%	2	4%	0	0%	0	0%
Intergenerational	5	6%	5	6%	2	5%	3	4%	1	2%	0	0%	2	5%
On-site day care	3	4%	1	1%	2	5%	1	1%	0	0%	0	0%	0	0%
Preschool	6	7%	18	23%	8	20%	18	25%	9	18%	13	18%	6	16%
School	36	43%	34	44%	19	48%	30	41%	24	49%	34	47%	17	45%
Home School	1	1%	2	3%	1	3%	2	3%	0	0%	2	3%	0	0%
When?														
Holiday	20	24%	12	16%	7	18%	24	33%	21	43%	19	26%	11	29%
What they do														
Perform for	49	59%	36	47%	23	58%	34	47%	13	27%	35	49%	6	16%
Perform with	11	13%	11	14%	5	13%	9	12%	6	12%	10	14%	7	18%

Children	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Responses	18	90%	43	98%	104	94%	62	95%	49	94%	3	100%	**685**	94%
Who Comes														
Church	11	55%	15	34%	14	13%	16	25%	14	27%	1	33%	**177**	24%
Community	4	20%	17	39%	24	22%	19	29%	8	15%	0	0%	**160**	22%
Family	0	0%	1	2%	3	3%	3	5%	2	4%	0	0%	**14**	2%
Intergenerational	0	0%	1	2%	14	13%	3	5%	1	2%	1	33%	**38**	5%
On-site day care	0	0%	0	0%	5	5%	1	2%	0	0%	0	0%	**13**	2%
Preschool	7	35%	6	14%	11	10%	5	8%	7	13%	1	33%	**115**	16%
School	9	45%	19	43%	42	38%	27	42%	24	46%	1	33%	**316**	43%
Home School	0	0%	1	2%	2	2%	4	6%	0	0%	0	0%	**15**	2%
When?														
Holiday	1	5%	17	39%	38	34%	16	25%	16	31%	1	33%	**203**	28%
What they do														
Perform for	11	55%	21	48%	53	48%	36	55%	24	46%	2	67%	**343**	47%
Perform with	3	15%	4	9%	18	16%	8	12%	5	10%	1	33%	**98**	13%

Table 4.42: Children Participation by PSA

Question 8. Please list other groups or individuals that bring music to your residents and describe the activities.

The results from this question were divided into three sections – who comes, what do they do, and what style music they perform. All size facilities, JCAHO facilities, and areas reported that churches bring music more frequently than any other groups or individuals with the exception of PSA 3 (Lima) that reported volunteers. PSA 8 (Athens/Marietta) responded more churches and less volunteers than did the average. More facilities in PSA 3 (Lima) reported seniors and residents as performers than any other size, area or certification grouping. Other responses were specific performers by name, volunteers, community groups, staff, paid performers, and music therapists. PSA 4 (Toledo) had the most responses for music therapist at 10% of responding facilities. This was followed by the Cleveland (10a), Youngstown (11), and Cincinnati (1) areas. Athens/Marietta (8) was the only area that did not include music therapist in its response.

Playing instruments was the most reported type of performance. Resident involvement was reported by 22% of the facilities compared to 21% responding performance only. The results for JCAHO facilities were the same as for the total – instruments, residents involved, performance only, singing, bands, choirs, and karaoke.

Bluegrass bands played in Marietta/Athens (PSA 8) (25%) more than average (6%). Ethnic music (i.e. Polish, Slovakian, German) was played Cleveland (10a) (10%) and Youngstown (11) (12%) more than average (5%). Gospel/religious was the most reported style music in all size facilities, JCAHO-certified, and areas with the exception of PSA's 8 (Marietta/Athens), 10b(Akron), 10a (Cleveland), and 11 (Youngstown).

Classical music was the least reported in all but Cincinnati (1), Cleveland (10a), Dayton (2) and Lima (3).

Thirty-six facilities (5%) responded that a music therapist was the provider of music. Ten percent of large facilities and facilities in PSA 4 (Toledo) responded "music therapists"; 6% in PSA 1 (Cincinnati); 9% of PSA 10a (Cleveland), 8% of PSA 10b (Akron) and 6% of JCAHO.

Performers	Small		Medium		M-Large		Large		Total	
Facilities Responding	96	88%	233	88%	284	88%	27	87%	**640**	88%
Who?										
Paid	10	9%	20	8%	30	9%	2	6%	**62**	9%
Specific Performers	17	16%	41	15%	39	12%	4	13%	**101**	14%
Volunteers	17	16%	36	14%	50	16%	2	6%	**105**	14%
Church Groups	39	36%	74	28%	117	36%	8	26%	**238**	33%
Community Groups	9	8%	42	16%	30	9%	7	23%	**88**	12%
Music Therapists	4	4%	12	5%	17	5%	3	10%	**36**	5%
Resident/Staff/Family Performers	16	15%	31	12%	36	11%	2	6%	**85**	12%
Senior Performers	12	11%	14	5%	22	7%	3	10%	**51**	7%
What?										
Bands	8	7%	40	15%	27	8%	5	16%	**80**	11%
Choirs	11	10%	30	11%	24	7%	2	6%	**67**	9%
Instruments	43	39%	106	40%	90	28%	5	16%	**244**	34%
Karaoke	10	9%	16	6%	12	4%	0	0%	**38**	5%
Performances	37	34%	71	27%	45	14%	3	10%	**156**	21%
Residents Involved	16	15%	58	22%	80	25%	5	16%	**159**	22%
Singing	22	20%	57	21%	45	14%	3	10%	**127**	17%
Style										
Bluegrass	7	6%	22	8%	15	5%	1	3%	**45**	6%
Classical	4	4%	11	4%	14	4%	2	6%	**31**	4%
Country	12	11%	31	12%	24	7%	2	6%	**69**	9%
Ethnic	7	6%	13	5%	13	4%	0	0%	**33**	5%
Gospel	16	15%	37	14%	46	14%	1	3%	**100**	14%
Holiday/Seasonal	3	3%	18	7%	7	2%	1	3%	**29**	4%
Jazz & Big Band	4	4%	19	7%	15	5%	1	3%	**39**	5%
Oldies	2	2%	16	6%	19	6%	1	3%	**38**	5%

Table 4.43: Performers by Size

Performers	JCAHO		Non-JCAHO		Total	
Facilities Responding	**99**	93%	541	75%	640	88%
Who?						
Paid	**8**	7%	54	8%	62	9%
Specific Performers	**16**	15%	85	12%	101	14%
Volunteers	**17**	16%	88	12%	105	14%
Church Groups	**27**	25%	211	29%	238	33%
Community Groups	**13**	12%	75	10%	88	12%
Music Therapists	**6**	6%	30	4%	36	5%
Resident/Staff/Family Performers	**9**	8%	76	11%	85	12%
Senior Performers	**12**	11%	39	5%	51	7%
What?						
Bands	**16**	15%	64	9%	80	11%
Choirs	**8**	7%	59	8%	67	9%
Instruments	**35**	33%	209	29%	244	34%
Karaoke	**2**	2%	36	5%	38	5%
Performances	**23**	21%	133	18%	156	21%
Residents Involved	**25**	23%	134	19%	159	22%
Singing	**21**	20%	106	15%	127	17%
Style						
Bluegrass	**5**	5%	40	6%	45	6%
Classical	**4**	4%	27	4%	31	4%
Country	**8**	7%	61	8%	69	9%
Ethnic	**6**	6%	27	4%	33	5%
Gospel	**13**	12%	87	12%	100	14%
Holiday/Seasonal	**4**	4%	25	3%	29	4%
Jazz & Big Band	**6**	6%	33	5%	39	5%
Oldies	**9**	8%	29	4%	38	5%

Table 4.44: Performers by JCAHO

Performers	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Facilities Responding	77	93%	72	94%	36	90%	60	82%	44	90%	61	85%	31	82%
Who?														
Paid	9	11%	10	13%	2	5%	5	7%	2	4%	7	10%	2	5%
Specific Performers	10	12%	10	13%	7	18%	10	14%	7	14%	13	18%	4	11%
Volunteers	11	13%	14	18%	10	25%	11	15%	7	14%	13	18%	7	18%
Church Groups	28	34%	31	40%	8	20%	19	26%	18	37%	25	35%	16	42%
Community Groups	14	17%	10	13%	1	3%	9	12%	9	18%	3	4%	5	13%
Music Therapists	5	6%	2	3%	1	3%	7	10%	1	2%	2	3%	1	3%
Resident/Staff/Family Performers	6	7%	9	12%	8	20%	7	10%	7	14%	7	10%	6	16%
Senior Performers	4	5%	7	9%	7	18%	4	5%	5	10%	6	8%	1	3%
What?														
Bands	8	10%	7	9%	7	18%	10	14%	2	4%	7	10%	4	11%
Choirs	9	11%	3	4%	4	10%	6	8%	6	12%	10	14%	1	3%
Instruments	20	24%	25	32%	22	55%	28	38%	21	43%	23	32%	15	39%
Karaoke	0	0%	2	3%	1	3%	3	4%	4	8%	5	7%	6	16%
Performances	25	30%	20	26%	11	28%	17	23%	10	20%	18	25%	10	26%
Residents Involved	17	20%	11	14%	10	25%	16	22%	14	29%	12	17%	5	13%
Singing	15	18%	15	19%	6	15%	12	16%	7	14%	11	15%	7	18%
Style														
Bluegrass	3	4%	4	5%	3	8%	6	8%	5	10%	6	8%	5	13%
Classical	8	10%	5	6%	3	8%	1	1%	1	2%	1	1%	0	0%
Country	5	6%	9	12%	7	18%	2	3%	7	14%	3	4%	7	18%
Ethnic	1	1%	2	3%	2	5%	4	5%	2	4%	3	4%	0	0%
Gospel	11	13%	14	18%	5	13%	12	16%	10	20%	9	13%	7	18%
Holiday/Seasonal	8	10%	5	6%	1	3%	1	1%	2	4%	2	3%	1	3%
Jazz & Big Band	9	11%	8	10%	2	5%	3	4%	2	4%	0	0%	0	0%
Oldies	6	7%	12	16%	2	5%	4	5%	2	4%	2	3%	4	11%

Table 4.45: Performers by PSA 1-7.

Performers	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Facilities Responding	18	90%	38	86%	93	84%	60	92%	48	92%	2	67%	**640**	88%
Who?														
Paid	1	5%	2	5%	15	14%	2	3%	5	10%	0	0%	**62**	9%
Specific Performers	2	10%	7	16%	17	15%	6	9%	8	15%	0	0%	**101**	14%
Volunteers	1	5%	7	16%	14	13%	2	3%	8	15%	0	0%	**105**	14%
Church Groups	13	65%	14	32%	26	23%	25	38%	15	29%	0	0%	**238**	33%
Community Groups	3	15%	2	5%	16	14%	10	15%	5	10%	1	33%	**88**	12%
Music Therapists	0	0%	1	2%	10	9%	5	8%	1	2%	0	0%	**36**	5%
Resident/Staff/Family Performers	3	15%	2	5%	11	10%	9	14%	10	19%	0	0%	**85**	12%
Senior Performers	1	5%	1	2%	6	5%	3	5%	6	12%	0	0%	**51**	7%
What?														
Bands	4	20%	10	23%	6	5%	7	11%	7	13%	1	33%	**80**	11%
Choirs	3	15%	6	14%	8	7%	7	11%	4	8%	0	0%	**67**	9%
Instruments	6	30%	11	25%	35	32%	16	25%	20	38%	2	67%	**244**	34%
Karaoke	1	5%	2	5%	2	2%	2	3%	10	19%	0	0%	**38**	5%
Performances	1	5%	8	18%	18	16%	9	14%	9	17%	0	0%	**156**	21%
Residents Involved	3	15%	10	23%	30	27%	12	18%	18	35%	1	33%	**159**	22%
Singing	9	45%	10	23%	10	9%	14	22%	11	21%	0	0%	**127**	17%
Style														
Blue Grass	5	25%	1	2%	0	0%	3	5%	4	8%	0	0%	**45**	6%
Classical	1	5%	0	0%	10	9%	1	2%	0	0%	0	0%	**31**	4%
Country	4	20%	6	14%	5	5%	7	11%	7	13%	0	0%	**69**	9%
Ethnic	0	0%	0	0%	11	10%	2	3%	6	12%	0	0%	**33**	5%
Gospel	4	20%	5	11%	11	10%	5	8%	6	12%	1	33%	**100**	14%
Holiday/Seasonal	0	0%	2	5%	4	4%	2	3%	1	2%	0	0%	**29**	4%
Jazz & Big Band	0	0%	3	7%	4	4%	3	5%	5	10%	0	0%	**39**	5%
Oldies	0	0%	1	2%	2	2%	3	5%	0	0%	0	0%	**38**	5%

Table 4.46: Performers by PSA 8-Total.

Question 9. Please describe your most successful music activities.

Over all, 48% percent reported activities that were initiated by the activity department and 46% involved outside entertainment. Only medium size facilities and PSA's 1(Cincinnati) and 8 (Athens/Marietta) reported more entertainment than activities. Facilities in PSA's 3 (Lima), 6 (Columbus), 10a (Cleveland), and 10b (Akron) reported more activities than the average. Specific performer, resident/staff, special events,

children, and music therapist were the next frequent responses depending on size, certification and area. Eight percent of Cincinnati (1) area facilities reported music therapy, followed by Toledo (4) at 5%, and Lima (3) and Cleveland (10a) with 3% each. JCAHO and large facilities reported more music therapists than average.

Singing and sing-alongs were the most frequent activity responses followed by games and karaoke. Games that were mentioned included "Name that Tune," "Music Trivia," "Music Wheel of Fortune," "Music Bingo," and "Music Millionaire." Several facilities reported using music during bathing, dining and craft activities.

Facilities with musicians reported more resident activities (51%) than entertainment (23%). Activities include bell choir, drumming, music appreciation, "Name that Tune," resident band, resident chimes, "Stump the Piano Player," resident talent show, "Walk n Roll," "Music Millionaire," "Musical Wheel of Fortune," resident choir, singing and sing-alongs. Therapy activities included group and individual sessions, meeting resident's individual needs, music relaxation, musical skills, reminiscence, sensory stimulation, and songwriting.

Successful Activities	Small		Medium		M-Large		Large		Total	
Total Facilities Responding	89	82%	240	90%	279	87%	31	100%	**639**	**88%**
Activity by Resident	42	39%	121	45%	167	52%	20	65%	**350**	**48%**
Entertainment	41	38%	126	47%	157	49%	12	39%	**336**	**46%**
Entertainment w/ Involvement	8	7%	39	15%	28	9%	3	10%	**78**	**11%**
Activity Department Initiated	16	15%	53	20%	103	32%	10	32%	**182**	**25%**
"All Music Activities"	4	4%	18	7%	11	3%	2	6%	**35**	**5%**
Children Involved	9	8%	16	6%	20	6%	0	0%	**45**	**6%**
Church Sponsored	3	3%	10	4%	9	3%	0	0%	**22**	**3%**
"Music Therapy"	1	1%	7	3%	10	3%	2	6%	**20**	**3%**
Residents/Staff/Family involved	3	3%	32	12%	18	6%	4	13%	**57**	**8%**
Specific Performer	12	11%	26	10%	19	6%	2	6%	**59**	**8%**
Background Music	3	3%	4	2%	1	0%	0	0%	**8**	**1%**
Holiday Events	7	6%	8	3%	7	2%	1	3%	**23**	**3%**
Special Events	10	9%	22	8%	35	11%	2	6%	**69**	**9%**

Table 4.47: Successful Activities by Size

Successful Activities	JCAHO		Non-JCAHO		Total	
Total Facilities Responding	**94**	**88%**	545	88%	639	88%
Activity by Resident	**60**	**56%**	290	47%	350	48%
Entertainment	**42**	**39%**	294	47%	336	46%
Entertainment w/ Involvement	**10**	**9%**	68	11%	78	11%
Activity Department Initiated	**33**	**31%**	149	24%	182	25%
"All Music Activities"	**7**	**7%**	28	5%	35	5%
Children Involved	**6**	**6%**	39	6%	45	6%
Church Sponsored	**1**	**1%**	21	3%	22	3%
"Music Therapy"	**8**	**7%**	12	2%	20	3%
Residents/Staff/Family involved	**8**	**7%**	49	8%	57	8%
Specific Performer	**5**	**5%**	54	9%	59	8%
Background Music	**1**	**1%**	7	1%	8	1%
Holiday Events	**5**	**5%**	18	3%	23	3%
Special Events	**10**	**9%**	59	10%	69	9%

Table 4.48: Successful Activities by JCAHO

Successful Activities	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Total Facilities Responding	77	93%	64	83%	37	93%	66	90%	43	88%	62	86%	32	84%
Activity by Resident	32	39%	32	42%	25	63%	34	47%	24	49%	38	53%	14	37%
Entertainment	48	58%	31	40%	14	35%	36	49%	24	49%	35	49%	18	47%
Entertainment w/ Involvement	10	12%	4	5%	3	8%	9	12%	6	12%	8	11%	4	11%
Activity Department Initiated	16	19%	17	22%	6	15%	18	25%	10	20%	22	31%	9	24%
"All Music Activities"	4	5%	2	3%	7	18%	2	3%	2	4%	5	7%	0	0%
Children Involved	7	8%	6	8%	1	3%	2	3%	3	6%	2	3%	6	16%
Church Sponsored	1	1%	3	4%	0	0%	3	4%	2	4%	3	4%	4	11%
"Music Therapy"	7	8%	1	1%	1	3%	4	5%	0	0%	1	1%	0	0%
Residents/Staff/Family involved	3	4%	8	10%	3	8%	2	3%	8	16%	4	6%	5	13%
Specific Performer	7	8%	9	12%	6	15%	3	4%	7	14%	3	4%	3	8%
Background Music	2	2%	0	0%	0	0%	1	1%	0	0%	1	1%	1	3%
Holiday Events	1	1%	2	3%	1	3%	3	4%	1	2%	2	3%	2	5%
Special Events	5	6%	3	4%	9	23%	7	10%	5	10%	9	13%	2	5%

Successful Activities	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Total Facilities Responding	16	80%	39	89%	96	86%	59	91%	46	88%	2	67%	639	88%
Activity by Resident	7	35%	20	45%	62	56%	35	54%	26	50%	1	33%	350	48%
Entertainment	10	50%	22	50%	42	38%	31	48%	23	44%	2	67%	336	46%
Entertainment w/ Involvement	1	5%	2	5%	12	11%	11	17%	8	15%	0	0%	78	11%
Activity Department Initiated	4	20%	12	27%	35	32%	19	29%	13	25%	1	33%	182	25%
"All Music Activities"	2	10%	1	2%	5	5%	1	2%	4	8%	0	0%	35	5%
Children Involved	1	5%	3	7%	9	8%	0	0%	5	10%	0	0%	45	6%
Church Sponsored	2	10%	0	0%	1	1%	3	5%	0	0%	0	0%	22	3%
"Music Therapy"	0	0%	1	2%	3	3%	2	3%	0	0%	0	0%	20	3%
Residents/Staff/Family involved	0	0%	3	7%	13	12%	6	9%	2	4%	0	0%	57	8%
Specific Performer	0	0%	6	14%	5	5%	7	11%	3	6%	0	0%	59	8%
Background Music	0	0%	0	0%	2	2%	1	2%	0	0%	0	0%	8	1%
Holiday Events	1	5%	1	2%	7	6%	2	3%	0	0%	0	0%	23	3%
Special Events	0	0%	3	7%	12	11%	5	8%	9	17%	0	0%	69	9%

Table 4.49: Successful Activities by PSA

Music Activities

Please include how you measured success.

Participation, comments, attendance, and response were the most frequent responses. Participation by residents was the most frequently given answer by all sizes,

areas and JCAHO certification. The term "response" was not defined but examples were given – facial expressions, laughing, body language, and emotional expressions.

Comments were both verbal and written in satisfaction surveys. Only 3% measured success by whether it made the resident feel or perform better (therapeutic). One percent of all facilities responded that the activity was a success if the residents stayed and 3% thought it a success if they stayed awake.

Facilities with musicians ranked participation (47%) first followed by attendance (26%) and comments (23%).

Measure Success	Small		Medium		M-Large		Large		Total	
Facilities Responding	67	61%	187	70%	246	77%	30	97%	**530**	**73%**
Attendance	15	14%	56	21%	71	22%	7	23%	**149**	**20%**
Comments	25	23%	58	22%	70	22%	7	23%	**160**	**22%**
Enjoyment	10	9%	33	12%	39	12%	5	16%	**87**	**12%**
Participation	32	29%	93	35%	141	44%	10	32%	**276**	**38%**
Response reaction	26	24%	54	20%	38	12%	6	19%	**124**	**17%**

Table 4:50: Success Measurement by Size

Measure Success	JCAHO		Non-JCAHO		Total	
Facilities Responding	**73**	**68%**	457	74%	530	73%
Attendance	**19**	**18%**	130	21%	149	20%
Comments	**26**	**24%**	134	22%	160	22%
Enjoyment	**14**	**13%**	73	12%	87	12%
Participation	**43**	**40%**	233	38%	276	38%
Response reaction	**19**	**18%**	105	17%	124	17%

Table 4.51: Success Measurement by JCAHO

Measure Success	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Facilities Responding	67	81%	60	78%	25	63%	49	67%	37	76%	46	64%	29	76%
Attendance	23	28%	12	16%	6	15%	19	26%	11	22%	11	15%	8	21%
Comments	20	24%	19	25%	5	13%	15	21%	13	27%	13	18%	8	21%
Enjoyment	7	8%	7	9%	4	10%	10	14%	8	16%	9	13%	4	11%
Participation	36	43%	28	36%	14	35%	26	36%	18	37%	24	33%	14	37%
Response/Reaction	15	18%	17	22%	7	18%	11	15%	8	16%	9	13%	9	24%

Measure Success	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Facilities Responding	11	55%	35	80%	85	77%	48	74%	36	69%	2	67%	530	73%
Attendance	4	20%	10	23%	21	19%	12	18%	12	23%	0	0%	149	20%
Comments	3	15%	10	23%	25	23%	19	29%	10	19%	0	0%	160	22%
Enjoyment	0	0%	5	11%	14	13%	10	15%	8	15%	1	33%	87	12%
Participation	5	25%	17	39%	43	39%	24	37%	26	50%	1	33%	276	38%
Response/Reaction	2	10%	9	20%	22	20%	7	11%	8	15%	0	0%	124	17%

Table 4.52: Success Measurement by PSA

Question 10. In general, what are the purposes of engaging the resident in music activities? Please rank the responses according to importance. (1 being the most important.)

According to Alicia Ann Clair (1996), some of the purposes of music with older adults are as follows: development of new musical and listening skills; diversion from inactivity, discomfort, and daily routine; physical stimulation; emotional expression; pleasure; rehabilitation/therapy; and facilitation of social interaction. The data for this question yielded means, modes, range, frequency, and median for rankings given for each of the uses of music by size, certification, and PSA. Data reduction was accomplished by using the mode data. If there was a tie in ranking, then the mean data was used.

The overall responses by the facilities ranked the purposes in the following order: pleasure, social interaction, emotional expression, physical activity, diversion, rehabilitation, and development of new musical and listening skills. JCAHO facilities

responded in a slightly different order: pleasure, social interaction, diversion, emotional expression, physical activity, rehabilitation, and development of new skills. All of the facilities regardless of size or location or certification ranked new musical and listening skills last, and all but Youngstown (11) ranked pleasure first. Rehabilitation was ranked either 5th or 6th by all facilities. The most frequent "other" responses reported were responses (undefined), reminiscence, therapy, "depends," and enjoyment.

Facilities with music therapists ranked them in order as pleasure, social interaction, emotional expression, diversion, physical activity, rehabilitation, and development of new skills. Facilities that employed persons with music degrees responded in a slightly different order – pleasure, emotional expression, social interaction, diversion, rehabilitation, physical activity, and development of new musical skills. "Other" responses given by facilities with musicians were worship, engagement, self esteem, meet needs, recall, reminiscence, and past and present roles.

Purpose	Small	Medium	M-Large	Large	Total
New musical and listening skills	7	7	7	7	**7**
Diversion	4	5	5	4	**5**
Emotional Expression	3	3	3	3	**3**
Physical Activity	5	4	4	5	**4**
Pleasure	1	1	1	1	**1**
Rehabilitation	6	6	6	6	**6**
Social Interaction	2	2	2	2	**2**

Table 4.53: Purpose by Size

Purpose	JCAHO	Non-JCAHO	Total
New musical and listening skills	7	7	**7**
Diversion	3	5	**5**
Emotional Expression	4	3	**3**
Physical Activity	5	4	**4**
Pleasure	1	1	**1**
Rehabilitation	6	6	**6**
Social Interaction	2	2	**2**

Table by 4.54: Purpose by JCAHO

Purpose	PSA 1	PSA 2	PSA 3	PSA 4	PSA 5	PSA 6	PSA 7
New musical and listening skills	7	7	7	7	7	7	7
Diversion	5	5	6	6	6	6	4
Emotional Expression	3	3	3	3	3	3	3
Physical Activity	4	4	4	4	4	4	6
Pleasure	1	1	1	1	1	1	1
Rehabilitation	6	6	5	5	5	5	5
Social Interaction	2	2	2	2	2	2	2

Purpose	PSA 8	PSA 9	PSA 10a	PSA 10b	PSA 11	Unknown	Total
New musical and listening skills	7	7	7	7	7	7	**7**
Diversion	4	6	3	6	5	6	**5**
Emotional Expression	3	3	4	3	3	3	**3**
Physical Activity	5	4	5	4	2	4	**4**
Pleasure	1	1	1	1	4	1	**1**
Rehabilitation	6	5	6	5	6	5	**6**
Social Interaction	2	2	2	2	1	2	**2**

Table 4.55: Purpose by PSA

Personnel

The next three questions elicited information on the titles of the persons who plan and implement the music activities and their music training.

Question 1: What is the title of the person(s) who plans the music activities programs at your facility?

"Activity Director" is the title of the person who plans the activities at 70% of the facilities that responded. Other titles within the activities department were: activity leader, activity supervisor, activity specialist, activity consultant, activity aide, activity coordinator, and activity assistant. Eight percent of all facilities reported that the certified trained recreation specialist (CTRS) planned activities and 5% listed a certified activity director (ADC). A higher number of facilities reported CTRS in Akron (10B) and Toledo (4) areas, and ADC's in Youngstown (11) and Lima (3). Music therapists were reported by only 3% of all facilities overall (even though 5% reported music therapists in question 8 as individuals who bring music) and in 7% of JCAHO facilities. The highest areas with facilities reporting music therapists were PSA 9 (Cambridge), 10a (Cleveland), 1 (Cincinnati), 7 (Rio Grande) and 8 (Athens). The smaller facilities reported more "other staff" than did the larger. The larger the facility the more certified activity directors, recreation specialists, and music therapists. The title "activity coordinator" was more common in PSA 3 (Lima). There were no music therapists reported in areas 11 (Youngstown) and 5 (Mansfield).

Plans	Small		Medium		M-large		Large		Total	
Facilities	103	94%	258	97%	312	97%	31	100%	**704**	**97%**
Activity Department	2	2%	3	1%	13	4%	1	3%	**19**	**3%**
Activity Director	67	61%	197	74%	229	71%	17	55%	**510**	**70%**
Activity Coordinator	14	13%	20	8%	18	6%	4	13%	**56**	**8%**
Activity Assistant	6	6%	17	6%	23	7%	2	6%	**48**	**7%**
ADC	6	6%	17	6%	14	4%	2	6%	**39**	**5%**
CTRS	6	6%	13	5%	33	10%	4	13%	**56**	**8%**
MT-BC	4	4%	5	2%	10	3%	5	16%	**24**	**3%**
Other Staff	11	10%	10	4%	13	4%	2	6%	**36**	**5%**
Volunteer	1	1%	2	1%	3	1%	0	0%	**6**	**1%**

Table 4.56: Activity Planner by Size

Plans	JCAHO		Non-JCAHO		Total	
Facilities	**104**	**97%**	600	97%	704	97%
Activity Department	**3**	**3%**	16	3%	19	3%
Activity Director	**66**	**62%**	444	72%	510	70%
Activity Coordinator	**11**	**10%**	45	7%	56	8%
Activity Assistant	**9**	**8%**	39	6%	48	7%
ADC	**3**	**3%**	36	6%	39	5%
CTRS	**8**	**7%**	48	8%	56	8%
MT-BC	**7**	**7%**	17	3%	24	3%
Other Staff	**2**	**2%**	34	5%	36	5%
Volunteer	**2**	**2%**	4	1%	6	1%

Table 4.57: Activity Planner by JCAHO

Plans	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Responses	82	99%	74	96%	38	95%	73	100%	48	98%	68	94%	37	97%
Activity Department	2	2%	2	3%	2	5%	0	0%	1	2%	1	1%	0	0%
Activity Director	62	75%	61	79%	26	65%	52	71%	37	76%	54	75%	30	79%
Activity Coordinator	9	11%	5	6%	5	13%	2	3%	2	4%	4	6%	3	8%
Activity Assistant	5	6%	2	3%	2	5%	8	11%	3	6%	7	10%	4	11%
ADC	1	1%	2	3%	6	15%	2	3%	3	6%	4	6%	2	5%
CTRS	7	8%	2	3%	2	5%	14	19%	2	4%	2	3%	1	3%
MT-BC	5	6%	1	1%	1	3%	1	1%	0	0%	1	1%	2	5%
Other Staff	3	4%	3	4%	2	5%	1	1%	6	12%	4	6%	1	3%
Volunteer	0	0%	2	3%	0	0%	0	0%	2	4%	0	0%	0	0%

Plans	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Responses	19	95%	43	98%	106	95%	62	95%	51	98%	3	100%	704	97%
Activity Department	0	0%	5	11%	4	4%	2	3%	0	0%	0	0%	19	3%
Activity Director	16	80%	28	64%	68	61%	41	63%	34	65%	1	33%	510	70%
Activity Coordinator	2	10%	4	9%	9	8%	7	11%	4	8%	0	0%	56	8%
Activity Assistant	1	5%	1	2%	8	7%	4	6%	3	6%	0	0%	48	7%
ADC	0	0%	4	9%	5	5%	0	0%	9	17%	1	33%	39	5%
CTRS	0	0%	2	5%	10	9%	13	20%		0%	1	33%	56	8%
MT-BC	1	5%	3	7%	8	7%	1	2%		0%		0%	24	3%
Other Staff	0	0%	5	11%	9	8%	1	2%	1	2%		0%	36	5%
Volunteer	1	5%	0	0%	1	1%	0	0%		0%		0%	6	1%

Table 4.58: Activity Planner by PSA

Question 2. What is the title of the person(s) who implements the music activities programs at your facility?

Fifty-two percent of all facilities responding reported that the title of the person who implements the music programs is "activities director." Thirty-seven percent reported "activities assistant." The smaller the facility the more frequently responses were "other staff." In the larger facilities the more frequent responses were CTRS and music therapists. Ten percent of JCAHO facilities reported that the music therapist

implemented the activities. PSA's 3 (Lima), 7 (Rio Grande) and 11 (Youngstown) were the only areas that reported no music therapists. Cleveland (10b), Athens (8), and Cincinnati (1) areas had the highest percentage of music therapists, followed by Dayton (2), Toledo (4), Cambridge (9), Mansfield (5), Columbus (6), and Akron (7). More certified activity directors (ADC) were reported in areas 3 (Lima) and 11 (Youngstown) and more certified therapeutic recreation specialists (CTRS) in areas 10b (Akron) and 4 (Toledo). Areas 3 (Lima) and 8 (Athens/Marietta) reported more volunteers than the average.

Implements	Small		Medium		M-Large		Large		Total	
Responses	101	93%	248	93%	309	96%	29	94%	**687**	**94%**
Activities Department	5	5%	16	6%	20	6%	2	6%	**43**	**6%**
Activities Director	61	56%	152	57%	155	48%	8	26%	**376**	**52%**
Activities Coordinator	11	10%	18	7%	22	7%	4	13%	**55**	**8%**
Activities Assistant	26	24%	98	37%	136	42%	6	19%	**266**	**37%**
Activities Aide	0	0%	8	3%	14	4%	0	0%	**22**	**3%**
ADC	4	4%	12	5%	9	3%	1	3%	**26**	**4%**
CTRS	5	5%	8	3%	20	6%	4	13%	**37**	**5%**
MT-BC	4	4%	8	3%	16	5%	4	13%	**32**	**4%**
Other Staff	15	14%	13	5%	16	5%	1	3%	**45**	**6%**
Volunteer	3	3%	16	6%	27	8%	2	6%	**48**	**7%**

Table 4.59: Activity Implementer by Size

Implements	JCAHO		Non-JCAHO		Total	
Responses	103	96%	584	94%	687	94%
Activities Department	7	7%	36	6%	43	6%
Activities Director	48	45%	328	53%	376	52%
Activities Coordinator	11	10%	44	7%	55	8%
Activities Assistant	38	36%	228	37%	266	37%
Activities Aide	7	7%	15	2%	22	3%
ADC	3	3%	23	4%	26	4%
CTRS	4	4%	33	5%	37	5%
MT-BC	11	10%	21	3%	32	4%
Other Staff	2	2%	43	7%	45	6%
Volunteer	9	8%	39	6%	48	7%

Table 4.60: Activity Implementer by JCAHO

Implements	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Responses	79	95%	73	95%	35	88%	73	100%	48	98%	67	93%	34	89%
Activities Department	4	5%	6	8%	3	8%	3	4%	1	2%	4	6%	1	3%
Activities Director	43	52%	46	60%	23	58%	42	58%	29	59%	35	49%	22	58%
Activities Coordinator	9	11%	8	10%	4	10%	1	1%	4	8%	2	3%	1	3%
Activities Assistant	30	36%	34	44%	11	28%	32	44%	11	22%	30	42%	14	37%
Activities Aide	5	6%	0	0%	1	3%	2	3%	1	2%	0	0%	1	3%
ADC	0	0%	2	3%	4	10%	3	4%	3	6%	3	4%	2	5%
CTRS	3	4%	1	1%	0	0%	10	14%	1	2%	2	3%	0	0%
MT-BC	8	10%	3	4%	0	0%	3	4%	1	2%	1	1%	0	0%
Other Staff	7	8%	2	3%	2	5%	1	1%	7	14%	4	6%	6	16%
Volunteer	5	6%	1	1%	5	13%	9	12%	0	0%	6	8%	3	8%

Implements	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Responses	19	95%	43	98%	104	94%	60	92%	49	94%	3	100%	687	94%
Activities Department	2	10%	7	16%	5	5%	5	8%	2	4%	0	0%	43	6%
Activities Director	9	45%	22	50%	54	49%	26	40%	24	46%	1	33%	376	52%
Activities Coordinator	2	10%	4	9%	8	7%	6	9%	6	12%	0	0%	55	8%
Activities Assistant	5	25%	16	36%	37	33%	23	35%	23	44%	0	0%	266	37%
Activities Aide	2	10%	0	0%	2	2%	4	6%	4	8%	0	0%	22	3%
ADC	0	0%	0	0%	3	3%	0	0%	5	10%	1	33%	26	4%
CTRS	0	0%	0	0%	9	8%	10	15%	0	0%	1	33%	37	5%
MT-BC	2	10%	3	7%	10	9%	1	2%	0	0%		0%	32	4%
Other Staff	0	0%	3	7%	10	9%	1	2%	2	4%		0%	45	6%
Volunteer	3	15%	4	9%	7	6%	4	6%	1	2%		0%	48	7%

Table 4.61: Activity Implementer by PSA

Question 3. Does this person(s) have training or education relating to music? If yes, please specify.

Larger facility size, JCAHO certification, and area all indicated a greater likelihood of staffing with music degrees and training. The total response was 58% no education, 36% yes, and 6% no responses. Of the music degrees listed, music therapy was the highest in Cleveland (10a) Cincinnati (1) and Akron (10b), JCAHO, and

medium/large facilities. All areas, sizes and certification reported at least one person with a music therapy degree. Other music degrees listed were music education, minor in music, and other music degree. Music training reported was, in order, specific instruments lessons, school music training (band and choir), non-specific training, and performing musician. Other types of music training results were "music training received as part of activity training" and "experience." Many small facilities and the majority of non-JCAHO facilities listed "experience" as music training.

Music Training/Education	Small		Medium		M-large		Large		Total	
Yes	30	28%	84	32%	133	41%	16	5%	**263**	**36%**
No	71	65%	163	61%	173	54%	14	4%	**421**	**58%**
No Response	8	7%	19	7%	15	5%	1	0%	**43**	**6%**
	Small		**Medium**		**M-large**		**Large**		**Total**	
Music Degree/s	8	7%	12	5%	33	10%	5	16%	**58**	**8%**
Music Certification/s	3	3%	7	3%	17	5%	4	13%	**31**	**4%**
Professional Affiliations	3	3%	10	4%	17	5%	3	10%	**33**	**5%**
Music Training	24	22%	67	25%	82	26%	8	26%	**181**	**25%**
Other	17	16%	28	11%	49	15%	8	26%	**102**	**14%**
Music Training	**Small**		**Medium**		**M-large**		**Large**		**Total**	
Non specific	3	3%	13	5%	22	7%	1	0%	**39**	**5%**
Specific	11	10%	29	11%	27	8%	5	2%	**72**	**10%**
School	7	6%	14	5%	21	7%	1	0%	**43**	**6%**
Performing Musician	3	3%	11	4%	12	4%	1	0%	**27**	**4%**
Other	**Small**		**Medium**		**M-large**		**Large**		**Total**	
Activity Training	7	6%	25	9%	45	14%	7	2%	**84**	**12%**
Experience	10	9%	3	1%	5	2%		0%	**18**	**2%**
Degree	**Small**		**Medium**		**M-large**		**Large**		**Total**	
Music Therapy	6	6%	8	3%	17	5%	3	1%	**34**	**5%**
Music Education		0%	2	1%	3	1%	0	0%	**5**	**1%**
Minor in Music		0%	1	0%	4	1%	0	0%	**5**	**1%**
Other	2	2%	1	0%	9	3%	2	1%	**14**	**2%**

Table 4.62: Music Training by Size

Music Training/Education	JCAHO		Non-JCAHO		Total	
Yes	**53**	**50%**	210	34%	263	36%
No	**49**	**46%**	372	60%	421	58%
No Response	**5**	**5%**	38	6%	43	5%
	JCAHO		**Non-JCAHO**		**Total**	
Music Degree/s	**14**	**13%**	44	7%	58	11%
Music Certification/s	**8**	**7%**	23	4%	31	4%
Professional Affiliations	**10**	**9%**	23	4%	33	4%
Music Training	**32**	**30%**	149	24%	181	22%
Other	**20**	**19%**	81	13%	101	13%
Music Training	**JCAHO**		**Non-JCAHO**		**Total**	
Non specific	**4**	**4%**	35	6%	39	6%
Specific	**16**	**15%**	56	9%	72	10%
School	**7**	**7%**	36	6%	43	3%
Performing Musician	**5**	**5%**	22	4%	27	4%
Other	**JCAHO**		**Non-JCAHO**		**Total**	
Activity Training	**20**	**19%**	64	10%	84	4%
Experience	**0**	**0%**	18	3%	18	4%
Music Degree/s	**JCAHO**		**Non-JCAHO**		**Total**	
Music Therapy	**10**	**9%**	24	4%	34	5%
Music Education		**0%**	5	1%	5	1%
Minor in Music	**2**	**2%**	3	0%	5	1%
Other	**2**	**2%**	12	2%	14	2%

Table 4.63: Music Training by JCAHO

Music Training/Education	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
Yes	25	30%	26	34%	14	35%	27	37%	17	35%	26	36%	9	24%
No	55	66%	46	60%	23	58%	44	60%	30	61%	41	57%	26	68%
No Response	3	4%	5	6%	3	8%	2	3%	2	4%	5	7%	3	8%
	PSA 1		**PSA 2**		**PSA 3**		**PSA 4**		**PSA 5**		**PSA 6**		**PSA 7**	
Music Degree/s	10	12%	4	5%	3	8%	4	5%	2	4%	3	4%	3	8%
Music Certification/s	5	6%	2	3%	2	5%	2	3%	0	0%	2	3%	2	5%
Music Professional Affiliations	7	8%	2	3%	3	8%	1	1%	0	0%	1	1%	1	3%
Music Training	15	18%	13	17%	12	30%	22	30%	12	24%	17	24%	10	26%
Other	10	12%	11	14%	5	13%	12	16%	7	14%	8	11%	3	8%
Music Training	**PSA 1**		**PSA 2**		**PSA 3**		**PSA 4**		**PSA 5**		**PSA 6**		**PSA 7**	
Non specific	3	4%	4	5%	3	8%	6	8%	2	4%	5	7%	0	0%
Specific	7	8%	5	6%	6	15%	8	11%	2	4%	7	10%	4	11%
School	3	4%	2	3%	2	5%	5	7%	4	8%	3	4%	4	11%
Performing Musician	2	2%	2	3%	1	3%	3	4%	4	8%	2	3%	2	5%
Other	**PSA 1**		**PSA 2**		**PSA 3**		**PSA 4**		**PSA 5**		**PSA 6**		**PSA 7**	
Activity Training	10	12%	10	13%	2	5%	10	14%	5	10%	7	10%	1	3%
Experience	0	0%	1	1%	3	8%	2	3%	2	4%	1	1%	2	5%
Degree	**PSA 1**		**PSA 2**		**PSA 3**		**PSA 4**		**PSA 5**		**PSA 6**		**PSA 7**	
Music Therapy	7	8%	2	3%	1	3%	2	3%	1	2%	1	1%	2	5%
Music Education	1	1%		0%		0%		0%		0%		0%		0%
Minor in Music	2	2%	1	1%		0%	1	1%		0%		0%		0%
Other		0%	1	1%	2	5%	1	1%	1	2%	2	3%	1	3%

Table 4.64: Music Training by Areas 1-7

Music Training/Education	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
Yes	10	50%	16	36%	48	43%	25	38%	20	38%	0	0%	**263**	**36%**
No	9	45%	26	59%	54	49%	34	52%	30	58%	3	100%	**421**	**58%**
No Response	1	5%	2	5%	9	8%	6	9%	2	4%	0	0%	**43**	**6%**
	PSA 8		**PSA 9**		**PSA 10a**		**PSA 10b**		**PSA 11**		**Unknown**		**Total**	
Music Degree/s	1	5%	3	7%	18	16%	5	8%	2	4%	0	0%	**58**	**8%**
Music Certification/s	1	5%	3	7%	9	8%	1	2%	2	4%	0	0%	**31**	**4%**
Music Professional Affiliations	0	0%	2	5%	12	11%	1	2%	4	8%	0	0%	**34**	**5%**
Music Training	5	25%	10	23%	34	31%	15	23%	16	31%	0	0%	**181**	**25%**
Other	3	15%	6	14%	17	15%	12	18%	8	15%	0	0%	**102**	**14%**
Music Training	**PSA 8**		**PSA 9**		**PSA 10a**		**PSA 10b**		**PSA 11**		**Unknown**		**Total**	
Non specific	2	10%	2	5%	7	6%	2	3%	3	6%	0	0%	**39**	**5%**
Specific	2	10%	4	9%	18	16%	5	8%	4	8%	0	0%	**72**	**10%**
School	1	5%	4	9%	4	4%	5	8%	6	12%	0	0%	**43**	**6%**
Performing Musician		0%	0	0%	5	5%	3	5%	3	6%	0	0%	**27**	**4%**
Other	**PSA 8**		**PSA 9**		**PSA 10a**		**PSA 10b**		**PSA 11**		**Unknown**		**Total**	
Activity Training	3	15%	5	11%	13	12%	12	18%	6	12%	0	0%	**84**	**12%**
Experience	0	0%	1	2%	4	4%	0	0%	3	6%	0	0%	**19**	**3%**
Degree	**PSA 8**		**PSA 9**		**PSA 10a**		**PSA 10b**		**PSA 11**		**Unknown**		**Total**	
Music Therapy	1	5%	1	2%	11	10%	4	6%	1	2%	0	0%	**34**	**5%**
Music Education		0%	1	2%	3	3%		0%		0%	0	0%	**5**	**1%**
Minor in Music		0%		0%	1	1%		0%		0%	0	0%	**5**	**1%**
Other		0%	1	2%	3	3%	1	2%	1	2%	0	0%	**14**	**2%**

Table 4.65: Music Training by Areas 8-Total

CHAPTER 5

STUDY SUMMARY, DISCUSSION, CONCLUSION

> "Music is one of the great pleasures of life. It has the power to command our attention and inspire us. It speaks to our spirit and to our inner feelings. It provokes thoughts about the mysteries of life such as why we exist, the vastness of the universe, and our purpose on earth. Music reaches deep into our nature to console us, to reassure us, and to help us express who and what we are as human beings" (Fowler, 1994, p.5).

Study Summary

The purpose of this study was to investigate and analyze the status of the use of music in nursing homes in the state of Ohio. Areas of concern included qualifications of personnel planning activities; sources of ideas for planning; available materials and equipment; frequency and duration of activities; types of activities, trips, or performances; intergenerational and community activities; and purposes and philosophical view on including music activities. The specific purposes of this questionnaire for the nursing homes in the state of Ohio were as follows:

5. What is the status of music in Ohio nursing homes including materials, activities and personnel?

6. How many long-term care facilities in Ohio receive services by Licensed Music Therapists or persons with music degrees?

7. Are there apparent differences in music activities in facilities categorized by size, accreditation, and region?

8. What are the reasons cited by facilities personnel for the inclusion of music activities? What are the intended outcomes?

The need for this study was based on a lack of information on the use of music in the nursing homes. The most current survey of nursing home music activities was done in Maryland in 1970's. The most recent survey of recreational activities in Ohio was done in 1952. While activities, music education, and music therapy professions have been researching and developing what appear to be parallel programs using music to improve the quality of life for older adults, and while there was a large amount of literature giving directions on specific music activities and an entire industry providing music supplies to nursing homes, no data showed what had been done. The Music Educators National Conference's Research Agenda for Music Education, called for research in outreach programs that will provide lifelong music learning, the extensions of programs to older adults, and exploration of opportunities for intergenerational participation (Lindeman, 1999). In A Guide to Research in Music Education, Phelps wrote: "with another population besides children and young people demanding attention, personnel must be trained to deal with this challenge" (Phelps, 1993, p.326). Do the music activities in long-term care facilities and especially nursing homes reflect the research and the profession's priorities?

To obtain this information, a questionnaire (Appendix A) consisting of nineteen questions was sent by U.S. Mail to all Medicare and Medicaid-certified nursing homes in the state of Ohio. Of the eighteen questions, eleven were multiple choice with the

category “other” to elicit related information, three asked for descriptions, one required a ranking, and three needed short answers. Seventeen questions examined concrete facts asking who, what, where, when, and how. The other question was more intangible, asking why.

To strengthen content validity, the draft questionnaire (Appendix A) was given to two music education faculty and a gerontology faculty member at Ohio State University and to a former nursing home administrator. These experts evaluated the questionnaire on organization, ambiguity, redundancy, possibility of offense, and terminology. Further refinement of the survey instrument was accomplished by field -testing the questionnaire. The researcher asked for appraisal of the questionnaire from activity directors employed by four Medicare/Medicaid certified nursing homes in the State of Virginia (Appendix B).

The population was a census of every Medicare and Medicaid-certified nursing home in the state of Ohio listed in the Nursing Home Compare database accessible on U.S. Government Site for People with Medicare. In the summer of 2002, there were 995 Medicare and Medicaid-certified nursing home in the state of Ohio.

The survey questionnaire, “Uses of Music in Ohio Nursing Facilities,” a cover letter, a list of music resources, and an addressed stamped business reply envelope was mailed to the activity director for the Medicare and Medicaid nursing facilities in the state of Ohio (Appendix C). The directors were requested to complete and return the questionnaire within two weeks. Two weeks after the initial mailing a reminder card was sent to all facilities that had not responded. Two weeks later, a second mailing was sent to those facilities that had not responded with a new cover letter, questionnaire, Ohio

State sticker, and a stamped addressed business reply envelope. The envelope and questionnaire were numerically coded by county, JCAHO certification, and facility and color-coded by size. The questionnaires were numerically recoded as the data was transferred to a computer spreadsheet to further maintain anonymity, yet offer a way to check for accuracy of data entry.

Information provided by the "Uses of Music in Ohio Nursing Facilities" questionnaire was presented descriptively and as frequency and percentages. To shorten the amount of time it took for directors to answer the questionnaire, information about the profiles of the facilities was gathered from Medicare/Medicaid data and reported descriptively and in charts.

Summary

Based on the information provided by the "Uses of Music in Ohio Nursing Facilities" questionnaire and an analysis of the profile of nursing homes provided by governmental agencies, the following information is a summary of the status of music in the nursing homes in the state of Ohio showing the most salient discoveries by question and then by size, certification, and area.

Nursing Homes

Of the 727 facilities that returned the questionnaire, 109 were small facilities (<50 beds); 266 were medium (50-99 beds); 321 were medium/large (100-199 beds); and 31 were from large (200+) facilities. One hundred-seven (15%) of these were certified by the Joint Commission on Accreditation of Healthcare Organizations (referred to as JCAHO). The return rate across the state ranged from 63% in the Cincinnati area to 87% in the Marietta/Athens area, averaging 73%.

How to Get Ideas?

The first section answered the question "how" by focusing on materials. Of the facilities responding, 54% indicated networking as where they get ideas for music programs. Small facilities and areas 2 (Dayton), 5 (Mansfield) and 8 (Athens/Marietta) reported more volunteer expertise sources. Books were also a major source in large facilities and in areas 7 (Rio Grande) and 9 (East Central Ohio). Creative Forecasting was the most frequently reported publication. Only three percent of the medium/large, JCAHO facilities, and PSA 1 (Cincinnati) reported using music therapy publications.

The majority of facilities (89%) reported owning pianos ranging from 1 to 10 with an average of 1.4 pianos per responding facility. Rhythm band and small percussion instruments were the most frequently reported "other."

Larger (55%) nursing homes had more computers than smaller (26%) and areas 2 (Dayton) and 3 (Lima) more than other areas. Music listening programs, games and the internet were the most frequent responses to available software. The majority either did not respond or responded "no" to music listening programs.

Only 16% of all facilities reported owning a DVD player. The majority own VCR players, televisions, tape players, and CD players. Karaoke machines were the surprising addition to electronic equipment. Cassette tapes, videotapes, and compact discs (CDs) were owned by the majority of homes.

When?

This section answered the question "when" by eliciting responses to frequency and length of music activities. Daily and 3-5 times per week were the most recurrent responses at 35% each. More facilities in PSA's 1 (Cincinnati), 2 (Dayton), 8 (Athens), and 10a (Cleveland) reported 3-5 times per week than average. The typical activity was reported as lasting between 30-45 minutes and 45-60 minutes.

Another set of questions asked for frequency of performances and frequency of participation invitations. One third of all facilities reported having outsiders perform weekly. One third responded monthly (16% monthly + 16% monthly and holidays). Residents were encouraged to participate in 34% of facilities weekly, 22% monthly, and 7% monthly and holidays. Singing was the most reported activity. Forty-seven percent of all facilities reported that the children performed for the residents (as opposed to performed with).

What?

Listening to recorded music, singing and listening to live performed music were the top music activities reported by the majority (91-93%) of nursing homes. Listening to live music was slightly higher than the average in homes that employ persons with music degrees. Singing was slightly higher than other choices in homes with music therapists. Singing was also the most frequently reported activity in the small and medium/large facilities and in areas 3 (Lima), 7 (Rio Grande), and 8 (Marietta/Athens). Other frequent responses were moving to music (exercising and dancing) and watching performances on television. Playing instruments were reported by 78% of facilities. Other activities reported were games, therapy, karaoke, bell choirs and kitchen bands.

Where?

The majority of the music activities were offered on site. A few (4%) described specific trips to summer park concert series, schools performances, and church. Bluegrass concerts were more popular in area 8 (Athens/Marietta) and ethnic music more popular in areas 10a and 10b (Cleveland and Akron). Lack of transportation and the frailty of the residents were the most frequent given reason for not taking trips.

Who Performs?

Children performed in 94% of all facilities. Five percent of all homes reported intergenerational activities. This increased in homes with musicians (13%) and music therapists (17%). Mostly (43%) the children come from schools except in area 8 (Athens/Marietta) (55%) that reported more children from churches. Other responses were community organizations such as scouts, 4-H, private music and dance studios, preschools, daycare centers, and Headstart programs, family of residents and staff, and home school children. Singing by the children was the more reported activity.

Across all areas, size and certification, churches (33%) were the most frequently reported group to bring music to the responding nursing homes except in Lima (area 3) that responded "volunteers." Area 8 (Athens) was the only area that did not report music therapy. PSA 4 (Toledo) has the most responses (10%) for music therapists as performers. Other facilities with higher than average music therapy responses were JCAHO, large, and PSA's 1 (Cincinnati), 10a (Cleveland) and 10b (Akron). The most frequent performance was instrumental. Bluegrass bands were more popular in Athens (area 8), ethnic music in Cleveland and Youngstown (PSA's 10a and 11) and gospel in all others. Demographically, Athens is part of Appalachia and the northeast section of Ohio

(Cleveland, Akron, Youngstown) has a higher population of European immigrants. Classical was the least reported choice except in PSA's 1 (Cincinnati), 10a (Cleveland), 2 (Dayton), and 3 (Lima). Each of these areas has cities with orchestras. According to data available in the 2000 U.S. Census, PSA's 10a (Cleveland), 1 (Cincinnati), (6) Columbus, 10b (Akron), 4 (Toledo), and 2 (Dayton) have the most population with college degrees. In previous studies, the more educated were found to prefer classical music (Lathom, Petersen & Havlicek, 1982).

In response to the most successful activity question, resident's activities and entertainment with involvement totaled 59% of the answers compared to 46% responses of entertainment without involvement. More responses from PSA's 1 (Cincinnati) and 8 (Athens/Marietta) were for entertainment than the average.

The activities department initiated 25% of all reported successful music activities. Of these, sing-alongs and singing were the most frequent responses followed by rhythm band, games and dancing. Facilities with employees who reported music degrees responded with different activities than those without music degrees i.e. drumming, music appreciation, resident choir, resident talent show, "walk n'roll." Other games reported by facilities with degreed musicians were "Stump the Piano Player," "Music Millionaire," "Music Wheel of Fortune." Music therapy sessions involved groups and individuals, relaxation techniques, reminiscence, and sensory stimulation. JCAHO, large, and PSA's 1 (Cincinnati), 3 (Lima), 4 (Toledo), and 10a (Cleveland) reported more music therapy activities than the average

How?

Success of activities is measured by participation, attendance and resident response in all size, area, and certification categories of homes.

Why?

Why are music activities offered? Pleasure was the number one purpose for engaging residents in music activities given by all facilities, except Youngstown (area 11) that ranked social interaction first. The order was as follows: pleasure, social interaction, emotional expression, physical activity, diversion, rehabilitation, and developing new music and listening skills. Eliciting responses was the most frequent response to "other." Facilities with music therapists responded with similar rankings. Rehabilitation was ranked "6" out of "7" in facilities with degreed musicians and music therapists.

Who Plans?

This set of questions sought information on who plans and implements the music programs and their qualifications. The activities departments at the majority of facilities plan and implement the music program. Music therapists plan in only 3% total and 7% of JCAHO homes, but implement in 4% total and 10% of JCAHO. PSA 9 (Cambridge), 10a (Cleveland), 1 (Cincinnati), 7 (Rio Grande), and 8 (Athens) reported more music therapist planning than did other areas and Cleveland (10a), Athens (8), and Cincinnati (1) more music therapist implementing. Areas 5 (Mansfield) and 11 (Youngstown) reported no music therapists planning and areas 3 (Lima), 7 (Rio Grande), and 11 (Youngstown) reported no music therapists implementing programs.

The most music degrees were reported in large and in JCAHO certified facilities. More music therapy degrees than average were reported in JCAHO, large, and PSA's 1

(Cincinnati), 10a (Cleveland), and 10b (Akron). Universities that offer music therapy degrees are in PSA's 2 (Dayton), 10b (Akron), 8 (Athens/Marietta), and 10a (Cleveland). Music degrees listed were music therapy, music education, minor in music and music degree. Music training reported other than school or specific instrument lessons was received as part of activity training and experiences. Fifty-eight percent of all facilities reported no staff with music training or experiences.

Discussion

Quality of life research has included study of the use of activities in the nursing home. "In the institution, as in the community, recreation serves as a way of improving the quality of life" (Weiner, Brok, & Snadowsky 1987, p. 135). As a result of his research, Iso-Ahola concluded that "recreation programs in the institutionalized settings are not to be means of simply filling the patients' time; the objective is to induce residents to look forward to their future and enjoyable living." Because music permeates life – joys and sorrows – and because almost everyone enjoys music, it is a valuable and integral part of a quality of life program in any nursing facility. " In the institution as in the community, recreation serves as a way of improving the quality of life" (Weiner, Brok, & Snadowsky, 1987). As stated by one respondent:

> "I really think the resident surprises themselves at what they're really capable of. Not only are they in a social atmosphere but also they're having fun, laughing at themselves and laughing along with others."

The data in this study indicate that music continues to be part of the nursing home quality of life programs. The main music activities suggested in activity/recreation texts and manuals for the past fifty years are the music activities that were reported in Ohio in

1950 and in 2003 - singing, listening to recorded music and performances by outside groups. Music activities suggested in the manuals for activity directors in the 1950's included the same activities that are found today - community sings; music appreciation classes; performances by residents; music from the community; rhythm band; and games. Other current activities such as reminiscence, bell choirs, composing, and dancing began to appear in the 1980's texts. Karaoke, a new reported addition, is just a technological version of the sing-along. These responses are consistent with where the activity directors reported getting ideas for music activities – networking with other activities professional, volunteer expertise, and books.

The National Association of Activities Professional's journal, Activities, Aging and Adaptation and Activities Directors' Quarterly for Alzheimer's and other Dementia Patients were not publications reported by the nursing facilities as a source of music ideas. Yet several articles have appeared in these journals on the therapeutic uses of music. Eldermusic, a catalog of books of music ideas written by a music therapist, was reported in only 8 homes and music therapy publications in only five. Publications such as Creative Forecasting and A New Day and on-line networking sites share music activities. These resources were reported by almost 50% of the facilities. More information needs to be made available on age appropriate music activities in the venue where they get their ideas – professional networks, publications, workshops, and books. Plus, the journals with music information need to be more assessable to the activity directors.

Age appropriate activities were recommended in both the activities and music therapy literature. Just what is age appropriate was never defined. Rhythm bands and

kitchen bands were reported being used in many homes. Unlike in the 1950's, rhythm bands are no longer part of the elementary school music programs. In schools, hand percussion instruments are used but with more musical purpose than shaking them to the beat. Are rhythm bands used in a way that they are age appropriate? For a person with advanced Alzheimer's disease, perhaps shaking a jingle stick is a purposeful activity that meets the goal of eliciting a response (Jellison, 1999). For a person with a higher cognitive level, perhaps this is not an age-appropriate activity. There is a need for a clear articulation of the philosophy and definition of age appropriateness and why this is important to quality of life, education, recreation, and therapy of the older adult in the literature available to the music activity planners.

In 1945 Hamilton and Van De Wall wrote: "A distinction between the recreational and therapeutic application of music is theoretical and academic and that in practice both uses overlap" (Hamilton & Van de Wall, 1945, p. 119). The overlap between therapeutic, educational, and recreational appeared in the responses. Homes that employ music therapists or musicians only reported slightly more live music and singing than homes with non-musician employees. Evidence from music literature on the uses of music with older adults was found in the following areas: aptitude and attitude (games such as Name that Tune and SINGO), the voice (singing and sing a-longs), and Alzheimer's disease (music to trigger responses and memories, for behavior modification in bathing and eating, and to increase socialization). Responses also gave evidence from the music education literature on life long learning – choirs and music appreciation. While these activities had therapeutic and educational side effects, pleasure was the

number one ranked purpose reported for their use. One facility's written response to the question of purpose was:

> "Music sessions raise levels of self esteem, elevate quality of life, exercise cognitive skills and offer a variety of levels of participation including active participation, active listening, sensory stimulation, memory recall of happy experiences, and leisure enjoyment."

Despite the years of research and experience, the purpose of improving or maintaining functional abilities and slowing the rate of decline compares to VanDeWall's 1930's advice that recreation should restore, develop, preserve, and prevent breakdown of potential and energy. Only one of the activity experts defined a difference – the purpose of therapy is to build skills; the purpose of activity programming is to maintain and reinforce skills for the participants (Crepeau, 1987). Yet in this study, the main reason for including music was pleasure. The residents enjoy music. The rehabilitative use of music ranked low, only ahead of the development of musical skills and knowledge. According to the National Therapeutic Recreation Society (2003), leisure should be enjoyable and as a contributor to quality of life, it may help prevent illness, prevent further deterioration, and promote functional abilities. Enjoyable living was both the definition of quality of life and the reason for participation in recreation (Iso-Ahola, 1980).

With only 34% of all facilities reporting staff with any music training, there seems to be a great need for professional development in music. Mathews, Clair and Kosloski (2000) reported the training of activity aides to increase the engagement of persons with dementia in rhythm activities. One facility wrote:

> "Students may serve credit hours in our facilities! We need them to help diversify our programs. Something else that would help us with music

> programs is to have your students come in our facilities and teach the Activity Staff how to implement programs."

Based on the literature review of the uses of music in a nursing home, a music therapist is a valuable resource for not only one to one and small group active music therapy, but also a resource for the entire facility on the passive uses of music. One of the "other" sources of ideas reported by facilities was music therapist. Thirty-four facilities (5%) reported employing a music therapist. Music therapists have training both in music and the needs of abilities of older adults, especially those with dementia. In the literature, music therapy was recommended to provide "meaningful substance to an already accepted activity" (Avery, 1997, p. 114). A professional music therapist can set up a research-based program with plans, goals and assessment. One respondent wrote:

> "I was never trained in music, so I believe that we would need someone with a music background to have a successful group that had goals & objectives."

Conclusion

Based on the results of this study, it appears that the music is an important program in the activities departments of nursing facilities in the state of Ohio. Seventy percent responded either daily or 3-5 times per week involvement, and no responding facility responded "none." It can be inferred that music is a valued activity in a quality of life program both as entertainment and active involvement. Even though pleasure was the most frequent reason for including music, there were also descriptions of responses and evidences of engagement that ranged from smiles to toe tapping. Older adults are listening, performing, and responding to a variety of music on a frequent basis. The following comments are from respondents:

> "It has been my experience that music is one of the greatest things we can offer our residents. It is very stimulating for those who are usually unresponsive, and also very calming for those who are agitated or are exhibiting aggressive or inappropriate behaviors."
>
> "Some residents that never talk will sing and seem to know songs. When don't seem to know or respond to anything else we have had some tap toes or some unresponsive cry. Music is a very wonderful way to get residents to respond also brings back many memories."
>
> "Music plays a very important part of our activity programs. Our residents so enjoy every aspect of music from listening, to playing, to singing. We are a very close-knit facility and it is not uncommon to walk in the building and hear various staff leading a few to many in a sing-along or playing piano."
>
> "I am committed to the belief that music is the touchstone for all of life's stages and experiences. We loose the ability to fully connect to our emotions without music as a lure to bring them to the surface."

Implications for Music Education

Just as an aesthetic experience results in a richer and more meaningful life, the value of music with older adults is in its ability to add to the quality of life of the older adult. Philosophies of music education stress the aesthetics of music. An aesthetic experience is valued for the enjoyment that is provides; involves feelings, awareness, and attention; must be experienced; and results in a richer and morning meaningful life" (Abeles, Hoffer & Klotman, 1994, p. 75). The majority of activity directors of the nursing facilities in the state of Ohio ranked the pleasure (enjoyment) as the main reason for including music. Just as an aesthetic experience involves attention and experience, activity directors measured success by the participation and involvement of the residents. The therapeutic benefits of having a pleasurable experience, while not articulated as such, were evidenced by descriptions such as comments as:

> "It makes the person feel very special when we sing their favorite song, it soothes and calms a resident in pain, and it cheers up the depressed person who can't socialize."
>
> "Education is intended to improve the quality of life" (Jellison, 2000, p.113).

Music in the adult life is the ultimate goal of school music experiences and the " impact of school experiences on the quality of life of future generations is a recurring theme" (Jellison, 2000, p. 113). With children, teachers, schools, and parents are responsible for the learning experiences. In nursing homes with older adults, activity directors are responsible for providing quality of life opportunities. Only 36% of all persons returning the questionnaire reported having any music training and 12% reported it as part of their activity training. If the music education of the activity directors is limited to elementary school and not transferable to adult activities, then elementary music skills will be all they know to share with the residents. If the music education of the residents was not transferable to adult music activities, then they will not know to request more age appropriate activities. School music programs need to teach for transfer to adult music activities. Not many adults sit around and tap rhythm sticks to compact discs.

Schools can be encouraged to provide intergenerational opportunities and use nursing homes as performance venues for programs other than during holidays. The residents enjoy children performing.

Community singing was a popular event when this cohort of nursing home residents was young (Mark, 1994). Rhythm bands were part of the school music program through the 1950's. Singing and rhythm bands are popular activities for that generation in nursing homes. Looking back at the baby boom generation, what predictions can be made on the types of music activities that will be enjoyable for them? Garage bands?

Rock concerts? Hootenannies? Based on the musical experiences provided in the current school music programs, what kind of activities will future activity directors plan?

Questionnaire Improvement

Seventy-three percent of the nursing facilities in the state of Ohio returned the questionnaire. Several facilities returned the questionnaire unanswered with a note that they were too busy at that time. Several e-mailed saying the month of December was a difficult month to find time to respond. If this population is surveyed again, determine when the less busy time of year is.

> "What you need to know is that you have put out your survey at the worst time of the year for most Activity Professionals as they kick into Thanksgiving and Christmas."

If used again, the question on "trips" would need to be reworded to elicit information on "off-site" music events. Questionnaires could also be coded by ownership and source of payment to determine if those variables affect number and type of music activity. "Investor-owned nursing homes deliver lower quality care than do nonprofit or public facilities" (Harrington, Woolhandler, Mullan, Craillo, Himmelstein, p. 1453),

Questions for further research

Examine the use of continuous background music in nursing facilities: Is music always on? Does that lessen its therapeutic value? Why is this done?

How is music used in other older adult facilities: assisted living, retirement homes, continuing care communities, senior centers? Do the activities change when the older adult is less frail? Do the activity directors choose more age appropriate activities when there is less cognitive decline?

What is taught in the music component of activity directors training in the programs certified by NAAP and the National Therapeutic and Recreation Society? How does it vary from school to school? What continuing education courses are being offered for activity directors in the uses of music?

What music courses on music and older adults or life-long learning are offered? What courses are offered in universities and colleges on the teaching of music to adults (androgogy) or older adults (gerontogogy) or on life-long music learning? What opportunities are there for older adults to participate in music classes? What university level intergenerational activities are there?

Is there a difference in music activities offered in investor-owned, non-profit, hospital-based, and public nursing facilities? In chain versus independent? Medicare, Medicaid, or private pay? Those who have adopted the Pioneer Network philosophy?

The present study showed that music plays a prominent role in nursing homes, but that there is a need for further development in programming, materials, and personnel. Additional research in these and other suggested areas would serve to improve the quality of life for older adults living in nursing facilities.

APPENDIX A

Uses of Music in Ohio Nursing Facilities

Uses Of Music In Ohio Nursing Facilities

For this survey, music activities refer to all planned activities in the facility that have music as a component. These typically would appear on the activity calendars.

Materials:

1. Where do you get ideas for music programs? (circle all that apply)
    a. Books
    b. Networking
    c. Newsletters
    d. Professional publications (please list)_____
    e. Staff meetings
    f. Volunteer expertise
    g. Web-based materials
    h. Workshops or Coursework
    i. Other (please list) _____

2. Which musical instruments are available for use by residents in your facility? (circle all that apply)
    a. Electronic keyboard
    b. Guitar
    c. Hand bells or hand chimes
    d. Harmonicas
    e. Organ
    f. Percussion instruments
    g. Piano - how many?
    h. Recorders
    i. Other - _____

3. Does your facility have computers available for use by the residents?
    a. Yes
    b. No

    If yes, what computer music software is available? (circle all that apply)
    a. Music listening programs
    b. Music theory or learning programs
    c. Music writing or publishing
    d. Piano lesson program
    e. None
    f. Other _____

4. What kind of electronic equipment is available for use by residents? (circle all that apply)
    a. CD player
    b. DVD player
    c. Record player
    d. Tape player
    e. Television
    f. VCR player
    g. Other _____

5. What kind of electronic media is available for use by residents?
    a. Cassette Tapes
    b. Compact Discs (CDs)
    c. DVDs
    d. Records
    e. Videotapes
    f. Other _____

Music Activities:

1. How often are music activities offered?
    a. Daily
    b. 3-5 times per week
    c. 1-2 times per week
    d. Rarely
    e. Never

2. How long does the typical music activity last?
    a. 45-60 minutes
    b. 30-45 minutes
    c. 15-30 minutes
    d. Other (specify) _____

3. What kind of music activities are the residents offered? (circle all that apply)
    a. Discussing music
    b. Listening to live performed music
    c. Listening to recorded music
    d. Moving to music/Dancing
    e. Playing instruments
    f. Singing
    g. Watching performances on television
    h. None
    i. Other _____

4. What types of music trips were offered during the past 12 months? (circle all that apply)
    a. Big band/Jazz
    b. Church/Synagogue
    c. Musicals/Plays
    d. Orchestra concerts
    e. Pops concerts
    f. Recitals
    g. None
    h. Other _____

5. In the past 12 months, how often have groups or individuals from the community performed for the residents in your facility?

a. Daily
b. Weekly
c. Monthly
d. Holidays and Special Occasions
e. Other _____

6. In the past 12 months, how often have residents been invited to participate in music activities with groups or individuals who have visited the facility?

a. Daily
b. Weekly
c. Monthly
d. Holidays
e. Other _____

7. Do children perform or participate in music activities with your residents? (please describe)

_____

_____

_____

8. Please list other groups or individuals that bring music to your residents and describe the activities.

_____

_____

_____

9. Please describe your most successful music activities. Please include how you measured success.

_____

_____

_____

10. In general, what are the purposes of engaging the resident in music activities? Please rank the responses according to importance. (1 being the most important)

____Development of new musical and listening skills
____Diversion
____Emotional Expression
____Physical Activity
____Pleasure
____Rehabilitation
____Social interaction
____Other (please state)
_____

Personnel

1. What is the title of the person(s) who plans the music activities programs at your facility?

_____

2. What is the title of the person(s) who implements the music activities programs at your facility?

_____

3. Does this person(s) have training or education related to music?
   a. Yes
   b. No

If yes, please specify:

a. Music Degree/s_____
b. Music Certification/s_____
c. Music Professional Affiliations _____
d. Music Training _____
e. Other (please list) _____

If you would like a copy of the results or more information on the uses of music, please include your request along with your name and address on a separate piece of paper.

Any questions, contact: Judith Murphy 614-451-8274 (murphy.415@osu.edu) or Patricia Flowers 614-292-6389 (flowers.1@osu.edu)

Please return completed form to Judith Murphy 1487 Bridgeton Drive Columbus, OH 43220

APPENDIX B

Pilot

September 11, 2002

Dear Director of Activities:

The enclosed questionnaire serves as the data-gathering instrument for my doctoral dissertation at The Ohio State University. Evidence from the music, activities and nursing professions is showing music as a valuable resource for therapy and for recreation in the nursing home. The purpose of the study is to investigate and analyze the status of the use of music in nursing homes. The survey will be sent to all the Medicare/Medicaid Certified nursing homes in the state of Ohio.

Before sending out the survey to facilities in Ohio, I am pilot-testing it at several facilities in another state and requesting suggestions for improvements. I'm estimating the survey will take approximately fifteen minutes to complete. Because a high response rate is important to the validity of the study, your participation in the survey would be greatly appreciated. Your identity and the identity of your place of employment will remain confidential and will not be reported in any writing resulting from the study.

I would appreciate having your completed questionnaire by September 22, 2002. If after looking at the survey, you feel it has been sent to you in error, please forward it to the appropriate person. As a thank you in advance for your interest in contributing to this study, I have enclosed a list of music resources.

Sincerely,

Judith W. Murphy
614-451-8274
murphy.415@osu.edu
Ph.D. Candidate

Dissertation Supervisor
Patricia J. Flowers, Ph.D.
614-292-6389
flowers.1@osu.edu
Professor and Chair of Graduate Studies

PILOT EVALUATION FORM

1. Approximately how long did it take you to complete the "Uses of Music in Nursing Facilities" questionnaire?

_____

Please offer suggestions on the number of questions and the amount of time it took.

_____

_____

_____

2. Are you interested in the topic? _____Yes _____No

3. Were the instructions clear? _____Yes
_____No

Please make suggestions to clarify instructions:

_____

_____

_____

4. Are the questions and terms easily understood? _____Yes _____No

If no, which questions or terms need clarification?

_____

_____

_____

5. Are the response choices logical and cover all possibilities? _____Yes _____No

If no, which responses need additions or corrections?

_____

_____

_____

6. Are the questions and responses arranged in an easy to follow order?

_____Yes _____No

If no, please comment on problem areas:

_____

_____

_____

7. Please comment on any aspect of the survey instrument that you feel needs revision.

_____

_____

_____

September 24, 2002

Dear Director of Activities:

Recently I mailed a pilot survey questionnaire to you requesting suggestions for improvements. The purpose of the study is to investigate and analyze the status of the use of music in nursing homes. The survey will be sent to all the Medicare/Medicaid Certified nursing homes in the state of Ohio and serve as the data-gathering instrument for my doctoral dissertation at The Ohio State University. Your home was chosen for the pilot because present or former residents there are relatives or family friends.

If you have already completed the questionnaire, thank you very much. If not, I am hoping that you will take fifteen minutes of your time to complete and return it by the 5th of October. Evidence from the music, activities and nursing professions is showing music as a valuable resource for therapy and for recreation in the nursing home.

Sincerely,

Judith W. Murphy
614-451-8274
murphy.415@osu.edu
Ph.D. Candidate

Dissertation Supervisor
Patricia J. Flowers, Ph.D.
614-292-6389
flowers.1@osu.edu
Professor and Chair of Graduate Studies

APPENDIX C

Survey Mailings

November 20, 2002

Dear Director of Activities:

The enclosed questionnaire serves as the data-gathering instrument for my doctoral dissertation at The Ohio State University. Evidence from the music, activities and nursing professions is showing music as a valuable resource for therapy and for recreation in the nursing home. The purpose of the study is to investigate and analyze the status of the use of music in nursing homes and is being sent to all the Medicare Certified nursing homes in the state of Ohio.

The enclosed survey will take approximately fifteen minutes to complete. Because a high response rate is important to the validity of this study, your participation in this survey would be greatly appreciated. While participation is voluntary, if you choose to complete and return the survey, you are agreeing to participate in the study. Your identity and the identity of your place of employment will remain confidential and will not be reported in any writing resulting from the study.

I would appreciate having your completed questionnaire by December 4, 2002. If after looking at the survey, you feel it has been sent to you in error, please forward it to the appropriate person. Multi-level care facilities should only report on activities for nursing care. As a thank you in advance for your professional and personal interest in contributing to this study, I have enclosed a list of music resources.

Sincerely,

Judith W. Murphy
murphy.415@osu.edu
Ph.D. Candidate

Dissertation Supervisor
Patricia J. Flowers, Ph.D.
614-292-6389
flowers.1@osu.edu
Professor and Chair of Graduate Studies

MUSIC RESOURCES

BOOKS

Aldridge, D. (Ed). (2000). Music Therapy in Dementia Care: More New Voices. London: Jessica Kingsley Publishers. ISBN 1-85302-7766.

Aldridge, D. (Ed.) (1999). Music Therapy in Palliative Care: New Voices. London: Jessica Kingsley Publishers. ISBN 1-85302-739-1

Clair, A.A. (1996). Therapeutic Uses of Music With Older Adults. Baltimore, MD: Health Professions Press, Inc. ISBN 1-878812-32-7.

United States Senate, Special Committee on Aging. (1991). Forever young: music and aging. Washington DC: US Government Printing Office.

MUSIC ACTIVITY MANUALS

Chavin, M. (1991). The lost chord: Reaching the person with dementia through the power of music. Maryland: Elder Song Publication.

Clipp, K. B., & Cox, B. (1994). Sensory awareness and music focus: Protocols for environmental enrichment for seniors. Maryland: Chess Publications

Cordrey, C. (1994). Hidden treasures: Music memory activities for people with Alzheimer's Maryland: ElderSong Publications.

Douglass, D. (1985). Accent on rhythm - music activities for the aged. Missouri: MMB Music.

Karras, B. (ed.). (1987). You bring out the music in me: Music in nursing homes. New York: The Hawthorne Press.

Karras, B. (1991). I hear memories! Maryland: ElderSong Publications.

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Karras, B. (1985). Down memory lane. Maryland: ElderSong Publications.

Messenger, B. (1995). The power of music: A complete music activities program for older adults. Maryland: Health Professions Press.

Grant, R.E. (1973). Sing along senior citizens. Springfield, IL: Charles C. Thomas.

WEBSITES

American Music Therapy Association 8455 Colesville Road, Suite 1000 Silver Spring, Maryland 20910 Phone: (301) 589-330 (http://www.namt.com/)

Music Therapy Info Link (http://members.aol.com/kathysl/index.html

ElderSong Publications, Inc. (www.eldersong.com)

ElderSong Online Newsletter: Using Music with Older Adults. (http://www.eldersong.com/nl/)

Sing-a-long Video: (http://www.music-therapy-video.com/)

Reader's Digest Songbooks. Reader's Digest Association, Inc. Pleasantville, NY 10570. (1-800-431-1246). Family Songbook; Popular Songs that Will Live Forever; Treasury of Best-Loved Songs; Country and Western Songbook; Unforgettable MusicMemories. (www.rd.com).

Bi-Folkal Productions - program materials for remembering. (http://www.bifolkal.org/)

December 1, 2002

Dear Director of Activities:

Recently I mailed a survey to your facility, requesting that the activities director or designee answer some questions about music resources and programming at your facility. I am gathering this information as part of my doctoral dissertation at The Ohio State University. The purpose of the study is to document current status and make recommendations for the use of music in nursing homes. The survey was sent to all the Medicare/Medicaid Certified nursing homes in the state of Ohio.

If you have already completed the questionnaire, thank you very much. If not, I am hoping that you will take fifteen minutes to complete the questionnaire and return it by the 9th of December. Every completed questionnaire is important to the study and I would be most grateful for your participation in this research project.

Sincerely,

Judith W. Murphy
614-451-8274
murhy.415@osu.edu
Ph.D. Candidate

Dissertation Supervisor
Patricia J. Flowers, Ph.D.
614-292-6389
flowers.1@osu.edu
Professor and Chair of
Graduate Studies

January 1, 2003

Dear Director of Activities:
Recently I mailed a survey questionnaire to you requesting information on the uses of music in your facility. The survey was sent to the activity directors of all nursing facilities in the State of Ohio that are listed on the Medicare website as certified by Medicare, Medicaid or both. This questionnaire serves as the data-gathering instrument for my doctoral dissertation at The Ohio State University.

If you have already completed the questionnaire, thank you very much. If not, I am hoping that you will reconsider and take ten minutes of your time to complete and return it by the 20th of January. If life is just too hectic as this time, I would appreciate your returning it uncompleted. As a thank-you in advance I am enclosing a Buckeye Sticker.

Sincerely,

Judith W. Murphy
614-451-8274
murphy.415@osu.edu
Ph.D. Candidate

Dissertation Supervisor
Patricia J. Flowers, Ph.D.
614-292-6389
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Professor and Chair of
Graduate Studies

APPENDIX D

County and Planning & Service Areas

Code	County	PSA	Sent	Ret.	%
1	Adams	7	4	3	75%
2	Allen	3	14	8	57%
3	Ashland	5	6	6	100%
4	Ashtabula	11	14	11	79%
5	Athens	8	5	5	100%
6	Auglaize	3	10	9	90%
7	Belmont	9	10	9	90%
8	Brown	7	3	1	33%
9	Butler	1	23	15	65%
10	Carroll	9	2	2	100%
11	Champaign	2	4	2	50%
12	Clark	2	19	15	79%
13	Clermont	1	11	7	64%
14	Clinton	1	5	2	40%
15	Columbiana	11	16	12	75%
16	Coshocton	9	6	3	50%
17	Crawford	5	7	5	71%
18	Cuyahoga	10a	109	70	64%
19	Darke	2	7	7	100%
20	Defiance	4	4	2	50%
21	Delaware	6	8	6	75%
22	Erie	4	10	10	100%
23	Fairfield	6	11	6	55%
24	Fayette	6	6	3	50%
25	Franklin	6	53	41	77%
26	Fulton	4	5	3	60%
27	Gallia	7	3	1	33%
28	Geauga	10a	8	6	75%
29	Greene	2	13	10	77%
30	Guernsey	9	4	3	75%
31	Hamilton	1	81	50	62%
32	Hancock	3	5	5	100%
33	Hardin	3	4	4	100%
34	Harrison	9	3	3	100%
35	Henry	4	3	3	100%
36	Highland	7	5	5	100%
37	Hocking	8	3	3	100%
38	Holmes	9	6	4	67%
39	Huron	5	6	6	100%
40	Jackson	7	4	4	100%
41	Jefferson	9	10	9	90%
42	Knox	5	9	8	89%
43	Lake	10a	14	11	79%
44	Lawrence	7	6	4	67%

Code	County	PSA	Sent	Ret.	%
45	Licking	6	10	8	80%
46	Logan	2	6	5	83%
47	Lorain	10a	22	16	73%
48	Lucas	4	38	32	84%
49	Madison	6	3	3	100%
50	Mahoning	11	25	17	68%
51	Marion	5	6	4	67%
52	Medina	10a	13	8	62%
53	Meigs	8	3	2	67%
54	Mercer	3	7	7	100%
55	Miami	2	6	4	67%
56	Monroe	8	2	2	100%
57	Montgomery	2	37	29	78%
58	Morgan	8	2	2	100%
59	Morrow	5	4	3	75%
60	Muskingum	9	7	5	71%
61	Noble	8	1	1	100%
62	Ottawa	4	3	3	100%
63	Paulding	4	2	1	50%
64	Perry	8	2	1	50%
65	Pickaway	6	4	2	50%
66	Pike	7	5	3	60%
67	Portage	10B	8	5	63%
68	Preble	2	4	3	75%
69	Putnam	3	6	5	83%
70	Richland	5	12	6	50%
71	Ross	7	7	7	100%
72	Sandusky	4	8	7	88%
73	Scioto	7	13	9	69%
74	Seneca	5	9	8	89%
75	Shelby	2	4	1	25%
76	Stark	10B	37	22	59%
77	Summit	10B	39	30	77%
78	Trumbull	11	16	12	75%
79	Tuscarawas	9	10	6	60%
80	Union	6	3	3	100%
81	VanWert	3	3	3	100%
82	Vinton	7	2	1	50%
83	Warren	1	12	9	75%
84	Washington	8	5	4	80%
85	Wayne	10B	12	8	67%
86	Williams	4	5	5	100%
87	Wood	4	9	7	78%
88	Wyandot	5	4	3	75%

Table D.1 Return by County & PSA

Area	PSA	County		Area	PSA	County
Cincinnati	1	Butler		Columbus	6	Licking
Cincinnati	1	Clermont		Columbus	6	Madison
Cincinnati	1	Clinton		Columbus	6	Pickaway
Cincinnati	1	Hamilton		Columbus	6	Union
Cincinnati	1	Warren		Rio Grande	7	Adams
Dayton	2	Champaign		Rio Grande	7	Brown
Dayton	2	Clark		Rio Grande	7	Gallia
Dayton	2	Darke		Rio Grande	7	Highland
Dayton	2	Greene		Rio Grande	7	Jackson
Dayton	2	Logan		Rio Grande	7	Lawrence
Dayton	2	Miami		Rio Grande	7	Pike
Dayton	2	Montgomery		Rio Grande	7	Ross
Dayton	2	Preble		Rio Grande	7	Scioto
Dayton	2	Shelby		Rio Grande	7	Vinton
Lima	3	Allen		Athens/ Marietta	8	Athens
Lima	3	Auglaize			8	Hocking
Lima	3	Hancock		Athens/ Marietta	8	Meigs
Lima	3	Hardin			8	Monroe
Lima	3	Mercer		Athens/ Marietta	8	Morgan
Lima	3	Putnam			8	Noble
Lima	3	VanWert		Athens/ Marietta	8	Perry
Toledo	4	Defiance			8	Washington
Toledo	4	Erie		Cambridge	9	Belmont
Toledo	4	Fulton		Cambridge	9	Carroll
Toledo	4	Henry		Cambridge	9	Coshocton
Toledo	4	Lucas		Cambridge	9	Guernsey
Toledo	4	Ottawa		Cambridge	9	Harrison
Toledo	4	Paulding		Cambridge	9	Holmes
Toledo	4	Sandusky		Cambridge	9	Jefferson
Toledo	4	Williams		Cambridge	9	Muskingum
Mansfield	4	Wood		Cambridge	9	Tuscarawas
Mansfield	5	Ashland		Youngstown	11	Ashtabula
Mansfield	5	Crawford		Youngstown	11	Columbiana
Mansfield	5	Huron		Youngstown	11	Mahoning
Mansfield	5	Knox		Youngstown	11	Trumbull
Mansfield	5	Marion		Cleveland	10a	Cuyahoga
Mansfield	5	Morrow		Cleveland	10a	Geauga
Mansfield	5	Richland		Cleveland	10a	Lake
Mansfield	5	Seneca		Cleveland	10a	Lorain
Mansfield	5	Wyandot		Cleveland	10a	Medina
Columbus	6	Delaware		Akron	10B	Portage
Columbus	6	Fairfield		Akron	10B	Stark
Columbus	6	Fayette		Akron	10B	Summit
Columbus	6	Franklin		Akron	10B	Wayne

Table D.2 Ohio Planning and Service Areas

APPENDIX E

Comments

COMMENTS

Went to concerts few years until we were asked not to bring residents in what they called "those beds (Jeri Chairs)." They said residents in wheel chairs were welcome but those beds might be a safety issue. We decided that if all were not welcome then none of us would go.

All instruments are/should be made available to all residents that express interest. It is our responsibility to provide any/all materials necessary if a resident requests or has past interest.

All music activities are success. Even if residents are non-verbal any slight movement a success. Also dementia residents when there is music can usually remember the words.

All special events. An Exploring Music Series with each session featuring a classic composer was very well accepted - used live music, the most recent unusual event which was not only successful, but exciting was the story of Bab Yuaga told by the witch herself (in costume) and also used the music of Modest Mussorgsky "Pictures at an Exhibition." The violin part was played "live" along with the CD. Some of the residents had been to a concert 2 weeks earlier to hear the Mussorgsky - now thy heard the story - done on Halloween.

At least one day a week there is a structured music act that lasts 30 minutes. Music is played daily w/residents singing and dancing. The radio is always on.

Difficult to answer for each resident the importance is different. Someone in distress it could mean calming; someone who is s music enthusiasts it could be pleasure; someone who is reclusive it could be to promote socialization etc.

Each resident has an individual plan of care for musical & recreational needs.

Energetic staff, food and music are drivers for resident participation.

Good Resource: I Love America's Music by Gary Grimm & Asso.

Great connection and seems to be on the of the last things that stay with them as the disease progresses

I am committed to the belief that music is the touchstone for all of life's stages & experiences. We loose the ability to fully connect to our emotions without music as a lure to bring them to the surface.

I am employed as a music therapist at 3 local long-term care facilities part-time.

I have several Alzheimer's residents whom cannot verbalize what they want to say, repeating and stuttering words, but when singing they have no problem getting all the word out correctly and you can see on their faces how happy it makes them.

I hired a professional as an assistant and brought out professionals to present programs for residents. For 4 years we employed a PRN and part-time music therapist-certified etc. I'm a believer in the value of music so wrote proposal for position to assist with programming. It may have been the therapist, but the return for what was paid were poor. Few patients possible 6-8 seen within a week's time in |:| music in 2 years. Program was cut. This was a 20 hr wk. position-prep work done by therapist ate up most of time.

I measured success by the interaction and the responses we received from the residents, especially if it is a resident who has Alzheimer's disease, paralyzed , suffering from any illness. To see them respond in such a positive way (blinking- eye movement, singing, smiling, moving their hand, finger foot, clapping, pat their feet to the beat of the music to me) that is a success!!

I really think the resident surprises themselves at what they're really capable of. Not only are they in a social atmosphere but they're having fun, laughing at themselves and laughing along with others

I would like to share that our facility is unique in that we are a facility for the deaf. Music is difficult at times to interpret & must be accompanied by lyrics and dance in order for our residents to benefit.

Music in motion - our restorative program put together movement and music for a very successful exercise program. Movements are with range of motion to all extremities as the residents are able to participate. Staff work with other residents needing range of motion. Exercise sticks residents used are made by residents. Music is Glenn Miller, Mitch Miller, etc.

Music played during all physical activities and during lunch and dinner daily. Many time records or music video's on in between scheduled activities. Music activities are usually once a week (name that tune, big bands era, rhythm band - they play along w/ recorded music, plus church vol. weekly w/ church & music/music movies.) We are very small -- 6-22 fairly low functioning residents.

Music plays a very important part of our activity programs. Our residents so enjoy every aspect of music from listening, to playing, to singing. We are a very close-knit facility and it is not uncommon to walk in the building and hear various staff leading a few to many in a sing-along or playing piano.

Music sessions raise levels of self esteem, elevate quality of life, exercise cognitive skills and offer a variety of levels of participation including activity participation; active listening; sensory stimulation, memory recall of happy experiences, leisure enjoyment.

Music therapist provides 4 music therapy groups per day and 1-6 1:1 individual sessions based on caseload for both facilities.

One person (paid entertainer) is music therapist.

It has been my experience that music is one of the greatest things we can offer our residents. It is very stimulating for those who are usually unresponsive, and also very calming for those who are agitated or are exhibiting aggressive or inappropriate behaviors. I am always interested in finding new information to implement into our program.

APPENDIX F

Tables

Publications	Small		Medium		M-Large		Large		Total	
"d"	5	5%	13	12%	17	16%	2	2%	**37**	**5%**
A New Day	4	4%	16	15%	16	15%	2	2%	**38**	**5%**
Activities Director Guide	2	2%	3	3%	7	6%	0	0%	**12**	**2%**
Creative Forecasting	21	19%	53	49%	58	53%	2	2%	**140**	**19%**
Eldersong	0	0%	1	1%	5	5%	3	3%	**8**	**1%**
Music Therapy	0	0%	1	1%	3	3%	1	1%	**5**	**1%**
Other (catalogs,flyers,newspapers,books)	5	5%	13	12%	10	9%	1	1%	**26**	**4%**

Table F.1: Publications by Size

Publications	JCAHO		Non-JCAHO		Total	
"d"	**5**	**5%**	32	5%	37	5%
A New Day	**7**	**7%**	31	5%	38	5%
Activities Director Guide	**0**	**0%**	12	2%	12	2%
Creative Forecasting	**24**	**22%**	116	19%	140	19%
Eldersong	**2**	**2%**	6	1%	8	1%
Music Therapy	**3**	**3%**	2	0%	5	1%
Other (catalogs,flyers,newspapers,books)	**1**	**1%**	25	4%	26	4%

Table F.2: Publications by JCAHO

Publications	PSA 1		PSA 2		PSA 3		PSA 4		PSA 5		PSA 6		PSA 7	
"d"	5	6%	4	5%	4	10%	2	3%	2	4%	2	3%	2	5%
A New Day	4	5%	5	6%	0	0%	5	7%	1	2%	7	10%	2	5%
Activities Director Guide	3	4%	2	3%	2	5%	0	0%	2	4%	1	1%	1	3%
Creative Forecasting	19	23%	17	22%	5	13%	13	18%	10	20%	13	18%	4	11%
Eldersong	0	0%	1	1%	1	3%	2	3%	0	0%	1	1%	0	0%
Music Therapy	3	4%	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%
Other (catalogs,flyers,newspapers,books)	3	4%	4	5%	4	10%	5	7%	0	0%	2	3%	3	8%

Table F.3: Publications by PSA 1-7

Publications	PSA 8		PSA 9		PSA 10a		PSA 10b		PSA 11		Unknown		Total	
"d"	2	10%	4	9%	6	0%	2	3%	2	4%	0	0%	**37**	5%
A New Day	2	10%	1	2%	8	0%	2	3%	1	2%	0	0%	**38**	5%
Activities Director Guide	0	0%	0	0%	1	0%	0	0%	0	0%	0	0%	**12**	2%
Creative Forecasting	9	45%	10	23%	22	0%	9	14%	6	12%	3	100%	**140**	19%
Eldersong	0	0%	1	2%	1	0%	1	2%	0	0%	0	0%	**8**	1%
Music Therapy	0	0%	0	0%	1	0%	0	0%	0	0%	0	0%	**5**	1%
Other (catalogs,flyers,newspapers,books)	0	0%	2	5%	1	0%	1	2%	1	2%	0	0%	**26**	4%

Table F.4: Publications by JCAHO 8-Unknown.

Other Ideas	Small	Medium	M-Large	Large	Total
Catalogs	1	0	6	1	**8**
Community	7	11	17	0	**35**
Music Therapist	3	5	5	1	**14**
Musicians	4	13	16	2	**35**
Other	4	8	3	0	**15**
Professional	4	7	3	1	**15**
Residents/Family	3	11	7	0	**21**
Self	4	9	11	1	**25**
Staff	2	8	1	1	**12**
Total	37	72	77	7	**180**

Table F.5: Other Ideas by size

Other Ideas	JCAHO	Non JCAHO	Total
Catalogs	**3**	5	8
Community	**1**	34	35
Music Therapist	**6**	8	14
Musicians	**3**	32	35
Other	**1**	14	15
Professional	**1**	14	15
Residents/Family	**2**	19	21
Self	**6**	19	25
Staff	**0**	12	12
Total	**23**	157	180

Table F5: Other Ideas by JCAHO

Other Ideas	PSA 1	PSA 2	PSA 3	PSA 4	PSA 5	PSA 6	PSA 7
Catalogs	2	0	0	0	0	2	0
Community	5	3	0	0	2	3	1
Music Therapist	3	2	1	1	0	1	1
Musicians	5	3	0	2	4	5	0
Other	1	1	3	2	3	3	0
Professional	6	4	1	1	0	0	1
Residents/Family	6	1	1	0	0	4	1
Self	3	4	3	1	2	0	0
Staff	1	0	0	0	1	1	3
TOTAL	22	18	9	7	12	19	7

Other Ideas	PSA 8	PSA 9	PSA 10a	PSA 10b	PSA 11	Unknown	Total
Catalogs	1		2	1			8
Community		5	5	3	8		35
Music Therapist		1	4				14
Musicians			6	5	5		35
Other			1	2			16
Professional			1	1			15
Residents/Family	1	1	3		3		21
Self		2	5	2	2		24
Staff			2	1	3		12
TOTAL	2	9	29	15	21		170

Table F.7 Other Ideas by PSA

Piano	Small	Medium	M-Large	Large	Total
Facilities Responding	80	237	302	31	**650**
% of Facilities	73%	89%	94%	100%	**89%**
Average Response	1.30	1.52	1.69	4.42	**1.67**
Mode	1	1	1	2	**1**
Minimum	1	1	1	0	**0**
Maximum	6	7	10	12	**12**
Total Pianos	78	323	448	94	**953**
"g"	20	21	37	2	**80**
"g" + Total pianos	98	344	485	96	**1033**
Per facility average	0.9	1.3	1.5	3.1	**1.4**
No Response	29	29	19	0	**77**

Table F.8: Pianos by size

Piano	JCAHO	Non JCAHO	Total
Facilities Responding	**102**	548	650
% of Facilities	**95%**	88%	89%
Average Response	**1.58**	1.68	1.67
Mode	**1**	1	1
Minimum	**0**	1	0
Maximum	**10**	12	12
Total Pianos	**145**	798	953
"g"	**10**	70	80
"g" + Total pianos	**155**	868	1033
Per facility average	**1.4**	1.4	1.41
No Response	**5**	72	77

Table F.9: Pianos by JCAHO

Piano	PSA 1	PSA 2	PSA 3	PSA 4	PSA 5	PSA 6	PSA 7
Facilities Responding	70	72	37	69	45	68	33
% of Facilities	84%	94%	93%	95%	92%	94%	87%
Average Response	2.0	1.7	2.0	1.7	1.5	1.7	1.1
Mode	1	1	1	1	1	1	1
Minimum	1	1	1	1	1	1	1
Maximum	10	10	8	7	5	7	2
Total	124	108	63	114	57	106	25
"g"	8	9	5	3	7	5	10
"g" + Total Pianos	132	117	68	117	64	111	35
Per facility average	1.5	1.5	1.7	1.6	1.3	1.5	0.9
No Response	13	5	3	4	4	4	5

Piano	PSA 8	PSA 9	PSA 10a	PSA 10b	PSA 11	Unknown	Total
Facilities Responding	19	41	95	54	45	2	650
% of Facilities	95%	93%	86%	83%	87%	67%	89%
Average Response	1.2	1.6	1.8	1.6	1.3	2	1.67
Mode	1	1	1	1	1		1
Minimum	1	1	0	1	1	2	0
Maximum	3	6	12	5	3	4	12
Total	22	54	148	75	51	6	953
"g"	1	7	13	7	5	0	80
"g" + Total Pianos	23	61	161	82	56	6	1033
Per facility average	1.2	1.4	1.5	1.2	1.1	2	1.41
No Response	1	3	16	11	7	1	38

Table F.10 Pianos by PSA

Other Instrument	Small	Medium	M-Large	Large	Total
Accordion		1	3		**4**
Autoharp, Q-chord, Omnichord	2	3	4	3	**12**
Dulcimer	1	3	1	1	**6**
Electronic *	2	3	7		**12**
Harp			3		**3**
Kazoo		1	3		**4**
Keyboard			2	1	**3**
Miscellaneous	2	2	1	4	**9**
None	6				**6**
Orff		1	2	2	**5**
Percussion	11	24	19	4	**58**
Ukulele			1		**1**

Table F.11 Other Instruments by Size

Other Instrument	JCAHO	Non-JCAHO	Total
Accordion	**1**	3	4
Autoharp, Q-chord, Omnichord	**3**	9	12
Dulcimer	**1**	5	6
Electronic *	**2**	10	12
Harp	**0**	3	3
Kazoo	**1**	3	4
Keyboard	**1**	2	3
Miscellaneous	**1**	8	9
None	**1**	5	6
Orff	**1**	4	5
Percussion	**10**	48	58
Ukulele	**0**	1	1

Table F.12: Other Instruments by JCAHO

Other Instrument	PSA 1	PSA 2	PSA 3	PSA 4	PSA 5	PSA 6	PSA 7
Accordion	1					1	
Autoharp, Q-chord, Omnichord	3	1	1	1	1		
Dulcimer				2			1
Electronic *	1	1	1	1		2	1
Harp						1	
Kazoo			1	3			
Keyboard		3					
Miscellaneous		2	1	1		1	
None				1	1		1
Orff	3			1		1	
Percussion	8	6	5	5	4	4	6
Ukulele							

Other Instrument	PSA 8	PSA 9	PSA 10a	PSA 10b	PSA 11	Unknown	Total
Accordion		1	1			0	2
Autoharp, Q-chord, Omnichord			4	1			7
Dulcimer	1		2				3
Electronic *	1	2	1		1		7
Harp			2				1
Kazoo							4
Keyboard							3
Miscellaneous			4				5
None		1	2				3
Orff							5
Percussion		3	9	3	5		38
Ukulele			1				0

*radios,tape players, TV

Table F.13: Other Instruments by PSA

Small	Skills		Diversion		Emotional		Physical		Pleasure		Rehabilitation		Social	
Facilities	78	72%	88	81%	89	82%	90	83%	101	93%	74	68%	102	94%
Rank														
1	0	0%	3	3%	8	7%	4	4%	41	38%	8	7%	26	24%
2	1	1%	6	6%	17	16%	5	5%	13	12%	8	7%	30	28%
3	2	2%	18	17%	22	20%	9	8%	12	11%	4	4%	12	11%
4	8	7%	18	17%	12	11%	14	13%	6	6%	13	12%	7	6%
5	8	7%	14	13%	12	11%	17	16%	7	6%	10	9%	5	5%
6	13	12%	10	9%	4	4%	17	16%	1	1%	14	13%	2	2%
7	34	31%	7	6%	0	0%	8	7%	0	0%	10	9%	0	0%
8	2	2%	1	1%	0	0%	1	1%	0	0%	0	0%	0	0%
x	10	9%	11	10%	14	13%	15	14%	21	19%	6	6%	20	18%
none	31	28%	21	19%	20	18%	19	17%	8	7%	35	32%	7	6%
Statistics														
range min	2.0		1.0		1.0		1.0		1.0		0.0		1.0	
range max	8.0		8.0		6.0		8.0		6.0		7.0		6.0	
mode	7.0		3.0		3.0		5.0		1.0		6.0		2.0	
median	7.0		4.0		3.0		5.0		1.0		4.5		2.0	
mean	6.1		4.3		3.2		4.6		2.1		4.3		2.3	

Table F.14: Purpose by Small

M-Large	Skills		Diversion		Emotional		Physical		Pleasure		Rehabilitation		Social	
Facilities	240	75%	275	86%	288	90%	276	86%	303	94%	244	76%	306	95%
Rank														
1	5	2%	8	2%	46	14%	9	3%	140	44%	13	4%	54	17%
2	2	1%	16	5%	56	17%	19	6%	38	12%	9	3%	106	33%
3	5	2%	27	8%	68	21%	37	12%	29	9%	31	10%	43	13%
4	20	6%	37	12%	40	12%	63	20%	21	7%	33	10%	24	7%
5	20	6%	51	16%	17	5%	61	19%	13	4%	47	15%	11	3%
6	55	17%	49	15%	14	4%	27	8%	6	2%	54	17%	6	2%
7	103	32%	43	13%	0	0%	17	5%	0	0%	32	10%	5	2%
8	7	2%	4	1%	0	0%	1	0%	0	0%	3	1%	0	0%
x	19	6%	36	11%	47	15%	41	13%	56	17%	21	7%	57	18%
none selected	81	25%	46	14%	33	10%	45	14%	18	6%	77	24%	15	5%
Statistics														
rangemin	1.0		1.0		1.0		1.0		1.0		1.0		1.0	
range max	10.0		9.0		6.0		8.0		6.0		8.0		7.0	
mode	7.0		5.0		3.0		4.0		1.0		6.0		2.0	
median	7.0		5.0		3.0		4.0		1.0		5.0		2.0	
range mean	6.1		4.9		2.9		4.3		2.0		4.8		2.5	

Table F.15: Purpose by Medium/Large

Medium	Skills		Diversion		Emotional		Physical		Pleasure		Rehabilitation		Social	
Facilities	204	77%	229	86%	238	89%	234	88%	251	94%	205	77%	252	95%
Rank														
1	3	1%	9	3%	33	12%	15	6%	123	46%	7	3%	56	21%
2	5	2%	16	6%	51	19%	11	4%	47	18%	11	4%	76	29%
3	5	2%	16	6%	51	19%	11	4%	47	18%	11	4%	76	29%
4	19	7%	29	11%	30	11%	55	21%	15	6%	26	10%	24	9%
5	25	9%	39	15%	24	9%	53	20%	7	3%	45	17%	9	3%
6	39	15%	42	16%	11	4%	29	11%	2	1%	49	18%	4	2%
7	82	31%	42	16%	0	0%	9	3%	2	1%	33	12%	1	0%
8	7	3%	3	1%	0	0%	1	0%	0	0%	0	0%	0	0%
x	15	6%	27	10%	29	11%	27	10%	35	13%	13	5%	36	14%
none	62	23%	37	14%	28	11%	32	12%	15	6%	61	23%	14	5%
Statistics														
range min	1.0		1.0		1.0		1.0		1.0		1.0		1.0	
range max	9.0		8.0		6.0		9.0		7.0		7.0		7.0	
mode	7.0		7.0		3.0		4.0		1.0		6.0		2.0	
median	6.0		5.0		3.0		4.0		1.0		5.0		2.0	
mean	5.9		4.9		3.0		4.2		1.8		4.9		2.4	

Table F.16: Purpose by Medium

Large	Skills		Diversion		Emotional		Physical		Pleasure		Rehabilitation		Social	
	27	87%	27	87%	30	97%	28	90%	31	100%	29	94%	31	100%
Rank														
1	0	0%	2	6%	5	16%	3	10%	14	45%	2	6%	3	10%
2	1	3%	4	13%	6	19%	0	0%	4	13%	1	3%	11	35%
3	0	0%	5	16%	8	26%	1	3%	2	6%	2	6%	6	19%
4	2	6%	4	13%	4	13%	8	26%	2	6%	4	13%	0	0%
5	5	16%	1	3%	0	0%	5	16%	2	6%	9	29%	1	3%
6	4	13%	4	13%	2	6%	5	16%	1	3%	5	16%	3	10%
7	11	35%	5	16%	0	0%	3	10%	0	0%	1	3%	1	3%
8	2	6%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
x	2	6%	2	6%	5	16%	3	10%	6	19%	5	16%	6	19%
none	4	13%	4	13%	1	3%	3	10%	0	0%	2	6%	0	0%
Statistics														
min	2.0		1.0		1.0		1.0		1.0		1.0		1.0	
max	8.0		7.0		6.0		7.0		6.0		7.0		7.0	
median	7.0		4.0		3.0		5.0		1.0		5.0		2.0	
mode	7.0		3.0		3.0		4.0		1.0		5.0		2.0	
mean	6.1		4.2		2.8		4.6		2.1		4.5		2.9	

Table F.17: Purpose by Large

Non JCAHO	Skills		Diversion		Emotion		Physical		Pleasure		Rehabilitation	
Facilities	457	74%	520	84%	547	88%	528	85%	583	94%	459	74%
Rank												
1	6	1%	19	3%	79	13%	28	5%	254	41%	21	3%
2	7	1%	31	5%	108	17%	32	5%	91	15%	27	4%
3	10	2%	58	9%	134	22%	67	11%	53	9%	47	8%
4	41	7%	74	12%	70	11%	118	19%	40	6%	62	10%
5	47	8%	91	15%	45	7%	105	17%	26	4%	100	16%
6	90	15%	90	15%	22	4%	65	10%	8	1%	102	16%
7	196	32%	81	13%	0	0%	30	5%	2	0%	58	9%
8	17	3%	4	1%	0	0%	2	0%	0	0%	2	0%
x	43	7%	70	11%	88	14%	79	13%	109	18%	39	6%
none selected	163	26%	100	16%	73	12%	92	15%	37	6%	161	26%
Statistics												
rangemin	1		1		1		1		1		0	
range max	8		9		6		9		7		8	
mode	7		5		3		4		1		6	
median	7		5		3		4		1		5	
range mean	6.0		4.8		2.9		4.3		2.0		4.8	

Table F.18: Purpose by Non-JCAHO

JCAHO	Skills		Diversion		Emotional		Physical		Pleasure		Rehabilitation		Social	
Facilities	90	84%	99	93%	98	92%	100	93%	103	96%	93	87%	104	97%
Rank														
1	2	2%	3	3%	13	12%	3	3%	63	59%	10	9%	17	16%
2	2	2%	11	10%	21	20%	3	3%	11	10%	2	2%	42	39%
3	3	3%	15	14%	23	21%	13	12%	10	9%	11	10%	17	16%
4	8	7%	14	13%	16	15%	22	21%	5	5%	14	13%	11	10%
5	12	11%	13	12%	8	7%	31	29%	3	3%	11	10%	6	6%
6	21	20%	15	14%	10	9%	13	12%	2	2%	19	18%	0	0%
7	35	33%	16	15%	0	0%	6	6%	0	0%	18	17%	2	2%
8	2	2%	4	4%	0	0%	2	2%	0	0%	1	1%	0	0%
x	3	3%	6	6%	7	7%	7	7%	9	8%	6	6%	9	8%
none selected	15	14%	9	8%	7	7%	8	7%	6	6%	15	14%	5	5%
Statistics														
rangemin	1		1		1		1		1		1		1	
range max	10		9		6		8		6		8		7	
mode	7		3		3		5		1		6		2	
median	6.25		4		3		4.75		1.5		4.5		2.25	
range mean	5.81		4.151		3.389		4.757		2.169		4.044		2.748	

Table F.19: Purpose by JCAHO

PSA 1	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
Rank 1	1	0	8	3	33	1	16
2	1	3	17	4	10	3	24
3	1	6	25	9	5	2	13
4	6	8	5	20	7	10	4
5	8	19	3	13	2	13	2
6	14	12	2	9	3	15	2
7	26	12	0	4	1	11	1
8	1	1	0	0	0	1	0
x	5	11	17	9	19	6	18
no response	20	11	6	12	3	21	3
range min	1	2	1	1	1	1	1
max	8	8	6	7	7	8	7
mode	7	5	3	4	1	6	2
median	6	5	3	4	1	5	2
mean	5.9	5.2	2.7	4.3	2.1	5.2	2.4

Table F.20: Purpose by PSA 1

PSA 5	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	1	1	10	4	25	2	11
2	1	3	8	4	7	2	14
3	0	2	9	10	4	4	7
4	1	9	5	7	2	8	4
5	6	5	6	8	2	7	2
6	9	9	0	2	0	9	1
7	18	4	0	2	0	6	1
8	0	1	0	1	0	0	0
x	2	2	4	5	6	4	6
no response	11	13	7	6	3	7	3
range min	1	1	1	1	1	1	1
max	7	8	5	9	5	7	7
mode	7	4	1	3	1	6	2
median	6.5	5	3	4	1	5	2
mean	6.0	4.9	2.8	3.8	1.8	4.7	2.5

Table F.21: Purpose by PSA 5

PSA 9	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	1	1	8	2	15	3	11
2	0	4	4	1	6	2	12
3	3	3	6	4	4	3	5
4	5	5	5	7	2	2	1
5	0	5	3	6	3	8	1
6	4	4	3	7	0	7	0
7	13	6	0	2	0	2	1
8	0	0	0	0	0	0	0
x	3	6	8	7	11	3	11
no response	15	10	7	8	3	14	2
range min	1	1	1	1	1	1	1
max	7	7	6	7	5	7	7
mode	7	7	1	4	1	5	2
median	6.5	5	3	5	1.5	5	2
mean	5.6	4.6	3.0	4.5	2.1	4.4	2.1

Table F.22: Purpose by PSA 9

PSA 2	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	0	4	7	1	41	3	13
2	0	6	17	9	5	2	24
6	3	9	14	13	4	7	14
4	6	6	15	15	5	8	5
5	5	12	3	17	8	10	4
6	11	15	4	6	0	10	4
7	24	8	0	0	0	13	0
8	3	0	0	0	0	0	0
x	6	7	9	8	10	5	10
no	19	10	8	8	4	19	3
min	3	1	1	1	1	1	1
max	8	7	6	6	5	7	6
mode	7	6	2	5	1	7	2
median	7	5	3	4	1	5	2
mean	6.1	4.6	3.0	3.9	2.0	4.9	2.6

Table F.23: Purpose by PSA 2

PSA 6	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
Rank 1	0	2	7	3	33	2	15
2	1	6	11	2	11	1	22
3	1	8	17	8	2	7	11
4	6	8	10	10	6	8	5
5	6	8	2	21	3	10	2
6	10	10	5	5	1	12	1
7	20	10	0	3	0	7	1
8	3	0	0	0	0	0	0
x	3	6	9	8	10	4	9
no response	22	14	11	12	6	21	6
range min	2	1	1	1	1	1	1
max	8	7	6	7	6	7	7
mode	7	6	3	5	1	6	2
median	6	5	3	5	1	5	2
mean	6.0	4.6	3.1	4.4	1.9	4.9	2.4

Table F.24: Purpose by PSA 6

PSA 10a	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	3	5	9	4	54	8	21
2	2	10	20	5	17	3	37
3	0	20	21	9	9	8	15
4	6	8	22	21	6	8	10
5	15	14	12	17	1	17	4
6	18	15	3	14	2	20	1
7	30	12	0	10	0	12	2
8	6	3	0	2	0	0	0
x	8	12	11	13	16	7	16
no response	23	12	13	16	6	28	5
range min	1	1	1	1	1	1	1
max	8	8	6	8	6	7	7
mode	7	3	4	4	1	6	2
median	6	5	3	5	1	5	2
mean	5.9	4.4	3.2	4.6	1.8	4.7	2.4

Table F.25: Purpose by PSA 10a

PSA 3	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
Rank 1	1	2	6	2	14	2	8
2	0	1	5	2	11	5	9
3	2	3	8	7	3	2	6
4	6	6	6	1	2	2	5
5	5	5	3	7	1	7	1
6	3	4	1	7	0	8	1
7	9	9	0	2	0	3	0
8	1	0	0	0	0	0	0
x	4	5	4	5	6	2	6
no response	9	5	7	7	3	9	4
range min	1	1	1	1	1	1	1
max	8	7	6	7	5	7	6
mode	7	7	3	5	1	6	2
median	5	5	3	5	2	5	2
mean	5.4	5.0	2.9	4.4	1.9	4.5	2.5

Table F.26: Purpose by PSA 3

PSA 7	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	1	5	6	4	13	2	8
2	2	3	6	0	4	1	11
3	0	2	8	4	4	3	3
4	1	3	4	6	3	3	5
5	1	8	2	5	2	6	0
6	3	3	1	6	2	6	1
7	16	2	0	1	0	2	0
8	1	1	0	0	0	0	0
x	4	4	6	7	8	2	8
no response	9	7	5	5	2	13	2
range min	1	1	1	1	1	1	1
max	8	8	6	7	6	7	6
mode	7	5	3	6	1	5	2
median	7	5	3	4	2	5	2
mean	6.1	4.0	2.7	4.2	2.4	4.6	2.3

Table F.27: Purpose by PSA 7

PSA 10b	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	0	0	9	2	29	2	10
2	0	0	10	2	11	3	25
3	0	4	17	4	7	11	9
4	3	10	6	16	4	8	6
5	6	13	7	14	2	8	3
6	14	11	4	10	0	9	0
7	24	11	0	3	0	9	0
8	1	2	0	0	0	1	0
x	4	4	6	7	8	4	9
no response	13	10	6	7	4	10	3
range min	4	3	1	1	1	1	1
max	8	9	6	7	5	8	5
mode	7	5	3	4	1	3	2
median	7	5	3	5	1	5	2
mean	6.3	5.4	3.1	4.6	1.8	4.7	2.4

PSA F.28: Purpose by PSA 10b

PSA 4	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	0	0	10	2	36	3	9
2	1	2	19	1	9	2	26
3	2	7	16	7	8	5	14
4	7	13	5	16	2	12	5
5	3	9	5	16	2	16	4
6	14	14	4	9	1	11	0
7	25	13	0	6	1	5	1
8	2	1	0	0	0	0	0
x	4	9	8	8	10	3	11
no response	15	5	6	8	4	16	3
range min	2	2	1	1	1	1	1
max	8	8	6	7	7	7	7
mode	7	6	2	4	1	5	2
median	6.5	5	3	5	1	5	2
mean	6.0	5.2	2.8	4.6	1.8	4.6	2.5

Table F.29: Purpose by PSA 4

PSA 8	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	0	0	3	1	7	1	6
2	1	1	3	1	4	0	6
3	0	2	6	1	3	1	1
4	1	6	1	3	0	3	1
5	1	0	1	6	1	1	0
6	1	2	1	0	0	6	1
7	6	2	0	1	0	1	0
8	2	0	0	0	0	0	0
x	2	3	3	2	5	1	5
no response	6	4	2	5	0	6	0
range min	2	2	1	1	1	1	1
max	8	7	6	7	5	7	6
mode	7	4	3	5	1	6	2
median	7	4	3	5	2	6	2
mean	6.3	4.5	2.8	4.2	1.9	4.9	2.1

Table F.30: Purpose by PSA 8

PSA 11	Skills	Diversion	Emotiona	Physical	Pleasure	Rehabilitation	Social
Rank							
1	0	2	9	2	17	2	12
2	0	4	10	4	7	3	12
3	1	5	10	5	9	4	8
4	1	6	4	16	4	4	3
5	4	8	4	6	2	8	3
6	8	6	2	3	1	11	2
7	19	7	0	3	0	4	0
8	2	1	0	0	0	0	0
x	1	7	10	8	9	4	10
no response	16	6	3	5	3	12	2
range min	3	1	1	1	1	1	1
max	8	8	6	7	6	7	6
mode	7	5	3	4	1	6	1
median	7	5	3	4	2	5	2
mean	6.4	4.7	2.7	4.1	2.3	4.7	2.5

Table F.31: Purpose by PSA 11

Measurement	Music Degree		Music Therapy		Music Total	
Attendance	4	25%	8	26%	12	26%
Comments	4	25%	7	23%	11	23%
Participation	7	44%	15	48%	22	47%
Response	2	13%	4	13%	6	13%
Affect		0%	2	6%	2	4%

Table F.32: Success Measurement

CHILDREN	Music Degree		Music Therapy		Music Total	
For	14	88%	16	52%	30	64%
With	2	11%	4	15%	6	13%
Interdisciplinary	3	16%	5	19%	8	17%

Table F.33: Children

Music Activities	Music Therapy		Music Degree		Music Total	
Discussing	21	68%	8	50%	29	62%
Listening to live	29	94%	10	63%	39	83%
Listening to recorded	30	97%	8	50%	38	81%
Moving	25	81%	8	50%	33	70%
Instruments	27	87%	4	25%	31	66%
Singing	31	100%	5	31%	36	77%
TV	23	74%	4	25%	27	57%

Table F. 34: Music Activities

Performances	Music Therapy		Music Degree		Music Total	
MT	11	35%	2	13%	13	28%
For	13	42%	14	88%	27	57%
With	6	19%	3	19%	9	19%

Table F. 35: Performances

Activities	Music Therapy		Music Degree		Music Total	
Residents	14	45%	10	63%	24	51%
Performances	5	16%	6	38%	11	23%
Therapy	15	48%	0	0%	15	32%
With	0	0%	2	13%	2	4%

Table F.36: Activities

Purposes	Music Therapy	Music Degree
New Music Skills	**7**	**7**
Diversion	**4**	**4**
Emotional Expression	**3**	**2**
Physical Activity	**5**	**6**
Pleasure	**1**	**1**
Rehabilitation	**6**	**5**
Social interaction	**2**	**3**

Table F.37: Purposes

Activities		Therapy
Music Degree	**Music Therapy**	**Therapy**
Bell Choir	Bell Choir	Group & individual sessions
Drumming	Games	Increase quality of life
Games	Hymn sings	Meet resident needs
Music Appreciation	Party with dancing	Music relaxation
Resident band	Resident choir	Musical skills
Resident choir	Rhythm instruments	Reminiscence
Rhythm Band	Roll balls to music	Sensory stimulation
Sing along	Sing along	Songwriting
Talent Show - residents		
Walk N Roll		

Table F. 38: Activities and Therapy

PSA	Income
2	$26,294.89
8	$31,225.38
7	$31,914.90
9	$33,202.56
11	$35,844.75
5	$38,745.00
3	$41,053.71
10b	$42,003.25
4	$42,273.10
6	$47,200.00
1	$47,330.80
a10	$49,796.80

Average Household Income

PSA	Education
a10	3.3
7	3.6
9	3.6
5	4.0
8	4.5
3	4.9
4	5.1
2	5.8
6	6.3
11	6.9
1	7.8
10b	10.2

Average Education Level

Table F.39: Household Income

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