NCPD Symptom Management Series
2.0 ANCC Contact Hours

OPEN

Music Therapy and Nursing Cotreatment in Integrative Hospice and Palliative Care

Noah Potvin, PhD, LPC, MT-BC ❍ Molly Hicks, MMT, MT-BC ❍ Rebecca Kronk, PhD, MSN, CRNP, FAAN, CNE

Integrative hospice and palliative care is a philosophy of treatment framing patients as whole persons composed of interrelated systems. The interdisciplinary treatment team is subsequently challenged to consider ethical and effective provision of holistic services that concomitantly address these systems at the end of life through cotreatment. Nurses and music therapists, as direct care professionals with consistent face-to-face contact with patients and caregivers, are well positioned to collaborate in providing holistic care. This article introduces processes of referral, assessment, and treatment that nurses and music therapists may engage in to address family support, spirituality, bereavement, and telehealth. Clinical vignettes are provided to illustrate how cotreatment may evolve and its potential benefits given diverse circumstances. As part of this framing, music therapy is positioned as a core—rather than alternative or complementary—service in hospice that satisfies the required counseling services detailed in Medicare's Conditions of Participation for hospice providers. The systematic and intentional partnering of nurses and music therapists can provide patients and caregivers access to quality comprehensive care that can cultivate healthy transitions through the dying process.

KEY WORDS
hospice, integrative medicine, palliative care, interdisciplinary, music therapy, nursing

INTEGRATIVE HOSPICE AND PALLIATIVE CARE

Integrative care is a family of methods and approaches that (*a*) frames patients and their health as singular parts in complex, subjectively experienced cultural and health ecologies; (*b*) cultivates egalitarian partnership among specialists, patients, and informal caregivers as collaborative stakeholders; and (*c*) necessitates holistic treatment that concomitantly assesses, supports, and evaluates health needs manifesting along multiple dimensions (eg, psychological, physiological, physical, spiritual, social, and emotional).[1] In keeping with this framing of health as an amorphous and dynamic concept, there is no singular model of integrative care in hospice and palliative care, but a central guiding thesis nevertheless exists: that the type, quality, and provision of treatment are negotiated and shaped by the distinct expertise of each health care professional.

Such collaboration manifests in cotreatment, an egalitarian collaboration between 2 or more health care professionals applying their distinct practices in a clinical encounter to address holistic outcomes. Cotreatment stresses a democratic approach wherein no one health care professional assumes a dominant or hierarchal position, but rather expertise is shared among professionals and with the patients themselves. Previous literature has framed cotreatment between music therapists in physical rehabilitation,[2,3] medical inpatient,[4] and military treatment[5] settings, but cotreatment in hospice has remained unexplored. Nurses, as case managers in hospice with significant face-to-face time with patients and caregivers, are ideal partners for cotreating with music therapists, who also spend considerable time providing direct care through all phases of the dying process.

MUSIC THERAPY AS A CORE SERVICE IN HOSPICE AND PALLIATIVE CARE

Similar to the nursing profession, music therapy is an evidence-based and board-certified health care field with an expanding clinical and scholarly footprint in hospice and palliative care. The nursing interventions are established and implemented upon evidence-based research results. It is important for nursing to not only recognize but also promote the growing body of literature indicating that

Noah Potvin, PhD, LPC, MT-BC, Mary Pappert School of Music & School of Nursing, Duquesne University, Pittsburgh, Pennsylvania.

Molly Hicks, MMT, MT-BC, Penn Medicine Hospice, University of Pennsylvania Health System, Philadelphia.

Rebecca Kronk, PhD, MSN, CRNP, FAAN, CNE, School of Nursing, Duquesne University, Pittsburgh, Pennsylvania.

Address correspondence to Noah Potvin, PhD, LPC, MT-BC, Mary Pappert School of Music, Duquesne University, 600 Forbes Ave, Pittsburgh, PA 15282 (potvinn@duq.edu).

The authors have no conflicts of interest to disclose.

DOI: 10.1097/NJH.0000000000000747

music therapy (*a*) addresses diverse symptoms and health conditions (eg, anxiety, pain, and resolution/closure) across multiple diagnoses present in hospice care,[6-9] (*b*) is an asset to other members of the interdisciplinary treatment team,[8-11] and (*c*) provides a support integral for patients and caregivers to prepare for death, say goodbye through the dying process, and construct meaning from these experiences.[12] Emergent theoretical and clinical models over the past 5 years have helped these gains in knowledge be organized into dynamic protocols for assessment, intervention, and evaluation.[13] Subsequently, best practices in hospice care have begun to take shape, informing clinicians about clinical decision making in the context of indications for potential benefit and contraindications for potential harm.[14-16]

Despite these advancements in practice, establishing music therapy as a core service in hospice has been a challenge, with multiple obstacles complicating effective partnership with nurses as part of the interdisciplinary treatment team. One such obstacle is the inconsistent usage and role of music therapists across hospice agencies. Full-time employees are often treatment team members and regularly participate in routine team meetings and treatment planning with nurse case managers, social workers, and chaplains, whereas part-time or per diem employees are often not invited or not allowed to participate. Cotreatment opportunities are cultivated when music therapists have space to consult with team members and coordinate plans of care, thus providing patients and caregivers increased access to comprehensive holistic care.

Relatedly, broad recognition and implementation of music therapy in hospices are hindered by hierarchical structures of service delivery and administration. Some hospices include music therapists with other psychosocial-spiritual professionals (eg, social workers, spiritual care counselors, and bereavement coordinators), whereas others label music therapy as a "complementary" or "adjunctive" therapy. When music therapists are located on the margins in this way, referrals for music therapy focus less on clinical needs (ie, acute pain, labored respirations, complicated prebereavement, and heightened depression/anxiety) and more on generalized music enjoyment or socialization that music volunteers, who are not trained health care professionals, can address. Studies have indicated that staff members and hospice administrators may not have an accurate picture of the range of therapeutic goals that music therapists can address,[17,18] deficiencies that only stand to be reinforced when music therapists are situated as "other than" other types of psychosocial-spiritual support.

However, the most consequential obstacle has been music therapy's absence in Medicare's Hospice Conditions of Participation (CoPs), the regulatory document dictating the nature of hospice care in the United States.[19] The CoPs regulate the "core" services (Code 418.64) required of any hospice provider but do not articulate a broad philosophical definition of what is considered "core" (see Code 418.64) and "noncore" (see Code 418.70), instead identifying 4 "standard" services as core: physician, nursing, medical social, and counseling.

Notably, music therapy is neither mentioned nor indicated under Code 418.64, and without explicit requirements in the CoPs necessitating that music therapy be made available to all patients, hospices are not obligated to budget for a board-certified music therapist or, when hired, integrate music therapists into the treatment team. This absolves hospices from interrogating how music therapy aligns with a holistic and integrative plan of care.

Of the 4 "standard" services identified in the CoPs, only counseling is described without language dictating the *type* of professional necessary to perform that service: "Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process."[19(p77)] Embedded in this definition is a call for counseling services to provide systems-level family support. In addition, there are 2 types of counseling explicitly identified: bereavement[(pp77–78)] and spiritual.[(p79)] By identifying the services but not the type of professional, there is opportunity for any professional field whose clinical practice addresses family support, bereavement, and spiritual needs to be considered a core service.

The capacity and ability of music therapists to address such needs are supported by the Board Certification Domains compiled by the Certification Board for Music Therapists.[20] The Board Certification Domains is updated every 5 years to reflect the scope of contemporary entry-level competence in music therapists and makes clear that music therapists assess, treat, and evaluate family systems support (eg, Codes II.D.3 and III.A.2.s); patients' and caregivers' spiritual needs (eg, II.B.3.h and III.A.2.bbb); and bereavement support (eg, III.A.2.o, III.A.2.j and III.A.2.x). The literature cited at the top of this essay further corroborates this assertion.

Consequently, music therapy is positioned here as a core service that can address family systems, spirituality, and bereavement as identified in the CoPs and as a telehealth service in the context of virtual service delivery necessitated by the COVID-19 pandemic. Core service is not explicitly defined in the extant literature but is understood here as a direct health care practice that plays a uniquely integral role in supporting patients to die with dignity and caregivers to transition into bereavement with resilience. This position is based on 3 factors in the context of the CoPs' framing of counseling: (1) music therapy's effectiveness as a diverse practice addressing multiple areas of care at the end of life,[6-9] (2) music therapy's unique practice distinct from other treatment team services that explicitly locates transformational change and health gains in a

musical domain of functioning (similar to chaplaincy and the spiritual/religious domain),[15,16] and (3) music therapy's capacity—as an intrinsically integrative practice drawing from creative arts, psychology, spirituality, and medicine—to cotreat with colleagues on the interdisciplinary treatment team in providing holistic care.[10]

NURSING AS A PROFESSIONAL ALLY IN HOSPICE CARE

In 2016, the American Nurses Association (ANA) and the Hospice and Palliative Nurses Association convened a panel to discuss, among other things, the steps and strategies for nurses to lead and transform palliative care. The ANA now reports 3.8 million registered nurses nationwide who have the opportunity and responsibility to provide holistic care.

Also, in 2016, the ANA revised their position statement on the nurse's role and responsibilities in providing end-of-life care and stated the following:

> Nurses are obliged to provide comprehensive and compassionate end-of-life care…Nurses should collaborate with other members of the health care team to ensure symptom management and to provide support to patient and family.[21]

Comprehensive care considers all facets of the patient, including the physiologic, spiritual, mental, and cultural components. This can be accomplished only through collaborative efforts among team members that include the patient and family. To ensure symptom alleviation and optimize comfort, both pharmacologic and nonpharmacologic measures should be considered in concert with patient preferences. End-of-life care requires nurses to advocate for accessible and effective nonpharmacologic interventions.

Given the recent public health crisis brought on by COVID-19, Rosa and colleagues[22] urged for "accessible models of universal palliative care"(p341) and encouraged more dialogue on the crucial role of the palliative nurse. Nurse scientists and clinicians should explore, develop, and use successful interventions to manage end-of-life care in the face of such acute crises. Telehealth and digital communication platforms provide opportunities to promote continuity of integrative and holistic care.

A nursing theoretical framework that can help guide this work is the Roy Adaptation Model. This model incorporates a holistic approach and purports that a person is in continuous interaction with a changing environment, involving both current and past stimuli, that can affect health and treatment. End-of-life care can be influenced by improved person-environment interactions, or in other words improved adaptation. Guided by this model, Bowers and Wetsel[23] performed an integrative review on the utilization of music therapy in palliative and hospice care. Their study revealed that anxiety, pain, depression, and quality of life generated most referrals for music therapy. Single or multiple sessions reduced symptoms in most studies. One study provided a cost-benefit analysis and found that music therapy intervention reduced the number of nurse visits and lessened medication consumption that resulted in a savings of $3.14 per patient per day, for a total of $2984 over the duration of the study.[24] A systematic review of 124 randomized controlled trials in palliative care unveiled that most studies demonstrated significant patient or caregiver outcomes.[25] Nurse-only interventions comprised 39% of trials, but the most effective models of care were team-based.

Nurses cannot and should not do this work in silos. Nurses serve not only as leaders but also as partners in developing innovative and effective models of health care delivery. By partnering with music therapists, nurses can support a holistic and collaborative approach to end-of-life care and even change the dynamics within health systems providing palliative care. Most importantly, interdisciplinary partnerships such as this can encourage patient and family engagement in decision making beyond the physical components of care to also enhance the psychological, spiritual, and cultural dimensions.

COTREATMENT BETWEEN MUSIC THERAPISTS AND NURSES

The following vignettes detail real-life collaborative cotreatment between music therapists and nurse case managers that addresses both the required counseling services identified in the CoPs (family support, spirituality, and bereavement) and the new frontier of telehealth service delivery. These vignettes demonstrate how cotreatment founded upon mutuality among stakeholders can elevate care beyond what a singular service can provide by complementing different sets of expertise and scopes of practice.

Vignette 1: Family Systems Support

Walter was an 82-year-old hospice patient with a diagnosis of congestive heart failure. He developed 2 decubitus ulcers in his sacral area, which caused him pain, especially during repositioning and dressing changes. The nurse case manager had worked with Melinda, Walter's daughter and primary caregiver, to premedicate Walter with morphine and lorazepam before personal care. However, Walter began to associate being repositioned or cleaned with pain, leading to increased anxiety and shortness of breath and decreased medication efficacy. During a discussion at the interdisciplinary team meeting, the nurse case manager made a referral to the music therapist, citing Walter's pain and shortness of breath during care and Melinda's and Walter's anxiety surrounding the personal care routine.

The nurse case manager and music therapist planned to make a joint visit the following day with goals of symptom management, emotional support, and procedural support.

In anticipation of the dressing change, Melinda administered medication to Walter immediately before the visit. Before any procedures, the music therapist conversed with Walter about his music preferences and relationships; Walter shared that he enjoyed a variety of popular, folk, and traditional music and that he sang with a local community choir for 30 years. Melinda and the nurse case manager engaged in the discussion as well. Melinda shared specific song titles, as Walter verbalized feeling tired and forgetful during the visit. Melinda tearfully reminisced how meaningful this music was for Walter and how she experienced joy watching him sing in the past. The music therapist encouraged Melinda to hold Walter's hand while she played and sang a medley of 2 of Walter's preferred songs. The nurse observed—and Melinda agreed—that Walter's affect appeared more relaxed and his respirations even.

The music therapist and nurse case manager recommended that the music therapist continue to provide live music for procedural support during the dressing change, to which Walter consented. The music therapist repositioned herself at the head of the bed turned toward Walter and began to chain together multiple songs, creating an environment of continuous music that responded to Walter's moment-to-moment physical and emotional presentation. The nurse case manager and Melinda—having completed the wound dressing change—both agreed that Walter seemed to have experienced less discomfort with the presence of music therapy. Melinda expressed feeling more relaxed and confident in performing the wound care owing to the presence of music Walter found supportive, and by witnessing the music therapist carefully adapting the music to his needs in the moment. The nurse case manager commented that she and Melinda developed a rhythm in working together influenced by the musical qualities present and that she valued learning about Walter's musical background.

The music therapist wrote song titles for Melinda, who created a playlist on her smartphone for future dressing changes when the music therapist was not present. The nurse case manager created a similar playlist to use during routine visits. The music therapist and nurse case manager planned another joint visit in 2 weeks to reassess Walter's sensory needs during wound care and evaluate his responsivity to the previously selected familiar and preferred music.

Vignette 2: Spiritual Support

Yvette was a 49-year-old hospice patient with a diagnosis of multiple myeloma. A devout Baptist who still belonged to the church in which she was raised, Yvette shared about her faith with her nurse case manager during his first visit to her home but adamantly declined an assessment from the spiritual care counselor. Instead, Yvette stated that her spiritual needs would be fully addressed by her pastor and church family. A few weeks into Yvette's hospice stay, the nurse case manager noticed that Yvette appeared to have an unusually sad affect. The nurse case manager asked Yvette how she was feeling, and Yvette stated she has been overwhelmed with sadness and confusion, asking why God would allow her to become sick with a terminal illness at such a young age. She stated that she hesitated to discuss this question with her pastor, worrying that he would interpret this existential struggle as a lack of faith. Furthermore, Yvette stated that she was becoming too weak to attend church services in person and was anticipating missing the fellowship, ritual, and music of her spiritual community. The nurse case manager introduced the idea of music therapy, explaining that the music therapist's repertoire included religious music and that the music therapist could serve as a neutral person with whom to explore spiritual questions. Yvette accepted the offer of music therapy and requested that the music therapist visit with the nurse case manager.

A week later, the music therapist and the nurse case manager arrived for a joint visit. Yvette stated that she was having more energy than usual and spontaneously broke into an upbeat gospel song as the music therapist sat down. The music therapist joined in singing while handing a tambourine to the nurse case manager, first demonstrating how to keep the beat in the meter of the song. The music therapist used the guitar to find the key in which Yvette was singing and began playing an accompaniment. Yvette continued to lead the session by singing 2 more songs immediately after the first one. She became tearful at the end of the third song, expressing how powerful it was to share the joy of her faith through music. She complimented the nurse case manager for being able to join in the music and stated that she would like to sing a song with him each visit.

Yvette also stated that she was now feeling tired, prompting the music therapist to select 2 hymns with a slower tempo to close the session. One of the songs contained lyrical themes of God's love and care through difficult circumstances. Yvette commented on these lyrics after the song, noting that she was unfamiliar with the hymn but appreciated how it acknowledged the trials of life while affirming the need for a strong faith. She asked the music therapist to begin the next session with this song so she could learn to sing it. The nurse case manager noted during the interdisciplinary team meeting that Yvette was looking forward to the next music therapy visit and started a list of songs she would like to sing with the music therapist.

Vignette 3: Bereavement Support

Ethel was a 90-year-old hospice patient with a diagnosis of Alzheimer disease. Throughout Ethel's 6-month hospice

stay, Sasha, her primary caregiver and niece, only allowed the nurse case manager to visit the home, with monthly check-in telephone calls from the social worker. Sasha shared with the nurse case manager that Ethel raised her, and she wanted to care for Ethel with the same devotion Ethel showed to her as a child.

Ethel began to experience a decline as evidenced by increased sleep and time in bed, in addition to decreased intake and output. During the nurse case manager's most recent visits, Sasha was observed to give thickened water and pureed food to Ethel despite Ethel's difficulty swallowing. In response to the nurse case manager's education about the disease process and risk for aspiration, Sasha stated that offering food and drink was a sign of love that has been very important to her relationship with Ethel. She indicated she would feel guilty if she stopped offering nutrition and that she would feel responsible for hastening Ethel's death. The nurse case manager had already been educating Sasha about the transition to bereavement care after Ethel's death and had encouraged her to accept an introductory call from the bereavement counselor, who was also a board-certified music therapist. When Sasha expressed that withholding nutrition would be a source of guilt for her, the nurse case manager decided to make a prebereavement referral. Sasha agreed to the visit only if the nurse case manager would be present.

During the joint visit with the nurse case manager, the bereavement counselor explained his role on the team, highlighting his close working relationship with the nurse case manager to build trust. He shared about his use of verbal counseling as well as music therapy experiences to give Sasha more information about the types of support offered. The bereavement counselor engaged Sasha in a discussion of her caregiving experience and her earlier life with Ethel. The nurse case manager reflected how devoted Sasha has been to Ethel and how difficult the decline has seemed for Sasha. The bereavement counselor asked if he could share a song with Sasha that might reflect some of the themes of caregiving she described; Sasha agreed. Sasha became tearful during the song and was able to identify aspects of the music and lyrics that touched her. She pointed out the lyrical theme of an uncertain future and referred to preparing food for Ethel as one aspect of the process she can still control. Sasha also expressed that she would feel guilty if she no longer offered food. The bereavement counselor affirmed that feeling out of control and feelings of guilt are normal responses to anticipatory grief.

Rather than delve further into the guilt during this visit, the bereavement counselor chose a resource-oriented approach and asked Sasha to share ways that she shows love to Ethel, other than by feeding her. Sasha discussed holding Ethel's hand in the evening when they watch a favorite show together. The nurse case manager listed other ways she has observed Sasha's care for Ethel, and the bereavement counselor asked if he could write these down to reference later. Sasha stated it was helpful to share her feelings and agreed to another joint visit. The bereavement counselor asked Sasha to save the list of ways she shows love to Ethel and to reference it when she is feeling out of control. The bereavement counselor also tentatively planned to use this list as material for a future music therapy songwriting experience. After the visit, the nurse case manager commented on how relieved she feels to have the support of another team member in the home, as she was feeling isolated in this challenging case.

Vignette 4: Telehealth Support

Dwayne was a 63-year-old hospice patient with a diagnosis of prostate cancer. A resident of a long-term care facility, Dwayne received few visitors during his stay on hospice, as he had no family in the local area. Dwayne had previously shown the nurse case manager a book of poetry he wrote over a number of years and stated he would like to write additional poems and possibly songs before his death. Dwayne's needs for life review and affirmation of self-determination and creativity, as well as his relative social isolation, prompted the nurse case manager to refer Dwayne for music therapy. During the assessment visit, the music therapist read select poems of Dwayne's, talked about his music preferences, and explored how Dwayne might want to adapt his poems to music.

A week after the initial visit, the COVID-19 pandemic struck, and psychosocial staff were no longer permitted to visit the long-term care facility. As the nurse case manager was the only hospice team member allowed to visit Dwayne, he and the music therapist coordinated virtual visits for Dwayne using a tablet computer belonging to the hospice and a video chat app. After Dwayne's physical assessment was completed, the nurse case manager initiated the video chat with the music therapist. The nurse case manager assisted Dwayne with accessing his book of poems and helped him identify which poem he would like to work on adapting to a song. The music therapist offered live musical samples from which Dwayne could select, and the nurse case manager took notes at Dwayne's request. Dwayne stated he would love to perform the song with the music therapist in the facility's common area once pandemic restrictions are lifted, expressing a desire to share his work with other residents. After the visit was completed, the nurse case manager reported the visit to the activity director and the director of nursing, emphasizing the innovative hospice team approach even during the pandemic.

DISCUSSION

The preceding vignettes illustrate several critical aspects of cotreatment among any interdisciplinary treatment team

members. First, cotreatment is not a random occurrence but rather an intentional effort by both the music therapist and the nurse in response to extraordinary and/or persistent treatment needs not isolated to a singular health domain or scope of practice. These collaborative efforts are often actualized in interdisciplinary treatment team meetings where holistic plans of care are designed to address patients' unmanaged needs, underscoring the essentiality of music therapists being present at treatment team meetings. Consequently, when music therapists are not provided equitable access to interdisciplinary treatment team meetings, the team loses valuable opportunities to be educated about the potential contributions of music therapy, and patients, by extension, lose access to the full breadth of hospice services.

Second, cotreatment involves the music therapist and nurse collaborating as joint stakeholders removed from hierarchical relationships defined by power and decision making. Stakeholders are entities with equal investment, agency, and empowerment in the outcome(s) of a situation or encounter.[26] Music therapists and nurses, as stakeholders, concomitantly retain their individual expertise as defined by their distinct scopes of practice and professional competencies while exploring how their individual expertise may enhance interaction to activate a unique type of care not possible by music therapy or nursing alone. Cotreating stakeholders demonstrate courage and humility by acknowledging their clinical limitations and allowing their partner's expertise to complement those limitations. When such collaborations actualize, nurse case managers and music therapists stand to feel more supported by one another, leading to increased job satisfaction and decreased risk of burnout.[27,28] Hospice work can be isolating for professional caregivers, but intentional interdisciplinary cotreatment may be a protective factor.

Third, cotreatment addresses whole systems, both within and around the patient. The patient is a whole system composed of multiple overlapping health domains (eg, emotional, social, spiritual, and physical) that inform and shape each other. The patient's environment is similarly a whole system composed of numerous human (eg, caregivers) and nonhuman (eg, physical setting) actors. The music therapist and nurse working in concert with each other allows for a more comprehensive and holistic plan of care to be implemented.

All stakeholders (ie, music therapists, treatment team members, patients, and hospice agencies) stand to benefit from music therapy being explicitly recognized as a core hospice service. At present, music therapists dedicate significant time advocating within their organizations to ensure greater job security; however, if recognized as a core service provider, music therapists could reallocate that time toward developing innovative treatment models and expanding programming (eg, staff and bereavement support groups, internship programs, and procedural support). Treatment team members would subsequently benefit from expanded and routine access to the music therapist for consultation and cotreatment, and patients and caregivers would benefit from increased visit frequencies, expanded clinical services, and better integrated service provision. Such robust interdisciplinary partnership assists hospices pursuing accreditation from agencies (ie, The Joint Commission) focusing on standards of assessment, individualized care plans, and performance improvement. When music therapists are firmly embedded in all facets of the clinical environment of a hospice, they are well positioned to substantively contribute to end-of-life care programming in ways unique and distinct from other team members.

This clinical commentary establishes philosophical and pragmatic rationales for future studies to (*a*) position music therapy as a core service in end-of-life care, (*b*) determine cotreatment protocols for music therapy and other interdisciplinary treatment team disciplines, and (*c*) explore how the distinct scopes of practice for each interdisciplinary treatment team members—such as social workers (eg, family dynamics), chaplains (eg, psychospiritual care), and bereavement coordinators (eg, complicated grief)—interface with music therapy in the provision of holistic care. Such clinical and theoretical developments support a philosophy of integrative care that can provide optimal services for patients as they prepare for death and caregivers as they transition through bereavement.

References

1. Chiaramonte DR, Adler SR. Integrative palliative care: a new transformative field to alleviate suffering. *J Altern Complement Med*. 2020;26(9):761-765.
2. Leonard H. Live music therapy during rehabilitation after total knee arthroplasty: a randomized controlled trial. *J Music Ther*. 2019;56(1):61-89.
3. Halle NC. A Theoretical Model of Contributing Variables in Music and Physical Therapy Co-Treatment in Pediatric Physical Rehabilitation [dissertation]. Lawrence, KS: The University of Kansas; 2018.
4. Khan SH, Wang S, Harrawood A, et al. Decreasing delirium through music (DDM) in critically ill, mechanically ventilated patients in the intensive care unit: study protocol for a pilot randomized controlled trial. *Trials*. 2017;18(1):574.
5. Vaudreuil R, Biondo J, Bradt J. Music therapy with active-duty service members: group protocol description and secondary analysis of protocol evaluations. *Music Ther Perspect*. 2020;38(2):167-177.
6. Gallagher LM. The role of music therapy in palliative medicine and supportive care. *Semin Oncol*. 2011;38(3):403-406.
7. Gao Y, Wei Y, Yang W, et al. The effectiveness of music therapy for terminally ill patients: a meta-analysis and systematic review. *J Pain Symptom Manage*. 2019;57(2):319-329.
8. Gutgsell KJ, Schluchter M, Margevicius S, et al. Music therapy reduces pain in palliative care patients: a randomized controlled trial. *J Pain Symptom Manage*. 2013;45(5):822-831.

9. Warth M, Kessler J, Hilliecke TK, Bardenheuer HJ. Trajectories of terminally ill patients' cardiovascular response to receptive music therapy in palliative care. *J Pain Symptom Manage*. 2016;52(2):196-204.
10. Horne-Thompson A, Bramley R. The benefits of interdisciplinary practice in a palliative care setting: a music therapy and physiotherapy pilot project. *Prog Palliat Care*. 2011;19(6):304-308.
11. Schmid W, Rosland JH, von Hofacker S, et al. Patient's and health care provider's perspectives on music therapy in palliative care—an integrative review. *BMC Palliat Care*. 2018;17(1):32.
12. DiMaio L. Grief choir: a retrospective narrative study of lived experiences. *Qual Inq Mus Ther*. 2019;15:1-33.
13. Potvin N, Bradt J, Ghetti C. A theoretical model of resource-oriented music therapy with informal hospice caregivers during pre-bereavement. *J Music Ther*. 2018;55(1):27-61.
14. Kirkwood J, Graham-Wisener L, McConnell T, et al. The MusiQual treatment manual for music therapy in a palliative care inpatient setting. *Brit J Music Ther*. 2019;33(1):5-15.
15. Wood C, Cutshall SM, Wiste RM, et al. Implementing a palliative medicine music therapy program: a quality improvement project. *Am J Hosp Palliat Care*. 2019;36(7):603-607.
16. Potvin N, Flynn C, Storm J. Ethical decision-making at intersections of spirituality and music therapy in end-of-life care. *Music Ther Perspect*. 2020;38(1):20-24.
17. O'Kelly J, Koffman J. Multidisciplinary perspectives of music therapy in adult palliative care. *Palliat Med*. 2007;21(3):235-241.
18. Horne-Thompson A, Daveson B, Hogan B. A project investigating music therapy referral trends within palliative care: an Australian perspective. *J Music Ther*. 2007;44(2):139-155.
19. Centers for Medicare & Medicaid Services. Hospice Conditions of Participation. October 9, 2015. https://www.cbmt.org/wp-content/uploads/2020/03/CBMT_Board_Certification_Domains_2020.pdf. Accessed July 15, 2020.
20. Certification Board for Music Therapists. Board Certification Domains. https://www.cbmt.org/wp-content/uploads/2020/03/CBMT_Board_Certification_Domains_2020.pdf. Accessed August 10, 2020.
21. American Nurses Association. Position statement: nurses' role and responsibilities in providing care and support at end of life. https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/endoflife-positionstatement.pdf. Accessed July 20, 2020.
22. Rosa WE, Meghani SH, Stone PW, Ferrell BR. Opportunities for nursing science to advance patient care in the time of COVID-19: a palliative care perspective. *J Nurs Scholarsh*. 2020;52(4):341-343.
23. Bowers TA, Wetsel MA. Utilization of music therapy in palliative and hospice care: an integrative review. *J Hosp Palliat Nurs*. 2014;16(4):231-239.
24. Running A, Shreffler-Grant J, Andrews W. A survey of hospices use of complementary therapy. *J Hosp Palliat Nurs*. 2008;10(5):304-312.
25. Singer AE, Goebel JR, Kim YS, et al. Populations and interventions for palliative and end-of-life care: a systematic review. *J Palliat Med*. 2016;19(9):995-1008.
26. Leviton LC, Melichar L. Balancing stakeholder needs in the evaluation of healthcare quality improvement. *BMJ Qual Saf*. 2016;25:803-807.
27. Velando-Soriano A, Ortega-Campos E, Gómez-Urquiza JL, Ramírez-Baena L, De La Fuente EI, Cañadas-De La Fuente GA. Impact of social support in preventing burnout syndrome in nurses: a systematic review. *Jpn J Nurs Sci*. 2020;17(1):e12269.
28. Kim Y. Music therapists' job demands, job autonomy, social support, and their relationship with burnout and turnover intention. *Arts Psychother*. 2016;51:17-23.