

Veterans Hospital Administration Telehealth Utilization for Recreation and Creative Arts Therapies: A Brief Report

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Abstract

Background: A brief query was fielded to Veterans Health Administration (VHA) facilities across the United States to provide an initial assessment of recreation therapy (RT) and creative arts therapy (CAT) telehealth utilization.

Methods: To develop an understanding of barriers and identify potential solutions for better delivery of services, a cross-sectional survey was deployed to points of contact at 136 VHA facilities. The survey included questions across five areas: staff, infrastructure, barriers to use, training, and interventions being deployed. Descriptive statistics were calculated, and a thematic analysis of qualitative responses was conducted.

Results: The most frequent themes from aggregated responses indicated a need for hands-on training, reliable telehealth

equipment, and accessible training and tools for Veteran patients who want to use telehealth services.

Conclusion: Telehealth delivery of RT/CAT has increased services to Veteran patient populations; however, equipment and training are needed to expand consistent delivery to enhance patient reach across a national health care system.

Keywords: telehealth, telemedicine, military medicine, communications, behavioral medicine

Introduction

The United States Veterans Health Administration (VHA) began implementation and testing of telehealth in 2003 and telehealth services have risen rapidly this past year.¹ For example, there was a 1,653% increase in weekly video visits from February 2020 to November 2020 with >40,000 telehealth visits completed daily.² Since the coronavirus disease 2019 (COVID-19) pandemic, telehealth is increasingly being implemented across disciplines.³⁻⁵ Recreation therapy (RT) and creative arts therapy (CAT) are provided as an integral part of Veteran care and employ complementary and alternative health interventions to support physical and psychological health (i.e., functional outcomes in cognitive, physical, psychosocial/emotional, social, and leisure domains). Examples of RT interventions are crafts, nature groups, sports, or exercise groups including yoga and Tai Chi. CAT comprises art, dance, drama, music, and poetry with art therapy and music therapy being the most frequently used mediums at the VHA. The majority of RT and CAT services are in-person, but virtual RT and CAT were being implemented before the COVID-19 pandemic and have rapidly increased in the last year to provide continuation of care and support the needs of Veterans.⁶⁻⁸ The objective of this quality improvement study was to conduct a nationwide assessment of VHA RT and CAT telehealth

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utilization to inform strategic planning that will support training, protocol development, equipment, and guidance for better telehealth implementation.

Materials and Methods

A cross-sectional semistructured survey was deployed to 136 facilities across 18 U.S. regions known as Veterans Integrated Service Networks (VISNS). The facilities employ ~986 full-time equivalent (FTE) RT and CAT therapists. A point of contact from each facility was identified by the National Rehabilitation and Prosthetic Service, Recreation Therapy Service and contacted by e-mail to complete the online survey. Points of contact for facilities were primarily an RT/CAT service chief, supervisor, or lead therapist. In smaller facilities without a direct supervisor, the seniormost therapist was the point of contact. The brief survey included both close-ended (six items) and open-ended (four items) questions. Summary statistics were calculated. For duplicate responses from a facility (n=5), only the most recent response was included for calculating facility-level variables. For other variables, all responses were included in analyses. We conducted a thematic content analysis using the open-ended survey responses and frequencies of themes were tabulated. An iterative process was used to identify themes. A primary coder with CAT expertise applied the themes, and a secondary coder reviewed them for accuracy. Any disagreement between coders was discussed and consensus reached. This query that collected facility level data was designated a quality improvement project and did not require approval by an Institutional Review Board.

Results

A total of 97 responses were returned between November 5 and November 25, 2020, yielding a response rate of 71% from facilities. The responses represent 17 of 18 VISNS and 667 FTE RT and CAT therapists. *Table 1* provides a summary of results from close-ended questions. The median number of FTE RT and CAT therapists per facility was 6 (interquartile range 3–9). Some respondents included therapy assistants in their totals and some combined two half-time therapists into a response of one FTE. Approximately 67% reported more than half of their RT/CAT FTEs were telehealth capable; however, 19% of facilities reported 0% of their FTEs were telehealth capable. The majority of facilities (61%) reported having the clinical grid installed to capture proper clinic workload; the remaining facilities either did not (22%) or were unsure (17%). Respondents reported staff comfort level with telehealth on the higher end of the scale (median = 7), with 14% reporting 10 for comfort (scale 1–10, with 10 indicating the most comfortable).

Table 1. Summary Statistics for Closed-Ended Questions

SURVEY QUESTION	RESULT
What is the total number FTE (Therapists—recreation therapist and/or creative arts therapists) in your facility? median (interquartile range)	6 (3–9)
What is the total number FTE (therapists—recreation therapist and/or creative arts therapists) in your facility telehealth capable (TMS trainings complete)? n (%)	
0–25%	17 (18.9)
26–50%	13 (14.4)
51–75%	9 (10.0)
76–100%	51 (56.7)
Does your facility currently have clinical grids for telehealth set-up completed to capture proper workload in clinic? n (%)	
Yes	56 (60.9)
No	20 (21.7)
Unknown	16 (17.4)
On a scale from 1 to 10 how comfortable are your staff with using telehealth services? (10 being most comfortable), median (interquartile range)	7 (4–9)
Biggest barriers are to utilizing telehealth? n (%):	
Veterans lack of understanding	67 (33.2)
Equipment issues	44 (21.8)
Lack of comfort implementing	32 (15.8)
Lack of training	29 (14.4)
Other	30 (14.9)
Which telehealth services are your staff currently providing within their practice? n (%):	
Interventions	61 (65.6)
Assessments	50 (53.8)
Evaluations	37 (39.8)
National event preparation	34 (36.6)
Adaptive sports equipment evaluations	26 (28.0)

FTE, full-time equivalent; TMS, Talent Management System.

BARRIERS TO TELEHEALTH DELIVERY

The most consistently reported barrier to telehealth utilization was Veteran’s lack of understanding (33%). For this question related to barriers, respondents could also complete an open-ended text field to indicate other barriers. Among these responses, lack of administration support (4%) and setting or environmental restrictions (10%), such as inpatient services only or lack of private office space to facilitate

Table 2. Summary of Themes Present in Open-Ended Responses

QUESTION NUMBER	CATEGORY/THEME	PERCENT	QUOTES/EXAMPLE FROM TEXT
What would increase your staffs comfort level in utilizing telehealth within their practice? (n= 110)	Training	35.5	<i>Trainings on how people are implementing RT virtually</i>
	Experience	26.4	<i>Need more practice and opportunities to do this.</i>
	Equipment/internet issues	20.9	<i>Quality of connection (stronger bandwidth/wifi)</i>
	N/A	10.9	<i>WE are comfortable at a successful working level</i>
	Administrative support	3.6	<i>Support from the leadership team</i>
	Other	2.7	<i>To know that it is benefitting Veterans</i>
What current interventions are your staff currently utilizing via telehealth? (n=297)	Exercise focus	21.2	See Table 3 for activities under each category
	Events	10.8	
	Meditation	10.4	
	Specific therapy groups	10.1	
	Social groups	9.8	
	Not an intervention	8.1	
	Music therapy	7.1	
	Other (not specified)	6.1	
	Leisure education	5.4	
	Art therapy	4.0	
	Other CAT	4.0	
	Wellness groups	3.0	
Please describe any potential future training needs related to utilizing telehealth. (n=97)	None or N/A	24.7	<i>None required</i>
	Intervention/platform specific	21.6	<i>Further training in specific sports training</i>
	Best practice examples and hands-on	16.5	<i>Mentor program offered on Microsoft Teams on best use and examples</i>
	Other	9.3	<i>Process of obtaining/documenting Veteran consent consistently</i>
	Equipment training	8.2	<i>Utilization of the equipment</i>
	Training to train Veterans	8.2	<i>Training in how to help Veterans troubleshoot on their end</i>
	General training	5.2	<i>I think any additional training beyond the TMS courses would be helpful</i>
Any additional information you would like to share regarding telehealth and RT/creative arts therapies? (n= 49)	Positive comments	32.7	<i>This is a great modality and we hope to incorporate more in FY 2021</i>
	Intervention/platform specific	22.4	<i>The VVC program needs some update to become more user friendly for Veteran</i>
	Administrative support	14.3	<i>Additional funding and support for these programs are necessary. Dedicated positions would be helpful</i>
	Staffing or setting	10.2	<i>The recreation therapy services provide is focused on inpatient treatment</i>
	Networking	8.2	<i>Will be interested to learning how other facilities are utilizing it in their regions</i>
	Veteran need	8.2	<i>Most of the older Veterans do not like the virtual classes and/or because they don't have the technology or need assistance with learning it</i>
	Other	4.1	<i>Recreation therapy is heavily working on resolving barriers in this area</i>

CAT, creative arts therapy; N/A, not applicable; RT, recreation therapy; VVC, VA Video Connect.

sessions, were identified as barriers to telehealth delivery of RT/CAT. Two responders indicated that they did not have barriers or were easily able to overcome them, and one response indicated difficulty with medical record documentation and a stop code for administrative purposes. The most used telehealth services were therapy interventions (66%) and assessments (54%).

IMPROVING STAFF’S COMFORT WITH TELEHEALTH DELIVERY OF RT/CAT IN VHA

Thematic analysis of 110 suggestions for improving staff’s comfort with telehealth delivery of RT/CAT yielded 5 themes (Table 2). The most frequent themes for increasing comfort

were training (36%), experience (26%), and having the proper equipment/stable internet connections (21%). Many requests favored hands-on training that included examples and models of best practices. Five responders reported having no need to increase staff’s comfort level and seven wrote in not applicable.

THERAPY INTERVENTIONS

There were 297 identified RT and CAT interventions offered through telehealth. As given in Table 2, therapists reported a wide range of individual and group interventions through telehealth, with interventions having an exercise focus being most frequent (21%). The CAT combined (art, music, and other

Table 3. Intervention Categories and Descriptions

CATEGORY	DESCRIPTION (WHAT WAS INCLUDED)
Art therapy	Art therapy or interventions that would be associated with art therapy (art sessions, art therapy, art therapy with community partners, arts and crafts, photography, visual arts)
Events and community	Included events, meetings, concerts, visits, and community resources (community integration, community meetings, community resources, concerts, national event preparation, NVGAG meetings, online resources, virtual tours, visits with families)
Exercise focus	Any interventions aimed at physical exercise (adaptive sports, bike rides, exercise programs, fitness groups, functional fitness, Golden Age Game training, group exercise, home exercise, line dancing, low-impact exercise, low-intensity balance exercises, Mixed Martial Arts, MOVE, movement groups, Range of Motion exercise, seated exercise, sports for recovery, therapeutic exercise, virtual exercise sessions, yoga), excluding exercise evaluations and assessments or education
Leisure education	Related to leisure skills, education, or resources (adaptive leisure skills, golf lessons, home leisure, leisure awareness, leisure education groups, leisure engagement, leisure lifestyle management, leisure skills, recreation resources)
Mindfulness	Mindfulness and relaxation specific (iRest, iRest Yoga, meditation, mind body activities, mindfulness, mindful movements, progressive relaxation, relaxation training, tai chi)
Music therapy	Music therapy or interventions that would be associated with music therapy (guided imagery, guitar lessons, music, music for wellness, music sessions, music therapy, music therapy interventions, sound healing, The Sound of Relaxation).
Not an intervention	Included assessments and evaluations as well as items not defined enough to classify (assessments, COVID-19 screenings, daily programming, evaluations, follow-ups, HBPC services, IN2L Computers, Inpatient interaction during quarantine, One Day Annuals, WC)
Other CAT	Included interventions that would be associated with other creative arts therapies, excluding art and music (creative arts, creative expression, creative writing, journal group)
Other intervention	Includes general sessions that do not fit into other categories (1:1 interventions, diversional activities, education, group programming, i-pad lessons, My Life My Story, skill training, virtual groups, volunteer-led programs)
Social	Includes groups focused on social interaction and meet-ups (Bingo, book club, cards and board games, canine interventions, current events, discussion groups, equine visits, games, gaming, group activities, fly tying, knitting groups, Name That Tune, PPH Psychosocial groups, social games, social groups, social participation groups, social stimulation, social well-being interventions, socialization, trivia, virtual meet-ups)
Specific therapy groups	Interventions focused on a certain domain, patient diagnosis, or paradigm of therapy but did not specify a particular intervention (addiction recovery, alternative pain coping, anger management, behavioral health group, cognitive, cognitive behavioral therapy, coping skills, goal setting, motivational enhancement therapy, motivational interviewing, psychodynamic, psychoeducational, reality orientation, recovery coaching, reminiscence, self-help group, sensory stimulation, social skills, stress management, time management)
Wellness groups	Including those that fall under Whole Health, but not specific interventions (aromatherapy, health and wellness, health promotion, performing wellness, TBI wellness group, wellness checks, Whole health coaching, WRAP groups)

COVID-19, coronavirus disease 2019; HBPC, Home-Based Primary Care; IN2L, It’s Never 2 Late; MOVE, Managing Overweight and/or Obesity for Veterans Everywhere; NVGAG, National Veterans Golden Age Games; PPH, Psychiatric Partial Hospitalization; TBI, traumatic brain injury; WRAP, Wellness Recovery Action Plan.

CAT) comprised 15% of interventions delivered. See *Table 3* for a description and detailed activities for each intervention category.

The most frequently requested training topic was for intervention/platform-specific training (22%), such as how to implement telehealth for groups or adaptive sports. However, 25% responded none/not applicable for future training needs. There were additional comments from 49 respondents. Approximately 33% of these comments were positive statements about the use of telehealth and its benefits for Veterans. Many positive comments reflected expanded reach of services to Veterans. Other emergent themes from additional comments were a need for administrative support, Veteran needs related to successful use of telehealth, suggestions for networking, and comments specific to platforms, interventions, staffing, or setting (*Table 2*).

Discussion

Results from this study support previous findings of identified barriers to telehealth utilization including technology issues and lack of patient knowledge, especially among patients who are older or have limited technology experience.^{9,10} Themes that emerged across all responses in this study were training, Veteran barriers, and problems related to equipment or technology. In addition, more regular use and direct experience with different technologies was important for incorporating telehealth into practice. The bridge between training and experience was a frequent request for hands-on training, mentors in the field, and models or protocols to help guide therapists. About one third of respondents reported that Veterans' lack of understanding was a barrier to telehealth use. In additional comments, there was an expressed need to train Veterans on technology use or troubleshoot technological problems with them. Older Veterans and those with hearing or visual impairment were identified as needing additional support to utilize telehealth services. Alternately, some therapists felt that telehealth allowed certain Veterans to receive services that were not previously accessible. Requests for better equipment, the need for stronger internet connection, and preferences for different platforms were also themes found across questions. However, there was lack of agreement for a specific platform; whereas some requested to continue with WebEx over VA Video Connect (VVC), others stated that Zoom (currently not used) has better technology for facilitating groups. Finally, the need for administrative support (including documentation, additional staff, needs particular to the setting where sessions were facilitated, and support from supervisors) was identified across questions.

A limitation to this study was that individual points of contact for each facility were responding to the survey based

on information gathered from multiple RT and CAT therapists at each facility. Although facility-level data provided a rapid and general assessment of current use, it may have failed to capture more nuanced issues pertinent to specific therapists. Follow-up studies are currently underway that will help address these limitations. The first study is a direct survey of all CAT therapists working in the VH, including interviews with a subset of therapists. The second, a pilot study of a telehealth music therapy intervention, will include interviews with Veterans. Findings from these studies will provide more nuanced information about the context in which therapists work and Veteran self-identified facilitators and barriers to their participation in telehealth CAT sessions. In addition, VHA has set up "Digital Divide" consults at each facility to assist Veteran patients with their telehealth connections. Our direct survey study with CAT therapists includes questions on the availability and use of the service that can inform greater integration of CAT services with the Office of Digital Divide as a way to help overcome challenges Veteran's experience while using telehealth CAT. Other limitations were reliance on self-report and potential issues of generalizability of findings to therapists outside the VHA organization.

Conclusion

Results from facility key informants provided an overview of how telehealth was deployed for the delivery of RT/CAT across VHA. Identified themes across questions were the need for increased training and experience, especially in the form of hands-on training and training that is specific and relevant to the therapists' services, support, and training to help Veterans understand and use the technology, and support from administration. Moving forward, based on respondents' feedback, potential solutions from the synthesis of this query include the following:

- Identification of superusers of telehealth to serve as mentors at the VISN level.
- Established networking groups through Microsoft Teams organized by therapist specialty or topic.
- Dedicated positions to deploy RT and CAT telehealth services.
- Workshops and continuing education dedicated to specific interventions or apps.
- Guidelines, protocols, and models for best practices of RT and CAT telehealth delivery.

It is recommended that future research include direct feedback from Veterans, hybrid models that address effectiveness and implementation, and integration with the Office of Digital Divide to improve Veteran access.

Ethical Approval

This study was quality improvement. Ethical Approval was not required.

Authors' Contributions

H.A.B. and D.O. contributed to the study conception, framing, and data collection. K.M.S. and M.E.F. contributed to the data preparation and extraction, and K.M.S., M.E.F., S.L.R., and T.M.D. to the data analysis. The first draft of the article was written by K.M.S. and M.E.F. All authors commented on the subsequent versions of the article. All authors read and approved the final version of article.

Disclosure Statement

No competing financial interests exist.

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