

ARTS IN HEALTHCARE FOR RURAL
HOSPITALS AND COMMUNITIES

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THESIS

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Dedicated to Mom, Dad, and Matt

“Families are the compass that guide us. They are the inspiration to reach great heights and our comfort when we occasionally falter.”

-Brad Henry

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I. INTRODUCTION

The original purpose of this thesis was to investigate the processes by which rural hospitals hire arts administrators to coordinate and implement arts programming for the hospital environment. I wanted to interview hospital administrators as well as current arts administrators to answer the research question, “what common elements have occurred that prompted hospital administration to hire a full-time/part-time arts administrator?” I believed that the best strategy to incorporate arts programming into rural hospitals was to focus on the hiring of an arts administrator to work internally within the rural hospital environment. I felt the arts administrator as a figurehead and leader for arts programming would greatly benefit the hospital by improving cost effectiveness, improving patient care, humanizing the hospital environment, improving staff retention, as well as providing nonthreatening approaches to teaching preventative health care and counteracting the health concerns unique to rural locations.

I quickly discovered, however, that my original research question was not appropriate for small, rural hospitals. I had a difficult time locating small rural hospitals that had any sort of arts programming, let alone a paid arts administrator to direct and implement the programming. Fortunately, I came across an initiative led by the University of Florida’s Center for Arts in Medicine, funded by the State of Florida Division of Cultural Affairs and the Kresge Foundation, the Arts in Healthcare for Rural Communities initiative. It helped establish arts in healthcare programs in nine rural communities across the Florida Panhandle. I was able to connect with a few of the arts programming leaders, but realized quickly that the

program leaders were not in budgeted positions, which made my original research question a bit irrelevant.

Upon speaking with my first interviewee from Florida, I discovered that though I needed to abandon my original research question and primary focus, there were other invaluable and fascinating points discussed on arts programming in a rural community. In lieu of time constraints, my problem statement section does admittedly center around my original research question, but the rest of this document brings to light the important themes that arose from my two methodologies for investigation.

II. LITERATURE REVIEW

A. BENEFITS OF ARTS IN HEALTHCARE

Arts in Healthcare (AIH) is a multidisciplinary field that incorporates many art forms into the healthcare environment (Tokuda and Pratt 2003, 1). Music, art, dance, theater, literary art, creative therapies and visual imagery can all be used to benefit diverse patient populations with varying diseases and conditions that are located in both inpatient and outpatient settings (2). Patients, family members, and medical staff can all benefit from the kinds of arts programming frequently found in hospitals, assisted-living facilities, rehabilitation centers, palliative care and hospice care centers, and senior homes (2). Creative therapies and arts programming have been described as a means to improving the symptoms of many diseases and health issues such as autism, mental disorders, chronic illnesses, cancer, Alzheimer's, dementia, brain injuries, neurological disorders, post traumatic stress disorder, and physical disabilities (State of the Field Committee 2009, 16).

There are numerous benefits that the arts can provide to patients and their family members. The arts can alleviate common stressors found in the healthcare environment such as navigation through a confusing hospital layout, a patient's feeling of powerlessness due to limited control over medical situations, and a patient's apprehension for medical procedures while sitting in a discomfoting, waiting room (Tokuda and Pratt 2003, 4-5). For example, prominent pieces of art can act as landmarks for patients, helping patients easily navigate around hospitals (Ugandi) and offer points of familiarity (Tokuda and Pratt 2003, 4-5). Healing gardens and art exhibitions can give patients a choice in destinations at a time when they may have limited options in their lives (4-5). Also, music played in waiting rooms can decrease stress in patients and visitors, often eliminating their aggression for medical staff and

medical procedures leading to more effective medical outcomes (Staricoff 1994-200, 20).

Arts programming in healthcare facilities such as hospitals can also help improve the perception of care by patients and visitors. Survey results discussed in the article, “The Arts in Healthcare Movement in the United States Concept Paper,” stated that art improved “the perception of quality of care by bringing more warmth, stimulation, and comfort to a healthcare facility” (Tokuda and Pratt 2003, 5). It was also mentioned that patients prefer healthcare facilities that contain art programs when deciding between two different facilities for medical attention (5).

Arts programming in healthcare facilities can also benefit medical care professionals that administer direct patient contact, such as nurses and doctors. It is difficult to attract and retain talented nurses, doctors, and other hospital staff who are susceptible to heavy workloads and burnout (Hamer 2002, 38). Medical staff who participate in music and art programs have described the experiences useful in alleviating stress, lifting their mood (State of the Field Committee 2009, 15), and contributing to better job satisfaction (Staricoff 1990-2004, 20), which in turn can lead to a reduction in medical errors by the medical staff (20). Taking part in art programs can also help staff members share an experience with a patient, leading to a better relationship between the care provider and patient (Wikoff 2003, 9).

B. HISTORY OF THE ARTS IN HEALTHCARE

The arts have been a unique part of eastern and western healthcare structures for thousands of years (Tokuda and Pratt 2003, 7). For example, visual art has been used for centuries to aesthetically improve the waiting areas of health facilities (Gates 2008, 761). In Athens around 400BC, sick and wounded Greek community members gathered at healing temples for comfort. The art used to decorate the temples represented the beliefs and culture of the surrounding community (761). Between the 10th and 16th centuries, murals and frescoes were painted on the walls of Italian monastic hospitals, such as the Santa Maria della Scala in Siena (761). The most important works of art

were showcased inside the Santa Maria della Scala to improve the interior aesthetic of and to promote a healing environment (761).

Scholars and philosophers such as Pythagoras and Plato are credited with discussing the healing qualities derived from music (Sonke 2011, 8). According to Boethius, Pythagoras anecdotally stated that hearing musical modes could bring individuals back to health (Jones 1994, 18). Plato was known for his belief that "music is a moral law. It gives soul to the universe, wings to the mind, flight to the imagination, a charm to sadness, gaiety and life to everything (LaRue)."

In the late 1800s, music was becoming more incorporated into Eastern healthcare facilities, with England at the forefront. Around 1891, the Guild of St Cecilia was founded in England with the purpose of playing sedative music for patients in London Hospitals (Bunt 1994, 8). By the late 1800s in the United States, doctors also started to hire musicians to play in hospitals - primarily to boost morale and relieve stress, with the assumption that music could only have a positive effect on patients (3).

However in the early 20th century, Western healthcare began to completely eliminate the arts from the health care environment (Tokuda and Pratt 2003, 8). A combination of the Modernist movement in architecture and the desire to make healthcare facilities look more sanitary and polished contributed to the dehumanized, sterile hospital environment (8). Fortunately by the mid 20th century, there was a revival in returning art to healthcare facilities (8).

The community arts and public arts movements of the late 1960s both aided in strengthening the backbone of the AIH movement by incorporating programming with a vast array of art disciplines and structures (Tokuda and Pratt 2003, 8-9). The "arts in communities" movement was at its peak by the 1970s, which pushed for both accessibility to the arts and the production of high quality, diversified artworks (8). Steady funding by the National Endowment for the Arts (NEA) helped arts councils and arts service organizations flourish (8).

In 1978, the NEA gave Duke University Hospital a Special Projects grant with which the hospital started its internally run, arts program (Tokuda and Pratt 2003, 9). The arts program at Duke was formed through its collaboration with a local arts council and under the consultation of a leader from the New York City based, Hospital Audiences Inc. (HAI) (9). The nonprofit HAI which is still very active, set an incredible example in the 1970s, incorporating artists into facilities with underserved populations such as prisons, nursing homes, and psychiatric centers (9).

During an AIH interview, Helen Orem, a major pioneer of the arts design field, stated that in the 1970s, healthcare facilities became more focused on marketing efforts to attract patients. (Tokuda and Pratt 2003, 10). For example, surveys on patient and family satisfaction were used more regularly, and indicated that the public wanted a more comfortable and less cold healthcare environment (10). This awareness, led hospitals to embark on new strategies to improve their dull environment and appease public desires.

By the 1980s, there were many AIH advocates, but they were largely decentralized (10). AIH advocates began to seek each other out to ask for guidance and to share practical AIH information (10). In 1991, a national organization called the Society for the Arts in Healthcare (SAH) was founded which has helped to connect AIH professionals across the nation (10). SAH has been a major force in building the arts in healthcare field through professional AIH networking opportunities and spearheading valuable research that has influenced the professionalization of the arts in healthcare field.

C. CURRENT STATE OF ARTS IN HEALTHCARE

Many healthcare facilities across the nation have begun to integrate the arts into the healthcare environment. A 2004 survey on 2,333 health facilities showed that 43% of the surveyed facilities had arts programming (State of the Field Committee 2009, 4). Of the positive respondents, hospitals contained the most art activities, with a smaller percentage in long term care facilities as well as palliative and hospice care centers (4). A 2007 survey that used a smaller pool of healthcare respondents noted similar findings

(4). 61% percent of the healthcare facilities with arts programming were hospitals, 5% were in long term care facilities, and 4% were in hospice and palliative care centers (4).

In recent years, there has been an increase in internal funding for arts programming among healthcare facilities. In 2004, 40% of healthcare facilities stated that their operating budgets were used to fund arts programming (State of the Field Committee 2009, 5). By 2007, that rose to 56% (5). These increases show that there is growing permanence for arts programming, and that there is increasing recognition of the value of the arts by healthcare facilities (5).

D. CHALLENGES OF RURAL HOSPITALS

Rural hospitals face numerous challenges that can affect their long-term sustainability. Rural residents in the United States have unique health concerns that can put added strain on healthcare institutions (Barnidge and others 2010, 81). According to a Pemiscot County study in Missouri, rural communities often suffer from a general lack of opportunities, such as steady employment, which can lead to unhealthy eating habits, drug usage, and health conditions such as heart disease (Barnidge and others 2010, 83). Living in a community that has few opportunities can also cause depression and stress in the residents due to difficulty in finding jobs even when residents have knowledge and skills (84).

Another strain on rural healthcare facilities comes from the health issues that are common for older populations. The proportion of older populations in rural areas is often higher than that of the general population in non-rural communities. As a result, medical workers have to deal with elderly people suffering from multiple and chronic diseases such as increased rates of asthma (Rygh 2007, 766), increased rates of disabilities, and high rates of cardiovascular disease (Corwin 2006).

Another major challenge for rural hospitals is attracting patients from the surrounding communities (Escarse and Kapur, 2009). Many residents avoid rural hospitals and

attend urban facilities even if the rural hospitals are in closer vicinity (2009). Rural residents often perceive that the quality of care in rural hospitals is poor due to the fact that rural hospitals offer fewer services and sometimes lack updated technology (2009).

A third challenge that hospitals have to overcome is limited access to well-trained and knowledgeable health workers (Strasser and Neusy 2010, 777). Rural health care practitioners such as nurses, doctors, dentists, and pharmacists, carry a heavier workload and are expected to provide broader services than urban practitioners (777). As a result, being able to attract and retain skilled medical professionals is often a problem.

E. BACKGROUND OF THE PROBLEM

Rural hospitals are imperative in assuring access to quality healthcare services for the rural public. At least 72 million people live in rural areas throughout the United States, and though some seek out urban hospitals, many residents look to local hospitals as the only source of medical care (American Hospital Association 2010, 1). Medical care providers in rural hospitals must have a broad knowledge of many diseases and conditions while also taking on the role of teaching preventative health measures to residents (Strasser and Neusy 2010, 777).

Integrating arts programming into hospitals is a vital way to improve attrition among health care providers and counteract the health problems that are common in a rural setting. Passive and active arts programming are beneficial to both patients and their family members, as well as the hospital staff. Arts programming can improve the well-being of patients, promote healing, provide pain diversion, promote acceptance of a patient's medical condition, decrease the usage of medications, improve stress, and decrease the length of hospital stays for patients (State of the Field Committee 2009, 2).

III. PROBLEM STATEMENT

Based on my own observations while living in rural Virginia, I think that despite the advantages of incorporating the arts into the healthcare environment, there are a limited number of rural hospitals that have successfully done so. I have scanned a wealth of research studies provided by the Drexel Library databases, and have browsed through search engines such as Proquest, Google Scholar, Sage Journals Online, and Jstor. Unfortunately, I have not discovered any journals, articles, or research studies that can address my assumption. This indicates a need for further research on the topic of urban vs. rural hospital arts programming.

I was fortunate enough to connect with two arts in healthcare professionals in November of 2012, Jill Sonke, Director of The University of Florida Center for the Arts in Healthcare (CAHRE) and Assistant Director of Shands Arts in Medicine, and Jenny Lee, CAHRE Research Coordinator for Arts in Healthcare for Rural Communities. Both professionals fully agreed with my assumption, and recognized that there is little research to prove my assumption correct. Ms. Sonke has presented her unpublished literature review “AIM for the Panhandle,” at numerous conferences across the United States, discussing the overall lack of arts programming in rural healthcare facilities:

“While there are many models in place for arts in healthcare programs in urban and suburban healthcare settings, review of the literature indicates that no models have yet been presented for such programs in rural areas, and that these programs have the potential to contribute to improved health outcomes in rural communities...In all of the literature reviewed, healthcare facilities were either located in urban or suburban areas or no mention was made of facility size or urban/rural status of the community.”

A. IMPORTANCE OF ARTS ADMINISTRATORS IN HOSPITALS

As previously indicated, many urban hospitals have successfully integrated arts programming into the healthcare environment. Hospitals in urban locations typically have a myriad of nonprofit arts organizations and artists available to provide music, visual art, dance, theater, and writing programs to patients, visitors, and staff members. In most cases the arts programming is either coordinated by an internal arts coordinator or from the efforts of a volunteer (State of the Field Committee 2009, 4).

According to “The Arts and Healthcare Movement in the United States,” some of the most thriving arts in healthcare programs include arts administrators or consultants who were hired as full-time or part-time staff members (Tokuda and Pratt 2003, 27). A 2004 report issued by the Society for the Arts in Healthcare found that at least 79% of the healthcare facilities with arts programming had a paid arts coordinator, which they described as demonstrating a “commitment to professionalism in the management of arts programming in healthcare institutions” (State of the Field Committee 2009, 4). Rural locations, it would seem, would benefit greatly by having a full-time arts administrator on staff that has general art knowledge, the ability to assess the community for potential artists, and an understanding of the sensitive nature of the hospital ecology.

Arts administrators working in hospitals take on many responsibilities to successfully facilitate and implement arts programming that will provide benefits to patients, patients’ families, and hospital staff. According to the report, “Cultures of Care: A Study of Arts Programs in U.S Hospitals”, arts administrators organize and curate exhibits that can feature hospital patients’ artwork or the artwork from local amateur and professional artists (Wikoff 2004, 8). Arts administrators must be aware that certain types of art, such as controversial or abstract art, may not be suitable for the hospital setting (Staricoff 2006, 116). They must also take into consideration that all art material should be nontoxic and safe for the hospital environment (Wikoff 2004, 8). Other responsibilities include recruiting and training artists and arts volunteers (8), placing live music performances in appropriate hospital locations (Staricoff 2006, 116),

working with the community to connect musicians and artists with the healthcare setting, and fitting arts programming into “the highly structured hospital environment” (Wikoff 2004, 8).

According to Scheirer’s cross study analysis, there are five factors that can contribute to the sustainability of programming (Scheirer 2005, 325). One of these factors is the internal organizational presence of a “program champion” who is responsible for facilitating the continuation of the programming, and ensuring the programming falls within the mission of the organization (325). An arts administrator on staff in a hospital can act as the so called “program champion”, overseeing program implementation and continued evaluation.

IV. GENERAL OVERVIEW

The purpose of this thesis was to discover the appropriate steps needed to integrate arts coordinators or arts administrators into rural hospitals as full-time staff members. An arts administrator or arts coordinator on staff in a hospital is an important part for the successful facilitation and sustainability of arts programming. The hospital can be positively improved by the leader's efforts to implement arts programs that humanize the environment and provide numerous benefits to patients and their families. This knowledge influenced my choice of populations for my first methodology in which I interviewed four arts coordinators or leaders who are currently working in rural hospital settings. The second methodology involved surveying 25 rural hospitals located throughout the United States. More in-depth descriptions can be found in the analysis section.

A. RESEARCH FRAMEWORK

To answer my original research question which asked, "what common elements have occurred that prompted hospital administration to hire a full-time/part-time arts administrator" I had planned on using two methodologies. For one, I designed a short survey that primarily contained closed-ended questions but also provided the option to include open-ended comments. I administered the survey to 25 rural hospitals across the United States. With my survey design, I hoped to determine if there was a lack of arts programming in rural communities. I was successful in completing the survey and its results are further explained in the survey section.

For the second methodology, I planned to qualitatively interview hospital administrators as well as arts administrators currently working in hospitals with AIM and Arts in Healthcare programs. I unfortunately had little luck in discovering an abundance of rural AIM and Arts in Healthcare programs in the United States. I did, however, find AIM programs in nine rural Florida

communities that were originally initiated with the help and guidance of the University of Florida's Center for the Arts in Healthcare (CAHRE). Its pilot AIM program for rural communities was founded in 2009 at George E. Weems Memorial Hospital in Apalachicola, Florida. After much success, a second program was established at Sacred Heart Hospital on the Gulf, located at Port St. Joe, Florida, in the spring of 2010. Since then, seven other AIM programs have been founded in rural communities of Florida.

In January of 2012, I contacted Jill Sonke, Director of The University of Florida CAHRE and Assistant Director of Shands Arts in Medicine. I anticipated that she could help connect me to the arts coordinators, arts directors, and hospital administrators of the rural Florida AIM programs. By mid-February of 2012, I also contacted Jenny Lee, Research Coordinator for CAHRE in the area of Arts in Healthcare for Rural Communities, to find hospitals that had already implemented the AIM programs. While awaiting a reply, the Center for Arts in Healthcare updated its website, listing the hospitals and communities that had either implemented or were in the process of implementing the AIM programs. Later, Jenny Lee wrote back, providing a list of leaders for the current AIM programs in Florida's rural communities. With this list, I was able to contact and set up interviews with the representatives and leaders for four of the nine AIM and Arts in Healthcare programs.

However, as I began interviewing my respondents, I realized that my original research question was rather irrelevant in comparison to other important issues brought up by the interviewees pertaining to arts programming in rural communities. Rather than interviewing hospital administrators, I chose to focus on the arts directors and coordinators of the AIM and Arts in Healthcare programs to acquire more in-depth information surrounding rural arts in healthcare programs. My sample hospitals or communities were George E. Weems Memorial Hospital, Sacred Heart Hospital on the Gulf, Jackson Hospital, and the Immokalee community.

The following sections provide a detailed context and summary of results for both the survey and the four interviews.

V. SURVEY SECTION

A. CONTEXT

My first methodology was a survey, which had four primary purposes. First, I hoped to prove that there are a limited number of rural hospitals across the United States that have arts programming incorporated into the hospital environment. Second, I wanted to determine the common barriers that hospital administrators feel are preventing them from incorporating arts programming into the hospitals. Third, I hoped to prove that rural hospital administrators indeed want arts programming in the hospital setting. Lastly, I hoped to learn if hospital administrators would consider hiring an arts administrator to coordinate arts programming for their hospitals and what would be necessary for them to potentially hire an arts administrator.

I surveyed a sample of 25 rural hospital administrators across the United States. I wanted to use hospital settings licensed for at least 50 or fewer patient beds. I focused on smaller hospitals because I felt that smaller hospitals are typically in rural locations and those hospitals are susceptible to numerous challenges to remain sustainable. I knew that it would be difficult to locate rural hospitals that are defined as having 50 or fewer beds, therefore I felt 25 hospitals would be a suitable sample size to potentially acquire.

a. RESEARCH DESIGN

As previously mentioned, I aimed to find 25 rural hospitals across the United States. Originally, I hoped to locate rural hospitals that would at least represent 25 individual states of the nation. However, once I began researching rural hospitals that met my parameters, I quickly discovered that it would be more practical to use the few hospitals that I could find, despite many of them being located in the same states. I was very fortunate to discover that

some states, such as Oregon, had helpful websites listing every hospital in that particular state and segmenting them by total number of patient beds.

In the end, the 25 rural hospitals that I used came from the states of Pennsylvania, Oklahoma, Oregon, California, Nevada, and South Carolina. The settings of the hospitals varied from inpatient facilities to rehabilitation centers and community hospitals. Though it would have been beneficial to focus on hospitals with similar settings, the level of research required to do so while staying within my set of parameters went beyond the time constraints of my research.

To garner a higher response rate, I kept the survey short, with a total of six questions. Hospital administrators are relatively busy and hoped that they would be more prone to completing a survey that took less of their time. The survey was structured with six questions, five of which were multiple choice questions with the option to choose more than one answer, if applicable. Though the initial phase of each question was closed-ended, I included space after each question for respondents to leave comments. The sixth question was strictly an opportunity for respondents to provide any additional comments or feedback.

After much contemplation, I decided to use SurveyMonkey software to generate my survey. For the general purposes of my research, SurveyMonkey was a practical option that offered free access to surveys containing 10 or fewer questions.

To send the survey to my identified respondents, I created a cover letter that I emailed to all 25 hospital administrators¹. The cover letter introduced me, described my purpose for contacting the administrators, described why they had been chosen to participate in the survey, described the survey and its brief length, and explained how to participate in the survey. At the end of the cover letter, I included a hyperlink to the survey which respondents could click on to easily navigate to the survey site.

¹ A copy of the cover letter and survey can be located in the appendix section.

On February 16, 2012, I emailed the cover letter with the hyperlinked survey to my identified respondents. After two weeks, 11 people had responded. On March 1, 2012, I sent a reminder email to encourage and prompt more respondents. After March 11, 2012, I received no more responses, bringing the total number of respondents to 13.

b. SAMPLE ERROR

It is important to note that at least two hospitals had multiple representatives complete the survey. It is evident that this fact could have skewed the results of the survey as two hospitals were overrepresented. Though this was out of my control, I still think the analysis of my survey provides valuable information about arts programming in rural hospitals.

B. SUMMARY

Question One:

The first question of my survey asked, “Does your hospital provide arts programs for its patients and/or staff?” Of the 13 administrators that responded:

- 61.5% or eight hospitals, do not provide arts programs for its patients and/or staff
- 38.5% or five hospitals, do provide arts programs for its patients and/or staff

Question Two:

The second question of my survey asked, “if you answered no to the first question, please indicate the reason(s) why. (Multiple answers can be selected).” Of the eight administrators that had previously responded no to question one, their answers are listed below:

- Six administrators responded with financial limitations
- Four administrators responded they are unsure how to implement such programs
- Four administrators responded they do not have time to devote towards creating such programs

- One administrator responded she did not know the arts could be used in the healthcare setting.
- One administrator responded the hospital staff does not have any arts expertise
- No administrators responded they do not see the benefit or purpose of arts programs in the health care setting

There was one additional, open-ended comment that stated the following:

“We have been adding beds yearly and have grown significantly. Would love to have an art program ongoing. Have highlighted art from children during safety week/ rehab week and art from a major event in the community and have changed out the art on our walls to brighten the place even more.”

Question Three:

The third question of my survey asked, “If you answered yes to the first question, please indicate the type of arts programs provided by your hospital. (Multiple answers can be selected).” Of the five² administrators that responded yes to the first question, their answers are listed below:

- Six administrators responded their hospitals have musicians performing for patients and staff in hospital spaces
- Five administrators responded their hospitals contain healing gardens
- Two administrators responded their hospitals contain music/art/creative therapists working with the patients
- One administrator responded that her hospital contains visual artists helping patients create arts and crafts projects

² This question contains some bias as six respondents answered the question. Five respondents answered yes to question one, demonstrating that only five respondents should have responded to question three.

- One administrator responded that an Arts Administrator coordinates the hospital's arts activities

There were two additional, open-ended comments that stated the following:

“Our volunteers seek artwork from the community to display in our hospital. There is a coordinator of this project. This artwork is rotated regularly.”

“We are working on a healing garden, but it has not yet been completed. Occasionally, an outside source will come in and play music in our lobby or cafeteria area. We do use music therapy with patients.”

Question Four:

The fourth question of my survey asked, “In the future, would your hospital consider hiring an Arts Administrator to coordinate and implement arts programming into the hospital environment?” Of the thirteen administrators that responded:

- 61.5% or eight administrators, responded no
- 30.8% or four administrators, responded maybe
- 7.7% or one administrator, responded yes

Question Five:

The fifth question of my survey asked, “What would be necessary for your hospital to hire an Arts Administrator to coordinate arts programming? (Please select all answers that apply)”

Of the ten administrators that responded to this question:

- There were ten responses for funding from an external organization to support the administrator's salary
- There were eight responses for proof that hiring an Arts Administrator would benefit the hospital's patients and staff

- There were seven responses for proof that hiring an Arts Administrator could lead to cost containment for the hospital
- There were five responses for examples of other rural hospitals that have hired Arts Administrators as staff members

There were two additional, open-ended comments that stated the following:

“Evidence that such a role and the services it provides can 1) improve population health 2) reduce or contain health care costs (vs. add to it) 3) improve the patient experience.”

“We have an extremely active group of volunteers whose backgrounds far exceed our expectations. We are a blessed hospital to have such talent and skills available to us through our volunteers.”

Question Six

Question six of my survey asked respondents to provide any additional comments, thoughts, or feedback. There were four comments that stated the following:

“We use the Community Artist Guild members to provide art resources as needed and appropriate including: Revolving art exhibits, Music, etc.”

“We have beautiful art throughout our facility that was created by children under the direction of professional artists. That is about all we can afford to do. Also, our average length of stay is less than 3 days so there are no long-term patients who would have time to create art while they are here.”

“Given the acuity of the hospital, our short length of stay and patients' limited ability to participate in art, I would recommend exploring this service in long term care, home health and hospice settings. I also think there is may be good opportunities to focus on working with staff--providing a thoughtful means to process their experiences of working in health care--the meaning the find, the

suffering they encounter. How can art help healers to integrate their experience...?”

“We hope this helps you.”

VI. INTERVIEW SECTION – INTERVIEW 1

A. CONTEXT

George E. Weems Memorial Hospital is located in Apalachicola, Florida, situated in what is known as the Northwestern Panhandle of Florida and provides medical care to many of the 11,000 residents of Franklin County. As listed on George E. Weems Memorial Hospital's website, medical services offered by the facility include 24 hour emergency care, Swing-Bed Services³, Medical-Surgical Care; an urgent care clinic in Carabelle, FL, 25 inpatient beds used for acute care circumstances, 23 hour observations, short-term rehabilitation, and skilled nursing care.

According to the 2010 U.S Census Bureau's population estimates, the majority of Franklin County's residents are 65 years and older, making up of 17.5% of the population. The second highest age demographic is those under the age of 18, at 17.1% (U.S Census Bureau). The race demographic of the county is 82.6% white, 13.8% African American, with various races making up the remaining 3.6% (U.S Census Bureau). At least 75.8% of the population over the age of 25 earned a high school diploma and 18.8% of the population earned a Bachelor's degree or higher (U.S Census Bureau).

George E. Weems Memorial Hospital is publicly owned, governed by nine Board of Directors, and administratively led by its Chief Executive Officer (CEO) and Chief Nursing Officer (CNO). As stated by David Alderstein in his online article for *The Times* titled "Davie Lloyd out as Weems CEO," in 2008 Weems Memorial Hospital established a partnership with Tallahassee

³ "The Swing Bed Program was introduced as a part of the Omnibus Reconciliation Act of 1980, which was implemented in 1982, allowing small rural hospitals to use some of their acute care beds as skilled and intermediate nursing beds. Beds used for such care generate income that would otherwise be lost if they remained empty or were occupied by long-stay Medicare patients." (Lammers, Eugene J. 1992. Swing bed program in a small rural hospital. *Southern Medical Journal* 85, no. 12, 1184, <http://search.proquest.com.ezproxy2.library.drexel.edu/docview/196355286>, (accessed April 20, 2012).

Memorial Healthcare (TMH) in which TMH provides financial and administrative supervision, including the employment of Weems Memorial Hospital's CEO and CNO. As a county hospital it is also overseen by the directors of Franklin County Board of County Commissioners, who ensure that the hospital is effectively serving Franklin County (George E. Weems Memorial Hospital).

In October of 2008, hospital administration at George E. Weems Memorial Hospital was contacted by the leaders of University of Florida's Arts in Medicine (AIM) Program at Shands Hospital. Shands Hospital recognized that George E. Weems Memorial Hospital would be an ideal location to implement a new model for rural arts in healthcare programs. After discussing the matter with community leaders and community members, Weems Memorial agreed to establish an AIM program, and offered its first arts programming in 2009.

I first contacted Ginny Griner, Director of the Arts in Medicine program at George E. Weems Memorial Hospital on March 15, 2012. In this conversation, I explained the topic of my thesis, and asked to set up a full interview at her earliest convenience. This interview was conducted over the phone on March 21, 2012, and lasted a total of 49 minutes. In the interview, I spoke to Ms. Griner and Joe Taylor, the Arts Coordinator of the AIM program.

B. SUMMARY

Below is an analysis of my interview with Ginny Griner and Joe Taylor, leaders of George E. Weems Memorial Hospital's AIM program.

- The Arts in Medicine program was first discussed by the administration of George E. Weems Memorial Hospital, after being approached by leaders of the AIM program at Shands Hospital in October of 2008. Weems Memorial Hospital's administration with Ginny Griner, assessed the Franklin County community and its health care needs, deciding that an AIM program would be beneficial to the hospital and Franklin County community.
- After the initial conversation with leaders of the AIM program at Shands Hospital, the administration of Weems Memorial Hospital, with the assistance of Ginny Griner, hosted

multiple meetings with Franklin County community leaders and community members. These meetings served several purposes:

- To promote and encourage community acceptance of the AIM program in Franklin County.
 - To educate community leaders and businesses on the benefits of an AIM program to the rural, Franklin County community.
 - To garner support and potential partnerships with community health organizations, arts organizations, artists, and musicians.
 - To discuss and promote awareness of the critical health concerns and disparities that are unique to Franklin County.
- During the strategic planning phase of the AIM program and throughout its existence, leaders of the AIM program at Shands Hospital offered guidance and assistance whenever needed.
 - Though George E. Weems Memorial used the AIM program proposed by Shands Hospital as an example, the leaders of Weems Memorial were able to take complete ownership of their program. As Mr. Taylor mentioned, “they didn’t come in and tell us what to do. They came in and offered resources and assistance and let the community come up with what it wanted to do and then kind of helped coach us through the process.”
 - The Arts in Medicine program at George E. Weems Memorial Hospital was initially funded by a partnership grant provided by the University of Florida’s Arts in Medicine program at Shands Hospital and the Florida Division of Cultural Affairs (E). The program is currently still funded in part by the partnership grant, as well as other external grants, private donations, and individual fundraising from current participants in the program. Fundraising to support sustainability of the program was described as a challenge, similar to any nonprofit, but as Mr. Taylor stated, “it’s something that everyone is working on and constantly thinking about.”
 - No monetary support is provided by the George E. Weems Memorial Hospital’s operational revenue. However, indirect support has been provided by the hospital’s administration, such as:
 - Speaking on behalf of the AIM program to other community leaders
 - Writing letters of support for the AIM program
 - Serving on the board of the AIM program
 - Allowing staff members to spend time during the work day on coordination and implementation of the AIM program

- The position of Director of Arts in Medicine was established during the initial planning phase of the AIM program. At the time, Ginny Griner was the Human Resources Director and Medical Staff Affairs Coordinator at George E. Weems Memorial Hospital. She was asked by the hospital to take the lead as the Director of AIM, a title she still holds.
- Ms. Griner's AIM position as Director of Arts in Medicine is not budgeted. She volunteers her time during the hospital work week, splitting her hours between her other two positions. When describing the amount of time she spends on the AIM program she stated, " I probably, because I have such a great coordinator in Joe, and we have great providers in our programs, I probably don't have to spend but about an hour or two a week on the Arts in Medicine program, average."She listed her responsibilities as follows:
 - Acts as the liaison between the hospital and the community. Makes sure the community consistently has a strong awareness of the program and that the program has a presence at important community meetings.
 - Ensures the hospital is working within its legal requirements.
 - Leads the AIM Board of Directors in strategically conceiving and implementing new arts programs for the hospital and community.
 - Keeps the AIM program running effectively, and serving the hospital and community to its fullest capacity.
- Joe Taylor voluntarily acts as the Arts Coordinator for the AIM program. He is also the Executive Director of Franklin's Promise Coalition, a community coalition of Franklin County. He listed his responsibilities as the Arts Coordinator as follows:
 - Coordinates and plans activities and arts programs in the hospital and within the community.
 - Leverages financial support from community organizations when necessary.
 - Investigates opportunities for new partnerships with community organizations.
 - Handles administrative tasks such as email correspondences, creation of promotional posters, representation of the program at health fairs, and the set-up of meetings.
- Ms. Griner stated that she thinks having leadership positions in AIM programs, such as her Director position and Mr. Taylor's Coordinator position, are vital to the sustainability of those programs in the rural healthcare capacity. She also indicated that it is important to have a structured team of individuals, including a board of directors, that will keep the AIM program on track and functioning as it should. In response, Joe emphasized one challenge that AIM programs face in rural settings: finding workers with the time to

devote to the program. “You only have those few people who are hyper-engaged in working on things and usually people are involved on many different levels who are juggling... four or five or sometimes eight different hats.”

- Mr. Taylor discussed a current need for growth in the AIM program’s organizational capacity. He stated that there is much demand in the community for the AIM programs, pointing towards the need for a full-time or part-time budgeted position devoted to the AIM program. “Having capacity and having a designated leader, particularly that would be a part-time or full-time position, based on the need, I think is ultra important.”
- Ms. Griner and Mr. Taylor both felt that extending the AIM program beyond the walls of the hospital and into the community is vital in fulfilling the mission of the AIM program. As Ms. Griner mentioned, “when you get into rural healthcare in rural settings, community involvement is going to be the key to the success of whatever that program is.” Mr. Taylor responded that, “it has been a fairly critical component.”
- Ms. Griner and Mr. Taylor both stated what they believe to be the benefits of the AIM program to the hospital and to the community. Their statements are paraphrased or quoted below:
 - The AIM program can be used as an outreach service to connect health care to community members. Joe Taylor said, “I see these Arts in Medicine programs as a highly effective way to address issues especially in underserved populations because it’s a nonthreatening kind of process. If we can get folks regularly involved in exercise, there is that benefit and it maybe goes far beyond just weight but also dealing with things like depression or hypertension” Mr. Taylor believes that AIM acts as a way to build trust among community members through arts participation. Rather than inviting community members who may be wary of the hospital to a long meeting on diabetes, they are invited to dance classes which may have educational components or address health issues.
 - The art programs offered by AIM can be used as a means to open up conversations with individuals who have difficulties expressing their feelings on uneasy situations. For example, the victims’ advocate for the local sheriff’s department uses the AIM program’s pottery studio when speaking with victims of crime. As Joe stated, “She can get much more productive conversations with a victim while they make a piece of pottery then they can sitting in her office... It’s just a total different setting when their hands our busy and they’re being creative - they communicate much better.”

- With many of the arts programs extending beyond the walls of the hospital, AIM can help build relationships within the community, creating a community that is supportive of and respectful towards each other.
- The AIM program can help improve health outcomes of the community members who have health issues such as diabetes and depression by offering them an opportunity to escape or forget their problems briefly, through art participation. Mr. Taylor states that, “In a way it’s like a treatment even though it’s not clinical...for them to actually come out, learn, and actually participate... they report being a healthier person so to me that’s the strongest connection, is the health benefits for the residents.”
- The AIM program can decrease costs to the county by improving the overall health of the community. As Mr. Taylor said, “If you look at the population, the healthier you can make that population, most likely the less cost it will be to our county for healthcare.” In response to his comment, Ms. Griner had the following to add, “That’s right...we are out there trying to decrease a health risk and improve the health cost for all individuals...it just becomes a healthier environment for everybody, financially too.”

VII. INTERVIEW SECTION – INTERVIEW 2

A. CONTEXT

Sacred Heart Hospital on the Gulf is located on the Northwestern border of Florida, in the city of Port St. Joe. Situated off of highway 71 and less than a mile from Saint Joseph Bay, Sacred Heart Hospital on the Gulf provides healthcare services to the 15,000 residents and visitors of Port St. Joe and the surrounding Gulf County. As listed on Sacred Heart Hospital on the Gulf's website, it is licensed as a 25-bed facility and offers inpatient services, 24-hour emergency care, surgical services, diagnostic and laboratory services, as well as a helipad to be used for rapid transport situations, such as with seriously ill patients and critical traumas.

According to the 2010 U.S Census Bureau report, the largest portion of the Gulf County population is over the age of 65, at 16.3%, with the second largest portion of the population being under the age of 18, at 16.2% (U.S Census Bureau). Gulf County is predominantly white, at 78.1%, with the second largest segment being African Americans, at 18.7% (U.S Census Bureau). At least 77.7% of the population over the age of 25 has received a high school diploma while 13.6% has received a Bachelor's degree or higher (U.S Census Bureau).

According to Sacred Heart Hospital on the Gulf's website, the first Sacred Heart hospital was founded in Pensacola, Florida, by The Daughters of Charity in 1915. Since then, Sacred Heart has branched out into a network of comprehensive healthcare facilities across Northwest Florida, all as part of the Sacred Heart Health System. Sacred Heart Health System is also a member of Ascension Health, the largest Catholic and nonprofit Health System in the nation. Hospitals participating in Ascension Health have similar missions and abide by the Health System's core values, which is stated on Ascension Health's website.

Sacred Heart Hospital on the Gulf is the most recent healthcare structure of the Sacred Heart Health System, first opening its doors in March of 2010. At the head of the hospital's

organizational structure is the President, Roger Hall, who also serves as President at Sacred Heart Hospital on the Emerald Coast. Aside from the President, financial and fiduciary leadership is maintained by the Sacred Heart Health System's Board of Trustees, guided by the hospital's mission.

On March 16, 2012, I spoke to Paulina Pendarvis, Coordinator of the AIM program at Sacred Heart Hospital on the Gulf. In our initial phone conversation, I explained the topic of my thesis and my intention to set up a phone interview. At her request, I emailed Ms. Pendarvis a potential list of questions for the interview, which I mailed a week before the interview date. The phone interview was conducted on March 27, 2012 and lasted 45 minutes.

B. SUMMARY

Below is an analysis to my interview with Paulina Pendarvis, Coordinator of the AIM program at Sacred Heart Hospital on the Gulf.

- Sacred Heart Hospital on the Gulf started its Arts in Medicine program in July of 2010, after it was contacted by the leaders of University of Florida's AIM program at Shands Hospital. The leaders described past examples of AIM programs, discussed current frameworks for AIM programs and then invited the staff of Sacred Heart to attend training sessions at the University of Florida's Center for Arts in Medicine.
- The Arts in Medicine program at Sacred Heart Hospital on the Gulf was initially funded by the University of Florida's Center for Arts in Medicine program. The seed money came from the Kresge Foundation's \$200,000 partnership grant awarded to the University of Florida's Center for Arts in Medicine program and Shands Arts in Medicine's initiative for Arts in Healthcare for Rural Communities. The President of Sacred Heart also helped the AIM program to secure a secondary grant from the University of Florida.

- Further funding for the AIM program is expected to be provided in the following ways:
 - Securing funds from foundations and private donors.
 - Receiving support from a partnership with the Health Department. Ms. Pendarvis stated that, “they have some funding for Wellness Programs and we are hopeful that they will be able to fund our programs throughout the rest of the year.”

- The framework for the AIM program at Sacred Heart Hospital was loosely based around the George E. Weems model. Originally, the AIM program was to have two overseeing committees, an internal committee and a committee in the community. After holding two meetings, it was apparent that their AIM program was not yet at a point to need such oversight. Ms. Pendarvis stated, “it become pretty apparent that that really was not a very functional model at the time for us. So we’ve kind of regrouped or I guess I’ve regrouped and I’m trying to let things happen a little more organically.”

- The first arts programming offered by Sacred Heart’s AIM program were Wellness-focused, contemplative art classes such as yoga, tai chi, and zumba which were offered in the community. In deciding on the beginning programs, Ms. Pendarvis stated she was looking for, “Something that would appeal to broad audiences, not just to throw it out there and see if anybody bit, so to speak.” Other programs include:
 - A relaxation station for employees, equipped with two massage chairs, an assortment of hot teas, a film projector with calming images, and soothing music.
 - Exhibitions of the art work of volunteers at the hospital.
 - Knitting and crocheting classes led by volunteers as part of a Bedside Art program.

- Hosting an annual art exhibit in the community, which was titled “Portrait of Spirit: One Story at a Time” in 2012, which documented the 1996 Special Olympics in Atlanta.
- The arts programming provided by Sacred Heart Hospital on the Gulf are free to the patients and community members. Ms. Pendarvis stated that the goal of the AIM program was not to produce income, and that adding costs becomes a barrier to participants. “It’s a barrier not just for those that can’t afford it but also for those that can... The goal of the program in actuality is to provide people with a better sense of physical and mental health.”
- Before the AIM program was implemented at Sacred Heart Hospital on the Gulf, the hospital did take genuine care in placing distinctive artwork throughout the facility that represents the culture of Gulf County. At least 38 local photographs and additional pieces donated by staff members from the community, line the walls of the hospital. Sacred Heart also has a 24 piece art collection, donated by a local artist in an impressionistic style called Plein Air, which is worth at least \$45,000.
-
- Ms. Pendarvis stated that the AIM arts programming helps the hospital comply with the standards of the Swing-Bed program of Medicaid and Medicare services. She said that we “have to include some kind of activity for the patients. For us, we’ve been able to utilize the Arts in Medicine program to help build part of that need.”
- The Coordinator position for the AIM program at Sacred Heart Hospital on the Gulf was established after Sacred Heart’s initial conversation with the leaders of the University of Florida’s AIM program at Shands Hospital. At that time, Ms. Pendarvis was the Volunteer Coordinator for the hospital, and after being approached by Shands Hospital, she became the Coordinator for the AIM program as well. She mentioned it was common for the staff of AIM programs in rural locations to be obtained from preexisting employees in the hospital, as staffing is always a challenge. “Typically Arts in Medicine

programs, for rural hospitals in any case, are developed by using existing personnel and volunteers from the community.”

- Ms. Pendarvis has numerous job titles and responsibilities at Sacred Heart Hospital on the Gulf. Her positions and areas of work include Coordinator for the AIM program, acting as a grant seeker, leader of Volunteer Services, serving as a Physician Liaison, as well as working in Marketing, Public Relations, and staying in charge of community events. She splits her time among all her positions in the hospital, often working 60 hour weeks, depending on the need. Her responsibilities as Coordinator for the AIM program are as follows:
 - Coordinating all arts programming and activities for Sacred Heart Hospital on the Gulf and the Gulf County community.
 - Securing funds for the AIM program.
 - Overseeing and enforcing brand management for the AIM program.
 - Establishing AIM collaborations with other healthcare providers in the community.
 - Ensuring that contracted artists are paid on time.
 - Hiring and training volunteers for AIM program events.

- When asked about the potential for rural hospitals to hire full-time arts coordinators, Ms. Pendarvis stated that in her opinion, hiring a full-time, budgeted position for an AIM program would be unlikely. She mentioned that the monetary constraints of most rural hospitals serve as a major barrier to create and support another full-time position. As she said, “A lot of rural hospitals are going under so the likelihood of them hiring someone specifically for something that’s non-billable is extremely unlikely.”

- Ms. Pendarvis stated that health issues common in most rural communities such as diabetes, heart disease, and cancer can potentially be decreased by activities and the opportunities for socialization in the community. She also said, “being able to provide

something beyond the walls [of the hospital] has a huge impact on who comes in our front door. It has a huge impact on the economic viability of our community which affects the hospital drastically.”

VIII. INTERVIEW SECTION – INTERVIEW 3

A. CONTEXT

As described by the City of Marianna’s website, Jackson Hospital is located in southern Florida, and provides medical care to the small city of Marianna, also known as “The City of Southern Charms”. Residents of Marianna as well as community members of Jackson County, look to Jackson Hospital for quality healthcare services. Jackson Hospital’s website states that it is a 100-bed facility, provides 24-hour emergency care, primary care, and medical specialties, as well as inpatient and outpatient services such as Orthopedic, Gynecological, labor and delivery, and Urological care.

According to the most recent population estimates completed by the U.S Census Bureau, Marianna city contained 6,102 residents in 2010. The largest segment of Marianna’s population, at 24.8%, were under the age of 18, with the second largest segment being over the age of 65, at 17.7% (U.S Census Bureau). The race demographics of Marianna residents in 2010 were 53.3% white and 42.0% African American (U.S Census Bureau). At least 72.9% of residents over the age of 25 were high school graduates, with 17.4% having received a Bachelor’s degree or graduate education (U.S Census Bureau).

As stated on its website, Jackson Hospital is managed by the Jackson Hospital Corporation, a nonprofit corporation “created by special act of the Legislature of the State of Florida in 1939...[it] is governed and managed by nine, Governor appointed, Board of Trustees, each member serves four year terms and ensures that Jackson Hospital fully represents its outlined mission, vision, and core values.” The Board of Trustees also makes certain that the hospital is operating within the terms of the 1939 Act and its amendments.

On March 23, 2012, I contacted Rosie Smith, Program Administrator of the Arts-in-Healthcare program at Jackson Hospital to schedule an interview. I mentioned that I was interested in speaking with a representative of the hospital because the Arts-in-Healthcare program was the

most recent rural arts in healthcare model to be implemented with the help of the University of Florida. I stated that it would be valuable and insightful to acquire information from a young program that had just started its first arts programming. Upon scheduling a date and time, the interview was conducted on March 30, 2012 and lasted a total of 19 minutes.

B. SUMMARY

The following is an analysis of my interview with Rosie Smith, Program Administrator of the Arts-in-Healthcare program at Jackson Hospital.

- The initial outreach to start an arts in healthcare program at Jackson Hospital came from Chris Sullivan, an employee of the University of Florida, in November of 2011. He was well-informed on the numerous rural hospitals in Florida that, “might be good program implementers to continue the spread of arts and medicine in the Pan Handle area,” as stated by Ms. Smith. Soon thereafter, key employees of the hospital, such as Rosie Smith, who was the Director of Public Relations and Marketing, as well as the Director of Infection Control and Employee Health, and Director of Nursing, met at Calhoun Liberty Hospital to learn more about its already established AIM program. Next, the key employees met with Chris Sullivan and another University of Florida individual to decide if an arts in healthcare program was feasible for the Jackson Hospital.
- Before agreeing to start the Arts-in-Healthcare program at Jackson Hospital, key issues had to be considered:
 - Infection control issues.
 - Health Insurance Portability and Accountability (HIPAA) concerns.
 - Ensuring that artists and volunteers were adequately screened and trained to work in the hospital.
- Jackson Hospital had already implemented one arts program in the hospital’s environment - a Pet Therapy program. Ms. Smith stated, “we thought the arts in medicine would be kind of a continuation of our program to provide alternatives to patients in the hospital.” The program is still run by a trusted individual from the community, who

brings a trained dog to the hospital, and visits any inpatients or outpatients that enjoy the presence and company of the dog.

- In the strategic planning phase of the Arts-in-Healthcare program at Jackson Hospital, the key employees discussed the type of arts programming that the hospital should offer as its first program. Topics addressed in their strategic planning are as follows:
 - They wanted to determine the best setting and area of the hospital that would benefit the most from an arts program.
 - They initially wanted to offer an arts program to pediatric patients, but soon realized that their inpatient pediatric population was not large enough to justify a targeted program.
 - After much thought, the key employees decided that the hospital's outpatient chemotherapy setting would see the most benefit from an arts program. As Ms. Smith mentioned, patients undergoing outpatient chemotherapy at Jackson Hospital are often visit the facility on consecutive days. The chemotherapy sessions were described as inclusive, with patients openly talking and encouraging each other. The key employees felt that this was an ideal setting for open art sessions, which involve a sense of community and group effort.

- Jackson Hospital's first Arts-in-Healthcare program began on March 14, 2012, five months after being approached by the University of Florida. As planned, the arts program was implemented in the outpatient chemotherapy setting, where patients completed watercolor and pencil drawings under the guidance of two artists-in-residence of the program. Currently, the program is free of charge and offered from 9am-10am, every-other Wednesday.

- Benefits from the first program have already been noted, such as the decrease in hypertension in a participating chemotherapy patient. Ms. Smith stated, "they measured her blood pressure before she started her artwork and after she started her artwork and

there was a significant reduction. That kind of really crystallized for us that it is a calming influence while individuals are receiving chemotherapy treatment.”

- A formalized administrative hierarchy has yet to be implemented for the Arts-in-Healthcare program, as it is still in its “infancy,” as stated by Ms. Smith. However, the University of Florida continues to support the Arts-in-Healthcare program by offering strategic planning and advising on programmatic growth. In reference to the University of Florida, Ms. Smith said, “they are extremely supportive in helping to make sure we are on the right track and so we’ve been leaning pretty heavily on them to make sure we are going in the right direction.” Both parties meet via conference call every few months and Jackson Hospital plans to participate in the 2012 summer Arts-in-Healthcare session hosted at the University of Florida.
- The Arts-in-Healthcare program at Jackson Hospital was initially funded by the University of Florida. Those funds came from a Kresge Foundation grant awarded to the University of Florida for its efforts in implementing arts in healthcare programs in rural communities across the Florida panhandle. To remain sustainable, Jackson Hospital will seek external private funds as well as foundation grants.
- Ms. Smith stated that the Arts-in-Healthcare program plans to eventually offer more arts programs inside the hospital. She has begun to consider settings for the potential programs, saying, “we have one floor which would probably be the best floor, and that floor is where we do our pet therapy and that’s on our Medical-Surgical floor.”
- The Arts-in-Healthcare program also plans to extend its arts programming into the community of Jackson County. Ms. Smith said that she and other key employees at Jackson Hospital have been working out ways to obtain the resources from the community, such as:
 - Talking to the program’s current artist-in-residence, who has contacts in the fine arts program at Chipola College and the local arts community.

- Contacting the Chipola Regional Arts Association to discuss the best approaches in offering arts and healthcare programs in the community.
 - Showcasing the artwork created by patients at community events, like Sunday Afternoon at the Arts, to demonstrate the benefits of the program.
- Ms. Smith works in the Jackson Hospital as both the Director of Public Relations and Marketing, and the Program Administrator of the Arts-in-Healthcare program. Originally there was another staff member, the Director of Employee Health, who co-administrated the Arts-in-Healthcare program. That employee moved into another position, leaving Ms. Smith as the sole administrator. Ms. Smith's responsibilities as Program Administrator are as follows:
- Ensuring paperwork is completed properly in accordance to Florida law.
 - Fulfilling administrative duties such as managing and overseeing budgets, and paying artists and other contracted workers.
 - Working with artists to ensure that they are content, and that grant protocols are being fulfilled.
- In reference to the possibility of budgeted positions in the Arts-in-Healthcare program, Ms. Smith said the following:
- “We have a budget cycle that follows the federal government so I think that it will really be determined by the hospital's success, its profitability. You know we are a nonprofit hospital but you still have to make your margins to stay in business and I think that as the hospital gets more successful by offering programs like this, I think it will make it a much easier business proposition.”

IX. INTERVIEW SECTION – INTERVIEW 4

A. CONTEXT

The Immokalee community is located in southern Florida and is considered a census-designated place (CDP)⁴, as listed on the Collier County’s website. An unincorporated area of Collier County, Immokalee is a highly agricultural site with one primary highway, State Road 29, running through the area. According to the 2010 U.S Census Bureau’s Quick Facts, Immokalee encompasses 22.7 square miles and is populated with 24,154 people.

The largest age segment of the Immokalee population, 33.7%, is under the age of 18, and the second largest, 10.7%, is under the age of five (U.S Census Bureau). Of the Immokalee’s race demographics, 43.2% of the population reported being white, and the second largest segment of the population, 18.9%, reported being African American (U.S Census Bureau). At least 46.7% of the population reported that they were born in a foreign country, and 75.6% reported that they were of Hispanic or Latino origin (U.S Census Bureau). 84% of the population over the age of five speak a language other than English in their home (U.S Census Bureau). 29.7% of the population over the age of 25 have earned a high school degree, and 3.9% have received a Bachelor’s degree or higher (U.S Census Bureau).

The Immokalee community is the most recent rural community in Florida to be chosen by the Shands Hospital AIM program, the University of Florida Center for Arts in Healthcare, and the State of Florida Division for Cultural Affairs as an ideal community for which to establish an

⁴ “CDPs are statistical geographic entities representing closely settled, unincorporated communities that are locally recognized and identified by name. They are the statistical equivalents of incorporated places, with the primary differences being the lack of both a legally-defined boundary and an active, functioning governmental structure, chartered by the state and administered by elected officials.” (Census Designated Place(CDP) Program for the 2010 Census –Final Criteria, *Federal Register*, February 13, 2008 (Volume 73, Number 30, accessed April 20, 2012.)

Arts in Medicine program. The Immokalee Arts in Medicine leaders hope to provide arts programming that can decrease the healthcare concerns of the community.

On March 29, 2012, I contacted Javier Rosado through an email correspondence to attempt to schedule an interview. In the initial email, I provided information on the purpose of the interview, mentioned the other interviewees with whom I had already spoken, and offered to send a list of interview questions if needed. After two email correspondences, we were able to set an interview, for April 3, 2012. The interview lasted a total of 12 minutes and 55 seconds.

B. SUMMARY

Below is an analysis of my interview with Javier Rosado, Program Coordinator for the Arts in Healthcare program for the Immokalee community.

- The Arts in Healthcare program for the Immokalee community was initiated by the University of Florida Center for Arts in Healthcare (CAHRE). Leaders from the University of Florida CAHRE had previously toured rural communities in Florida, and determined Immokalee as a potential location for a rural arts in healthcare program. In October of 2011, they approached Mr. Rosado and his colleagues, who were working with the Florida State University College of Medicine and the Healthcare Network of Southwest Florida, a nonprofit community center. After some discussion, it was agreed that a new arts in healthcare program would be integrated into the Immokalee community.
- After agreeing to implement a new Arts in Healthcare program in Immokalee, Mr. Rosado and his colleagues organized a meeting with community members to educate those interested on the benefits of the program, and to acquire members for the program's steering committee. Mr. Rosado felt that the meeting primarily accomplished the following:
 - Promoted the awareness that the program would be centered in the community, and would not be restricted to a healthcare facility.

- Succeeded in acquiring members for the steering committee, which is made up of artists, community leaders, and community members.
- The University of Florida provided funding to the Immokalee Arts in Healthcare program, which came from the \$200,000 Kresge Foundation grant, awarded to the University of Florida to further its initiative for arts and healthcare programs in rural communities. Mr. Rosado is optimistic that the arts programs will prove to be cost effective, and will in turn encourage other healthcare administrators to both see the importance of such a program, and perhaps contribute monetarily. As Mr. Rosado stated, “we hope that we can use the results from the seed money to get a little bit more buy-in from [the healthcare administrators].”
- Though the only current funding comes from the University of Florida, both the Healthcare Network of Southwest Florida and the Florida State College of Medicine, have donated indirectly, by means such as:
 - Providing the use of office materials and building space.
 - Allowing current employees of both facilities to attend program functions, such as steering committee meetings, during normal working hours.
- The Arts in Healthcare program in the Immokalee community also plans to seek additional funding by establishing its own fundraising efforts for private funds, as well as applying for external grants from organizations such as the Florida Division of Cultural Affairs.
- Mr. Rosado stated that the Arts in Healthcare program in Immokalee is currently in a planning phase and they are trying to develop long-term programs. A few programs have already been implemented, which focus primarily on healthcare workers, but include various one-time events. The programs are as follows:
 - An ongoing contemplative arts program providing Zumba classes to healthcare workers, located at the main healthcare facility in Collier.

- A relaxation station for employees and behavioral health patients at the main healthcare facility.
 - An annual health fair in partnership with the Department of Health and the Florida State College of Law, incorporating arts programming into healthcare screenings.
- Though Mr. Rosado fills the role of Program Coordinator, Florida State University currently manages and directs the Arts in Healthcare program in Immokalee. Mr. Rosado acts as a point of contact for the University, and directs the steering committee.
 - Mr. Rosado believes that the Arts in Healthcare program will benefit the community by increasing access to healthcare, and improving literacy on healthcare. As he stated:
 - “I think that arts programming can...help to take the medical care and medical information outside of the clinic walls because we have a lot of people that wouldn’t necessarily come into the clinic.”
 - “We live in a community where there is very little information available, however, we’re a cultural rich community, I think. If we can somehow combine that culture with the medical care and medical information that they need, I think it would be more of a benefit to the community.”

X. CONCLUSION

It is evident that the scope of my thesis took a different direction than originally planned; however, I am content with the shift in focus, and feel this change in direction was necessary. When I first proposed my research question, I was intent on proving that arts administrators are vital to the integration of arts programming in rural hospitals. Though leadership was indeed shown to be integral to the success of rural arts programming, after speaking with rural arts directors and program coordinators, I found myself faced with other, broader issues that demanded my attention. From my two conducted methodologies - a survey and four interviews - I was able to collect informative data regarding arts programming in rural hospitals and the community.

A. INTERVIEWS

It is apparent that the foundation for and creation of the AIM and Arts in Healthcare programs, at all four locations, came from the funding and support of the University of Florida's Center for the Arts in Medicine. A generous grant from the Kresge Foundation, as well as funding from the Florida Division of Cultural Affairs, allowed the University of Florida to spread its Arts in Healthcare in Rural Communities initiative to George E. Weems Memorial Hospital, Sacred Heart Hospital on the Gulf, Jackson Hospital, and the Immokalee community. Based on my interviews, the initiative has had great success, creating AIM and Arts in Healthcare models in nine rural locations in Florida, and potentially extending to more locations in the future.

One factor that seemed crucial for the successful founding of the AIM and Arts in Healthcare programs was an understanding of each community's unique health needs. Three of the four

interviewees stated that they had held community meetings before the implementation of their arts programming both to garner community support, and to determine the prevalent health concerns of their communities. All interviewees were able to quickly articulate the predominant health concerns of their own communities. That knowledge proved to be vital, as it helped the directors and coordinators to implement the best programs to match their community's particular health concerns. For example, George E. Weems Memorial hospital uses movement and pottery classes to focus on depression and hypertension. Jackson Hospital discovered that since their hospital community contained more oncology patients than pediatric patients, it would be more advantageous to offer its first visual arts program to the outpatient chemotherapy center.

Based on the four interviews with the directors and coordinators of the AIM and Arts in Healthcare programs, it was evident that the presence of a leader was imperative for the successful implementation and general longevity of those programs. Each program had one primary leader who, from the very beginning of the program, was responsible for strategic oversight and planning. Their ability to communicate the importance of arts in healthcare to their communities, effectively collaborate with external organizations and businesses, as well as recognize the useful arts resources in their communities have enabled each of them to keep their programs sustainable. As Ginny Griner stated, "... if you don't have people in place who are structured and focused then it's likely that you'll have a program that could run astray."

Another common element apparent in all four locations was the extension of arts programming into the communities, beyond the confines of the healthcare facilities. Not only were art activities offered within the hospital, but interviewees discussed how their arts activities were also provided at locations such as community centers, art and health fairs, and other public areas. If the AIM and Arts and Healthcare programs are capable of reaching a larger portion of their communities, then the programs' missions to improve the overall health of their communities, will have a greater impact. As it was stated by Ginny Griner, AIM Director for George E. Weems Memorial Hospital, "when you get into rural healthcare

in rural settings, community involvement is going to be the key to the success of whatever that program is.”

According to the interviewees, offering arts programs outside of healthcare facilities can improve a community’s access to healthcare services and healthcare education. It is common for rural residents to avoid hospitals, which are sometimes viewed as threatening or unfamiliar. Avoidance of hospitals and overall inattention to preventative healthcare can lead to an unhealthier community that lacks the knowledge to improve treatable conditions or prevent certain diseases and conditions from worsening. Arts programming can serve as a nonthreatening means to teach communities about healthier living habits as well as create a more trusting relationship between hospitals and their communities.

Arts programming integrated into the hospital environment, however, is also beneficial to rural hospitals in a number of ways. It can help rural hospitals participating in Swing-Bed programs to fulfill certain requirements of participation. Swing-Bed programs require a certain amount of therapy for recovering patients, and in most cases, arts interaction such as bed-side arts participation can serve that role. Paulina Pendarvis, Coordinator for the AIM program at Sacred Heart Hospital on the Gulf, stated that “we’ve been able to utilize the Arts in Medicine program to help build part of that need [to include some kind of activity for the patients].”

As was previously mentioned, arts programming in the community can also help create stronger connections with community members, improving the overall health of the community. This allows the hospital to better accomplish its mission, and can ultimately reduce costs for the hospital. According to Ginny Griner, “we are out there trying to decrease a health risk and improve the health cost for all individuals...it just becomes a healthier environment for everybody, financially too.”

B. SURVEY

The other body of research for this thesis came from a survey administered to 25 rural hospital locations, primarily from the states of Pennsylvania, Oregon, California, Nevada, South Carolina, and Oklahoma. Though the survey had a limited sample size, it proved multiple points. Data collected from the survey demonstrated that there is a lack of arts programming in rural hospitals. Eight out of thirteen hospitals that responded to the survey stated their hospitals did not contain any arts programming.

Additionally, the survey enumerated the most common barriers to implementing arts programming into the rural hospital environment. The three top reasons were financial limitations, limited knowledge on how to implement arts programming, and limited time to devote to arts programming. This demonstrates that if arts programming could be implemented with no or limited cost to rural hospitals, such as by external funding, those hospitals may be more willing to consider arts programming.

Finally, five of the hospitals surveyed stated that they did in fact have arts programming in their facility. The most common was the use of musicians in designated locations throughout the hospital. The second and third most common were healing gardens in the facility, and the use of creative therapists, such as music, art, and movement therapists. It is possible that these art programs are being used because they are the easiest to coordinate and implement within a rural hospital.

C. DIRECTIONS FOR FUTURE RESEARCH

While completing this thesis, it became evident that arts programming in rural hospitals and rural communities is an area that desperately requires more in-depth research. The collection of more data regarding arts programming in rural healthcare settings could better demonstrate the importance and benefits of such arts programming. This, in turn, could lead to the widespread acceptance of arts programming by rural hospital administrators, increasing the number of rural hospitals and rural communities across the nation with arts in healthcare programming.

Potential areas of research on rural arts in healthcare programs are as follows:

- A vast survey of all rural hospitals across the United States – segmented by number of patient beds and facility settings - that have implemented arts programming into the hospital environment. This would help demonstrate the most common types of arts programs used by rural hospitals therefore showing the kinds of programs that are more accessible and easiest for rural hospitals to implement.
- A more in-depth research study that examines rural arts in healthcare programs in locations other than Florida. Though I had great difficulties in finding such programs, it would be beneficial to learn about the implementation of other arts in healthcare programs that were not initiated by the funding of the University of Florida. Potentially, these programs could be compared to the rural arts in healthcare programs in Florida for similarities in implementation.
- A continued study on the rural AIM and Arts in Healthcare programs used in this thesis, documenting the sustainability of the programs a few years in the future. A primary factor that led to the successful implementation of the four arts in healthcare programs was the seed money provided by the University of Florida. It would be beneficial to see the funding mechanisms used to sustain the programs after the University of Florida funding was eliminated.

APPENDICES

APPENDIX A
SURVEY COVER LETTER

Dear Hospital Administrator:

I am a graduate student at Drexel University completing my Master's degree in Arts Administration. I have reached the final stage of my degree, and am finishing research for my thesis on the topic of Arts in Healthcare in rural hospitals.

You were selected to participate in this survey because of your hospital's rural location as well as its capacity of 50 or fewer beds. At least 25 hospital administrators with equivalent characteristics will be contacted to participate.

At the bottom of this email you will find a hyperlink to a brief, 10 minute survey, composed of six simple questions. The purpose of the survey is to collect information on arts programming and arts administrators in rural hospitals. It will only take a moment of your time, and will provide invaluable information for an area of research that has often been overlooked. Only people involved with my research will have access to your survey results and any sensitive information will be kept confidential.

Please click on the link below to navigate yourself to the quick survey. Thank you for your cooperation and please feel free to contact me if you would like a finalized copy of my thesis!

APPENDIX B

ONLINE SURVEY INSTRUMENT

- 1) Does your hospital provide arts programs for its patients and/or staff?
 Yes No

- 2) If you answered No to question 1, please indicate the reason(s) why?
 Did not know that the arts can be used in hospitals
 Financial limitations
 Unsure of how to implement such programs
 Hospital staff does not have any arts expertise
 Do not have time to devote towards creating arts programs
 Do not see the purpose or benefit of arts programs in healthcare
 Other...please explain in the space below

- 3) If you answered yes to question 1, please indicate the type of arts programming listed below.
 Music/Art/Creative Therapists working with patients
 Musicians performing for patients and staff in hospital spaces
 Visual artists helping patients create arts and crafts projects
 Hospital has a healing garden
 An Arts Administrator coordinates the hospital's arts activities
 Other...please explain in the space below

- 4) In the future, would your hospital consider hiring an Arts Administrator to coordinate and implement arts programming into the hospital environment?
 Yes
 Maybe
 No

- 5) What would be necessary for your hospital to hire an Arts Administrator?

- Funding from an external organization to support the administrator's salary
- Proof that hiring an Arts Administrator would benefit the hospital's patients and staff
- Proof that hiring an Arts Administrator could lead to cost containment for the hospital
- Examples of other rural hospitals that have hired Arts Administrators on staff
- Other...please explain in the space below:

6) Please provide any additional comments in the space below:

APPENDIX C

TRANSCRIBED INTERVIEW 1 (WEEMS ARTS IN MEDICINE LEADERS)

Lauren: How long has Weems Memorial Hospital had a Director for its Arts in Medicine Program? Was it created from the beginning or was it a position that was adapted?

Ginny: Actually when Shands came down, we began the Arts in Medicine program, which was back in 2008, when they had their initial visit with us. There was not an individual who was hired to be the Arts in Medicine director. We multi-tasked in our community and most rural communities do, and our administrator recognized that we have a need for this kind of program to be in our community. Our whole concept started out of that initial conversation with Shands, as not containing the Arts in Medicine program for Weems within the confines of the hospital. We wanted to reach out beyond that. I guess at some point in time shortly thereafter, I was knighted, and given the distinction, the designation of the Director. It's not a budgeted position, I voluntarily give-up my time, but the hospital so graciously allowed me to work on Arts in Medicine, the program, while I'm here at work.

Lauren: Are you considered full-time with this position or are you splitting your time as the HR Coordinator as well as the director of the arts program?

Ginny: No, my position as the Arts in Medicine Director would not be considered full-time. Not only do I do the HR directing but Medical Staff Affairs Coordinator too. So to give you the nuts and bolts, probably Arts in Medicine, we come into situations when it takes more than the 8 hours a day...I probably, because I have such a great coordinator in Joe, and we have great providers in our programs, I probably don't have to spend but about an hour or two a week on the Arts in Medicine program, average.

Lauren: You sound like a busy person, in general.

Ginny: It's just the nature of working in rural health, a rural community, period.

Lauren: Before the Arts in Medicine program was implemented into Weems Memorial Hospital was there any arts programming that was offered to the patients or staff?

Ginny: No, what we had, what we participated in the Center for Medicaid and Medicare Services called a Swing-Bed Program, the hospital has a certificate, a license to participate in that program. Part of that program, there are certain components in a clinical nature and it covers clinical therapy, or physical therapy, or speech therapy, that are required. That was one of the things we felt like we could offer as we are generally not a long-term facility, except for the swing-bed stay. We felt the Arts in Medicine program could benefit the patients in that stage, during the swing-bed stay. We are a critical access hospital and we average about 5 patients a day in our facility. If our patient volume were up, to 15 or 20 and 5 or 6 were clean-bed, then probably we would be in a need for our Arts in Medicine program to try and hire a part-time or full-time Arts in Medicine Director, dedicated to that role. Because so much of our program is outside the walls of the hospital, in fact all of them are at this point in time, we do very few bedside art right now, it doesn't require a lot of my time, because we have great providers and a coordinator.

Lauren: Do you think that that is important in a rural location to have arts programs in the hospital but to also extend those to the community, that community element is very vital?

Ginny: I will let Joe speak to that also, but I wanted to tell you that when you get into rural healthcare in rural settings, community involvement is going to be the key to the success of whatever that program is. So to answer your question from my side, absolutely. You need to be involved in the community and you need those individuals who can reach out to their own section or parts of the community to make it successful. Joe can tell you about that because he has coordinated those kinds of things.

Joe: Personally I believe for our community, I don't know about other communities, but those like ours, it has been a fairly critical component. I don't know if you are familiar with the Asset Based Community Development kind of principle, but essentially, even if you have a strong medical facility you don't necessarily have a healthy population. They have to use it and become comfortable with it and get exposed to it. I always saw this as a tool for our hospital to be seen as a caring institution about the general health of the community, so to me it's really much more of an outreach program as much as it is a direct service for those individuals who participate. What we see is a lot of relationship building in many cases going throughout the community and to me that creates a healthy community. And specifically the courses that we do, the results, give us strong relationships and many times people who may not have actually been involved and encountered the hospital in other situations, have become more familiar with the program or services of it. And you know in a small community of less than 12,000 people, feeling comfortable and knowledgeable and supportive about you, if

you're a medical institution it's important, or it was to me. So I think there's that community outreach, that relationship building, that is a really important component of that. Now I can tell you as well, as on a personal level, I've seen and we have validated the benefits of programs. Especially the movement and pottery program, as far as really focusing on those with depression or hypertension, so there's that personal benefit but I also think there's that greater community benefit of relationship building and/as that outreach element for the hospital. So I felt like being outside these walls was very important for our hospital for that (this) point in time.

Lauren: Since you were speaking a little bit on benefits, what benefits does the hospital see from your Arts in Medicine program? Are you focusing on the hospital benefits but the community benefits as well?

Joe: Well, from what I understand when I read our hospital's mission statement it is that direct responsibility for the health care of the people within our county. So if we can get folks regularly involved in exercise, there is that benefit and it maybe goes far beyond just weight but also dealing with things like depression or hypertension. Especially if we've been through these last few years with challenges in the community ranging from the ??? or the economy. We've read a lot of reports about how important it was for their physical and mental kinds of conditions or well-being. So I think we directly support that element for the hospital.

Lauren: So you think it helps to improve the quality of life...

Joe: I think it helps improve and even though it may be small, it improves health outcomes. Because to me those two things are a little different. Quality of life is wonderful but I think it goes a little bit deeper than that and especially if you have a person maybe dealing with diabetes or you may be dealing with depression. Having these tools available in a very kind of open, giving, kind of nonjudgmental atmosphere. You don't have to come to the hospital, to get that moment of, not really therapy but just that moment of escape. In a way it's like a treatment even though it's not clinical. But for them to actually come out, learn, and actually participate, maybe escape their problems for an hour. For me they actually end up being healthier. They report being a healthier person so to me that's the strongest connection, is the health benefits for the residents. That's how we support the hospital mission-wise and I think then there are a lot of secondary benefits. What we do is create relationships and go out and meet them in the community and we may meet them other times for other purposes. It might mean we set up tables and chairs at a health fair, and so we have a volunteer base. Or we may have a need to be, at a health fair and a Zumba class represents what we're doing. So that relationship that's established through these programs and services for the hospital,

they have a volunteer support base to some degree because people can connect it to the product.

Lauren: That all makes so much sense and it wasn't really something I was thinking of in terms of the rural hospital also playing the community role and helping to improve the healthcare of those within the community.

Joe: If you look at the population, the healthier you can make that population, most likely the less cost it will be to our county for healthcare.

Ginny: That's right, because it knows no economic boundaries. We are out there trying to decrease a health risk and improve the health cost for all individuals. So when your immigrant population is high, which it is in Franklin County, then to improve on that, you still need healthcare, obviously, emergencies happen, and you need primary care, things of that nature, it just becomes a healthier environment for everybody, financially too.

Lauren: How are you all able to financially sustain your program, is it part of the hospital's operational funds that goes towards support or do you have to look for external support, in the sense of grants?

Joe: I think it's a combination of some local donations, some amount of fundraising from the participants and then mostly grant support from outside...and are you actually familiar that we serve as a role model to Florida?

Lauren: Yes, actually when I was speaking with Ginny last week she mentioned that and I looked on your website and discovered that as well through there.

Joe: So that again helps us have some support, but sustainability as far as funding in a world where funding is shrinking is probably the biggest challenge for any programs. But it's something that everyone is working on and constantly thinking about.

Lauren: Does the CEO of your hospital play any part in the programming that you have? I didn't know if he takes on any sort of fundraising role?

Ginny: Actually our CEO... we have changed administrators on two occasions since the implementation of our program, and they have all been very supportive of the Arts in Medicine Program. They do step up to the plate when we go into areas where the place of the hospital needs to be noted they have been very supportive in writing letters of support for our programs, so yes, very supportive. Our current bylaws of our Arts in Medicine Board, actually has a spot on the membership for the board for the CEO. We also have a membership spot for the Chief Nursing Officer recognizing again that

helping the community is important and the Arts in Medicine Director. So those are two spots actually that are included in our Board of Directors for the Arts in Medicine Program. So yes the hospital administrator and the hospital community are very supportive of the program.

Lauren: How much strategy and planning went into creating the Arts in Medicine Program before it was actually implemented? I was curious how long discussions occurred before it was actually started within the hospital's facility?

Ginny: We probably started to have discussions, I want to say about the October timeframe of 2008 and then probably it was a year the next fall before we actually started having programs, and developing what are needs were within the community, and coordinating activities for our bedside art standpoint. A lot of planning and thought, because this was a situation where SHANDS came in, there was not anybody else who was doing it and so we had to think differently than the other programs that had been established at other facilities. We had to get a community base, build those community partners. Initially what we did on two separate occasions we brought in community leaders and businesses, to have an informational. I would say when SHANDS walked in that day and said we'd like to talk to you about the Arts in Medicine Program, the Chief Nursing Officer forgot to tell me that they were coming. I knew about 5 or 10 minutes before they walked in the door, I looked at them like they fell off the planet because I had no idea what that kind of program was. So we had to take that same concept out into our community leaders to let them know what this kind of program could be for this county, for the healthcare, for the hospital, and to other healthcare providers. And then we turned around and we had a call to artists. We fortunately live in a community, and a lot of small rural communities are this way, where you are blessed with a variety of individuals. And to pick for the art standpoint, we had a boatload, a number of diverse artistic talent that are here. So you want to get those people because it is art in healthcare after all, you want to get those people involved and encouraged to participate because ultimately some of those individuals are going to become providers in the program. So we had those two major get-togethers in that first year trying to get some general educational information out about the program and trying to get them to be providers with us, absolutely.

Lauren: It sounds like a lot of work, but very meaningful work.

Lauren: Could you both briefly describe some of the responsibilities of both of your positions?

Ginny: I do what Joe tells me to do. {laughs}

Joe: Here's what I see from Ginny. Ginny's our liaison, our connection with the hospital. She makes sure our program is operated with integrity, that we match all of the legal requirements, and all of the crossing the t's and dotting the i's that have to happen to represent the hospital as an institution and as a county facility. So she helps make sure that those things are done and I think the biggest thing is that she serves the role of helping us strategically assess what we need to do and what decisions we need to make as a board and she makes sure we meet all of that criteria that we need to do so that we can appropriately perform the services as an Arts in Medicine program. Ginny helps us as well, as a public face. She helps us attend certain meetings and go to certain activities and check in and just represent the program we speak for. She is for and with us on many indications because she herself is also an artist. She is that kind of public presence, and administratively she keeps us within the parameters of what we're supposed to be doing. You know, for a community driven program, that's a big chore because you are empowering different people to do different things and to some degree you are either having to encourage or sometimes pull people back to make sure we are staying on track and on task. So I think it's a challenge, is that fair?

Ginny: That's very fair.

Lauren: So you (Joe), your role, do you work internally within the hospital?

Joe: No, I'm just a volunteer and I send out emails and set up tables and make posters and make sure the PA system is where it's supposed to be and try to get out and pre-establish where we are going to do what. I try to get the foot-work done and then Ginny follows through with the details and the official work.

Ginny: He's being very gracious there, Lauren, because he does the foot-work and he coordinates. His actual role title is the coordinator, the Arts in Medicine Coordinator and he lets me know also when there are areas where Arts in Medicine needs to have a presence and helps to coordinate activities. He's also the one that's very involved with a lot of community based programs throughout our county and so he knows when opportunities may present themselves to facilitate new partners whether it be from a programmatic standpoint or a financial, and it takes that. It takes going out into the community to see what's there, what's needed and honestly what can be provided through the program.

Lauren: Do you think having these leadership positions is vital for the arts programs to stay sustainable in the rural healthcare capacity?

Ginny: Yes, if you don't have people in place who are structured and focused then it's likely that you'll have a program that could run amuck. So, yes. You do have to have

people in play that are of common themes like with your steering community or your board or whatever it is you are going to call it. Then you have to have people at the top of that that go out and make sure you are functioning correctly and in support of the mission of the program.

Joe: Yeah it's critical. Part of the challenge in rural communities is building what I call organizational capacity and that I think continues to be a challenge not just for this program but any program in a rural community because you only have those few people who are hyper-engaged in working on things and usually people are involved on many different levels who are juggling, you know everybody says sometimes four or five or sometimes eight different hats. In some degrees that's a benefit because you can take care of many things at one time and you pool resources and that's when you know, in maybe what's happening with one organization and how can you incorporate and work together. So in many times there's benefits but on the other hand, there's only so much that so many people can do and get done. Having capacity and having a designated leader, particularly that would be a part-time or full-time position, based on the need, I think is ultra important. If we could graduate our program to the level... because the community would like more programs, not less, we are restricted by how much income we can generate. They would take programs almost every day of the week if we could facilitate it, there is just not enough time. If we were able to graduate that from volunteer roles to paid staff who are committed to that, then that might be the next level. And to be quite honest, that's one of the things we are discussing and looking at how we work together with other communities to address certain needs and to be able to build that capacity. We are looking at how we address health and nutrition and diabetes and these kinds of things and how we can actually what we say, build organizational capacity for Arts in Medicine programs by addressing those issues. The need collectively. So that's kind of what we are dealing with right now.

Lauren: Do you have a healthcare background Joe. You sound very knowledgeable of diseases and everything medical related?

Joe: No, my healthcare background comes from Ginny. My role in my other job is I serve as the Executive Director for our community coalition and health disparities is one of those things that we're focused on all the time and I see these Arts in Medicine programs as a highly effective way to address issues especially in underserved populations because it's a nonthreatening kind of process. It's not like inviting everyone to a classroom on diabetes. They love to go to groove and dance because it's fun. They don't realize really the health benefits and what's happening. And then once you build that trust and that relationship, then you can start maybe talking about food choices and other things once you kind of spark that interest. So I see the arts for all of our social

programs as a tool to get folks that we really need to serve. As an example one of our partners, is our victims' advocate for the sheriff's department and she meets with some of her clients at our pottery studio on Wednesday nights. She can get much more productive conversations with a victim while they make a piece of pottery than they can sitting in her office at the Sheriff's department where they pretty much clam up. It's just a total different setting when their hands are busy and they're being creative. They communicate much better. So that's where I see some of the benefits. And of course a lot of those folks who are having those challenges are also those clients at the hospital who are most likely uninsured and creating our syndicate care challenges - so to me it all fits together.

Lauren: What do you think are some of the first steps in starting the arts programming within the hospital and the community?

Joe: I think that we actually went about it in a very smart way, and we can't take credit for it. I think that credit has to go to, between the University of Florida and Shands and the way they approached our community. I don't know if other rural communities are as sensitive as we are about how folks who bring programs and services into an area are, but they were highly effective, they were very considerate of our cultural norms. They did not tell us how to do it. They maybe facilitated some questions that led us to learn how to do it, but I think that that is the most important thing that I've learned from them, they didn't come in and tell us what to do. They came in and offered resources and assistance and let the community come up with what it wanted to do and then kind of helped coach us through the process. So I think that is the main thing, buying in. Again I go back to that Asset Based Community Development . Are you familiar with Asset Based Community Development?

Lauren: I am not. I'll write that down.

Joe: The folks at Northwestern University and I think his name is McKnight, Professor McKnight. Basically that's the process you realize what resources lie within the community and how to access those and you put the community in charge and basically then you facilitate the communities wishes. That's that lesson and they did that extremely well, I think. What do you think?

Ginny: I think that's very accurate, you have to look at those things to establish guidelines.

Joe: And then once you find out what the community wants you to do, then you have to know what can be done, and what's legal, to kind of help you put it in perspective. That was the process that they did for us, and I think that was the lesson that I've learned.

We've been involved as a community in many other projects where resources were brought in and none of them has been as successful in the long term as the approach that they brought in when they did Arts in Medicine. Did Ginny tell you that they just left here for a week? Out of this relationship that they built with this organization, they do an alternative spring break and come and spend about eight days in our community working on health related issues, visiting with our middle and high school students about STDs and intimate partner violence, and self esteem and theater programs and at the end of this third year of that, basically they are as known in our community as we are, and they really don't need the same introductions or the same assistance as they did in the first two years because they've earned some credibility on their own. People are now looking forward to them coming back and having a presence here and the arts work that they do. They've built a community garden at the senior center and last year we built one at the ABC School and next year we're building one at the new senior center this end of the county in Apalachicola. So it really is how you approach the community and I bet most rural communities are probably like us.

Lauren: So do you think that your model, I know that other hospitals within Florida have implemented your Arts in Medicine model, do you think that other rural hospitals or rural locations in other states, do you think the model would be able to adapt to those areas as well?

Joe: What I think that happened was two models were created. One model was the outright model for our program in Franklin County that had the component that operated within the hospital when it was appropriate and the component that operated within the community and in conjunction with other social service or partnering organizations. I think that was one model. I think the bigger value was the model that was created while our model was developed, if that makes sense. It's how they approached the rural communities and how they led the conversation because now they've done that in eight other cities. This year we have nine total programs and very few are like us. Some are more similar to us and some are very different and everyone figured out what's appropriate for their community but the model that was closely followed was the one that was looking at the assets of each community and how to implement them. That was more important than the lesson, than how we did it. We used the tools that were available to us and the resources that we had within the community and I think each of those other communities did something very similar. They may have a stronger theater presence, we may have had a stronger ceramics presence – to me those little things are not that critical. Have you spoken to the folks there at the University?

Lauren: Is Jill Sonke part of that?

Joe: It's her mission. Yes. She's amazing.

Lauren: I spoke to her and the research coordinator Jenny. Earlier on in November when I was discovering there was not a lot of research on rural locations and arts programming, I randomly came across Jenny's contact info and sent her an email just asking if I could speak with her, I was having trouble narrowing down my topic and research articles. She set-up a conversation with myself, Jenny, and Jill as well. I've coordinated with Jill a few times through email and she's a very knowledgeable person and I think that she's a chairperson for the Society for the Arts in Healthcare?

Joe: If she's not currently she was in the past, yes. I don't know how long their seat is. I think to me the real lesson that you're looking for and to me I think it would be interesting for you to examine how the different models of the nine here in Florida did develop because they did slightly different paths but we all have kind of a central core. I wondered if you had spoken to Paulina?

Lauren: I'm actually speaking with her next week on Tuesday.

Joe: You are going to get a lot of variety. We were here Lauren, the first one, then the program was at Calhoun Liberty in the second year and then there was a broader group in the third year which are actually neighbors of us on the other side, and that county doesn't even have a hospital at the Calhoun Liberty medicine program. That is the reality in many rural communities is that you have to work with what you're given, we have to see what's rich. We are resource rich but with tight funding but Ginny probably can't speak towards this but I'll say it...when I looked at each of those nine counties with Annett, with a group this past February, we learned some lessons in the process. I understand some hospitals run as county facilities and they operate within the government system like we are. Some are private, nonprofit, they operate with a board of directors much like Sacred Heart, which is a chain. Sacred heart is a very large nonprofit. They are the largest nonprofit hospital. Then you go to our friends in Calhoun Liberty who are a lot like us, they're a nonprofit as well but it's just one hospital, so that's how it's a little bit different. To me that's been part of the learning process is how we function in that administrative structure and to build that capacity and actually serve the hospital and we learned some things through that and I think that we're in a better place. As the first ones we learned by doing it.

Lauren: Do you all have a coalition where all of the hospitals that are operating under the same Arts in Medicine model, where you get together and have conversations and ask conversations of each other or is it kind of on your own accord when you interact with those people?

Ginny: We don't get together as hospitals, we get together as the Arts in Medicine programs because some of these programs are not in counties that actually have hospitals.

.....

Lauren: Well, I think you guys have gone above and beyond in answering my questions because as I was hearing what you were saying it was bringing up other questions that I had as well. I want to thank you both for taking time out of your busy schedules to speak with me. I've definitely learned a lot and I'm excited to go back and go through again what all was said. I really do appreciate it, you guys speaking with me.

Ginny: You are more than welcome and any further information that you need from us, feel free to contact us. You've got my email address and I'd be glad to forward you Joe's as well.

Joe: Let me tell you about this in case you're interested. By no means are we a coalition, we're just a group of Arts in Medicine programs that come together each February to focus on rural programming. If you're interested, each February we meet for about four days. We had people last year who came from as far as India and from all over the country as well as all of our programs from Florida. I think that if you continue to go in this path and want to go deeper, it would be a highly productive time for you to come and speak face to face with a large number of folks who do this.

Ginny: Absolutely.

Lauren: Is it always held at the same location or do you change each year where you meet?

Joe: No we host it here in Apalachicola.

Lauren: Is that information that I would be able to find online and how to register for that?

Joe: It usually comes out right after Christmas and Jenny and Jill have that on their website. If you go to their toolkit, you'll see a lot of information that we've developed and posted there. You'll even find information about our communities and Jill did a study about Weems, so there's a lot of good stuff there on the website.

APPENDIX D

TRANSCRIBED INTERVIEW 2 (ARTS IN MEDICINE AT SACRED HEART)

(To give context) In my introduction, I described how I arrived at my thesis topic mentioning my research in an entrepreneurship class. I also briefly mentioned that the Professor I have been working with had past experience in a music therapy research study. Paulina's first discussion is in response to that comment:

Paulina: Well music therapy or art therapy is related but definitely separated from Arts in Medicine because Arts in Medicine is therapeutic but is not necessarily clinical and definitely not billable. So it's a completely different set of skills, not to say they don't overlap, but we do hear a lot of comments about does this encroach upon music therapy or recreational therapy or art therapy and while there are some similarities they are very different modalities.

Lauren: Do you offer any sort of arts therapies within your program or is that separate?

Paulina: No, that's completely separate. In fact, we don't offer those services here, we don't have music therapy or art therapy. Those things are very unlikely to be found in a rural hospital system. I would like to address some of your comments earlier about hiring someone to work in an Arts in Medicine program. A lot of rural hospitals are going under so the likelihood of them hiring someone specifically for something that's non-billable is extremely unlikely. Typically Arts in Medicine programs, for rural hospitals in any case, are developed by using existing personnel and volunteers from the community.

Lauren: That is definitely insightful and good to know.

Paulina: Yeah, you might have some contract people. I have an artist who is contractual here. She comes in twice a week to work with patients. But for instance my position, I actually am the Volunteer Coordinator and that's how it grew, or at least I was the Volunteer Coordinator at the time that we were given the grant to start our program.

Lauren: Ok, so your program started out of getting funding?

Paulina: Yes, we were approached by the University of Florida and they received a grant from The Kresge Foundation.

Lauren: Were you in a partnership at first with Shands or they sort of let the leadership of your program take on that role in trying to figure out how to organize and structure it?

Paulina: They came to us with funding and said these are some of the models of Arts in Medicine that have been done in the past, we'd love to see something here. Here's some very basic framework, we'd love for you to come down for some training and you guys could get started immediately. We started with the Wellness component or the contemplative classes for the community as our first launching pad for that. So we did yoga, tai chi, and zumba. Yoga was our first highlight. To understand the significance of that you have to kind of put it in a framework of, we are a small community, we have about 15,000 people in the county, and within this county, a vast majority of our people have never practiced yoga and there is not a certified yoga instructor in the county. For us to be able to offer classes we had to recruit someone from outside the county and have them drive 45 minutes to teach a class. It was something that many people had never experienced before or more or less had never seen it offered free. It was a wonderful opportunity to be introduced to it.

Lauren: Are all of your programs offered free to the community?

Paulina: Currently they are. We'd like to keep that model but what other programs have experienced is that by placing some kind of monetary value on it in their counties that it becomes a barrier for participation. It's a barrier not just for those that can't afford it but also for those that can. The goal of the program is not to be income producing although it would be nice if we had a means of paying for the classes to making it supportive. The goal of the program in actuality is to provide people with a better sense of physical and mental health.

Lauren: Was there a reason that you decided to start your program with the yoga and the tai chi classes or was that brought up by Shands? Was that part of their model?

Paulina: No, actually I don't think they offer those particular classes at Shands. I know they do dance for Parkinson's and some other things that are more targeted towards specific health populations. I was looking at something that involved contemplative arts which would typically be Tai Chi and Yoga, they're the only two that are included in contemplative arts but are physical wellness programs. Something that would appeal to broad audiences, not just to throw it out there and see if anybody bit, so to speak.

Lauren: I don't think I could find it online, but when was your program started?

Paulina: July 2010. We opened our hospital in March 2010.

Lauren: How many beds are at your hospital?

Paulina: We are licensed for 25. One thing that might be of interest to you is use of swing beds. Swing beds are the use of medical and surgical rooms or beds and reserved for long term rehab. So if you have a hip or knee replacement, you are in the hospital for 2-3 days and typically you are going to be discharged either to home and then have outpatient rehab or you're going to be discharged to a long-term care facility for rehab depending on your network at home. Swing beds are long-term rehab beds that are used through the Medicare and Medicaid programs, the National Program for Rural Hospitals, but they follow under long-term care criteria which means that they have to include some kind of activity for the patients. For us, we've been able to utilize the Arts in Medicine program to help build part of that need. But swing beds are only specific to rural communities and applies to hospitals with 25 or fewer beds.

Lauren: I noticed, at least when looking at your organizational chart, that yourself and Jeff Ryan are co-chairs of your Arts in Medicine committee. Would both of you be considered the directors of your Arts in Medicine program in coordinating and implementing all of the different classes and reaching out to the community?

Paulina: Well in actuality Jeff Ryan moved to one of our other facilities so it is just me, and I do it all. Rural hospitals are faced with a lot of financial challenges but staffing is always a big question. So for instance in my role I'm over Arts in Medicine, other grants, Volunteer Services, a Physician Liaison, marketing, public relations, community events, you name it. Where those would all be very separate positions at a large hospital.

Lauren: How many hours a week are you able to dedicate to the Arts in Medicine program?

Paulina: It fluctuates wildly. Some weeks it is 30 hours a week, some weeks it's four. It varies greatly. When I say it's 30 hours a week, one of the challenges is that if I'm giving 30 hours a week to Arts in Medicine, it doesn't mean I am giving 10 hours a week to the rest of my responsibilities. It means that I'm probably working a 60 hour week.

Lauren: Wow, you are a very busy person.

Paulina: I am and that is not a badge of honor by any stretch it's just a badge of insanity.

Lauren: So what would you say are some of your responsibilities in what you are doing with the Arts in Medicine program?

Paulina: Well I coordinate all the activities that we currently have, I do all of the PR to promote the program in the community, I am responsible for brand management, fund securing, building collaborations with other health care providers, any kind of financials that include making sure that the independent contractors are paid such as our yoga instructor, organizing volunteers to help with specific events.

Lauren: So you are pretty much coordinating everything that is involved with the Arts in Medicine program?

Paulina: Yes.

Lauren: I don't know if this has changed, but in looking at your organizational chart with your Arts in Medicine committee there are a number of different positions listed. Someone is with social work, research, marketing...do those people help in those areas that they are assigned or was that a beginning framework that you started with?

Paulina: Yes the latter. For instance Lisa is no longer here so I now have her responsibilities as well.

Lauren: I know you spoke about overseeing some of the grants, does the hospital provide any funding for the Arts in Medicine program or are you strictly looking for external funds?

Paulina: Strictly external at this point. But you know we are working in partnership with the Health Department, they have some funding for Wellness Programs and we are hopeful that they will be able to fund our programs throughout the rest of the year for here and for the north side of the county and for potentially expanding some additional classes.

Lauren: I think it is really interesting, I don't know if it is still offered, but the fact that you have some sort of offering for your employees. Basically you have hot tea and music, is that still something that occurs?

Paulina: Yes, our relaxation station. Those have been really successful actually and the staff seem to really like them if they can get away. There are a few studies (NEA) that show when offering people 15 minute breaks, particularly clinical associates, tend to be more accurate in their documentations, they tend to be better caregivers, in other words they have a lot more patience and empathy, and it will also increase their job satisfaction.

Lauren: Yeah I could imagine so. I feel like that's a good way of helping them distress and I'm sure it definitely helps with retention as well. If they're happy they want to stay where they're at.

Paulina: Right. Well it's a very inexpensive program. Volunteers manage it outside of the standard day. The only costs included is the original purchase of the chairs, which for us having two chairs, I think we spent \$650 which is very minimal and the cost of the tea. We have a projector already, we created a slideshow, and we bought a CD for music. It's kind of relaxing music, with waves crashing in the background. It's very sedate but also true to this area as we are right on the coast of Florida.

Lauren: Assuming you were around at the very start of your program, but could you talk a little bit about some of the strategy and planning that went into implementing the Arts in Medicine Program?

Paulina: That's an excellent question. The idea when we started the program was that we would have two different committees. One within the hospital to oversee the program overall and then a community program so that we could garner information as well as support from the community in not having conflicting programs and making sure that we recruited people that had either assets or skills that we could utilize. After probably two meetings, about six months out, it became pretty apparent that that really was not a very functional model at the time for us. So we've kind of regrouped or I guess I've regrouped and I'm trying to let things happen a little more organically. I felt like I was Sisyphus pushing the boulder up the hill and just watching it roll down again. We have a great number of artists within our community and I imagine that pursuing the career field that you are in, you probably are an artist yourself. What you find with an artist is that people will constantly approach you asking for something for free. You know, can you give us this, not realizing what an investment of your time and your money and your spirit, creating a piece of art can take. I've had great difficulty trying to gather momentum for programs. We've had great success for the wellness programs, people have been really happy with them but it tends not to be artists, which is fine, that's great, you know it means we're doing some outreach. We've started trying to approach it in a different way. We have an artist who is a watercolorist and one of the volunteers here at the hospital. We had a reception for her on Friday and we are exhibiting some of her work here in the hospital so that we could open up the simple conversation of we're willing to offer something in return, that this could be a win-win situation. I think once people get into the hospital and kind of experience what it's like either to display their work or work with patients, that they sort of learn how valuable it is and how they might get something back instead of it just being, give me, give me, give me.

Lauren: Do you have the bedside arts that you offer to your patients and is that run by your volunteer artists?

Paulina: Well we don't really have volunteer artists. We have a volunteer who is an artist and we would be displaying her work for the next three months. What I do have is someone who was a volunteer previously who's on contract and comes in on Mondays and Wednesdays. Then I have a new volunteer, because art is a very large framework. You know you're going from yoga to visual art to performing art. She's a knitter and crocheter and she's coming in and working with patients in knitting classes. Then we have a lot of pieces in the community. We've done sponsorships for literacy programs. There's a summer program here with the Gulf Alliance for Local Art (GALA), which is one of our local art cooperatives. We sponsored a visual art camp for kids last summer. It ended up budding into this huge program. We only provided the funding for this one strategic piece and they ended up getting three other groups to partner up so they were able to offer play, music, dance, and then the visual art piece that we provided the funding for. Now it's also a summer program and afterschool. It's kind of blossomed on its own and GALA program has now taken that on, on their own. We just provided that little bit of seed and it took off. The other thing that we've done is we've had a community first Friday Art Exhibit. We offered an exhibit, it was "Portrait of Spirit: One Story at a Time", it was a photography exhibit from the 1996 Special Olympics in Atlanta. It was a combination of photography and biographies of people with special skills and abilities or who have overcome difficulties in their life. For instance, one of my favorites is a woman who was shot by her, now ex-husband, and it severed her spinal cord and she's in a wheel chair. But she is a Paralympics Equestrian Athlete. It's beautiful, it's just amazingly moving to me the portrait of her with her horse. I would strongly suggest that you look it up and just look at some of the photos that are available online because they are very striking. Each of the people in this piece, I think there are 26, actually in each panel, surviving some kind of difficulty in their life and how they've overcome it. It was the right combination of health art combined.

Lauren: I want to say I read an article that was featuring or talking about some of that artwork because when you're talking about the image, explaining the woman with her horse, I have a visual of that... Do you think that it is important being located in a rural area to have your Art in Medicine program extend beyond the walls of the hospital into the community, do you think that is very vital to improving the health of the community overall?

Paulina: I do and the National Endowment for the Arts, they are completing a three year study about the effects of the arts on communities. Art is a huge economic and wellness cultivator. If you look at rural communities, the challenges tend to be poor health, and

that's usually associated with diabetes, cancer, heart disease, and all of these are interrelated. Wellness programs can do a huge amount to decrease those events like smoking is a huge issue in most rural communities. Part of that sadly, is a lack of community activities and a lack of social opportunity. When you're in a rural community, for instance in this community and Appalachicola is further out than we are, the nearest Walmart is 45 minutes away and the nearest movie theater is an hour away. So if you are here in the community and you don't have a job, the likelihood of you getting one is slim, you don't have financial resources to buy good food, you don't have cultural opportunities. Being able to provide something beyond the walls has a huge impact on who comes in our front door. It has a huge impact on the economic viability of our community which affects the hospital drastically.

Lauren: Do you do anything such as administer surveys to try and discover what some of the benefits of your programs might be towards the hospital...?

Paulina: No, we have to be really careful. We provide surveys at the end of our classes because we usually do six or eight week programs and garner information about how people feel about the classes. When you are looking at outcomes, that becomes research and with medical facilities you have to go to your board. The IBC (International Building Code) requires and they'll have a whole control unit and it becomes very complicated. So we are restricted from doing this kind of thing.

Lauren: Very interesting, I didn't know that there was a kind of process that had to happen.

Paulina: Yes, and that's true for most hospital systems that don't have their own review board for research then there's probably a university system within their regions that manages that.

Lauren: I guess with your program being relatively new, has there been any research conducting on it or do you think in the future the hospital may want to do that?

Paulina: It's unlikely. We are not a research hospital, even in our largest unit we are not a research hospital.

Lauren: Does the president of your hospital have any sort of involvement with your Arts in Medicine Program? Does he act as a spokesperson for it or help try to secure any funding?

Paulina: Not really. The Arts in Medicine program is pretty low on the totem pole in his concerns and justifiably so. You also have to keep in mind that he is the president of two locations so he is probably here at our facility once a week. It's not as though he's a

figure-head that is speaking to the community and it's a commonplace event. He was very helpful though in helping secure the grant, we received a secondary grant from the University of Florida. He was willing to give his time in order to help secure that for our Destin location which is also in a rural county.

Lauren: Sacred Heart Hospital, how many hospitals are actually within that, is it just the two hospitals?

Paulina: We're in a system of four hospitals. We have a large center in Pensacola and it's an urban hospital, it's the major trauma center. There is a long-term care nursing facility in Pensacola also in an urban area and then there are the other two outlying hospitals. From Pensacola if you travel east for about an hour and a half, you'll come to our facility in Destin and the facility here in Port Saint Joe is two hours beyond that. We've recently as of April 2nd, we had a lease on a facility in Panama City so as to how that's going to work out is still undetermined.

Lauren: Was there any sort of arts programming that was offered at the hospital before the Arts in Medicine program itself was implemented?

Paulina: Well, we were only opened for three or four months before the Arts in Medicine program was implemented. They did take a lot of care in building the hospital in providing extensive artwork throughout the building.

Lauren: Do you have a healing garden?

Paulina: No, not yet. There's probably 38 local photos throughout the hospital and an additional eight pieces that were taken by staff members of Sacred Heart from this particular community. And since that time we've also received two additional donations of artwork. One is, are you familiar with plein air? It's a form of impressionism that originated in France and it basically means taken from the air and the pieces are done in a very compressed time period, usually between two or three hours. If it takes longer than that they have to come back and complete the piece in the same location, same time of day, the next or the day after, because they want the exact same light. We have a collection that was donated by the artist in the name of someone who was very instrumental in the community and in developing a tour that happens here every year, called the Plein Air Paint Out. The collection, I'm guessing, has about 23 or 24 pieces to it and it's worth about \$45,000. They are wonderful, beautiful pieces. I'm a big fan of impressionism.

Lauren: I'll have to look that up. My background is in music, I like visual artwork but my knowledge on different types of art is very minimal.

Paulina: You might also be interested in, have you heard of, Musicians On Call?

Lauren: I have, there is actually a program that was started here in Philadelphia. I think it's run by one of the radio stations, or funded by that and I think a few musicians go to the Children's Hospital of Philadelphia and maybe University of Pennsylvania Hospital. I'm under the impression that there are certain musicians that donate their time and if a patient is requesting to have music played then a staff member can call the musician and they'll come in and perform. Is that how it functions?

Paulina: Something to that effect. There's actually a national organization called Musicians On Call and they have offices in New York; Nashville, Tennessee; Miami, Florida; and they do that. I think their primary focus, and they have a lot of national stars I'd say who provide concerts to provide additional funding for the program. They also do a program called a CD Pharmacy. The CDs are donated by the labels and you can have a request, which we did for our Arts in Medicine Program. We have two hundred CDs, three CD players, they were all provided free by the organization so that we can provide music opportunities for the patients in town. We would go from room to room with a list of the CDs. The patients can check them out and listen to them in their room and of then of course they return them before they leave. As you can imagine with a clinical environment, infection control is always an issue with anything we do so whenever you are working with an artist or music, anything that goes in a room, needs to stay in the room until the patient is discharged or it has to be disinfected. So for instance the CD players and the CDs can be wiped down and sanitized, the earphones will go home with the patients. If you're taking visual art supplies in, you don't take the entire bottle of paint. You take what you need in with you, once it goes in and is put down somewhere, it needs to stay there.

Lauren: Wow, that's very thorough. The hospital that I worked at, there were particular patients who would be considered on isolation and for those you would know if you were taking something in, it had to stay in there. The other patients who were not on isolation, you could actually take in items and bring them out but you would clean them off afterwards. So that's very thorough what you guys are doing. I feel like you've answered all of my questions and you've definitely given me great information. I can't think of anything else at the moment. As I'm speaking with other people who are working in arts programming in the rural locations, I'm realizing that I'm probably going to have to adjust my topic and it will be interesting to see what sort of themes come out of speaking with everyone. It's an exciting process to be going through.

Paulina: How wonderful. Well if you come up with any additional questions, you are more than welcome to shoot me an email. I'll try to get back to you as soon as I can.

APPENDIX E

TRANSCRIBED INTERVIEW 3 JACKSON COUNTY ARTS-IN-HEALTHCARE

Lauren: Can you tell me how the Arts in Medicine Program at Jackson hospital started?

Rosie: Sure. It started with an outreach by Chris Sullivan at the University of Florida and he knew of other small hospitals in the region of the Pan Handle that might be good program implementers to continue the spread of arts and medicine in the Pan Handle area. We had our initial meeting with the folks at Blountstown because they have a program started there. Then Chris and another lady from the University of Florida met internally with some of our staff; myself being the Director of Public Relations and Marketing, our Infection Control and Employee Health professional, and then our Director of Nursing - just to make sure that it was something we could implement here at our hospital. This came after a time where we implemented a Pet Therapy program. An individual in the community really championed that and it's bringing a dog that has had training to the hospital to certain floors and to any patient that wants to have a Pet Therapy presence. We thought the Arts in Medicine would be kind of a continuation of our program to provide alternatives to patients in the hospital.

Lauren: How long were you planning or strategically thinking before you launched your program two weeks ago?(mid-March)

Rosie: We were a little later starting, we thought we would start in January, that was the goal. We started talking about the program in November I believe. We originally were going to focus on pediatric patients (inpatient) but we don't get enough of them in the inpatient setting where the child is actually admitted to the hospital. Then we kind of rethought that and felt our outpatient chemotherapy setting would be far more favorable to ongoing arts in medicine because these patients come for maybe five consecutive business days each week or longer to receive their chemotherapy. That setting is in the outpatient so that way the Arts in Medicine artist resident does not have to come in to the hospital proper and the setting for outpatient chemotherapy is one of very much, community, because right now everybody wants to have an open therapy session for their chemotherapy. That way they can support each other and talk and visit - the

chemotherapy sessions are long appointments. That's what really changed our focus to the outpatient chemotherapy setting and it's been working very well.

Lauren: Do you plan on eventually offering your arts in healthcare programs to the community such as at a community center, similar to some of the other Arts in Medicine programs?

Rosie: Yes, we are reaching out...one of the artists in residence is a well-known artist in the community and she is associated with the artist guild here and she has contacts at Chipola College. Chipola College has a wonderful fine arts program. There's another arts group (she has contact with) called the Chipola Regional Arts Association and we are using her contacts as a way to reach out and figure out how to spread this innovation into the community, outside the community members who happen to have chemotherapy and are coming to the hospital.

Lauren: Within the hospital do you eventually think that you will continue to add programs, sort of as you evolve?

Rosie: Yes, I think we'd be very receptive based on the success of this program to add other types of therapies. It's been very well received so far and with this particular group of outpatients it would also be nice to have different kinds and then move it into the main hospital. We have one floor which would probably be the best floor, and that floor is where we do our pet therapy and that's on our Medical-Surgical floor, not withstanding any infection control issues.

Lauren: Are you considered the head of the Arts in Healthcare program?

Rosie: Yeah, I am like the administrator of the program. The Director of Employee Health who first joined with me to bring it here has taken a new position as a practicing ARNP (Advanced Registered Nurse Practitioner) so the administration is now resting with me so I'm working with the artists as that role.

Lauren: What do you think some of your main responsibilities have been?

Rosie: Well it's to make sure all the paper work is done with the rules of Florida and I will be doing a lot of the administrative work, making sure the artists get paid and budgets stay balanced. Supporting the artists – so far my experience has been the artists are so creative that there is a little bit of a disconnect with some of the practical implementations of a grant. I'm here to be a shoulder to run things by and to support them to make sure that they are feeling successful.

Lauren: Does your Arts in Healthcare program have...I noticed some of the other programs have steering committees or board of directors, have you all looked into that or do you have one as well?

Rosie: No, our steering committee is basically me and the two artists right now with the support of the University of Florida. We just had a conference call with them, they are extremely supportive in helping to make sure we are on the right track and so we've been leaning pretty heavily on them to make sure we are going in the right direction. Since we are in our infancy, I'm not sure at what point it would make good sense to kind of have that more formalized structure.

Lauren: How often are you able to meet with the people at the University of Florida? Do you have set meetings or just whenever you feel you need guidance you can speak with them?

Rosie: Yes, they always have an open door. What we kind of have been...it seems like it might be every couple of months they'll check-in with us and then of course we'll be attending the summer session which has the grant track as well as the artistic. We definitely want to participate in that so we will get a full immergence with the University of Florida Arts in Medicine program. I think that will be very instructive.

Lauren: Right now your program was started by the grant provided by the University of Florida. Do you think your hospital will ever at some point provide funding or will you strictly have to look externally for funding?

Rosie: Yeah I think the internal funding is kind of an indirect because of my participation and we are a 100 bed hospital and we do not receive any state or federal funding outside of Medicare and Medicaid so the budgets are tight. My one artist is pursuing a grant which will help us continue our program so I think we will really have to rely on outside direct funding to pay for her services and the artist services and supplies.

Lauren: What do you think were some of the deciding factors in the hospital agreeing to implement the Arts in Healthcare program? I imagine that you had to have the hospital board of directors sort of on board with starting the program.

Rosie: Actually we did not bring it up to the board. We saw this more as an operational task rather than a strategic task, if you will. We administratively made that call to implement the program. Now our Board of Trustees have certainly been informed of our program but we do not need their approval to implement it. What we had to do is make sure that we could get through any infection control issues, work through any

HIPAA (Health Insurance Portability and Accountability Act) concerns, and then of course make sure that the outside artist had received the proper orientation and identification, that way she would meet all of our requirements for volunteering. The other artist is a nurse that works on our fourth floor, Maternal-Child, so she's already been through that so she did not need that kind of orientation and training.

Lauren: How extensive is the training process with your artists? Is it a matter of making them aware of how to work with patients? I'm just curious what goes into that...

Rosie: It probably lasts about an hour to make sure that they understand HIPAA because the people that they could interact with could be people they know or people in the community who are receiving health care, so they really needed to be schooled on HIPAA. They needed to have an overview of our codes so that way if they were involved in some code they would know how to respond. They had to have proper identification and a background check to volunteer at our hospital because this was a volunteer who has come at a certain period of time. We separate shadow people from volunteers. Volunteers are defined as people that have a routine schedule, so the orientation is a little bit different for them.

Lauren: You were already working internally within the hospital, but do you ever foresee that there will be budgeted positions for the Arts in Medicine Program?

Rosie: You know, right now, I don't. I can't say definitively yes or no. I think that as this gets more successful that that will help drive funding. We have a budget cycle that follows the federal government so I think that it will really be determined by the hospital's success, its profitability. You know we are a nonprofit hospital but you still have to make your margins to stay in business and I think that as the hospital gets more successful by offering programs like this, I think it will make it a much easier business proposition.

Lauren: Where do you think in five years from now the Arts in Healthcare Program will be?

Rosie: Well hopefully it won't be extra at our hospital but incorporated into the fabric of what we offer the community.

Lauren: I think you spoke to this a little before, but have you had any conversations with people in the community, like business leaders or other leaders of the community, just trying to get feedback from community members as to what programs they would eventually like to see or that would be successful to improving the healthcare of the community?

Rosie: I think that will come a little bit later this year since we just kind of kicked off our program and really started getting the mechanics worked out. I think that will be part of a later conversation. The one thing I would add, if we have an individual that has participated in our program that has art, a completed art piece that was generated by participating in our program...there is an annual in the late fall, Sunday Afternoon at the Arts, and we are hopeful that the individual would let us enter that art to showcase our Arts in Medicine Program.

Lauren: Yeah I think that is definitely a great idea.

Rosie: That would also be another way to impress upon the community the program and its importance.

Lauren: Definitely and to kind of show what you are doing and the effect you are having.

Rosie: Yeah, you know we are not allowed to share so much because of the HIPAA laws but we had a patient that participated in our launch and they measured her blood pressure before she started her artwork and after she started her artwork and there was a significant reduction. That kind of really crystallized for us that it is a calming influence while individuals are receiving chemotherapy treatment. That really is the truth in the pudding right there, how does the patient react to this program, and that kind of really jelled it for us that that is exactly what we are looking for.

Lauren: Is that something that you plan on continuing, possibly conducting research or surveys so you can evaluate your programs and really have quantifiable data for the benefits that you are providing?

Rosie: Yes.

Lauren: I think that those are pretty much all the questions I had unless there is anything else you think that would be beneficial to add?

Rosie: I don't at the moment but we are having some media releases next week on our program. Would you like me to send you links to those when they come out just as a follow-up?

Lauren: Yes, that would be amazing- thank you!

APPENDIX F
TRANSCRIBED INTERVIEW 4
(ARTS IN HEALTHCARE – IMMOKALEE COMMUNITY)

Lauren: First could you tell me how the Arts in Healthcare Program was first initiated? What actually brought about this new program?

Javier: Well the program was really initiated as a result of some of the outreach efforts of the University of Florida. They have a program that works to bring art into rural communities and they had some funding from the Florida Division of Cultural Affairs and they also got funding from the Kresge Foundation. They used some of that money to kind of give different seed money to rural communities throughout Florida. I believe they went on a tour of different communities in the state. Immokalee was one of the communities they saw. They approached our organization and we are a partnership between Florida State University College of Medicine and then also the Healthcare Network of Southwest Florida which is a nonprofit community health center. So they approached us, gave us the seed money and now we are in the beginning stages of establishing a program.

Lauren: When exactly did they first approach you, was it very recently?

Javier: It was probably October or November of last year (2011).

Lauren: So you are probably the most recent of the rural communities to initiate this Arts in Healthcare Program with the University of Florida?

Javier: Yes.

Lauren: Ok, well that's very exciting.

Javier: Yeah it really is.

Lauren: So what part of the process of starting your program are you guys in right now?

Javier: We are probably in the planning phases still. We have had some programs already – we have two ongoing programs that are established that are happening regularly and then we've had several one-time events. We are in the process of establishing more ongoing programs. What we have right now focuses mostly on the

healthcare providers. We have a Zumba program for healthcare workers at the main healthcare facilities in town and then we also have a relaxation station that's been set up for healthcare employees and also for some behavioral health patients who receive treatment there at the center. So those are two ongoing programs that are regularly used and then we've had several one-time events. In March this past month we did a healthcare fair. Every year the Health Department in Immokalee partners with other agencies to do a healthcare fair where we offer free screenings to the community and this year we had the first arts at the health fair event so we combined healthcare screenings with some art programming. We also partnered with some legal services as well such as the Florida State University College of Law was there. It was a pretty unique event where we had an art fair, health fair, and legal fair all at the same time, so that was our first year doing that.

Lauren: So your programs, you want them to be integrated within healthcare facilities but also in community areas as well?

Javier: Correct, they are not restricted necessarily to our healthcare facility. The way that we started our program, we put together a steering committee. There was an open call to the community, any agency, or individual who was interested in the initiative, they were invited to come forth and out of that response we put together a steering committee. It is composed of our individuals from our healthcare facility but also community members. There are people from other organizations that are involved; there are professional artists who are also on the steering committee, so we are not just restricted to our healthcare center. We do want to also go out into the community as well.

Lauren: I was trying to find it online, but what is the name of your healthcare facility?

Javier: We just underwent a name change this week, so we have been known as Collier Health Services however our new name is The Healthcare Network of Southwest Florida. I believe our old website is up, it's collier.org, but that will be replaced by the new website in the coming week. That's the healthcare facility. The actual campus where we are located in Immokalee is a joint campus between that healthcare center and then the Florida State University College of Medicine.

Lauren: Ok and do you know how many beds are within each of those facilities?

Javier: It's not an inpatient facility, it's outpatient.

Lauren: Oh ok. So what has your role been in creating the Arts in Healthcare Program?

Javier: My role has been sort of as a coordinator for the program, somewhat of a coordinator right now. I represent the Florida State University which is kind of taking the lead on the initiative, so I'm the contact person from the University point of view and then the person who sort of leads the steering committee. That's been my role to date.

Lauren: Ok, and do you foresee yourself staying with this program for a while or were you sort of contacted to help in the start-up phase and then eventually new leaders will be designated?

Javier: I mean I don't know how the program will grow. The program is kind of taking a life of its own right now, it sort of all depends on how it grows. I hope to be involved with the program but I think my role, I don't know in the future what it will be. But I do hope to remain involved in the program, certainly yes.

Lauren: I know you mentioned you have a few grants but how will the program be funded starting out? Is there any funding from the healthcare facilities going towards the Arts in Healthcare Program or are you strictly looking for external funds from foundations and government support?

Javier: Yes, well I think the initial grant was important because it really was what got us going. It brought a lot of attention to the field of Arts in Medicine and the need for it and a lot of education around how it can improve the care that we give to our patients; so it was really instrumental in getting the program started. Now that we have the seed money, what we are trying to do is really create some programming so we can better show the value and the outcomes of that programming to other healthcare center administration. It is so that they then will also buy into the program, buying into it in terms of seeing the value. I don't know if they are ready from the very beginning to actually pay for some of that programming. What we want to do is use that seed money to show how the programming can improve the care and even be cost effective, so they then will begin to contribute financial support. They're contributing already in other ways in the sense of materials, building space, and allowing some of the employees' time to be used towards the programming. No one is assigned specifically to it but healthcare employees do participate in the steering committee; that's part of their workload. They're contributing indirectly but they're not contributing in any specific dollar amount. But we hope that we can use the results from the seed money to get a little bit more buy-in from them and then we also do plan to apply for some government funds. I know that the Division of Cultural Affairs here in our state has a grant process and they have money available annually so we plan to apply for that and then just

private funds too. As our program grows we do want to do some fundraising ourselves from private donors but that's in the works still.

Lauren: In your opinion, why do you think your community needs the Arts in Healthcare Program?

Javier: I think our community needs it, and in our particular community one of the big things that it can help with is accessing care. It's a very rural community and we have a lot of people that do not come to seek treatment, either preventive or for an already existing illness. I think that arts programming can number one, help to take the medical care and medical information outside of the clinic walls because we have a lot of people that wouldn't necessarily come into the clinic. An example is the arts and health fair that we had which allowed us to go and take the service treatment to the community so I think that it can help in improving access to care. I think it can also help to improve literacy around healthcare. We live in a community where there is very little information available, however we're a cultural rich community, I think. If we can somehow combine that culture with the medical care and medical information that they need, I think it would be more of a benefit to the community. So I think improving access to care and then also improving literacy around healthcare.

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