Kathleen Baxley

Behind the Mask

February 10, 2022

Barr: Good morning. Today is February 10, 2022. My name is Gabrielle Barr, and I am the archivist at the Office of NIH History and Stetten Museum. Today I have the pleasure of speaking with Miss Kathleen Baxley. Miss Baxley is the Chief of Social Work at NIH's Clinical Center, and today she is going to be speaking about her personal experiences during COVID-19 as well as how her department contended with the virus. Thank you very much for being with me.

Baxley: Thank you for having me.

Barr: Will you briefly discuss the different types of services your department offers to get us started, and how do medical social workers at NIH partner with others on campus to care for the patients who come to the Clinical Center? A lot of people do not know about your department.

Baxley: Absolutely. [I am] happy to shed some light. We provide clinical social work, supportive counseling services, and language access to research participants that arrive at the Clinical Center for both inpatient or outpatient care. We have the full range of psychosocial support available from assessment, safety, assessment for any kind of psychosocial crises that might be occurring. We also have counseling. We do brief counseling while people are here. We do a lot of resource referral to folks who may not be staying for prolonged periods of time and may need ongoing care in their communities. We help the hospital with discharge planning so when patients have been inpatient and they need to move on to the next level of care, we help set up those services in their home communities. On the language access side, we provide 24-hour support for our research participants who use English as a second language or have limited English proficiency. We provide support with oral interpreting by phone, by video, and in person. We have done that throughout the pandemic. We also have a small footprint that provides written translation of patient education materials for our patients that have limited English proficiency.

Barr: Will you find an interpreter for any language? Has there been a challenge sometimes, to find a person in the [Washington] DC community who can help somebody?

Baxley: We certainly have some languages that provide us with more of a challenge than others. Those are called our languages of lesser diffusion. We can provide support in about 150 languages.

Barr: Wow!

Baxley: That changes over time certainly, and with demand. As you would imagine, we compete with all the other hospital systems in the region for in-person interpreters and sometimes, it can be quite challenging to find enough support for our research participants when they are here. We do have our phone system that can supplement our in-person interpreters and so, that is our stop gap measure, but even then, it can be a challenge sometimes. That is truly the benefit that we have being a research facility. We can usually plan our admissions, not always, but mostly, we know when people are coming, and we have the opportunity, and the luxury, of finding the language support services, and wrapping

them around the patients before they come and so, with enough advanced planning, we usually are fairly successful but not always. There have been some times when we just could not find an interpreter.

Barr: Do patients usually get the same interpreter for their given stay or appointment, or does it vary depending on the day?

Baxley: It varies by the day and by the language. For Spanish, which is the highest utilization language, the highest demand, we can have upwards of 55 or 60 different appointments in one day, so that obviously could not be one person. And people who are providing interpreting services cannot do so continuously. You can imagine what it would be like to talk for eight hours straight. That would be too much! They do need to take breaks and so it would not be the same person even in the whole day, if somebody needed that much support. We try to get as much consistency as we can but we have to be mindful of the human factor, what our staff need as well.

Barr: You said you use the phone, but have you all also started using Zoom or other conferencing platforms?

Baxley: We have. For all of our services MS Teams is the platform that by policy the Clinical Center has adopted for its patient care encounters, and so, early in the pandemic we were able to get our contract vendor who provides most of our language support for in-person interpreting to adopt MS Teams for their services as well. That required a contract modification, and we were able to do that. We had a brief period of about a month and a half when we were seriously limited in our ability to provide our in-person and video interpreters, but after that we were able to do so throughout the pandemic.

Barr: How did the patients their families and the interpreters end up liking the new changes?

Baxley: It varies. Those who were more along lines of tech natives, or very comfortable with technology, adapted to it well, really adapted, and were able to utilize all the functions of the platforms that we had to offer, and took advantage of the services in that manner. It has helped us certainly, reach a younger patient population with more ease, and some have found it more convenient. Those who were not so familiar or comfortable with technology had problems and challenges. Folks with communication challenges have problems accessing the system sometimes anyway and leveraging technology too. If you cannot physically hold a phone, or you do not have one, it is hard to want to talk to somebody remotely. We have tried, as a whole system, as a hospital system, to find some ways to fix that issue, enhancing volume so people could hear better, providing things like an iPad on a stick, or an iPad through our IT Department, so that patients had access to technology so they could use it, and teaching them how to use it, which is another issue. Sometimes, people do not know how to use technology, or are uncomfortable with it.

Barr: Sometimes we forget about that. You started to speak a little bit about the language part, but can you talk about other ways the emergence of COVID-19 impacted how you and your staff went about your jobs?

Baxley: It was pretty drastic. I remember it distinctly. March 2020, we had our staff meeting in person, at which time, I announced that starting the next day we would be 100% virtual. Everybody was there on Monday, and I said, “Spend the day making sure that your laptops and your cell phones all work and connect, get everything together, take home anything that you think you might need, and we are off site starting tomorrow.” We did have people on board throughout the pandemic, both social work staff and

certainly the entire management team has been coming in on a limited basis throughout the pandemic. And then also our language interpreters were early volunteers to come in. We are still, as a Clinical Center in that status, everybody who is on site has volunteered to do so, and I am happy to say that my entire staff is on board, though not 100% every day. As you can see, I am currently teleworking myself, and that is because of the density limits and the need for distancing that we have. We have many people in the same very small offices and so we cannot have more than one person in them at a time so to provide for staff safety, folks are not in more than a few days a week; some are in one, some are in two, or three, that is really about the max.

Barr: A family is not being allowed to visit as much as maybe they would have otherwise. How did NIH social workers step up to fill that supportive role for the patient and for the families as well?

Baxley: We have been again pretty fortunate. We have helped patients in this manner in in several ways, and I will talk a little bit about the challenges that the situation has posed for them as well. We have been fortunate enough to allow what we call "rooming in visitors" for our inpatients who have to be in the hospital for quite some time. In various points of time throughout the pandemic, we have had to limit as a hospital who comes because we have challenges with transportation. Should somebody be here and then test positive, we cannot ethically send them on a plane back home; we cannot send them to a hotel because we know that they are positive for COVID, and we do not want to spread the infection through the community, and so, our research partners in our ICs have graciously really thought carefully about who we are bringing, when we are bringing them, and really only brought those folks who absolutely had to be here. I know that has also been a challenge for our patients because they want to be here and participate in research, and some of them really need to be here to access care that in their community it either is not available or is not available to them. That poses challenges, not being able to be here and participate in protocols, but for those who are here, we have been fortunate enough to allow one person to stay with them. It is not a lot, some would say it is not sufficient, and certainly it has impacted our folks in our hospice unit the most because at the end of life really many families want to be there and support the patients. In that situation, we will allow two people to be in the room at a time, but it has been challenging. That sense of human connection that folks need especially during very stressful times like being in the hospital, or being sick and needing care, that is a time when you really want that support.

We have definitely stepped up to try help folks connect in different ways to people, by using some of those same technologies that we just talked about, by giving them access to calls, to video calls and to other ways that they can reach out to their family members for support. Everybody checks in on them, and we do the best that we can. It is not the same as pre-pandemic, but it is better than no visitors, which we have had in our outpatient setting; no visitors for quite some time until pretty recently, but things are starting to ease a little bit, and I expect that if it continues, and we do not have yet another variant, we could see some loosening of the restrictions for visitors.

Now patients can have visitors that are rooming in or not, they can stay elsewhere on campus, so we have eased our restrictions a little bit. It used to be they would have one rooming in visitor, and they had to stay in the room and could not leave the room throughout the length of the hospitalization. They could not have anybody else come in. Now if they have a rooming in visitor, that person can leave the room but cannot leave the campus so that is a little bit better. They cannot have other visitors rotate in. That is unfortunate, but we are looking at that for folks who do not have rooming in visitors. They can have folks come in and visit them one at a time, and they could have different people come one at a time. We are still limited to folks over 18 so those with children feel that impact greatly.

Barr: Definitely. What are some common challenges for your staff and meeting the needs of both patients with COVID-19 and with other diseases, who are dealing with COVID restrictions?

Baxley: Right. I talked a little bit about this. Not having access to care is a huge issue. It has been unavoidable for a little bit of time because our patients come from all over the world and COVID has caused a lot of restrictions, not just because if somebody comes here and tests positive, we do not have a good option for them to get anywhere, to go anywhere if we cannot admit them. If they are our patients, it is easier. We can admit them. If they bring a caregiver with them, that is usually the problem because if the caregiver is positive, they are not our patients and so we cannot admit them to our hospital, and we do not have great options for them, and that has been an issue. Then, we have had patients who early on, when there were more travel restrictions and flights were canceled, were unable to leave the country and were not able to go home. They were ready for discharge, but they could not go home because there were no flights.

Barr: So, what did you guys do for them?

Baxley: We helped them extend their stay legally. That is one of the services that my department helps our patients with. We helped them extend their tourist visa and provided them with lodging in the local area until such time that they could go home.

Barr: Were some patients here for months because of that?

Baxley: Yes. We had a few that were definitely here for several more months than they would have been normally, because there were no flights. Their flights were restricted to their home country.

Barr: Oh, my goodness!

Baxley: Yes. It is less common now. We really do not have travel bans like we did early in the pandemic. There are still times when flights are canceled for other reasons other than COVID: because they do not have [functional] flights, do not have crew, or the weather is bad. But those are normal-ish delays, more normal delays, and those usually resolve in a couple of days, not that "prolonged with no flights and we do not know when they are going to allow air traffic" kind of situation that we had early in the pandemic. That was challenging.

Barr: You said that your department helped them move on to the next level of care. Did you encounter any issues, just that medical staff were pushed to the ninth degree on all levels of care?

Baxley: We, unfortunately, are finding a lot of problems with discharge planning. Bed space is difficult to find in facilities, so if somebody needs a skilled nursing facility, or long-term care, or even hospice, those facilities are stressed and stretched thin because their staff is getting sick as well. Staffing out in the community is an issue. The same thing for home care. It is hard to get home care started because it is taking a lot longer than it would have [before the pandemic], because so many people need home care after being in the hospital for COVID, and those systems are stressed and stretched. We have problems finding equipment, especially home oxygen, CPAP machines, BiPAP machines, anything that has to do with respiratory needs. That market has been tapped because of COVID, many people needing new oxygen at home, causing up to a six-to-eight-week delay in getting some types of equipment, and that is not insignificant if you can imagine that you cannot be discharged from a hospital until you

get home oxygen, and you cannot get a portable oxygen concentrator for six-to- eight- weeks to travel home with. That is a long time to have to be in a hospital because you cannot get discharged, and you are not there because you have medical need for an acute care facility, but you are there because you cannot get home because you cannot get the services or the care that you need to get there. So, it is an issue and a challenge across the board for all different levels and types of care in the community.

Barr: Have you found any tricks or solutions to help with any of those situations?

Baxley: Unfortunately, no. We do the best that we can, but we cannot fix nationwide or global shortages of equipment. I wish I had the power to wave my magic wand and make staffing in all the other facilities better, but unfortunately, I cannot do that. We do the best that we can trying to support people when they get stuck here because we cannot find the care that they need in their community.

Barr: How did you go about helping patients return to their communities, especially in the beginning of the pandemic, when society that they knew had changed things to a large degree, and how did you make sure that they felt safe and adjusted?

Baxley: That is also a challenge. Everybody is distancing and staying away from other people, and that makes it really hard to get the social support that people need sometimes to be home and be safe in their homes after they have been in the hospital. So, it has been quite challenging to even find formal home care. The informal helping systems have unfortunately, in some instances, just collapsed, because of the need to distance. Sometimes though, it has been the opposite. Sometimes there are folks who have good family support and a lot of family available because they are stuck at home. They are remote working, and they are no longer going into the office, and may or may not still have a job. Sometimes there is more family support than there ever was because people are home, and so, people can go home and be there more successfully. We have had this dichotomy of experience. Sometimes, it has led to heartbreak and more tragedy, and sometimes frustration because you cannot get your needs, the needs met for the patients; they cannot get their needs met. And sometimes we have had the opposite effect where people have more support than they would normally have had.

Barr: Interesting. Has your department brought counsel to NIH staff, some who are quite stressed and nervous, and overworked, and overwhelmed?

Baxley: We play a smaller role in that effort. Our partners in the National Institute of Mental Health have a large footprint in providing a helping line. We did that early in the pandemic, but it was not getting a lot of utilization, so they discontinued it for a while. They have restarted it recently, and they partner with our employee assistance program (EAP), which is the formal helping process for any employee, trainee, and volunteer. My folks have provided informal support, so folks know our therapists. They see us around. They might just need a listening ear, and we fill that role, informally. We do have a partnership with the Spiritual Care Department in the hospital, and when there are unanticipated deaths, that hits the staff hard, and they are having a difficult time dealing with it, we do what we call stress debriefings with spiritual care. We talk about the situation, how everybody is feeling about it, provide some tips about self-care, keep an eye out, and offer services to anybody who might be struggling more than others with the situation. Unfortunately with COVID, and with only bringing in the most acute patients, we have had a lot of patients' deaths over the last two years, and probably, a higher concentration than we normally would have had, so that has been difficult for staff to deal with. It is difficult for our staff to deal with too. [The patients are] here for a long time, and we get to know them in addition to the medical team.

Barr: After around two years of the COVID-19 pandemic, what is your assessment of performing all the different tasks that your department does in a different way than they had been previously conducted?

Baxley: You may guess that I am not a tech native. When I grew up, there were no computers, and no cell phones. They did not exist. When I was going to social work school, I learned early on, and had it ingrained in my professional ethos, that we are a face-to-face service. We talk to people, we meet with people, that is what we do we do. A lot of our coordination planning and logistics behind the scenes, used to be by phone, and it still is largely by phone, using some electronic means, but mostly by phone. In fact, if you would have asked me before this pandemic, "Could social workers and interpreters provide their services remotely, not face to face? Could you do it electronically?" I would have said, "Well, certainly, we provide phone services for patients who have interpreting needs, but that really is an after-hours backup for emergencies, and for non-medical kinds of conversations, if somebody wants to order food, or somebody wants to talk to one of the visitors that happen to come, or somebody else. That is what the phone is for. If there is an unanticipated emergency after hours, it is there as a stopgap, but we really prefer to have our in-person interpreters there to do that work."

That all changed with the pandemic because we could not be face to face. We have still found the need to have in-person interpreters, and we have done that throughout the pandemic. We have had to limit the types of things they come in to see people for, but we keep expanding that scope over time so we are not quite back to a place where we can have everybody in person face-to-face doing interpreting work. Social workers, I would have said, "Absolutely not. You cannot do this work remotely. You are face-to-face, and it makes no sense for us to do remote work because our patients are here and we need to see them. It might make some sense for you to have maybe a half telework day a month, but really, you have to be here to see people." With the pandemic, that changed. You heard me say we went 100% virtual. We did not stay that way for very long, but certainly, we still provide most of our work remotely, virtually. Most of our encounters are telehealth appointments. We have, as we did with the language interpreters, increased the scope of what we do face to face, but there are still patients that we cannot get in to see including anybody under the extreme respiratory isolation and anybody with COVID on the COVID floor, because we are not allowed in there, and we do not have N95 respirators. We are not fit tested for them. Historically, even before the pandemic, anybody on that level of isolation, we had to work with remotely. We have done a little bit [of remote social work], but we are doing much more than we ever have and I would have said that we cannot do it, but we did it, and so I was mistaken. I have learned a lot throughout this pandemic about what is possible, and [that is] good news.

Barr: I was just going to ask what are some of the lessons, and what were some of the positives and negatives of being removed?

Baxley: So, negatives of being remote, what you would expect with everybody, are the distractions that happen when you're working in a non-office environment: kids, pets, families. Most people have other folks in their space. Having to find a place that is private enough to provide patient care can be a challenge. That is very important. There is one thing for mental health professionals that is a little bit of risk when providing virtual appointments because if you are not face to face with the person in front of you, and they are truly in crisis, there could be a safety issue. If they were in my office, I would have the means to get support if they needed it in that moment, but not if they are somewhere else, and I am not entirely sure where they are, because they could be anywhere. They could be in a car; they could be on their phone and walking around a park; they could be in their home which could be in

another state. We cannot yet do telehealth appointments for folks in other countries. There is some level, some measure, of risk that we assume in doing this kind of work with folks who are not physically in front of us. Those are some of the challenges. And again, we talked a little bit before about the challenges that some people have using technology, and that includes some staff members who are not as versed and facile in using technology. So, that can be a challenge.

But there are definitely some benefits. It has helped with work-life balance, and it helped greatly folks who had small children when all daycares and schools were closed or virtual. The flexibility of being able to split your schedule to take care of your children, to be able to do that work from home so that you did not have to try to find a caregiver at a time when you really did not want people that were not already living there to be in your home, allowed for a better work-life balance, although in some ways, it made it a challenge to have work-life balance because home is work and work is home.

Barr: Yes, I was going to ask you about that. Do you have a social worker on call 24/7, and then how has that translated to being home?

Baxley: We do have a social worker on call 24/7 just like we have to have language support after hours. Psychosocial crises do not always occur during business hours, and so, we handled that remotely, the way that we would for any other crisis during the pandemic; we handled it by phone; we handled it by telehealth appointment, and when we needed to, we have started coming in for any safety assessments. If there is a concern about a patient's safety, we would physically come in. An immediate safety crisis would be abuse, neglect, exploitation, and intimate partner violence. Those are the things that we see folks for face to face.

Barr: Yeah, that makes sense. In addition to many of the other things that you do, you also support hospital volunteers to some degree. Can you speak a little bit about how you kept them engaged during the pandemic?

Baxley: We do not manage the volunteer services, but we have a few folks who volunteer to provide social work care—clinical social workers and language interpreters. We have had a little bit larger footprint of language interpreter volunteers. With volunteers not allowed to come onto campus, it has been a challenge to keep them engaged, although we do have a dedicated core of folks and have had many volunteers who have volunteered with us for many years. They do reach out periodically, and it is pretty self-sustaining, which is the good news. They keep engaged with us. The manager for the language interpreter program talks to them from time to time just to see how they are doing and lets them know where we stand from an organizational standpoint. Our social work volunteers work in other places, and they typically volunteer at NIH. I usually get a few volunteers who are clinical social workers, and used to work for my department, but have moved on to a non-clinical role, and need to keep in touch with that clinical part of their training. They are by and large Public Health Officers, although I do have one of my clinical staff who just retired and just became a volunteer as well. It is folks who really want to keep in touch with doing clinical work even though life and circumstances have taken them away from it. They have been employed throughout the pandemic, but I am happy to say that we are now able to have them come on board and perform services for our patients, so we will be restarting that program.

Barr: That is really exciting! In addition to being working with patients, you have also been an individual who has felt the effects of the pandemic. Personally, what have been some challenges and opportunities that COVID-19 has presented?

Baxley: Personally speaking, and I have talked to my colleagues about this as well, I miss seeing other people. Even when I am in the office, I do not get to see other people.

Barr: Yes, I know. It is weird.

Baxley: It is. I come in, I have one in-person meeting that is very brief, about 15 minutes, where there are about six to seven other people spread out throughout the room. We say "hi", we wave to each other as we are walking to and from, that is pretty much it for the day. Then, I go back to my office, and I have Zoom meetings all the rest of the day, or Teams meetings all the rest of the day from my office. It has allowed me to telework, which again, it is challenging finding space. I live here with my husband, and he teleworks as well. Sometimes we have conflicting meetings, and we have to try to find other spaces because we only have one office. It is those same challenges that everybody else has faced in trying to work from home remotely. But it is also a benefit, and it has improved my quality of life, [while it] posed some challenges in trying to shut down at the end of the day and have a separate space that is work and a separate space for after and before. I do try to be pretty strict about that. Literally, work in the office that is mostly where I do my work, and then, at the end of the day, I close the office door, and I go out, and I do not go back. [The pandemic] is a challenge because there is really not a lot to do [outside of work]. I miss all the social activities that I used to be able to do, and I certainly miss seeing friends and getting together with them. I am looking forward to a time when I can do that again.

Barr: Definitely. Well, is there anything else that you would like to share about your experiences or your department's experiences during the pandemic, or whatever lessons that you feel you all have learned over the past two years?

Baxley: I think we have learned a lot about how we can continue to come together as a team, how we can keep up morale, and how we can support each other throughout these really challenging times. I am happy to say that I have an awesome team, and I am very fortunate to work with everybody in my department. We have been able to keep up morale and do have social gatherings - remotely, but we have them. We have tried to do some neat things to keep spirits up. We recently had a post-holiday celebration, and we had a rolling potluck where people brought in individually wrapped dishes, different ones, the individual serving portion size, and put them in the fridge, and people would just come in and take them when they came on site.

Barr: Oh, that is a good idea!

Baxley: Those are some of the things we have been able to do. My team has been really creative.

Barr: What are some of the other creative ideas?

Baxley: They have done virtual jeopardy games. We all get together, and they create these specialized questions, and then we all play jeopardy just for the sake of bragging rights, not because we give prizes out. That has been really fun. They have had a lot of different creative kinds of virtual games that we have played during gatherings and celebrations. We used to have birthday sweets/ treats like cake and such during staff meeting for anybody who was celebrating a birthday that month, because we have a once a month staff meeting. We are going to do that now, starting this month, virtually as well, and so, that rolling kind of birthday celebration where whoever is the treat person for that month is going to bring in treats, put them in the fridge in individual servings, and people can take them as they come in

throughout the week, because everybody rotates onto campus at least one day a week. So, it has been interesting. I have learned a lot about the way we can continue to provide care. I have been very fortunate to be able to safeguard the safety of our patients and our staff alike, and promote some good work-life balance by providing the ability to telework in a more meaningful way,
and found to my surprise that this is something that is possible, valuable, and meaningful to our patient population as well.

Barr: That is wonderful! I wish you and your team continued success and continued health.

Baxley: Thank you very much, and I wish the same for you and your team.

Barr: Thank you. Well, have a wonderful day.

Baxley: You too.