Adoption and Expansion of Telehealth Solutions

Multidisciplinary Profile: Social Worker

The Association of Community Cancer Centers (ACCC) conducted a brief interview with Sarah Everette, MSSW, an oncology social worker at Baptist Health Louisville in Kentucky, and Karen Kayser, PhD, MSW, professor emeritus at the University of Louisville's Kent School of Social Work.

Telehealth Then and Now

Like other healthcare organizations, Baptist Health Louisville, which serves the majority of Louisville and some surrounding counties, was slow to adopt telehealth. Prior to the COVID-19 pandemic, the practice was actively using a commercial patient portal, but it had not yet introduced video or audio-only visits. With the pandemic underway, Baptist Health quickly expanded its telehealth program to support video visits within its established patient portal. While Everette believes her organization will continue using video visits, she has seen less demand for virtual services as the local COVID-19 situation has improved. At the height of COVID-19, the social work team was conducting roughly 75% of visits via video or telephone. Today, almost 75% of patients are seen in person. However, provider-to-provider communications in cancer committee meetings, tumor boards, and multidisciplinary case conferences remain virtual.

Adapting to Change

As an oncology social worker, Everette assists with patients' psychosocial needs, provides referrals to support groups, serves as a link to community resources, and contributes to the development and management of educational programs. Before the pandemic, Baptist Health had established workflows that worked well for both in-person and virtual social work services. These workflows include using the National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List as an indication of the need for social work intervention.

A high score on the Patient Health Questionnaire (PHQ-9) screening tool can also trigger an automatic referral for social work. "If a patient scores a 4 or higher on the distress tool, that sends us an automatic referral through the EHR," said Everette.

Making an Impact Through Telementoring

Responding to the need for telehealth education. Dr. Kayser is a lifelong educator and researcher. She established the oncology social work program at the University of Louisville's Kent School of Social Work, and for the past 30 years, she has conducted research in the area of psychological oncology. Now retired, Dr. Kayser remains actively involved in provider education through her work using the ECHOTM model for virtual tele-mentoring. When COVID-19 hit, many Kentucky-based health systems and providers struggled to make the transition to telehealth. This struggle was particularly true among cancer care providers, as telehealth was rarely used in oncology before the pandemic. They needed guidance to make it happen. Dr. Kayser and her colleagues responded by developing a 5-part educational series to mentor providers, administrators, and others on how to manage COVID-19 in a cancer setting.

Dr. Kayser worked with a multidisciplinary team to develop the ECHO series. Her colleagues included a surgeon, medical oncologist, public health practitioner, and doctoral student. Sessions in the series included infection control, how to conduct telehealth, ethical implications of telehealth and COVID-19, palliative care during COVID-19, and psychosocial care. In her interview, Dr. Kayser noted that there was a lot of interest in the ECHO sessions; more than 100 individuals have participated in at least one session.

Other referrals come via phone, directly from providers. Because social workers at Baptist do not bill for their services, Everette schedules and conducts all video and telephone visits outside of the EHR environment.

When asked how well she was able to provide care virtually, Everette replied, "It's pretty good. I feel like I can establish rapport and a therapeutic alliance pretty quickly." While she personally prefers in-person interactions, Everette knows that her services can successfully be provided virtually: "I think all of us have had to be flexible and creative in order to meet with our patients—wherever they are." Those same characteristics were important during the height of the pandemic, when patients had to be unaccompanied during onsite visits. To create more supportive environments, Everette leveraged multiple apps and technologies to allow family and friends to be with the patient remotely. Everette believes that her ability to quickly establish rapport, mirror emotions, engage people, and answer questions has proven beneficial, regardless of whether her patient interactions are in person or via telehealth.

Lessons Learned

While Everette's experience has been positive overall, she believes that telehealth-specific training is essential. Organizations should be prepared to quickly supply computer hardware such as cameras and microphones to help scale up more efficiently and effectively, says Everette. She adds that bringing on additional staff to train and oversee the rollout of telehealth services is extremely important, and she recommends that organizations train all staff in remote operations as part of emergency preparedness.

Tracking Progress

While Everette does not track telehealth metrics as a part of her duties, she has personally noted several positive outcomes of her organization's telehealth expansion:

Telehealth has reduced appointment fatigue and enabled participation from people who were unable to be seen in-person due to logistical challenges.

There has been more diversity and better attendance at oncology support groups, including patients from rural areas.

Patient education opportunities, like chemo class, have seen increased participation and may be offered via telehealth going forward.

Attendance at tumor board and cancer committee meetings was higher when hosted virtually.

Advice for Peers

"It is definitely an adjustment period," said Everette as she reflected on her telehealth journey. She recognizes telehealth as an important opportunity to improve care continuity, and she recommends:

- Ensuring that monitoring and evaluation is patient-centered.
- Taking time to build rapport. When both the patients and providers are remote, let patients see their providers' "real lives." For example, patients may feel more at ease when they see a provider's cat, learning something personal about them they did not know before.
- Allow time for training, as many people are not accustomed to using telehealth technologies.