

## Q&A

### Pamela Klein (she/her)

Pamela Klein, Nurse Manager of Transgender Services at Boston Health Care for the Homeless Program (BHCHP) and Nurse Liaison for Boston Medical Center (BMC)'s Center for Transgender Medicine and Surgery (CTMS), shares how the COVID-19 pandemic has affected her practice and her patients and reflects on which changes in care she believes will become permanent.

#### Biography

Pamela Klein obtained her BSc in Psychology from McGill University, served in the Peace Corps in Niger, West Africa, obtained her BSc in Nursing from The Johns Hopkins University and began working as a registered nurse at the University of California Medical Center (UCSF). While working toward her Master's in Community Health Nursing from the UCSF School of Nursing, she explored the health issues affecting the San Francisco transgender sex worker population. The project entailed conducting focus groups with the patients of a newly created Transgender Clinic developed within the San Francisco Department of Public Health (DPH)'s Tom Waddell Health Center (TWHC). This experience crystallized Pam's desire to work in Transgender Health, and she began working at TWHC and met many patients and staff whom to this day she considers some of her best mentors. She also began working in a pilot DPH HIV project called Action Point, offering HIV medication adherence to patients in San Francisco's Tenderloin District. She became an AIDS Education and Training Center faculty member, educating providers and allied professionals about Transgender Health and HIV care, and she continues this work on the East Coast. In 2004, Pam moved to the Boston area, settled in Cambridge, MA and began working at the BHCHP HIV Clinic. After getting her bearings, she conducted a community-needs assessment to determine whether a BHCHP clinic modeled on the TWHC clinic would serve the community. Many well-established health care entities and service organizations serving the transgender population in the Boston area resoundingly supported the creation of this clinic, as they knew of many individuals who remained out of care



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despite outreach efforts. BHCHP leadership put their full support behind the project, and with input from many prospective patients, the clinic launched in 2008 on Thursday evenings (<https://www.bhchp.org/specialized-services/transgender-program>). The clinic maintains a strong connection to BMC's CTMS, which Pam helped initiate in 2016. As the CTMS Nurse Liaison, Pam's role is a combination of clinical care, nursing case management, training and education, and presentations to national and international entities. She also represents both BMC and BHCHP in multiple advocacy efforts including serving as the "health expert" on a Massachusetts governor's Special Commission charged with evaluating and making recommendations for the health and safety of LGBTQ+ individuals incarcerated in the Commonwealth of Massachusetts.

#### How has your practice changed over the course of the pandemic?

I have incorporated telehealth visits via video and phone, gone from working Monday through Friday in the office to working from home 3 days a week, and shifted patient support groups from in-person to Zoom. I educate patients about COVID-19 and assure that they know how to access the COVID-19 vaccine.

#### How has the pandemic altered your care for patients with non-COVID-19 illnesses?

I think wearing masks has had a profound effect on the level of connection with patients. It never occurred to me how much difference smiles can make until we couldn't share them anymore. When people are vulnerable, perhaps ill or embarking on major surgery, feeling support from a caring healthcare provider can be grounding and reassuring. Masks make it harder for me to communicate my support. I make a concerted effort to conduct a video visit prior to meeting someone for the first time so that when we are masked in clinic, our interaction feels less disconnected than if we hadn't already seen each other fully.

At BHCHP, we have increased outreach efforts in response to the pandemic. This is because during the height of the pandemic, patients were urged not to come in unless they had urgent issues, therefore requiring us to re-engage with those who fell out of care. Though the majority of patients do have cell phones, many have limited data plans and don't want to use video or talk on the phone for any length of time. Many of my patients have become "lost-to-follow-up" in the past year or so, and we have begun going out to patients' last known whereabouts to try and find them. Recently,

we partnered with BMC’s Addiction Medicine team to begin a pilot outreach program to the “Mass and Cass” area in Boston—an area known for its tent encampments that during the pandemic has experienced a sharp rise in the number of people living outdoors with extreme health risks (<https://www.patriotledger.com/story/news/2022/01/04/mass-and-cass-most-visible-example-statewide-homelessness-problem/9082024002/>). I accompanied this outreach team recently to locate transgender-identified people and try to link them to care. We found a patient I feared had died. She and I shared a long hug, which though once a commonplace occurrence, felt like a special event given how relatively little direct patient contact I have had since the pandemic arose. We chatted outside her tent and made a plan for her to come in the following Tuesday to meet the case manager and work on housing. She also planned to meet with me to start receiving injectable estrogen in the clinic. There were notices posted on all the tents indicating that the city would dismantle them in a few days, but my patient was hopeful that she would get a spot in a hotel provided by Boston’s Homeless Services Program. Unfortunately, she didn’t show up on Tuesday, and her phone number was no longer active. The city has removed the tents from the area, and we once again have no idea where she is. She is just one example of an already-marginalized patient who became lost to care due to COVID-19. Before the pandemic, there were patients who were difficult to help, but now it has become almost impossible to help them. COVID-19 didn’t create health care disparities—it simply made them more evident.

Another BHCHP outreach effort involved a collaboration with the Transgender Emergency Fund (<https://transemergencyfund.org>), which received a grant to provide fresh fruits and vegetables via Hello Fresh to housed transgender individuals whom COVID impacted. Many of our patients work “under the table” or “at will” at restaurants and hotels. They were laid off during the pandemic and very much appreciated this help. It was gratifying to deliver these boxes to patients, connecting over leafy greens on the sidewalk in front of their homes.

**What is an example of a positive change in your practice that has come from the pandemic?**

Telehealth has been a huge change in care, though the benefit has largely been afforded to those privileged enough to take advantage of it and has been much less impactful for those with little means. For example, at BMC, telehealth has been almost universally positive for the patients I work with, and not only because of the opportunity to see each other’s full faces. The individuals who are pursuing gender-affirming surgery at BMC often live well outside the Boston area. They have welcomed the opportunity to have a requisite nurse assessment over video without having to come to the clinic. This contrasts with the situation for many of my BHCHP patients who have limited data plans or may not have phones at all. BHCHP has enabled patients to come to the clinic and use BHCHP tablets to engage in telehealth visits, but the patient must come to the clinic to do so and sit in a clinic waiting room. This obviates much of the benefit of telehealth for them, though waiting rooms are being maintained at lower capacity to reduce exposure risk there, and the protocol lowers the risk of exposure to the provider.

The benefits and drawbacks of video communication have played out differently with respect to our support groups. At BHCHP, we offer a weekly support group in English and a biweekly one in Spanish, and both have transitioned to Zoom due to the pandemic. We have patients who have attended groups regularly for years, and the groups have become a sort of chosen family for them. Switching to Zoom presented challenges but also opportunities. The change was problematic for some patients who don’t have either the technological know-how, the desire, or the resources to participate. But for those with mobility issues and/or transportation issues (cost and/or fear of traveling at night), the online forum was a welcome alternative. One patient, a transgender woman in her 70s, had never used Zoom before. It took three home visits to help her load and use the app, but she has been there every week since. We recently resumed in-person English language groups twice a month, and this seemed to be a good balance—our older

patient referenced above would come to both the in-person and online forums, but many attend only one or the other. Sadly, because of the recent upsurge in Omicron, we have gone back to 100% online groups again for the foreseeable future.

At BMC, I host a monthly group for patients who either are post-gender confirmation surgery or plan to have this surgery within the coming year. It’s a great forum for patients to ask questions, share their experiences, and make connections. There are actually very few patients who express the desire to return to support group in person. Perhaps because this is more of an information-sharing group and is only monthly, people seem happy to join online. And as mentioned above, we have patients who live many hours’ drive from Boston who were never able to attend in-person but can do so now.

**What is an example of an adverse change in your practice that has come from the pandemic?**

Patients come from all over New England and beyond to have gender-affirming surgery at BMC. In normal circumstances, they come the day of surgery to check in, but due to the pandemic, all BMC surgical patients must present two days prior to surgery for a COVID-19 test. For some, the testing requirement is at worst a glitch in their plans. If they come from far away, they may decide to spend the night prior to surgery in a Boston hotel. For patients with limited resources, the need to come to Boston for a test and then return the day of surgery can present a real hardship, especially if they live far away. Paying to stay in Boston for a night is expensive, and even with a BMC discount at a couple of area hotels, the cost can be prohibitive.

Another adverse change directly because of the pandemic is that we are currently in a phase of postponing all non-emergent surgeries at BMC due to the hospital being stretched to over-capacity and due to staffing shortages. This occurred once already from March 2020 to July 2020 and, at that time, was incredibly anxiety-producing and very disruptive. It feels now that patients are generally less surprised and less unnerved than they were in 2020, but it’s still a hardship and a worry for people. So

many patients have told me how afraid they are, unrelated to COVID-19, that something is going to crop up—such as loss or change of insurance, a medical issue, a change in living circumstances—that will prevent them from having this surgery that only recently became a feasible reality for them in terms of insurance coverage and surgeon availability. The COVID-19-related moratorium only exacerbates that fear.

Another adverse change has to do with the loss of connection to patients, especially with some of our most vulnerable. I referenced this issue earlier with the example of our outreach efforts, but the following anecdote encapsulates how the pandemic's snowball effects impacted a patient's ability to stay connected to care and prevented the ability to engage with her and perhaps intervene to prevent the traumatic event I describe below.

I had been trying since April 2021 to reach a patient I will call Stephanie. I wanted to encourage her to get a COVID-19 vaccine if she hadn't already. She is on probation and whenever I can't get in touch with her, I worry she has been picked up for a violation. She used to drink alcohol regularly and excessively, had gotten into multiple altercations while under the influence, and this had finally led to an incarceration. She had been released with the help of advocacy from pro bono lawyers and her health care team. We successfully petitioned for her release, as she is a transgender woman who was being held in a men's facility due to her identity documents still reflecting her given male name, even though she identified and presented as female.

Stephanie arrived in the United States about 10 years ago from Honduras to escape the persecution she would face if she ever revealed herself there publicly as a woman. She gained asylum in the United States with the help of the same pro bono lawyers and our health care team, who made the case that she had made irreversible changes to her body (with hormone treatment) and therefore could not return and safely resume a male role in Honduras, which is what the Immigration and Naturalization Service expected her to do. For the past year

while on probation, she had remained sober, was working in a restaurant, was preparing to enter a job training program, and lived with a sister who supported her.

One day in June 2021, I was relieved to see she had left me a voicemail, but when I listened to it, my heart sank. I heard her describe that she was home from the hospital where she had been in a coma for 2 months with COVID-19. She felt lucky to be alive. She had been told to make an appointment with her primary care provider and was calling me to help with this. I called her back, and she expressed concern that a wound in her neck was infected. I wasn't sure I was understanding everything she was saying (she is a monolingual Spanish speaker; I speak Spanish fairly well, but it's often harder on the phone). I called her back with the aid of an interpreter service to assure I was getting the whole story. That's when I understood that she had been in a situation warranting a tube inserted directly into her trachea (a tracheotomy) to enable her to receive oxygen. That's why she had the neck wound. I was overcome with emotion, as she had probably been very close to death during that hospitalization. I asked her why she hadn't come in or called the clinic when she was first having symptoms of shortness of breath. She said that she had lost her job, had no money for transportation, had her phone shut off as she couldn't pay the bill, and just figured she would try and get better on her own.

It hit me how vulnerable so many of my patients are, living in the zip codes hardest hit by this virus and working at jobs they are unable to do from home. I thought about the cascade of events that led to her hospitalization. She had a low-paying at-will job with no potential for earned time off. It was a job that put her at high risk of COVID-19—there was no option for her to work from home. She had no savings, so losing her job led to lack of funds, which led to inability to pay for her phone and inability to come to the clinic. I couldn't help but think that if I had been able to reach her in early 2021, she would have gotten vaccinated and none of this would have happened to her. I would have assisted her in coming

to the clinic or directed her to a vaccine site near her apartment. Stephanie's situation exemplifies the point made earlier that the COVID-19 pandemic has illuminated a vast disparity in health care that exists within a context of social inequity, and it has negatively impacted access to the safety nets in place to care for some of those whom those disparities and social inequities most affect.

### **Which changes do you think are here to stay?**

I imagine that the changes here to stay are telehealth visits for clinical interactions that don't require physical exam, keeping some portion of support group meetings over Zoom, and working some days from home.

### **What changes do you envision might be around the corner?**

Hopefully, we will start to see more effective COVID-19 treatments and increased COVID-19 vaccine options. It is also heartening to think that perhaps the research and work on COVID-19 vaccines is potentially leading to development of a HIV vaccine. I think that we are starting to see the fallout physically and psychologically for people who have been suffering in this pandemic. This feels like it will only get worse over time. Whether due to COVID-19 infection, the despair of losing a loved one to COVID-19, the inability for some young people to fully engage with school, the loss of social engagement, or the inability to access care and other resources along with myriad other things, the full ramifications of this pandemic remain unknown.

### **What is one way in which COVID-19 impacted you outside of your practice?**

My relationship with my spouse was tested as we experienced co-existing all day every day at home. Neither of us was particularly confident there wouldn't be major bumps along the way, but I am happy to say that it's gone pretty well. The next test will be co-existing when we are both retired, but at least we have this experience under our belts!

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