Housing For Health in the VA Greater Los Angeles Tent Community

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Word Count: 525, Tables: 1, Figures: 2, Appendices: 5

Conflicts of interest: authors report none.

THE INNOVATION

In response to the COVID-19 pandemic, an innovative approach to providing integrated primary care services was initiated in the Veterans Administration Greater Los Angeles Healthcare System (Figure 1). The Care, Treatment and Rehabilitation Services, a unique street medicine program, was placed within an encampment that is supported by the West Los Angeles VA health care services including onsite provision of 24/7 security, stability of tent sites, 3 meals a day, unlimited water, hygiene stations, face masks, showers and housing placement services (Appendix A).

WHO & WHERE

We are primary care providers in a Veterans Affairs interprofessional, academic patient-centered medical home, known as the Homeless Patient Aligned Care Team (HPACT). We implemented a primary care street medicine clinic to treat Veterans admitted into the Care, Treatment and Rehabilitation Services program.

HOW

The medical team consisted of 5 nurse practitioners, 2 primary care physicians, and 1 preventive medicine physician. We report here on the period of establishment of the primary care program in CTRS, 6/23/2020- 8/7/2020, during which 110 Veterans were admitted into the program. Of the 110 Veterans, 64 were seen and treated by the medical team. Medical visits were conducted on- site either in front of the Veterans assigned tent or in a secluded area on the tent site (Figure 2). All were tested for COVID within 24 hours of admission and monthly thereafter. Initial medical services focused primarily on the delivery of episodic or urgent care which did not address the complex medical needs and chronicity of conditions that the Veterans were experiencing. The majority were empaneled to a primary care team but, many did not seek

routine primary or mental health care. As a result, we changed our approach from solely providing episodic care to building a foundation for delivery of holistic Veteran- led primary care.

To conceptualize the delivery of street primary care, we established five categories of care (Appendix B). This approach aimed to optimize the Veteran's current care team, if they had one, while providing needed care on-site. Many exhibited an active substance use disorder, uncontrolled chronic medical and mental health conditions, and social isolation. This necessitated an interprofessional approach consisting of collaboration with psychiatrists and psychologists via video visits on an iPad.

Adherence to the treatment plan centered on successful engagement of the Veteran. As this population is highly vulnerable, disengaged and distrustful, multiple meaningful interactions were needed to build trust, engagement and a partnering in care.

Characteristics of the Veterans are presented in Table 1. Only 2 of the Veterans tested COVID-19 positive and the average Care Assessment Need Score was 90 among the highest medical severity of any Veterans.

LEARNING

The innovation of a multi-level approach to primary care provision within a federally run, low-barrier tent encampment is applicable to other programs working with unhoused populations. Structuring care that is Veteran led, using interprofessional collaboration across a wide network of social and healthcare services provides efficient care that avoids duplication of primary care services. Future implementation will include, HOUSED BEDS PLUS, a targeted street medicine oriented assessment (Appendix C) and interventions related to substance use disorders, serious mental illness, cognitive impairment and functional limitations.

Acknowledgements

The authors wish to acknowledge all staff of the West Los Angeles Homeless Patient Aligned Care Team, Community Engagement Reintegration Services and other interprofessional teams for their enthusiasm and support of this project. We also acknowledge the support of Joshua Robers, MSN, FNP-BC, Elizabeth Duggan, OT and Dr. Anjani Reddy, MD.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding Support

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The VA Homeless Program Office funds the Greater Los Angeles VA interprofessional HPACT.

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References

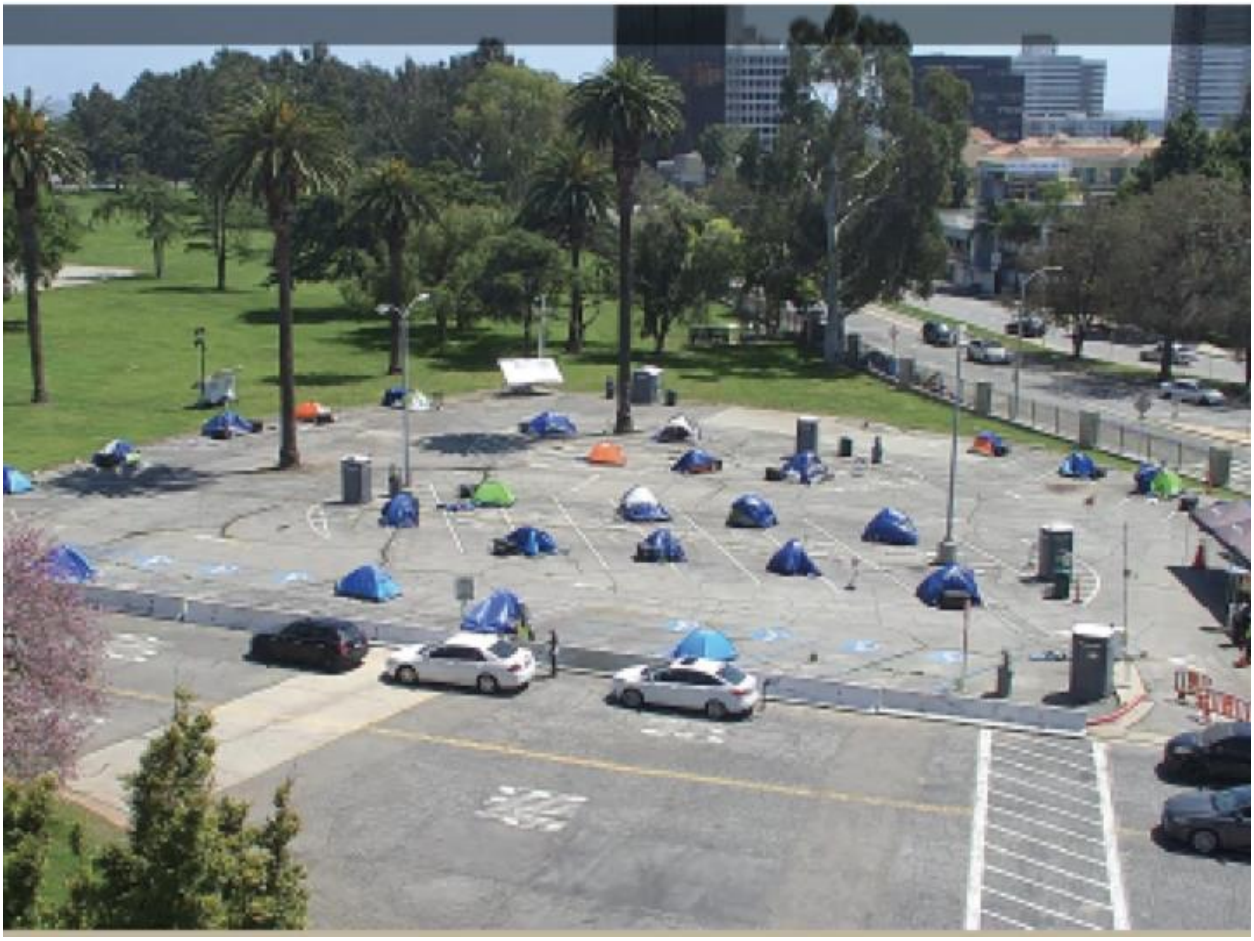
1. Feldman, C., Feldman, B., & Hunt, J. (2019). HOUSED BEDS: A Clinical Tool for Taking a History on an Unsheltered Homeless Patient. Retrieved from https://osf.io/2qb3h/

Table 1. Sample characteristics of Veterans in homeless living in the VA CTRS Tent Community, 6/23/2020- 8/7/2020

	n	%	Median (range)
All subjects	110		
Gender			
Males	105	95.5	
Females	5	4.5	
Age	110		57 (26-79)
Race/Ethnicity	**n**		
Black	41	37.2	
White	49	44.5	
Other	20	18.3	
Visit Status	**n**		
Seen	64	58	
Not Seen	46	42	
CAN Score	**n***		
All Subjects			90 (5-99)
Males			90 (5-99)
Females			95 (20-99)
CAN Score Seen by PC Team	**n***		
Seen	64 (63 with CAN)		85 (15-99)
Not Seen	46 (44 with CAN)		90 (5-99)
COVID- 19	**n**		
Positive	2	1.8	
Negative	108	98.2	

*Note: The Care Assessment Need (CAN) score is a statistical algorithm used by the VA to identify patients at the highest risk of hospitalization or mortality. It considers multiple factors such as demographics, coexisting conditions, utilization of health services, pharmacy, etc. The score places patients into percentiles from zero (lowest risk) to 99 (highest risk). The numbers on denoted on the table show the average CAN score of all subjects in the program during the indicated period and the average CAN score of the subjects seen by the primary care team.

Figure 1. Aerial view of the Care, Treatment and Rehabilitation Services (CTRS) tent encampment site



Note: Image shows the CTRS site during early stages of development including the staff tent (*far left side*), multiple porta-potties and handwashing stations. Tents were spaced 6 feet apart to comply with COVID- 19 safety precautions.

Figure 2. Nurse practitioner resident team onsite at the Care, Treatment and Rehabilitation Services tent encampment site

Note: Medical team working with Veterans on the Care, Treatment and Rehabilitation Services (CTRS) tent site.

Appendix A

Care Treatment Rehabilitation Service (CTRS) Fact Sheet

Care, Treatment, and Rehabilitative Services (CTRS) Initiative

FACT SHEET

What is CTRS?

CTRS provides high-risk homeless Veterans with healthcare, social work, hot meals, a clean environment, and transitional housing assistance in a designated tenting area on the West Los Angeles (WLA) campus.

CTRS is a pilot initiative that expands unsheltered homeless Veterans' access to the VA Greater Los Angeles Healthcare System's (VAGLAHS') Domiciliary Care for Homeless Veterans Program during the COVID-19 pandemic. Its goal is to improve unsheltered Veterans' healthcare outcomes, while moving them toward permanent housing solutions.

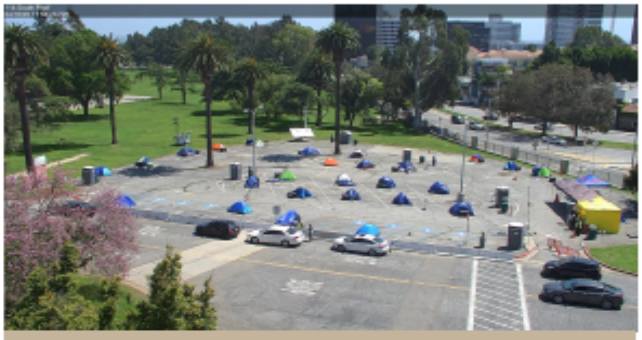


Image of a CTRS Site, WLA Campus

Why is CTRS Necessary?

Los Angeles' homeless Veteran population remains the largest in the country. Unsheltered homeless Veterans have unique needs, including:

- Greater medical fragility than the general Veteran population.
- Difficulty and/or resistance to accessing VA services from off-site encampments.
- Higher risks of exposure to and complications from the COVID-19 virus resulting from living in an unsheltered environment.

VAGLAHS is committed to providing innovative and effective care and services that meet homeless Veterans' complex needs, especially but not exclusively during the pandemic.

What are the conditions Veterans must agree to in order to participate in the CTRS Initiative?

- Veterans must be VA healthcare-eligible and agree to rules of behavior that balance respect for individual Veterans' autonomy with public health and safety concerns. The rules incorporate established public-health and infection-control protocols such as social distancing, frequent hand-washing, good hygiene behaviors, and masking when near others.

How Can I Get Involved?

- **Veterans in Crisis should call 1-800-273-8255 and press 1.**
- VAGLAHS' CTRS Point of Contact is Peter Capone-Newton (Peter.Capone-Newton@va.gov)
- Veterans interested in participating in CTRS can call 1-877-222-8387 to learn about services available to them.
- Volunteers may call the VAGLAHS Volunteer Opportunities line at 310-268-4350.
- Media inquiries should be directed to the VAGLAHS Public Affairs Office at 310-268-3340 or vhaglapublicaffairs@va.gov.

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Appendix B

Five Categories of Primary Care Offered on CTRS

Appendix C

Housed Beds Plus Intake Assessment

Image shows the screening tool piloted by the medical team. It was created by the Keck Street Medicine team. It contains a specific set of questions that clinicians can use to better understand the reality for homeless or unsheltered individuals and how a treatment or care plan will fit into their current circumstances (Feldman, Feldman, & Hunt, 2019). Utilization of this tool enabled the medical team to better understand the Veteran's history of homelessness and its impact on the Veterans current state. Reprinted from https://osf.io/2qb3h/

Appendix D

Homeless Patient Aligned Care Team Information Sheet

Welcome to HPACT Primary Care Clinic (Bldg 402)!

Important HPACT Information:

When are you open?	
Hours: Monday through Friday 7:30 AM to 4:00PM **closed on federally observed holidays	
Important phone numbers	
VA Call Center: (877) 251-7295	Schedule appointments, relay messages to your care team
VA Nurse Advice line: (877) 252-4866	Provide advice on if you should come to VA for further evaluation **(open 24/7)**
VA Pharmacy Refill line: (800) 952-4852	Request refills on medications
Veterans Crisis Line: (800) 273-8255	Provide mental health support if you are experiencing a crisis
What resources are available to me?	**Who are my team members?**
Primary Care (PC) Nursing care Mental Health Social Work & Housing Assistance Same Day Care* for PC & Mental Health *see reverse side for conditions that may be appropriate for same day care visit	PCP: _____ Mental Health 1: _____ Mental Health 2: _____ RN Care Manager: _____ LVN: _____ SW:_____ Pharmacist: _____

How do I get a primary care appointment?

- **Veterans Affairs (VA) Call Center**: (877)251-7295
  - Call this number any time to schedule an appointment with members of your primary care team
- If you need a same day care visit, our front desk can schedule you with a nurse to address your needs
  - You may been seen by a medical provider after this evaluation; all attempts will be made to schedule with your assigned provider

How do I get in touch with my provider before or after a visit?

- **VA Call Center**: (877)251-7295
  - Can take and relay any questions to your care team for follow-up
- Sign up for My HealtheVet to send secure internet messages to your care team! (https://www.myhealth.va.gov/mhv-portal-web/web/myhealthevet/home)

How do I make an appointment for HPACT Mental Health or Social Work?

- **402 Front Desk**: (310) 268-3566
  - Can schedule routine appointments for mental health and social work

Where do I go to be seen?

Unsure where to go?	Call nurse advice line first if not life-threatening: (877) 252-4866 **(open 24/7)**

Nearest Emergency Room or 911	Any **serious or life-threatening condition**, for example: - Stroke or heart attack/chest pain - Serious trauma or bleeding - Extreme difficulty with breathing - Mental health emergencies
Same Day Care	Any non-urgent condition that cannot wait for your regularly scheduled appointment, for example: - Mild or moderate infections - Problem with urination - Sudden changes to your chronic medical conditions - If you are out of medications for chronic medical conditions **and** have zero refills *if you have refills see box below
Regular follow-up visits	Management of your chronic medical or mental health conditions or for paperwork requests
How do I request refills on my medications?	
No appointment needed **as long as refills are available**!	- Call the pharmacy refill line at (800) 952-4852 o Have social security number & prescription number ready - Request online through My HealtheVet portal - Ask a pharmacist to refill at the pharmacy triage desk in Bldg. 500 or in HPACT if present
We want to be able to reach you too!	
• Regularly update your telephone number and mailing address in order to receive messages regarding lab tests or procedure results and your prescription refills • The call center or front desk can assist you with this task as well!	

Appendix E

Assessment and Documentation Template for Progress Notes for Future Use in CTRS

CC:

HPI:

DEMOGRAPHICS:
- Race/ Ethnicity:
- Gender (preferred):
- Language (preferred):
- Military Service: Branch: Years:
- Last grade completed in school:

Employment

GENERAL HEALTH:
- PMH:
  - ACEs Score:
  - On a scale 1-5,with 5 being the best, how would you rate your physical health:
  - Does your physical health prevent you from doing what you want to do? If yes, what?

- Hx of Mental Illness (include hospitalizations, hx of treatment):
  - On a scale 1-5, with 5 being the best, how would you rate your mental health:
  - Does your mental health prevent you from doing what you want to do? If yes, what?

- Hx. of Substance Use (incl. substance type, length of use, route, cost/volume, etc.)
  - Does your substance use prevent you from doing what you want to do? If yes, what?

- Active/Past Medical Conditions:

- Hospitalizations/ Surgeries:

- Medications:

- Allergies:

HOUSED BEDS+:
- H (homeless) history:
- O (outreach):
- U (utilization):

- S (salary):
- E (eat):
- D (drink):
- B (bathroom):
- E (encampment):
- D (daily routine): (#1)
    - Access to a phone/internet/ know how to use:
    - Where do you usually get health info from?
    - Social support:
    - IADLS Screening:
- S (safety):
    - Do you worry about your safety while living outside?
    - Have you been attacked or assaulted while living outside?
    - In the past year, have you been physically or sexually assaulted:
    - Witnessed community violence:
- P (priorities):
    - What are your worries:
    - What are you top 3 priorities:
    - Aspirations
    - Goals

ACCESS TO HEALTHCARE:
- Where do you go when you need medical care?
    - If "nowhere" or "the ER/ED"- what are some reasons you don't see a regular doctor?
    - On a scale of 1-5, how easy (1) or hard (5) is it to get into a clinic or office to be seen?
- When was the last time you were seen at the clinic or office?
- How many times have you been seen at the clinic or office in the last 12 months?
- Have there been times in the past 12 months when you needed to see a doctor but you didn't go?
    - Reasons:

REVIEW OF SYSTEMS:

FAMILY HISTORY:

VITAL SIGNS:

PHYSICAL EXAMINATION:

LABORATORY TESTS:

DIAGNOSTIC TESTS:

ASSESSMENT/PLAN: