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Authors
Lynch, Kimberly A
McCoy, Matthew
Gabrielian, Sonya

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Veterans Finding Community and a "Home" Within an Emergency Housing Environment

Kimberly A. Lynch[1,2*], Matthew McCoy[2*], and Sonya Gabrielian[2,3]

Abstract

In April 2020, the Department of Veterans Affairs responded to the COVID-19 pandemic and escalating unsheltered homelessness in Los Angeles by sanctioning a tent turned tiny shelter encampment at the West Los Angeles Veterans Affairs medical center. Initially, staff offered linkages to on-campus VA healthcare. However, as many Veterans living in the encampment struggled to avail themselves of these services, our "encampment medicine" team was launched to provide on-site care coordination and healthcare at the tiny shelters. This case study showcases the team's engagement with a Veteran experiencing homelessness struggling with opioid use disorder and depicts how this co-located, comprehensive care team allowed for trusting care relationships formed with, and empowerment of the Veterans living in the encampment. The piece highlights a healthcare model that engages with persons experiencing homelessness on their own terms while building trust and solidarity, focuses on the sense of community that formed in the tiny shelter encampment, and gives recommendations for how homeless services might adapt to use the strengths of this unique community.

Keywords

access to care, patient-centeredness, primary care, quality improvement, underserved communities

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In April 2020, the Department of Veterans Affairs (VA) responded to the COVID-19 pandemic and escalating unsheltered homelessness in Los Angeles (LA) by sanctioning a tent encampment at the West LA VA medical center.[1,2] Initially, this "Care, Treatment and Rehabilitation Service" (CTRS) initiative offered Veterans tents, cots, 3 meals/day, portable toilets, and access to VA services (eg, on-site case managers and transportation to showers, laundry, and healthcare). CTRS followed harm reduction principles. On-site substance use (forbidden on federal property) was not allowed, but behaviors consistent with intoxication were accepted barring violence. CTRS' goal was to eventually transition Veterans into permanent housing.

Adjacent to CTRS on the sidewalk outside the VA gates was an already established "unsanctioned" encampment called "Veterans Row." Here, Veterans collectively organized to advocate for permanent housing—"a home for Veterans"—on VA grounds. However, after a homicide occurred, the community, VA, and LA Sheriff's Department collaborated to move Veterans Row into CTRS. The ethos of community (Veterans supporting one another) continued within CTRS.

Subsequently, CTRS expanded rapidly, propelled by COVID-19 outbreaks in congregate settings and Veterans' preferences for low barrier housing (eg, without requirements for sobriety, groups, or curfews). Initially, CTRS offered linkages to on-campus VA healthcare.[1] However, as many CTRS Veterans struggled to avail themselves of these services, our "encampment medicine" team, built from existing funding/personnel for homeless Veteran services (as well as VA's Whole Health Initiative and physician time from a VA health services research fellowship), was launched in October 2021 to provide on-site care coordination and healthcare at CTRS.

[1]VA Greater Los Angeles Healthcare System and UCLA National Clinician Scholars Program, Los Angeles, CA, USA
[2]VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA
[3]UCLA David Geffen School of Medicine, Los Angeles, CA, USA

*These authors contributed equally to this article as co-first authors.

Corresponding Author:
Matthew McCoy, PhD, VA Greater Los Angeles Healthcare System, 11301 Wilshire Boulevard, Building 500, Los Angeles, CA 90073, USA.
Email: Matthew.Mccoy5@va.gov

Figure 1. Tiny shelter external and internal views.

CTRS' structure uniquely allowed us to implement this co-located, comprehensive care team inspired by Street Medicine.[3,4] We cared for, built trusting relationships with, and empowered CTRS residents through establishment of a Veteran-led Veteran Engagement Committee, which allowed Veterans to offer recommendations on encampment improvements and learn about local health and housing resources. In the first 7 months, the encampment medicine team provided care to 95 Veterans in 356 individual visits, which served as an impetus to hire a psychiatrist (70% time at the encampment) and permanently allow the existing street medicine nurse practitioner to provide primary care 50% time at the encampment. Additionally, 1 full-time preventive medicine physician and 1 VA health services research fellow/internist remained and recruited 2 additional VA preventive medicine fellows to help with quality improvement (QI) projects. The team initiated QI projects surrounding COVID-19 vaccination and other vaccines on-site, naloxone prescription and trainings, hepatitis C screening and treatment with on-site weekly medication delivery, on-site monthly phlebotomy screening for basic laboratory testing, and HIV screening in addition to care coordination activities.

Mr. Z was one of our team's first patients. He previously lived on Veterans Row, where he was a leader and advocate for permanent VA housing for his community of Veterans experiencing homelessness. We first spoke with him as Veterans Row was being dismantled. As he frantically packed, he expressed anger about being relocated to CTRS. Previous experiences with VA services had left him distrustful of the system.

Mr. M, a Veteran with hepatitis C and a friend of Mr. Z who also relocated from Veterans Row to CTRS, convinced Mr. Z to seek our assistance. Mr. Z showed us his chronic leg wounds and bottle of antibiotics, which he confided he had not used consistently as prescribed by a community physician. We gave him a pillbox, bandages, and a referral to infectious disease. Mr. Z was grateful for our help but bluntly reiterated his distrust of VA services. The next week when we visited him, he was again comfortable with our on-site team. He asked to speak privately about his erectile dysfunction and wanted a prescription to a non-VA pharmacy.

At our next encounter, Mr. Z was in ill spirits. He refused to open his tent and cursed the team away. Around this time, the VA began to replace all of CTRS' tents with "tiny shelters" (Figure 1: 8′ × 8′ lockable cabins with beds, electricity, heat, and air-conditioning). Mr. Z obtained a tiny shelter before our next visit, during which he pulled up his pant leg to show us pus seeping from his wounds. We set up 2 chairs outside his shelter and cleaned and dressed his wounds.

Mr. Z spoke more intimately about his health, revealing his opioid use and history of overdoses despite buying fentanyl test strips to prevent them, and expressed fear that he would die of an overdose. He wasn't ready for opioid disorder treatment; he wished the VA could prescribe him safer versions of the opioids he bought on the street. Mr. Z had assisted our team with naloxone to save a fellow Veteran's life a few months earlier on Veterans Row. He worried about other Veterans including Mr. M who also used opioids.

Mr. Z missed his infectious disease appointment, so we coordinated with the VA's brick-and-mortar clinic to obtain a wound culture. Leveraging the trust cultivated by our team, we convinced Mr. Z to go to the clinic for care, transported by a friend. Afterwards he reported: "the lady who took my vitals was rude; that's the reason I don't use VA healthcare." Despite this, Mr. Z told us he still trusted our team.

Mr. Z was diagnosed with MRSA cellulitis. Because of his poor experiences with traditional care, the team brought bandages and antibiotics to his shelter. As his legs began healing, he started thinking about moving into an apartment. One day, when he ran out of opioids and was withdrawing, he felt comfortable enough to call us and request a buprenorphine prescription. A few weeks later, he sauntered by our vaccination table in a tie, boasting that he was on his way to view an apartment. He excitedly showed us his healing wounds.

Mr. Z underwent a transformation while in our care. He evolved from a distrustful "problem" patient per medical records to a well-engaged patient. This highlights the tremendous value of providing on-site, consistent care in a tiny shelter community. An on-the-spot referral by his trusted friend, Mr. M—whose hepatitis C we eventually cured on-site without requiring a single clinic visit—allowed our team to develop an ongoing, trusting relationship with Mr. Z, resulting in care engagement. The tiny shelter community, at its best, has compelled Veterans, many of whom were on the streets for decades, to feel at home by providing neighbors and co-located VA staff to lean on for support, and showers, food, and a locked door to aid with a proper night's rest.

Sadly, 1 month after he was housed in an off-campus apartment with a housing voucher, Mr. Z was found dead in his apartment of a suspected overdose.

Permanent housing as a solution for homelessness—usually considered the ultimate goal—often runs up against these devastating outcomes. The foundational importance of community integration and relationships is often neglected by an over-emphasis on housing alone.[5-7] Given the ease with which Mr. Z's friends at the tiny shelter community checked on him by knocking on his door, our team wonders if his death might have been avoided if he had never been separated from his community. His community was more of a "home" for him than his supportive housing apartment. If permanent housing is to succeed, it is critical to incorporate the kind of community and supports found in emergency housing encampments. What would have happened if Mr. Z and Mr. M were next-door neighbors in an on-site VA apartment with quick access to a medical team?

As encampments and tiny shelter communities grow in number we have several recommendations. First, establish designated, consistent, on-site care teams. Second, as Mr. Z proposed, consider "safer supplies" of drugs and supervised drug consumption spaces to combat the overdose crisis.[8,9] Third, work to preserve relationships and community among individuals experiencing homelessness; consider housing people, particularly communities that have a special bond due to their shared experiences (eg, Veterans), near their friends and consider how clearing unsanctioned encampments negatively impacts community. With deaths of despair on the rise, friendships and community may be the most important way to save a life.

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ORCID iDs

Kimberly A. Lynch https://orcid.org/0000-0002-5435-1776
Sonya Gabrielian https://orcid.org/0000-0002-1790-4271

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