

AN EVALUATION OF THE RISK ASSESSMENT AND RESOURCE PRIORITIZATION
PROCESS FOR HOMELESS AND AT-RISK OF HOMELESSNESS POPULATION

By

Shelby Sprang BSN, RN

The University of Kansas School of Nursing

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Dr. Colleen Paramesh, DNP, ARNP

Faculty Committee, Chair

Dr. JoAnn Peterson, DNP, APRN, FNP, WHNP

Faculty Project Committee, Co-Chair

The DNP Project committee for Shelby Sprang certifies that is the
approved version of the following DNP Project:

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Dr. Colleen Paramesh, DNP, ARNP

Faculty Committee, Chair

Dr. JoAnn Peterson, DNP, APRN, FNP, WHNP

Faculty Project Committee, Co-Chair

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Abstract

Homelessness and at risk for homelessness is a growing public health concern as these individuals have poorer health outcomes and increased morbidity due to multiple risk factors. Currently, the U.S. Department of Housing and Urban Development (HUD) provides funds to local and national organizations for resources to be allocated to this population based on the prioritization of one's needs. United Way of the Plains is one of many organizations that serves this population and needs a more reliable risk assessment tool for the prioritization of resources. Many barriers impact the proper utilization of the current risk assessment tool (VI-SPADT) and the organization has recognized a lack of validity and inter-rater reliability amongst the available screening tools. The purpose of this project was to evaluate the process providers utilize within the Continuum of Care Program (CoC). First, an interview was conducted with the director of the UW of the Plains to align project goals, timelines, and identify the problem within the organization. Based on this interview, a fishbone diagram was created to identify the needs and determine current barriers. A formative evaluation of field notes, provider feedback in interviews, survey results, and a search on other available screening tools was conducted and a table comparing other available tools was created. The data was compiled and presented to the UW of the Plains director and providers in an executive summary report and SWOT analysis with future recommendations for the organization.

Keywords: inter-rater reliability, homeless population, at risk of homelessness, risk assessment tools, and validity.

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Introduction

As of 2019, the U.S. Department of Housing and Urban Development (HUD) recognized approximately 568,000 individuals in the United States to be considered homeless on any given night (Kilduff & Jarosz, 2020). This count was taken as a PIT (point-in-time) which captures a Snapshot of those experiencing homelessness at any given state including sheltered and unsheltered people but does not account for those living in others' homes (Kilduff & Jarosz, 2020). Homelessness and at risk of homelessness continue to be a public health concern as these individuals have higher rates of physical and psychiatric morbidity across the lifespan (Kisely et al., 2008). One can define homelessness in a variety of categories: absolute, hidden, and relative and it is necessary to know which category an individual falls within to best meet their needs (Tutty et al., 2012).

The HUD supplies federal funding to many CoCs across the country to support and provide resources to this underserved population. The United Way of the Plains organization is one of the many providers within the CoC that commits to providing education, income, and health for community members within eight counties in south-central Kansas (United Way, 2021). To best serve these individual's needs and prioritize care and resources a risk assessment or screening tool must be utilized. There are a variety of tools used nationwide, however not all tools have been assessed for accuracy, provider compatibility, accessibility to individuals and families, and inter-rater reliability amongst the team serving this population. Many independent variables are affecting the validity of these tools that should be addressed for providers to find the 'right' risk assessment tool. The goal of United Way of the Plains is to integrate an assessment tool that is sensitive enough to identify the highest priority person, easy to administer

without particular skills set, and has a high inter-rater reliability amongst team members participating in the assessment (L. Sanders, personal communication, March 5, 2021).

HUD's Categories for defining homeless

Literally homeless-Individual or family who lacks a fixed, regular, and adequate nighttime residence

Imminent risk of homelessness -individual or family who will imminently lose their primary nighttime residence: within 14 days, lacks resources or support to obtain housing

Homeless under other Federal statutes-unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition but who: are defined homeless under other statutes, have not had a lease or ownership interest during 60 days before assistance, have experienced persistent instability (at least two moves) and can be expected to continue in this status for an extended period due to special needs or barriers

Fleeing/Attempting to flee DV-any individual or family who: is fleeing or attempting to flee domestic violence, has no other residence, and lacks resources or support to obtain other permanent housing

(HUD Exchange, 2019)

Problem Statement

Homeless and at risk of homelessness impacts a person's entire mental, physical, and social well-being. Studies show that one in every five people that gets re-housed will end up homeless again within 18 months (McQuiston et al., 2014). The state of Kansas statistics indicates that an average of 12.9% of these counties live below the federal poverty line as of 2019 compared to the state's average of 12.4% and 99.3 of 1000 persons receiving Kansas Medical Assistance programs (Kansas Health Matters, 2021). The UW of the Plains provides

resources to many vulnerable populations with aims to improve community health outcomes. The homeless population is one of their biggest focuses and goals for re-housing and providing counseling and mental health support for these individuals (L. Sanders, personal communication, March 5, 2021). Researchers have identified that the current assessment tools being utilized do not have a strong evidence base and are limited in identifying an individual's needs for successful intervention (Levitt, 2015). The providers that serve in the different organizations consist of social workers, case managers, mental health physicians/NPs, substance abuse treatment providers, housing specialists, or any shelter staff member. These providers encounter individuals in a variety of settings whether it be on the streets, in clinics, treatment facilities, or therapy sessions. The identified problem is the lack of inter-rater reliability with the current screening tool. It has been identified that 89% of the time there is a change in scoring when screens are conducted by two individual observers (L. Sanders, personal communication, March 5, 2021).

Purpose Statement

The purpose of this project is to evaluate the current risk assessment tool and process utilized at the different organizations within the CoC to determine the validity of the VI-SPDAT (tool shown in Appendix A) in assessing risk and resource prioritization of homeless and at-risk homelessness populations. The intent is to provide evidence-based recommendations to UWP. The following AIM of this project is to compare the validity and inter-rater reliability of the VI-SPDAT to other existing risk assessment tools to determine if (1) continued utilization of the VI-SPDAT will provide the highest validity and risk prioritization for homeless and at-risk of homelessness persons, (2) an existing risk assessment tool would provide enhanced evaluation, (3) the development of a novel risk assessment tool would improve the ability of providers to

prioritize services, or (4) improved training of providers would decrease both variability and/or bias during the intake evaluation improving inter-rater reliability.

Literature Review

Early identification and assessment of the homeless and at-risk of homelessness population is effective in ensuring community resources and services are available in meeting the needs of the individual or family (Moore, 2011). The UW of the Plains (2021) has a mission to improve the lives of their community members through caring power within the community. The organization conducts a community needs assessment every 3 years to reevaluate issues that need to be addressed. The most common identified barrier has been the challenge of allocating resources to individuals without proper assessment or screening. The main gap in the literature is identifying assessment tools that have high inter-rater reliability or have been tested for validity.

Methods for Literature Review

A review of literature was completed to examine the current information on inter-rater reliability and validity of the VI-SPADT and other existing risk assessment tools. The research databases utilized for this search consisted of Cochrane Library, PubMed, Google Scholar, and other online articles. Supporting data was also utilized from interviews with staff members from the UW of Plains. Studies conducted greater than 10 years ago were excluded from the search as well as those not focused on risk assessment tools. Keywords entered for the search are inter-rater reliability, homeless population, at risk of homelessness, risk assessment tools, and validity. Three main themes were identified in the research are challenges to tool administration, logistical barrier of tool utilization, lack of validated tools, and education and training on risk assessment tools. While not all articles utilized focused on the targeted population, they did provide support and recommendations towards improvement in inter-rater reliability amongst members of a team.

Themes

Challenges to tool administration. One of the main barriers identified in conducting risk assessment tools on this population has been the variability of how, when, where, and by whom the tool is being utilized. There are many confounding variables that need to be considered when conducting a risk assessment on these individuals. Given the demographic challenges of the homeless population the first encounter could be on the streets, in-person at a clinic, or a therapy session with a mental health guide. Depending upon which encounter is the first time meeting the individual or family the tool could be conducted by a variety of ‘providers’ such as a social worker, case manager, housing specialists, mental health physician/NP, substance abuse treatment provider, or any shelter staff member. Each ‘provider’ has their own level of knowledge and skills which causes variance in the conduction and scoring of the tool. Abet et al. (2010) states that inconsistency of components of a risk assessment can allow for communication of overall uncertainty. Another variable in this encounter is the relationship with the person (established vs non-established) based on whether this is their first encounter or if the individual is a patient seeking recurrent treatment and has established connection. This creates room for administration bias, favoritism, judgment bias, and discounts the effectiveness of the tool’s validity. To address this barrier, it is necessary to take important steps in planning and decision making when selecting or implementing a common risk assessment tool. One suggestion by Abet et al. (2010) is to bring all your stakeholders together early in the planning and decision-making process to determine the major factors that need to be considered and lay down the context, timeline, and depth to ensure the right questions are being asked in the context of the assessment.

Logistical barrier. The next barrier identified in conducting the current risk assessment tool (VI-SPADT) was the logistical barrier or time it takes. As previously described, the

circumstance of the individual determines who performs the assessment and in which setting. The providers perform a screening on the individual at first contact, for any major event that takes place in their life (substance abuse, hospitalization, mental health change, etc.), and if it has been more than 6 months since the initial screen (L. Lank, personal communication, March 5, 2021). Since the screens are taking place all the time and often within the organizations it is necessary to have a tool that is concise and accessible to all, yet effective. One current complaint from the providers is that the current tool does not allow the option to leave open comments (L. Sanders, personal communication, March 5, 2021). Other risk assessment tools utilized for this population, such as the DESC-Vulnerability Assessment tool allow for this option to be taken into consideration in final scoring and prioritization of resources (DESC, 2020).

Lack of validated tools. Another common theme noted amongst the assessment of tools was the lack of validated tools utilized in the homeless and at risk of homelessness population. The HUD (2015) compiled a table of most utilized risk assessment tools and out of the 15 tools listed only two had psychometric properties tested for validity and inter-rater reliability and one is currently undergoing a pilot study. The overview of tools lack continuity between domains, number of questions, and areas of focus whether that be subjective or objective data. This makes it a challenge to compare tools and rate effectiveness. The importance of measuring inter-rater reliability is to measure the consistency between different individuals collecting data and the variability that arises amongst human observers (McHugh, 2012). Inter-rater reliability testing on the current risk assessment tools would provide insight into the tool effectiveness and consistency over a large population. The providers want to ensure that the current tool they use within the organization has been tested high for inter-rater reliability.

Education and training on assessment tools. Studies have found that in conducting a needs assessment the provider's perspective of needs is often much different than the individual's perspective creating errors in the prioritization of one's needs (Beran, 2015). This has been identified as a barrier by the providers when conducting assessments with the current tool and transposed the question is it the tool or the lack of training and education in the utilization of the tool by the providers. Reliability is defined as the consistency of a research study or measuring test (McLeod, 2013). Holland et al. (2020) conducted a study that found structured training methods including a model assessment, training webinars, practice assessments, and a facilitated discussion amongst the group to contribute to a higher inter-rater reliability. To increase inter-rater reliability amongst the providers within the CoC it was recommended that staff incorporate further training into conducting a risk assessment. This will not only improve inter-rater reliability but ensure the proper use of the tool when prioritizing an individual's need amongst the population. The consistency with risk assessment tool use should display overall effectiveness in those with greater need to be prioritized highest for resources.

Theoretical Framework

Organizational Elements Model

A theoretical framework is utilized to connect ideas and theories to research and aid in the organization of the research (Walden University, 2020). For the purpose of this project, one main conceptual framework was used to guide and support the implementation of the project within the organization. Roger Kaufman is the creator of Mega thinking and planning, a paradigm model to shift focus to individual performance improvement to add value to the organization ultimately, impacting external clients and society (Kaufman, 2009). This model is identified as the Organizational Elements Model (OEM) taking what "an organization uses, does,

produces, and delivers to achieve external client and societal value-added” (Kaufman, p.2, 2009). In utilizing this model for the purpose of this project it allowed for organizational critique at the macro and micro level with six critical success factors: assess needs, determine a solution, select methods and means, design, develop and implement method and means, and evaluate effectiveness for continual improvement as displayed in (Appendix B) (Kaufman, 2009).

The first factor identifies a change that is necessary, the UW of the Plains and other providers have identified a problem within their CoC with the current risk assessment tool which is impacting the proper utilization and prioritization of resources for the homeless population they serve. The second factor allowed for an ideal vision to guide the improvement process which is the analysis of the current risk assessment tools being utilized and what changes the organization would like to take place for higher inter-rater reliability. The third factor of the OEM model encouraged the organization to focus on the end results first to determine what is needing to be fixed and what should be abandoned moving forward. For this project, the end results include identifying whether the current risk assessment tool (VI-SPADT) is a reliable enough tool or whether another tool would allow for more success. The fourth factor to prepare objectives will be achieved through field notes, provider feedback, and the rigorous analysis of risk assessment tools with set measurable objectives that align with UW of the Plain's timeline for project completion. The micro, macro, and mega levels of planning were utilized in factor five to break down the clients being impacted. Within this project, the mega level of planning included the homeless population, the macro-level of planning included the organizations within the CoC, and the micro-level was the providers within the organization. The sixth and final factor called for defining the need as a gap between current and desired results (Kauffman, 2009). This implies the delivery of value-added to the organization through the successful

analysis of risk assessment tools and identifying a tool that will best serve the providers.

Application of Kauffman's Organizational Elements Model to this project allowed for a multi-level assessment within the organization for proper identification and modification of the current risk assessment tool and a plan to increase inter-rater reliability amongst providers.

Methods

Project Design

This is a quality improvement project using a process evaluation format to analyze the current risk assessment tool being utilized by providers within the UW of the Plains and other organizations compared to other available screening tools for the homeless/at risk of homelessness population.

Project Site and Population

The setting for this project was the United Way of the Plains in south central Kansas region serving eight counties. The population inclusion criteria for this project included any staff member who has direct contact with an individual or family member who is homeless or at risk of homelessness (as described in the definitions above).

Steps of Implementation

The first step included a semi-structured interview with the leadership team at the UW of the Plains to identify current problems and barriers. From this meeting a fishbone diagram was created to aid in visualizing the current needs. Using the identified needs as a foundation, a search of available risk assessment tools was conducted. The second step included the creation of a table to compare tools for inter-rater reliability, validity, questions, domains, and scoring for prioritization of resources. A formal review of the current process took place through survey results, round table discussion with semi-structured questions, field notes, and feedback from

providers. Finally, information gathered from the needs assessment, tools evaluation, and field work was summarized in formative and summative reports and presented to the UW of the Plains.

Data Collection

An evaluation of current needs included information that was collected from the survey, field notes, comments, opinions and semi-structured interviews between the directors, staff members, and providers at the UW of the Plains organization. A fishbone diagram was created for the purpose of assessing needs. The current tool was compared to other available evaluation tools utilized for risk assessment. A table was made comparing available current screening tools which included identifying the specific domains, validity, and inter-rater reliability scores. A table was made to display direct quotations from providers during interviews.

Data collection for the SWOT analysis was originally intended to occur through a variety of in-person meetings and site visits to gather the highest quantity and quality of responses. Due to the COVID-19 pandemic restrictions and policies at the time of data collection, it was necessary to modify that plan so data was collected through brief site visits to three of the facilities and the rest collected electronically to limit exposure and decrease risk of myself and participants.

A survey was created to send to all directors of the CoCs in the Wichita area in conjunction with the United Way of the Plains. This survey was a brief 7-question “yes” or “no” response with the last question being a comment box for additional feedback regarding the use of the VI-SPADT tool in their facility: (1) What is your provider role at the United Way of the Plains? (2) How satisfied are you with using the VI-SPADT tool in your practice? (3) Have you used other risk assessment tools (other than the VI-SPADT)? (4) Do you feel the VI-SPADT tool

properly assesses and prioritizes the population you serve? (5) Do you feel you had adequate training and education of the tool before using it in practice? (6) Would you consider the use of a new risk assessment tool? (7) Please feel free to provide any further feedback or comments about the use of the VI-SPADT tool in your practice setting. (See Appendix D). The survey link was sent out through email and also included in the project implication presentation provided to the directors. Overall, the directors were receptive to the survey and made commitments to complete the survey themselves and share it with their staff to ensure a variety of input from differing clinical roles. The CoC directors sent the survey link to their staff via email, with a reminder email, and provided in-person discussion about the purpose and encouraged staff participation and feedback. The providers were reassured the survey was brief, anonymous, and did not require a significant time commitment.

The collected in-person data consisted of field notes and site visits to the following three organizations: Independent Resource Center, the Salvation Army, and the Substance Abuse Center of Kansas (SACK). The site visits included interviews with directors, case managers, shelter staff providers, and coordinated entry directors. The interviews were conducted in a round table discussion manner with informal discussion guided with questions regarding the use of the VI-SPADT tool in their organization. The responses led to further questions and guided the rest of the meeting, notes were taken throughout the discussion, and participants were informed that the feedback would remain anonymous. The informal discussion allowed participants an opportunity to openly share their true feelings towards the use of the VI-SPADT tool and how it impacts the care they provide the homeless and at-risk of homelessness population. Each site visit consisted of about an hour to an hour and a half in time. One of the case managers utilized a hard copy of the VI-SPADT tool in our interview to identify and

highlight specific questions that she found concerning. Overall, the visits were successful, and the field notes taken at each site were plentiful.

One more collection period took place via Zoom meetings with two different providers within the CoC, the Robert J. Dole VA Medical Center and the City of Wichita. The first meeting included a social worker, a homeless program supervisor, and a coordinated entry director. The meeting lasted an hour and was conducted in the same manner as the in-person visits with a guided round table discussion with interview questions. Once again, field notes were collected during the visit and the meeting concluded when the providers expressed they were done sharing feedback. The supervisor volunteered her organization to be available for any future pilot study of a new risk assessment tool or process to take place. The second meeting was with a senior housing specialist for the City of Wichita, the meeting lasted 45 minutes and resembled all the same principles as the other Zoom meeting. All the participants were informed that their feedback would remain anonymous and only be identified by the organization when used for project purposes.

Analysis

A formative report was utilized to summarize the recommendations. This information was presented in the format of an executive summary and a SWOT analysis to the UW of the Plains to address recommendations which included the potential use of a new tool or modifications and additional training for the current risk assessment tool process. A summative report will be created to provide inter-rater reliability, validity, and specific domains of the current tool and additional tools used within CoC's.

Organizational Approval

The approval for this quality improvement project was granted by Luella Sanders, Director of Collective Impact for the United Way of the Plains organization located in Wichita, KS. This project aligns with organizational goals to improve the risk assessment tool utilized by their providers in assessing and prioritizing resources from the CoCs for the homeless/at risk of homelessness population they serve.

Human Subjects Protection

The project was implemented by the United Way of the Plains organization and serves as a needs assessment to provide feedback and analysis to the stakeholders. Given the nature of this project, confidentiality and protection of patient's rights do not apply. To fully evaluate risks, an application was submitted to the University of Kansas Medical Center Human Subjects Committee and approved with a Quality Improvement designation.

Timeline

The projected timeline for this project is April 2021-June 2021 (as displayed below).

Table 1. Project Timeline

	April	May	June
Needs Assessment			
Tools Evaluation			
Field Study			
Recommendations			

Results

Demographics

A total of 8 responses were collected within the first two days and reminder emails were sent at the one-week mark to complete the survey. In total, the survey had 12 responses from a variety of coordinated entry coordinators, social workers, case managers, and homeless program directors from different providers within the CoC. A few of the providers did not participate, but the majority did or admitted that they took the survey with others and agreed with their responses.

The in-person visits consisted of program managers, rapid rehousing and transition supervisors, emergency housing case managers, and site directors. The virtual meeting consisted of a homeless program supervisor, a coordinated entry specialist, and a social worker (all participants were licensed social workers) (see Figure 1). Within the providers that participated, more than half have more than 10 years of experience working with the homeless and at-risk homelessness population (see Figure 2).

Figure 1. Participants' roles in the organization.

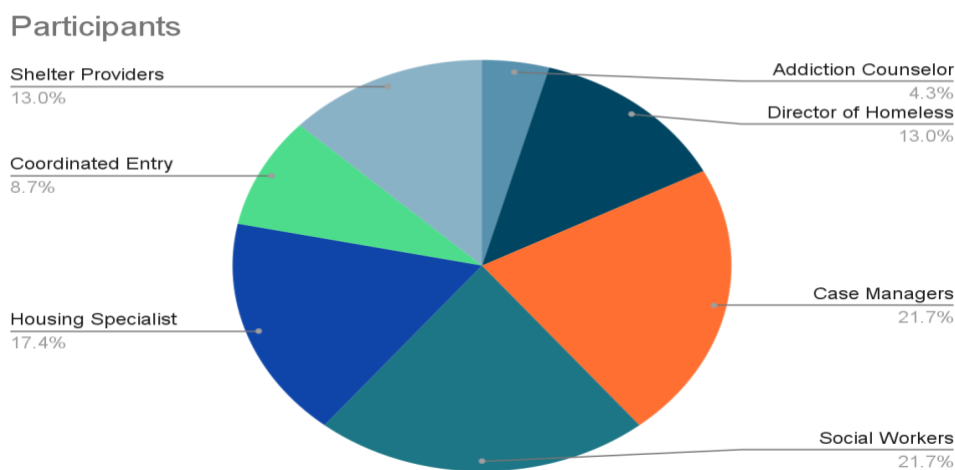
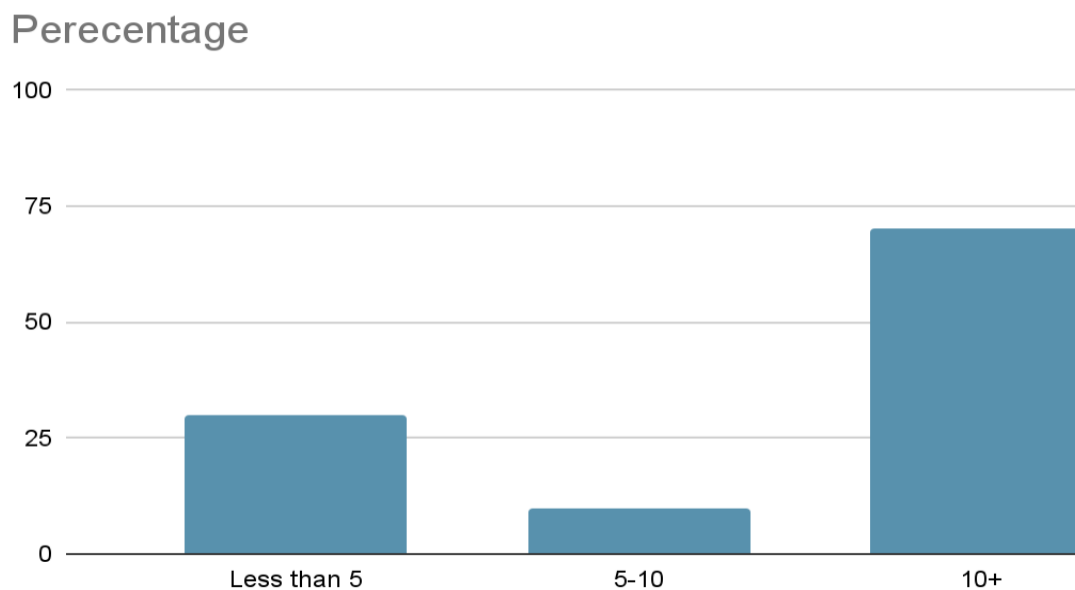


Figure 2. Participants’ years of experience with the homeless population (at the current organization or elsewhere).



Survey Results

The overall results of the survey showed conflicting evidence with the current use of the VI-SPADT tool and resource prioritization process. The majority of providers (66%) stated they were satisfied with the VI-SPADT tool. However, when asked if they feel the VI-SPADT tool properly assessed and prioritized the population (58.33%) stated “no.” Seventy percent of providers completed the survey and stated they have not used any other risk assessment tools and all providers agreed they had proper training and education of the tool prior to use in practice. All the providers answered “yes” regarding the consideration of a new risk assessment tool. The subjective information (seen in Table 2) was collected in the feedback/commentary box of the survey and was combined into the main themes identified during field notes and interviews with providers.

Table 2. Providers’ responses.

Data Collection Method	Commentary (Direct Quotations)
<p>Survey:</p> <p>Question 7- Please feel free to provide any further feedback or comments about the use of the VI-SPADT tool in your practice setting.</p>	<p>“When clients see the pages of the VI-SPADT they literally get frustrated as it is evident by their facial gestures and posture.”</p> <p>“People do not want to admit to being kicked out. Some questions like #9,14,27 are too long. I have to repeat them at least 2-3times. Maybe their length may be one obstacle that confuses people.”</p> <p>“My concern (and while maybe it is not appropriate for this survey) is that our community uses this tool as an “absolute” tool for working/not working with an individual/family. It is my hope that a score would be used more as a guide.”</p> <p>“It works as a tool since we don’t have anything else...it has been a good start. However, it doesn't encapsulate everything that is going on with clients and ends up screening some people out of some housing programs that may have been a good fit while allowing others in who are not a good fit. For example, a chronically homeless person with a lot of issues scoring a 5 on the assessment and being placed in a rapid rehousing program and they end up back on the street because the program doesn’t have enough support for their actual needs vs. what they reported.”</p>
<p>Interviews/Round Table Discussions</p>	<p>“$\frac{1}{3}$ people does not address their mental health issues”</p> <p>“Almost weekly I feel my staff are coming to me and saying well this patient got a 6 but in all actuality should be a score of 10 or higher.”</p> <p>“The term stable housing means something different to everyone.”</p> <p>“I have never had a client actually admit that they engage in risky behavior.”</p>

“These individuals do not have a trusting relationship with the government, police force and have fear that if they answer questions correctly DCF will take their kids, they will not be able to get a job, or be eligible for housing. When in reality those types of behaviors score them higher and make them more eligible for resources.”

“I feel most of the interviews I conduct the client gets distracted by the first questions and does not answer or even hear the rest.”

“If I do not manipulate the script of the VI-SPADT then I would never be able to complete an interview with a client. I know that's not how it is designed. I am performing these interviews with the best interest for my clients and in order to get housing they need a high VI score.”

“It feels like the end all be all once a score is attached to a client's name.”

“The time frames during the tool switch back and forth several times and this always confuses the client.”

“The clients openly admit, “I’m not saying all that I need housing.” they feel by being honest they will not be eligible.”

Discussion

Themes

User observation bias. Several providers that perform the VI-SPADT tool daily with the patient population felt they had biases of the person due to outside knowledge (medical, criminal, etc.) they obtained prior to performing the tool. The providers acknowledged it was difficult to have this information and know that the interviewee was answering the questions incorrectly and be unable to modify the response. The providers felt if they were able to use the subjective data about the person then the VI-SPADT tool score would be more accurate. The participants reported that utilizing the subjective information results in a higher overall score in most circumstances allowing more appropriate resources to be available for the individual.

Lack of transparency. Another common theme received in the feedback from the providers was the lack of transparency from the population. Many providers stated in their interviews with the person, the majority admitted to answering the VI-SPADT incorrectly or refrained from answering the VI-SPADT altogether out of fear. Many individuals are afraid of answering personal questions about themselves to a person they have never met before. Providers stated that in their experiences working with this population the patients have a fear of the KS Department of Children and Families (DCF) taking their children, not being able to get a job, getting in trouble with law enforcement, or the government, therefore decreasing the truthfulness of responses. Therefore, questions regarding past drug use, engaging in risky behaviors, and history of HIV/AIDS are rarely answered truthfully from individuals (which would result in a higher score). Providers feel they would get more appropriate responses if they had an established relationship with the person before performing the tool on them.

Concerns with VI-SPADT complexity. From the collection of survey responses, interviews, round table discussions, and field notes gathered, there were many providers who expressed concern with the complexity of the VI-SPADT tool. The providers feel that the questions can be too lengthy, written at too high of a reading level for most of the population, and confusing to know which time frame the question is referring. Some examples of this include the first several questions (Q3) refer to the last 3 years of the individual's life, then (Q4) switches to the last 6 months, (Q6) refers to the last year, and (Q14) refers to current date and time of survey (see VI-SPADT tool in Appendix A). The providers feel this adds to the confusion and lack of truthfulness of survey responses since the tool jumps around time frames. Many of the questions on the tool ask more than one question in a single question. For example, question 4 has 6 questions within it. The providers can agree that this contributes to loss of focus during tool performance with the individual. The reading level at which the VI-SPADT tool was written appears to be too high for most individuals as questions need to be regularly repeated or rephrased for understanding. The tool is designed to be scripted to allow for elimination of biases, however, consensus among providers is that if they did not further explain the question to the person, then there would be no response.

Score is not consistent with reality. The housing resources are divided into 3 scoring categories based on their VI-SPADT, 0-4 housing plan for the individual, 5-10 supportive or transitional housing options, and 10+ permanent housing options. The provider's responses revealed that most of the time individuals were scoring in the incorrect category based on their needs due to incorrect responses on the VI-SPADT. An example provided is that an individual may not answer truthfully to questions on the VI-SPADT out of fear resulting in a lesser total score placing them into a supportive or transitional housing category when in fact, they really

need a more permanent housing option. The providers state this is happening often and that there is high recidivism with this population due to inaccurate scores on the VI-SPADT. The providers express that this score is creating an “end all be all” to the individual’s name once the score is attached. This population is missing out on provided and available resources if they do not score appropriately on the VI-SPADT. The provider’s opinion is that if they were able to send the VI-SPADT score plus a narrative of “why” client score is not accurate to the homeless management information system (HMIS) then maybe the individual would have better outcomes. Another concern voiced by the providers is that case conferences for individuals are happening way too often due to inaccurate scoring, and this is a barrier in the process for this population.

Executive Summary

SWOT analysis

The SWOT analysis below (see Figure 3) demonstrates the strengths, weaknesses, opportunities, and threats identified in the provider’s current use of the VI-SPADT tool. A SWOT analysis is an instrument that can be utilized for employees in an organization to make improvements through recognizing strengths and opportunities while working to eliminate weaknesses and threats to meeting objectives and goals (Arshad, Noordin, & Othman, 2017). The SWOT analysis for this project showed internal strengths including the majority of the providers having 10 + years of experience in working with this population. This is an example of the commitment this team has in serving these individuals. The providers are educated and specialize in working with this vulnerable population. A highly experienced motivated leadership team that is driven to meet the needs of their staff and the population they serve is necessary for successful outcomes. The identified strengths of the tool consist of its conciseness, accessibility via paper or web thus making it versatile to use in different settings. One of the providers

mentioned that the tool is quick to access online and can even be administered over the phone which makes it easier to score more individuals because you can't always rely on them coming into the clinic (anonymous, personal communication, May 24, 2021). Providers feel they are well trained and prepared to utilize this tool in their practice setting. Additionally, the tool is universal and many other CoCs in the state of Kansas currently utilize this same tool to serve their homeless population.

The weaknesses identified in the SWOT analysis consist of the inconsistency of use of the VI-SPADT tool between providers, the staff frustration with the current tool use, and the shortage of staff members at each organization. Staff are dissatisfied with the tool because of slow data entry it takes to input the paper format of the tool into the HMIS system. Along with the lack of subjective information that can be included with the individuals score contributing to high recidivism from inaccurate scoring of individuals. One provider mentioned that the rate of homeless individuals returning to the streets after having housing has increased due to improper scoring from the VI-SPADT tool (anonymous, personal communication, May 24, 2021).

The SWOT analysis of the VI-SPADT tool and process evaluation at UW of the Plains consisted of external opportunities including provider feedback for the purpose of this project, increase in inter-rater reliability with tools use, increase in staff compliance and satisfaction of tool usage, and increase in efficacy of scoring individuals for housing resources. The providers within the CoC are well trained on utilizing the tool and denied the need for further training and education on its use. By participating in this project providers have identified that there is a problem with the current process and change is necessary to best meet their clients' needs. Improving inter-rater reliability amongst the tools will create more positive outcomes in the scoring of individuals for housing resources and reduce recidivism. The providers agree that if

the VI-SPADT tool is not able to be modified then a new tool may be necessary for the CoC to commit to.

The external threats that could lead to potential barriers in updating this process include recognizing that change is a commitment and that this process will involve many different providers and organizations at all levels. There could be some resistance to the whole CoC accepting a new tool and there is potential for increase in staff frustration learning a new tool and process. All of this is important to consider and plan for as the process is being updated.

Figure 3. Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

SWOT Analysis

■ Helpful ■ Harmful

Providers:

- Useful feedback
- Increase Interrater reliability
- Increase staff compliance
- Increase staff satisfaction

Tool:

- Adaptive rating scale
- Longer tool, more simplified questions
- Increase efficacy of score

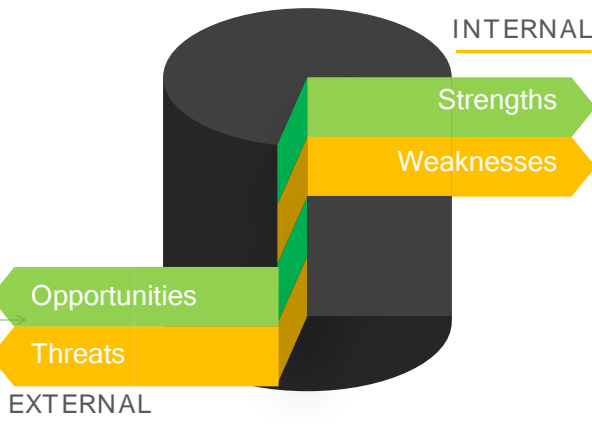


Providers:

- Change of current process

Tool:

- Training and implementation of new tool



Providers:

- Specialty trained
- Years of experience
- Commitment to the population



Tool:

- Concise
- Universal
- Virtual

Providers:

- Inconsistency with tool use
- Staff shortage
- Staff frustration



Tool:

- VI-SPADT on paper-slow data entry
- No Subjective data
- High recidivism due to inaccurate scoring

Impact of Outcomes

Overall, the overwhelming response has been that this tool is not working for the providers in successfully scoring and providing resources for this population. The general agreement from providers is they perceive they are completing the tool because it is required for resources to be an option but that it is merely a guide and not necessarily accurate to the individual's needs. Another concern from the providers is that they are not able to be good stewards of resources when they are needing to have meetings or conferences regarding clients after utilizing the VI-SPADT tool to come to a better solution for that individual. This process is time-consuming, repetitive, and improper use of time with staffing shortages being a current problem. It has been a long-time problem that has been impacting providers' daily workflow for the last several years. The providers were relieved to finally share this information with an opportunity that change will occur. Providers want to feel like they are benefiting the homeless population in their community, and they hope the process will be updated based on the feedback they provided. Many providers were open to change and one organization even volunteered to be a pilot study for a new tool or process. The willingness of providers to adopt a new tool or modify their current processes makes it evident that change is necessary. Since the project's goal is to improve the current risk assessment tool and resource prioritization process then an implication for practice improvement should be put in place.

Future Implications to Practice

This QI DNP project could potentially be a step forward to the future practice for providers at the United Way of the Plains and other organizations within the CoC. The project evaluated the current tool and process, collected feedback from a multitude of providers within the CoC via interviews, field notes, and a survey, analyzed other risk assessment tools suggested

by HUD, and compiled an executive summary. The project has clearly identified barriers in the current process and eliminated the intervention for further education and training of the current tool. The recommendation for future practice is for the current VI-SPADT tool to be removed from the current housing and resource prioritization process for the homeless and at-risk of homelessness population and for the CoC to adopt a new tool. The summary of data collected from this project identifies the problem and breakdown in current tool's use. This is the first step in making a change for future practice. Given the provider feedback a preferred tool would be adaptive in nature considering the mental health, potential fears, and substance use of this population. A clinician that is well-trained and experienced can construct an unstructured interview utilizing an adaptive behavior assessment tool to best assess the individual in their current everyday living situation (Reschley, Meyers, Hartel, 2002). This kind of tool is commonly utilized on mentally and intellectually disabled individuals and allows for the individual to score themselves as well as the provider to score the individual then merge the two scores on an adaptive scale. A summary of current tools recommended by HUD were compiled in a table (see Table 3) to compare domains, cost, and inter-rater reliability. This table is further evidence that creating a new tool is necessary because current tools do not fit the recommended criteria providers are requesting. None of the tools are conducted on an adaptive scale and only two out of the 12 tools have been tested for inter-rater reliability. The closest tool to meeting the expected domains, the Homelessness Assest and Risk Screening tool (HART) and the Rehousing triage and assessment tool have not been assessed for IRR and the DESC-vulnerability index tool does meet the domains necessary but is costly. The current tools are not sufficient in updating and improving the current process. The nursing research department at KUMC would be an option for creating a new tool. That process including full development, pilot study, and

validation would take approximately 1-2 years. It is recommended that the United Way of the Plains organizations take this offer into consideration for the opportunity to vastly improve their outcomes in housing homeless and at risk of homelessness individuals in their community as well as improve provider satisfaction in their daily workflow and provide them with the tools necessary to successfully serve this population.

Table 3. Risk Assessment Tools recommended by HUD

Tool	Costs	Interrater reliability	Self collected or interview	Total # Questions	Hx Housing and homelessness	Risks	Socialization/ Daily Function	Wellness	Survival Skills	Basic Needs	Indicated Mortality Risk	Medical Risks	Organization Orientation	Mental Health	Substance Use	Communication	Income/ Education	Childhood/ Youth Factors
VI-SPADT (version 2)	Free	No data	SC/I	27	X	X	X	X	X						X			
DESC	\$	IRR=.67	I	10	X		X		X	X	X	X	X	X	X	X		
Multnomah Community Ability Scale	\$	IRR=.85	I	17			X							X				
Vulnerability Index	\$	No data	SC	30	X			X	X	X		X		X	X			
Rehousing, triage, and assessment	Free	No data	SC/I	45	X						X	X		X	X			
Memphis/Shelby County Intake/Assessment Packet	Free	No data	SC	?	X						X				X			
Homelessness Asset and Risk Screening Tool (HART)	N/A	Pilot study	I	21	X		X											X
Alliance Coordinated Assessment Tool	Free	No data	I	27	X	X	X											
Hennepin County Rapid Exit Screening	N/A	No data	SC	?	X						X			X	X		X	
Denver Acuity Scale	N/A	No data	SC	?	X		X			X	X			X	X			
Calgary Acuity Scale	Free	No data	SC	?														
Rural Arizona Self-Sufficiency Matrix	N/A	No data	I	?			X			X	X			X	X	X	X	X

Conclusion

This project aimed to improve the risk assessment tool and resource prioritization process utilized by the providers at the UW of the Plains organization and other organizations within the CoC. Utilizing an Organizational Elements Model to align the needs assessments, identified barriers, collection of field notes, and evaluation of available screening tools allowed for project success. An analysis of the data revealed that the providers are in need of change in the current risk assessment process. Considering the participation and feedback gathered from the providers it is arguable that the staff is dissatisfied with the current workflow and feel a new tool would better serve their population. A SWOT analysis was prepared to identify strengths and opportunities within the organizations and an executive summary was constructed. From this a recommendation for future practice was formulated to create a new adaptive scale tool from suggested criteria from the providers. This information will be presented to the UW of the Plains director to decide a plan for moving forward. This QI DNP project was the first step in what could be a process improvement project with the adjunct of KUMC's nursing research department involvement in creating a new tool. This project has the potential to make a significant difference in the paradigm of providers assessing and meeting the needs of the homeless population.

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Appendix A

VI-SPADT Risk Assessment Tool Version 2

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)
- Shelters
 Transitional Housing
 Safe Haven
 Outdoors
 Other (specify): _____
 Refused

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1. **SCORE:** 0

2. How long has it been since you lived in permanent stable housing? _____ Years Refused
3. In the last three years, how many times have you been homeless? _____ Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1. **SCORE:** 0

B. Risks

4. In the past six months, how many times have you...
- a) Received health care at an emergency department/room? _____ Refused
- b) Taken an ambulance to the hospital? _____ Refused
- c) Been hospitalized as an inpatient? _____ Refused
- d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____ Refused
- e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? _____ Refused
- f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? _____ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR EMERGENCY SERVICE USE. **SCORE:** 0

5. Have you been attacked or beaten up since you've become homeless? Y N Refused
6. Have you threatened to or tried to harm yourself or anyone else in the last year? Y N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF HARM. **SCORE:** 0

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.01

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? Y N Refused

IF "YES," THEN SCORE 1 FOR LEGAL ISSUES.
SCORE:

0

8. Does anybody force or trick you to do things that you do not want to do? Y N Refused
9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? Y N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF EXPLOITATION.
SCORE:

0

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? Y N Refused
11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? Y N Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR MONEY MANAGEMENT.
SCORE:

0

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? Y N Refused

IF "NO," THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY.
SCORE:

0

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? Y N Refused

IF "NO," THEN SCORE 1 FOR SELF-CARE.
SCORE:

0

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? Y N Refused

IF "YES," THEN SCORE 1 FOR SOCIAL RELATIONSHIPS.
SCORE:

0

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.01

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? Y N Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? Y N Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? Y N Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? Y N Refused
19. When you are sick or not feeling well, do you avoid getting help? Y N Refused
20. **FOR FEMALE RESPONDENTS ONLY:** Are you currently pregnant? Y N N/A or Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH**.

SCORE:

0

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? Y N Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing? Y N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE**.

SCORE:

0

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
- a) A mental health issue or concern? Y N Refused
- b) A past head injury? Y N Refused
- c) A learning disability, developmental disability, or other impairment? Y N Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? Y N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH**.

SCORE:

0

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**.

SCORE:

0

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? Y N Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? Y N Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.

SCORE:

0

27. YES OR NO: Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced? Y N Refused

IF "YES", SCORE 1 FOR ABUSE AND TRAUMA.

SCORE:

0

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	0 /1	Score: Recommendation: 0-3: no housing intervention 4-7: an assessment for Rapid Re-Housing 8+: an assessment for Permanent Supportive Housing/Housing First
A. HISTORY OF HOUSING & HOMELESSNESS	0 /2	
B. RISKS	0 /4	
C. SOCIALIZATION & DAILY FUNCTIONS	0 /4	
D. WELLNESS	0 /6	
GRAND TOTAL:	0 /17	

Follow-Up Questions

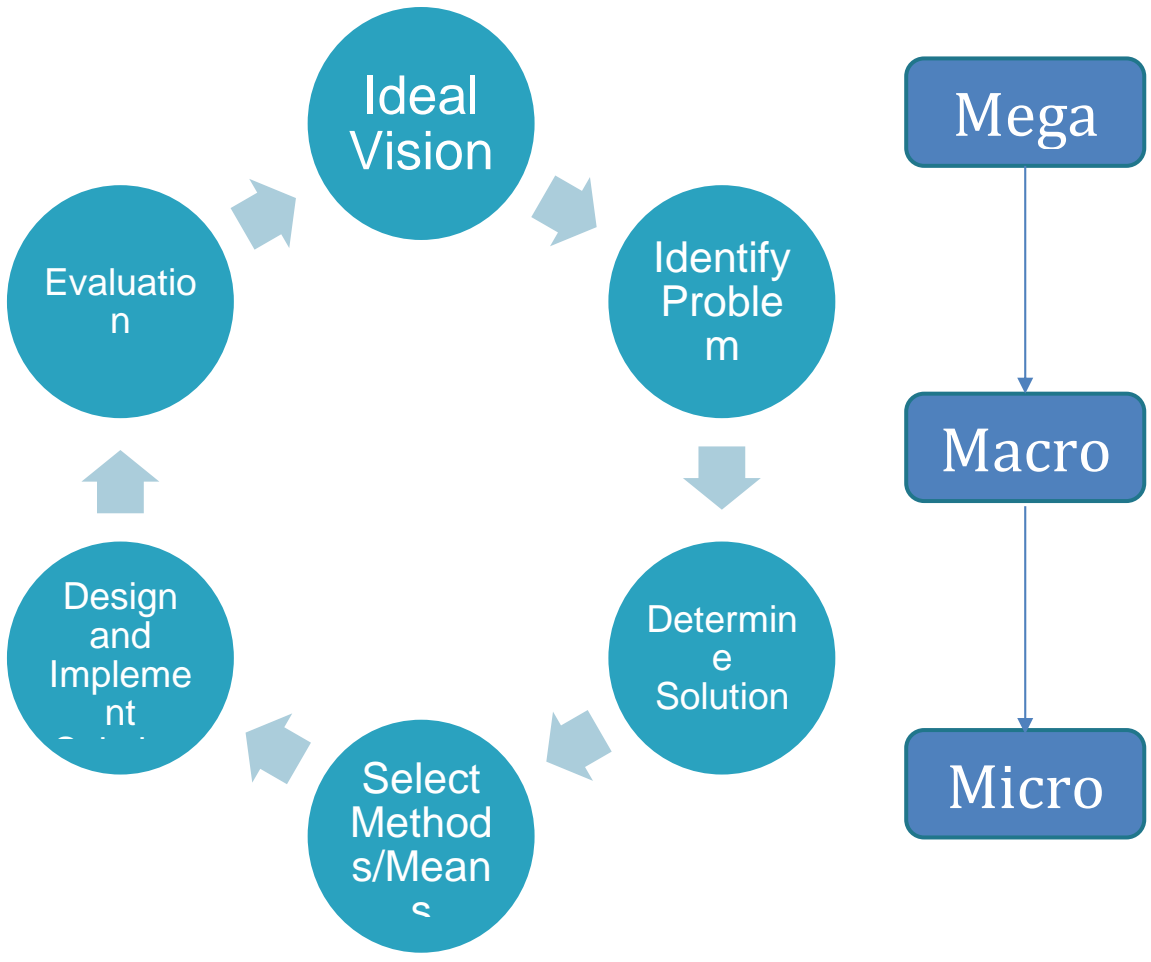
<p>On a regular day, where is it easiest to find you and what time of day is easiest to do so?</p>	<p>place: _____</p> <p>time: ___ : ___ or Night</p>
<p>Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?</p>	<p>phone: (____) _____ - _____</p> <p>email: _____</p>
<p>Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused</p>

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- legal status in country
- children that may reside with the adult at some point in the future
- ageing out of care
- income and source of it
- safety planning
- mobility issues
- current restrictions on where a person can legally reside

Appendix B

Theoretical Framework Concept Map



Appendix C

Organizational Approval Email



Luella Sanders <lsanders@unitedwayplains.org>

Wed 2/17/2021 8:33 PM



To: Shelby Sprang; Colleen Paramesh

Cc: Beth Oaks <boaks@unitedwayplains.org>

Shelby,

Thank you so much for your willingness to get phase 1 started. We can't wait to meet you and hear your ideas on the project!

I will compare calendars tomorrow with our team and suggest some days/times for a ZOOM meeting for the first part of next week.

Kindest regards,
Luella

Luella Sanders, Ph.D.
Director of Collective Impact
United Way of the Plains
245 N. Water
Wichita, Kansas 67202
Phone: 316-267-1321, Ext. #4214
lsanders@unitedwayplains.org

Appendix D

Provider Survey

Link to survey: <https://www.surveymonkey.com/r/Y288PZR>

Responses to Question 7 of survey included in Table 2: Provider Responses

Q7



Please feel free to provide any further feedback or comments about the use of VI-SPADT in your practice setting.

Answered: 4 Skipped: 8

RESPONSES (4) WORD CLOUD TAGS (0) Sentiments: OFF

PAID FEATURE
Text Analysis lets you search and tag comments and see word clouds of frequent words and phrase
To get this feature, upgrade to a paid plan.

Upgrade [Learn more »](#)

Filter: by tag

Showing 4 responses



What is your provider role at United Way of Plains?

Answered: 11 Skipped: 1

RESPONSES (11) WORD CLOUD TAGS (0) Sentiments: OFF

PAID FEATURE
Text Analysis lets you search and tag comments and see word clouds of frequent words and phrases. To get this feature, upgrade to a paid plan.
[Upgrade](#) [Learn more »](#)

Filter: by tag Search responses

Showing 11 responses

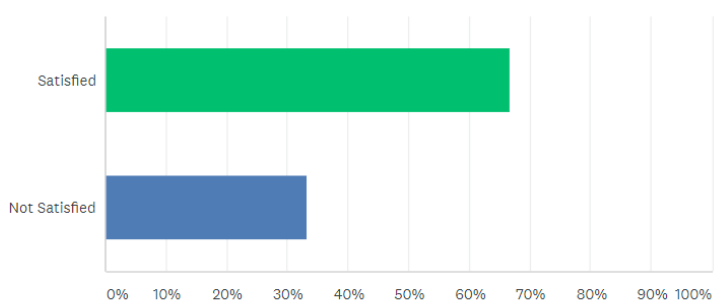
- Coordinated Entry Coordinator/Robert J Dole VAMC
5/24/2021 8:24 AM [View respondent's answers](#) [Add tags](#)
- VA Social Worker
5/19/2021 9:23 AM [View respondent's answers](#) [Add tags](#)
- I work at a mental health clinic as a CM
5/17/2021 1:00 PM [View respondent's answers](#) [Add tags](#)
- Comcare Center City, Homeless outreach cm

Q2

[Customize](#) [Save as](#)



How satisfied are you with using the VI-SPADT tool in your practice?

Answered: 12 Skipped: 0



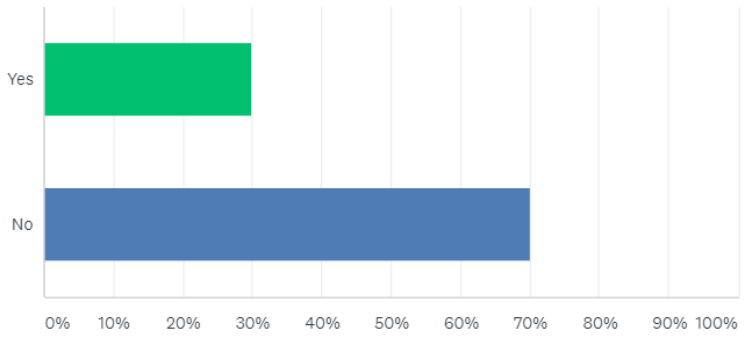
ANSWER CHOICES	RESPONSES
Satisfied	66.67% 8
Not Satisfied	33.33% 4
Total Respondents: 12	

Q3

 Customize  Save as


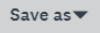
Have you used other risk assessment tools (other than the VI-SPADT)?

Answered: 10 Skipped: 2



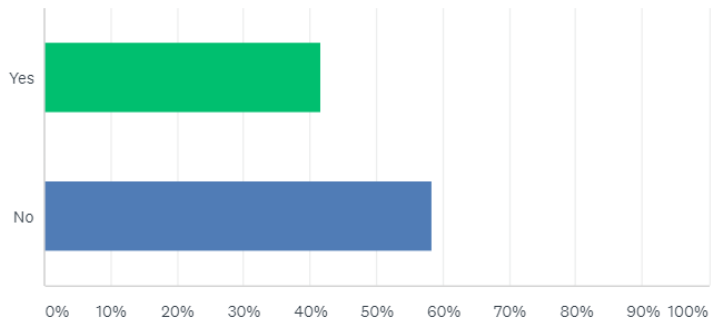
ANSWER CHOICES	RESPONSES	
▼ Yes	30.00%	3
▼ No	70.00%	7
TOTAL		10

Q4

 Customize  Save as


Do you feel the VI-SPADT tool properly assess and prioritizes the population you serve?

Answered: 12 Skipped: 0



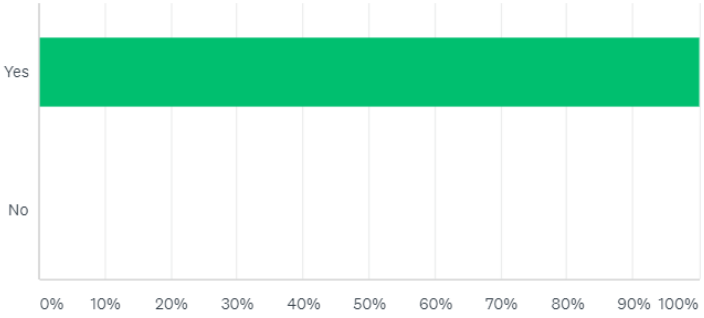
ANSWER CHOICES	RESPONSES	
▼ Yes	41.67%	5
▼ No	58.33%	7
TOTAL		12

Q5

 [Customize](#) [Save as ▼](#)


Do you feel you had adequate training and education on the tool prior to using it in practice?

Answered: 12 Skipped: 0



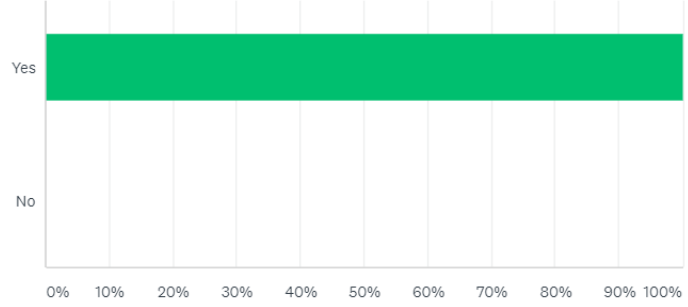
ANSWER CHOICES ▼	RESPONSES ▼	
▼ Yes	100.00%	12
▼ No	0.00%	0
TOTAL		12

Q6

 [Customize](#) [Save as ▼](#)

Would you consider the use of a new risk assessment tool?

Answered: 12 Skipped: 0



ANSWER CHOICES ▼	RESPONSES ▼	
▼ Yes	100.00%	12
▼ No	0.00%	0
TOTAL		12

