

MAY 2019



Who Gets Housing First?

Facilitated Discussion on Prioritization following Coordinated Assessment

/ Validation and Psychometric Testing of the Vulnerability Index – Service Prioritization Decision Assistance Tool

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Quick poll

Does your HCH screen and/or enter
Coordinated Assessments into the system?

Quick poll

...Who's a fan?

Quick poll

What Coordinated Assessment prioritization tool do you use in your Continuum of Care?

Overview

- I. Overview
- II. Past Experience (discussion)
- III. Review of VI-SPDAT v1 evaluation
 1. Measurement Domains (discussion)
 2. Dimensions of Vulnerability (discussion)

Overview

IV. Equity in Prioritization

1. Factor Analysis

- Measurement Domains (discussion)

2. Equity

- Drivers of disparity (discussion)

3. Crowd sourcing solutions (discussion)

Discussion

What has your experience been like in regard to the Coordinated Assessments?

Discussion

Big Picture:

What are your concerns with the way
Coordinated Assessment works?

What does the perfect system for
prioritization look like?

Discussion

Do you notice a pattern in who gets housing now?

Discussion

Describe a patient who got a low score, but you felt should have been higher priority for housing.

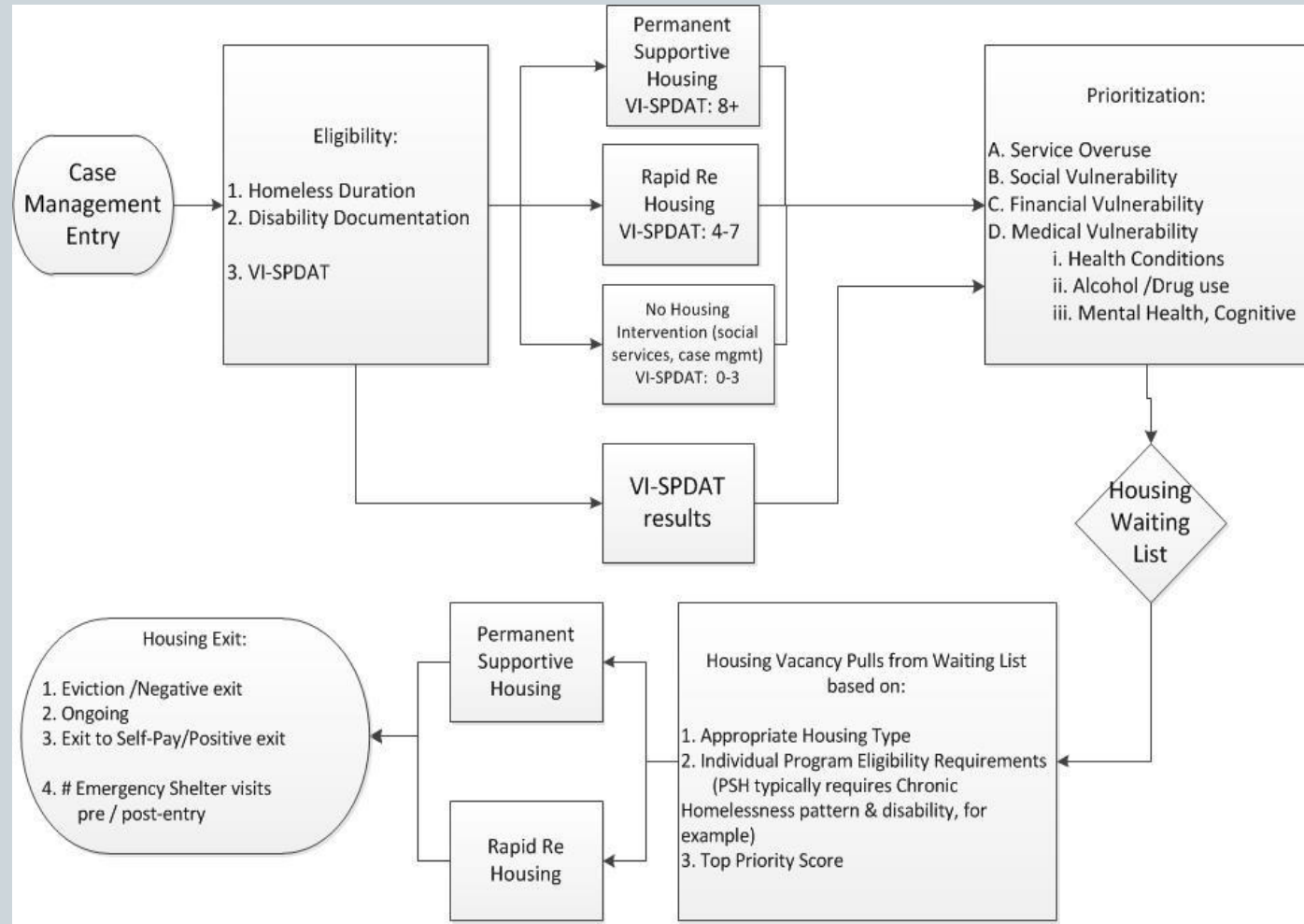
What made them higher priority in your mind?

Review

Prioritization tools

- VI-SPDAT v1, v2
- Individual scores developed by community (VAT, B-DAT, Houston's HPT, etc.)

Review



Review

- History
- Behavioral Model of Vulnerable Populations

Evaluation of the VI-SPDAT v1

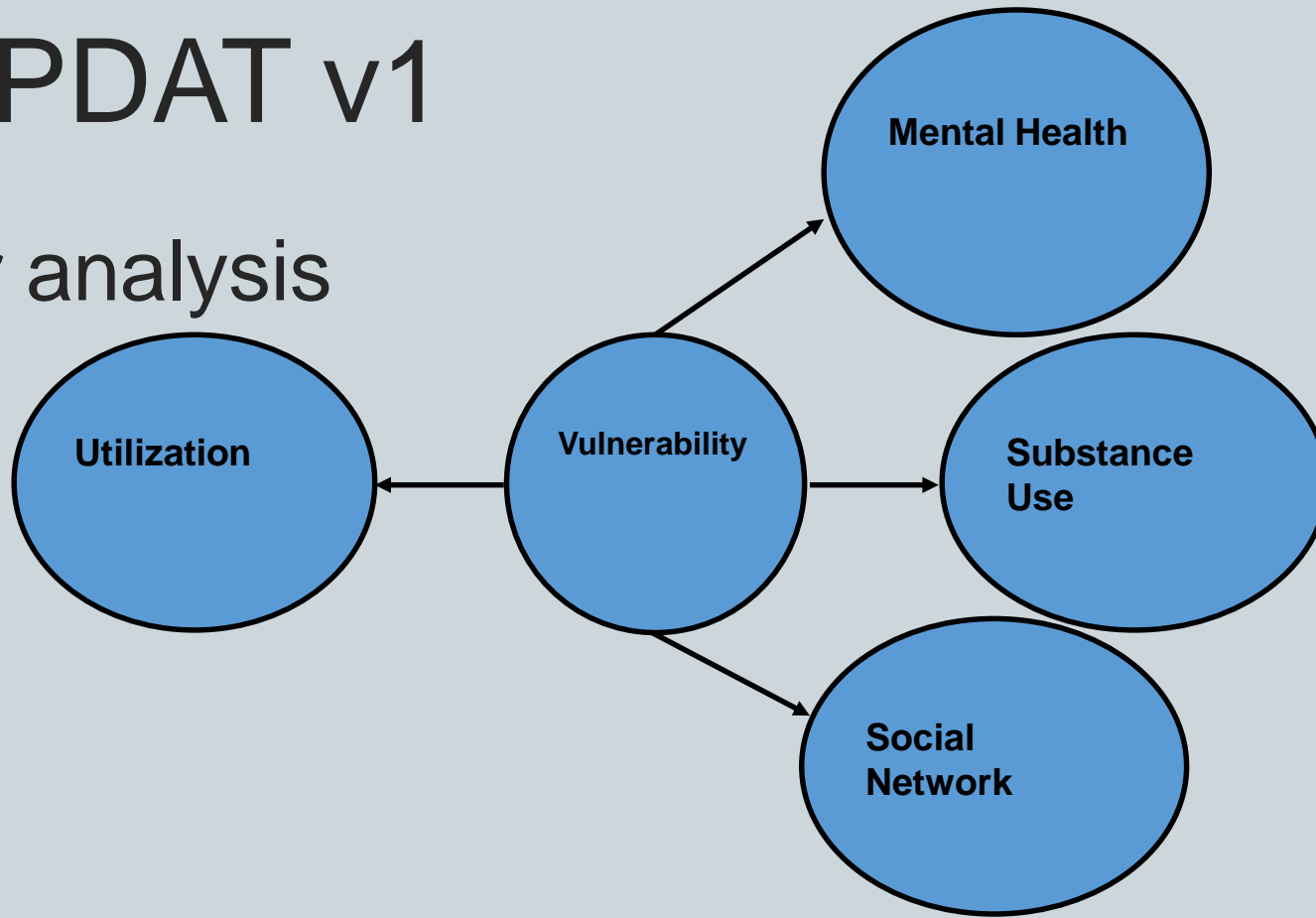
- Aim 1: Test-retest, Internal consistency, Factor analysis;
- Aim 2: Concurrent validation with Medical records;
- Aim 3: Between group differences, Modeling the total score, Modeling eventual placement into housing;

Major findings

- Non-significant internal consistency within domains identified by v1 (and v2)
- Proportional Odds Assumption fails at every interval (both versions)
- Exploratory and Confirmatory Factor Analysis

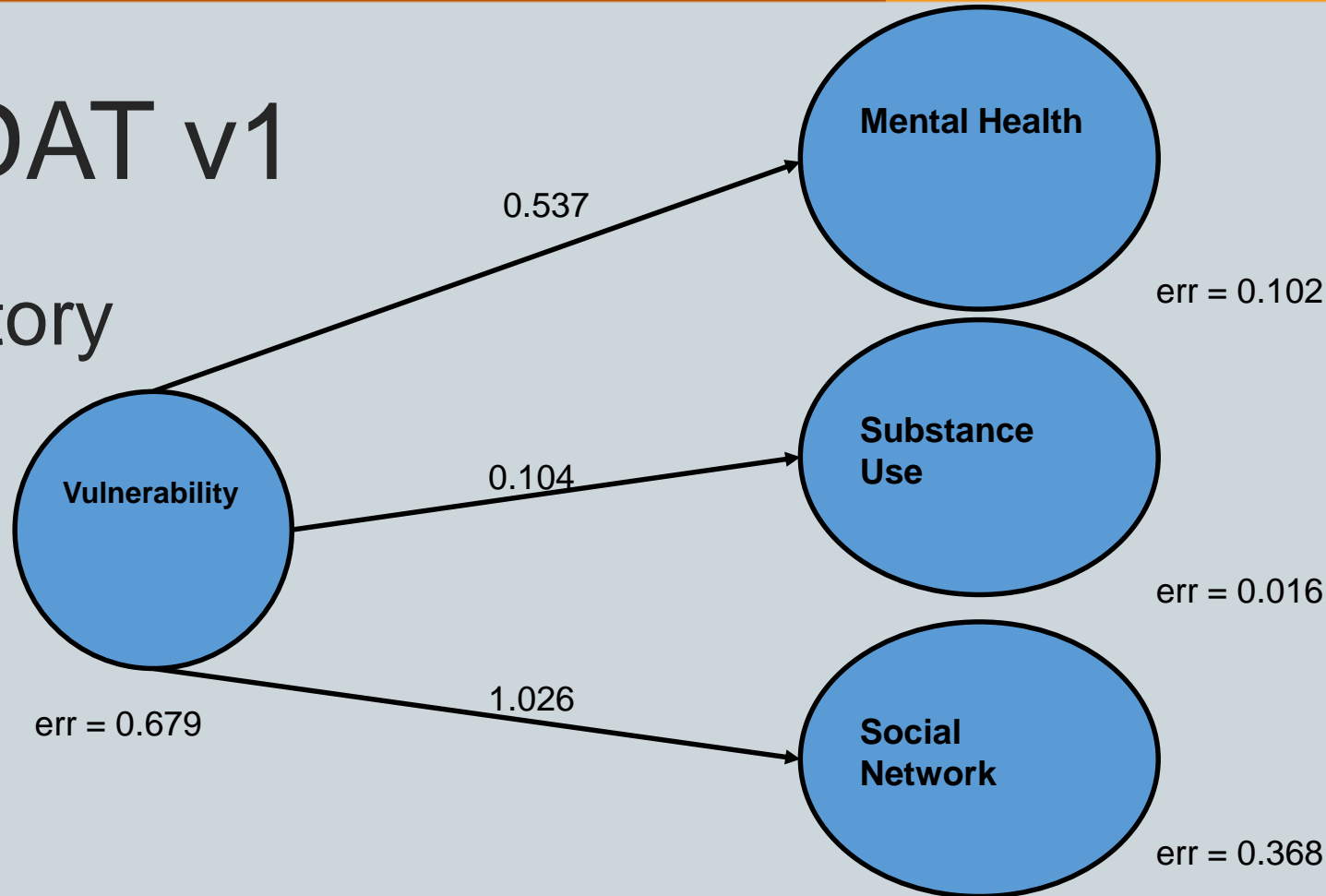
VI-SPDAT v1

Factor analysis



VI-SPDAT v1

Confirmatory Factor Analysis



RMSEA = 0.042
 pRMSEA<.05 = .
 CFI = 0.891
 SRMR = 0.038
 CD = 0.818

Discussion

Forget the word 'Vulnerability' for a minute:

What domains or issues would you like to prioritize?

Discussion

What does 'Vulnerability' mean to you?

What are the components or building blocks that you think comprise 'Vulnerability'?

Major findings

Concurrent /criterion validation (Aim 2)

- In general, HIE > EMR in estimated prevalence
 - Specificity > Sensitivity
- HIV/AIDS: 88.4% sensitivity and 98.0% specificity
 - AUC: 0.932
- HCV: 86.5% sensitivity, 82.9% specificity
 - AUC: 0.947
- Problematic drug or alcohol use: 70.4% sensitivity, 53.3% specificity
 - AUC: 0.619

Discussion

Are there other ways that we can assess someone's 'Vulnerability' without asking them directly, in-person?

Differences by Race

Whites scored ~1 point higher on the VI-SPDAT

Non-White individuals were:

- more often homeless for greater than 2 years,
- less likely to use healthcare services, sleep in a shelter, have been forced or tricked into things, been attacked, to harm self or others, have negative social influences, or to owe someone money,
- less likely to report most health conditions, substance misuse behaviors, mental health conditions
- more likely to have any income,
- more likely to report history of HIV/AIDS or TB;

Differences by Ethnicity

Hispanic individuals were:

- younger,
- less often veterans,
- less likely to report having income, problematic substance use or have relapsed after treatment,
- less likely to report emphysema, heart disease, or frostbite/hypothermia,
- more likely to visit ED for care and report having diabetes and cancer;

Differences by Gender

Female individuals were:

- younger,
- homeless more often, but for less time,
- they use ED and crisis services more often,
- more likely to be attacked, forced or tricked to do things, owe someone money, have negative social influences, have asthma and mental health conditions,
- less likely to report substance misuse, have legal issues, or report histories of infectious diseases, frostbite, brain injury;

Major findings (Aim 3)

- Racial disparities in total score *did not lead to faster or greater placement in housing*
- BUT race did predict increased % of Whites placed in PSH vs RRH relative to non-Whites

Discussion

What are some reasons we might see unequal effects from using a standard prioritization tool?

Drivers of Disparity: My 4 Theories

- Disparities reflect real differences in “vulnerability”
- Cultural competency limitations of data collectors
- Self-report bias / Health literacy limitations
- Measurement error (group model variance)

More major findings

- Total VI-SPDAT score was best modeled by 13/50 questions
- Total VI-SPDAT score did not predict eventual placement in housing (in Travis County)

Housing placement

Associated with housing placement:

- 14. Is there anybody that thinks you owe them money?
- 15. Do you have any money coming in on a regular basis?
- 17. Do you have planned activities each day other than just surviving that bring you happiness and fulfillment?
- 38. Have you used non-beverage alcohol in the past 6 months?
- 44. Any visit with mental health provider past 6 months?

Inversely associated with housing placement:

- 21. Does not seek healthcare
- 46. Learning disability /developmental disability
- 42. Hospitalization for mental health issue against your will
- 49. Not taking prescribed medication for any reason

Discussion

How would you improve the housing wait-list prioritization system if you were in charge?

