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A Formative Evaluation Using RE-AIM Framework for Enhanced Shelter Services

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Abstract

Background: Poor health is not only a major cause of homelessness but being homeless also worsens existing health issues. Effective interventions that address the unique needs of this population are a critical component of ending homelessness. A review of literature has revealed four evidence-based approaches that includes a Housing First approach, Trauma Informed Care (TIC), case management, and service integration as key priorities for homeless service providers. It is important for service organizations supporting this population to conduct program evaluations to ensure best practices are utilized in program implementation.

Objectives: The objective was to perform a formative evaluation guided by the RE-AIM theoretical framework which prioritizes evidence-based approaches.

Methods: A formative evaluation was completed with shelter program participants over a nine-month period using quantitative data and descriptive statistics. In addition, a quantitative staff survey was completed to measure Attitudes Related to Trauma Informed Care (ARTIC) which is a measurement of trauma-informed care attitudes for human/health service providers.

Results: The chart review included 93 shelter program participants using descriptive statistics to compare demographics to surrounding regions. Additionally, the evaluation measured case management goals including transition to housing services, coordination of healthcare, and exit to housing. Lastly, the staff survey (n=20) established an overall baseline and five subscale scores.

Implications: Program evaluation provides baseline measurements for future evaluations and recommendations to improve enhanced shelter program outcomes.

Keywords: Attitudes Related to Trauma Informed Care (ARTIC) survey, homelessness,

Housing First, RE-AIM Framework, and Trauma Informed Care (TIC).

Introduction

Poor health is not only a major cause of homelessness but being homeless also worsens existing health issues. According to the National Health Care for the Homeless Council (NHCHC), persons experiencing homelessness have higher rates of illness and die on average 12 years earlier than the general United States population (2019). People experiencing homelessness have an increased risk of death due to respiratory and cardiovascular disease as well as unaddressed infections and mental health problems (Lewer et al., 2019). In short, homelessness is a public health issue, and the provision of housing is healthcare. Fortunately, for service organizations working with this population there are several effective interventions recognized in the literature including: 1) Housing First Approach (Gentil et al., 2020; Luchenski et al., 2019; Magwood et al., 2019; Omerov et al., 2020; Parsell et al., 2020; Roncarati et al., 2018; Stafford & Wood; 2017), 2) case management services (Baggett et al., 2018; Gentil, et al., 2020; Lewer, et al., 2019; Luchenski et al., 2018; Magwood et al., 2019; Ramsay et al., 2019), 3) Trauma Informed Care (TIC; Becker & Foley, 2021; Duke & Searby, 2019; Landefeld et al., 2017; Lee et al., 2017; Luchenski et al., 2018; Magwood et al., 2019; Meacham et al., 2019; Milaney et al., 2020; Montgomery et al., 2016; Purkey & MacKenzie, 2019; Substance Abuse Mental Health Services Administration [SAMHSA], 2014; Weinrich et al., 2016), and 4) service integration (Baggett et al., 2018; Gentil, et al., 2020; Magwood et al., 2019; Omerov, et al., 2020; Parsell et al., 2020; Ramsey et al., 2019; Rogers et al., 2021; Roncarati et al., 2018). Addressing the service needs of the homeless population through evidenced based solutions is a critical component in achieving program outcomes.

Purpose and Aims

The purpose of this project was to complete a formative evaluation of enhanced shelter services for adults in North King County, Washington. The specific aims of this project were: 1) correlate racial, gender and age of shelter participants as compared to overall homeless population within King County; 2) measure long term impact of enhanced services; 3) measure staff attitudes toward Trauma Informed Care (TIC); 4) measure fidelity to case management priorities outlined in shelter's management plan.

Background and Significance

Impact of Trauma

An important concept in understanding homelessness is the recognition of the bidirectional relationship between trauma and homelessness. Trauma includes events in adulthood (Post Traumatic Stress Disorder [PTSD]), events in childhood (complex PTSD, developmental trauma, or Adverse Childhood Events [ACEs]) or the experience of homelessness itself (chronic PTSD). Trauma has adverse effects in the short and long term that include an inability to deal with the stress of daily living, difficulty establishing and maintaining secure and healthy relationships, and emotional dysregulation. Trauma can also result in cognitive impairment including memory, attention and thinking (SAMSHA, 2014a). A failure by service organizations to recognize and respond to trauma leads to re-traumatization and further stigmatization.

Two landmark contributions to understanding the significance of trauma came from Judith Herman's book *Trauma and Recovery* published in 1992 and the ACEs study based on Kaiser Permanente's San Diego Health Appraisal Clinic (Felitti, 1998). Heman established the foundational approach to PTSD including recognition of trauma symptoms as a means of self-

protection, not the personal failings of the individual. She established a triphasic model of recovery later linked within a neurobiological framework including hyperarousal (both sympathetic and parasympathetic), remembrance and mourning (trauma narratives), and reconnection (Zaleski et al., 2016). The critical point for service organizations is the importance of establishing a physically, emotionally, and psychologically safe environment for trauma survivors to learn autoregulation. Common signs of dysregulation may include disassociation, isolation, agitation, feeling overwhelmed, sleep disturbance and difficulty concentrating (Zaleski et al., 2016).

The ACE's study was groundbreaking in its recognition of childhood trauma and its impact on adulthood. According to SAMSHA (2014b) these impacts include:

> Significant increases in a number of negative social, behavioral health, and physical health outcomes, including alcohol and drug use disorders, depression, suicidality, risky sexual behavior, sexual victimization in adulthood, domestic violence, self-harm behaviors, physical inactivity, obesity, heart disease, cancer, liver disease, sexually transmitted diseases, teen pregnancy, homelessness, unemployment, and being both a and/or a victim of interpersonal violence (p.115)

The experience of trauma is common. In the United States 60.7% of men and 51.2% of women report experiencing at least one trauma in their lifetime (SAMSHA, 2014b). Women are more likely to meet criteria for PTSD and are more likely to experience intimate partner violence (22-25% of women) and sexual assault (25% of women). The impact of trauma on the population of unhoused individuals is well documented and research supports the inclusion of Trauma Informed Care (TIC) in service organizations providing services to people experiencing homelessness (Becker & Foley, 2021; Duke & Searby, 2019; Landefeld et al., 2017; Lee et al.,

2017; Luchenski et al., 2018; Magwood et al., 2019; Meacham et al., 2019; Milaney et al., 2020; Montgomery et al., 2016; Purkey & MacKenzie, 2019; SAMHSA, 2014; Weinrich et al., 2016)

Trauma Informed Care. SAMHSA recommends TIC model be implemented by service organizations working with populations impacted by trauma. Trauma includes violence, abuse, neglect, natural disasters, war, and other emotionally detrimental experiences. According to SAMHSA (2014a), unexamined trauma significantly increases risks associated with mental health disorders, substance use disorder (SUD), and chronic physical diseases. Conceptually assessing and treating trauma may be considered within the domain of behavioral health services, but it also applies to a myriad of other service organizations. These include the educational system, welfare system, medical system, and criminal justice. Any organization working with a population at elevated risk for a trauma history is appropriate for TIC. SAMSHA recommends organizations receive training regarding the four 'R's" of trauma: realize the impact of trauma, recognize signs and symptoms, respond by incorporating understanding into policy and procedures, and resist re-traumatization (2014a).

SAMSHA (2014a) outlines 10 implementation domains for an organization to undertake to implement TIC and these include leadership, policy, physical environment, engagement and involvement, cross sector collaboration; screening assessment and treatment services; staff training, quality assurance, financing, and evaluation. All the domains are grounded in the six key principles of TIC including safety, transparency, peer support, collaboration and mutuality, empowerment, and cultural, historical and gender issues (SAMSHA, 2014a). As the population of persons experiencing homelessness have higher experiences of trauma, when compared to the general population, TIC is a necessary framework for effective service offerings.

Housing First

The provision of housing was the most frequent recommendation in each article reviewed. Although the United States constitution does not list housing as a fundamental right, the United Nations identifies housing as universal human right. Additionally, based on Maslow's hierarchy of needs, housing is considered a basic physiological need and the foundation from which all other behavioral changes are built (1943). Making housing a priority is the responsibility of all care and service providers of persons experiencing homelessness.

Housing First is an evidence-based and effective solution to ending homelessness (Gentil et al., 2020; Luchenski et al., 2019; Magwood et al., 2019; Omerov et al., 2020; Parsell et al., 2020; Roncarati et al., 2018; Stafford & Wood; 2017). Housing First prioritizes permanent housing through two key programs, supportive housing for high needs populations and rapid re-housing for temporary relief for individuals and families. Housing first is based on the principle of meeting people "where they are at." For example, housing should not be contingent on meeting certain requirements such as abstinence from substance use or engagement in mental health services. According to National Alliance to End Homelessness (NAEH), Housing First Approach Model enables people to access housing faster and remain stably housed longer (2016).

Review of Literature

A review of literature was performed using three databases: Psych Info, CINAHL, and PubMed. Keywords of homelessness, rough sleeping (sleeping outside), and unhoused were used in combination with healthcare, mental health, older adults, or women. Further refinements included limiting articles to within the past five years, selection of adult age range when available, and English language. Duplicates and article titles focused on specific subset

populations including Veterans, women with children, pregnancy, and youth were excluded because they did not meet the intended target population. The remaining articles were summarized, categorized, and when indicated ranked with evidence-based medicine ranking from LoBiondo-Wood and Haber (2014). In the Lobiondo-Wood and Haber Level of Evidence Model, level seven is the lowest and level one is the highest.

Prevalence

According to NAEH, between 2019 and 2020, nationwide homelessness increased by two percent (2021). Previously, homelessness had primarily been on the decline, decreasing in eight of the nine years before the current trend began. The state of Washington has the sixth largest homeless population in the United States. There was a 22% increase in individuals experiencing homelessness from 2007-2020 (NAEH, 2021). Additionally, in Washington state and nationwide, there is difficulty meeting the bed requirements for the increasing population. For example, in 2020 there was a bed shortage of over 8,000 in Washington state and 201,818 nationwide (NAEH, 2021). North King County in Washington consists of Bothell, Kenmore, Lake Forest Park, Shoreline and Woodinville. In 2020, a survey was conducted for the annual point in time count for people experiencing homelessness and found 260 people experiencing homelessness in north King County, with 56 of them unsheltered (King County Regional Homeless Authority [KCRHA], 2020).

In the United States, a recent notable change is an increase in the median age of adults experiencing homelessness to 50 years old, compared with 37 in the early 1990s, and this older population experiences common geriatric conditions seen in housed adults in their 70s and 80s (Landefeld et al., 2017; Lee et al., 2017; Omerov et al., 2019). This increased risk of homelessness for older adults is due to a to shifts in family structure, having a fixed income, and

a lack of affordable housing options (Omerov, et al., 2019). Additionally, people over 50 experiencing homelessness tend to have multiple untreated health problems, lack social support, and not express their own healthcare needs adequately (Omerov, et al., 2019).

Men and woman share similar pathways to homelessness, but women are more likely than men to report that violent victimization led to homelessness, with estimates of 25-50% of woman indicating it as the primary cause (Broll & Huey, 2020). This includes intimate partner violence but also victimization in childhood which is associated with adult homelessness for women (Broll & Huey, 2020; Montgomery et al., 2017). Women are also at greater risk of homelessness post-incarceration and have a higher association with serious mental illness and homelessness (Montgomery et al., 2017). The risk for early death for a person experiencing homelessness is 52 years with men eight times higher and women 12 times higher than the average person (Omerov et al., 2019).

Individuals with Serious Mental Illness (SMI) is a subset of the population of persons diagnosed with any mental illness (AMI) and includes persons who experience disability and functional impairment, such as unemployment, social isolation, SUD, reckless behaviors, multiple psychiatric hospitalizations, poor activities of daily living (ADLs), and homelessness (Agency for Healthcare Research and Quality [AHRQ], 2014; National Institute of Mental Health [NIMH], 2019). Disorders typically included under this classification include schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder (Carey & Carey, 1999). In 2020, the prevalence of SMI was 5.6% of all United States adults and it is estimated that 25-30% of people experiencing homelessness that stay in a shelter have an SMI (Padgett, 2020; SAMHSA, 2021). Additionally, among adults aged 18 or older in 2020, 47.8 %

of SMI and 39.8% of AMI had a co-occurring SUD as compared to 17% of adults without a mental health disorder (SAMHSA, 2021).

Woman and Homelessness

Three articles rating an evidence level six specifically focused on the female experience of homelessness. Duke & Searby (2019) completed a literature review of fifteen articles including qualitative and quantitative studies which highlighted the importance of recognizing domestic violence, childhood trauma, and crime victimization as considerations of mental health status in women. Meacham et al. (2019), found the role of mental health as an independent correlate to condomless sex practices among human immunodeficiency virus (HIV) positive and negative homeless women. Questionnaires were administered to 300 homeless women and found two-thirds engaged in condomless sex regardless of HIV status. For HIV positive women, PTSD was a significant independent correlate. For HIV negative women, it was panic attacks. Lastly, Weinrich et al. in a small qualitative study highlight an important consideration when measuring trauma. According to Weinrich et al. (2016), 32% of homeless women in the United States, United Kingdom and Australia had experienced childhood sexual trauma. The study also measured sexual trauma across the participants lifespan and found 54% of the women had experienced sexual trauma at some point in their life. The article highlights the need for adequate interventions for sexual trauma before and after homelessness occurs.

Two mixed gender qualitative studies were reviewed. Montgomery et al. (2017) explored gender differences between unsheltered persons experiencing homelessness. The authors noted both genders have a strong association between experience of a violent attack and premature mortality. In Milaney et al. (2020), a Canadian qualitative study conducted 300 interviews with persons experiencing homelessness of which 27% were female and found women's experience

of homelessness, compared to men includes higher rates of ACEs, mental health diagnoses, and suicidal thoughts and attempts. Both studies advocate for utilizing TIC interventions.

Older Adults and Homelessness

The Health Outcomes in People Experiencing Homelessness in Older Middle Age (HOPE HOME) study included 350 homeless participants from the United States of which approximately 23% identified as female. The descriptive population studies utilized data to explore the impact of ACEs on older adult homelessness and recommended mental health considerations be identified in the treatment of chronic pain. In Lee et al. (2017), researchers found that older adults, like younger homeless populations, have a higher prevalence of ACEs, when compared to the general population. An independent, dose-response relationship between an exposure to childhood adversity and moderate-to-severe depression; and lifetime history of suicide attempt was found. Early childhood exposures of four or more were associated with psychiatric hospitalization. Landefeld et al. (2017) explored chronic pain in older unhoused adults and found 44.3% reported arthritis, 32.8% reported PTSD and 75.3% endorsed a personal history of abuse. Multivariate analyses found arthritis, PTSD, and history of abuse experience were associated with chronic moderate-to-severe pain. Both articles recognize the high reporting of ACEs in this population and support incorporation of TIC in older adults regardless of gender.

Healthcare and Homelessness

Morbidity and Mortality. According to Baggett et al. (2018), the impact of cardiovascular disease (CVD) on the unhoused population is a 2-3 times higher mortality rate than among the general population. Especially noted is the prevalence rate of hypertension and diabetes among the unhoused is equal to the general population. However, these diseases are often undiagnosed,

untreated, or experiences unique barriers to common lifestyle changes. Unhoused individuals have a higher prevalence of smoking (68-80%), heavy drinking, stimulant use, and injection use that contribute to increased mortality. Additionally, the risk is increased by psychiatric conditions and cardiometabolic risk factors associated with anti-psychotic medications. Lastly, the experience of homelessness is traumatic and increases the risk of a high allostatic load. Barriers to treatment include ability to access healthcare, the necessity to prioritize survival needs first, and obstacles to chronic disease management that includes maintaining communication and follow-up, continuity of care and medication adherence. The authors further suggest implementing strategies to improve the experience of unhoused people in healthcare by adopting case management and strategies from Health Care for the Homeless Program including integration and colocation with homeless service providers and recognition of the impact of trauma on this population (Baggett et al., 2018).

Three articles used single non-experimental studies to explore chronic disease, the impact of rough sleeping on mortality, and impact of COVID-19 on the population of persons experiencing homelessness. In Roncarati et al. (2018), a 10-year prospective cohort study was used to explore the increased mortality rate of rough sleeping as compared to sheltered persons in Boston, Massachusetts. The study highlighted the importance of integrated (medical, behavioral, substance use) care, patient centered focus, outreach service models and housing models to meet the needs of this subset of homeless population. Rogers et al. (2021) addressed the emergent impact of COVID-19 on this population in a cross-sectional community-based surveillance study in King County, Washington uncovering an unmet need for viral testing outside of clinical settings. Additionally, it noted 86% of persons with a positive test were sleeping in a communal space versus private or shared rooms. Lastly, Lewer et al. (2018)

explored chronic diseases in a cross-sectional survey finding respiratory diseases, epilepsy, and heart problems as the most common chronic conditions amongst homeless persons in England. The authors recommend routine surveillance data, utilizing case management in management of chronic conditions, and further research into finding effective healthcare solutions for this population.

Barriers and Effective Interventions in Healthcare. Nine articles were reviewed that explored barriers or interventions for effective delivery of health services for persons experiencing homelessness.

In an article by Becker & Foli (2021), the authors used a concept analysis to formulate a definition of health seeking behaviors in the homeless population as:

> A complex process where an individual who is homeless seeks out healthcare for a problem or illness, but first meet his or her physiological needs, and then deem current symptoms severe enough to seek medical treatment despite his or her distrust in the healthcare system and barriers to accessing healthcare. (p. 4)

Stafford and Wood (2017) used three case studies to highlight the importance of addressing social determinants of health and assert that medical and social issues should be treated concurrently. Failure to do so leads to inadequate discharges, poor continuity of care, and higher costs of health care. The authors recommend prioritizing Housing First programs to positively impact health outcomes and to include more voices from the lived experience of homelessness in health literature.

Luchenski et al. (2018) conducted a literature review and analyzed effective interventions. They recommended case management, disease prevention including harm

reduction, Housing First, occupational therapy, an approach recognizing ACEs, and tailored programs for women and persons under 25.

Four mixed methods studies explored barriers including the role of stigma (Purkey & MacKenzie , 2019), lack of trust of healthcare providers (Ramsey et al., 2019), providers not understanding the complexity of homelessness (Purkey & MacKenzie., 2019; Ramsey et al., 2019), poor continuity of care including discharges (Ramsey et al., 2019), lack of autonomy (Parsell & Vorsina., 2020; Purkey & MacKenzie, 2019), inaccessibility (Parsell & Vorsina, 2020; Ramsey et al., 2019), and the lack of family physicians (Gentil et al., 2019; Ramsey et al., 2019). Each article offered unique intervention areas. According to Purkey and MacKenzie (2019), Equity Oriented Health Care programs incorporated trauma and violence informed care, harm reduction, and cultural safety. Ramsey et al. (2019), recommended centralized services, co-located shelters with healthcare services, and prioritizing positive relationship encounters. Parsell & Vorsina (2020), advocated for integration of health care and psychosocial support in a Multidisciplinary Model framework that helps rough sleepers move toward access to housing. Finally, Gentil et al. (2019) recommended Housing First, tailoring primary care to the specific needs of this population, healthcare integration with mental health and SUDs; and addressing continuity of care concerns with case management.

Finally, Omerov et al. (2019) analyzed 22 articles and divided them into three themes which included unmet basic human needs, interpersonal dimensions to accessing care, and structural and organization barriers. Basic human needs include necessities (food, clothing, shelter), dental care, respite care, shelters lacking medical resources, lack of social contacts and accessibility (insurance, transportation, identification). Interpersonal dimensions include stigma, unhelpful relationships (lacking respect, empathy, and understanding), and unrealistic advice.

Organizational concerns include inconvenient hours or locations, overcrowding, and mistrust of staff. Structural recommendations include integration of primary care and behavioral health, respite care, and peer navigators. In Magwood et al. (2019), 35 articles were analyzed to determine factors that improve the acceptability of healthcare including permanent supportive housing, case management, income, substance use interventions, and tailored programs for gender and age subcategories. Additionally, the studies from Magwood et al. (2019), found that when addressing the personal experience of homelessness there were reports of recurrent feelings of marginalization, dehumanization and exclusion, a high value on trust and safety, an expressed need for autonomy, and the importance of social support.

In summary, homelessness is a complex and interdependent phenomenon. To address this issue, it is necessary to draw upon the evidence-based solutions found in the literature. Fortunately, there is a consensus on which strategies work, and these include a low barrier Housing First Approach (Gentil et al., 2020; Luchenski et al., 2019; Magwood et al., 2019; Omerov et al., 2020; Parsell et al., 2020; Roncarati et al., 2018; Stafford & Wood; 2017), the incorporation of case management services (Baggett et al., 2018; Gentil, et al., 2020; Lewer, et al., 2019; Luchenski et al., 2018; Magwood et al., 2019; Ramsay et al., 2019), the prioritization of TIC by service providers (Becker & Foley, 2021; Duke & Searby, 2019; Landefeld et al., 2017; Lee et al., 2017; Luchenski et al., 2018; Magwood et al., 2019; Meacham et al., 2019; Milaney et al., 2020; Montgomery et al., 2016; Purkey & MacKenzie, 2019; SAMHSA, 2014; Weinrich et al., 2016) and service integration (Baggett et al., 2018; Gentil, et al., 2020; Magwood et al., 2019; Omerov, et al., 2020; Parsell et al., 2020; Ramsey et al., 2019; Rogers et al., 2021; Roncarati et al., 2018). The next step is to ensure the translation of evidence-based strategies into real world practice settings.

Methods

Design

The purpose of this project was to complete a formative evaluation of enhanced shelter services for adults in North King County, Washington. The specific aims of this project were: 1) correlate racial, gender and age of shelter participants as compared to overall homeless population within King County; 2) measure long term impact of enhanced services; 3) measure staff attitudes toward TIC; 4) measure fidelity to case management priorities outlined in shelter's management plan.

Theoretical Framework

This project was guided by the RE-AIM (Reach, Effectiveness, Adoption, Implementation and Maintenance) theoretical framework (Kwan et al., 2019). The authors redefine framework components to address unique needs of projects within community settings. Reach is defined as the type of participants reached by the intervention, including how they generalize to the target population of the program. Effectiveness refers to the expected outcome of the program. Adoption is defined as the type of department staff willing to implement the new intervention. Implementation demonstrates fidelity to the plan and individual use of intervention strategies. Lastly, Maintenance is defined as the measurement of primary outcome six months after follow-up. As this is a formative evaluation and the shelter program does not follow participants after exiting, it was difficult to find a measurement. According to Gaglio et al. (2013), the use of "whatever information" is available to represent continuity of intervention after the study is complete is appropriate. For this project, recommendations to support

continuity of the program were used and are listed in the discussion section. The remaining components of this framework were addressed by at least one measurement.

Setting

The setting was a low barrier homeless shelter in North King County within the umbrella organization of Lake City Partners (LPC). LPC was established in 2015 to promote the development of programs and services for persons experiencing homelessness in North King County and is managed by a board of directors. The shelter opened on April 1, 2021, and serves unmarried adults and married couples, as well as their pets, in private rooms. Meal service is provided by the Hunger Intervention Program whose mission is to decrease food scarcity in underserved populations in North King County. The facility is staffed by shelter navigators who are on site 24/7, case managers, and other support staff (Table 1).

Table 1

Shelter Staff by Job Category

Shelter Staff	N=25, n (%)
Shelter Navigators	17 (68%)
Case Managers	5 (20%)
Supervisors	2 (8%)
Facilities	1 (4%)
Staff Survey Responses	20 (80 %)

Participants and Recruitment

Participants included shelter program clients and staff. Recruitment varied for each section of the RE-AIM framework. Data collection for chart review (Reach, Effectiveness, and

Implementation) included all shelter program participants enrolled between April 1, 2021 – December 31, 2021, regardless of discharge status at the time of the study.

For Adoption, a survey was conducted that included all staff at the organization. Staff are at least 18 years of age and hold various roles at the shelter (Table 1). Recruitment of shelter staff occurred through email, meeting announcements, and face-to-face outreach. An introductory email was sent to all shelter staff (Appendix A) which included informed consent (Appendix B), and the survey (Appendix C). Consent was given via their choice to participate in the survey. Seattle University Institutional Review Board (IRB) determined the project was Not Human Participant Research (NHPR) due to the limited risk involved in participating in the study. No demographic data, nor identifying information was collected.

Data Collection Procedures

Data collection included: 1) shelter program participant chart review, 2) Homeless Management Information System (HMIS) utilization review, and 3) shelter staff survey.

Shelter program participant data was reviewed over a three-week period that included client charts, shelter reporting data, and HMIS. Variables were guided by the RE-AIM framework and data was sorted in a spreadsheet. Missing data was included in the result section as not specified/missing. Informal data was accepted and included directly in the appropriate result category. For example, if a post-it note was found in a shelter program participant file and indicated connection to primary care, this was considered sufficient evidence. Within the HMIS system each shelter program participant file was reviewed to determine if the notes section documented a link to government identification, income, or health services. Additionally, data determined if HMIS indicated client as enrolled in shelter program and indicated the total

number of notes written in the client file. Lastly, the shelter staff survey was anonymous and conducted over a one-week period.

Measures

Reach

Quantitative statistics were used to define individuals enrolled at the shelter during the study. Data collected included participant's age, gender, race, referral city, and length of stay.

Effectiveness

Effectiveness was measured by determining if the shelter program participant was discharged from the program to permanent housing.

Adoption

Staff attitudes are a principal factor driving TIC behavior and service delivery (SAMSHA, 2014b). The ARTIC-10 (Attitudes Related to Trauma Informed Care) developed by Baker et al. (2016), served as an objective measurement of TIC within the organization (Appendix C). The ARTIC-10 is a 10-question Likert Scale survey written at a sixth grade reading level as measured by the Flesch-Kincaid Grade Level Test. ARTIC-10 was administered as an anonymous pen and paper survey which typically took under three minutes to complete. The scale included two items from each subscale measurement category: 1) underlying causes of problem behaviors and symptoms, 2) responses to problem behaviors and symptoms, 3) empathy and control, 4) self-efficacy at work, and 5) reactions to the work (Baker et al., 2021). The internal consistency of ARTIC-10 has an alpha significance level of 0.82 and a construct validity of a small to medium effect size (Baker et al., 2015; Baker et al., 2021).

Implementation

Implementation was guided by the shelter's four service priorities and corresponding measurement:

- Coordinated Entry for All (CEA) and housing measured by shelter program participant enrollment in the program in HMIS (Homeless Management Information System).
- Evidence of services provided resulting in government identification or legal documents associated with eligibility for a government identification. These documents are a prerequisite for housing applications.
- Connection to benefits and income through documentation of efforts to assist shelter program participants through employment or state/federal entitlement. Examples include Aged, Blind or Disabled (ABD), Social Security Income (SSI), Social Security Disability Income (SSDI), Housing and Essential Needs (HEN), or sources of employment.
- Activities for health and stabilization determined by documentation of connection to outside services such as primary care, substance use treatment, or mental health treatment as appropriate.

Maintenance

Based on the definition of Maintenance and the evaluation utilized by this project, there is no corresponding measurement for Maintenance. The recommendations outlined in the discussion are intended to improve and support continuity of the shelter services.

Data Analysis

Quantitative data analysis of chart reviews was completed using Microsoft Excel to report descriptive statistics regarding program outcomes. Demographic data was compared to the

statistics of unhoused persons in King County including age, race, and gender. Program outcomes (permanent housing, government identification, access to income and health stabilization) established a baseline for program performance and identified areas for improvement.

The ARTIC-10 determined the extent to which the shelter was providing TIC. The ARTIC-10 survey was scored through a two-step process in a Microsoft Excel spreadsheet included in the ARTIC-10 student package, such as reversing scores and utilizing Excel functionality to determine descriptive statistic outcomes. An established ARTIC-10 baseline can help prevent the reduction of trauma informed care practices over time, and potentially highlight areas requiring further training or supervision.

Results

Reach

Table 1 summarizes the demographics of the 93 identified persons in the shelter program between April 1, 2021- December 31, 2021. The chart review found 53% were male, 30% female and 16% had no documented gender. The median age was 47 with most participants between the age of 41-50 years old. Race was identified as 22.6% of Black Indigenous (and) People of Color (BIPOC), 72% non- BIPOC or Caucasian, and 5.4% data was missing. Referral sources were found to be 86% from North King County, 5.4% from Other King County, and 8.6% did not indicate a referral location. Lastly, length of stay could not be calculated as discharge dates or discharge reasons could not be ascertained from chart review.

Table 2

Sample Descriptive Statistics and King County Homeless Population Demographics

Demographics	Shelter N=93, n (%)	King County (KCRHA, 2020)
Gender		
Male	49 (53%)	56%
Female	28 (30%)	41%
Not Specified/Missing	16 (17%)	-
Gender Non-Conforming	-	2%
Transgender	-	1%
Age		
Mean, Median, Mode	44, 47, 58	
18-20	1 (1.1%)	19% Under 18
21-30	8 (8.6%)	9% 18-24 years old
31-40	12 (12.9%)	72% 25+
41-50	32 (34.4%)	
51-60	30 (32.3%)	
61-70	4 (4.3%)	
71-80	1 (1.1%)	
Not Specified/Missing	5 (5.4%)	
Race		
BIPOC Identified	21 (22.6%)	52% - BIPOC
Non-BIPOC Identified	67 (72.0%)	48% - Caucasian
Not Specified/Missing	5 (5.4%)	-
Referral Area		
North King County	80 (86.0%)	3% - North County
including Lake City	5 (5.4%)	
Other King County	8 (8.6%)	
Not Specified/Missing		

Note. BIPOC= Black, Indigenous, Person of Color; KCRHA = King County Regional Homeless Authority

Effectiveness

Effectiveness is defined as exiting the program to permanent housing and is the primary goal of both the shelter program and this project. The evaluation determined 9.7% of all shelter program participants were identified in the chart as discharged to housing (Table 4); however no other discharge reasons were found in the chart review.

Adoption

An anonymous staff survey was used to measure adoption of TIC. Twenty of the twenty-five staff (80%) returned a completed survey. The survey rated TIC perceptions on a scale from one to seven with seven being most aligned with Trauma Informed principles. The overall staff average was 5.9, which can be further broken down by the five subscales (Table 3).

Table 3

Staff ARTIC-10 Sub-Scale Interpretation and Results

Domain Names	Score N=20	Interpretation
Overall	5.9	Bipolar 7-point Likert scale. 1 is the least trauma informed attitude and 7 is the most trauma informed attitude.
Cause	5.6	Staff perception of underlying cause of problem behaviors and symptoms. Internal and fixed versus external and malleable.
Response	5.9	Staff responses to problem behaviors and symptoms. Rules and consequences versus flexibility and building healthy relationships.
Job Behavior	6.3	Job behaviors that endorse empathy versus control focus.
Self-Efficacy	6.0	Staff perception of their self-efficacy at work. Endorsing ability to meet demands of work or feel not able to meet demands.
Reactions	5.8	Staff reactions to their work. Recognizes and understands the effects of secondary trauma and coping by seeking support or unable to recognize the effects and seek support.

Implementation

Implementation includes four measurements associated with documented shelter service priorities: enrollment in HMIS (51.6%), linking to government identification (22.6%), obtaining benefits or income (16.1%), and connection to health services (33.3%).

Table 4

Shelter Program Priorities and Measurements

Shelter Service Priorities	N=93, n (%)
Exit to Housing	9 (9.7%)
Shelter Program Enrollment in HMIS	48 (51.6%)
Government Identification	22 (22.6%)
Benefits and Income	15 (16.1%)
Connection to Health Services	31 (33.3%)
Primary Care	17 (18.3%)
Mental Health Services	4 (4.3%)
Substance Use Disorder Services	10 (10.8%)

Discussion

The formative program evaluation is summarized within the framework of RE-AIM.

Reach

Demographic data presented in Table 2 show comparisons to King County demographics of people experiencing homelessness with two notable distinctions in racial and gender equity. First, 72% of shelter participants are Caucasian (Non-BIPOC) compared to the population of persons experiencing homelessness in King County (48%). Much of the diversity within King County is concentrated in South King County however homelessness disproportionately impacts persons of color (King County Government, 2020). There is limited availability of demographic data of unhoused people by region warranting further consideration. An exploration of potential barriers for BIPOC individuals in accessing shelter services within North King County is an important first step in addressing the disproportionate impact of homelessness on the BIPOC community. Second, the gender differences between the shelter program and King County data appear to be related to how gender data is captured. Gender data was not captured within the chart review outside of a referral form. This contributed to 17% missing gender data points. Additionally, the referral data source did not provide a non-binary gender option.

Shelter participants median age (47) is consistent with the national upward trend of median age of 50 in adults experiencing homelessness (Landefeld et al., 2017; Lee et al., 2017; Omerov et al., 2019). Lastly, 86% of referrals come from North King County which is consistent with the program goal of ending homelessness in this region.

Effectiveness

Of the total participants 9.7% were documented as having exited housing. It was difficult to draw conclusions on absolute numbers, however there were several important findings. The discharge dates were not tracked in a consistent manner, making it impossible to determine the average length of stay. Improved documentation of length of stay, reason for discharge, and discharge location (i.e., housing, street, inpatient services) can reveal additional information about the intended population and how best to service the needs within North King County.

Adoption

Eighty percent staff participation rate is a good indicator of interest in the topic. Most responses were completed within the first day. The data collected serves as a baseline, as no ARCTIC survey has been previously completed at the shelter, therefore there is no benchmark for comparison. The overall score is 5.9 out of 7 in favor of trauma informed responses indicates an above average attitude towards the framework. In addition, the score provides a starting point for future training by addressing the lowest sub-scale rating of staff perceptions of underlying cause of problem behaviors and symptoms. Lastly, the abbreviated survey of 10 questions excludes assessment of the two supplementary subscales, Personal Support of Trauma Informed Care and System-Wide Support. These could be utilized in future surveys via the ARTIC-35 and ARTIC-45 (Baker et al., 2021). The extended surveys would take additional time but would

reveal staff perceptions regarding support for TIC implementation by their colleagues, supervisors, and the administration. This would enable the prioritization of addressing systemic barriers preventing the TIC favorable staff from implementing the principles in day-to-day work.

Implementation

In addition to adoption, implementation is an important starting point for measuring program outcomes. The low enrollment within HMIS (51.6%) indicates a concern with how data is captured within this system. Although 93 people were actively participating in the program, only half were documented as enrolled in the program. In an ideal environment, monitoring and managing implementation priorities will generate improved program effectiveness resulting in increased eligibility for housing.

Maintenance and Recommendations.

As a result of this study, four improvements were recommended to the shelter: 1) implement consistent documentation and program monitoring; 2) document/track discharges and debrief following discharges; 3) assess current shelter policies and procedures to determine alliance with TIC principles; and 4) provide staff with annual mental health training.

This formative evaluation uncovered multiple key program indicators are missing or not documented in a consistent manner. This was particularly evident in the four service priorities and discharges. Establishing a standardized documentation system would support simplified program monitoring, prevent disruption due to employee turnover, provide a professional way to communicate adherence to program goals, and establish a record of accomplishment (Newcomer et al., 2015). Documentation could utilize existing HMIS tools or establish a unified Excel tracking system based on shelter service priorities.

The second recommendation is to routinely implement staff debriefing following discharges of individuals who do not exit to permanent housing. Specific assessment of what did and did not work in the shelter program participant's situation would foster a learning and growth environment. Additionally, common themes would emerge over time which could provide insight into barriers. For example, if a disproportionate number of discharges were associated with substance use, this creates an opportunity to discuss the agency's stance on harm reduction. In short, if the organization's goal is to deliver person-centered, recovery-oriented, and TIC - this requires continual and honest assessment.

The third recommendation is to examine existing policy and procedures through a trauma informed lens. As mentioned previously, TIC is an evidence-based delivery model for homeless services. It is evident staff attitudes align with these principles; however, it is unclear if support exists at the organizational level. A potential starting point is to look at how information is communicated to shelter program participants.

The final recommendation is to incorporate mental health training into the staff training curriculum. According to the SAMSHA, 26.2% of all homeless persons in a shelter met criteria for severe mental illness and 34.7% of them met criteria for chronic substance use (2011). Providing training would improve the recognition of the bidirectional relationship of homelessness and mental illness necessary for the provision of services to this population. Sources of training could include utilization of existing courses with other service providers in the area, identification of a speaker, or collaboration with Doctor of Nursing Programs to create a mental health training module.

Limitations

There were several limitations to project implementation. First, this project occurred during the COVID-19 pandemic which limited the available measurement options. Specifically, client voice is absent in the evaluation due to restrictions on in-person engagement. Focus groups and interviews of shelter program participants would have significantly enhanced the evaluation and would have demonstrated a key TIC principle - empowerment, voice, and choice (SAMSHA, 2014a). Second, due to time constraints the shorter ARTIC survey version was utilized omitting two sub-scale perceptions measurements. The omitted sub-scales may have revealed system barriers to implementing TIC. Third, access to HMIS was achieved using an outside investigator to extract data. As a result, any insights that this investigator may have found were lost.

Conclusion

In summary, this evaluation demonstrates translation of evidence-based approaches into real-world practice through quantitative data analysis within a RE-AIM theoretical framework. Like many homeless service providers, the shelter program is committed to the Housing First approach, an inclusion of Trauma Informed Care principles, utilization of case management services, and service integration. Through this formative program evaluation, objective baseline measurements have been established to further guide advancement towards these key service priorities. Additionally, program recommendations are offered and include: 1) support of Housing First approach through debriefing and tracking discharges, 2) enhancing TIC by examining existing policy and procedures, 3) advancing case management by ensuring consistent documentation and program monitoring, 4) integrating services by incorporating mental health best practices within the existing service delivery model through staff training.

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Appendix A: Survey Introduction

To: All Shelter Staff

From: Lauren Lawson, DNP, Public Health RN

RE: Program Evaluation to Begin Next Week I

As many of you are aware, Raissa Meegan is a graduate student tasked with completing a formative evaluation of our program. Starting next week (2/28) she will attend shift reports and staff meetings to discuss and distribute a brief survey. The survey is one component of our evaluation plan.

The survey will be brief, only 10 questions and anonymous. Please consider contributing because your responses are important.

I have attached informed consent information and the survey for your review. You may return surveys by sliding under my door or giving them directly to myself or Raissa.

Thank you in advance for your contribution.

Appendix B: Consent to Participate in Research

CONSENT TO PARTICIPATE IN RESEARCH

TITLE: A Formative Evaluation Using RE-AIM Theoretical Framework for Enhanced Shelter Services.

INVESTIGATOR: Raissa Meegan, RN, DNP Student

College of Nursing at Seattle University, 206-981-7932.

ADVISOR: Lauren Valk Lawson, DNP, RN

College of Nursing at Seattle University, 206-850-1450

PURPOSE: You are being asked to participate in a research project that seeks to investigate a formative program evaluation of shelter services from 4/1/21-12/31/21. You will be asked to complete a 10-question survey to evaluate your perceptions around trauma informed care.

SOURCE OF SUPPORT: **This study is being performed as partial fulfillment of the requirements for the Doctor of Nursing Practice** degree in Nursing.

RISKS: **There are no known risks associated with this study.**

BENEFITS: **Program evaluation and recommendations will be submitted to The Oaks to enhance program outcomes going forward.**

INCENTIVES: **You will receive no gifts/incentives for this study. Participation in the project will require no monetary cost to you.**

CONFIDENTIALITY: **There will be no names or demographic data collected in connection with the data. All research materials will be stored in a locked cabinet and only the private investigator, Raissa Meegan, will have access to the data**. Human subjects research regulations require that data be kept for a minimum of three (3) years. All the information you provide will be kept confidential.

RIGHT TO WITHDRAW: Your participation in this study is voluntary. You may withdrawal your consent to participate at any time without penalty. Your withdrawal will not influence any other services to which you may be otherwise entitled.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request. You may contact Raissa Meegan at 206-981-7932 or meeganraissa@seattleu.edu. A summary will be available in June 2022.

VOLUNTARY CONSENT: I have read the above statements and understand what is being asked of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason, without penalty. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any concerns about my participation in this study, I may call Raissa Meegan, who is asking me to participate, at 206-981-7932. If I have any concerns that my rights are being violated, I may contact Dr. Michael Spinetta, Chair of the Seattle University Institutional Review Board at (206) 296-2585.

Appendix C: ARTIC 10 Survey

Please contact the Trauma Stress Institute for a sample survey at

https://www.traumaticstressinstitute.org/the-artic-scale/