PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Kevin Green, Chief Executive Officer
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AHCCCS Fidelity Reviewers

Method

On November 27 – 29, 2017, Karen Voyer-Caravona and Thomas Eggsware completed a review of the AHCCMS Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

AHCCMS is contracted with the Regional Behavioral Health Authority (RBHA) to provide Permanent Supportive Housing supports. Members are introduced to AHCCMS services through three primary streams: (1) members who receive scattered-site housing vouchers through the RBHA select AHCCMS services after attending presentations by various PSH service providers at the housing briefing conducted by the voucher administrators, Biltmore Properties or HOM Inc.; (2) members (with a voucher or self-pay with an income) are directly referred by clinic staff to AHCCMS for assistance with the housing search and/or housing support services; or (3) members who are already housed are directly referred for in-home services, rather than going through any other application or waitlist procedures. PSH services are provided by two Clinical Coordinators (CCs), who coordinate with the clinical teams, complete assessments, and keep paperwork updated; four Community Support Workers (CSWs), who provide most direct services; and one Community Resource Coordinator (CRC), who also provides direct services and conducts outreach to provider clinics. According to agency marketing materials, in addition to assistance with the housing search, AHCCMS staff offer the following support activities: assessment and treatment planning, goal development, new tenant orientation and tenant rights, crisis intervention, budgeting training, meal preparation skills, safety and hazard recognition, housekeeping skills, hygiene and self-care skills, and psycho-education using a recovery curriculum, referred to as CORE.

At the time of the review, 40 members were receiving AHCCMS services, 38 of whom were housed. Twenty-nine members resided in independent housing; 18 were tenants of some type of subsidy voucher program, primarily those issued through the RBHA, and 11 were tenants of market rate (unsubsidized) units. Three members without vouchers lived in congregate settings with other people with disabilities. Six individuals chose to live with either family or friends; one of those had a scattered-site voucher and was engaged in an apartment search.

The individuals served through the agency are referred to as “clients” or “members”, but for the purpose of this report, the term “tenant” or “member” will be used.

During the site visit, reviewers participated in the following activities:

- Overview of the agency with the Chief of Behavioral Health Services and the PSH Program Director;
- Group interviews with AHCCMS direct service staff: the Community Resource Coordinator (CRC), a Clinical Coordinator (CC), and two Community Support Workers (CSW);
- Group interview with six tenant/members who are participating in the PSH program;
- Review of agency documents including intake procedures, eligibility criteria, wait list and criteria, team coordination and program rules; and
- Review of ten randomly selected member records, including some charts of interviewed members/tenants.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing (PSH) model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the PSH model along 7 dimensions: Choice of Housing; Functional Separation of Housing and Services; Decent, Safe and Affordable Housing; Housing Integration; Right of Tenants, Access of Housing; and Flexible, Voluntary Services. The PSH Fidelity Scale has 23 program-specific items. Most items are rated on a 4 point scale, ranging from 1 (meaning *not implemented*) to 4 (meaning *fully implemented*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) rate on a 4-point scale with 2.5 indicating partial implementation. Four items (1.1b, 5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

The PSH Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Choice of unit: AHCCMS staff assist members in selecting units that align with their preferences. AHCCMS staff help members in identifying priority locations, preferred features and amenities, and assist them with transportation to multiple units of interest.
- Functional separation: AHCCMS staff report that they do not have any role in housing management functions, such as collecting rent or reporting lease violations, and that landlords and property managers are not involved in providing clinical or support services. AHCCMS staff said they focus on eviction prevention and successful housing retention, and will advocate for tenants with landlords, if tenants permit.
- Housing integration: Per member and staff interviews, and data provided to reviews, the majority of tenants live in integrated community settings.
- Privacy/access to units: Per interviews with AHCCMS staff, CMs, and members, the majority of tenants control access to their units. Neither AHCCMS nor clinic staff maintain keys to housing units.

The following are some areas that will benefit from focused quality improvement:

- Choice of housing type/household composition: Some clinical teams may not fully embrace *Housing First* principles, impose readiness standards when making housing referrals, and attempt to steer members toward nonintegrated/higher level of care settings. Choice is also constrained when voucher administrators require clinical teams to approve additions to leases (for roommates and significant others).
- Housing quality standards: Per data provided, fewer than 65% of housed members lived in settings in which housing quality standards (HQS) could be verified. For tenants of self-pay or other housing that does not require HQS, system partners should collaborate to develop and implement training, protocols, and/or other options for verifying safety of units.
- Rights of tenancy: Per copies of lease agreements provided by the agency, rights of tenancy could only be established for 62% of tenants. In order to establish rights of tenancy, AHCCMS should have copies of leases for all housed members, including for those residing with friends or family.
- Clinic-driven service priorities: Ongoing staff training should occur regarding the development of personalized goals, needs and objectives, and clearly reflect the values and priorities of the member rather those of the clinical team; treatment plans should be updated regularly to reflect changes in member needs, priorities, status, and circumstances.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 2.5	Interviews with clinic CMs indicate that some clinical teams may not fully embrace independent housing as the default options for members seeking housing. Some clinical teams may continue to recommend treatment, staffed or semi-staffed settings to members, based on assessed level of care. CMs interviewed said that members who were actively abusing substances would be encouraged to pursue a treatment setting. Nonetheless, CMs understood that members ultimately make the final decision about which housing option to pursue. CMs interviewed expressed a wariness for "setting members up to fail" but that having PSH supportive services in place give vulnerable tenants a better chance of success at independent living. High turnover of clinic staff, reported by AHCCMS staff and members interviewed, may play a role in understanding and acceptance of *Housing First* principles related to choice of housing type. The lack of a voucher, insufficient income, the decreasing availability of safe and affordable housing, and a felony or eviction history may all determine the type of housing options explored. Members who are not homeless are not eligible for RBHA scattered-site vouchers, and wait times can be several years for members who have applied for Section 8. One member interviewed	• Clinical teams should empower members to choose the housing type that best meets their needs and preferences. System partners should ensure that clinical teams receive regular training on the *Housing First* principles supporting choice and self-determination.

			discussed how lack of a voucher/income and background issues regulated him to a halfway housing setting that compromised his mental health and contributed to problem behaviors.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 4	Once admitted into the AHCCMS PSH program, members seeking housing are assisted in finding their preferred housing unit. AHCCMS staff described gathering information from members about how they will pay for housing, either self-pay, scattered-site program voucher, or some other type of subsidy voucher, such as Section 8 or Bridge to Permanency. Staff ask members to indicate what geographical vicinity they desire, as well as specific needs such those pertaining to mobility, pets, and proximity to family or necessary services. Most records showed that members were shown several units before deciding on a unit. Consistent with staff and member interview, some records showed that members' choice of unit could be constrained by landlord willingness to accept subsidy vouchers, insufficient income, and background issues. AHCCMS staff said that a growing number of landlords, particularly among larger, corporate-owned apartment communities, have opted to discontinue accepting vouchers as the rental market has tightened. Additionally, staff said that the housing resource lists provided to members by the voucher administrators at the housing briefing were out-of-date. AHCCMS staff said they have mediated this issue by creating their own internal database of Phoenix landlords and property managers who accept scattered-site vouchers. Staff said that in the course of this project they have built relationships with new landlords who were willing to accept vouchers.	• AHCCMS should continue present efforts to build relationships with area landlords in order to increase participation in the RBHA scattered-site voucher program and expand the housing resources database. • System partners should continue to work with affordable housing stakeholders in an effort to increase the availability of affordable units and with attention to removing barriers to housing people with criminal histories.

			Staff said they plan to create similar inventories for Mesa and Tempe, as well as for *felony-friendly* housing. AHCCMS staff said that for members without RHBA vouchers, housing choices are increasingly limited by rising rents, as previously affordable apartments and complexes have been redeveloped into higher-end communities that are unaffordable to most members. As a result, some members who do not qualify for vouchers may accept housing units that do not align with preferences and needs. In these cases, AHCCMS staff said they encourage members to apply for low income housing programs for which they are eligible, such as Section 8.	
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 4	AHCCMS staff reported that they have not had to use a wait list because they are under capacity. However, they have, under advisement by the RBHA, developed a waitlist protocol, which is guided by the Vulnerability Index – Service Prioritization Decision Assistance Tool ((VI-SPDAT). For members with scattered-site housing vouchers, AHCCMS staff interviewed said that members have 30 days upon receiving a voucher to find housing, and that the voucher administrators will grant extensions. AHCCMS staff said that this time frame also applies to Section 8 vouchers. Clinic staff said that one of the voucher administrators allows for 30 days before requiring an extension, while the other administration issues an initial 60 days to find housing. Most agency and clinic staff said that members can receive up to two 30-day extensions, although one CM said that one member was granted five extensions. To receive extensions	• System partners should resolve delays in the exchange of required documentation needed to begin PSH services, especially for members who have been issued time-sensitive vouchers.

			members must show they are actively seeking housing and can show circumstances for declining available units. AHCCMS staff said that common factors delaying using the voucher are: difficulty finding landlords who accept vouchers, background issues, and difficulty maintaining contact with members who are homeless. AHCCMS staff also said that sometimes members are referred with only a few days before the voucher is set to expire. Staff said that they are not authorized to submit extension requests to voucher administrators; for RBHA affiliated voucher programs this must go through the CM. In some cases, the voucher is running out while AHCCMS is waiting for the clinic to provide documentation required to begin services.	
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 2.5	Tenants of self-pay units have complete control of household composition; roommates must pass any required background checks and be added to the lease agreement. Clinic staff said this also applied to Section 8 tenants. CMs said that for RBHA affiliated scattered-site voucher holders, the voucher administrators require that clinical teams approve roommates. Most AHCCMS staff were aware of this policy. One AHCCMS staff was uncertain about what the voucher administrator required to accommodate household composition preferences, but said that at housing briefings people are asked if they are living alone or with someone else, and then given paperwork to accommodate their family size. AHCCMS staff said they have no role in approving roommates. Tenants of half-way houses or sober living communities generally do not have control of household composition and may or may not have	• Empower tenants to have full control over the composition of their household by discussing pros, cons, etc. of having someone join their living situation. • All AHCCMS staff should have a common and accurate understanding of how RBHA vouchers are administered and policies regarding the accommodation of roommate requests. Housing providers should be knowledgeable to educate members on the process of adding others to leases, while supporting member choice in controlling the composition of their households, rather than seeking clinical team approval.

			their own bedroom.	
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management providers do not have any authority or formal role in providing social services	1, 2.5, or 4 4	Per interviews with AHCCMS staff and members, property management and supportive/clinical services are completely separate. Landlords are not involved in any areas related to treatment services nor attend staffings to discuss clinical issues. AHCCMS staff will advocate for members for accommodations related to their disabilities with tenant permission. Records showed that, with the tenant's permission, AHCCMS staff and the CM successfully advocated with a member, whose difficulties with symptom management caused him to repeatedly flood a downstairs apartment, to move to a ground floor unit.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	AHCCMS staff do not report violations of lease agreements to landlords but instead employ eviction prevention methods to help members retain their housing. For example, a record showed that when a tenant bought illicit drugs from someone in the presence of AHCCMS staff, the staff person notified the CM that the tenant may benefit from substance abuse engagement.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	The majority of PSH tenants live in voucher subsidized or self-pay situations, or with family where no social services staff would be located. AHCCMS staff do not keep office space in any building or complexes where PSH program participants reside. Four members (9%) live in staffed or semi-staffed settings that are meant to be temporary while they wait for permanent housing through RBHA scattered-site voucher or other affordable opportunities.	

Dimension 3 Decent, Safe and Affordable Housing				
3.1 Housing Affordability				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 3	Per data provided by the agency, three tenants pay between 31 - 40% of income toward rent, 13 tenants pay over 50% of income in rent, and 22 tenants pay no more than 30% of income in rent. Eighteen tenants live in units partially funded using some form of subsidy voucher, primarily RBHA scattered-site vouchers, followed by Section 8, and Bridge to Permanency. Voucher tenants without income pay no rent. AHCCMS staff reported that many individuals in self-pay units are on various voucher waiting lists for which they may qualify. Some members interviewed said they are on either the RBHA voucher or Section 8 waiting lists. AHCCMS staff said that, because most tenants have very limited incomes, they encourage members to look for housing that includes utilities. They also help them apply for and obtain resources such as Supplemental Nutritional Assistance Program benefits, food boxes, move-in assistance, and move-in boxes.	• For members who pay more than 30% of income toward housing costs, continue to explore tenant housing preferences in an effort to locate more affordable housing. A distinct cost burden exists when 50% or more of tenant income is used for housing costs, potentially leading to housing instability. However, tenants may choose to continue to pay more than 50% of income toward housing costs. • For those without vouchers, formalizing strategies to match roommates may aid members in sharing housing costs. • System partners should continue to work with affordable housing stakeholders to advocate for an increase in the availability of affordable units.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Per data provided by the agency at the time of review, the reviewers could verify only about 37% of units met housing quality standards (HQS). The agency provided inspection reports for 14 out of 38 units. AHCCMS staff do not have any specific training in HQS standards and acknowledged that some members prioritize factors such as size of unit or location over safety of the unit structure or surrounding environment. An AHCCMS staff described that one individual chooses to live in	• Refine mechanisms to obtain copies of the HQS inspection reports. Discuss with members of voucher-based units the benefits of allowing AHCCMS to hold a copy of the HQS and obtain a release of information to obtain them from the voucher administrator. • Develop procedures to confirm if units meet HQS for those who are in residences not associated to the RBHA or other

			unsanitary conditions on a friend's property while she waits for a Section 8 voucher due to her friend's flexibility and support.	voucher/subsidy programs. It may be beneficial to contract with an outside agency to perform HQS inspections for tenants in residences not affiliated with RBHA or other voucher administrators.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Per interviews with AHCCMS staff and members receiving services, as well as a review of data provided, the majority of tenants live in integrated community settings. Some clustering of people with disabilities may unintentionally occur due to low income. Three people were identified as living residences where they were clustered with individuals with disabilities. One tenant living in a halfway house reported that many of the other residents are also living with an SMI, and that this can be a source of stress for him.	
Dimension 5 Rights of Tenancy				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 1	The agency was able to provide the reviewers with standard lease agreements for 61% of tenant units. While it is assumed that all tenants of voucher based units have rights of tenancy, the agency lacked copies of lease for 15 of 38 residences. One member was living in a hotel with a friend. Most individuals living with families or friends do not have leases, although one member interviewed reported that she has an informal written agreement with her mother and that the Community Resource Coordinator for the agency has a copy of it. In some records, it appeared that tenants	• Develop mechanisms to obtain copies of all leases/rental agreements as soon as possible upon the tenant obtaining housing and/or enrollment in the PSH program, regardless if the housing is thru the RBHA. Discuss with tenants how having a copy of rental agreements enables the agency to confirm members have legal rights to their housing units. • Track when tenant leases will end, expire, or terminate so that PSH service staff can proactively support tenants on the process of renewing a lease. • AHCCMS staff may benefit from training in

			discussed breaking leases without AHCCMS staff suggesting approaching the landlord with a request for mutual rescission.	mutual rescission for members who are considering moving out before the end of a lease. AHCCMS should work with the RBHA to identify training opportunities in issues pertinent to the Arizona Landlord Tenant Act, rights of tenancy, etc.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Most members reside in independent housing; the reviewers saw no evidence from either the record review, interviews, or leases provided that tenants are required to comply with special rules or provisions in order to remain housed. The three members who live in congregate settings do have program rules that they must comply with in order to maintain residency.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	AHCCMS does not impose readiness requirements at program admission or for housing searches. Clinic staff interviewed said that tenants ultimately have the right to live independently if they want to; some clinic staff also indicated that clinical teams consider readiness (sobriety, symptom management, attainment of independent living skills) when making recommendations for housing. One CM said that the clinic Housing Specialist and the RBHA have provided information on "flow charts" that match members' independence level with appropriate housing options. The CM said a member who is actively using illicit substances would be encouraged to pursue a treatment setting, but housing referrals are also based on what the member is willing to accept. CMs said that wrap around supports through PSH programs were especially important for members who refuse staffed settings.	• On a regular basis, provide refresher education to clinic staff on a *Housing First* approach. This is especially important for clinical teams that have experienced a high rate of turnover among CMs.

6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Under the current system, it appears that members who meet the RBHA's PSH scattered-site voucher eligibility requirements have equal access to housing. However, most AHCCMS staff and CMs interviewed were not completely clear on the RBHA's PSH eligibility criteria, with CMs noting that clinic Housing Specialists (HS) having more specific information in this area. According to the RBHA's website, in order to be eligible for the scattered-site voucher the member must be homeless, living in a shelter designated for temporary living, or discharging from an intuitional setting, and have a VI-SPDAT score within a specific range. Members who do not meet the RBHA's definition of homelessness must pursue other options such as Section 8, public housing, market rate housing that they pay for themselves or through some level of assistance from family or friends. Most members interviewed were aware of the homelessness criteria. One member said that "someone" told him "to go to CASS and live on the ground" in order to qualify for a voucher. In some member records the VI-SPDAT score was below the threshold for PSH, but they were referred for PSH at AHCCMS.	• While system constraints may not allow full alignment with EBP criteria for this item, clinic and AHCCMS staff should have a common understanding of the RBHA eligibility criteria for scattered-site vouchers, as well as that of other subsidy voucher/housing programs. System partners should continue to provide education in this area to clinics and PSH programs.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	The majority of members live in independent units where they control access. AHCCMS staff do not hold keys to tenant units, nor do they attempt to gain entry without member permission. Most tenants interviewed said property management had to provide notice before entry, although one tenant reported a lack of response from HOM Inc. after reporting that building maintenance routinely entered their unit without permission. Three members live in settings where they do not fully control who can access their unit. One	• Work with members in settings where they do not have full control over entry to their unit to explore alternative options, and/or to affirm that their current situation aligns with their housing goal.

			member in a halfway house reported that he cannot lock his door, and two live in other congregate staffed settings with limited control of access. Although six members live with family or significant others and control of entry cannot be completely determined, one member interviewed reported that she chooses to live with her adult son and his family in order to assist them financially.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they want at program entry	1 or 4 1	The reviewers found examples of goals that were specific to members in clinic treatment plans, including housing goals, but often the needs and objectives reflected rote, clinical jargon, prioritizing psychiatric stability and treatment recommendations. For example, several plans indicated that the member "needs to follow the rules at HOM Inc." Some needs, such as "need to actively participate in mental health treatment to manage his symptoms", were listed on the service plans of multiple members.	• Ongoing staff training should occur regarding how to work with members to develop personalized goals, needs and objectives, and clearly reflect the values and priorities of the member rather than those of the clinical team. All service plans should be individualized and directly reflect the expressed goals, needs, and action steps for achieving those goals.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	Clinic staff reported that member service plans are updated a minimum of annually; the reviewers found most records were revised about every 12 months. Some goals appeared to be transferred from one year to another with minimal adjustment. Some records showed that plans were not updated to reflect significant changes in circumstances such as housing status, evictions, and psychiatric hospitalizations.	• Ensure service plans are modified to reflect the member's current status, goals, needs, and services. PSH and clinic staff should obtain input from each other when modifying plans if an integrated single plan is not an option. This collaboration may prompt staff to revise plans for their prospective agency when members have a change in status necessitating a service plan review.
7.2 Service Options				
7.2.a	Extent to which tenants are able	1 – 4	Tenants may choose whether or not to accept PSH services, and they have opportunities, either at the	• System partners should have a common understanding whether or not tenants

	to choose the services they receive	3	voucher administrators' housing briefing or through information shared by their clinic CM, to choose their PSH service provider. Once referred to AHCCMS, members reportedly have an array of service options to choose from, including assistance with housing searches, help with transportation to visit units, support at lease signings, budget training, and help with connecting to community resources and day programs; however, the reviewers found standardized content across several service plans and a lack of individualization. Most, but not all, service plans in ten member records reviewed included a goal. Staff said that members always have some type of housing goal and that budgeting to retain housing is a common goal. Needs/objectives, and *methodology* (services) were also listed, many of which contained content that was repeated across several treatment plans, including references to "up to 90 minutes of CORE psycho-educational counseling activities". In one record, services addressed CORE but not the member's identified need of finding safe and affordable housing. In another record it was documented that a member repeatedly declined CORE but the service remained on the plan. Members can terminate AHCCMS services at any time they wish without losing either their voucher or housing and can re-engage with PSH services at any time they determine a need. Some clinic staff interviewed believed that clinic services must be retained in order to keep RBHA affiliated vouchers, while others were uncertain. AHCCMS staff said that members do not need to participate in clinic services in order to retain housing vouchers and/or AHCCMS PSH services because they are	using RHBA affiliated vouchers can retain their voucher if they choose to decline clinic case management services. • While it is possible that autofill and drop down selection fields in electronic formats of service plans may explain redundancy found in many member plans, ongoing training should occur regarding how to engage members to develop personalized goals and needs/objectives.

			placed on "navigator" status, which does not require service provision.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	AHCCMS staff reported that they assist members in creating service plans upon program entry. Service plans are revised at least once annually, but CCs complete individual monthly summaries with members and offer the opportunity to add or remove goals to their service plans. AHCCMS staff estimated that service plans are updated quarterly for most members. Although most records reviewed showed no updated service plans, reviewers saw notes reflecting that opportunities were offered. One member interviewed reported having a staffing at the agency with her CM to review her goals and "fill in the loopholes". AHCCMS staff said there is no standard package but that most members have the same needs but they are addressed specifically using their own words on service plans. As reported above, the reviewers found standardized language and service selections across several service plans. However, some progress notes reflected member specific support services such as helping the member apply for Supplemental Nutritional Assistance or advocacy with the landlord to prevent eviction. One member said her CSW assisted her in obtaining eye glasses.	• Monitor member changes (e.g., obtaining or losing housing) and offer treatment plan revisions as they occur. Records reviewed show that members do not lead static lives; service planning should reflect this. Closer service coordination between clinics and the agency may result in more regular updates to treatment plans that more closely mirror their present needs and concerns.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	AHCCMS staff reported that members have the opportunity to participate in a member survey every six months. They also said that members can attend a member advisory board quarterly. The member advisory board does not appear to be made up of appointed members but a meeting open to service recipients to share their concerns	• Develop or enhance opportunities for members/tenants to drive services. Member input can be obtained in many ways such as interviews by peers, written opportunities, council meetings, PSH tenant forums and involvement in quality

			or obtain information. Staff said it is promoted with fliers and participation is low. AHCCMS does not prioritize hiring people with lived experience of recovery from SMI or co-occurring disorders and were not aware of any peers providing direct services, but one tenant interviewed mentioned receiving peer support from an AHCCMS staff assigned to her.	assurance activities, committees, or boards where the information gathered is used to inform service design decisions. Support true member control (e.g., the board could be chaired by a non-member but should include significant numbers of members).
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	Forty-three members are serviced by four CSWs, two CCs and one CRC. Staff said CSWs have caseloads of 15 or below. The two CCs share up to 20 members each with CSWs. The CRC also maintains a caseload of 15 or below. Currently, AHCCMS is operating under capacity; the member/staff (CSWs and CRCs) is approximately 9:1.	
7.4.b	Behavioral health services are team based	1 – 4 2	AHCCMS PSH program participants are referred from their provider clinics. The AHCCMS and clinical staff do not share any office space and maintain separate records management systems. Per interview, clinics may or may not integrate any AHCCMS documentation into their electronic records, and one CM said that he keeps AHCCMS monthly summaries in his office files rather than filing them in member records. The reviewers also noted what appeared to be redundancy of services already provided by the clinical teams on the part of AHCCMS. For example, the AHCCMS CCs conduct a clinical screening which appears to cover material provided on the annual assessment (Part E) provided by the clinical team. Further, AHCCMS and clinic staff appear to disagree regarding documentation requirements for admission into the PSH program; AHCCMS staff reported frequent delays from the clinics in receiving required documentation, while one CM	• Optimally, all behavioral health services are provided through an integrated team. If this is not possible due to the current structure of the system with separate service providers, hold regular planning sessions to coordinate care. Soliciting input, and sharing of service plans and other documentation is encouraged if an integrated health record is not possible.

			reported AHCCMS requires too much documentation and unnecessary face-to-face involvement of the CMs at intakes. Additionally, within the existing system, members may receive services from multiple providers for counseling, employment services, and substance abuse treatment. The reviewers saw no evidence that AHCCMS staff had interactions with service providers other than clinic CMs or HSs. Even though, AHCCMS occasionally schedules staffings with CMs, it appears that most communication occurs through email or phone calls.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	AHCCMS staff reported that they have a 24-hour paging protocol, provided to members at program entry. Typically, on-call begins with the CSWs and the CCs, but everyone, including the CEO, is available for on-call; if the first person is not available, the member is directed to go up the ladder until they reach someone. Staff said in the event of crisis, members usually only need to be verbally de-escalated over the phone. Staff said they do meet people in the community after hours but could not provide a recent example. One member interviewed said that AHCCMS is available to her 24 hours a day, seven days a week and that "they cover each other so you aren't ever left out in the cold."	

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	2.5
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		3.25
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.17
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	1
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	3
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		2.5
Total Score		21.42
Highest Possible Score		28