PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: 11/4/2015

To: Gigi Touchon-Grebb, Chief of Behavioral Health Services

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ADHS Fidelity Reviewers

Method

On September 28-29, 2015, Fidelity Reviewers Jeni Serrano and T.J. Eggsware completed a review of the Arizona Health Care Contract Management Services, Inc. (AHCCMS) Permanent Supportive Housing (PSH) Program. This review is intended to provide specific feedback in the development of your agency's Permanent Supportive Housing services, in an effort to improve the overall quality of behavioral health services in Maricopa County. In order to effectively review PSH services within the current behavioral health system, the review process includes evaluating the working collaboration between each PSH provider and referring clinics with whom they work to provide services. For the purposes of this review at AHCCMS, the referring clinics include Lifewell clinics Arcadia and Midtown. Due to the system structure, issues surrounding the implementation and delivery of PSH services are found at many levels, and therefore, will be noted as such throughout this report.

As described on the agency website, AHCCMS operates 11 residential group homes, each individually licensed by the Arizona Department of Health Services. AHCCMS also delivers support services in 14 community living facilities, 11 of which are homes and 3 of which are in apartment complexes. In this level of care, clients hold their own leases and typically consider their placement as more of a permanent housing situation. The review conducted during the fiscal year 2014-2015 focused on the community living facilities; at the time it was the program identified that most closely aligned with the PSH model. This review focuses on newly funded in-home services, as described below. The reports describe two different sets of activities, and should not be compared.

In January of 2015, AHCCMS was contracted with the Regional Behavioral Health Authority (RBHA) to provide 60 members with in home services who may already be housed or were referred with a housing voucher. Members are introduced to AHCCMS services through three primary streams: (1) members apply for a voucher through the RBHA, are put on a waitlist, and when issued a voucher they are offered AHCCMS services from a list of other similar providers (or elect to have no provider or services); (2) members who have an income and need assistance with the housing search and in-home supports may be directly referred by clinic staff to AHCCMS; (3) members who are already housed can be referred for in-home services directly rather than going through any other application or waitlist procedures. Per the RBHA website, clinical team staff can reach out to one of the five Permanent Supportive Housing Service Providers to request services for a member. Per the RBHA website it appears members who are already housed may be referred directly for support services, but at AHCCMS there were also examples of members who were not housed who were referred for assistance, all of whom have a source of income (e.g., Supplemental Security Income).

AHCCMS does not own or manage any properties, and the services are not directly linked to any voucher or subsidy program. At the time of review AHCCMS provides in-home support or housing search support to 26 total members who are currently housed or starting their housing search. Members referred with a voucher who were homeless, and who AHCCMS staff assisted in locating housing, account for only 19% (5) of the tenants served. Some members, 23% (6), were referred with no attached voucher, in order for AHCCMS to assist with the housing search as part of the PSH service. The majority of tenants, 58% (15), were already housed prior to referral for AHCCMS services.

The definition of Permanent Supportive Housing is "housing *and* services." Due to the unique referral processes at AHCCMS, with some members experiencing waitlists, some already-housed members being directly referred by clinic staff, etc., the agency is not directly involved in all aspects of the PSH model (e.g., Dimension 1, Choice of Housing) for all members served. Though, in other areas the structure of the program does appear to align more closely with the PSH model (e.g., Dimension 2, Functional Separation of Housing and Services). Consistent with fidelity review practices, this program has been evaluated on all dimensions of fidelity. In this report, the review team will attempt to differentiate the impact of the system and program structure on the members involved in PSH services through AHCCMS.

The individuals served through the AHCCMS agency are referred to as "clients," but for the purpose of this report, the term "tenant" or "member" will be used. The term "housing" in this report, unless specified otherwise, will refer to the Permeant Supportive Housing (PSH) arm of AHCCMS' program.

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

- Review of clinic electronic files
- Individual interviews with clinic Case Managers (Arcadia and Midtown)
- Interview with the Chief Executive Officer, and Chief of Behavioral Health Services of AHCCMS
- Interview with Permanent Supportive Housing Program Director of AHCCMS
- Orientation to the Permanent Supportive Housing services provided through AHCCMS
- Review of agency documents including operational and discharge policies and procedures, PSH program brochure, and summary of training and marketing activities over the course of PSH program implementation
- Interview with the PSH Community Support Worker, and PSH Community Resource Coordinator
- Interviews with four tenants who are participating in the Permanent Supportive Housing program
- Discussion of wait list and criteria with the Regional Behavioral Health Authority (RBHA)

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:

- AHCCMS staff interviews and documentation provided for this review suggested that staff are well-trained and knowledgeable about the evidence-based practice of PSH and the principles of Housing First.
- Functional separation exists between housing management companies and the PSH agency. AHCCMS staff only focuses on service concerns such as treatment planning and in-home supports. Tenants interviewed confirmed there are no overlapping roles and tenancy is not contingent on compliance with program provisions.
- Scattered site housing program allows for tenant choice and tenant privacy; AHCCMS staff and tenants confirm that scattered site units are integrated in the community, and tenants select units of their choice in the communities they want to live in. In-home service providers are based off site, not in the unit, and staff does not have keys for entry.
- All staff has optimal caseload sizes for effective service provision.

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

- To ensure decent, safe and affordable housing for tenants, maintaining records of Housing Quality Standards (HQS) inspections and leasing information is critical. The separation of housing management and program services does not eliminate the maintenance of housing information. High fidelity programs offer tenants full rights of tenancy. This cannot be assessed without access to the lease. In addition, meeting lease requirements can become part of the supports and services offered, if the tenant requests that assistance. This information is often used to tailor tenant services to provide that support and/or provide education on self-advocacy techniques. The HQS inspections can be performed by a trained staff, or a partnering agency/company.
- Clinical teams and the RBHA should focus on shifting the current “level of care” thinking that excludes the people with the most significant housing challenges (high service utilization, homelessness, chronic acute symptomology and substance abuse) to one that prioritizes those individuals as candidates for Permanent Supportive Housing. Referring clinics are constraining choice through this level of care determination. Clinic staff have some familiarization with options managed through the RBHA (e.g., scattered site lists, community living lists, flex-care), but continue to have some difficulty distinguishing who is appropriate to refer; opportunities exist to further train staff to support member choice over assessment of need or referral based on availability.
- AHCCMS should explore opportunities to increase tenant voice into the design and provision of services. Platforms such as tenant advisory councils only for PSH tenants and program improvement forums provide agencies opportunities to gain valuable insight into the tenants’ view on the effectiveness of their services.
- The RHBA should consider that based on the current structure of the system, with separate service providers, the clinical teams and PSH service providers should attempt to integrate services as much as possible. For example, holding regularly scheduled staffings to coordinate care and work as a team, sharing treatment plans and soliciting input for consistent, regular communication between primary staff, etc.
- The RHBA should explore ways to support the challenges of housing tenants with criminal histories to ensure integration and choice.
- Update the agency website to highlight the PSH program; the Behavioral Health page of the agency website highlights residential and community living facilities, but not the PSH program.

- Many members referred to AHCCMS receive some type of subsidy, and some are already housed prior to referral to AHCCMS services. Based on review of records and data, it appears the program struggles with assisting those with no subsidy to locate safe, affordable housing. Ensure frontline staff are adequately trained and aware of community resources they can offer members to aid in their search for housing that is affordable, safe, and based on the member's preference.

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 (1)	Tenant's choice of housing is restricted at the referral source, due in part to clinic team assessment of member needs rather than member's choice, as well as reportedly extended waitlists for voucher programs and limited affordable options in the system. It is not clear if all members already housed prior to referral for AHCCMS services had a choice of affordable housing, but more importantly it does not appear AHCCMS was directly involved in supporting member choice for the majority of members (i.e., those already housed) prior to referral for services. If a member is referred for services only (i.e., no voucher), choice is constrained. Those with a voucher have choice of affordable housing unit, but those with no voucher have limited affordable options; some pay in excess of 50% toward rent costs. Others with legal challenges may be directed by PSH staff to non-integrated settings such as halfway houses or sober living settings. Some members remain homeless, move in with family while awaiting a voucher, or return to jail due to issues securing stable housing. It does not appear staff at AHCCMS have any specialized training or experience to assist members to explore all housing options. If a member has no voucher, they may assist with applications, an action that would usually occur at the referring clinic. The program may also connect members with apartment locator services at a nominal fee to the prospective tenants.	• System-wide training efforts should continue; staff should be educated on available housing options, so they can adequately orient members in order to support member choice. Empower clinical staff to welcome PSH programs as the default option for SMI members. An affordable option should be offered as a choice, but members may choose to pay higher (e.g., above 50%) at their discretion. • The RBHA and AHCCMS should brainstorm options that allow AHCCMS staff to support member choice of housing. In-home services or tenancy retention supports to members already housed will likely be beneficial to the community; however, PSH programs should also be involved with assisting members to explore options, and obtain housing. • AHCCMS should train direct care staff to work with individuals with significant challenges, including expanding the housing search to aid members who are referred for PSH support with no voucher. As AHCCMS staff build relationships

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				with housing landlords they may be able to offer a wider variety of options to prospective tenants.
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 (1)	As noted above, choice of unit is constricted through the program if a tenant does not receive a housing voucher. If a tenant receives a voucher through Arizona Behavioral Health Corporation (ABC) Housing, the tenant is provided with a list of PSH in-home service providers to assist them with the housing search and/or other PSH in-home services. Once the tenant selects the provider, then the tenant and the provider meet at the briefing; AHCCMS and RBHA staff report AHCCMS is on the list of PSH service providers members could choose from, if they elect to receive PSH services. At the time of review, AHCCMS reported most of their PSH referrals are for tenants who are already housed and need in-home supports or who have an income and can pay full rent. The program had difficulty offering options to some members; some members remain homeless, were homeless and moved in with family, etc.	• AHCCMS should train PSH direct care staff to work with individuals with significant challenges, including expanding the housing search to aid members who are referred for PSH support with no voucher. As staff build relationships with housing landlords they may be able to offer a wider variety of options to prospective tenants.
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists.	1 – 4 (3)	At the time of review, AHCCMS served many tenants who were already housed with a voucher, already housed with no voucher, or lived with family prior to referral for in-home supports. However, some members are impacted by other system waitlists tied to vouchers. Some clinic staff report that members have a limited number of times to decline an option offered. AHCCMS staff, clinic staff and tenants all report during interviews that once a member receives a scattered site voucher, the tenant has 30 days to find an apartment of their choice that accepts the subsidy and background check. AHCCMS does not maintain a waitlist for services; some members already housed or in need of assistance locating housing are directly referred from clinic staff, and the	• The RBHA should provide clarification on waitlist procedures for voucher programs; orient clinic and PSH staff to the prioritization applied so they can properly educate members. • Agency, clinic staff and tenants should receive education on the process of how to file for voucher extension that allows for additional search time if needed.

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			program has not met capacity. Clinic staff report that referrals for Independent Living Skills (ILS) support service only, like those through AHCCMS, are processed more rapidly than waitlists for voucher programs.	
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 with vouchers are able to choose the composition of their household. Many of the other tenants served through AHCCMS appear to control the composition of their household, including those referred to AHCCMS who already resided in a subsidized scattered site housing residence, and those residing with family. Tenants have limits on the composition of their household if they do not receive a voucher, which accounts for about 46% (12) of those currently served by the agency (excluding members who remain homeless or are now incarcerated). One tenant interviewed shared that he and his wife had been living separate for years due to them both being homeless, but when his wife was eventually moved into a community living placement he was not allowed to live with her due to the rules of the placement. He was only allowed to spend a few nights a week and then he had to leave. Once he received his voucher for scattered site housing, he and his wife were able to find an apartment of their choice together and are now both on the lease. Other members experienced similar constraints on choice, per member report and some records reviewed. Some members were offered halfway houses or congregate settings, but it is not clear if other options where members were in control of the composition of their prospective households were fully explored with all members.	• The RBHA and provider leadership need to provide clinic and PSH staff with professional development opportunities to improve knowledge of housing resources that will allow tenants to explore residences where members have more control over the composition of their households. • AHCCMS should train direct care staff to work with individuals with significant challenges, including expanding the housing search to aid members who are referred for PSH support with no voucher. As staff build relationships with housing landlords they may be able to offer a wider variety of options to prospective tenants.
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which	1, 2.5,	AHCCMS staff, clinic staff and tenants all reported during	

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	housing management providers do not have any authority or formal role in providing social services	or 4 (4)	interviews that housing management staff has no authority or role in providing social services. AHCCMS does not own or manage any properties, the program is not linked to any landlord or housing management, and no other evidence of housing management or landlords engaging in social service functions was located in records reviewed. Program staff interact with housing management, if needed, to support or advocate with members.	
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, clinic staff and tenants all reported during interviews that AHCCMS staff only provide in-home services and has no authority to collect rent, enforce lease requirements, or authority to evict tenants. AHCCMS does not own or manage any properties, the services are not directly linked to any landlord or housing management, and no other evidence of AHCCMS staff engaging in any housing management functions was located in records reviewed. Program staff interact with housing management, if needed, to support or advocate with members.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	AHCCMS staff, clinic staff and tenants all reported during interviews that clinical services and AHCCMS are based off site and services are brought to the tenants at their request. AHCCMS does not own or manage any properties; the services are not directly linked to any setting where tenants reside and no evidence of this was documented in records.	
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 (2)	The AHCCMS staff report during interview that if a tenant receives an ABC voucher then they pay 30% of their income or zero if they have no income; however, if the tenant does not receive a voucher then they may pay over 30% of their income. As noted above, many members referred to AHCCMS receive some type of subsidy, and some are already housed prior to referral to AHCCMS services.	• AHCCMS should maintain documentation in tenant records to verify affordability. Obtaining a copy of the lease will help staff to support advocacy and budgeting with tenants.

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			Incomplete rental data was provided for 36% of the tenants served; the amount of income paid toward housing cannot be determined. Data was provided for 48% of tenants, with payments ranging from zero to over 58% of income paid toward rent.	• The program should assist members who pay over 50% of income toward housing costs to explore other more affordable options. Tenants who pay over 50% of income for housing may be more likely to experience housing instability caused by financial instability. Some tenants may still elect to pay 50% or more for rent, but alternative options should be offered to allow for member choice, and this should be documented in member records.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 (1)	AHCCMS stated that they do not obtain copies of the Housing Quality Standards (HQS) inspections because inspections are done by the housing management. AHCCMS data was incomplete at time of review.	• AHCCMS should obtain copies of HQS inspections. Obtaining copies of the HQS inspections assures whether housing meets the Department of Housing and Urban Development (HUD) Housing and Quality Standards and assures housing is decent and safe for tenants; PSH should meet HUD HQS. • Ensure PSH staff are familiar with HUD's Housing *Choice Voucher Guidebook*, Chapter 10, as well as applicable Public Housing Authority standards, if more stringent. Familiarization with these resources may aide in tenant advocacy efforts, if needed.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				

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4.1.a	Extent to which housing units are integrated	1 – 4 (4)	AHCCMS staff, clinic staff and tenants interviewed report housing units are integrated. Tenants who are selected for the scattered site program are able to choose a unit in their community within Maricopa County that accepts the housing subsidy voucher. AHCCMS staff, clinic staff and tenants did express some concerns regarding integration with tenants who have criminal convictions and/or eviction history, stating that there are limited landlords that will accept their voucher, which creates a type of clustering. Additionally, some members remain homeless or are incarcerated due in part to issues with housing stability.	• The RBHA should continue all efforts to develop relationships with private landlords that may be able to assist with expanding options for SMI tenants. Consider partnering with the other contracted PSH provider agencies to help expand this effort. Consider marketing, public relations efforts, etc. that may encourage them to accept vouchers for tenants with housing supports, educating them on the benefits that come with partnership in this type of endeavor. • Though the PSH provider agency may have limited ability to impact this item directly, the PSH provider can attempt to build relationships with private landlords that may be able to assist with expanding options for SMI members system wide, even those without vouchers.
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)	AHCCMS does not retain copies of leases. For this review AHCCMS obtained 5 leases out of 21 tenants (excludes those five members who are homeless or incarcerated); however, due to lack of data, legal rights to the housing unit could not be verified.	• AHCCMS staff should obtain a copy of the tenant's lease after attending lease signing to ensure tenants have full rights of tenancy according to local landlord/tenant laws.
5.1b	Extent to which tenancy is contingent on compliance with program provisions.	1, 2.5, or 4 (4)	Tenancy is not contingent on compliance with program provisions or participation in treatment. Tenants are not required to accept PSH services in order to maintain tenancy. PSH services through AHCCMS are not tied directly to any housing subsidy or site-based housing locations. Supportive housing services through AHCCMS are	

Item #	Item	Rating	Rating Rationale	Recommendations
			completely voluntary; tenants can start, stop and restart services at any time they choose. Tenants who disenroll from the RBHA system become ineligible for the scattered-site voucher but can maintain tenancy as long as they adhere to the lease and standard community rules, and rent is paid.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstration housing readiness to gain access to housing units.	1 – 4 (1)	Clinical team assessment of needs influences which housing applications are completed; some clinic staff reported there is a level of readiness needed to gain access to scattered site housing and if the clinical team does not deem a member ready for independent living, they may be referred for a higher level of care such as community living placement (CLP) or residential. Clinic staff attempt to assess members and then match their needs to the program they feel is best suited to meet those needs. One clinic staff cited a training facilitated by the RBHA in which staff were instructed to complete an application for community housing rather than an application for scattered site housing for members assessed to have a higher level of need. However, some staff state you cannot force a member to go somewhere against their will. The extent that members of PSH services through AHCCMS were required to demonstrate housing readiness is difficult to determine; many tenants were housed prior to referral. PSH support services through AHCCMS might not be offered if a member has no income. For example, a tenant reported that when she had no income she was directed to residential treatment, and although she did not like the program rules, no other options were offered even though her goal was to live independently. The tenant hired her own lawyer to secure Social Security Disability Insurance	• Studies have shown that Permanent Supportive Housing is effective for a wide range of clients, including families, people with correctional histories, and people with addictions and chronic diseases. The RBHA should continue to provide training and support to clinical staff on the opportunities to expand housing options for tenants. The shifting attitude of staff to support member choice over readiness assessment was reflected in some interviews, but further training will likely be beneficial. • The RBHA should offer training and support to referring provider staff, with a focus on: supporting choice, expanded options, maintaining tenancy, and screening for tenancy related criteria (e.g., ability to pay rent, ability to care for apartment, respecting rights of other tenants, following crime free and drug free ordinances), which would generally be allowable, versus screening

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			(SSDI), and left the residential program when she independently secured housing. The tenant stated that her clinical team supported her decision once she had an income and offered a referral to AHCCMS for in-home supports to maintain independent living. Although the tenant experienced challenges before accessing AHCCMS services, she feels AHCCMS staff is her case management support and finds the services they offer beneficial. AHCCMS staff interviewed stated that members referred to AHCCMS meet with eligibility screeners, and then separately with the Program Director prior to starting services. These steps do not appear to be a level of assessment to screen members out of services, but it is not clear if meeting with more than one staff possibly delays PSH services.	members based on functional or readiness criteria. The systematic training can be buttressed by ongoing education thru AHCCMS and similar PSH service providers. • The RBHA should provide ongoing training to staff regarding application requirements for services; review opportunities to streamline applications. Some staff have difficulty explaining differences in applications, or programs (e.g., flex care, community living, or scattered site housing). • AHCCMS should consider streamlining the initial screening and assessment of referrals so PSH services can begin more rapidly, including training direct service staff to conduct intake tasks. • The system should collaborate to brainstorm alternative options that clinic staff can offer members when an underlying barrier to housing stability is linked to lack of income (i.e., in part to address the potential issue that some members may be referred for residential treatment if they have no other options, and no income).
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (1)	Program referrals are influenced by level of care assessment of members by their clinical teams. Clinic staff attempt to assess members and then match their needs to the program they feel may best meet those needs, but a member must show some independence and psychiatric	• The system should prioritize members with obstacles to housing, which may include factors such as: patterns of homelessness, difficulties maintaining housing,

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			stability to be referred to scattered site housing program. It is not clear if AHCCMS members with housing obstacles were prioritized, or if members who receive a voucher were simply offered PSH support once a voucher was attached. As noted above, many tenants were housed prior to AHCCMS referral, so it is unclear how they were prioritized. RBHA staff reports that in the current system structure, once members are referred for scattered site housing, certain prioritized categories are considered that include individuals who are homeless, those in transitional living programs, those who are hospital discharge ready, those who are incarcerated, high utilizers of crisis services, and transition age youth. It appears those members who are homeless or hospitalized are likely to be prioritized over those members in other situations. The RBHA implemented the use of the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) and provided an overview to the tool to staff in June, 2015; some direct care staff were trained directly by the RBHA or are guided by other clinic staff who attended trainings facilitated by the RBHA. Prioritization of members for the service only package through AHCCMS has not been implemented. The Program Director reports that she was trained on the VI-SPDAT and will implement the prioritization as the program approaches the 60 member capacity. AHCCMS staff reported during interview that they understand that they need to continue to meet with clinical staff to educate them on PSH model as well as market their program for referrals.	substance use challenges, poor rental histories, frequent crisis intervention, legal issues, difficulties with addressing basic needs, and limited social supports. At the RBHA level, ensure functional considerations are weighed to prioritize members versus a limited set of situational factors. • The RBHA should continue to provide training and guidance to clinic staff to clarify prioritization of members for PSH services. Some clinic staff are familiar with the VI-SPDAT as a tool to prioritize members for voucher programs, but are unable to provide specifics on how prioritization is applied. Some staff report the waitlist should be a first-come first-served basis. Increased transparency on how members are prioritized may allow clinic staff to better inform members of their estimated waitlist timeframe for a voucher, and to understand the purpose of the VI-SPDAT.
6.2 Privacy				
6.2.a	Extent to which tenants control	1 – 4 (4)	AHCCMS staff, clinic staff and tenants all report that tenants control entry to their units. No staff have keys or	

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	staff entry into the unit.		any access to tenants' units.	
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)	Many members served through AHCCMS appear to be the primary author of service plans, indicating they want to live in some type of independent setting, and most are in independent residences. Some of those members were able to select AHCCMS from a list of similar service providers. However, it appears about 27% of members were referred to AHCCMS without being offered alternative service provider options following AHCCMS presentations at the referring clinics. Additionally, some tenants were referred to AHCCMS with goals of independent living, but were directed to congregate living settings.	• The RBHA, clinics, and PSH staff should work to support member choice of setting, services, and service provider. Ensure tenants are the primary authors of their service plans. Training with referring clinics through the RBHA and at the provider level is recommended.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (1)	AHCCMS and clinic staff stated that tenants have the opportunity to modify service selection as often as needed; however, there was no evidence of this in the clinic or agency records. Clinic plans for members reviewed were generally updated annually. Based on interviews with AHCCMS staff and tenants, if tenants want to modify their service plans at AHCCMS they must meet with the Program Director but there was no evidence this occurred.	• AHCCMS should consider allowing direct staff to modify service plans and assure that it is documented in tenant files. • The RBHA should consider opportunities to facilitate the integration of clinic and PSH provider files.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	AHCCMS staff stated tenants must be connected to clinic services in order to retain services through AHCCMS. Clinic staff and tenants were not certain if tenants must be connected to case management in order to retain AHCCMS support. Tenants can choose services, but choosing no services is not an option. Although AHCCMS services are not tied directly to a voucher program, many tenants in the PSH program receive some type of subsidy through their connection to RBHA services.	• The RBHA and AHCCMS should collaborate to allow members to retain PSH services through AHCCMS if they elect to close clinic services; consider expanding the scope of the voucher program to include a provision extending the subsidy for a period of time after disenrollment from all RBHA services. Efforts may include exploring alternative funding

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			Those tenants who receive a subsidy attend a housing briefing prior to searching for a residence; AHCCMS and other similar service providers are offered at that time. Tenants who have no subsidy can be directly referred to AHCCMS or other similar providers for support if they desire the level of service. AHCCMS staff reports that once a member is referred to AHCCMS then they are offered a range of services. Tenants interviewed stated that they receive services from AHCCMS staff and feel that they can choose their services; however, not all are agreeable to work on AHCCMS curriculum lessons.	sources that do not require enrollment in the RBHA system for eligibility.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (4)	AHCCMS staff and tenants report the service mix is highly flexible and can adapt type, location, intensity, and frequency based on tenants' changing needs or preferences. Tenants interviewed stated that some of them are working on decreasing isolation and AHCCMS staff offers many different social activities in the community to support their goal as well as providing in home support in order to attend the offered activities. One member stated that due to her moods, sometimes she wants to work on her goals and other times she would just rather be alone and feels AHCCMS staff respects her wishes and doesn't force her to engage on days she requests to be left alone. There was also an example of a tenant's AHCCMS plan being modified to incorporate a new objective and services	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 (2)	Tenants have input into their services at the time of service planning or when tenants ask to amend their services, however it does not appear tenants have input into the design and structure of service delivery. AHCCMS reported that they just started a tenant advisory board for all of their tenants (including residential and community living programs) and to this date no tenants from their PSH program have attended.	• As a first step to solicit tenant input into service delivery and design, AHCCMS should consider forming an advisory board specifically for PSH tenants due to the distinct difference of PSH services in comparison with traditional residential, or community living settings.

Item #	Item	Rating	Rating Rationale	Recommendations
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	AHCCMS has two direct in-home staff members and 21 tenants, two incarcerated members, and three who are homeless. AHCCMS staff reported that they are within the PSH recommended caseload size of 12 to 15 tenants per caseload, and administrators reported they have plans to hire additional staff as the program expands and the caseloads increase.	
7.4.b	Behavioral health services are team based	1 – 4 (2)	AHCCMS staff and clinic staff report that the clinical staff is responsible for all behavioral health coordination for the tenants. AHCCMS staff state that they primarily coordinate with the CM, with regular updates via phone calls, emails, and occasional face-to-face contact, but they are not a part of the clinical team. Regular staffings do not occur, and collaboration can vary by clinic or CM assignment.	• Preferably, 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, it is recommended the full clinical team and PSH service provider hold regular staffings (e.g., at least monthly as a first step) to coordinate care in order to work more fluidly as a team. Ongoing coordination with the clinic CM is also encouraged.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (3)	AHCCMS staff report that services are flexible and can occur in the evenings and weekends for special circumstances or events, but are not provided 24 hours a day. If there is a crisis overnight staff report they will not go to the tenant's residence but will coordinate with crisis services and attempt to meet with the tenant in the morning.	• Optimally, PSH services should be available 24 hours a day, seven days a week. The agency should brainstorm avenues in order to expand the availability of PSH services to members.

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	1
1.1.b: Real choice of housing unit	1,4	1
1.1.c: Tenant can wait without losing their place in line	1-4	3
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		1.88
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	2
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		1.5
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	1
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	1
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		2
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	4
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	3
Average Score for Dimension		2.5
Total Score		18.38
Highest Possible Score		28