PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Dan Wheeler, Director, Community Living Services

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AHCCCS Fidelity Reviewers

Method

On December 5-7, 2016, Jeni Serrano and T.J. Eggsware completed a review of the Lifewell Behavioral Wellness 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.

Lifewell provides services including outpatient counseling, vocational rehabilitation, residential treatment, transportation, community living and housing. While Lifewell serves as housing management to some properties in the community, Lifewell's PSH Program is the focus of this review. The agency Community Living flyer highlights three programs: Transitional Living, Flexcare, and Permanent Supportive Housing. Flexcare and PSH appear to offer similar service packages, with flexcare designed to help members attain community housing, and PSH services designed to help members maintain community tenure. Lifewell PSH services are not transferable if members elect to move from a property where Lifewell is the identified service provider; services are attached to properties, most of which are houses or small unintegrated apartment complexes. Lifewell provided a roster of 27 current tenants, two of whom reside in the scattered site housing. Due to the nature of the referrals, which originate at external clinics, information gathered at the Lifewell South Mountain and La Frontera-EMPACT Comunidad clinics were included in the review, with a focus on co-served members.

The individuals served through the agency are referred to as *clients*, 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:

- Interview with the Senior Director of Community Living & Residential Services (i.e., PSH Administrator);
- Group interview with three clinicians (i.e., PSH direct service staff);
- Group interviews with two Case Mangers (CM) and a Housing Specialist (HS) at the La Frontera-EMPACT Comunidad clinic, and three CMs at the Lifewell South Mountain clinic;
- Group Interview with five tenants who participate in the PSH program;

- Review of ten randomly selected records, including charts of some co-served clinic and PSH member/tenants; and,
- Review of agency policies, community living flyer and organizational chart, intake paperwork, scope of work, staff caseloads, PSH program description, training materials, etc.

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:

- All staff has optimal caseload sizes for effective service provision.
- Functional separation exists between housing management and services; when service staff interacts with housing management (i.e., landlords) it is to advocate with or on behalf of tenants, or to facilitate tenant communication with housing management at the request of the tenant.
- Tenants do not have to accept program services or treatment through Lifewell in order to remain housed.

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

- Due to the current program structure, with services linked to residences and not tenants, it may be difficult to fully align with the PSH model. For example, the house and small nonintegrated apartment options constrict member choice of housing type, housing unit, tenant control over the composition of their households (i.e., if house or shared apartment), and housing integration.
- Clinic staff should discuss housings options with members. Although member input is sought, it appears choice remains constricted at the clinic level, with staff reporting assessment of members to determine housing or treatment options pursued. Though Lifewell may have little direct impact on this item, they should partner with the RBHA and clinical providers to provide training and education on the evidenced-based PSH model, with a focus on how housing services support recovery and housing stability.
- Ensure members with housing obstacles are prioritized. System partners should collaborate to expand access and choice in housing for members who are in substandard housing, are tenuously housed, etc. Clinic and agency staff should also focus on assisting members who do not qualify for voucher programs to explore independent housing options, advocating for members to expand housing access and availability by developing relationships with landlords and housing providers.

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 1	An integrated, affordable apartment may not be an available option for all members who request housing assistance. Clinic staff interviewed for this review reported that members are screened for psychiatric stability, financial stability, legal history, and ability to live independently. If their history shows evidence that they are unable to live independently, members are less likely to be referred to PSH, and the teams may refer to residential treatment. It was not clear if all clinic staff distinguishes treatment settings and PSH, or are aware how to access PSH. If a member is not homeless they may be ineligible for certain types of housing assistance through the RBHA. Per the RBHA website, housing subsidies are available to homeless adults enrolled with Mercy Maricopa Integrated Care (MMIC) who have been determined to have a serious mental illness, with a qualifying VI-SPDAT score.	• Provide training to differentiate PSH from other supports available in the system; PSH should include services to help members with the most significant challenges to obtain and maintain independent housing. • Clinic staff should work with members who do not qualify for RBHA vouchers to explore alternative living arrangements or other resources to obtain and maintain safe, stable, and affordable housing. • The PSH program can work to support member choice by assisting members to locate other housing if they elect to decline a house or apartment setting offered, and by assisting tenants to explore other integrated, safe, and affordable housing options if they want to move.
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	Lifewell's PSH program does not provide for choice among a range of housing types. Lifewell offers two housing types: the house model and the apartment model. Assignment to Lifewell housing types is entirely dependent upon availability. Potential tenants can accept a unit, or decline it, but there appears to be no other comparable or viable options offered or immediately available. They are not offered a true choice of unit. On occasion, a tenant may move from a smaller bedroom to a	• In an effort to pivot from the CLP model to PSH, train Lifewell staff to search for affordable housing, and build relationships with landlords. Though market factors or individual landlord exclusions may pose barriers to assisting members with locating housing, training and consultation on how to cultivate community resources may be beneficial.

			master bedroom in a house model setting, or can transition from a house to apartment, but those situations appear to be uncommon; it appears they occur only after a tenant has accepted a unit not of their choosing in order to obtain housing. PSH services are not transferable if members elect to move from a property where Lifewell is the identified service provider; services are attached to properties, most of which are house or small unintegrated apartment complexes.	
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	LIfewell does not manage a waitlist separate from the RBHA. There was no evidence reported during the review that if tenants are selected from the RBHA managed waitlist, but decline the unit offered at Lifewell, that members go to the bottom of the list or have a certain number of times they can decline before being removed from the waitlist.	
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	About 59% of tenants are in residences where they have their own bedroom, but do not control the composition of their household. Of those tenants, about 52% reside in house model settings, and about 7% reside in apartment settings with roommates. The program attempts to set up meetings between existing tenants and potential tenants, but they have limited options to decline to live together. Existing tenants cannot decline the new roommate, and the new roommate is likely declining immediate housing if they reject the roommate situation. One member record included documentation that a tenant felt another tenant wanted the member to move so they could move into the larger bedroom. Members interviewed and records reviewed for tenants in roommate situations cited numerous examples of conflict, disagreements, or safety	• Due to constrictions that exist with the house and unintegrated apartment settings, additional steps the program can take to align more closely to this fidelity item are limited. Continue efforts to assist tenants in advocating for control of the composition of their household when those opportunities exist, such as switching roommates, or arranging for tenants to move from house to apartment, or apartment to house settings based on their preference.

			issues.	
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	Although many tenants reside in properties where Lifewell is the service provider, as well as the holder of the lease (i.e., housing provider), tenants appear to distinguish between Lifewell service and housing management staff. Based on interviews with staff and tenants, it does not appear that housing management has any formal role in providing social services.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Lifewell service provider staff reported that they have no role in housing management. Service staff are not required to report lease infractions or collect rent. When Lifewell's service staff interacts with landlords, it is with, or on behalf of, tenants.	
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 tenants are in residences where they control entry to their household. Staff and members report that social services staff is based off-site. However, some tenants are in residences with other enrolled tenants where social service staff may be on site to provide services to roommates, placing some restriction on the choice of other tenants to decline to allow staff into the residences, or results in tenants needing to make accommodation for privacy while service staff is on-site. At times, roommates go to their rooms, or staff meets with tenants in their rooms to minimize the risk of discussing confidential information in front of roommates.	
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 4	Tenants with no income pay nothing toward rental costs, and all others who have an income pay less than 30% toward rental costs.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 4	Evidence of passed annual inspections was provided for the majority of tenant units (93%). HQS reports were provided for units managed through LIfewell, as well as other agencies (i.e., housing providers) that lease units where members reside.	
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 1	About 85% of tenants reside in house model or small unintegrated apartment model settings, where units have been set aside for people meeting disability-related criteria. Of the remaining tenants enrolled with Lifewell for PSH services, two reside in an apartment complex that appears to be integrated, and two reside in integrated settings following the demolition of their prior setting, with the opportunity to move to another setting.	• Increasing the availability of scattered site options in the system would increase integration of housing units. If this is not an option for Lifewell's program, the agency should explore long range planning to expand the apartment model options, with a focus on larger multi-housing settings that can provide greater integration. House models could be preserved for other uses such as short-term and transitional housing.
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 4	Leases were provided for most tenants (96%), supporting their legal rights of housing.	
5.1.b	Extent to which tenancy is contingent on compliance with	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	

	program provisions.		order to maintain tenancy. Tenants can start, stop, and restart services through Lifewell at any time they choose.	
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 2	Lifewell's PSH Program does not apply readiness standards to housing. However, evidence in clinic member records and clinic staff interviews indicated that sometimes members are required to demonstrate readiness in order to gain access to housing units. It appears members experience a continuum of care, with some expectation to complete a treatment program prior to gaining more independent housing. Many of the member clinic service plans reviewed included language that implied housing was contingent on treatment, including: the desire to continue living in the current placement, needing to show respect for roommates, and to follow the rules of the residential community. Some tenants interviewed reported they moved into their current residences from a treatment setting, such as residential or transitional living.	• Provide training to differentiate PSH from other supports available in the system; PSH should include services to support members with the most significant challenges to obtain and maintain independent housing. Some clinic staff equate Lifewell housing primarily as a community living, short-term housing program for members who need the increased support of service staff to learn independent living skills (ILS). • Staff at the clinics should use a *housing first* approach and not screen members for readiness to live independently, or determine the options offered to members, but rather focus efforts first on housing members, based on their stated preferences, then engaging them in services to maintain housing.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Lifewell staff does not have a role in prioritizing housing recipients. Per clinic and agency interviews, the RBHA system prioritizes homeless individuals using the VI-SPDAT score. It is not clear what other safe and affordable options are explored with members if they do not qualify for scattered site vouchers based on this prioritization. CMs interviewed discussed frustration with insufficient affordable housing for members with a low income and don't qualify for RBHA vouchers. Lifewell staff report that they are unsure how members are	• With the current system structure, Lifewell has limited capacity to fully align housing priority with the EBP criteria. However, PSH services should not be limited to only members who qualify for RBHA affiliated housing vouchers. Agency staff should also focus efforts on exploring other independent housing options, promoting the benefits of PSH services, advocating for members to expand housing access and availability, and by developing relationships

			prioritized since the process occurs prior to tenant move-in.	with landlords and housing providers.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 4	Per staff and tenant report, staff does not hold copies of keys and tenants control the entry of staff to the units. Although one clinic staff reported that Lifewell service staff can utilize a key code to enter a residence, this report was unconfirmed in other interviews.	
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	Clinic plans reviewed included clinical jargon, some primarily focused on symptom management, or information that did not appear to reflect the voices of the members. The members interviewed all stated that their living goal is to live independently in their own apartment. Rather than steps to work toward identified independent living goals, on some clinic plans, needs and objectives indicated members needed to follow the rules of residential treatment, or learn the names, doses, times, uses and side effects of medications.	• Ongoing training should occur regarding how to work with members to develop personalized goals and objectives. Member service plans should reflect the housing goals, and the necessary action steps for achieving those goals. Clinical teams should always prioritize the successful fulfillment of goals set by tenants.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic plans reviewed were usually updated annually. Tenants who are co-served through a Lifewell operated clinic and PSH program may experience more frequent opportunities to revise their treatment plans. Lifewell PSH tenants have the opportunity to review their service plan at a monthly scheduled Lifewell staffing. Tenants can also modify service selections at any time upon request. The reviewers found evidence that most tenant service plans were updated every 30 – 60 days with needs and objectives closed or attained or new ones added.	

7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	It appears Lifewell has accommodations in place to allow members to decline services, or to close from agency services and maintain tenancy. Program staff reported that of 106 "beds," 79 tenants either never started PSH services at Lifewell, or began services then subsequently closed. However, based on staff and tenant report, it was unclear if tenants can close from RBHA or clinic services and maintain tenancy. Actual services provided by direct staff documented in the records seemed limited to conducting home visits, prompting, or discussing a member's status related to completing tasks, and scheduling and participating in staffing's, but there was limited direct assistance with tasks or skill building activities	• System partners should collaborate to develop mechanisms for tenants to choose from an array of services, including the option of not having services (e.g., to ask for case management or refuse case management). • Clarify with staff the issue of whether vouchers and tenancy can be maintained if a member closes from RBHA services.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	While the service mix on most plans appeared predictable, focusing on activities of daily living, independent living skills, and self-administration of medication, the reviewers also found evidence that some Lifewell service plans were updated to address treatment needs such as grief counseling, and assistance with independent living needs such as budgeting and grocery shopping. Members interviewed said they felt in control of their Lifewell services plans and that they review their plans with Lifewell staff and CMs monthly.	• Lifewell plans and services should prioritize assisting members to obtain housing, or explore housing options, if that is the primary goal voiced by the member. • Lifewell should encourage direct staff to review tenant needs and interests in support of modifying their service plans and assure that it is documented in tenant files.
7.3 Consumer- Driven Services				

7.3.a	Extent to which services are consumer driven	1 – 4 1	Member input is solicited for individual service plans. Other than satisfaction surveys, there was no evidence that avenues exist for PSH tenants to have input on how services are structured or delivered at the program level.	• Expand the tenant's role in designing, assessing, and determining services. For example, involve individuals with a lived experience in quality assurance activities. Educate members about the EBP of PSH and then obtain tenant input on the agency documents that describe PSH services. • In addition to surveys, tenant satisfaction can be measured in many ways, such as interviews by peers, group discussions, and written notifications. • Consider developing an advisory board, and support true member control of the advisory board (e.g., the board could be chaired by a non-member but should include significant numbers of members), and incorporate feedback in the program design.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	It appears PSH staff carries out PSH activities in addition to other duties in more traditional treatment settings (e.g., flexcare). Direct service staff is assigned a small number of PSH tenants, usually three or less. However, staff has responsibilities at other treatment settings where they are assigned members who are not part of the PSH program. Per staff report, actual caseloads for direct service staff are below 12 members each.	
7.4.b	Behavioral health services are team based	1 – 4 2	Services are provided through multiple staff and agencies, but it does not appear that the agencies coordinate all efforts. Members receive services from clinics that are separate from the PSH staff. Staff at Lifewell operated clinics share an electronic record system with PSH staff, allowing for sharing of written information. The level of integration at LIfewell clinics and clinics operated by other	• Optimally, PSH services are provided by an integrated team. The provider operates clinic services and is identified as a PSH agency, so consider integrating PSH services at the clinic level, with PSH staff working as part of clinical teams.

			providers seems to be limited to staffing's, where clinic staff are invited to attend but do not always participate in person, sometimes by phone and at times, not at all. In addition to monthly staffing's PSH staff and clinic staff occasionally inform each other of a tenant's status. It appears tenants are on two un-integrated services tracks, one through the clinic and one through the PSH provider. Additionally, staff duties at the PSH agency are split. Direct service staff identified as clinicians perform home visits, coordinate staffing's, and update service plans, but other staff transport members in the community for other activities or errands (e.g., grocery shopping), and it is not clear how often those sets of staff communicate.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 2	Tenants are reportedly provided with an extensive list of resources and contact numbers to utilize. However, availability of PSH staff seems dependent on the regular shift hours the staff are assigned. For example, one staff interviewed works during the day, and another works at a location with staff through the evening. However, staff reported PSH tenants would need to call the crisis line or 911 outside of those hours, and that as clinicians they would not be on call over the weekend, but on rare occasion may provide services beyond their normal shift.	• Optimally, PSH services should be available 24 hours a day, seven days a week.

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	4
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		2.13
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	4
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	4
Average Score for Dimension		4
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	1
Average Score for Dimension		1
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	4

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		4
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	2
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		2.83
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	4
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	1
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	2
Average Score for Dimension		2.5
Total Score		20.46
Highest Possible Score		28