PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: 12/16/2014

To: John Stephens, CEO
Janet Rubin, Director of Behavioral Health Services

From: Georgia Harris, MAEd
Karen Voyer-Caravona MA, MSW
ADHS Fidelity Reviewers

Method

On November 17-18, 2014, Georgia Harris and Karen Voyer-Caravona (Fidelity Reviewers) completed a review of the Arizona Health Care Contract Management Services, Inc. (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. 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 Choices - Midtown and People of Color Network - Comunidad. Taking into account the current 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.

The Arizona Health Care Contract Management Services, Inc. (AHCCMS) administrative office is located at 110 W Camelback Rd, Phoenix, AZ 85013. AHCCMS has been in operation for nearly 25 years. AHCCMS is a contracted housing and residential treatment provider through the Regional Behavioral Health Authority (RBHA) for Maricopa County, AZ. AHCCMS is also a service/housing provider for those with developmental disabilities. Both programs jointly serve approximately 140 members experiencing a Serious Mental Illness (SMI). AHCCMS' housing program began in response to the lack of available housing options for members experiencing an SMI, many of who were being discharged from the Arizona State Hospital (ASH).

AHCCMS considers their *Community Living* program to be the most closely aligned to the Permanent Supportive Housing model. AHCCMS currently supports 14 Community Living sites. Eleven of the Community Living sites are single, detached homes in residential communities across the greater Phoenix area. Two of the homes are for specialty groups: Acoma residents are primarily deaf or hearing impaired; Morristown residents are primarily those with probation or surveillance agreements. All of the Community Living homes have between four and five bedrooms; all bedrooms are single occupancy. The remaining three sites are comprised of apartment units. All 14 of the Community Living sites were considered in this

review. AHCCMS does not own any of the Community Living properties. The properties themselves are managed by either Biltmore Properties or Lifewell Behavioral Wellness. Along with the referral clinics, the relationships with these providers will also be mentioned throughout the report.

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:

- Orientation to the services provided by AHCCMS.
- Interviews at the referring clinics with six clinical case managers and one rehabilitation specialist.
- Interview with the PSH Administrators: Chief Executive Officer, Director of Behavioral Health Services, and the Clinical Supervisor.
- Interviews with a PSH supervisor/clinical coordinator, and two direct service staff.
- Interviews with 13 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.
- Interview with a housing department employee from the Regional Behavioral Health Authority (RBHA).
- Review of 20 randomly selected records, including charts of interviewed member/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 seven 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

AHCCMS is uniquely placed in the current RBHA system as a provider focused on housing options for those who would have once been considered some of Maricopa County's most vulnerable members - the Arizona State Hospital (ASH) population. Of all the AHCCMS programs, the Community Living affords tenants the most flexibility and autonomy. Tenants receive opportunities to learn valuable skills through programs such as *CORE* – a training course designed to develop awareness and strategies for overcoming barriers to the achievement of personal goals. Staff members are flexible and attentive, using sound clinical strategies (i.e. Motivational Interviewing) to promote self-sufficiency and good decision making in all of the tenants.

AHCCMS offers apartment style housing; however, the PSH approach at AHCCMS is primarily a *house model*. All tenants are those who are diagnosed with a serious mental illness, and services are attached to the residence, rather than to the individual. In this approach, access to program services and staff access to the residents' home are virtually synonymous; staff members are placed onsite to provide services between eight and 24 hours a day. In each of the single detached homes, tenants can expect staff monitoring and rules regarding overnight guests that are not created and agreed upon by the residents, but rather imposed by some other entity. In high fidelity PSH programs, social and clinical service providers are located offsite, are mobile and are readily accessible to members as needed, which eliminates the use of staff in overlapping functions such as monitoring and enforcing landlord agreements.

The partnership between AHCCMS and its affiliates, as it relates to PSH, is relatively shapeless; instead of functioning as a system, the responsibility of each entity to the other is unplanned. The Community Living program operates in silos; clinical case managers refer members through the RBHA to a "level of care" rather than a "program of choice"; AHCCMS receives members into the program, but has virtually no role in assisting members in the identification of housing suited to their preferences. The Community Living program staff does not attend lease signings with members, keep copies of signed rental agreements or maintain any binding operational agreements with the property management companies. This becomes problematic in instances when members are having difficulty getting property managers to complete crucial repairs in their units. As AHCCMS prepares for their PSH expansion in the upcoming weeks, it is imperative that Memorandums of Understanding (MOUs)/ Memorandums of Agreement (MOAs) are used to define their relationship with affiliate agencies. These documents will not only improve agency relations, but also will create a common line of action when addressing matters concerning tenants.

The agency demonstrated strengths in the following program areas:

- It appears that housing management staff has no authority or role in providing social services. AHCCMS works with two housing management companies that focus their efforts on lease signing, execution and unit repairs.
- AHCCMS has maintained small caseloads by only assigning caseloads to clinical coordinators for clinical oversight and service planning. There are seven clinical coordinators assigned to the 70 members served.
- Tenants initiate and are offered routine opportunities to modify their service selections. Members can modify their services when they want and can determine the setting in which they would like their services administered (i.e. shopping for groceries in the community vs. education on reading grocery store fliers/circulars).

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

- Overall, staff and partner organizations (RBHA/PNO/Providers) involved in providing PSH services throughout the system will benefit from more in-depth training on the evidence-based practice of Permanent Supportive Housing and how it should be implemented at every point, from referral to move in. Increased knowledge of the model will result in more successful application across the system.

- At the PNO level, clinical staff members should receive education on how the PSH model plays a valuable role in recovery.

- Clinical staff also would benefit from training in the differences between residential treatment, Flex Care residences, and Permanent Supportive Housing. See recommendations in 1.1.a regarding expanding scattered site options system-wide.

In addition to training, below are more specific recommendations that support the dimensions of the Fidelity Scale:

Housing Options

With the current system structure, AHCCMS may have limited capacity to act independently to address systematic barriers to fully supporting member choice. Meaningful choice of type of housing, housing units, and housing composition is not present in the system as it is currently operating. For example, access to housing programs is controlled by clinical teams who often make decisions independent of preferences and perceived needs of the people involved. Selection of housing is performed by the RBHA, also without regard to the choice of the individual, and housing composition is controlled by the housing provider/RBHA assignment. Housing choice is a central feature of the evidence-based practice of Permanent Supportive Housing. In good fidelity PSH programs, members can decline housing options that do not reflect their needs and preference without losing their place on a waiting list.

- It is recommended that the RBHA explore how and why a discrepancy exists in how the wait list is managed and clarifies that issue with the PSH providers and PNOs.
- If members can wait for the unit of their choice without losing their place on eligibility lists, then clinical staff members need additional information regarding how the waiting list is managed, so they can effectively educate members of their ability to exercise choice.
- The RBHA should expand partnerships with landlords/housing programs/ affordable housing initiatives in the community. In a high fidelity PSH program, housing is provided in apartments scattered throughout a community. Increasing the number of available options will improve the likelihood of tenants obtaining their preference. Also, staff at AHCCMS can improve member services by developing relationships with landlords in the community who will work with members and accept vouchers (if provided).
- An expansion of voucher-based housing will improve outcomes for all providers. Consider structuring that program around the HUD standards for housing vouchers for open-market housing. Clinical teams should be empowered to assist members with finding/applying for housing options that are aligned with member preferences instead of clinical needs. In PSH, housing is based solely on member preferences.
- The PSH provider should explore other options for vouchers, even beyond current funding streams. High fidelity PSH programs help members to secure housing that meets their criteria because members have better outcomes in conditions where their input has been requested and advocated for.

Functional Separation of Housing and Services

- Though the housing management has no apparent role in providing social services, the amount of communication between them and the housing provider is nominal. The lack of joint agreements/protocols between these entities renders each agency powerless to enforce action when an entity is lacking in service fulfillment. Developing Memorandums of Understanding (MOUs)/Memorandums of Agreement (MOAs) will help to mitigate instances when roles are overlapping. Fidelity for this item requires functional separation between agencies,

with defined roles for each entity. Defined roles/agreements are not solely for clarification, but to restrict overlap in services.

- Continue to provide training and education to staff members on their relationship with housing management. Also see recommendations for 2.1.a. Establishing MOUs/MOAs can help to guide the direction of future trainings for staff members.
- The program should continue to explore options to expand individualized services. These should be based offsite and can be brought to members at their request.

Decent, Safe, Affordable Housing

- AHCCMS should have documentation in member records that will verify the affordability of members' units. Tracking affordability will also help staff empower members to take action when the stipulations in their agreement have been violated and bolster independent living activities (i.e. budgeting) with the members.
- Annual Housing Quality Standards (HQS) or equivalent inspections, as per the federal Housing and Urban Development Administration (HUD), should be done at each property, and it is recommended that AHCCMS maintain copies of those inspections in member records. Or, AHCCMS may consider training internal staff to complete HQS inspections.
- It is also recommended that the agency, RBHA and property management companies coordinate efforts for improving the quality of living for the members. Determining the ramifications of housing violations will be imperative to the improvement and success of PSH programs system wide.

Housing Integration

- See recommendations for *Housing Options* above. It is difficult to achieve fidelity in this dimension with "House models," which cannot be integrated into the community due to their ratio of units set aside for those with disabilities.

Rights of Tenancy

- AHCCMS should maintain copies of member leases. Access to the leases will provide opportunities to educate both the staff and the member on the roles of each entity. This will also help staff empower members to take action when the stipulations in their agreement have been violated.
- In high fidelity PSH programs, there are no "house rules" outside of the lease agreement. Like in any other rooming situation, members may decide on items that will establish respect for each other while living together. All staff (residential and Community Living) should be trained on the differences in staff responsibilities for each program. This will help to minimize undesirable staff interactions that may be in violation of basic landlord/tenant rules. See recommendations for *Legal rights of Tenancy* in section 5.1.a.
- Members should have control of access to their home, and there should be no third party control of access. In a scattered site PSH model, third party control of member access to their home is virtually unfeasible. The same provisions should be given to those living in house setting as those in the apartments; tenants should have full control of access to their homes (i.e. keys) and control of access by others to their homes.

- Consider establishing clear guidelines concerning agency deliverables to members receiving probation services. In high fidelity PSH programs, providers are not responsible for monitoring member compliance with other programs. It is not clear at this time if further system intervention is needed for this item.

Access to Housing

- Providers should strive to immediately engage with members. Prior to and during the lease signing, these early appointments are good opportunities to build a relationship with the member, ensure the unit meets the preferences of the individual, and advocate for members' rights with the property management company. The provider should work with the RBHA/PNOs to find ways to engage members prior to program enrollment. (I.e. property tours, housing fairs, pre-leasing meetings, etc.)
- See recommendations for *Legal rights of Tenancy* in section 5.1.a.

Flexible, Voluntary Services

- Explore methods for aligning treatment plans more closely with member-driven goals. While exploring clinical individual service plans (ISP) during this process, it was evident that the majority of members expressed interest in living independently without roommates. The housing goals from the clinical ISP should be expanded in the service provider's ISP. The role of the service provider is to help the member with the steps to fulfilling their housing goals. In a scattered site approach, the member would already be living independently, and therefore would be working on goals that will help them to maintain their housing.
- Review mandatory medication guidelines set by the PNO and/or RBHA. Mandatory service requirements are not consistent with the PSH model, specifically with regard to matching clients with the right level of service.
- Once the goals on treatment plans become more diverse, program offerings should diversify as well. Consider building relationships with other service providers in the community that may be able to assist members with other non-clinical, housing -related goals they may have (i.e. Budgeting, housekeeping, being a good neighbor, self advocacy w/ landlord, etc.) Consider developing a member advisory board. The board helps providers to obtain consistent, organized feedback on the effectiveness of services, as well as ideas on how to improve services for all members.
- Based on the structure of the system, with separate providers involved primarily for housing services, and other providers for case management and psychiatric services, it may not be possible for AHCCMS to provide services through a team. To the extent possible, AHCCMS should continue efforts to coordinate with the assigned SMI treatment teams.
- It is recommended that cross-agency housing team(s) are built to include housing coordinators and other system points of contact that can help address and navigate issues and resources.
- AHCCMS should continue to review the program's capacity to provide service coverage 24 hours a day, seven days a week. Examine the feasibility of providing this service in the current structure of the PSH program.

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	Tenants are not given a choice of type of housing but are assigned their housing. Clinical case managers at the Provider Network Organization (PNOs) are responsible for the initial referral to the PSH program. Case managers stated that often the members applying for housing are in desperate situations (i.e. hospitalized, recently released from jail, etc.). The case managers talk to the members about their preferences whenever possible, however, case managers will fill out the RBHA housing application based on what they have assessed as the member's housing and services need. One team affirmed that the Psychiatrist must verify the member's need for the "level of care" they are applying for. The application is sent to the RBHA, who then connects the case manager to an available opening that most closely matches the request submitted. Case managers at both clinics stated that members do not choose among types of housing, rather, it is based on availability of units or "beds". AHCCMS staff commented on this process, stating that they [AHCCMS] are only responsible for reporting their openings to the RBHA. They will then receive anyone sent to them into the program.	With the current system structure, AHCCMS may have limited capacity to act independently to address systematic barriers to fully supporting member choice. Meaningful choice of type of housing, housing units, and housing composition is not present in the system as it is currently operating. Options for all system partners are as follows: • The RBHA should expand partnerships with landlords/housing programs/ affordable housing initiatives in the community. In a high fidelity PSH program, housing is provided in apartments scattered throughout a community. Increasing the number of available options will improve the likelihood of tenants obtaining their preference. Also, staff at AHCCMS can improve member services by developing relationships with landlords in the community who will work with members and accept vouchers (if provided). • An expansion of voucher-based housing will improve outcomes for all providers. Consider structuring that program around the HUD standards for housing vouchers for open-market housing. Clinical teams should be empowered to assist members with finding/applying

				for housing options that are aligned with member preferences instead of clinical needs. In PSH, housing is based solely on member preferences. ● The PSH provider should explore other options for vouchers, even beyond current funding streams. High fidelity PSH programs help members to secure housing that meets their criteria because members have better outcomes in conditions where their input has been requested and advocated for.
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	After referral process, the member may choose to decline the unit offered through the Permanent Supportive Housing provider. If declined, the member would then be placed in queue for the next available placement. This queue is maintained through the RBHA. Case managers report that they are unsure of the number of units a member is able to refuse. The RBHA reports that members are placed in queue rather than moving them to the bottom of the list. In the AHCCMS Community Living program, there are both house models and apartment-style homes. Members cannot choose units because of their limited availability.	• See comments and recommendations above for section 1.1.a.
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	Per RBHA staff, members who decline a placement are highlighted as individuals referred and waiting for another referral; they are not moved to the back of the waitlist. The member's status is tracked to include when they were referred and type of setting. However, case managers and AHCCMS have different viewpoints of this process.	• Members should be able to decline housing options that do not reflect their needs and preference without losing their place on a waiting list. • It is recommended that the RBHA explore how and why a discrepancy exists in how

			Case managers and AHCCMS staff both reported hearing that members had up to three options before being placed at the bottom of the waitlist. Neither group could confirm that members were removed from the list permanently after declining the options presented. None of the three groups indicated that members were allotted time for searching the local market or voucher programs (i.e. section 8).	the wait list is managed and clarifies the issue with the PSH providers and PNOs. All levels of the system must have a clear understanding of how Permanent Supportive Housing is implemented at every point, from referral to move in. • If members can wait for the unit of their choice without losing their place on eligibility lists, then clinical staff members need additional training/information regarding how the waiting list is managed, so they can effectively educate members of their ability to exercise choice.
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	The RBHA Community Housing Application asks about member preferences regarding living with roommates. It is not clear if this preference is a primary consideration. Staff said that members in the AHCCMS program, whether in the apartments or the house model units, must accept a predetermined household. AHCCMS supplies services to 20 members in apartment-style units and 46 members, scattered among their 11 house model sites. All members have a private bedroom. All but one of the apartment units are single occupancy units. In the houses, members are offered an individual bedroom in a house with a living space shared by up to four roommates.	• The system must explore routes for expanding scattered site housing options to members. Aside from recommendations made in Section 1.1, PSH providers should explore other options for vouchers, even beyond current funding streams. High fidelity PSH programs help members to secure housing that meets their criteria because members have better outcomes in conditions where their input has been requested and advocated for.
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management	1, 2.5, or 4	It appears that housing management staff has no authority or role in providing social services. AHCCMS works with two housing management	Though the housing management has no apparent role in providing social services, the amount of communication between them and

	providers do not have any authority or formal role in providing social services	4	companies: Biltmore Properties and Lifewell Behavioral Wellness. Lifewell has a behavioral health arm; however, the AHCCMS staff did not indicate that members are required to attend any of Lifewell's behavioral health groups/services. Biltmore Properties has been identified by staff as solely a property management company. It appears that interactions between Biltmore Properties and members are centered on the lease signing, rent collection, and repairs in the unit. Members and staff report lengthy delays in necessary maintenance requests such as heat or A/C repairs and water leaks due to potential health and safety concerns. Staff report the disconnection between agencies can often make collaboration for members' household needs (i.e. repairs) an arduous undertaking.	the housing provider is nominal. The lack of joint agreements/protocols between these entities renders each agency inert in enforcement of action when an entity is lacking in service fulfillment. Developing Memorandums of Understanding (MOUs)/Memorandums of Agreement (MOAs) will help to mitigate instances when roles could potentially become overlapping.
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 2.5	Members echoed the same sentiments as the AHCCMS staff with regards to the disconnection between housing and service agencies (See 2.1.a). Members stated that they often ask AHCCMS staff to facilitate communication between themselves and the property management companies, mostly because they feel their requests have been overlooked. AHCCMS leadership stated that they will often redirect and educate staff members who intervene in what are housing-only matters. Per AHCCMS staff, they will discuss the housing concern with the member and help them to plan their course of action. However, there have been occasions where members have been without working air conditioners/heaters for extended periods of time, and AHCCMS purchased these items to provide relief to the members.	• Continue to provide training and education to staff members on their relationship with housing management. Also see recommendations for 2.1.a. Establishing MOUs/MOAs can help to guide the direction of future trainings for staff members.

2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 2	AHCCMS services 11 house model units in their Community Living program. The remaining three properties are apartment-style properties in the community. All of the house model units have a space designated for staff, which could be a bedroom or a desk in the dining room/den. Eight of these homes are staffed 24 hours a day. The remaining three homes are staffed 16 hours a day. Each of the three apartment-style properties has an apartment onsite that is the designated staff office. This office is staffed daily for eight hours, from 8am-4pm.	• The program should continue to explore options to expand individualized services. These should be based offsite and can be brought to the members at their request.
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	When asked about the affordability of the units, AHCCMS leadership stated that they to do not maintain copies of the members' leases. The lack of leases, or any other documentation of this nature, made it difficult to verify affordability for the members. Some of the details of members' leases were found in their records at both clinics. During the clinical record review, it was noted that a few members were paying approximately 33% of their SSI income for their units. Staff and members both verified that utility costs varied depending upon where you resided: some units had utilities included; other utilities were split among the residents.	• Maintain documentation in member records that will verify the affordability of members' units. Tracking affordability will also help to bolster independent living activities (i.e. budgeting) with the members.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	AHCCMS does not maintain records of HQS inspections for the units; however, many staff expressed their concerns for the members in some of the homes. Staff stated that there is a stark contrast in how repair requests are handled by each property management company and for each	• Annual HQS or equivalent inspections should be done at each property, and it is recommended that AHCCMS maintain copies of those inspections in member records. • AHCCMS may consider training internal

			property; one company tends to be more attentive than the other to repair requests. Staff and members expressed frustration in determining where repair requests should go; in some apartment properties, members are asked to direct them to the property management company, who then directs them to the building ownership. In single detached homes, the members and staff will occasionally be told that the property manager is unable to contact the owner to fulfill the request. As mentioned in 2.1.b, AHCCMS has purchased portable air conditioning units/heaters for member units when a property management company did not fix a broken unit for an extended period of time. In one property, the carpeting in the home was in desperate need of replacement, due to water damage and mold. AHCCMS staff would cover the floor with assorted accent rugs as a temporary fix. AHCCMS staff also noted instances when they requested that modifications be made to members' bedrooms for sanitary reasons. The request was not fulfilled unit the member's situation became a potential health hazard to the other members (and staff) in the home. AHCCMS Leadership stated that the repair for these units "needs to be more consistent".	staff to perform HQS inspections. • It is also recommended that the agency, RBHA and property management companies jointly explore options for improving the quality of living for the members. In a high fidelity PSH program, housing falls in compliance with HUD's Housing Quality Standards. Determining the ramifications of housing violations will be imperative to the improvement and success of PSH programs system wide.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 1	AHCCMS serves 70 members in the 14 properties assigned to the Community Living program. All of the bedrooms in the single detached homes are designated for those with a disability. Two of the three apartment sites have units that are scattered among units that are rented to anyone in the community. Seventy-nine percent of the units are in disability-only settings.	• See recommendations in *Housing Options* in 1.1.a. It is recommended AHCCMS collaborate with system partners to explore options other than house model settings. • AHCCMS should start developing relationships with landlords in the

				community who will work with members and accept vouchers (if provided) supporting a scattered site approach to expand housing integration.
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	Tenants do not have full legal rights of tenancy according to local landlord/tenant laws. During the clinical record review, it was noted that the stipulations in member leases mirrored those of any standard lease agreement. Nonetheless, the members, case managers and AHCCMS staff all state that the members have additional rules (i.e. members cannot have guests stay for more than three consecutive days). No one was able to verify the source of this rule. Staff themselves do not enforce this rule; instead they will encourage members to take those types of concerns directly to the property management company. Case managers expressed concerns regarding instances where members have had staff complete "night checks" in their rooms. AHCCMS leadership stated that there are occasions when staff from the residential units will provide shift coverage. Some of those staff have to be reminded that the rules for community living properties are different than residential housing Staff in the apartment complexes will wait for members to give them access to their homes. However, those who work in 24-hour home settings enter upon arrival. It was explained that the staff are entering for a shift-change, and therefore may forget to knock or ask for permission to enter. It was also noted that all members have keys to	• AHCCMS should maintain copies of member leases, so that member obligations can be verified in the housing contract. Also, access to the leases will provide opportunities to educate both the staff and the member on the roles of each entity. This will also help staff empower members to take action when the stipulations in their agreement have been violated, and it will help verify affordability of member housing. • Train all staff (residential and Community Living) on the differences in staff responsibilities for each program. This will help to minimize undesirable staff interactions that may be in violation of basic landlord/tenant rules. • Clinical staff should receive education on the PSH model and the valuable role PSH plays in recovery. In a scattered site model, controlling member access to their home is virtually unfeasible. In high fidelity PSH programs, members control their own access and any third party control is contraindicated. The same considerations should be given to those living in house setting as those in

			their bedrooms, but not all members have keys to the front door of the home. Leadership stated that sometimes the doctors or probation officers will not authorize members to have keys to the home for various reasons (i.e. wandering behaviors, access to minors, etc.). In some instances, members must leave or stay in the home for a specified amount of time in order to keep another roommate from violating their probation terms. AHCCMS staff stated that meeting the demands in these situations can be difficult at times.	the apartments. • Establish clear guidelines concerning agency deliverables to members receiving probation services. In high fidelity PSH programs, PSH providers are not responsible for monitoring member compliance in other programs. It is not clear at this time if further system intervention is needed for this item.
5.1b	Extent to which tenancy is contingent on compliance with program provisions.	1, 2.5, or 4 2.5	According to AHCCMS staff, members are able to stay at the properties as long as they like. Some members report living in the Community Living properties for over 10 years. AHCCMS does not require members to participate in ongoing services, and discharge from the program is determined by the RBHA and property management company. According to agency documentation, "clients may be involuntarily discharged from the program if they are not actively participating in the program". AHCCMS staff state that though they cannot discharge members, the clinical team is contacted if there are pressing issues with the members. AHCCMS staff were unsure if members were required to maintain services with the RBHA to keep their housing.	• Program administrators should review agency documentation applicable to the Permanent Supportive Housing program that may be in conflict with actual company practices. If there are written rules that are in conflict with company practices, rewrite them to reflect the current values of PSH provider.
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstration	1 – 4 1	The SMI clinical teams play a primary role in the assessment process and in determining the type of referrals sent to the RBHA. Clinical teams determine the "level of care" a person needs. Case	With the current system structure, AHCCMS may have limited capacity to act independently to address systematic barriers to housing access. Options for all system partners are as

	housing readiness to gain access to housing units.		managers report discussing housing preferences with members; however, the limited availability of suitable properties system wide leaves members with limited opportunities to acquire their preferred home setting. One clinical staff stated, "There are not enough options; One person wanted to live in PV [Paradise Valley], and they placed him in Gilbert." It was reported that AHCCMS staff have minimal interactions with members prior to signing a lease into their program. "We don't have any say in the referral process. We do not refuse anyone. We take who we are sent, even if they are inappropriate for this program". Though housing referrals in the RBHA system are filtered by a "level of care" determination, it acts as a barrier by limiting housing options based on members' performance (or lack thereof). As stated through interviews with staff at both provider and clinical agencies, members can move to a lower level of care as they grow increasingly independent. The decision to move a person from a house model, 16-hour unit to an 8-hour apartment-style unit depends on their assessed performance.	follows: • Clinical staff would benefit from training in the referral process, and the differences between residential treatment, Flex Care residences, and Permanent Supportive Housing. See recommendations in 1.1.a regarding expanding scattered site options system-wide. • Providers should strive to immediately engage with members. Prior to and during the lease signing, these early appointments are good opportunities to build a relationship with the member, ensure the unit meets the preferences of the individual, and advocate for members' rights with the property management company. The provider should work with the RBHA/PNOs to find ways to engage members prior to program enrollment. (I.e. property tours, housing fairs, pre-leasing meetings, etc.)
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	As discussed in 6.1.a, members are referred by clinical teams to different housing programs based on the "level of care" they need. The RBHA is then responsible for matching members with housing that matches their level of care and housing preferences. All members on the RBHA housing list have equal access to housing. The greatest challenge, as described by the RBHA, PNO staff and AHCCMS staff is the availability of suitable properties for members.	• See recommendations for 6.1.a.

6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 1	At AHCCMS, the extent to which tenants control staff entry into the unit is determined by the type of property in which they reside. In the eight hour apartment units, staff will not enter the unit without permission from the member(s). Per AHCCMS administration, their staff will not enter a home; instead the police will be called if such an emergency arises. In the 16 and 24 - hour properties, which are house models, staff have full access to housing units. Staff report occasionally knocking before entering; however, there is no evidence that staff can be denied entry into the homes. According to clinical staff, members who have not been given keys to the main entryways (due to doctor recommendations or probation terms) have experienced occasions when they were locked out of their homes until the group of residents (with staff) returned.	• See recommendations for 5.1.a.
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	AHCCMS creates service plans for each of their members. These plans consist of goals that are focused on independent living skills. AHCCMS staff reports that Clinical Coordinators are responsible for assessment and the creation of the treatment plan. Members are not required to complete any particular groups or services. “There are no chore goals if they don’t want to do chores. They come up with what they need from you.” Individual programs are available if needed. When asked about the flexibility of service plans, one staff stated “Our plans are currently very measureable.	• Explore methods for aligning treatment plans with member-driven goals only. While exploring clinical ISP during this process, it was evident that the majority of members expressed interest in living independently without roommates. However, only the members who lived in apartment-style housing were given this option. The housing goals from the clinical ISP should be expanded in the service provider’s ISP. The role of the service

			We want to make them more open-ended." Upon review of the service plans in the record review, it was noted that all plans had documented goals for 100%medication compliance. Other common goals were medication identification and hygiene. Clinical coordinators can provide psychoeducational counseling in the members' homes.	provider is to help the member with the steps to fulfilling their housing goals. In a scattered site approach, the member would already be living independently, and therefore would be working on goals that will help them to maintain their housing. • Review mandatory medication guidelines set by the PNO and/or RBHA. Mandatory service requirements are not consistent with the PSH model, specifically with regard to matching clients with the right level of service.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Tenants initiate and are offered routine opportunities to modify their service selections. Per AHCCMS staff report, members can modify their services anytime they want. Members always have a choice to participate (or decline) groups and other agency programming. Regardless of participation, members will always have a service plan. When asked about the medication goal on the services plans, staff stated, "there is always a medication goal on the service plan, even though the member can decline meds at any time." If a member would like to modify services, all they must do is ask.	• Though members are able to modify services at any time, the review team has questions about the necessity of mandatory goals on member service plans. The provider should consider reviewing this requirement at the PNO/RBHA level.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	As discussed in 7.1.b, members have both required and optional services written into their treatment plans. However, the method for carrying out these activities can be adapted for members. Staff members will accommodate member preference to attend individual or group activities for the topics offered. Staff will also do informal trainings for members as teachable moments arise. In one	See recommendations in 7.1.a

			instance, staff stated that they spontaneously walked through the process of preparing a certain meal for all of the household members. Though tenants may choose from an array of formal (and informal) services, refusal of services does not mean removal of them from the treatment plan. The goals of the treatment plan (i.e. medication adherence) will remain, regardless of participation or refusal.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	As discussed in 7.1.b and 7.2.a, AHCCMS staff will adapt and change services based on member preferences. AHCCMS has a number of groups available to members, to aid in their development of independent living skills and mitigation of barriers to goal achievement (CORE group). The CORE group is highly flexible and can be adapted to meet the needs of the members individually, however, the service mix offered (based on the frequency of particular treatment planning goals), is predictable.	• Once the goals on treatment plans become more diverse, the program offerings should diversify as well. Focus on building relationships with other service providers in the community that may be able to assist members with other non-clinical, housing - related goals (i.e. Budgeting, housekeeping, being a good neighbor, self advocacy w/ landlord, etc.)
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	AHCCMS staff and members all stated that members have the right to decline participation in any activity, at any time. Members are able to request particular activities/services from AHCCMS. Though members may have some input into their services, little evidence exists to demonstrate significant member input into the design and structure of service delivery.	• Consider developing a member advisory board, which can help providers obtain consistent, organized feedback on the effectiveness of services, as well as ideas on how to improve services for all members.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum	1 – 4 4	AHCCMS staff are not assigned individual caseloads but are assigned to service a property. Staff can be moved around to different properties, depending on the coverage need. Clinical	

	caseload sizes		coordinators are assigned caseloads for clinical oversight and service planning. There are seven clinical coordinators assigned to the 70 members served.	
7.4.b	Behavioral health service are team based	1 – 4 2	In the current system structure, multiple entities are involved in providing member care. The individual case managers from the clinic providers are responsible for all behavioral health coordination for members. As a result of this arrangement, the team approach is missing for those members who are not on ACT teams. AHCCMS staff report meeting with case managers in situations where members are experiencing difficulties that may need clinical intervention.	• Based on the structure of the system, with separate providers involved primarily for housing services, and other providers for case management and psychiatric services, it may not be possible for AHCCMS to provide services through a team. To the extent possible, AHCCMS should continue efforts to coordinate with the assigned SMI treatment teams. • The RBHA, PNOs and Providers should consider in-depth training in the evidence-based practice of Permanent Supportive Housing. Increased knowledge of the model and how it has been developed in other systems could result in more successful implementation. • Based on the structure of the system, with separate providers involved primarily for housing services, and other providers for case management and psychiatric services, it may not be possible for AHCCMS to provide services through a team. To the extent possible, AHCCMS should continue efforts to coordinate with the assigned SMI treatment teams.
7.4.c	Extent to which services are	1 – 4	Currently, the availability of services is based on the type of property (level of care) to which a	• AHCCMS should continue to review the program's capacity to provide service

	provided 24 hours, 7 days a week	2	member is assigned. AHCCMS offers eight, 16 and 24 hours of staff availability. The three apartment settings have eight hour staff availability. The hours of availability are from 8am-4pm. Staff report that they are working on revamping services to accommodate a more flexible staffing schedule.	coverage 24 hours a day, seven days a week. Examine the feasibility of providing this service in the current structure of the PSH program.

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		1.87
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	2.5
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	2
Average Score for Dimension		2.83
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	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	1
5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	2.5
Average Score for Dimension		1.75
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	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	1
Average Score for Dimension		1.5
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 then, 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	2
Average Score for Dimension		2.62
Total Score		13.07
Highest Possible Score		28