PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: David Covington, CEO

From: Annette Robertson, LMSW
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AHCCCS Fidelity Reviewers

Method

On October 26-28, 2021, Annette Robertson and Nicole Eastin completed a review of the RI International (RI) 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 the Central Region of Arizona.

RI provides services across the country as well as New Zealand. This review will focus on the PSH program, *Community Building*. The housing subsidy provided to tenants through this program historically has been funded by the Regional Behavioral Health Authority (RBHA) through a block grant. As of October 1, 2021, the subsidy funding was transitioned to Arizona Health Care Cost Containment System (AHCCCS) and HOM, Inc. was awarded the contract to manage the delivery of that subsidy funding. Due to the system structure with separate treatment providers, information gathered at the COPA Health Arrowhead and Valle del Sol Red Mountain clinics were included in the review as sample referral sources. However, some data obtained reflects services provided by other partner clinics.

This review was conducted remotely in consideration of public health conditions associated with the pandemic, Coronavirus (COVID19).

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

During the fidelity review, reviewers participated in the following activities:

- Program overview and discussion with Vice President of the Southwest Region and the Recovery Services Administrator for Community Building.
- Interview with the Recovery Services Administrator for Community Building.
- Interview with PSH direct service staff and a former PSH staff.
- Group interviews with two Case Managers and a Housing Specialist from one partner clinic and two Case Managers from another.

- Interviews with members (3) participating in the PSH program.
- Review of agency documents including intake/annual update procedures/documents, *Welcome Packet*, program protocols, job descriptions, and copies of team clinical supervisions for the past three months, as well as documents relating to housing such as copies of rental agreements/leases, rent calculations, and Health Quality Standards inspections.
- Review of ten randomly selected agency and partnering clinics member/tenant records.

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.

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- Affordable housing: Rent for tenants in the RI housing program averages less than 30% of tenant income. Rent includes utilities.
- Tenants control household composition: Members do not need to seek clinical team approval to add individuals to their households.
- Option to modify services plans: Clients of the program report having the opportunity to choose and modify services with the clinics with whom they are enrolled. Progress notes show that clinic staff are responsive to clients' needs and concerns.
- Integrated housing: The PSH program supports members in obtaining scattered site housing that is well integrated throughout the community.

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

- Safe housing: the program should support members to be living in safe housing. Engage with subsidy administrator to build a collaborative relationship to support members' housing safety by ensuring Housing Quality Standards (HQS) inspections are conducted regularly. The program should increase services to members at risk of losing stable housing due to health and safety issues.
- Consumer driven services: Develop additional strategies to solicit and incorporate member input on program design and service provision.
- Caseload sizes: Reduce caseloads to no more than 15 members/tenants per PSH staff. PSH is designed for members with significant functional impairments which impacts housing stability. Without adequate staffing, members' housing is potentially at risk.
- Team based services: Program staff should coordinate care with clinical teams to improve member care. Ideally, PSH programs and behavioral health services are delivered by an integrated team to improve member care.

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 4	Based on interviews with members, and clinic and PSH staff, members have choice in housing. Clinic staff reported having open conversations with members about the type of housing and ideal location they desire. Housing staff interviewed at one clinic explained that members are informed about and offered different housing types, and the member chooses among those options. Clinic staff reported they will assist members in applying for the housing of their choice, including waiting lists for housing subsidy programs that expand a members' options in housing. Tenants of the program reported they were supported in searching for the housing of their choice based on their preferences.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 4	Based on interviews with members, and clinic and PSH staff, members have choice in the unit within the housing model. One member reported being offered options and choosing the unit that best suited them. Clinic staff reported PSH staff have assisted members in viewing different floor plans available to choose from in apartment complexes. Direct service staff reported members choose the unit they prefer. Choices may include different floor levels or location of the unit within the complex. One staff reported that if a member is not happy with what is available, they will support the member finding something different.	• System stakeholders should work in collaboration to increase the availability of affordable housing options for members who do and do not receive subsidy vouchers. Work to maintain agreements with complexes undergoing improvements to prevent turn out of tenants with vouchers. Consider developing a public information campaign, or other tactics to educate and enlist landlords and property management companies as partners in providing affordable housing throughout the community.

			PSH staff reported they do not suggest where members should live, instead ask them for their preferences and give them choices based on those. At intake, members express their ideal housing situation; the search for housing begins there. Staff stated that offering choices is essential to what they do. Barriers identified include high rental prices, low income, and colorful backgrounds that may prevent members from qualifying for some units. Staff said the selection of units has become constrained due to higher rent rates. One staff reported less than a 2% vacancy rate throughout the Phoenix metro area. PSH staff also reported recently being challenged by landlords unwilling to work with housing programs. PSH staff continue advocacy efforts.	
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	Members are referred to the PSH Community Building program by a provider agency. Each member's Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) score is obtained from the referring agency to establish eligibility for PSH services. Historically, eligible members were referred and added to the RI Community Building waitlist which included a rental subsidy voucher. The PSH program prioritized the waitlist using the member's VI-SPDAT score. Program staff reported there was not a waitlist at the time of the review. Based on interviews, members can decline a unit and remain in services until they find housing of their preference. One member stated that after being declined at some complexes, the PSH staff continued to assist in finding the type of housing the member wanted	

			and did obtain. The member attributed their success to the PSH program.	
		1.2 Choice of Living Arrangements		
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 4	PSH staff and members interviewed reported that tenants control the composition of their household. One member reported, and PSH also reported, having gotten married while in the program and being able to add their spouse to the lease. The spouse has income and is responsible for a portion of the rent. PSH staff also noted a member obtained custody of their grandchildren and was able to add them to the lease. That tenant was supported in obtaining a unit with additional space to accommodate the children. Staff at one clinic were unsure if tenants had the ability to add family or significant others to their lease.	
		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	PSH staff and tenants stated that housing management providers do not have any authority or role in providing social services. The PSH program has clearly defined roles among housing staff. The Housing Specialist position, vacant at the time of review, is responsible for assisting members in finding housing, lease signings, relocation efforts, determining tenants rent responsibility, and managing the program's rent responsibility, while Recovery Coaches provide additional support services once the member is housed.	
2.1.b	Extent to which service providers do not have any responsibility for	1, 2.5, or 4 4	Clinic and agency staff denied having responsibility for housing management. The PSH agency does market themselves to housing management as a resource and requests contact when a member's housing may be a risk due to high traffic, etc. Staff	

	housing management functions		reported tenants have requested PSH staff to accompany them when feeling unfairly targeted by housing management.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Clinic and PSH staff reported that social service offices are based off-site and are not located in complexes where members of the program reside. Members interviewed report receiving services through their integrated clinics and through other providers off site from their residences.	
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	Of the data provided to reviewers, forty-three members in the program were housed. On average those tenants pay 22% of their income toward rent. No tenant pays more than 30% of their income toward rent. Members with no income pay no rent. Agency documents provided indicate the program may pay the full rent amount if the member is hospitalized or is incarcerated for less than three months. Tenants housed in units that did not include utilities prior to January 1, 2020, were supported by the PSH agency in paying those utilities. Tenants after that date, were responsible for utilities if they were not included. As of October 1, 2021, members can get utility assistance through the new housing subsidy organization. One record reviewed showed that a member of the program recently requested financial support from the clinical team for assistance in paying a utility bill.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing	1, 2.5, or 4	PSH staff reported that some members' annual Health Quality Standard (HQS) inspections were delayed due to the public health emergency but	• Staff should develop procedures to collect copies of current HQS reports from the subsidy administrator. If feasible, voucher

	Quality Standards	2.5	that all are now up to date. Of the data provided to reviewers, forty-three members are housed. Of those members, forty tenants were identified by the program as having a passing and current HQS inspection on file. Of the documents provided to reviewers for twenty randomly sampled members, 13 out of 16 housed members, 81%, had a current and passing HQS. One member record contained a notice of a failed inspection due to inability to enter the unit. PSH staff reported that the subsidy administrator is now responsible for ensuring members HQS inspections are completed annually.	administrators (HOM, Inc.) should share current HQS reports with PSH service providers, as one component to supporting tenants' ability to self-advocate, and as an eviction prevention measure. • As a new partner, the PSH agency should consider outlining processes and activities that support building a collaborative relationship with the subsidy administrator to support members in having safe housing.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Based on data provided relating to where members of the program reside and information given through tenant and clinic staff interviews, members of the *Community Building* program are integrated into the community. Members are not clustered in housing units occupied by other people with disabilities.	
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	Housed members of the PSH program have full rights of tenancy. Of the member sample that were housed and still open with the program, 15 of the 16 leases reviewed were current. Some leases reviewed converted from a 12-month contract to a month-to-month agreement, which potentially puts a tenants' housing stability at risk. Members interviewed reported receiving copies of their lease at signing. Some members interviewed were unsure if they still had their signed lease.	

5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Housed members interviewed reported that they only have to follow rules included in their leases and had no other specials rules. Of the leases examined by reviewers, several had addendums covering issues such as pets, bed bugs, crime free properties, etc., but none had special rules that tenants enrolled in the PSH program had to follow. PSH staff interviewed reported educating and supporting tenants to know and understand the rules of their individual leases.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	PSH staff interviewed reported that members do not have readiness requirements to obtain housing and that the Community Building program is designed after the *housing first* approach. Staff at one clinic were able to articulate the *housing first* approach and denied screening members for referral. However, staff at another clinic were unfamiliar with the approach and expressed prioritizing members without substance use issues.	• PSH staff and system partners should collaborate with clinic staff to increase understanding of the *Housing First* model and how PSH supports that. Assessing members' needs would be an appropriate measure if the purpose were to identify skills and services needed to support the member in being successful in living independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs. Prioritize outreach to clinics that do not have a Housing Specialist for training and informational meeting opportunities.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 4	Staff interviewed reported that members referred to the program must score an eight or higher on the VI-SPDAT and that those with a higher score are prioritized. Members must be homeless, have an SMI diagnosis, and be eligible for Medicaid per staff report.	
6.2 Privacy				

6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Members interviewed reported they have privacy in their units. Data provided by the agency showed that all members live in units where they control entry. PSH and clinic staff confirmed that members control entry and have privacy in their units. Neither PSH nor clinic staff retain keys for member units. Although PSH staff reported creating a document to guide when staff should take extra measures to contact natural supports, none of the member records reviewed had examples.	
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 4	PSH and clinic staff report members can choose the services they want at program entry. One member reported being able to get additional services needed when going through a difficult time, including housing services. Another member stated the services available at the clinic are flexible to their needs.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic staff reported updating member service plans when a new service is requested. Some staff stated that plans should be updated every six months, but all clinic staff agreed that at a minimum service plan should be updated annually. Most clinic service plans evaluated by reviewers were updated annually. Members interviewed reported they can modify their service plans when they want to add or remove goals and services. Records reviewed showed that clinics updated member service plans at members' requests.	
7.2 Service Options				
7.2.a	Extent to which tenants are able	1 - 4	PSH and clinic staff, and members interviewed reported that members can choose the services	

	to choose the services they receive	4	they desire. Partnering clinic staff reported members can decline services without losing their housing. When members are not engaged in services at the clinic, members are moved to *Navigator Status,* engaged once a year, and remain housed. Clinic staff stated currently having one member in *Navigator Status* in subsidized housing with a voucher and that it has not impacted the member's housing. One member interviewed believed it is an option that if they are no longer interested in services at their clinic, they can remain housed. The PSH program *Welcome Packet,* completed at intake, includes a form that encourages members to choose additional services and activities such as employment, budgeting, peer support, exercise, and spiritual activities.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 - 4 2	The program literature states the program offers a 90-day service plan to members to assist with identifying goals, but few current plans were seen in member records provided. Staff at the agency and clinics reported that PSH staff adjusted services to the needs of members during the public health emergency. One member reported receiving services by teleconference when PSH staff were not allowed to meet in-person at members' homes. One member interviewed reported feeling enormously supported by the PSH team, saying that the team will provide additional supports when needed, but also voiced wanting more frequent contact from the program, expressing concern for staff's workload. One member reported being offered groups and individual sessions through telehealth.	• Hire additional staff to be able to respond to member needs and to coordinate care with clinical teams as well as other providers supporting members. • Consider providing staff additional training on how to engage members in addressing other areas of vulnerability, concern, or prior issues that led to eviction or homelessness. Staff may benefit from training in motivational interviewing and co-occurring disorders to better support the needs of tenants whose tenancy may be at risk.

			Records reviewed showed one member seeking additional support from the clinic Housing Specialist for additional affordable housing resources after unsuccessfully utilizing the program's resources. Another member had gotten a five-day Health and Safety notice to clean the apartment. PSH staff were aware of rodents in the apartment and missed HQS inspections yet did not increase services or supports to ensure the member's housing was maintained. Another record showed a staffing between PSH and clinic staff. It appears it was determined that the agency was not prepared to provide the level of service the member required to be successful in the program to live independently. Documentation lacked evidence that PSH staff inquired or assessed member needs and adjusted services or intensity to meet member needs. Eventually the member was discharged from the program. One member interviewed reported it is difficult to reach the correct person at the program when wanting to connect with PSH staff. Another member said the program has difficulty filling vacant positions and expressed concern of staff burden. Of the member records reviewed, two members had a current service plan with the PSH provider. One member had opened and closed within a short period and a service plan had not been completed.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 3	The PSH program has peer staff delivering services to members. Reviewers were told peers make up one-half of staff at the agency.	• Consider alternative options to facilitate member/tenant input using videoconference, conference calls, or social

			Staff at the agency and clinics reported that PSH staff adjusted services to the needs of members during the public health emergency. Members interviewed reported the program primarily made contact by phone and stopped visits to homes. Members reported PSH staff reported they speak with members on their experience within the PSH program to gain their input. Program specific satisfaction surveys are completed with 5-6 members per month. It was also reported having a suggestion box and are always open for feedback. One member reported completing a satisfaction survey with PSH staff during every home visit.	media so that members can voice their concerns and desires for program design. • Explore additional ways to solicit and incorporate member input on program design and service provision. For example, explore if members receiving PSH services can serve on sub-committees to the agency board of directors, participate in quality management, or other processes that impact service design and provision.
		7.4 Quality and Adequacy of Services		
7.4.a	Extent to which services are provided with optimum caseload sizes	1 - 4 2	At the time of the review, the program had two staff, a Peer Coach and the PSH Administrator, with a maximum census of 60 members. PSH staff reported the 55 members currently enrolled in the program are evenly split between staff.	• Reduce caseloads to no more than 15 members/tenants per PSH staff. PSH is designed for members with significant functional impairments which impacts housing stability. Without adequate staffing, members' housing is potentially at risk. • Hire, train, and retain PSH staff. Seek input from current staff and others that have moved on to other departments what will/would keep them in the position to help support retainment. Consider opportunities to celebrate successes of members, share resources, and team building activities in an effort to support current staff.
7.4.b	Behavioral health services are team based	1 - 4 2	One member record documented PSH staff being aware an unhoused member was having difficulty obtaining medications, and staff did not reach out to the clinical team for support. Few of the ten	• Providers, PSH and clinic, should obtain input from each other when modifying member plans if an integrated plan is not an option. Share updated plans when

			member records reviewed showed PSH staff coordinating with clinic staff.	completed. This collaboration may prompt staff to revise plans at their program when members have a change in status and raise awareness of stated goals. • The PSH program should reach out to clinical teams regularly to improve member care. • See recommendations for 7.4.a.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 - 4 4	Staff interviewed reported that members of the program create plans for when they fall out of contact with the team. None were located in the member records provided to reviewers. Staff interviewed reported the PSH program hours are 8 - 4:30pm, Monday - Friday. Members can call the agency's main number after hours and weekends which it is routed to the Recovery Connections Line that is staffed 24 hours a day by non-PSH program staff. PSH leadership is then contacted if a tenant requires support. PSH leadership reported staff are available 24/7, but that they rarely receive after hours calls to assist members. One member reported ability to contact PSH leadership anytime.	• Ideally, members/tenants can call PSH staff directly after hours for supportive services. When staffing of the program is more secure, consider adding direct access to PSH staff after hours, rather than routing them through another program that is unfamiliar with members/tenants. PSH staff often have

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	4
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	4
Average Score for Dimension		4
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	2.5
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	4
Average Score for Dimension		3.25
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	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	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	4
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.67
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
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	4
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	2
7.3.a: Extent to which services are consumer driven	1-4	3
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	2
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		3.13
Total Score		26.05

Highest Possible Score		28