# PERMANENT SUPPORTIVE HOUSING (PSH)
# FIDELITY REPORT

Date: May 24, 2021

To: Steven Sheets, President/Chief Executive Officer

From: Karen Voyer-Caravona, MA, MSW
Annette Robertson, LMSW
AHCCCS Fidelity Reviewers

**Method**

On April 12 – 14, 2021, Karen Voyer-Caravona and Annette Robertson completed a review of the Southwest Behavioral and Health Services (SBHS) 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.

SBHS offers a range of services, including treatment for substance use disorders, residential treatment, and community living. The PSH program, The Link, located within the Community Living program, is the focus of this review. Per interviews and program documents provided to the reviewers, Link staff can help members with housing search, move-in and organization, budgeting and daily living skills, symptom management, transportation, community integration activities, resource identification and access, problem solving, and coping skills. Due to the nature of referrals, which usually originate at external provider clinics, information gathered at LaFrontera-EMPACT Comunidad and Southwest Network Northern Star clinics was included in the review.

March 11, 2020 the Governor of Arizona made a Declaration of Emergency and an Executive Order in response to the pandemic, Coronavirus 2019 (COVID-19). Among others, recommendations were made to practice social distancing of six feet to avoid spreading the disease as well as limiting gathering of groups of more than ten people. This review was conducted during the pandemic and adjustments were made to the review process to observe the Governor's requests and to reduce burden on providers, including reducing the sample size of member records reviewed, conducting staff and member interviews telephonically or videoconferencing, remote access to provider electronic health records when available, and other adjustments as needed to be in compliance with public health guidance.

The individuals served through the agency are referred to as *clients* and *members*; for the purpose of this report, the terms "tenant" or "member" will be used.

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

- Interview with the Program Director for Community Resilience, who supervises the Link program.

- Interviews with three Behavioral Health Technicians from the Link program.
- Group interviews with two Housing Specialists and two Case Managers from one partner clinic and one Housing Specialist and two Case Managers from another partner clinic.
- Interviews with three members/tenants who are participating in the PSH program.
- Review of agency documents including organizational structure, intake procedures, eligibility criteria, PSH program meeting agendas and criteria, copies of income/rent calculation documents, tenant leases, team coordination, and program rules.
- Review of 10 randomly selected records, including charts of some 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**

The agency demonstrated strengths in the following program areas:

- PSH staff reported encouraging members to view multiple units and make selections based on their unique priorities rather than accepting the first available, while also educating them on the rental market, leasing requirements, and potential barriers to tenancy. Records reviewed and tenants interviewed confirmed that they are offered choices in units and do not experience pressure to accept units that do not meet their needs and preferences.
- Link program staff do not have a role in property management functions, nor do property managers play a role in provision of support services. Interactions between Link program staff and property managers are typically at tenant discretion and focused on tenant advocacy/eviction prevention.
- At the time of review, Link program staff carry caseloads within the optimum range of 15 or fewer.
- The agency provides on call after hours service to address housing related needs; staff encourage and support members in accessing a local crisis response team in the event a tenant feels unsafe due to experiencing acute psychiatric symptoms or overwhelming situations.

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

- System partners should ensure that clinical teams and PSH housing and service providers have a shared understanding of *Housing First* principles so that members expressing a need for housing are assisted in obtaining the housing that aligns with their stated needs. Preferences for independent housing in the community should be respected, regardless of the presence of psychiatric symptoms, attendance to appointments, or active use of alcohol or illicit substances.

- Documents necessary to support member tenancy and safe housing, leases and HQS inspection, were not consistently obtained by the program. Maintain leases and, where applicable, HQS reports for tenants in the program to support and educate them when issues arise relating to such. For members living with family, encourage informal lease agreements that clearly establish expectations and responsibilities of both parties. For tenants living in market rate, or other housing where HQS inspections are not applicable, consider developing an inspection checklist for tenants and Link staff to use at leasing walk-through to support decent and safe housing.
- The Link program lacks an obvious mechanism for people with the lived experience of psychiatric recovery to shape housing program design and service provision. To develop a peer perspective, system partners should consider collaborating on opportunities for peer representation on area affordable housing work groups or the formation of a PSH advisory committee to provide input. Technical assistance in this area is advised.

**PSH FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| **Dimension 1<br>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<br><br>2.5 | Some restrictions to tenant choice of housing type may exist at the clinic level. Staff at one clinic reported that members who request housing choose the type pursued and discussed the importance of encouraging PSH services to support long-term tenancy, especially for those with repeated eviction histories. Staff at the other clinic appeared to endorse a continuum of care approach by which members step down to independent housing as they demonstrate improvements in stability, rules compliance, and independent living skills. Staff at that clinic did not have a shared understanding on who chooses the housing type – the member or the clinical team. Staff at one clinic reported that some PSH providers do not work with members who do not have an income and are referred back to clinical team for assistance.<br><br>Records reviewed showed that members were supported in their pursuit of independent housing or maintenance of independent housing. One record showed that a member residing in a staffed community living placement (CLP) unit was referred for to the Link program for assistance in independent a housing search. | • System partners should ensure that clinical teams receive ongoing training and education in PSH and Housing First principles. Members seeking independent housing should be supported through identification of needs and offering of relevant wraparound supports and resources.<br>• It is perceived by some referral sources that members without income are not eligible for PSH services at all PSH providers. The Link should continue efforts to educate referral sources on eligibility requirements for program enrollment. |

| | | | | |
|---|---|---|---|---|
| | | | Link staff interviewed reported no awareness of restrictions to choice in housing type at the clinic level and perceived clinics as being increasingly supportive of member choice of housing type. | |
| 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<br><br>4 | PSH staff interviewed said that they begin housing searches by gathering information from members on their housing priorities, needs, and preferences. Staff said that members often prioritize geographic proximity to family or their clinic, accessibility issues (i.e., first floor, elevator, etc.), pet policies, access to public transportation, and property amenities such as a patio, balcony, or swimming pool. Staff said they encourage members to visit multiple units rather than accepting the first available because tenants are less likely to be successful in housing that does not align with their preferences. Staff said that income and background issues (i.e., poor credit, and eviction/criminal history) may present significant barriers to attaining the ideal unit. Staff start by exploring what is available and encourage members to adjust their needs and preferences as they gain a greater understanding of the rental market and the limited supply of affordable units.<br><br>Staff said that the public health emergency has exacerbated some already existing restrictions to choice in unit in the area housing market. Staff said that in-person viewing of units has been difficult to schedule due to landlords and leasing staff adherence to the public health guidance. In addition, staff described less turnover in apartments due to tenants staying in place and the imposition of policies discouraging evictions. Staff said that rents continue to climb, pricing out even members with income and subsidy vouchers. One record showed a member with over a decade at a | |

| | | | | |
|---|---|---|---|---|
| | | | unit subsidized by a voucher engaged in an apartment search after the property manager announced the complex would no longer accept voucher. Records showed staff assisting the member in locating a new apartment, viewing many in person and ultimately making concessions on preferences in favor of affordability. | |
| 1.1.c | Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists | 1 – 4<br><br>4 | Members with subsidy vouchers are granted extensions to find the unit of their choice. Some records reviewed showed PSH staff encouraging members to keep track of units viewed for the voucher administrator to show effort at housing search. Some records showed members declining multiple units before choosing a unit. Staff said that members seeking vouchers, regardless of their origin (i.e., Section 8, Regional Behavioral Health Authority (RHBA) affiliated, Coordinated Entry) may be several years long wait. Staff also said that wait lists for affordable units available through public housing authorities (PHA) or income eligible housing providers are lengthy, with years long wait times. | |
| **1.2 Choice of Living Arrangements** | | | | |
| 1.2.a | Extent to which tenants control the composition of their household | 1, 2.5, or 4<br><br>2.5 | The majority, but not all, member/tenants reside in housing in which they have control of household composition. Control of household composition varies between housing types. Three members living in their own homes and receiving supportive housing services have complete control of household composition. Tenants of market rate housing have considerable control of household composition and can live with whomever they wish, in accordance with a standard lease agreement. Those living with family or friends are considered to have control of household composition as well. Tenants living in CLP, with or without staff, cannot add additional people to | • Roommates can enhance affordability and serve as valuable natural supports to successful housing outcomes. Tenants should be able to add others to leases when they are able to meet the conditions required by the landlord or property manager. Clinical teams and PSH service providers should educate tenants on the benefits and risks associated with adding roommates to housing vouchers and leases, in addition following the procedures required for doing so. PSH service providers should also be knowledgeable about |

| | | | | |
|---|---|---|---|---|
| | | | their lease but are guaranteed a room of their own with a lock and key. Tenants of group homes or temporary placements do not control household composition and may or may not have a private room. Tenants of RBHA affiliated scattered site units (approximately 29% of housed tenants) have considerable control of household composition. Household members (dependents and significant others) are identified on the voucher application and at the housing briefing. Similar household composition requirements usually apply to other voucher programs as well as PHA units and income eligible properties. It was reported that RBHA affiliated vouchers do not require clinical team approval but that the administrator limits roommates to family/significant others, on condition of background checks and income verification. PSH said that some persons being put forward to be added as household members may be screened out by property managers, based on background issues such as poor credit or criminal history.<br><br>Most members interviewed were unclear whether they could add roommates to their leases. One member reported that they would talk to the voucher administrator if the matter came up. Another member said they believed roommates were allowed. | differences in policies among the various subsidy voucher programs respecting the addition of roommates. |
| **Dimension 2<br>Functional Separation of Housing and Services** | | | | |
| **2.1 Functional Separation** | | | | |
| 2.1.a | Extent to which housing management providers do not have any | 1, 2.5, or 4<br><br>4 | Most members in the PSH program live in settings where property managers have no role in social services. PSH and clinic staff interviewed said that property managers and support staff may have interactions as they related to eviction prevention | |

| | | | | |
|---|---|---|---|---|
| | authority or formal role in providing social services | | activities but do not otherwise participate in clinical decision making or staffings. One record showed that the voucher administrator appeared to act as a liaison between the clinical team and a property manager to resolve an unauthorized guest and behavior contributing to pest infestation.<br><br>Six tenants reside in staffed CLPs with staff (n=4) and group homes (n=2), but it is unclear to what, if any, extent housing management merges with social service roles. | |
| 2.1.b | Extent to which service providers do not have any responsibility for housing management functions | 1, 2.5, or 4<br><br>4 | Both clinic and PSH staff reported no responsibility in property management functions such as reporting lease violations or delivering eviction notices. PSH staff said they limit their contact with property managers to eviction prevention activities and advocating for tenant concerns such as maintenance issues. Staff said that interactions with property management are with tenant permission. One record showed that a PSH staff introduced themself as someone who would help the tenant with planning the move and returning leasing documents. Other records showed PSH staff explaining lease requirements to members and providing education on maintaining tenancy. | |
| 2.1.c | Extent to which social and clinical service providers are based off site (not at the housing units) | 1 – 4<br><br>4 | Most tenants (84%) live in residences where there are no clinical providers based on-site, primarily scattered site and market rate units, but also those living with family or friends, and member owned homes. In some shared CLP units (with or without staff), group residences, and temporary placements unwanted staff presence may occur if other residents invite clinical staff in for services, or if clinic staff or other service providers conduct groups or other meetings at the residence. | |
| **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<br><br>3 | The agency was not able to provide complete data on rent to income paid for all tenants served. The agency lacked complete rent to income data on 12 (21%) of 56 housed members. Of the members in which data was provided, tenants paid an average of 29% of income in rent. Members carrying RBHA affiliated, or other subsidy vouchers paid 30% or less in rent; those without income paid no rent. One clinic staff interviewed said that market rate for a one-bedroom apartment in Maricopa County was about $1050 per month, far exceeding the monthly income of many tenants. Per data provided, self-pay units appeared to rent for well over 50% - 75% of income. One PSH staff said that an affordable housing partner charged 30% of income in rent but the wait list for those units is lengthy. PSH staff described one income eligible property management company charging $700 a month for a studio apartment, which is still burdensome for many PSH tenants. Staff said that affordable units might include water and gas with rent, but electricity service often is not. The RBHA will provide subsidy, which is deducted from the tenant's portion of rent, for the utilities with scattered site units. Tenants are responsible for utility fees that go beyond the subsidy.<br><br>Some members living with family live rent free. One member's rent for an apartment was paid entirely by a family member.<br><br>Clinic and Link program staff said they attempt to help members bridge gaps between income and rent by directing them to community resources | • For tenants paying more than 50% of income toward rent, explore more affordable housing options based on their preference, or discuss ways they can reduce that burden by increasing income, i.e., seeking employment, utilizing community resources. Any housing that costs 50% of a tenants' income is generally considered a financial burden. Some tenants in the program may choose to maintain this housing due to individual preferences, i.e., near family, supports, or employment.<br>• System partners should continue to collaborate on strategies to expand affordable, community-based housing options, including building and sustaining partnerships with local and state housing authorities and housing developers. |

| | | | | |
|---|---|---|---|---|
| | | | such as food banks, Meals on Wheels, programs that provide utilities assistance, private and faith-based charities, applying for benefits for which they qualify, and encouraging employment. One Link staff noted that financial assistance programs formerly used to help members in need have been stretched thin since the public health emergency and often cannot provide aid. | |
| | | **3.2 Safety and Quality** | | |
| 3.2.a | Whether housing meets HUD's Housing Quality Standards | 1, 2.5, or 4<br><br>1 | The agency provided no evidence of housing quality standards (HQS). Link program staff said that HQS inspections on required units (i.e., scattered site, CLP) were delayed and not occurring regularly.<br><br>The reviewers were told that an agency employee with past experience as an inspector has provided training to housing support staff on HQS and they in turn educate tenants what to look for when viewing units. Link program staff did say they make efforts to assist members in reviewing their units for maintenance and repair issues and support them in advocating for themselves, such as documenting issues at walk through inspections. | • Staff should develop procedures to collect copies of current HQS reports. If feasible, voucher administrators should share current HQS reports with PSH service providers, as components to supporting tenant self-advocacy and eviction prevention.<br>• Staff should develop procedures to ensure that all tenants in the Link program are in housing that meets decent and safe standards, including those who are in market rate housing. If not currently in effect, train Link program staff in HQS and consider developing a checklist based on HQS standards that can be used to document deficiencies for maintenance and repair at leasing walk through. |
| | | **Dimension 4**<br>**4.1 Housing Integration** | | |
| | | **4.1 Community Integration** | | |
| 4.1.a | Extent to which housing units are integrated | 1 – 4<br><br>4 | Data provided the reviewers and interviewee reports indicate that most members live in units that are well integrated throughout the Maricopa County/Phoenix area. Link staff said they make efforts to help members locate housing in their preferred geographic locations. Link staff acknowledged some cities and towns have very | • System partners should collaborate with stakeholders in the homeless and affordable housing advocacy community to expand the availability of affordable housing throughout Maricopa County. Housing integration supports recovery through the formulation of identities in |

| | | | limited affordable options. Most clinic and PSH staff interviewed agreed this has been exacerbated by both market conditions and the public health emergency, and that expansion of affordable options throughout the community would be an important step forward for PSH. Unintentional clustering may occur in neighborhoods or zip codes due to low income and leasing restrictions that exclude potential tenants with specific background issues. All staff agreed that members convicted of sexual offenses face especially high barriers to integration and may be limited to housing near other people with similar histories. | which disability status is merely one facet. This should also be considered for individuals difficult to house due to past criminal convictions. |
|---|---|---|---|---|
| **Dimension 5<br>Rights of Tenancy** | | | | |
| **5.1 Tenant Rights** | | | | |
| 5.1.a | Extent to which tenants have legal rights to the housing unit | 1 or 4<br><br>1 | Staff interviewed said that they attempt to obtain copies of leases at the time of signing and renewal but are not always successful. PSH staff said that many members like for them to be at lease signings. In some cases, property managers will email staff copies of leases. One Link staff reported taking pictures of leases with a smart phone to retain a copy. PSH staff did not appear to have a clear process for obtaining leases or method of educating members as to the benefits of providing staff with copies of their leases. The agency provided the reviewers very few complete leases out of records sampled, and data showed that they had less than half of tenant leases at the time of the review. It was not clear that all staff understand the importance of member and agency lease retention in providing housing support. When asked by the reviewers where tenant leases are stored, one PSH staff said they were stored in a binder at the agency. A review of records did not | ● PSH agencies should obtain and maintain current copies of all leases. For scattered site units, explore the feasibility of having voucher administrators being able to provide copies of leases to PSH provider as leases are an important tool supporting tenant advocacy and eviction prevention. Members participating in PSH services should be educated as to the benefits of sharing the lease with the PSH services provider.<br>● Explore options of formal agreements so that members living with family or friends know their responsibilities and expectations as either tenant or landlord.<br>● It is recommended that leases be easily accessible to PSH staff via members' electronic record, especially when staff are working in the community or working |

| | | | | |
|---|---|---|---|---|
| | | | show any copies of leases present in member records although some showed PSH staff at leases signings. Members interviewed said they signed standard leases, but some were uncertain where to locate their leases. | remotely and access to a physical copy stored at the office is not possible. |
| 5.1.b | Extent to which tenancy is contingent on compliance with program provisions | 1, 2.5, or 4<br><br>4 | Eighty-four percent (84%) of tenants live in housing without special rules or compliance provisions outside what would be found in a standard lease agreement. Some clinic staff interviewed said that vouchers from one housing administrator could be assumed for people receiving behavioral health services. One clinic staff stated the opinion that some property managers monitor PSH tenants more closely and are less lenient with minor lease infractions they might otherwise ignore.<br><br>Nine (16%) of 56 of tenants live in housing, such as CLP, group, or temporary placement, where tenancy may be based on following rules and provisions related to sobriety, possession of alcohol or participation in meetings such as Alcoholics Anonymous. | |
| **Dimension 6<br>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<br><br>3 | The majority but not all clinic staff interviewed have some familiarity the *Housing First* philosophy and appear to embrace it as a basic need from which recovery starts. Some clinic staff appear to employ a continuum of care approach to housing, whereby members are encouraged to accept housing with some level of staff monitoring and/or treatment and move to lower levels of care, potentially to independent housing, as they achieve treatment milestones or are assessed to | • Train clinical teams to avoid imposition of housing readiness criteria and instead provide members seeking housing with information on how to access available housing options, including independent housing. When skill deficits are assessed, clinic staff should offer wrap around support, framing their benefits to support success in the member's stated housing goal. |

| | | | | |
|---|---|---|---|---|
| | | | have reached preferred skills. Staff at one clinic described efforts to first steer more symptomatic members and those struggling with activities of daily living/independent living skills toward staffed and semi staffed settings to learn skills and later explore step down to independent housing. Some clinic staff embrace the *Housing First* approach from a clinical perspective, noting that members who are housed are easier for them to locate. Most clinic staff agreed that members in independent housing should be referred for housing support services to improve housing retention. PSH staff reported seeing considerable progress in the embrace of the *Housing First* approach at the clinic level. One PSH staff attributed this partly to the public health emergency and clinic staffs' urgency in ensuring member' health and safety. | • Ensure all clinic staff with a role in assisting members in accessing housing receive training and mentoring in the Housing First philosophy and its role in recovery. |
| 6.1.b | Extent to which tenants with obstacles to housing stability have priority | 1, 2.5, or 4<br><br>2.5 | It was unclear if clinic staff interviewed have a shared understanding of how members are prioritized for housing. Some clinic staff did recognize the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as measure for determining the type of housing program for which a member might quality based on vulnerability scores. Some clinic staff interviewed discussed the urgency in housing members who are chronically homeless and medically and psychiatrically fragile such that remaining unhoused could result in death<br><br>Members receiving vouchers have usually been prioritized for subsidy before referral to the PSH program. The agency reported that they do not maintain a waiting list, yet one clinic staff reported the agency always having a waitlist. It appeared that all tenants who meet eligibility requirements | • System partners should ensure that clinic staff assisting members with accessing permanent supportive housing and services across all provider clinics have a common and accurate understanding of eligibility and prioritization. Lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results.<br>• The PSH program should formalize a procedure to prioritize support for those members/tenants with the most significant housing challenges.<br>• If possible, identify trends or at what point(s) there are delays between referral and intake. If a trend appears linked to a particular provider or clinic, collaborate |

| | | | | |
|---|---|---|---|---|
| | | | have equal access to housing search and support services. Some Link staff said that the program did not prioritize members for assistance with housing. However, one Link staff said that if a member's voucher was about to expire, had received a 10-day eviction notice, or had an immediate health risk, such as the COVID-19, the program would make them a priority.<br><br>Some clinic case managers said that the Link program follows up with and schedules intakes with members quickly. However, data provided the reviewers showed that in about 12 instances (19% of 64 housed and unhoused members) intake did not occur for 30 days or more after the referral. *Although unrelated to scoring of this item, some potential impact on access could be created when delays in intake occur*. Link staff stated that some members are difficult to schedule due to other appointments with providers and that some members have been reluctant to engage upon referral follow up due to concerns about the public health emergency. | with staff from those clinics to streamline processes. |
| | | **6.2 Privacy** | | |
| 6.2.a | Extent to which tenants control staff entry into the unit | 1 – 4<br><br>4 | Most members live in units where they have control over staff entry. Clinic and PSH staff interviewed reported that they do not hold keys or enter units without permission. About 16% of members live in units that have some level of on-site staff presence and do not have complete control, since there may be scheduled groups, or home visits, or staff may be invited in by other residents. | • For members that reside in settings where they do not have full control over entry to their unit, assist them in exploring other housing options and/or confirm that their current situation aligns with their housing goal. |
| | | **Dimension 7<br>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<br><br>4 | Most members interviewed appeared to see themselves as the primary authors of their service plans. Clinic staff said that service plans are developed around what members identify as recovery goals. One clinic staff said that when members sign their service plans, they make a commitment to their recovery. Members reported choosing the services they want at their assigned clinics. Some members said that since the public health emergency, their clinics have eliminated or cut back on some groups and activities provided through the clinics. Some clinic service plans appeared to be more member focused than others. One PSH staff interviewed expressed that clinic service plans are often rote and jargon laden. Records reviewed showed some variation of needs and objectives in service plans between members. | |
|---|---|---|---|---|
| 7.1.b | Extent to which tenants have the opportunity to modify service selection | 1 or 4<br><br>4 | Interviewees reported the shutdown related to the public health emergency and related staffing issues may have resulted in less attention to providing members with opportunities to review and modify service selections. One member interviewed reported not having a new Case Manager assigned after the previous one left the team. However, most service plans were updated at least twice a year. Variations were seen in service plans year to year. A member interviewed stated that they decide what is on their plan and their ideas are respected; all members interviewed said they could update clinic service plans when wanting to make a change. One Link staff reported that a member noticed goals/services on their service plan to which they had not agreed, and others have reported that they never have seen their clinic service plans. | |
| **7.2 Service Options** | | | | |

| 7.2.a | Extent to which tenants are able to choose the services they receive | 1 – 4<br><br>3 | Staff and members interviewed reported that members choose the services received in the PSH program. One clinic case manager described service plans at SBHS as member driven and strengths based. SBHS service plans and progress notes examined by the reviewers showed housing support services that were individualized and delivered at the rate requested by members. Members can choose from a range of housing support services upon entry, including direct assistance with housing searches, support in completing and submitting rental applications and supporting documentation, education and guidance in budgeting, help with packing and organizing, and supportive counseling to enhance problem solving and coping skills. Members can also have access to more formalized in-home or telehealth counseling services offered by the agency for matters such as grief/loss, depression, or relational issues.<br><br>Members must be clinically enrolled to retain the RBHA affiliated voucher or subsidy housing, but do not have to participate in clinic services. | • For RBHA affiliated vouchers, the agency may have limited ability to affect this area under the current system structure. If possible, considerations should be made to extend the voucher benefit for a period of time after disenrollment. Efforts may include exploring alternative funding sources that do not require enrollment in the RHBA system for eligibility. |
|---|---|---|---|---|
| 7.2.b | Extent to which services can be changed to meet tenants' changing needs and preferences | 1 – 4<br><br>2 | Records reviewed showed that PSH staff update and review service plans with members every three or four months. Members self-rate their progress toward goals at service plan reviews. However, when goals are accomplished, members are discharged from the program; the program does not provide monthly check-ins with members not working on specific housing goals. One record showed that when a member expressed anxiety about being on their own after PSH staff discussed potential discharge with a member, the staff then explained that services were meant to be short-term and that their case manager could re-refer if | • SBHS should evaluate aspects of their expectation of short-term services. PSH programs are designed for those with the most significant challenges to housing stability and retention and who often need long-term support service. Although a re-referral may be sufficient for members with a stable history of tenancy and adequate self-advocacy skills, many tenants, especially those who have experienced repeated episodes of eviction and homelessness, benefit pro-active check-ins that can avert problems before they arise. |

| | | | | |
|---|---|---|---|---|
| | | | needs arose. Members who are discharged from the Link program can continue to receive counseling from the in-home program, and progress notes indicate in some cases the service focuses on coping and problem solving that supports tenancy. Members interviewed stated that could change their service selections. | Housing support services can be delivered at decreasing intensity over time but at a frequency greater than what most clinical teams provide. |
| **7.3 Consumer- Driven Services** | | | | |
| 7.3.a | Extent to which services are consumer driven | 1 – 4<br><br>1 | The agency also runs an activity program, Adventure Club with a peer support component, although most opportunities for in-person interactions were put on hold due to the public health emergency. Staff said that two Recovery Support Specialists staff are available to provide peer support to PSH participants. However, program design and provision of services appear staff controlled, without an obvious mechanism by which peers have a collective voice such as a PSH member advisory committee or member meeting. The reviewers were provided a copy of the *SBHS Customer Satisfaction Survey*, but it is general to the agency and does not ask PSH program specific questions. No members, or previously enrolled members of the program were reported to be active participants on a Board of Directors. | • Explore opportunities that allow tenant/member input on service design and service provision. Member input can be obtained in many ways, such as interviews by peers and involvement in quality assurance activities, where information gathered is used to inform service design decisions.<br>• Consider revising the agency satisfaction survey to include housing specific items. Consultation with other PSH providers on survey formats may be helpful. |
| **7.4 Quality and Adequacy of Services** | | | | |
| 7.4.a | Extent to which services are provided with optimum caseload sizes | 1 – 4<br><br>4 | PSH staff interviewed reported that as a result of the public health emergency, the program received fewer referrals. Staff said some members were less interested in engagement in services due to concerns about their health risk. Additionally, some staff left the program, and it was difficult to find new staff that were interested in working in the community. Although, the reviewers were told | |

| | | | | |
|---|---|---|---|---|
| | | | that the current roster was roughly half of what it had been before the public health emergency, two new staff have recently been hired. Staff said that rosters usually range from 14 – 16 members. Of the seven BHTs providing services to members/tenants, caseloads ranged from six to fourteen, and compromised a mix of members determined as either SMI or general mental health. | |
| 7.4.b | Behavioral health services are team based | 1 – 4<br><br>3 | Within the behavioral health system, most tenants receive the majority of their psychiatric care and case management services through separate behavioral health clinics and may have still other services, such as substance use treatment and supported employment, from outside providers. The Link program primarily assists members with housing searches and supportive and skill-building services to find and retain housing. Some member records also showed participation in other SBHS programs such as formal in-home and site-based counseling, participation in socialization groups, or pre-employment activities. One Link staff interviewed described case managers as helpful and responsive, adding that the public health emergency has improved care coordination since clinic staff are meeting in-person with members less often. However, it appeared that one Link participant was referred internally for counseling, yet neither evidence of staffings nor coordination of care with the assigned clinical case management team were located in the record.<br><br>Clinic staff interviewed reported good communication with the Link program via phone calls and emails. A review of Link and some clinic electronic records showed some evidence of Link staff sharing agency service plans with case | ● Optimally, all behavioral health services are provided through an integrated team. Separate providers create barriers to this, such as separate intake processes and electronic records systems, redundancy in information gathering and record keeping, etc. When an integrated service plan is not possible, staff should obtain input from each other when modifying plans. Updated service plans and monthly service summaries should be shared when completed, stored in the member's electronic record, and, if feasible, flagged for the case manager's review.<br>● System partners should collaborate to create a culture of a team of providers that coordinate care on behalf of members rather than operating in silos. |

| | | | | |
|---|---|---|---|---|
| | | | managers and coordination of care. However, records from one clinic showed staff were unaware of whether members were engaged in PSH with SBHS or with whom. A case manager at one clinic said that before the public health emergency they had more in-person meetings with Link staff. Clinic staff reported that they do get invited to meetings with Link staff and members to review service plans, and evidence of this was located in clinic and PSH member records. One case manager reported mostly referring members to the Link program for housing support, describing staff as efficient, well-trained, supportive of members, and communicating well with the clinical team. Another case manager expressed that the PSH initiative would produce better care coordination if it were all run through the behavioral health clinics. | |
| 7.4.c | Extent to which services are provided 24 hours, 7 days a week | 1 – 4<br><br>4 | Link program material provided to the reviewers stated that staff are available to members 24 hour a day, seven days a week. Link staff told reviewers that on-call responsibilities are shared between several of Link's direct service staff, with supervisory staff providing back up. The service is for housing related emergencies, but on-call staff can assist members in connecting to their clinical team and crisis services if they are having a behavioral health emergency. One record reviewed showed a crisis call, which the on-call staff was able to support the member in de-escalating over the phone. Staff said they can go on site if necessary but that it is rarely needed. | |

**PSH FIDELITY SCALE SCORE SHEET**

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

| | | |
|---|---|---|
| 5.1.b: Extent to which tenancy is contingent on compliance with program provisions | 1,2.5,4 | 4 |
| Average Score for Dimension | | 2.5 |
| 6. Access to Housing | | |
| 6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units | 1-4 | 3 |
| 6.1.b: Extent to which tenants with obstacles to housing stability have priority | 1,2.5,4 | 2.5 |
| 6.2.a: Extent to which tenants control staff entry into the unit | 1-4 | 4 |
| Average Score for Dimension | | 3.17 |
| 7. Flexible, Voluntary Services | | |
| 7.1.a: Extent to which tenants choose the type of services they want at program entry | 1,4 | 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 | 3 |
| 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 | 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 | 3 |
| 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** | | 22.05 |

| | | |
|---|---|---|
| **Highest Possible Score** | | 28 |