PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: John Moore, Chief Executive Officer

From: Georgia Harris, MAEd
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AHCCCS Fidelity Reviewers

Method

On May 1- 3, 2017, Georgia Harris and Karen Voyer-Caravona completed a review of the Marc Community Resources Permanent Supportive Housing Program (PSH), known as the Hope Network. 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 operation since the 1950s, Marc Community Resources, Inc. (Marc) is a non-profit agency that provides educational, rehabilitative, therapeutic, and social services to people with physical and/or behavioral health challenges. Marc's Hope Network program provides PSH services to Maricopa County residents experiencing a Serious Mental Illness (SMI). The Hope Network office is located at 3737 North 7th Street in Phoenix, Arizona. The program does not own or manage any properties, but assist prospective tenants in their housing search and provides in-home support/PSH services to tenants who are currently housed. In addition, through their partnerships they engage in ongoing provision of furniture vouchers and over 300 home starter kits. The agency's implementation of PSH utilizes the Critical Time Intervention (CTI) approach, which loads services heavily during the housing search and initial move in period, then gradually withdraws services as tenants accomplish goals identified in their service plans. The program envisions participation for up to one year as tenants become more connected to natural and community supports. At the time of review, Hope Network program was serving 47 tenants.

In order to effectively review PSH services in Maricopa County, the review process also includes evaluating the working collaboration between the PSH provider and the referring clinics with whom they work to provide services. For the purposes of this review at Marc, the two referring clinics included were the Lifewell Oak and Terros Enclave clinics.

The individuals served through the agency are referred to as "clients", "members", and "tenants"; for the purpose of this report, the term "tenant" or "member" will be used. Direct service staff at the Hope Network may be referred to as "Peer Supports" or "Recovery Coaches", and will be referred to in this report as "Recovery Coaches" (RC).

During the site visit, reviewers participated in the following:

- Orientation to the agency;
- Group interview with four Marc administrators: the Chief of Operations, the Director of Supportive Housing and Transitional Services, the Associate Director of PSH Services, and the Program Manager for PSH.;
- Individual interview with the Director of Supportive Housing and Transitional Services;
- Group interview with four PSH Recovery Coaches;
- Group interview with six members who are participating in the PSH program;
- Individual interview with one Case Manager at Lifewell Oak clinic;
- Group interview with four Case Managers at Terros Enclave clinic;
- Review of agency documents including intake procedures, eligibility criteria, PSH Service Request form, PSH Orientation Packet, Hope PSH Program Parameters, PSH Program Protocol, program rules, copies of available tenant, leases and Housing Quality Standards reports, copies of member forum agendas; and,
- Review of 10 randomly selected member 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:

- Choice of housing unit: Once admitted to the Hope program, tenants are encouraged to select from a variety of units to find the one that best meets their needs and preferences. Also, tenants of subsidy vouchers are provided a reasonable timeframe in which to conduct their housing search, and can receive voucher extensions of up to 90 days or more to accommodate barriers such as felony convictions or eviction histories.
- Functional separation: Hope RCs ensure that landlords and property managers have no role in social service provisions. RCs do not engage in housing management functions but instead offer support in helping tenants avoid evictions and communicate effectively with property managers. Hope RCs do not maintain offices in any housing settings where tenants reside.
- Housing affordability: The majority of members participating in the Hope program reside in housing subsidized with vouchers and pay less than 30% of their income in rent. Members without an income pay no rent and receive assistance finding housing in which rent includes the utilities.

- Privacy/control of entry: Tenants have control of who enters their units. The Hope program does not maintain copies of keys, and evidence was seen in electronic records that RCs have declined landlord requests to enter units without tenant permission as a violation of tenant rights to privacy.

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

- Choice of housing type: Choice of housing type is constrained at the clinic level due to perceived or actual lack of availability of least restrictive or integrated options; some Case Managers or clinical teams may steer members to traditional settings, such a group homes and staffed/semi-staffed placement, based on lack of knowledge or acceptance of *Housing First* principles. System partners should continually engage relevant community stakeholders to increase the number of affordable units in Maricopa County. System partners should collaborate to ensure that clinical teams are educated about array of available housing options, the *Housing First* approach, and the role of intensive wrap around services in supporting independent, community based housing for individuals with the most serious behavioral health challenges.
- Priority to people with obstacles to housing: The system should clarify how eligibility for RBHA affiliated and subsidy voucher housing is prioritized; some Hope staff perceive that, after meeting eligibility criteria (homelessness, currently hospitalized, or exiting correctional settings) for placement on the waiting list, the system takes a “next in line” approach, rather than triage according to the acuity of need and chronic nature of obstacles to housing stability.
- Tenant services preferences: Agency service plan updates generally appeared to occur annually rather than with changes in clinical presentation, needs and preferences, or situational factors. Service plan goals should reflect individual member voice and a recovery orientation; needs and objectives should be similarly individualized to reflect how each member will attain their goals.
- The evidenced-based model of PSH calls for services to be available for as long as needed, where the member sets the pace around his/her specific requirements. The agency should consider technical assistance regarding how the time-limited aspect of CTI may conflict with this PSH principle.

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 2.5	Per interviews with some Case Managers (CM), tenant choice of housing type may be constricted at the clinic level when clinical teams steer members toward housing models based on perceived or actual availability. *Housing First* principles may not be universally understood or accepted among clinical teams. CMs said that members in immediate need of housing usually choose the housing type that is most readily available. Some CMs said teams determine the type of housing that is the best fit for members. Some CMs said that teams may determine that a higher level of care, such as Flex Care, is more appropriate and strongly encourage the member to seek that option. However, all CMs said that ultimately members can determine, unless guardianship or other legal mandate, the type of housing in which they want to reside.	• Marc should continue to partner with the RBHA and clinical providers to provide guidance on the PSH options available to members, as well as education on the benefits of PSH for tenants, such as how intensive and flexible wrap around services can reduce readmission rates to hospitals and other inpatient settings. • Empower clinical staff to welcome PSH programs as the primary choice for SMI tenants. • Continue efforts to educate property managers of the benefits of participating in subsidy voucher programs.
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are	1 or 4 4	Upon entry into Marc's Hope Network program, members have the opportunity to exercise choice and select units that best meet their needs and preferences. Staff interviewed said tenants are more likely to be successful when they are in units they have chosen and are satisfied with, and that tenants are encouraged to see at least three units before making a selection. Choice may be unintentionally constrained by income, limited availability of affordable housing in many areas of Maricopa	• Collaborate with housing advocates and stakeholders outside the behavioral health system to increase the availability of affordable housing options for members who do not receive subsidy vouchers.

	offered a choice of units		County, and increasing numbers of property managers and landlords who do not accept subsidy vouchers. Most members interviewed said they had their choice of units, but one member said her landlord put her in a studio unit next to the management office when she was supposed to receive a one bedroom apartment.	
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	The majority of tenants receive some form of subsidy voucher (RBHA, ABC Homeless Housing Program, or Bridge to Permanency). Tenants can wait for the unit of their choice without risk of discharge from the program or losing priority for services or units. Per interviews with Hope staff and tenants, members have 30 days to use their voucher. Staff reported that 30 days may be insufficient time for a successful apartment search for members who are homeless and difficult to locate, or those with barriers to housing such as felony convictions and eviction histories. When these concerns delay the attainment of housing, members, with the help of their CM, apply for extensions.	
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 vast majority of tenants use subsidy vouchers to assist in paying, or to pay entirely, the monthly rent. Tenants may choose to have roommates but guidelines and restrictions do apply. When applying for subsidy vouchers, members indicate on their application who will reside in the unit and that person is listed on the voucher. Roommates can be dependent children or adults, spouses, or caregivers. If the tenants of a unit would like a roommate to be added to the lease, they must seek approval from the voucher administrator. CMs and Hope staff reported that voucher administrators request their approval of roommates to ensure that the roommate will be someone who is a positive support, rather than someone who might exploit the tenant to engage in	• System partners should clarify policies regarding approval of roommates in scattered site settings so that, to the extent possible, they conform to those consistent with standard lease agreements.

			behaviors that would lead to the loss of tenant housing. Roommates must be added to the lease agreement, and if the roommate has an income, that individual is expected to pay half the rent. Some CMs interviewed acknowledged the potential for exploitation or abuse but expressed discomfort with having a role in determining with whom tenants can reside.	
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	Hope staff said that landlords are not involved in the provision of social services. Landlords may contact voucher administrators if problem behaviors occur, but it was reported that ABC and HOM Inc. focus conversations on “what is going to change” as an eviction prevention tactic. They do not have a role in providing social services or treatment. Hope staff said that they were aware of previous tenants living in affordable community housing where housing management had staff that provided social services; however, no current Hope program tenants reside in these settings.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Hope staff said that they do not carry out any property management functions such as reporting lease violations or collecting rent. Instead RCs focus on eviction prevention activities such as: helping members recognize behaviors or situations that could lead to eviction, supporting members in communicating effectively with landlords about maintenance concerns or difficulties with other tenants, or helping them find solutions when they are unable to pay rent.	

2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	The Hope program does not maintain offices at any apartment complexes or housing sites. RCs provide community-based services that may include services conducted at the tenant's residence when appropriate to their stated needs.	
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	Per data provided by the agency, the 44 currently housed tenants pay an average of 16% of their income toward rent. Members who do not have an income, but have a subsidy voucher, pay no rent. Two tenants holding some type of scattered-site voucher were listed as paying over 50% of their income in rent. One person in a self-pay unit paid over 74% of income in rent. One tenant living with family declined to provide the program with rent information.	• Continue to work with tenants who are paying over 30% of income for rent to find new units or assistance programs to help mitigate their rental costs.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 2.5	Per report, Hope RCs receive training in assessing safety and maintenance of housing units. Evidence of informal training in HQS was found in documentation provided to the reviewers. The agency has begun a process of working with voucher administrators to obtain copies of HQS reports where those inspections are conducted. At the time of the review, Hope had collected and provided the reviewers with 33 copies (75%) of HQS reports.	• Continue efforts to maintain copies of most recent HQS reports. • Continue efforts to train RCs in recognizing and helping tenants respond to HQS issues for properties that are not required to undergo these inspections (i.e. HUD properties).

Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Approximately 96% of housed Hope participants live in integrated settings, primarily using scattered-site vouchers. Two members reside in temporary living placements (TLP) with other people with disabilities. Tenants interviewed reported that housing units do not appear to be set aside for people with disabilities. Unintentional clustering of individuals with disabilities may occur as a result of the limited supply of affordable housing options in Maricopa Country.	• Continue to build relationships with landlords in diverse communities, with the intention of expanding housing opportunities for program tenants.
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	Staff interviewed reported that tenants sign their own standard leases and have rights of tenancy. Tenants interviewed agreed with this assessment. Leases examined by the reviewers appeared to be standard lease agreements. The agency is working with the voucher administrators and tenants to obtain copies of current lease agreements. The agency provided the reviewers with copies of 35 leases (80%). Hope did not have leases or occupancy agreements for three scattered site residents, tenants of TLP units (2) and or those living with family (4). Incomplete data is reflected in the score.	• Maintain complete and accurate records of leasing information for tenants in all settings, including those living with family and significant other(s). Living with family does not guarantee rights of tenancy.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Staff and tenants interviewed reported that their leases contained no special provisions specific to people with disabilities, nor were they subject to any rules requiring compliance with treatment. Two members (4.5%) are currently tenants of TLP settings where program requirements are in place.	

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	It appears that some CMs may attempt to impose readiness standards (for example, one record showed a CM attempting to tie attainment of treatment goals such as sobriety with access to independent housing). Nonetheless, most CMs said that ultimately members decide when they are ready. While the Hope program does not impose readiness standards, it was unclear to the reviewers if the program is prepared to provide the intensity of supports required by the more chronic or profound barriers to housing retention. One Marc staff noted that if a tenant has experienced repeated evictions they may not be ready to participate in the scattered-site voucher program.	• Continue efforts to educate and empower clinical teams to welcome independent housing within integrated settings (coupled with PSH services) as the primary option for tenants diagnosed with an SMI.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Per agency provided documents, eligibility for the Hope Network program is based on an SMI diagnosis and having a scattered-site voucher or some other form of income. The RBHA requires an SMI diagnosis, homelessness (including living in a shelter or leaving an institution such as a psychiatric hospital or correctional setting), a Vulnerability Index – Service Priority Decision Assistance Tool (VI-SPDAT) score of 8 or above, and enrollment in the RBHA to qualify for voucher subsidies. Staff interviewed said that the current system is structured so that once a person is deemed eligible for placement on the waiting list of scattered-site housing, vouchers appear to be awarded on a "next in line" basis rather than "who is at immediate risk of dying". Most new program participants are referred from various system partners, such as psychiatric hospitals and provider clinics. Some referrals come internally and members can self-refer. While the Hope Network	While system constraints may not allow full alignment with this area, system partners should clarify and ensure staff have a shared understanding of how priority is determined for scattered-site vouchers and community housing options.

			focuses their recruitment efforts on those within the SMI population who are in the most immediate need of housing, they are also open to providing house search and support services to general mental health clients who would benefit from a *Housing First* approach because of immediate risk of dying on the street.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Per staff and tenant report, Hope Recovery Coaches do not enter units without specific permission from tenants. The program does not hold keys to tenant units. Tenants said that property managers must give advance notice before entering their units. Some landlords may request social service providers to enter units without permission; documentation showed that one clinic CM declined to enter a unit without permission since it was a violation of the tenant's right to privacy. A small number of members live in TLP settings where they do not have full control of entry.	
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	The majority of tenants participating in the Hope program have been awarded some type of subsidy voucher, most often a RBHA scattered-site or ABC Homeless Housing voucher. Per the record review, clinic service plans showed that members wanted independent units in the community. All members appeared to receive their preferred housing type.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	The majority of clinic service plans were updated once every 10 – 12 months. Documentation showed that most treatment plans were not regularly updated to reflect significant changes in circumstances, as recorded in daily notes, with specific and individualized needs and objectives	• Tenant service plans should be updated to whenever there is a significant change in the tenant's life situation or goals, needs, and/or objectives.

			relevant to retaining housing. Marc staff said that tenant service plans are reviewed every six months but more often if needed. This was not reflected in the record review, however. While progress notes often reflected new needs with over half of Marc tenant service plans, over half of those service plans had not been updated in more than six months.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Marc staff said the importance of member choice is discussed during the intake and referred to in the Marc orientation binder. Tenants interviewed said that they believe they can choose the services they receive. For maintaining RBHA scattered-site vouchers, both tenants and Marc staff agreed that no specific service requirements are imposed upon tenants beyond maintaining enrollment in the RBHA and with clinical services. Tenants must remain engaged with the Hope team in some way to remain open with the program; usually a once a month check-in is agreed to ensure a successful transition to graduation.	• 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 2	Marc staff use a self-sufficiency matrix to guide the treatment planning process. Staff said that all tenants have a housing goal, either to obtain or maintain housing, as a starting point, and that transportation services are also usually included. Typically, the housing goal assumes primary focus in the initial stages of the program, followed by other unmet needs as identified in the self-sufficiency matrix and by the tenant during the course of service. The review of clinical notes showed RCs accommodating a range of unique service requests, sometimes identified spontaneously according to the tenants' immediate concerns.	• Marc should consider revisiting aspects of CTI that promote the expectation of time limited services, graduation, and transfer of services to other providers. PSH programs should provide the opportunity for tenants to receive long-term service and supports at their preferred intensity level.

			The Hope program follows the CTI model; it is understood upon program entry that tenants should expect to build self-sufficiency through the Hope program and graduate, usually within a year. This expectation appears to create tension for some members and has potential conflicts with the PSH provision for access to long-term service and supports. Staff said they prepare tenants for graduation, letting the relationship come to a natural end while dealing with the reality of intimacy that has developed. Staff said that some tenants, such as those who lack a natural support system, will never feel comfortable ending services; in such cases tenants might be offered transfer to Marc's In-Home Support program. According to staff, that program is separate from the Hope program and offers in-home support to those who just need help a few days a week but are not in jeopardy of losing their housing. Several tenants, however, reported deeply engrained patterns of isolating and inability to state their needs, and expressed acute awareness of the graduation expectation. Tenants expressed considerable concern that their RCs, who are peers, were critical to their housing success. They also felt that their clinical teams were too overwhelmed by high caseloads to meet their housing support needs, and that their families (who often contributed to stigmatization and trauma) could not be relied upon as healthy support.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 3	Services in the Hope program are delivered by individuals with the lived experience of serious mental illness and/or substance abuse. In the last year the agency instituted a PSH Member Forum; meetings occurred in November 2016 and again in April 2017, which were attended by five and three members respectively. The focus of the meetings	• Continue efforts to create opportunities for members/tenants to participate in collective decision making within the agency. Consider strategies that encourages the Member Forum to evolve into a Tenant Advisory Council in which members actively participate in shaping

			was to provide education and information to tenants, as well as obtain their feedback about services. Staff said that the agency promotes an open door policy, provides tenants with staff phone numbers in their orientation packet, and has a formal complaint process.	policy, decision making, education, quality assurance, and advocacy.
		7.4 Quality and Adequacy of Services		
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	At the time of the review, four Recovery Coaches served 47 Hope program participants, both housed and those not yet housed, for a member to staff ratio of 12:1. RCs reported caseloads ranging from five to 15.	
7.4.b	Behavioral health services are team based	1 – 4 2	In the current system structure, individual CMs are responsible for all behavioral health coordination for tenants. RCs are not assigned to clinical team or regularly participate in weekly treatment teams meetings. Most communications occur through email or over the phone, although face-to-face staffings do occur. As a result, the team approach is missing for those tenants who are not on ACT teams, which usually are the provider for their members. Hope program tenants often receive behavioral health services from a number of different providers, from general counseling psychotherapy to substance abuse treatment groups. Signed release of information forms (ROI) facilitate direct communication between various providers but sharing of information may not be consistent across the system. In cases where the tenants need services that can be provided by Marc (such as DBT), or another agency, Hope RCs must notify the clinical team so that the need is noted on the member's ISP. The CM can make a referral, or since Marc also creates their own ISP with members, RCs can make the referral directly.	• Based on the structure of the system, housing programs are handled as a specialty service referral, rather than an integral part of psychiatric case management services. Therefore, it may not be possible for Marc to provide services through a team. The RBHA, provider clinics, and PSH providers should explore the possibilities for integrating housing providers/specialists into supportive and connective level teams. For the time being, Marc should continue efforts to coordinate as much as possible with the assigned SMI treatment teams.
7.4.c	Extent to which	1 – 4	Services are not provided 24 hours a day, seven days	• Explore the potential for providing after

	services are provided 24 hours, 7 days a week	2	a week. Hope services operate between 8 a.m. – 4 p.m., Monday through Friday, although RCs can flex their hours to assist members with particular needs after regular business hours. Staff said they can offer general, over-the-phone support 24 hours a day, every day but do not provide crisis support services; RCs educate tenants on the crisis line, the warm line, and accessing their clinical team. RCs give tenants Emergency Cards with phone numbers for various crisis and emergency services. RCs will visit tenants in the hospital but do not transport or assist with admissions.	hours services through an employee pool or through collaboration with another agency. • Consider fostering relationships with local peer run agencies to provide extended and/or weekend support opportunities for tenants.

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	4
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	2.5
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	1,4	1

housing unit		
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	1
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	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	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		2.63
Total Score		22.8
Highest Possible Score		28