PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: January 3, 2019

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AHCCCS Fidelity Reviewers

Method

On December 3-5, 2018, TJ Eggsware and Annette Robertson completed a review of the Arizona Health Care Contract Management Services, Inc. (AHCCMS) Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

AHCCMS' website describes PSH at AHCCMS as voluntary; with flexible services that assist people to obtain safe, decent, integrated affordable housing where no special rules or service requirements exist. Members are referred to the PSH program through two primary routes: (1) direct referrals by clinic teams; (2) voucher programs, including through the Regional Behavioral Health Authority (RBHA). Members directly referred by clinic teams may already be housed and can benefit from tenancy retention support. The program can also assist them to obtain housing. Members who receive vouchers are offered a choice of service providers to assist them in their housing search. Referral to AHCCMS' PSH program often occurs after members are notified they will receive a voucher.

Over the course of the prior year the organizational structure at AHCCMS changed and impacted the PSH program. The Clinical Coordinator position no longer exists in the PSH program. One of the previous staff who held that position now holds the title of Clinical Supervisor. The PSH Program Director now oversees the residential and community living branches at AHCCMS and holds the title of Clinical Director. One of the direct care staff transitioned to act as a Community Resource Coordinator (CRC) for AHCCMS' PSH, community living and residential programs. Another direct care staff conducts intakes and carries a reduced PSH caseload.

Due to system structure with separate treatment providers, information gathered at the Partners in Recovery East Valley Campus Integrated Health Home and Southwest Network Estrella Vista location were included in the review as sample referral sources. However, records reviewed and members interviewed during the review at AHCCMS were not exclusively served at those clinics.

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

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

- Overview of the agency with the Chief of Behavioral Health Services and the Clinical Director;
- Group interview with the Clinical Director and the PSH Clinical Supervisor;
- Group interviews with AHCCMS direct service staff: the Community Resource Coordinator (CRC) and three Community Support Workers (CSW), one of who is also the PSH program Admissions Coordinator;
- Group interview with eight tenant/members who are participating in the PSH program;
- Review of documents including: AHCCMS' PSH program organizational chart, the program brochure and flyer, job descriptions, mission and values statement, AHCCMS PSH Member Survey, and, the *Permanent Supportive Housing Procedural and Guideline Manual*;
- Review of ten randomly selected member records at AHCCMS, including clinic record reviews for a subgroup of those members.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing (PSH) model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the PSH model along 7 dimensions: Choice of Housing; Functional Separation of Housing and Services; Decent, Safe and Affordable Housing; Housing Integration; Right of Tenants, Access of Housing; and Flexible, Voluntary Services. The PSH Fidelity Scale has 23 program-specific items. Most items are rated on a 4 point scale, ranging from 1 (meaning *not implemented*) to 4 (meaning *fully implemented*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) rate on a 4-point scale with 2.5 indicating partial implementation. Four items (1.1b,5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

The PSH Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Most members interviewed reported their satisfaction with services through AHCCMS.
- AHCCMS staff assists members in selecting units that align with their preferences and transport them to visit multiple units of interest.
- Functional separation exists between housing management and PSH staff. AHCCMS PSH services staff do not have any role in housing management functions and property managers are not involved in service provision. PSH staff, with tenant permission, advocate for tenants with landlords to prevent evictions and to support successful housing retention.
- AHCCMS' PSH members reside in integrated settings where they control access to their residences.
- Support services are available through AHCCMS PSH staff 24 hours a day, seven days a week, including the ability to respond to members in the community after normal business hours.

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

- Stakeholders, including AHCCMS, should seek opportunities to educate referral sources on *Housing First* principles. Most clinic staff interviewed were not familiar with the term. Further education in housing first principles may support staff who make referrals to PSH programs, and better equip them to understand the benefits of accurately assessing and providing suitable services to members in support of their independent living goals. PSH is intended for members with the most significant housing challenges.
- Clinic staff should ensure members who voice an independent living goal are supported to pursue that option. The focus of assessment should be on supporting tenancy.
- Staff at clinics, AHCCMS, and system stakeholders should continue their efforts to increase independent housing options. Continue to cultivate relationships with landlords and representatives of subsidy programs, and promote the benefits of PSH services in successful tenancy.
- Support members who are not affiliated with voucher programs to live in safe, affordable housing where they have rights of tenancy. Some tenants are in settings where it is unclear if they have rights of tenancy (i.e., no formal lease) or are safe (i.e., no HQS).
- Some members interviewed voiced their desire for more detailed information regarding what services the PSH program can provide. Reorient members to the scope or limits of PSH services at AHCCMS. Though treatment plans list general services available for identified needs and objectives, some members expressed they were unsure of the scope of PSH services.

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	Staff at one clinic reported if members request independent housing they are supported to explore their options. However, some members appear to have a restricted choice in housing types. At one clinic, if a member is assessed by clinic staff to not be ready for independent living, a treatment setting may be recommend versus independent housing. Staff cited concern with referring members to independent living too soon before learning certain independent living skills. One member identified on their clinic service plan that they wanted to live independently. The member was in a treatment setting and transitioned to a less intensive treatment setting before independent living. However, staff reported that members cannot be forced into a setting without their agreement. Affordability and access also contribute to constrained choice. Some clinic staff reported that in order to refer members to AHCCMS for PSH services, they need income or a voucher. Members have fewer avenues to access an integrated, affordable residence due to limited subsidy opportunities. If a member is not homeless, they are ineligible for subsidies through the RBHA or certain programs. Members who have a subsidy may experience	• Stakeholders, AHCCMS, and system partners should collaborate to provide ongoing training to clinic staff. Introducing referral sources to Housing First principles may aide them to support member choice and self-determination. • AHCCMS staff should inform clinic staff if members can be referred to AHCCMS' PSH program without a voucher or income. • System partners should work with affordable housing stakeholders toward advocacy efforts to increase the availability of affordable units with attention to removing barriers to housing. At the program level, build on the tracking system developed and efforts to cultivate resources to increase access.

			barriers to locate housing. Staff reported fewer landlords are open to rental agreements with members with vouchers. Another barrier is residences where rental costs are outside of the voucher allowance. Rental increases at renovated complexes often result in housing costs outside of voucher limits. Some landlords require applicants to have an income of twice or more of the monthly rental cost. Members with prior criminal convictions or evictions face added obstacles. In AHCCMS' records, an example was documented of a landlord taking into account evictions from the prior seven years.	
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	AHCCMS staff described gathering information from members about their housing preferences once they are admitted into the PSH program. Examples were found in AHCCMS' member records of PSH staff assisting members to explore available housing options based on their preferences. PSH staff usually met with members at least once a week to visit options. Most members interviewed reported they were afforded a choice of unit. Some reported constraints due to fewer options that offered amenities or certain accommodations, such as first floor units. AHCCMS staff said they track housing options including: rental costs, requirements, restrictions, and whether or not landlords accept vouchers.	
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	There is no waitlist for AHCCMS PSH services. A section of AHCCMS' *Permanent Supportive Housing Procedural and Guideline Manual* outlines the prioritization of members if the PSH program reaches capacity. Members who are homeless as defined by the RBHA are the first in a list of prioritized statuses.	• Continue efforts to streamline the referral process to PSH. Optimally those supports occur soon after members express an interest in housing services.

			Wait time for a voucher usually occurs before members are referred to PSH. Members may be placed on multiple distinct wait lists. Members who apply to programs not connected with the RBHA are subject to waitlists or application processes associated with those programs (e.g., Coordinated Entry, Section 8). For members with vouchers, AHCCMS and clinic staff interviewed said that members have 30 days upon receiving a voucher to find housing. Clinic staff can request extensions if members actively search for housing. This can allow for up to 120 days to locate housing, if needed. Common factors delaying using the vouchers relate to the constrained housing market and fewer locations that accept vouchers outlined earlier in this report. AHCCMS staff also said that occasionally, members are referred near the end of the time that their voucher is set to expire. Based on records reviewed, it appeared members may experience delays in first contact with their primary staff assignment at AHCCMS. In one record reviewed, a member's voucher expired well before referral to PSH. The referral process beginning at clinics can be rapid but may be delayed. One staff at AHCCMS conducts the intake process and schedules the intake meeting. Clinic staff is asked by AHCCMS to be present for the full intake session and typically is two separate sessions due to volume of information gathered. If the meeting needs to be rescheduled due to member or staff request, the intake is delayed. After the intake meeting, the primary PSH staff contacts the member. The staff may meet with the member that week or the	

			following week.	
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	Tenants who do not receive a voucher control the composition of their household. AHCCMS staff reported tenants with vouchers do not require authorization from clinic or AHCCMS staff if tenants want to add someone to their lease. Some clinic staff reported that voucher administrators have to approve it or ask for clinic team input whether members can have someone join their lease. Some clinic staff reported they were instructed by agency leadership to not link members with others as possible roommates due to the potential liability if a negative situation arises. Members in treatment programs or congregate settings often share living space with roommates not of their choosing. However, at the conclusion of the review, no AHCCMS members were in treatment or congregate living settings.	• Work with voucher administrators (i.e., housing providers) to educate members and clinics on the process of adding others to leases, while supporting member choice in controlling the composition of their households, rather than seeking clinical team approval. Empower tenants to have full control over the composition of their household by discussing pros and cons of having someone join their living situation. This type of interaction can support member choice if no outside approval is required.
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	At the conclusion of the review, no members were in settings where there was overlap between housing management and service provision. AHCCMS does not own or operate any properties where PSH members reside. No housing management staff provide services.	
2.1.b	Extent to which service providers do not	1, 2.5, or 4	AHCCMS staff have no role in housing management. They do not report violations of lease agreements and do not enforce any tenancy	

	have any responsibility for housing management functions	4	rules. PSH staff, with tenant permission, advocate for tenants with landlords to prevent evictions and to support successful housing retention.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	AHCCMS' PSH tenants live in independent settings or with natural supports. AHCCMS staff do not keep office space in any building or complexes where PSH program participants reside. At the conclusion of the review, no PSH members were in settings where social service staff are located on-site.	
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	At the time of review, 31 of the 33 members were permanently housed. One member's living situation was in flux as of the date of review. A second member was not in permanent housing and was tenuously housed. Of the housed tenants, ten reportedly pay nothing toward housing costs. Slightly less than half of tenants (15) pay 30% or less toward housing costs. The remaining tenants pay more than 30%, and four of those tenants pay more than 50% toward housing costs.	• For tenants who pay more than 30% of income toward housing costs, explore their housing preferences in an effort to determine if more affordable housing is desired. A distinct cost burden exists when 50% or more of tenant income is used for housing costs, potentially leading to housing instability. Relocation and a reduction in housing costs can be viewed as a positive step for those members. Some may still choose to pay more than 50% of income toward housing costs.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Per data provided by AHCCMS staff at the time of review, 53% of locations where members reside meet housing quality standards (HQS). PSH staff reported they support members during their walk-through when they move into new residences. Staff assists those members, and established tenants, to report potential issues to landlords so they can be resolved. AHCCMS administrators	• Develop procedures to confirm if units meet HQS for those members who do not receive a RBHA affiliated subsidy. • Partnering with other system stakeholders may offer avenues to resolve barriers to ensuring members are in safe housing.

			reported they do not have the resources to contract the completion of HQS through the program. AHCCMS staff do not have any specific training in HQS standards. They reported challenges obtaining inspections from subsidy programs not affiliated with the RBHA.	
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Per interviews with AHCCMS staff and members receiving services, as well as a review of data provided, tenants live in integrated community settings. Many tenants live alone and some live with their natural/informal supports. Some clustering of people with disabilities may unintentionally occur due to fewer locations that accept vouchers and market factors cited earlier in this report. A small number of tenants reside in the same large apartment complex.	
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	Based on data provided, 66% of tenants have lease agreements, an increase from the prior year review. Subgroups of members are in settings where formal agreements may not exist. For example, individuals living with families or friends do not have leases. Evidence was found in records that staff made recent efforts to educate members of the benefits of lease agreements.	• Continue efforts to support members to develop rental agreements for those without. • Discuss with members how having a copy of rental agreements enables the agency to confirm they have legal rights to their housing units and better advocate on their behalf.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Per agency interviews, tenancy is not contingent on compliance with program provisions or participation in treatment. There was confusion at the clinic level as to whether tenants were required to maintain services. No AHCCMS members are in settings where tenancy is linked to	• Ensure clinic staff are informed of members rights as they relate to maintaining housing and needing to participate in programming.

			compliance with rules of the program or treatment participation.	
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	AHCCMS staff reported they do not impose readiness requirements at program admission or for housing searches. Some clinic staff reported their belief that in order to be referred to AHCCMS members needed an income or voucher. Clinic staff reported members cannot be forced to accept an alternative treatment program if they want to pursue independent housing. However, at one of those clinics, it appears team assessment of member readiness to live independently might result in referrals to treatment programs, even if members express an independent living goal. One clinic staff interviewed was familiar with the Housing First approach, but others were not familiar or could not explain the principle.	• Ensure clinic staff assessment is targeted at identifying what services may be beneficial in supporting members' living goals. • On a regular basis, provide refresher education to clinic staff on a Housing First approach. For example, include information related to Housing First whenever residential treatment or independent living options are discussed. After an orientation, referring staff may be better equipped to weigh the pros and cons of the approach over team assessment for readiness and referring members to treatment settings. • If no income or voucher is required to refer members to PSH services, continue efforts to educate clinic staff on program requirements.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Members are prioritized differently depending if they seek voucher/subsidy assistance. Some subsidy programs require members to be homeless. The RBHA website provides two different eligibility guidelines. In one area it notes that PSH is available. It explains that housing subsidies are available to enrolled homeless adults determined to have a serious mental illness (SMI). Under the same description of PSH, it notes supportive services are also available to enrolled members determined to have a serious mental illness. In another area on the RBHA website, it indicates	• System partners should clarify on applicable websites if PSH is restricted to only individuals who are homeless and determined to have a SMI. • With the current system structure, the agency has limited capacity to fully align housing priority with the EBP criteria. Any type of prioritization usually occurs before members are admitted to the PSH program.

			PSH is available to homeless adults determined to have a serious mental illness. In that area it does not differentiate subsidies from services. Members must have a Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) score in the range for PSH. All clinic staff interviewed seemed aware that members who were homeless were prioritized for subsidy programs. Referral to AHCCMS PSH requires a VI-SPDAT be submitted.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	AHCCMS staff and tenants reported tenants control access to their units. No members are in settings where social service staff are in the residence or can access it freely, such as halfway houses, boarding homes or treatment settings.	
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	Generally, clinic plans reviewed seemed to reflect members' housing goals. Certain needs and/or objectives listed similar elements (e.g., symptom management), but plans also included individualized content. Members can select a PSH service provider of their choice to assist them to obtain or maintain a residence.	• All service plans should be individualized and directly reflect the expressed goals, needs, and action steps for achieving those goals.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	Clinic staff reported that member service plans are updated a minimum of annually but as often as needed if changes occur. Examples were found in clinic records of service plan updates within the year of the prior plan. Though, some goals or other content appeared to be transferred from one year to another, there were examples of modification based on change in status. Some members interviewed at AHCCMS reported the clinic plans	• Ensure service plans are modified to reflect the member's current status, goals, needs, and services. PSH and clinic staff should obtain input from each other when modifying plans if an integrated single plan is not an option. This collaboration may prompt staff to revise plans for their prospective agency when members have a change in status

			do not always reflect their goals, using their words, nor do they always receive a copy of their plans. Some clinic staff reported they may rephrase member statements when writing plans.	necessitating a service plan review.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Members may choose whether or not to accept PSH services. The AHCCMS CSW/Admissions Coordinator meets with members and clinic staff to complete the PSH intake, including their first service plan. It was reported the first goal usually focuses on obtaining housing. The goals on those initial plans seemed to be written using the member's perspective. However, the information wasn't always phrased as a goal statement of what members wanted to accomplish. AHCCMS PSH programs offer a variety of services. Plans listed the general categories of services available. The content of AHCCMS' plans in the needs/objectives areas seemed individualized to members. The methodology (services) section tended to have similar content if similar needs/objectives were identified. Per staff interviews, members can terminate AHCCMS services with no impact on tenancy. Some clinic staff said members with RBHA affiliated subsidies cannot close clinic services or transition to Navigator status and receive the subsidy. If members close from clinic services, they cannot retain PSH services through AHCCMS.	• System partners should evaluate requirements for members to maintain vouchers/subsidies and/or PSH services if they elect to end clinic services. Educate clinic staff to the extent members can withdraw from clinic services and maintain tenancy and/or PSH services. • PSH staff may benefit from review of how to elicit forward oriented goal statements. PSH staff use the member's words on their plans. That approach, however, should continue.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 4	Based on interviews with AHCCMS staff, PSH services include supporting members to obtain and/or maintain tenancy, but extend beyond that focus. Examples were found in AHCCMS records of staff assisting members to identify housing that aligned with their preferences. AHCCMS staff	

			transported members to visit multiple units. Once housed, supports can vary based on member goals, needs and objectives. Staff at AHCCMS reported service plans are revised at least once annually or if member goals or statuses change. Reviewers were unable to verify if all plans were revised at least every six months based on records reviewed. The slight majority of reviewed records of members were admitted to the PSH program in the six months prior to review. Members interviewed confirmed plans are updated. Member reports varied. Some said updates can occur as often as they want, at least every six months, or that goals were discussed at least monthly. Based on documentation, members generally meet with CSWs weekly. One member interviewed reported that they meet with staff every two weeks but could meet weekly if preferred. PSH staff attempted to visit with members who did not respond to phone calls or missed appointments. PSH staff documented contact with clinic staff to coordinate care.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	Most member input is provided through one-to-one interactions with staff. AHCCMS staff reported they conduct member surveys at least every six months. The form utilized is an example of a written opportunity for members provide input. The survey asks whether member housing preferences were honored during program admission. Other areas prompt for member knowledge about PSH, Rights of Tenancy, as well as general information related to staff availability, whether member input is sought and honored and	• The member survey includes details about PSH services and general services available. The survey may be a useful sample to guide system partners who have less specific PSH surveys. • Explore avenues to obtain member input on service provision giving consideration to varying abilities of members' reading and writing skills. Member input can be obtained in many ways such as individuals

			member reflections on services provided. Space is allotted for member responses. AHCCMS staff reported that no members participated when offered advisory board meetings. However, during the member interview, some members voiced specific areas of input for service provision at AHCCMS. During the interview, members shared their experiences, possible resource leads and discussed programs that other members seemed unware exist.	with lived experience as staff, interviews by peers, council meetings, PSH tenant forums and involvement in quality assurance activities, committees, or board membership where the information gathered is used to inform service design decisions. • Consider organizing member led forums where input and feedback can be provided. Forums may also offer members opportunities to share resources with each other.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	There are three CSWs. One of those being a CSW/Admissions Coordinator. That staff carries a smaller caseload to allow more time to complete PSH program admissions. At the time of review, there were 33 PSH members. A Community Resource Coordinator provides support to staff and members of the PSH program and a Clinical Supervisor provides oversight, but neither carry caseloads.	
7.4.b	Behavioral health services are team based	1 – 4 2	AHCCMS staff reported the implementation of the Housing Specialist position at the clinics aids coordination efforts. Clinic Housing Specialists are the primary liaison between AHCCMS staff and clinic staff. In records there was evidence of coordination between AHCCMS and clinic staff. Some clinic staff gave examples of positive collaborative efforts. Other clinic staff gave examples of coordination lapses. Members are served by two or more distinct providers that maintain separate files. All members receive services through the referring clinic and AHCCMS for PSH. In addition to clinic	• Optimally, all behavioral health services are provided through an integrated team. Soliciting input, and sharing of service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented. This collaboration may prompt staff to revise plans for their prospective agency when members have a change in status necessitating a service plan review. • Member housing searches may occur in a more timely fashion if system partners reduce or eliminate redundant paperwork

			and PSH staff, other providers may deliver counseling, employment services or substance use treatment. Members have two or more service plans. Plans can have similar or different information across providers. Generally, it was reported providers do not consistently solicit or include input from the other agency's staff when service plans are updated. Similar documents are completed at AHCCMS' intake that members take part in at their referring clinics. Clinic staff reported they are required by AHCCMS staff to be present during the intake to that agency. Clinic staff estimated the process can be up to three hours. AHCCMS staff complete monthly summaries of PSH services delivered to each member, usually completed during the month after the services were delivered. Though, examples were found of summaries completed more than a month later. It was not clear if the delayed updates would have been beneficial to the clinic teams. Some clinic staff said monthly summaries were not regularly provided by AHCCMS. Other clinic staff were uncertain if summaries were completed, transmitted or filed into records.	or processes that can lead to delayed PSH service delivery. Some members face constrained timelines to utilize vouchers. Those with or without vouchers may be tenuously or not housed at all. • Consider assigning the member's primary PSH staff contact as soon as possible after referral to start the housing search or to provide more immediate tenancy support.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	AHCCMS staff reported that staff are available on-call to members 24 hours a day, seven days a week. After hour services include meeting with members in the community if member concerns cannot be resolved over the phone. Members confirmed staff are available. Some members shared examples of times they called staff over the weekend to share news.	

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	1
Average Score for Dimension		2.5
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	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	4
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		3
Total Score		22.42
Highest Possible Score		28