PERMANENT SUPPORTIVE HOUSING
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with the Western Interstate Commission for Higher Education Behavioral Health Program to conduct fidelity reviews using the Substance Abuse and Mental Health Services Administration (SAMHSA) Permanent Supportive Housing (PSH) Fidelity Scale, an evidence-based practice (EBP). PSH refers specifically to the EBP of helping members with a serious mental illness (SMI) designation find and maintain safe and affordable housing in integrated communities, rather than communities with disability-related eligibility criteria.

Method

On November 3 – 6, 2025, Fidelity Specialists completed a review of the **Resilient Health** PSH program. This review is intended to provide specific feedback on the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in Maricopa County.

Resilient Health (formerly PSA Behavioral Health) is a behavioral health agency in Arizona with locations across the state. The agency specializes in trauma-informed care and provides services for children, adults, and families to build resilience and support long-term recovery. Services are offered to a diverse population, including persons with serious mental illness, unhoused individuals, and those seeking housing stabilization and support services in community settings. The individuals served through the program are referred to as *clients*, but for the purpose of this report and for consistency across fidelity reports, the term *member* will be used. At the time of the review, the program was serving 143 members.

In order to effectively review PSH services, the review process includes evaluating the working collaboration between each PSH provider and the referring clinics with whom they partner to deliver services. For the purposes of this review, the referring clinics include Resilient

Health 1st Street Clinic and Southwest Network Estrella Vista Clinic. Some data obtained also reflects services provided by other partner clinics.

This review was conducted remotely using videoconferencing and telephone to interview staff and members.

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

- Individual videoconference overview of the PSH program with the Program Administrator.
- Individual videoconference interview with the PSH Program Manager.
- Group videoconference interview with one Case Manager and the Housing Specialist from Southwest Network Estrella Vista clinic and two Case Managers from Resilient Health 1st Street clinic.
- Group videoconference interview with four PSH program's Housing Specialists.
- Individual phone interviews were conducted with members receiving services from the PSH program. Of the 17 members for whom information was provided, one (1) was successfully contacted.
- Closeout discussion with the PSH Program Manager, PSH Program Administrator, PSH Agency Quality Management Director, and representative from AHCCCS, and the contractor with a Regional Behavioral Health Agreement (RBHA).
- Review of documents: intake procedures, agency *Outreach and Re-Engagement* 3.21policy, PSH program flyer, member leases, and safety inspection documents.
- Review of 10 randomly selected member records, including charts of interviewed members/tenants. as well as remote review of member records from the two partnering clinics, including a sample of co-served members. The sample included members from the following health plans: the contractor with a Regional Behavioral Health Agreement and Other (Medicare, private, or other source of coverage).

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 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, with little room for improvement*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) are rated on a 3-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 been fully implemented or not implemented.

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

Summary and Key Recommendations

The agency demonstrated strengths in the following program areas:

- Choice of Housing: Members are supported to choose their housing type, unit, and the services they wish to receive. Staff

accompany members to view units, honor member preferences, and allow them to decline units without penalty.

- Ability to Wait for Preferred Unit: Members are allowed to wait for the unit of their choice without losing placement on eligibility lists or vouchers. Staff continue the housing search when units are declined, support extension requests, and help members remain active on multiple waitlists.
- Housing Management Does Not Provide Social Services: Property managers do not deliver clinical or social services, and their role remains limited to standard property operations.
- Tenants Control Staff Entry Into Their Units: Members fully control access to their housing units. Staff do not hold keys, visits are scheduled in advance, and entry only occurs with explicit tenant permission. Safety concerns are addressed through appropriate external wellness checks, demonstrating full protection of tenant rights and privacy.

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

- Housing Meets HUD Housing Quality Standards: The program does not use a standardized, Department of Housing and Urban Development (HUD) Housing Quality Standards (HQS)-aligned inspection tool, and home visit assessments are inconsistently documented. Expanding the current home visit form to include HQS-based criteria and ensuring staff use it regularly would strengthen monitoring of housing quality and enhance advocacy for timely maintenance and repairs.
- Prioritization of Tenants with Obstacles to Housing Stability: Although staff generally prioritize individuals with higher vulnerability using the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT), this practice is not supported by a formal, agency-wide prioritization protocol. Clinical teams also lack a structured referral prioritization process. Developing clear prioritization criteria and communicating them across teams would ensure that members with the greatest housing barriers are consistently prioritized.
- Extent to Which Services are Consumer Driven: Record review showed inconsistent application of the agency's outreach and missed-contact protocol, including closures occurring with limited follow-up and minimal coordination with clinical teams. Strengthening adherence to the outreach procedure and documenting engagement attempts more consistently will improve alignment with Housing First principles and help prevent premature service closures.
- Behavioral Health Services are Team Based: Coordination between PSH staff and clinical teams is limited and inconsistent. Monthly summaries are no longer sent, integrated meetings do not occur, and communication primarily centers around crises or transitions. Enhancing routine collaboration with clinics would improve service integration and better support tenants' behavioral health and housing stability needs.

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., recovery home, private landlord apartment)	1, 2.5, or 4 4	Per the member, clinic, and PSH staff interviews, housing type is driven by member choice. Staff from both the clinics and the PSH program reported providing education on the full range of housing options to support informed decision-making. Although members are encouraged to pursue independent housing that is integrated in the community, staff noted that limited or insufficient income often constrains available choices. Active substance use does not disqualify members from obtaining housing; instead, treatment-based programs may be offered as an immediate housing option when necessary, while efforts to secure independent and integrated placements continue. Staff from both clinics and the PSH program emphasized that the scarcity of affordable housing remains a significant barrier to expanding independent living opportunities. The member interviewed indicated that PSH staff supported the member's housing choice and advocated for that choice to be respected by external property managers.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example,	1 or 4 4	Interviews with PSH and clinic staff indicated that members have full freedom to select their preferred housing unit. PSH staff reported accompanying members to view available units, and members may decline options that do not meet their preferences. Staff continue to support members in the housing search until a suitable unit	

	within apartment programs, tenants are offered a choice of units		is identified. Staff stated that members are offered comparable units regardless of voucher status, ensuring equitable access across housing types. Examples were provided of members obtaining units that reflected their personal preferences, such as choosing a specific floor level or apartment layout. Although property availability may occasionally limit immediate access to a desired location or unit, staff reported that members are encouraged to consider temporary alternatives and are supported to make the final decision. Review of PSH service plans did not reflect documentation of member housing or location preferences, though Interviews confirmed that these discussions often occur verbally during the housing search process.	
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	Interviews with PSH and clinic staff indicated that members are permitted to wait for the unit of their choice without losing eligibility or placement on housing waitlists. When members decline an available unit, staff continue to support the housing search until a suitable option is identified. Members with vouchers generally have 60 days from the issuance date to secure housing. When additional time is needed PSH staff coordinate with the clinical team and the housing authority or voucher administrator to request an extension, which is typically granted in 30-day periods. Staff explained that in situations where housing availability is limited, staff facilitate open discussions with members to ensure they can make informed choices regarding accepting available units or continuing their search. Members that choose to wait remain active on applicable waitlists,	

			and PSH staff maintain communication with property managers and housing authorities to ensure the member's eligibility status is preserved. The member interviewed described being accompanied by PSH staff to view apartments, submit applications, and remain on multiple housing waitlists while awaiting a preferred unit.	
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 member, clinic, and PSH staff reported that members have the ability to determine the composition of their household. Members in non-subsidized housing may select their roommates, provided property requirements such as applications and background checks are met. For members with vouchers, additional household members must be approved through the voucher administrator to maintain eligibility. PSH staff assist with required paperwork but do not influence members' choice of household occupants. Staff may discuss safety or behavioral concerns, but final decisions rest with the member in accordance with voucher and property guidelines. Data reviewed reflected that 48% of housed members control the composition of their households, and approximately 51% reside in settings where housing composition may be program-controlled, such as community living placements (CLPs) and halfway houses.	
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management	1, 2.5, or 4	Interviews with members, PSH, and clinic staff indicated that property managers and landlords are not involved in providing clinical or social	

	providers do not have any authority or formal role in providing social services	4	services to tenants. The role of landlords and managers is limited to standard property management functions such as maintenance, lease enforcement, and rent collection. PSH staff reported that while some private landlords may voluntarily offer informal support or alert staff to tenant concerns, landlords do not deliver or coordinate behavioral health or supportive services. Of the 122 housed members, approximately 15% reside in settings where there may be an overlap between housing management and other provider staff delivering social services.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	PSH and clinic staff reported having no responsibility for housing management functions. PSH staff reported focusing on providing supportive services, not lease enforcement, rent collection, or eviction decisions. Resilient Health (RH) operates short-stay hospital transitional housing (i.e., 30 days or fewer), therapeutic and transitional housing programs (e.g., FlexCare units), and a ten-unit apartment building overseen by designated non-PSH agency staff. Across these settings, members sign residence agreements outlining expectations for continued stay. PSH staff may remind members of these expectations when necessary; however, PSH staff do not perform property-management functions.	
2.1.c	Extent to which social and clinical service providers are	1 – 4 4	Clinic and PSH staff reported that no offices are maintained at locations where members reside. Services are primarily provided in the community or through home visits as needed. Approximately	

	based off site (not at the housing units)		18 members (15%) reside in settings where on-site staff may offer supportive services.	
Dimension 3 Decent, Safe and Affordable Housing				
3.1 Housing Affordability				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 2	Interviews with PSH and clinic staff indicated that members receiving housing vouchers or subsidies typically pay 30% of income toward housing costs, consistent with standard affordability guidelines. Members residing in low-income or market-rate housing without vouchers were reported to spend between 50% and 60% of income on rent. PSH staff stated that staff discuss housing affordability with members, including financial risks and limitations associated with various housing options based on available income. Program data showed that approximately 30% of housed members had housing vouchers or paid less than 30% of income toward housing costs. In contrast, members without vouchers were found to pay substantially higher proportions of income, ranging from 31% - 89%, including some members that were documented as paying more than 100% of income toward housing. Staff expressed ongoing concern about the shortage of affordable housing in the community, noting that access remains challenging even for members with vouchers. Most records reviewed showed PSH or clinic staff engaging members in budgeting discussions, providing information about community resources, and assisting with utility-assistance applications. One record documented PSH staff coordinating	• To the extent possible with consideration for market factors, continue to work with tenants that are paying over 30% of income toward housing to find more affordable units. Consider assisting tenants in applying to assistance programs or finding employment to help mitigate rental costs. • 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.

			with clinic staff regarding a member's need for a food box. Based on rent-to-income data provided for 91 housed members, members of the program are paying an average of 47.03% of their income toward rent. Data was missing or incomplete for 31 housed members.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	PSH staff reported that voucher holders must pass HQS inspection prior to moving in. Members without housing vouchers do not receive HQS inspections. PSH staff reported conducting internal housing inspections to assess cleanliness, safety, and potential pest concerns. Staff complete a home visit form every three months to evaluate safety conditions, and during these visits staff advise members to submit maintenance requests when repairs are needed, offering assistance with work orders as appropriate. Data provided showed that 13% of housed members had current and passing HQS inspection reports. HQS inspections for six members were expired. Documentation of PSH home visit inspections were not seen in the records reviewed.	• Consider developing procedures for staff to collect copies of current HQS reports. Work with voucher administrators and other entities to collaboratively share current HQS reports with PSH service providers as a best practice to support tenant self-advocacy and eviction prevention. • Expand the existing home-visit inspection process to more closely align with HUD Housing Quality Standards. Using a standardized, HQS-informed checklist during move-ins and quarterly home visits would promote consistent assessment of safety and habitability, strengthen documentation of unit conditions, and support timely follow-up with property management. Implementing this enhanced tool across the program will improve monitoring of housing quality and increase alignment with PSH fidelity expectations.
Dimension 4 **4.1 Housing Integration**				

4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Program data indicated that housing units are dispersed throughout the community, with members living in a variety of neighborhoods rather than in concentrated or clustered locations. Per the data, nine housed members (7%) reside in settings located in close proximity to housing reserved for individuals that meet disability-related criteria. Staff reported that instances of members residing near one another occur naturally due to limited affordable housing options in certain areas, rather than intentional grouping by the program. PSH staff emphasized prioritizing member choice by assisting with applications, exploring private landlord options, and identifying units within members' income limits.	
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	PSH and clinic staff reported that all housed members have a signed lease or lease-like agreement. The program has developed a "family and friends" lease for situations where members reside with informal supports. Staff noted that this agreement sometimes meets resistance from family members but was developed to help verify basic tenancy expectations. Staff assist as needed by discussing the purpose of the agreement with families. The member, PSH, and clinic staff interviews confirmed that leases do not contain any special provisions outside of standard rental requirements. PSH staff reported attending lease signings when aware of a member's move-in date, to provide	• PSH programs obtain and maintain current copies of leases for 90%, or more, of housed members. Ideally, PSH programs accompany members during new lease signings and lease-ups. Work with members to support them during these times, consequently obtaining a copy of the lease to be used later as a reference when educating tenants on their rights and responsibilities with the intent to maintain stable housing and prevent eviction.

			support and ensure the member understands tenant rights and responsibilities. Program data indicates limited retention of member leases, with approximately 10% of housed members having a current lease on file.	
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Approximately 20% of housed members reside in settings where tenancy is linked to program provisions, such as staffed or treatment-oriented environments. Housing data indicated that most housed members live in settings where tenancy is not contingent on participation in services or compliance with program requirements. One member reported having no rules beyond those in the standard lease, which typically prohibits violence, criminal activity, drug use, and domestic violence.	
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	Interviews with clinic and PSH staff indicated consistent use of the *Housing First* model, noting that tenants are not required to demonstrate housing readiness to access PSH services or housing opportunities. PSH staff confirmed that the primary requirement for enrollment is a referral from the member's clinical team, though many referrals now originate through the UniteUs platform. Staff emphasized that members do not need to be linked to a health home to begin PSH services. Before beginning the physical housing search, members must obtain identification; however, PSH staff assist with securing all required documents, including identification cards, Social Security cards, birth	• Reinforce consistent *Housing First* practices by reducing variability in how engagement and readiness are interpreted across staff. Implement a clear outreach protocol prior to ensure members are not exited prematurely due to limited engagement. Emphasize that documentation barriers or behavioral health needs should not delay access to housing, and ensure this expectation is applied uniformly across PSH and clinical teams.

			certificates, and award letters. Staff described an educational and supportive approach, meeting members where they are in recovery and providing guidance regardless of substance use, treatment engagement, or functional challenges. Staff reported that no one is turned away due to perceived lack of readiness. Clinical staff reported that housing is prioritized even when members have unmet treatment needs. Staff from one clinic reported assessing whether members possess basic documents, such as an identification or Social Security card; however, the absence of these items does not prevent referral to the PSH program, and staff assist members in obtaining any needed documentation. Staff from the other clinic reported that members that do not engage in the housing search after multiple outreach attempts may be closed from PSH services due to lack of participation, not readiness criteria.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	PSH staff reported that members with obstacles to housing stability are informally prioritized using the VI-SPDAT tool, which assesses vulnerability and need. Staff noted that members that are unhoused are given priority for services; however, this is a team practice rather than an agency protocol. The PSH program flyer outlines available services, including housing transition and navigation, home management, budgeting assistance, health and wellness support, and linkage to community resources but it does not define any prioritization criteria. Clinical teams reported not utilizing a structured prioritization process when referring members for	• PSH is specifically designed to support individuals with significant behavioral health challenges in living independently in the housing of their choice through a combination of affordability tools and wrap around supports that are available upon request. In the EBP of PSH, individuals that are the most vulnerable to housing instability/homelessness are prioritized for housing supports. • Develop and formalize an agency-wide prioritization protocol to ensure members with significant housing

			PSH services. Referrals are submitted and supported in the order they are received.	barriers are consistently prioritized for PSH services. • Ensure staff across all provider clinics assisting members with accessing permanent supportive housing and services have an accurate and common understanding of eligibility and prioritization of PSH services. A lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Interviews with PSH and clinic staff indicated that tenants maintain full control over staff entry into their units. PSH staff do not possess keys and may only enter when invited by the member. Home visits are scheduled in advance, and staff do not enter units without explicit permission. When PSH staff are unable to reach a member and have concerns for the member's safety, staff first contact the clinical team and the member's emergency contacts. If necessary, staff may request a wellness check through property management or local law enforcement, but is used as a last resort. The member interviewed confirmed that staff cannot enter their unit without the member's consent.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of Tenant Preferences				
7.1.a	Extent to which tenants choose the type of services they	1 or 4 4	Interviews with PSH and clinic staff, along with member feedback, indicated that tenants have the opportunity to choose the services they wish to receive upon program entry. A review of clinic service plans confirmed the inclusion of individualized living skills and housing goals.	

	want at program entry		However, many plans reflected similar goal areas across members, such as independent living skills, housing support, medication management, and skill development, suggesting some use of standardized goal templates. The member interviewed reported initially identifying personal goals and working collaboratively with clinic staff to develop an individualized service plan. However, due to staff turnover and limited communication from the assigned clinical team, the member described difficulty maintaining engagement and receiving consistent support. A review of ten records showed that seven clinic service plans included a basic housing goal or documented a referral to RH for housing support. One record did not include a current service plan. Two additional records did not contain a clinic service plan, although both members were identified as being connected to a clinical team.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinical staff reported that service plans are reviewed and updated at least every six months, or sooner upon a member's request, allowing members to modify their chosen services as needed. Staff noted barriers to timely updates, including scheduling challenges and difficulty reaching members that are unhoused or lack reliable phone access.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the	1 – 4 4	PSH staff reported that members have full flexibility in choosing the services they receive, including the option to decline services altogether. Neither the PSH program nor voucher administrators require participation in specific services. Members may	

	services they receive		self-refer, select only the supports they want, or opt out of clinical services once housed. Commonly offered services members can choose from include support with securing housing, independent living skills, time management, budgeting, employment goals, accessing community resources, navigating vouchers, and developing coping skills. A review of PSH service plans showed that while housing needs are addressed in the general service plan, supplemental support plans are individualized and tailored to each member's specific needs. Of the ten records reviewed, eight contained a recent service plan. One record had no service plan, and one included a service plan that had been expired for more than two years. All records reviewed contained a current support plan.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	PSH staff reported that services are individualized and can be adjusted at any time based on members' changing needs or preferences. While many members request similar services, staff work with each individual to identify specific goals and tailor supports accordingly. Service plans are updated when members' want to add, revise, or shift goals, and are formally reviewed at least every six months. Staff described collaborating with members to determine preferred frequency of contact, which typically includes weekly meetings for housed members and more frequent contact, often daily, for unhoused members. As members progress, services are adjusted to reflect their evolving goals, and discharge occurs when the member feels their objectives have been met. One staff reported being	• Strengthen consistency in how services are adjusted by formalizing a process for regularly revisiting and updating member goals. While services are updated as needed, creating a clearer structure such as prompts during monthly contacts or a brief goal-review checklist would help ensure members are routinely offered opportunities to revise goals and preferences. Standardizing how staff document changes in member needs will also support more individualized, responsive services across the team.

			a certified Peer Support Specialist and offering peer services to all members. Reviewers were provided with a copy of the agency policy *Outreach and Engagement 3.21*, which includes criteria and guidelines for outreach and re-engagement for members receiving services across various RH programs; however, the PSH program was not included in the document. Of the 10 records reviewed, five showed members that missed appointments without documented follow-up from PSH staff. Of those, one showed a member struggling to remain engaged. Although documentation noted a conversation in which the member reported being ill, the program issued a letter notifying the member of the discontinuation of PSH services two weeks later due to a lack of contact. There was no documentation indicating coordination with the clinical team prior to closure. The member interviewed was not aware of the additional services offered through the PSH program. The member reported recently obtaining housing with assistance from PSH staff, noting that it took approximately two to three months to secure a housing voucher. Staff provided support throughout the process and explained each step involved.	
7.3 Consumer-Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 1	PSH staff reported that the agency distributes an anonymous survey once annually, which includes open-ended questions aimed at gathering member feedback about overall services. Additionally, the PSH team facilitates a weekly Tuesday group where members receiving PSH services can share what is working well and what challenges they are	• Offer members an opportunity that allows them to anonymously submit questions, concerns, and suggestions for program improvement. Consider options to facilitate member/tenant forums using videoconference and/or conference calls so that

			experiencing with their housing search and stability. While members have opportunities to voice concerns and suggestions, staff noted that the Tuesday group primarily focuses on independent living skills and community resources rather than serving as a structured mechanism for shaping or guiding the PSH program.	members can voice their concerns and desires for program design. • Explore additional ways to solicit and incorporate member input on program design and service provision. For example, explore if members can serve on sub-committees to the agency board of directors, participate in quality management, or other processes that impact service design and provision.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 2	At the time of the review, the PSH program served 143 members with five full-time Housing Specialists with a member-to-staff ratio of 29:1. Housing specialists reported caseloads ranging from 19 to 25 members, primarily individuals with SMI. Staff noted that caseloads were previously mixed due to staffing shortages, and two specialists each continued to carry one General Mental Health (GMH) member that had not yet been transferred to the PSH GMH team.	• The optimum caseload size for PSH services providers is 15 members to every staff, providing flexibility and responsiveness to support members in obtaining and retaining housing. • Ideally, the ratio of tenants to service staff to is no more than 15:1. With the current program structure of a HS with primary duties of managing housing searches, tenancy documents, and delivering rental payments, a fourth service staff seems necessary to achieve the ideal tenant to staff ratio.
7.4.b	Behavioral health services are team based	1 – 4 2	PSH and clinic staff interviews indicated that behavioral health services are primarily delivered through individual providers rather than through a team-based model. During the PSH intake, members determine their preferred contact frequency, and PSH staff deliver housing-focused supports independently of the clinical teams. PSH staff do not participate in integrated team meetings and reported no longer sending monthly	• Optimally, behavioral health services and PSH services are provided through an integrated team. With separate sets of staff at each branch of agency, there are barriers to integrated service, including maintaining separate record sets, with possibly redundant information.

			summaries to clinics, as the summaries were determined to be an ineffective method of coordination. Coordination with clinics occurs primarily by phone or email during crises, transitions, discharge planning, or when reporting a lack of member contact. PSH staff noted that collaboration varies significantly depending on the clinic and assigned case manager, and communication is often limited due to staff turnover and inconsistencies in follow-up. While PSH staff participate in staffings as needed and provide updates when concerns arise, routine team-based coordination is not in place. Clinical teams interviewed described coordination with the PSH program as minimal. Clinics retain responsibility for psychiatric services, housing referrals, and case management, with limited ongoing collaboration between clinical teams and PSH staff. Records reviewed confirmed limited coordination between the PSH program and clinical teams. One record showed PSH staff emailing a clinic Case Manager to request a food box for a member.	• To more closely align with the EBP, consider scheduling regular planning sessions between the PSH provider and clinic staff to coordinate member care, supporting an integrated treatment team approach. Soliciting input and sharing updated service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 3	PSH staff reported that services are primarily available Monday through Friday from 8:00 a.m. to 5:00 p.m. The program does not maintain a formal on-call system due to limited member use; however, staff noted that members are aware of available crisis resources and can access 24-hour support through on-call and warm lines operated by their clinical teams, as well as the national crisis line. During regular business hours, PSH staff are available to assist members in the community and	• Consider expanding after-hours support options to better align with PSH best practices. While members currently rely on crisis and warm line services outside of business hours, developing a formalized on-call structure or scheduled after-hours availability would improve access to non-emergent housing-related support Establishing clear guidelines

			will coordinate with clinical teams when crises arise. Staff reported that, with supervisor approval, staff can adjust work hours to accommodate members' needs by working designated evenings and weekends upon request; however, these instances are infrequent and are not a standard component of service delivery. The member interviewed expressed awareness that PSH staff were not available after hours or on weekends. Records reviewed show that crisis plans are collaboratively developed between members and clinic staff. The RH service plan (support plan) outlines how members present when well or dysregulated, indicators of mood changes, behaviors to monitor, and strategies to support regulation. PSH staff reported creating initial support plans with members referred from external agencies during intake. For internal referrals, staff and members review the existing support plan. It was unclear whether staff review the full plan during intake or focus only on housing-related goals.	for weekend or evening coverage—whether through rotating staff, designated crisis-response protocols, or collaborative agreements with clinical teams—would enhance housing stability and ensure members can receive timely assistance when urgent housing needs arise outside standard business hours.

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1, 2.5, 4	4
1.1.b: Real choice of housing unit	1 or 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		3.63
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1, 2.5, 4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, 4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1 - 4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1 - 4	2
3.2.a: Whether housing meets HUD's Housing Quality Standards	1, 2.5, 4	1
Average Score for Dimension		1.5
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1 - 4	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 or 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 or 4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1 or 4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1 - 4	4
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1 - 4	3
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	2
7.4.b: Behavioral health services are team based	1 - 4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1 - 4	3
Average Score for Dimension		2.88
Total Score		21.68
Highest Possible Score		28