PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: February 16, 2017

To: Frank Scarpati, CEO
Damian Hudson, Permanent Supportive Housing Supervisor

From: T.J. Eggsware, BSW, MA, LAC
Jeni Serrano, BS
AHCCCS Fidelity Reviewers

Method

On January 17-19, 2017, Jeni Serrano and T.J. Eggsware completed a review of the Community Bridges, Inc. (CBI) 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 Maricopa County.

CBI offers services that include prevention, education, and treatment services throughout Arizona. CBI provides PSH support services to 122 members, based on data provided. Approximately 84% of members are housed, most in scattered site housing with a voucher obtained through the Regional Behavioral Health Authority (RBHA) referral process. Most other members (about 15%) are homeless. Members are referred to the CBI PSH program through two main routes: (1) members apply for a scattered site housing voucher through the RBHA, are put on a waitlist, and when issued a voucher are offered services from a list that includes CBI and other providers (or elect to have no provider or services); (2) members who need assistance with their housing search and/or members who request in-home supports may be directly referred by clinic staff. Due to the nature of the referrals, which originate at external clinics, information gathered at the Lifewell Behavioral Wellness Oak and Southwest Network Highland clinics were included in the review, with a focus on co-served members.

The individuals served through the agency are generally referred to as *clients* or *patients*, but for the purpose of this report, and consistency with other fidelity reviews, the term "tenant" or "member" will be used.

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

- Group interviews with one clinic Housing Specialist (HS) and one Case Manager (CM) at Lifewell Behavioral Wellness Oak;
- Group interview with one HS and two CMs at Southwest Network Highland;
- Interview with the Permanent Supportive Housing Supervisor of CBI (i.e., PSH Administrator);
- Group interview with three CBI PSH direct service staff (i.e., Navigators);
- Interviews with eight tenants who participate in the Permanent Supportive Housing program;
- Review of ten randomly selected records at clinics and CBI;

- Review of leases and Housing Quality Standards (HQS) inspections; and,
- Review of agency documents, including: *MMIC SMI Permanent Supportive Housing Briefing Form*, *Income Disclosure Refusal Form*, *Housing Quality Standards (HQS) Awareness Form*, *Tenant Rights Awareness Form*, *Choice of Services Form*, survey form, *Honest Monthly Budget* worksheet, *Housing Assessment* form, program brochure, Navigator II job description, new employee orientation tracking, Navigator Program policy, PSH program referral workflow, and agency administrative organizational structure.

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:

- Based on clinic staff report, members determine the housing option pursued. It appears staff at the clinics use a *Housing First* approach, generally do not screen members for readiness to live independently, or determine the options offered to members. Treatment (e.g., in residential setting) is not mandated as a prerequisite to independent housing.
- CBI PSH staff interviews suggest staff is trained and knowledgeable about the evidence-based practice of PSH, the *Housing First* approach, the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT), with some staff trained in Supplemental Security Income/Social Security Disability Insurance Outreach, Access and Recovery (SOAR), and SPDAT. It appears clinic staff has learned about PSH services, in part, through interactions with CBI PSH staff.
- Staff and tenants confirm that scattered site units are integrated in the community, and PSH staff reportedly work to build a network of integrated housing options that can be explored with members. Once referred to CBI, members appear to have choice of unit.
- CBI staff may serve as a resource to other agencies that struggle to locate housing for members, or to build relationships with landlords. Though market factors or individual landlord exclusions may pose barriers to assisting members with locating housing, it appears CBI Navigators have an open-minded approach to the housing search with members, utilizing resources and relationships with landlords they cultivate, and remaining open to searching out new opportunities with members.

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

- The agency should continue to enhance program PSH materials and resources to distinguish those supports from other agency services. For example, it appears PSH is currently listed under *Supportive Services* on the agency website. Consider noting that the agency offers PSH services with a link to PSH resources and the current supervisor's contact information. Review CBI admission documents and remove any that are not connected to the PSH program. For example, in one record a member signed a residential rules form. In PSH agency documents provided for review, a *Housing Assessment* form was included, which prompts the person completing the form to report certain issues, including lease compliance, to property management.
- The program should continue efforts to obtain rental payment information, leases or residency agreements, HQS reports and other housing related documents for all members who receive supported housing services through the program. Consider developing mechanisms to track the term of the lease for members, so service staff can proactively assist tenants with lease renewals or relocation services.
- Treatment plans at clinics and CBI should reflect individual member goals, needs, and objectives, and be modified as statuses change. As much as possible, use the words of the members as they author their plans.
- In PSH, all behavioral health services are provided through an integrated team. If this is not possible due to the current structure of the system with separate service providers, it is recommended that all involved providers hold regular planning sessions to coordinate care in order to work more fluidly as a team, and to prevent duplication of efforts or conflicting approaches. Ongoing coordination with clinic CMs and other involved providers, including soliciting input into the service planning process and sharing of written documentation, is encouraged if an integrated health record or services through an integrated team cannot be implemented.

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 (4)	Clinic staff report they do not screen members for independent living readiness, do not limit the housing search based on availability, and all SMI members are eligible for independent housing and PSH services. Although the clinical team may recommend treatment versus independent housing, they report the member ultimately determines the option pursued. Most tenants confirmed their preference was honored. One tenant reported they were required to go through treatment prior to independent housing; however, this reportedly occurred several years prior to the review. Tenants interviewed, and most member records reviewed indicated the tenants receive a voucher. In general, it appears CBI tenants have a choice of housing.	
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)	The majority of CBI PSH tenants received a voucher and were able to choose a unit on the open market in Maricopa County that was within their budget, if accepted by the landlord or property management. CBI PSH Navigators help tenants search for a unit, as well as coordinate the move-in process. CBI staff report that the housing search begins with identifying the member's preferences, including area of town, with staff supporting members to apply for locations based on those preferences. Staff does not put restrictions on visiting locations, or areas of town. This may result in members experiencing the process of applying for housing, and being	

			accepted or not accepted. These are viewed as learning opportunities for members and staff. Despite the team's efforts, market factors can limit the housing options for some members. For example, members with felony conviction histories or eviction histories have fewer options, some landlords no longer accept vouchers, and some tenants have had to move due to rent increases.	
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 (4)	Members who receive a scattered site housing voucher are given 30 days to find a housing unit. Extensions can be arranged, usually by the clinical teams if needed. However, as documented in one record reviewed, CBI PSH staff can be actively involved in working with members to secure extensions. It appears tenants can wait for a unit of their choice.	
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)	Staff and tenants interviewed confirmed that tenants have control over the composition of their household. A minority of PSH tenants reside with others, including children, partners or other family. However, it appears the clinic team must approve for tenants to have others reside with them if they receive a subsidy. If tenants want someone to move into their residence, CBI staff refers back to the clinical team to make the determination. This puts some restriction on tenant control over the composition of their household, but it does not appear tenants are forced to live with others not of their choosing.	• CBI can advocate in an effort to empower tenants to have full control to determine the composition of their household rather than deferring to clinic team control. Staff at the clinic and PSH agency can work together with the tenant to discuss pros, cons, potential impact, etc. to tenants of having someone join their living situation. CBI staff referring this decision back to the clinical team does not relinquish CBI's role in the potential outcome (i.e., tenants not in control of the composition of their household).
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 (4)	Housing management staff has no authority or role in providing social services. For example, landlords are not invited to staffings unless	

	providers do not have any authority or formal role in providing social services		requested by the tenant. Per report of the CBI staff and tenants, service provider interactions with landlords are at the request of the tenants, when advocacy or support is needed. PSH staff have relationships with some landlords who may inform the service staff if tenants are struggling, but it does not appear management role in service provision extends beyond those types of courtesy calls.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 (2.5)	Staff and tenants reported that CBI staff do not have any responsibility for housing management functions, are not required to act on behalf of landlords, do not report potential lease violations, do not request repairs, do not deliver eviction notices, do not collect rent, etc. However, in the agency documents provided for review, there is a CBI *Housing Assessment* form. The form has space to enter tenant name and address, and yes or no responses for: bed bugs, community behavior, unnecessary clutter, change in income, lease compliance, unauthorized guests, property damage, and condition of unit/apt. If any of the items are marked yes, the person completing the assessment is instructed to inform property management.	• Eliminate the *Housing Assessment* form. Service staff should not have overlap with housing management functions, should not report lease issues, etc. Work with tenants to educate them on the potential consequences of the issues listed on the *Housing Assessment* form, and to resolve those issues if present, but do not ask service staff to report to housing management.
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	For the majority of tenants, social and clinical service providers are based off-site. PSH Services are readily accessible, mobile and can be brought to tenants at their request. A small minority of members reside in settings where social service staff may be on site (e.g., group home or project-based housing), but no CBI staff maintains office space where tenants reside.	
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)	Tenant housing costs range from 0-30% of their income for those tenants who receive a housing subsidy, which includes approximately 95% of the housed members. All interviewed tenants receive rental subsidies. Tenants with no income pay zero toward housing costs. Five tenants pay between 42% and 72% of income toward housing.	• For members who pay more than 30% of income toward housing costs, continue to explore tenant housing preferences in an effort to locate more affordable housing.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 (1)	The agency provided HQS documents, but some were not completed in the year prior to review or indicated the unit did not pass, with no subsequent passed inspection. As a result, evidence that units met HUD's HQS was confirmed for 58% of tenant units.	• Ensure housing service staff are informed about HQS and can advocate with tenants to ensure all units meet quality standards. Develop mechanisms to track when HQS were completed so PSH staff can obtain updated inspections as they occur.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 (4)	CBI staff, clinical staff and tenants interviewed report housing units are integrated. However, CBI and clinic staff report there are challenges to locating housing for some members which may result in unintentional clustering. A subset of tenants reside in areas where other members reside due to factors that include: fewer options exist for members with felony conviction histories, barriers to housing members with eviction histories, and some landlords no longer accepting vouchers. As a result, a small number of tenants reside in non-integrated settings (e.g., about 25% of tenants at one small complex receive PSH through CBI).	
Dimension 5 Rights of Tenancy				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have	1 or 4 (1)	Though the majority of tenants (67%) have a current lease, the extent to which tenants have	• The agency should attempt to obtain tenancy documentation, including leases,

	legal rights to the housing unit		legal rights to the housing unit could not be verified for all members. Some leases provided were not current, and a small number of members are in settings where they may not have legal rights to the housing unit (e.g., those who live with family, and one member in a group home).	addenda to leases, or residency agreements for all members. Develop mechanisms to track when tenant leases will end, expire, or terminate so that PSH service staff can proactively support tenants on the process of renewing a lease.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 (4)	For most members (about 98%), tenancy is not contingent on compliance with program provisions or participation in treatment. Staff reported, and tenants interviewed confirmed, that they are not required to participate in services through CBI in order to maintain tenancy; they can start, stop or restart services at any time they choose. It appears that tenants who disenroll from the RBHA system may lose their housing subsidy, but can maintain tenancy as long as they adhere to their lease, pay their rent, etc. However, in one record it was documented that a CM informed the CBI Navigator that a member had not attended a clinic appointment for about five months, and was required to meet with the doctor every three months in order to continue services and housing. Other than this example, there was no other evidence tenancy was contingent on compliance with program provisions.	• Ensure clinic staff is educated that tenancy is not contingent on program provisions.
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 (4)	Most clinic staff interviewed are familiar with a *Housing First* approach, noting that it may be easier for other issues to be addressed once tenants are in stable housing. Although some clinic staff seemed to associate PSH services primarily with voucher programs, it appears PSH support is available even if members do not have a voucher. CBI staff and tenants interviewed reported that	

			there is no required readiness to enter the program. Once members receive the scattered site housing voucher, they select from a list of service providers. PSH agencies present their services to potential members at housing briefings after vouchers are distributed, members select the provider, and the CBI staff assists in the housing search. Some members who are already housed are referred by clinic staff to CBI for services. Some of those members have a voucher and some do not have a voucher.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (2.5)	If a member requests housing, the clinic team will submit a housing application and the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) to the RBHA. Clinic staff confirmed members must be homeless to apply for the RBHA affiliated scattered site housing voucher. Per the RBHA website, Permanent Supportive Housing is available for enrolled homeless adults determined to have a SMI, and have a VI-SPDAT score in the range for Permanent Supportive Housing. The RBHA defines homeless as "individuals or families who don't have a fixed, sustainable or appropriate nighttime residence" which includes: a public or private place not meant for human habitation, a shelter designated to provide temporary living, and members being discharged from an institution (e.g., residential treatment center or similar facility, a behavioral health inpatient stay or a physical health hospitalization), and they were admitted to the institution as homeless. Reviewers were unable to confirm that members with housing challenges other than these circumstances are prioritized. However, clinic staff can directly refer members to CBI for PSH services, whether or not they have a voucher.	• With the current system structure, CBI has limited capacity to fully align housing priority with the EBP criteria. However, PSH services are not just limited to members who qualify for RBHA affiliated housing vouchers, so CBI staff should continue their efforts to explore other independent housing options, promoting the benefits of PSH services and developing relationships with landlords and housing providers.
6.2 Privacy				

6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 (4)	CBI staff and members interviewed confirmed that the PSH staff does not enter tenant units without permission. CBI staff do not have keys to units or ask housing management for entry. CBI staff reported that if they are concerned about a tenant they notify the tenant's clinical team for follow up. A small number of members (2% or less) reside in settings where they may not have full control over entry to their unit (e.g., group home).	
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 (1)	As reported by one clinic staff, plans are written in general terms to last for a year. Clinic plans reviewed generally seemed to identify member goals, but documentation was not located in all records that members were involved, or if goals were consistently written in the member's words. In some cases, objectives or needs identified appeared to be written from the clinical team perspective, using clinical jargon. For example, a living situation goal for a member to maintain mental health. Some clinic plans did not reflect PSH services through CBI. The format that clinic staff write service plans varies widely. For example, information documented under needs on some plans, are documented under the service section of other plans.	• Ongoing staff training should occur regarding how to work with members to develop personalized goals, and to identify needs and objectives. All service plans should be individualized and directly reflect the expressed goals, needs, and action steps for achieving those goals. Identity and resolve barriers to plans not reflecting specific services provided.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (1)	Clinic staff reported that service plans are updated at least annually but can be modified earlier if needed. However, evidence of modifications was not located. Clinic staff could not cite examples of addendums or revisions to plans. Evidence of annual or modified clinic plans could not be verified in CBI records as only one clinic plan was located in CBI files (i.e., at admission to CBI). CBI	• Afford tenants with opportunities to modify their plans. CBI and clinic staff should obtain input from each other when developing plans at each provider if an integrated single plan is not an option.

			staff reported CBI plans are reviewed every 30 days, and updated every 90 days, but evidence of those revisions were not located in all records.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	Per CBI staff report, once enrolled, tenants are able to change their service frequency, or decline participation in PSH services at any time and remain housed. Tenants can decline services through CBI, but it appears they must maintain services through the clinic RBHA system in order to maintain housing subsidy supports. CBI plans are developed at admission by staff that are not part of the PSH program. CBI plans seemed to be written using clinical jargon. For example, a member goal statement of "the client states he wants to maintain housing, have living skills, transportation and peer support." On some CBI plans, the goals were restated as needs. For example, under one member goal it was noted the person wanted to have living skills, and the need indicated the person needed independent living skills. Staff confirmed, and plans reviewed reflected that the same elements are included on all plans: peer services, independent living skills, transportation services. Revisions or modifications to plans after the initial plans were not located in all CBI records reviewed.	• System partners should collaborate to develop mechanisms for tenants to choose from an array of services, including the option of not having services (e.g., to ask for case management or refuse case management). • Clarify with staff the issue of whether the housing subsidy can be maintained if a tenant closes from RBHA services.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (4)	The actual services provided by Navigators appear to be flexible and can adapt type, location, intensity and frequency based on tenants' changing needs or preferences. There were multiple examples of Navigators assisting members to obtain food boxes, arranging transportation to complete various tasks in the community, discussing benefits, coordinating voucher extensions, working with a member to locate housing, and using the agency vehicle to	• Ongoing training should occur regarding how to work with members to develop personalized goals and objectives. • Ensure outreach and engagement occurs and is documented when members are not in contact with the team or PSH staff.

			assist tenants move into a residence. However, in some cases, there were lapses in documented outreach and coordination with clinic teams when members were not in contact with PSH staff. CBI staff reported the plans are reviewed every 30 days, and updated every 90 days, but this was not confirmed in records reviewed.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 (3)	CBI employs Certified Peer Support Navigators who provide housing support services to tenants in the PSH program. Tenant satisfaction is measured through individual feedback (e.g., satisfaction survey), and check-ins with staff when services are provided. The agency developed a quarterly tenant forum, which is described in program admission paperwork; members are invited to participate and to provide feedback to improve PSH services. Staff and tenants confirmed that tenant feedback regarding Navigator schedules (most work four ten hour days) was provided during a forum, with tenants requesting more flexible staff schedules to assist with unplanned issues that arise. The outcome was that the program adjusted one staff schedule to allow for additional coverage.	• CBI should build on the quarterly forums and develop other opportunities to solicit input from those receiving services, and for tenants to drive services.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	At time of review, CBI has 12 Navigators serving 122 members. Caseloads average less than 11 tenants to each Navigator. However, some tenants interviewed cited frequent changes in Navigator staff, often due to staff promotions within the agency.	
7.4.b	Behavioral health services are team based	1 – 4 (2)	Members receive services through clinics and may be referred to multiple external providers, including CBI. As a result, for some tenants, multiple providers are involved in delivering	• Preferably, all behavioral health services are provided through an integrated team. If this is not possible due to the current structure of the system with separate

			services. CBI and clinic staff report that they usually coordinate via phone calls, emails and occasional staffings. Staff at each agency complete service plans, but do not solicit input from each other, nor do they share updated plans. Some plans had other providers listed other than CBI or clinics, but evidence of coordination was not located in all cases. Documentation in CBI records indicated outreach by Navigators to CMs, usually when an issue or concern arose with a member, to bring a member to a clinic appointment, or in an effort to locate a member. However, in some CBI records, limited outreach to tenants or clinic staff was documented, with lapses of a month or more in some cases. CM contact with CBI staff was documented sporadically in clinic files.	service providers, it is recommended the full clinical team and PSH service provider hold regular planning sessions to coordinate care in order to work more fluidly as a team. Ongoing coordination with the clinic CM, soliciting input into the service planning process, and sharing of written documentation, is encouraged if an integrated health record cannot be implemented.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (3)	CBI staff report that services are provided daily from 7:00 am to 5:00 pm. Navigators can flex their time to accommodate activities in the morning or evening hours, but later evening or overnight coverage is not available through the PSH team. A list of after hour numbers is provided, and, if there is a crisis overnight, members contact the agency Access to Care staff (who are not part of the PSH program), and the PSH supervisor is on-call to offer support via phone and coordinate with crisis and/or clinical team. However, the PSH staff do not go into the field after hours. Tenants interviewed reported if a crisis arose they would contact the crisis line, and that Navigators were generally not available after 5:00 pm. However, one tenant who reportedly attends quarterly forums reported the issue was discussed and the agency was working to develop a resolution.	• Optimally, PSH services should be available 24 hours a day, seven days a week. Evaluate how the program can make adjustments so that PSH staff are available to respond to tenant issues or crisis beyond the flex-schedules currently available in the earlier morning or early evening hours. Rely on PSH staff to provide support to tenants, building on the rapport and relationships developed with tenants, rather than other CBI staff (e.g., at the Access to Care line) who may not know the 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	4
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	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	2.5
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		3.5
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	4
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		3.5
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
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	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	3
Average Score for Dimension		2.63
Total Score		22.26
Highest Possible Score		28